CMS Manual System

Pub. 100-24 State Payment of Medicare Premiums

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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SUBJECT: New State Payment of Medicare Premiums, (SPMP)

I. SUMMARY OF CHANGES:
The State Payment of Medicare Premiums manual (formerly called "State Buy-in Manual") provides information and instructions to states on federal policy, operations, and systems concerning the payment of Parts A and B premiums (or buy-in) for individuals dually eligible for Medicare and Medicaid. The manual reissuance is part of CMS' Better Care for Dual Eligible Individuals Strategic Initiative aimed at improving quality, reducing costs and improving customer experiences. CMS significantly revised all chapters of the manual to reflect current statute, regulation, operations, and systems changes that have evolved over time. The manual is re-organized to make it easier for states to discern federal requirements and find information.

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 8, 2020
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Or

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES:

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	State Payment of Medicare Premiums/Table of Contents
N	1/Table of Contents
N	1/Program Overview and Policy/1.0 Introduction
N	1/Program Overview and Policy/1.1 Definitions
N	1/Program Overview and Policy/1.2 Background
N	1/Program Overview and Policy/1.3 Medicare Eligibility and Enrollment
N	1/Program Overview and Policy/1.3.1 Premium-free Part A
N	1/Program Overview and Policy/1.3.2 Premium-Part A
N	1/Program Overview and Policy/1.3.3 Medicare Part B
N	1/Program Overview and Policy/1.3.4 Medicare Enrollment
N	1/Program Overview and Policy/1.3.4.1 Medicare Enrollment Table
N	1/Program Overview and Policy/1.3.5 Medicare Re-enrollment

N	1/Program Overview and Policy/1.4 Requirements for Enrolling Individuals Under Buy-in Agreements
N	1/Program Overview and Policy/1.5 Effect of Buy-in on an Individual
N	1/Program Overview and Policy/1.6 Part B Buy-in Coverage Groups - General
N	1/Program Overview and Policy/1.6.1 Cash Assistance and Deemed Recipients of Cash Assistance
N	1/Program Overview and Policy/1.6.1.1 Supplemental Security Income (SSI) Program
N	1/Program Overview and Policy/1.6.1.2 State Supplement Programs (SSPs)
N	1/Program Overview and Policy/1.6.1.3 Deemed Recipients of Cash Assistance
N	1/Program Overview and Policy/1.6.1.4 Children Eligible Based on Title IV-E
N	1/Program Overview and Policy/1.6.2 Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program (MSP) Groups
N	1/Program Overview and Policy/1.6.2.1 Qualified Medicare Beneficiary (QMB) Program
N	1/Program Overview and Policy/1.6.2.2 Specified Low-Income Medicare Beneficiary (SLMB) Program
N	1/Program Overview and Policy/1.6.2.3 Qualifying Individual (QI) Program
N	1/Program Overview and Policy/1.6.3 All Medicaid Categories
N	1/Program Overview and Policy/1.7 Part A Buy-in Agreement Group - Qualified Medicare Beneficiary (QMB) Program
N	1/Program Overview and Policy/1.8 Conversion From Part A Group Payer to Part A Buy-in Status
N	1/Program Overview and Policy/1.9 Federal Financial Participation (FFP) for Buy-in Categories
N	1/Program Overview and Policy/1.10 Streamlined Enrollment Under a Buy-in Agreement
N	1/Program Overview and Policy/1.11 Conditional Enrollment Process for QMBs to Enroll in Premium-Part A
N	1/Program Overview and Policy/1.12 Policy Regarding Which Entity Initiates Buy-in
N	1/Program Overview and Policy/1.12.1 Part B Buy-in for Cash-Related Recipients (SSI/SSPs)
N	1/Program Overview and Policy/1.13 Definition of Part B Buy-in Coverage Period (See Appendix 1.C)
N	1/Program Overview and Policy/1.13.1 Beginning of Part B Buy-in Coverage (42 CFR § 407.47)
N	1/Program Overview and Policy/1.13.2 End of Part B Buy-in Coverage (42 CFR § 407.48)

N	1/Program Overview and Policy/1.14 Definition of Part A Buy-in Coverage Period (42 CFR § 406.26) (See Appendix 1.C)
N	1/Program Overview and Policy/1.14.1 Beginning of Part A Buy-in Coverage
N	1/Program Overview and Policy/1.14.2 End of Part A Buy-in Coverage
N	1/Program Overview and Policy/1.15 Implications and Options for Beneficiaries When State Buy-in Coverage Ends
N	1/Program Overview and Policy/1.15.1 Voluntary Withdrawal (Termination) From Medicare
N	1/Program Overview and Policy/1.15.2 Options for Financial Relief From Retroactive Part B Premium Billing
N	1/Program Overview and Policy/Appendix 1.A Dual Eligibility Categories and Assistance with Medicare Part A and Part B Costs
N	1/Program Overview and Policy/Appendix 1.B Dual Eligibility Category Descriptions
N	1/Program Overview and Policy/Appendix 1.C Medicaid Effective Dates and Buy-in Start and Stop Dates
N	1/Program Overview and Policy/Appendix 1.D Classification of States by SSI and Part A Status as of July 2020
N	1/Program Overview and Policy/Appendix 1.E Implications and Options for Individuals Who Lose Buy-in Coverage
N	1/Appendices/Appendix 1.F Request for Termination of Premium Hospital and/or Supplemental Medical Insurance
N	2/Table of Contents
N	2/State Buy-in Data Exchange Processes/2.0 Introduction
N	2/State Buy-in Data Exchange Processes/2.1 Overview of State Buy-in Data Exchange
N	2/State Buy-in Data Exchange Processes/2.2 Frequency of State-CMS File Exchange
N	2/State Buy-in Data Exchange Processes/2.2.1 State Input Files
N	2/State Buy-in Data Exchange Processes/2.2.2 CMS Response to States (CMS Billing and Response Files)
N	2/State Buy-in Data Exchange Processes/2.3 Data Exchange Between CMS and SSA
N	2/State Buy-in Data Exchange Processes/2.4 Federal Resources for States to Support Buy-in and Medicaid Operations
N	2/State Buy-in Data Exchange Processes/2.4.1 CMS Data Systems for States
N	2/State Buy-in Data Exchange Processes/2.4.1.1 Territories and States Beneficiary Query (TBQ) File
N	2/State Buy-in Data Exchange Processes/2.4.1.2 Enrollment Database (EDB) File

N	2/State Buy-in Data Exchange Processes/2.4.1.3 Medicare Advantage Prescription Drug System User Interface (Marx UI)
N	2/State Buy-in Data Exchange Processes/2.4.1.4 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) File Exchange
N	2/State Buy-in Data Exchange Processes/2.4.1.5 Table of CMS Files That Provide Data on Medicare Eligibility
N	2/State Buy-in Data Exchange Processes/2.4.2 SSA Data Systems for States
N	2/State Buy-in Data Exchange Processes/2.4.2.1 State Verification and Exchange System (SVES)
N	2/State Buy-in Data Exchange Processes/2.4.2.2 State Online Query (SOLQ)
N	2/State Buy-in Data Exchange Processes/2.4.2.3 Beneficiary and Earnings Data Exchange (BENDEX)
N	2/State Buy-in Data Exchange Processes/2.4.2.4 State Data Exchange (SDX)
N	2/State Buy-in Data Exchange Processes/2.4.2.5 Low-Income Subsidy (LIS)
N	2/State Buy-in Data Exchange Processes/2.4.2.6 Table of SSA-State Data Exchanges
N	2/State Buy-in Data Exchange Processes/2.5 Accretions
N	2/State Buy-in Data Exchange Processes/2.5.1 Part B Buy-in Accretions
N	2/State Buy-in Data Exchange Processes/2.5.1.1 Part B Buy-in for Cash Assistance Recipients (SSI/SSPs)
N	2/State Buy-in Data Exchange Processes/2.5.1.1.1 Auto-Accrete States and States with Federal Administration of SSPs
N	2/State Buy-in Data Exchange Processes/2.5.1.1.2 Alert States
N	2/State Buy-in Data Exchange Processes/2.5.1.2 Members of The Buy-in Coverage Group Who Do Not Receive Cash Assistance
N	2/State Buy-in Data Exchange Processes/2.5.2 Part A Buy-in Accretions
N	2/State Buy-in Data Exchange Processes/2.5.3 Important Processing Rules for MSP Accretions
N	2/State Buy-in Data Exchange Processes/2.5.3.1 Required Steps for QMB, SLMB, and QI Part B Buy-in Accretions
N	2/State Buy-in Data Exchange Processes/2.5.3.2 Part B Before Part A Rule for QMB Accretions
N	2/State Buy-in Data Exchange Processes/2.5.3.3 Part A Buy-in State v. Group Payer State Status
N	2/State Buy-in Data Exchange Processes/2.5.4 CMS Adjustment of State Accretion Effective Date to Coincide with Medicare Enrollment
N	2/State Buy-in Data Exchange Processes/2.6 Deletions

N	2/State Buy-in Data Exchange Processes/2.6.1 State-Initiated Deletions
N	2/State Buy-in Data Exchange Processes/2.6.1.1 Medicare Parts A and B Deletions Based on Loss of Buy-in Coverage
N	2/State Buy-in Data Exchange Processes/2.6.1.2 Special Procedures for an Individual Who Loses SSI
N	2/State Buy-in Data Exchange Processes/2.6.1.3 CMS Processing of Part B Deletions Because A Beneficiary Is No Longer a Member of the State's Coverage Group
N	2/State Buy-in Data Exchange Processes/2.6.1.4 CMS Processing of State-Initiated Part A Deletion Requests Based on Loss of QMB Status
N	2/State Buy-in Data Exchange Processes/2.6.2 CMS-Initiated Deletions
N	2/State Buy-in Data Exchange Processes/2.6.2.1 Death of the Beneficiary
N	2/State Buy-in Data Exchange Processes/2.6.2.2 Beneficiary's Loss of Medicare Eligibility
N	2/State Buy-in Data Exchange Processes/2.6.2.3 Beneficiary Changes of State of Residency
N	2/State Buy-in Data Exchange Processes/2.6.2.4 Deletion as a Result of Another State's Accretion Action
N	2/State Buy-in Data Exchange Processes/2.6.2.5 Change of State Residence for SSI Recipients
N	2/State Buy-in Data Exchange Processes/2.6.2.6 Beneficiary Becomes Entitled to Reduced Or Premium-Free Part A
N	2/State Buy-in Data Exchange Processes/2.6.2.7 Deletions from Other Sources
N	2/State Buy-in Data Exchange Processes/2.7 Changes and Corrections
N	2/State Buy-in Data Exchange Processes/2.7.1 State Correction of a Previously Submitted State Accretion or Deletion Date
N	2/State Buy-in Data Exchange Processes/2.7.1.1 Adjustment to the Start Date – for Ongoing (Code 41) Billing Items
N	2/State Buy-in Data Exchange Processes/2.7.1.2 Adjustment of Accretion or Deletion Date - Closed Period of State Buy-in Coverage
N	2/State Buy-in Data Exchange Processes/2.7.2 State Request for Adjustment of SSI Actions Accreted By CMS
N	2/State Buy-in Data Exchange Processes/2.7.3 State-Initiated Change Records
N	2/State Buy-in Data Exchange Processes/2.7.3.1 Medicare Part B
N	2/State Buy-in Data Exchange Processes/2.7.3.2 Medicare Part A
N	2/State Buy-in Data Exchange Processes/2.7.4 CMS Reply to a State-Initiated Change Record (Code 99)

N	2/State Buy-in Data Exchange Processes/2.8 SSA-Initiated Accretions - Public Welfare Accretion Procedure (Code 1167)
N	2/State Buy-in Data Exchange Processes/2.9 Erroneous PW Accretion - All States
N	2/State Buy-in Data Exchange Processes/2.10 Enrollment of Persons Who Refuse to Establish Medicare Eligibility
N	2/State Buy-in Data Exchange Processes/2.11 State Accretion Procedure to Establish a Closed Period of State Buy-in Coverage
N	2/State Buy-in Data Exchange Processes/2.11.1 Medicare Part B
N	2/State Buy-in Data Exchange Processes/2.11.2 Medicare Part A
R	3/Table of Contents
R	3/State Input and CMS Response File Formats/3.0 Introduction
R	3/State Input and CMS Response File Formats/3.1 State Input
R	3/State Input and CMS Response File Formats/3.2 CMS Output
R	3/State Input and CMS Response File Formats/3.3 Data Exchange Files - States to CMS
R	3/State Input and CMS Response File Formats/3.3.1 State Agency Buy-in Exchange Header Record
R	3/State Input and CMS Response File Formats/3.3.2 State Agency Buy-in Exchange Input File
R	3/State Input and CMS Response File Formats/3.3.3 State Buy-in Exchange Trailer Record
R	3/State Input and CMS Response File Formats/3.4 Matching State Input Records to the CMS Enrollment Database (EDB)
R	3/State Input and CMS Response File Formats/3.4.1 State Input File Matching Criteria
R	3/State Input and CMS Response File Formats/3.5 Data Exchange Files - CMS to States
R	3/State Input and CMS Response File Formats/3.5.1 CMS/TPS Buy-in Exchange Header Record
R	3/State Input and CMS Response File Formats/3.5.2 State Agency SSI Alert Record (RIC-A)
R	3/State Input and CMS Response File Formats/3.5.3 Part A State Agency Billing Record (RIC-B)
R	3/State Input and CMS Response File Formats/3.5.4 Part B State Agency Billing Record (RIC-B)
R	3/State Input and CMS Response File Formats/3.5.5 Medicare Number Change Record (RIC-C)
R	3/State Input and CMS Response File Formats/3.5.6 Part A State Agency Date Change or Reply Record (RIC-D)
R	3/State Input and CMS Response File Formats/3.5.7 Part B State Agency Date Change or Reply Record (RIC-D)
R	3/State Input and CMS Response File Formats/3.5.8 Personal Characteristics Change Record (RIC-E)

R	3/State Input and CMS Response File Formats/3.5.9 State Agency Reject Record (RIC-F)
R	3/State Input and CMS Response File Formats/3.5.10 CMS/TPS Buy-in Exchange Trailer Record
N	4/Table of Contents
N	4/Buy-in Code Descriptions/4.0 Introduction
N	4/Buy-in Code Descriptions/4.1 State Buy-in Eligibility Codes (BIECs) - Position 71 on State Agency Input File and CMS Response Files
N	4/Buy-in Code Descriptions/4.1.1 Table of Buy-in Eligibility Codes
N	4/Buy-in Code Descriptions/4.2 Agency Codes for State Buy-in (Positions 73-75)
N	4/Buy-in Code Descriptions/4.2.1 Table of State Agency Codes
N	4/Buy-in Code Descriptions/4.3 Health Insurance Claim Numbers (HICNs)
N	4/Buy-in Code Descriptions/4.3.1 Table of Beneficiary Identification Codes (BICs)
N	4/Buy-in Code Descriptions/4.3.2 Table of Beneficiary Identification Codes (BICs) for Medicare Qualified Government Employees (MQGE)
N	4/Buy-in Code Descriptions/4.4 Railroad Retirement Board (RRB) Claim Numbers
N	4/Buy-in Code Descriptions/4.4.1 Conversion Table for Nine-Digit Numeric Portion of RRB Claim Number
N	4/Buy-in Code Descriptions/4.5 Table of RRB Prefixes and Equivalent SSA BICs
N	4/Buy-in Code Descriptions/4.6 CMS-Initiated Alpha-Numeric Character Changes to The HICN/MBI
N	4/Buy-in Code Descriptions/4.7 CMS Buy-in Transaction Codes - Positions 77-81
N	4/Buy-in Code Descriptions/4.7.1 Table of CMS Buy-in Transaction Codes
N	4/Buy-in Code Descriptions/4.8 Supplemental Security Income (SSI) Status Codes
N	4/Buy-in Code Descriptions/4.8.1 SSI Status Codes - Accretion
N	4/Buy-in Code Descriptions/4.8.2 SSI Status Codes - Deletion
R	5/Table of Contents
R	5/Premium Billing/5.0 Introduction
R	5/Premium Billing/5.1 State Billing for Medicare Part A and Part B Premiums
R	5/Premium Billing/5.2 Listed Agency Billing (LAB) - Summary Sheet
R	5/Premium Billing/5.3 Crediting of State Payments for Medicare Part A and Part B Premiums
R	5/Premium Billing/5.4 Interest Assessment

R	5/Premium Billing/5.5 Offset Against Medicaid Grant Award
R	5/Premium Billing/5.6 Methods States May Use to Pay Medicare Premiums
R	5/Premium Billing/5.6.1 Pay.gov
R	5/Premium Billing/5.6.1.1 Pay.gov Background
R	5/Premium Billing/5.6.1.2 Pay.gov Instructions
R	5/Premium Billing/5.6.2 Fedwire
R	5/Premium Billing/5.6.2.1 Fedwire Background
R	5/Premium Billing/5.6.2.2 Fedwire Instructions
N	5/Premium Billing/Appendix 5.A Medicare Part A Premium Amount
N	5/Premium Billing/Appendix 5.B Medicare Part B Premium Amount
N	5/Premium Billing/Appendix 5.C Summary Accounting Statement
N	5/Premium Billing/Appendix 5.D Listed Agency Billing (LAB) - Summary Sheet
N	6/Table of Contents
N	6/Problem Cases and Resources/6.0 Introduction
N	6/Problem Cases and Resources/6.1 Federal and State Components That Administer the State Buy-in Program
N	6/Problem Cases and Resources/6.1.1 CMS Central Office (CO) Baltimore, MD
N	6/Problem Cases and Resources/6.1.1.1 The Office of Financial Management (OFM)
N	6/Problem Cases and Resources/6.1.1.2 The Office of Information Technology (OIT)
N	6/Problem Cases and Resources/6.1.1.3 The Offices of Hearings and Inquiries (OHI)
N	6/Problem Cases and Resources/6.1.1.4 The Center for Medicaid and CHIP Services (CMCS)
N	6/Problem Cases and Resources/6.1.1.5 The Medicare-Medicaid Coordination Office (MMCO)
N	6/Problem Cases and Resources/6.1.2 Social Security Administration (SSA) Field Office (FO) or District Office (DO))
N	6.1.3 CMS Office of Program Operations and Local Engagement (OPOLE)/CMCS Medicaid and CHIP Operations Group (MCOG)
N	6/Problem Cases and Resources/6.1.4 Social Security Administration (SSA) Central Office (CO), Baltimore, MD
N	6/Problem Cases and Resources/6.1.5 Social Security Administration (SSA) Program Service Centers (PSCs)
N	6/Problem Cases and Resources/6.1.6 Railroad Retirement Board (RRB)
N	6/Problem Cases and Resources/6.1.7 The State Medicaid Agency
N	6/Problem Cases and Resources/6.2 Problem Cases - General

N	6/Problem Cases and Resources/6.3 Refund of Medicare Premiums to Individuals
N	6/Problem Cases and Resources/6.4 Cases Involving Duplicate Billing
N	6/Problem Cases and Resources/6.5 Correction of Demographic Data on the Third Party Master Record
N	6/Problem Cases and Resources/6.6 Resolution of State Buy-in Problems Received by the SSA Field Office (FO) Using Form CMS-1957
N	6/Problem Cases and Resources/6.6.1 State Eligibility Office Verification Required
N	6/Problem Cases and Resources/6.6.2 Local Eligibility Office Verification Required - State Verification Not Required
N	6/Problem Cases and Resources/6.7 Report of State Buy-in Problem Case By RRB (Form RL-380F)
N	6/Problem Cases and Resources/Appendix 6.A SSO Report of State Buy-in Problem (Form CMS-1957)
N	6/Problem Cases and Resources/Appendix 6.B RRB Report of State Buy-in Problem (Form RL-380F)
D	7/Part A Buy-in/Group Payer Transaction Codes
D	8/Premium Payments by States

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

State Payment of Medicare Premiums

(Rev. 4, 08-21-20)

Program Overview and Policy
Chapter 1

Table of Contents
(Rev. 4, 08-21-20)

Transmittals for Chapter 1

1.0 Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Since the inception of the Medicare program in 1966, section 1843 of the Social Security Act ("the Act") has afforded states the option to enter into an agreement with the federal government under which the state commits to enrolling certain individuals dually eligible for Medicare and Medicaid (dually eligible individuals) in Medicare Part B with the state paying the Part B premiums on their behalf. Since January 1990, states could amend these agreements to pay the Part A premiums for certain dually eligible individuals who must pay a premium to enroll in Medicare Part A. Section 1903(a)(1) and (b) of the Act authorizes Federal Financial Participation (FFP) for the payment of Part A and/or Part B premiums and cost-sharing for certain dually eligible individuals.

The Centers for Medicare & Medicaid Services (CMS), through authority delegated by the Department of Health and Human Services (HHS), administers this process, historically referred to as "state buy-in."

This chapter sets forth consolidated policy guidance regarding the state buy-in program for the 50 states and the District of Columbia (DC). A forthcoming Chapter 7 will apply to the U.S. territories identified in 42 CFR §§ 407.42 and 407.43.

***NOTE:** This manual contains links to the Social Security Administration (SSA) Program Operations Manual System (POMS) as of July 2020.*[1]

1.1 Definitions

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in Agreement ("agreement") means an agreement authorized by section 1843 of the Act, under which a state secures Premium-Part A or Part B coverage for "eligible individuals" (see definition below) in the buy-in group specified in the agreement, by enrolling them and paying the premiums on their behalf. See 42 CFR § 407.40.[2]

Buy-in Groups (also known as "coverage groups" in section 1843 of the Act) are identified by the state and are composed of multiple Medicaid eligibility categories specified in the agreement.[3] *See 42 CFR §§ 406.26 and 407.42.*

Eligible Individual (Part B) means an individual who is entitled to Medicare Part A or who is

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[1] The SSA POMS is the main reference for SSA employees to conduct daily business, including actions related to the state payment of Medicare premiums. As a courtesy to states, CMS provides links to the SSA POMS as of the time the manual was published. Changes may occur after release. To access the SSA POMS, go to https://secure.ssa.gov/apps10/poms.nsf/Home?readform.

[2] Note that the Medicaid state plan (state plan) pre-print form includes pages that reflect the method the state uses to pay Medicare Part A and B premiums for dually eligible individuals. See state plan, section 3.2(a).

[3] Generally, Medicaid beneficiaries are classified based on the eligibility "group" under which each beneficiary qualifies. For purposes of this Manual, we use the term "category" instead of "group" in order to avoid confusion with the reference to "buy-in group" in 42 CFR § 407.40 et. seq.

age 65 or over, is a resident of the United States and is either a U.S. citizen, or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the five years immediately preceding the month the individual applies for enrollment under Part B, and has not been convicted of crimes specified in 42 CFR § 407.10(b). See section 1836 of the Act; 42 CFR § 407.10.

Entitled to Medicare Part A refers to individuals who receive Part A, either without payment of a premium (Premium-free Part A) or by paying a premium (Premium-Part A). Such individuals satisfy both the eligibility requirements set forth in 42 CFR § 406.5 and the application or enrollment conditions set forth in 42 CFR § 406.6. See 42 CFR § 406(a).

General Enrollment Period (GEP) for Part B means the annual period (January through March, with coverage effective July 1) for an individual to apply for Part B if the individual did not apply during their Initial Enrollment Period (IEP). See 42 CFR § 407.15.

General Enrollment Period (GEP) for Premium-Part A means the annual period (January through March, with coverage effective July 1) for an individual to apply for Premium-Part A if the individual did not apply during their IEP. See 42 CFR § 406.21(c).

Group Payer Arrangement means an alternative method that may be used to pay Part A or Part B premiums on behalf of certain beneficiaries. See 42 CFR §§ 406.32(g) and 408.80.

Initial Enrollment Period (IEP) means the seven-month period comprising the three months before an individual meets the requirements for Premium-Part A or becomes eligible for Part B, the month the individual meets the requirements for Premium-Part A or becomes eligible for Part B, and the three months following. See 42 CFR §§ 406.21(b) and 407.14.

Member of a Buy-in Group means an individual who is a member of the buy-in group that the state has elected to include in its agreement under section 1843 of the Act. States may only cover an eligible individual who is a member of the buy-in group under the agreement. See 42 CFR §§ 407.40, 407.42, and 407.43.

Premium Increase for Late Enrollment (also known as "Premium Surcharge") means the additional amount that may be charged to an individual who enrolls in Premium-Part A or Part B after expiration of the individual's IEP or who reenrolls after previous coverage. For Part B, the premium is increased ten percent for each cumulative period of 12 full months during which an individual could have been, but was not enrolled in Part B. See 42 CFR § 408.22. For Premium-Part A, effective for premiums due for July 1986 and after, the premium increase is limited to ten percent and is payable for twice the number of full 12-month periods determined under the regulations. See 42 CFR § 406.32(d).

Premium-Part A means the hospital insurance benefits provided under Medicare Part A for certain individuals who do not qualify for Part A without monthly premiums under 42 CFR § 406.5(a) and can only enroll in Part A by paying a premium. See 42 CFR §§ 406.5(b) and 406.20.

1.2 Background

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Medicare provides health insurance coverage to individuals age 65 and older and certain persons under age 65 with disabilities or End-Stage Renal Disease (ESRD). Medicare Part A provides coverage generally of inpatient care, and most beneficiaries are entitled to these benefits without paying an additional premium based on eligibility for Social Security or Railroad Retirement Board (RRB) benefits. Some individuals are eligible to obtain entitlement to Part A benefits by enrolling in Premium-Part A. Medicare Part B, which is optional and requires payment of a premium, covers most other types of health coverage, including limited prescription drug coverage. Medicare Part D, also optional, requires a premium, and covers outpatient prescription drugs. Medicare Parts A, B, and D all require payment of cost-sharing (e.g., deductibles, coinsurance, and copayments).

Under the state buy-in program, states, the District of Columbia (DC), and specified U.S. territories can enter into buy-in agreements that make it easier to enroll certain Medicaid recipients into Medicare Part B and pay the premiums on their behalf ("Part B buy-in"). See section 1843 of the Act; 42 CFR § 407.40, et seq. All states, DC, and some of the specified U.S. territories have elected to enter into a Part B buy-in agreement with CMS.

Starting January 1, 1990, states could expand their buy-in agreements to enroll Qualified Medicare Beneficiaries (QMBs) in Premium-Part A and pay the premiums on their behalf ("Part A buy-in"). See section 1818(g) of the Act; 42 CFR § 406.26. Most states and DC have broadened their buy-in agreements to include the payment of Part A premiums for individuals eligible for the QMB program. The remaining states use the group payer arrangement to pay Part A premiums for QMBs. See section 1.7 for more information about paying Part A premiums for QMBs and appendix 1.D for a list of Part A buy-in and group payer states.

For an individual who is determined eligible for but not yet enrolled in Medicare, state buy-in serves to enroll the individual in Medicare Part A and/or B and directs the federal government to bill the state for his or her premiums. For an individual who is already enrolled in Medicare, state buy-in means the federal government will start billing the state for the individual's Medicare premiums and stop billing the individual for these costs through deductions from their monthly Social Security benefits (Old Age, Survivors, and Disability Insurance (OASDI) program)[4] or through bills CMS directly mails certain beneficiaries.[5]

Low-income individuals who receive assistance with Medicare premiums save critical funds to use for other life necessities, including food and housing. A beneficiary's monthly expenses will

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[4] OASDI benefits include Old Age Insurance Benefit Payments (also known as Social Security retirement benefits) and Social Security Disability Insurance (SSDI).

[5] CMS sends the beneficiary a Medicare Premium Bill (CMS-500) (see https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS500.pdf) for Medicare Parts A, B, and/or D if the beneficiary's premium liability exceeds the amount of the beneficiary's Social Security benefit or Office of Personnel Management (OPM) or Railroad Retirement Board (RRB) annuity.

drop by the amount of their Part B premium ($144.60 in 2020) once buy-in starts.[6] Eligible individuals without Medicare can enroll in the program and access Medicare services.

Buy-in agreements simplify the process for states to assist their low-income residents with Medicare expenses. Buy-in agreements permit states to directly enroll eligible individuals in Medicare Part A and/or B at any time of the year (without regard for Medicare enrollment periods) and to pay beneficiary premiums. CMS does not bill states with buy-in agreements for late enrollment or re-enrollment charges that may otherwise apply to an individual's monthly premium amount.

Easing the administrative processes for a state to pay Medicare premiums helps maximize the number of its "full-benefit" Medicaid recipients who are enrolled in Medicare, ensuring that Medicare pays primary to Medicaid. State buy-in agreements also facilitate enrollment in Medicare for low-income individuals not eligible for full-benefit Medicaid coverage[7] by paying Medicare premium and cost-sharing costs through three Medicare Savings Program groups: QMB, Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI). The state's regular Federal Medical Assistance Percentage (FMAP) rate applies to state expenditures for Medicare Parts A and B premiums and cost-sharing for certain Medicaid eligibility categories (see section 1.9).

1.3 Medicare Eligibility and Enrollment

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS regulations require states to enroll members of a buy-in group in buy-in if they meet the requirements for Medicare Parts A and/or B (an "eligible individual" as defined in section 1.1). See 42 CFR § 407.40(c).
This section summarizes Medicare eligibility requirements and enrollment processes to help states understand which Medicaid recipients may qualify for Medicare and become dually eligible.

1.3.1 Premium-free Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Certain individuals qualify for Premium-free Part A if they have the number of Social Security work credits required to qualify for monthly OASDI benefits.[8] Most Medicare beneficiaries get Premium-free Part A.

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[5] Most beneficiaries pay the standard Part B premium amount ($144.60 in 2020). States also pay the standard Part B premium amount on behalf of individuals enrolled in buy-in. See SSA POMS HI 01001.004 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601001004.

[7] "Full-benefit" Medicaid coverage generally refers to coverage for a range of items and services, beyond Medicare premiums and cost-sharing, that individuals may receive by qualifying for a mandatory Medicaid eligibility category (see 42 CFR § 435(b)), an optional Medicaid eligibility category (see 42 CFR § 435(c)) or a medically needy category (see 42 CFR § 435(d)) as provided for in the state plan.

[8] An individual accrues Social Security work credits when the individual pays Medicare payroll taxes while working (or is a spouse or dependent child of an individual who does). See 20 CFR § 404(b).

An individual age 65 or over meets the requirements for Premium-free Part A if the individual:

- *Already gets Old Age Insurance Benefit Payments (Social Security retirement benefits) or an Age and Service Annuity from the RRB (RRB retirement benefits) ;*
- *Is eligible to get Social Security or RRB retirement benefits but has not filed for them yet; or*
- *Is a government employee who paid the Medicare payroll tax while working for the required amount of time.*

An individual under age 65 meets the requirements for Premium-free Part A if the individual:

- *Has received Social Security Disability Insurance (SSDI) or a disability annuity from RRB (RRB disability benefits) for 24 months; or*
- *Has ESRD and the requisite work credits to otherwise qualify for Social Security or RRB disability benefits (or is a spouse or dependent child[9] of an individual who does).*

All individuals who qualify for Medicare on the basis of ESRD and the vast majority of individuals who qualify for Medicare on the basis of SSDI benefits receive Premium-free Part A.

***NOTE:** An individual who has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), qualifies for Premium-free Part A the month the individual's SSDI benefits begin.*

1.3.2 Premium-Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Individuals who lack the requisite Social Security work credits to qualify for OASDI can obtain Premium-Part A. See 42 CFR § 406.5(b).

Individuals age 65 or older qualify for Premium-Part A if they are:

- *U.S. residents;*
- *Receiving benefits under Part B or are in the process of enrolling in it;*
- *Not otherwise entitled to Part A; and*
- *Either:*
  - *U.S. citizens; or*
  - *Lawful permanent residents who have resided in the U.S. continuously during the five years immediately preceding the month they applied for enrollment in Medicare.[10] (See section 1818 of the Act; 42 CFR § 406.20(b)).*

In addition, individuals under age 65 qualify for Premium-Part A if they:

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[9] For information about qualifying for ESRD Medicare as a dependent child, see SSA POMS DI 45001.001 at https://secure.ssa.gov/poms.nsf/lnx/0445001001.

[10] The five years of continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. See SSA POMS HI 00805.005 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805005 and SSA POMS GN 00303.800 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

- *Were entitled to Premium-free Part A on the basis of entitlement to SSDI;*
- *Have lost entitlement to Premium-free Part A due to excess earnings;*
- *Are not otherwise entitled to Part A; and*
- *Continue to have a qualifying disability. (See section 1818(a) of the Act; 42 CFR § 406.20(c)).*

***NOTE:** As described in section 1.3.1, the vast majority of individuals under age 65 with disabilities qualify for Premium-free Part A. Individuals under age 65 only qualify for Part A with a premium if they: (1) lose disability benefits and Premium-free Part A after returning to work, and (2) continue to have a qualifying disability. States pay the Part A premiums for such individuals under age 65 who meet the requirements of the Qualified Working and Disabled Individuals (QDWI) program.[11] For more information about the QDWI program, see section 1.6.2.*

Individuals may qualify to pay a reduced monthly Part A premium under certain circumstances.[12] See 42 CFR § 406.32(c).

1.3.3 Medicare Part B

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All individuals eligible for Part B are charged a monthly premium through a deduction from their OASDI, RRB, or Office of Personnel Management (OPM) government retirement benefits; or a bill is mailed directly by CMS.[13]

Individuals who are entitled to Part A are also eligible to enroll in Medicare Part B. See section 1836(1) of the Act.

Individuals who are not entitled to Part A can enroll in Medicare Part B if they are age 65 or older and meet the citizenship and residency requirements for Premium-Part A. See 42 CFR § 407.10(a)(2). In other words, they must be:

- *Age 65 or older*
- *U.S. residents; and*

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[11] The QMB program is not available to individuals entitled to Part A solely based on eligibility to enroll as a QDWI. Section 1905(p)(1)(A) of the Act; 42 CFR §400.200. For more information about the QMB program, see section 1.6.2.1.

[12] Individuals may qualify for a reduced premium if they have obtained 30 work credits; were married for at least one year to a worker with at least 30 work credits; married for at least one year to a worker who attained 30 work credits prior to their death; divorced from a worker after 10 years of marriage and the worker attained 30 work credits at the time the divorce was final; divorced from a worker after 10 years of marriage and the worker died and had 30 work credits at the time the divorce was final, or the current spouse has at least 30 Social Security work credits. See 42 CFR § 406.32(c).

[13] Note that Medicare Advantage plans can reduce the standard Medicare Part B premium as an additional benefit for plan enrollees. The reduction must be less than the standard Part B premium amount and cannot be paid to the beneficiary or used to reduce a premium surcharge. If an individual receives a Part B premium deduction from a Medicare Advantage plan and is enrolled in Part B buy-in, CMS will notify the state of the amount of the premium reduction (not the adjusted premium rate) through the regular exchange of buy-in data.

- *Either:*
  - *U.S. citizens; or*
  - *Lawful permanent residents who have resided in the U.S. continuously during the five years immediately preceding the month of application for enrollment in Medicare.*[14]

1.3.4 Medicare Enrollment

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

In the absence of a buy-in agreement, individuals may only sign up for Premium-Part A or Part B during a prescribed Medicare Enrollment Period. Individuals can first sign up for Premium-Part A or Part B during the IEP. If they miss the IEP, they can only enroll during the annual GEP and may pay a premium increase for late enrollment.[15] *For an explanation of the premium increase for Premium-Part A, see section 1.1. Medicare enrollment periods do not apply to Premium-free Part A. Some individuals are automatically enrolled in Medicare, while others have to file for it, as described in section 1.3.4.1.*

1.3.4.1 Medicare Enrollment Table

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Automatic Enrollment	***Individual Enrollment***[16]
Individuals automatically get Premium-free Part A if they are: ***Age 65 and over and receive Social Security or RRB retirement benefits; or*** ***Under age 65 who receive Social Security or RRB disability benefits for 24 months.*** --- ***During their IEP for Part B, CMS mails the individual a welcome packet that contains background information and a Medicare card with the Part A and B effective dates. The mailing informs the beneficiary that:*** ***They do not pay a premium for Part A, which will start on the coverage date on the card;***	***Premium-free Part A:*** *Individuals can file for Medicare Premium-free Part A at SSA if they are:* *Age 65 and over and have not yet filed for Social Security or RRB benefits;* *An individual who qualifies for Medicare on the basis of ESRD; or* *A government employee who has paid the Medicare payroll tax for the required number of quarters.* *Individuals who file for Part A are enrolled in Part B unless they decline it.* ***Premium-Part A:*** *Individuals who qualify for*

[14] The five years of continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. See SSA POMS HI 00805.005 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805005 and SSA POMS GN 00303.800 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

[15] An individual who declined Part B during their IEP and is or was covered by an employer group health plan, may qualify for a time-limited Special Enrollment Period (SEP) to enroll in Part B without any applicable premium increases for late enrollment. For more information, see 42 CFR § 407.20; SSA POMS HI 00805.275 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805275.

[16] An individual can sign up for Medicare through SSA's toll-free number 1-800-772-1213, TTY 1-800-325-0778, by making an appointment at their local Social Security office, and with some exceptions, on the ssa.gov website.

Automatic Enrollment	*Individual Enrollment*[16]
and ***They do owe a premium for Part B, but can decline it by signing the back of the card and returning the card before the Part B effective date.***	*Premium-Part A must apply for Medicare at SSA. They can enroll in Part B only or Premium-Part A and Part B.* ***NOTE****: An individual can enroll in Medicare Part B without enrolling in Premium-Part A. Conversely, an individual cannot enroll in Premium-Part A unless the individual is receiving Part B benefits or files an application to enroll.* ***Part B:*** *Individuals who did not enroll in Part B during their IEP for Part B can enroll in Part B during the GEP or during a Special Enrollment Period (SEP) for those with current or former group employer coverage.*

1.3.5 Medicare Re-enrollment

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

An eligible individual who owes premiums from a past period of Premium-Part A or Part B coverage is permitted to re-enroll in Medicare. Payment of past-due premiums is not a pre-requisite for re-enrollment. See SSA POMS HI 01001.345 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601001345.

1.4 Requirements for Enrolling Individuals Under Buy-in Agreements

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All states have a buy-in agreement for Part B buy-in, and most have an agreement for Part A buy-in. The agreements and related Medicaid state plan (state plan) pages identify the buy-in groups for which the state will cover Part A or B premiums. See sections 1.6 and 1.7 for information about state buy-in group options.

States must pay the Part A or B premiums for any eligible individual who is a member of the buy-in group. See sections 1843(a) and 1818(g) of the Act; 42 CFR § 407.40(c)(1). A state cannot apply a "cost-effectiveness test" to choose individuals for buy-in (i.e., restrict buy-in to those who incur medical expenses).

Under buy-in agreements, states initiate buy-in for eligible individuals who are members of the buy-in group at any time of the year, without any premium surcharges. If a member of a buy-in group is already enrolled in either Medicare Part A or B, the state should directly enroll the individual in buy-in and refrain from referring the individual to SSA to apply for Medicare. See section 1.10 for more information.

States must follow federal requirements defining an individual's buy-in coverage period, including effective (start) and termination (stop) dates. See 42 CFR §§ 406.26, 407.47, and 407.48, and sections 1.13 through 1.15. States must honor the applicable buy-in start and stop dates, even if buy-in processing is delayed. See chapter 2 for information regarding state and CMS processes to start and end buy-in.

***NOTE:** If SSA makes a retroactive award of SSDI benefits, and the disability entitlement date is more than 24 months in the past, SSA will retroactively establish Part A entitlement (starting the 25th month after the SSDI entitlement date). If a state learns that SSA established retroactive Medicare Part A entitlement for an individual, the state must review the individual's eligibility for Part B buy-in over the retroactive period.*

An individual's enrollment under a buy-in agreement is involuntary. States must enroll an individual in buy-in if the individual applies for Medicaid and is determined eligible for a Medicaid eligibility category included in the state's buy-in coverage group.[17] A beneficiary cannot voluntarily terminate state buy-in coverage. See sections 1843(a) and 1818(g) of the Act; 42 CFR § 407.40(c)(1).

Eligibility for or enrollment in Medicare constitutes "a change in circumstances" that may affect an individual's Medicaid eligibility.[18] When a state anticipates or receives information that a current Medicaid recipient is newly eligible for Medicare, the state must promptly redetermine the individual's eligibility as required any time a beneficiary experiences a change in circumstances that may impact eligibility. See 42 CFR § 435.916(d). If the state finds the Medicaid beneficiary is no longer eligible for the eligibility category under which the individual is receiving coverage, the state must consider whether the beneficiary may be eligible under another eligibility category covered by the state. See 42 CFR § 435.916(f)(1). The state must continue to furnish Medicaid until an individual is determined ineligible. See 42 CFR § 435.930(b).

When the state has considered eligibility on all bases, the state must either move the beneficiary to the appropriate category if Medicaid eligibility continues, or provide the individual advance notice and hearing rights in accordance with 42 CFR Part 435, Subpart J and 42 CFR Part 431, Subpart E prior to terminating coverage. If the state determines the individual eligible for a Medicaid category included in the state's buy-in group, the state must start paying the Part A and/or B premiums for this individual.

***NOTE:** When an individual enrolled in Medicaid under 42 CFR § 435.119 (also known as the "adult group" or "adult category") becomes eligible for Medicare, the individual no longer meets the eligibility criteria for the adult category. The state must promptly redetermine eligibility based on the change in circumstances. The beneficiary must remain covered under the adult category until the state completes the redetermination of eligibility on all bases. In such instances, if the state includes all Medicaid beneficiaries in its Part B buy-in coverage group, the*

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[17] In states with 1634 agreements, an SSI application also serves as a Medicaid application. For more information about 1634 agreements, see section 1.6.1.1.

[18] For more information, see "Strategies to Streamline Transitions for Medicaid-eligible Beneficiaries Who Newly Qualify for Medicare," CMS Information Bulletin, June 7, 2017 at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060717.pdf.

state will need to pay the beneficiary's Part B premiums for the months in which the beneficiary was enrolled in the adult category.

Similarly, if an individual enrolled in a Medicaid category included in the state's buy-in group, experiences a change in circumstance and is determined to no longer meet the eligibility criteria for that category, the state must promptly redetermine eligibility in order to determine if the individual may be eligible under a different Medicaid category, including those encompassed by the buy-in group. See 42 CFR § 435.916(f). While the state is making this determination, the state must maintain Medicaid coverage and must not terminate the individual from buy-in. See 42 CFR § 435.930(b). Further, if the state determines the individual continues to qualify under another buy-in group category, buy-in coverage must continue without interruption.

Medicaid agencies communicate all enrollment and disenrollment information through the established data exchange process with CMS. CMS' Third Party System (TPS) will process all state-submitted buy-in actions. Buy-in data identifies each Medicaid recipient who is enrolled in Medicare, and for whom the state is paying the Part A or B premium. See chapter 2 for information about state-CMS buy-in data exchange.

1.5 Effect of Buy-in on an Individual

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

If an individual is eligible for Medicare but not currently enrolled in it, *state buy-in enrolls the individual in Medicare, providing access to Medicare-covered items and services.*

NOTE: *If an individual did not enroll in Premium-Part A or Part B during their IEP, or previously withdrew from the programs, Medicare entitlement will be established or re-established effective with the first month that the individual becomes eligible for state buy-in.*

If an individual is already enrolled in Medicare, *state buy-in means the state will assume payments for the beneficiary's Medicare Part A or B premiums.*

- *If SSA deducts Medicare premiums from a beneficiary's Social Security benefit (OASDI or Supplemental Security Income (SSI)), OPM or RRB benefits, the deductions will stop, resulting in the beneficiary receiving a higher monthly payment.*
- *If CMS directly bills the beneficiary for Medicare Part A and/or Medicare Part B, such billing will end.*

Once buy-in coverage is effective, the beneficiary shall receive a refund from SSA for any premiums (including any late enrollment penalties) that were deducted from the benefit amount or for premiums directly paid by the beneficiary to CMS, for any month the beneficiary is enrolled in state buy-in. Sometimes, a state accretes a beneficiary to the state's buy-in account in error, for months in which the individual was not eligible. States must provide buy-in coverage as if the beneficiary was in fact eligible and only end coverage as provided in 42 CFR § 407.48. In these instances, the beneficiary is entitled to keep any premium refunds received. The state must treat the individual as if they are eligible and may not attempt to recoup these

amounts from the beneficiary.[19]

***NOTE:** The refund of Medicare premiums is not countable income under SSI methodologies. As a result, Medicaid agencies cannot consider the refund as income when determining eligibility for individuals whose Medicaid eligibility is based on SSI methodologies.*

1.6 Part B Buy-in Coverage Groups - General

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Federal law allows states to select one of three Part B buy-in coverage groups. See section 1843 of the Act; 42 CFR §§ 407.42 and 407.43.[20] *The buy-in groups are listed below, in order of narrowest to broadest.*

- *Cash Assistance Recipients and Deemed Recipients of Cash Assistance (Section 1.6.1)*
- *Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program (MSP) Groups (Section 1.6.2); and*
- *All Medicaid Categories (Section 1.6.3)*

As of July 2020, all states, DC, and certain territories have Part B buy-in agreements that include either (a) the cash assistance recipients and deemed recipients of cash assistance plus three MSP groups or (b) all Medicaid Categories.[21]

***NOTE:** Part B buy-in coverage groups must include SSI/State Supplement Programs (SSPs)*

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[19] Recovery of an "overpayment" made to beneficiaries is considered to be a retroactive termination of Medicaid eligibility. Retroactive termination of eligibility is prohibited by regulations at 42 CFR §§ 431.211 to 431.214, which require states to provide at least ten days advance notice of a termination of eligibility in most situations; in a few discrete situations, termination on the date of action is allowed. Retroactive terminations of eligibility would also violate a beneficiary's due process rights under the U.S. Constitution and associated case law.
States are required to provide Medicaid to eligible state residents under 42 CFR § 435.403(a)) and must continue to furnish Medicaid to all eligible individuals until they are found to be ineligible pursuant to 42 CFR § 435.930(b). When a state receives information that suggests a beneficiary is not eligible for Medicaid, the state must promptly conduct a redetermination of eligibility for this beneficiary. See 42 CFR § 435.916(d)(1). This includes providing the beneficiary with an opportunity to demonstrate that the information the state received is not accurate or that the individual otherwise remains eligible for coverage. See 42 CFR § 435.952(d). If the redetermination results in a finding of ineligibility for the beneficiary, the state may terminate eligibility provided that the beneficiary is afforded advance notice and hearing rights in accordance with 42 CFR Part 435, Subpart J and 42 CFR Part 431, Subpart E.

[20] When states could first enter into buy-in agreements in July 1966, they could choose between two Part B buy-in groups: 1) individuals receiving federally-aided cash assistance; or 2) all Medicaid recipients. After numerous changes, federal law allows states to select one of the three buy-in groups outlined in this section.

[21] CMS has deemed all buy-in agreements to include Part B buy-in for QMBs, SLMBs, and QIs. CMS (then the Health Care Financing Administration (HCFA)) deemed all agreements to include Part B buy-in for QMBs starting January 1, 1989. See 56 Fed. Reg. 38074 at 38076 (August 12, 1991). Starting January 1, 1993, SLMB's effective date, all agreements were deemed to include SLMBs because the Act treats SLMBs like QMBs. See section 1843(h)(3) of the Act. Long-standing CMS operations effectively deem the agreements to include Part B buy-in for QIs, enacted in 1997. The state plan pre-print (3.2 Coordination of Medicaid with Medicare and Other Insurance) treats QIs the same as SLMBs.

recipients and deemed recipients of SSI/SSPs who qualify for Medicaid based on receipt (or deemed receipt) of such cash assistance. Aid to Families with Dependent Children (AFDC) is a cash assistance program that was replaced by Temporary Assistance for Needy Families (TANF), in 1996.[22] No Medicaid state plan eligibility groups are linked to TANF; a few Medicaid eligibility categories, however, are linked to eligibility standards of the former AFDC program and offer eligibility to certain individuals who meet such standards, as the program existed in 1996. Consistent with long-standing policy, states can choose to include one of these AFDC-related groups, Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E ("Children Eligible Based on Title IV-E") in their Part B buy-in coverage group as explained below.

1.6.1 Cash Assistance and Deemed Recipients of Cash Assistance

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This buy-in group includes only cash assistance and deemed recipients of cash assistance who are covered under the state plan as categorically needy.[23]

1.6.1.1 Supplemental Security Income (SSI) Program

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSI is a federal cash assistance program that serves low-income individuals who are age 65 or older, or have blindness or a disability. In most states, the receipt of SSI is a mandatory basis for Medicaid eligibility. Pursuant to section 1634(a) of the Act, "1634" states have an agreement with SSA to determine Medicaid eligibility for state residents whom SSA has determined eligible for SSI. 1634 states are also known as "auto-accrete" states because CMS will initiate, on behalf of the state, Part B buy-in for individuals receiving SSI.

Other states are referred to as "alert" states. In alert states, CMS identifies for states SSI recipients who are Medicare-eligible, but the states, not SSA, determine Medicaid eligibility and initiate Part B buy-in enrollment. Alert states fall into two categories: SSI criterion states and "209(b)" states.

Like 1634 states, SSI criterion states apply SSI methodologies in determining Medicaid eligibility. Unlike 1634 states, SSI criterion states require SSI beneficiaries to complete a Medicaid application for the state to establish their Medicaid eligibility. 209(b) states have elected the option, under section 1902(f) of the Act, to apply financial methodologies more restrictive than SSI in determining Medicaid eligibility for individuals age 65 or older, or have blindness or disability.[1] In 209(b) states, the receipt of SSI is not a basis for Medicaid eligibility. However, 209(b) states must have a mandatory Medicaid eligibility group that serves low-income individuals who are age 65 or older, or have blindness or a disability under 42 CFR § 435.121; many, if not most, SSI beneficiaries in 209(b) states qualify in this category. See chapter 2, section 2.5.1 for information about buy-in enrollment processes in auto-accrete and

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[22] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193).

[23] SSA notifies Medicaid agencies of individuals who are determined eligible for SSI (and SSPs, in some cases) and may qualify for Medicare through the SSA systems such as the State Data Exchange (SDX). See chapter 2, section 2.4 for more information about SSA data sharing with states.

alert states.

Appendix 1.D classifies states by whether they are an auto-accrete or alert state (including SSI criterion and 209(b)) as of July 2020.

1.6.1.2 State Supplement Programs (SSPs)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Most states operate their own cash assistance programs—known as optional SSPs—for people who are 65 years old and older, or who have blindness or disability. Payments from these programs are not counted as income under the SSI program. In many cases, these benefits supplement the SSI benefits an individual receives.[24] In other cases, individuals receive only an SSP payment if they would otherwise meet the requirements for SSI but for having too much income. States have the option to extend categorical eligibility to individuals who are not eligible for SSI, but who receive an SSP benefit.

Under the authority of section 1616 of the Act, many states have entered into "1616 agreements" with SSA to determine eligibility for their SSPs and to issue SSP payments to beneficiaries. In such states, an application for SSI is an application for SSPs. Other states perform determinations for SSPs themselves. See SSA POMS SI 01401.001 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0501401001.

1.6.1.3 Deemed Recipients of Cash Assistance
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Over time, federal law has mandated that certain individuals who were at one point receiving cash assistance but who lost it due to increases in Social Security benefits (OASDI) be treated, for purposes of Medicaid eligibility, as if they continue to receive cash assistance, i.e., these individuals are "deemed" to be receiving SSI/SSPs. Federal law and regulations make these individuals mandatorily eligible for Medicaid.[25] These individuals must be included in state buy-in agreements.

1.6.1.4 Children Eligible Based on Title IV-E
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

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[24] States in which the grant-in-aid cash benefit rate in December 1973 exceeded the SSI Federal Benefit Rate of January 1974, are required to pay a supplement to beneficiaries to make up the difference. Individuals who continue to receive these mandatory state supplements are mandatorily eligible for Medicaid. See 42 CFR § 435.130. There are no new applicants for this eligibility group.

[25] The following categories are deemed recipients of SSI/SSPs: certain individuals who would have been eligible for cash assistance in 1972 but who lost it because of an increase in their OASDI benefits (42 CFR § 435.134); certain individuals (sometimes known as "Pickle" individuals) who used to qualify for both SSDI and SSI but who no longer qualify for SSI because their income exceeds the SSI income limit (42 CFR § 435.135); certain disabled widow/ers (42 CFR §§ 435.137 and 435.138); and certain adult children with disabilities (section 1634(c) of the Act).

At state option, Part B coverage groups may include children (who may be up to age 21) enrolled in the state plan categorical eligibility group, Children Eligible Based on Title IV-E, under 42 CFR § 435.145.[26] Title IV-E of the Act provides for federal payments to states for foster care and kinship guardianship care maintenance and for adoption assistance on behalf of children who meet the program's eligibility requirements. Based on the Title IV-E agency's determination of eligibility, the Medicaid agency must provide Medicaid to the Title IV-E individual.

Consistent with the requirements described at 42 CFR § 435.145, the eligibility criteria for the title IV-E eligibility group require that, for a child, either: (1) an adoption assistance agreement with a state or tribe is in effect under title IV-E of the Act; or (2) the state or tribe is making foster care or kinship guardianship assistance maintenance payments under title IV-E of the Act.

Individuals meeting the eligibility requirements are "automatically" eligible for the title IV-E eligibility group and are typically enrolled without a Medicaid application.

1.6.2 Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program (MSP) Groups

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Pursuant to section 1902(a)(10)(E) of the Act, states must assist low-income Medicare beneficiaries with their Parts A and B expenses through one of four "Medicare Savings Programs," or "MSPs."

- *QMBs*
- *SLMBs*
- *QIs*
- *QDWI*

Under this buy-in coverage group, states cover QMBs, SLMBs, and QIs in addition to the cash assistance-related and deemed cash assistance-related coverage categories described in section 1.6.1.

***NOTE:** States pay Part A premiums (but not Part B premiums) for QDWIs. QDWIs are individuals under age 65 who became entitled to Part A based on their receipt of SSDI, but who subsequently lost SSDI, and, as a result, their Part A entitlement, on the basis of substantial*

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[25] Medicaid eligibility categories linked to AFDC, as in effect in 1996, include Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E. See sections 473(b)(1), 473(b)(3) and 1902(a)(10)(A)(i)(I) of the Act. Another category that treats individuals as though they were receiving AFDC is the Low-Income Families category consisting primarily of parents and other caretaker relatives and their dependent children living in the home. See section 1931 of the Act. Consistent with longstanding policy, individuals eligible in this latter category are not optional deemed recipients of AFDC for buy-in. Note that parents and other caretaker relatives in this category (who are most likely to qualify for Medicare) will, in the vast majority of cases, be eligible for a MSP group.

gainful employment.[27] States cannot include the Part A premium payments for QDWIs in their buy-in agreements. States pay the Part A premiums for QDWIs through the group payer process.

Individuals apply for Medicaid and/or the MSPs through their state Medicaid agencies. Additionally, federal law requires the Social Security Administration (SSA) to transmit to states "leads" data from Medicare Part D Low-Income Subsidy (LIS) applications processed by SSA (i.e., files containing data from LIS applications), and for states to treat the data as an application for the MSPs. See sections 1144(c)(3) and 1935(a)(4) of the Act. For more information about LIS leads data, see chapter 2, section 2.4.2.5.

State Medicaid agencies are generally required to determine an individual's eligibility for all categories for which they may qualify, including full-benefit Medicaid categories and MSPs. Accordingly, the eligibility system hierarchy should be programmed to reflect both determinations. Note that some states may have MSP-only applications that do not request the information necessary for categorical Medicaid determinations. Consistent with regulations governing eligibility determinations, states must explore all bases of eligibility. See 42 CFR § 435.911(c).

States must use income and resource methodologies and requirements no more restrictive than SSI's for MSP determinations. See 42 CFR § 435.601(b)(2). Under section 1902(r)(2) of the Act, states have the flexibility to expand eligibility by employing less restrictive rules in counting income and resources and using a more expansive definition of family size for MSP determinations. See 42 CFR § 435.601(d)(1).[28]

As noted in section 1.6, QMBs, SLMBs, and QIs are included in all state buy-in agreements in the 50 states and Washington D.C.

Current income and asset limits for the MSP categories are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html.

The sub-sections below contain additional information about the QMB, SLMB, and QI groups.

For detailed information on dually eligible individual categories, including the degree to which individuals in each category receive assistance with Medicare Parts A and B premiums and cost-

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[27] QDWIs have income up to 200 percent of the FPL, resources that do not exceed two times the SSI resource standard, and are not otherwise eligible for Medicaid. Note: Low-income individuals under age 65 with disabilities who have lost SSDI due to excess earnings may qualify for full-benefit Medicaid coverage (e.g., the Work Incentives Eligibility Group under section 1902(a)(10)(A)(ii)(XIII) of the Act).

[28] For example, states can disregard specific amounts of income or amounts or categories of assets, or effectively remove the asset limit by disregarding all assets. For more information on state flexibilities, see "Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees" CMS Information Bulletin, January 23, 2015 at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB-01-23-2015.pdf. See also, "Improving Participation in the Medicare Savings Programs," Chapter 3 in June 2020 Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission (MACPAC) at https://www.macpac.gov/publication/chapter-3-improving-participation-in-the-medicare-savings-programs/.

sharing, see appendix 1.A.

For more information about the buy-in start date for these categories, see sections 1.13 and 1.14, and appendix 1.C.

1.6.2.1 Qualified Medicare Beneficiary (QMB) Program
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Under the QMB eligibility category, states pay the Medicare Parts A and B cost-sharing expenses (i.e., monthly premiums, deductibles, coinsurance, co-payments,[29] and at state option, Part C premiums) for individuals who:

- *Are entitled to Medicare Part A (including individuals age 65 and over who are entitled to Premium-Part A);[30]*
- *Have income that does not exceed 100 percent of the federal poverty level (FPL); and*
- *Have resources that do not exceed the full LIS resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the Consumer Price Index (CPI).[31]*

See sections 1902(a)(10)(E)(i) and 1905(p) of the Act; 42 CFR § 400.200.

Current federal income and asset limits for QMB are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. As described in section 1.6.2, states can modify their financial eligibility methodologies to effectively increase the income or resource standard above the federal floor.

The QMB program is a mandatory eligibility group. The majority of individuals who qualify for QMB also qualify for a separate Medicaid eligibility group that entitles them to the full range of services provided under the state plan, in addition to Medicare cost-sharing assistance.[32]

Under section 1902 (e)(8) of the Act, QMB is effective the month following "the month in which the [QMB] determination first occurs." States have flexibility in applying this provision. States

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[29] Note that Medicare providers cannot charge QMBs for Medicare deductibles, coinsurance, and copays –even if the individual asks to pay them – but may charge any nominal Medicaid copays. See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

[30] Under section 1905(p)(1)(A) of the Act, QMBs must either be entitled to Premium-free Part A or entitled to Premium-Part A coverage for individuals age 65 and over. Individuals entitled to Part A solely based on eligibility to enroll as a QDWI. See also 42 CFR § 400.200.

[31] Note that while full LIS and the MSP categories use the same resource standard, the resource exclusions applicable to determinations for these programs are not fully aligned. A detailed description of the asset exclusions applied by SSA during LIS eligibility determinations is available at SSA POMS HI 03030.20 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030020. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to adopt MSP criteria that better align with those for LIS. For example, states can adopt LIS asset rules that exclude vehicles, the cash value of life insurance and $1,500/$3,000 (for a single individual and married couple, respectively) of burial funds without verifying that such funds have been put in a burial trust.

[32] In 2018, 78 percent of QMBs qualified for full-benefit Medicaid in addition to QMB (sometimes referred to as "QMB-plus" individuals), while 22 percent of QMBs qualified for QMB alone (sometimes referred to as "QMB-only" individuals).

can choose to define "the month in which the QMB determination first occurs" for the QMB coverage group as either: (1) the month that the applicant meets all requirements for QMB or (2) the month in which the eligibility determination is made (if those months are different).

For example, if an individual applies for Medicaid on January 1, and on February 15, the state determines the individual met all of the requirements of QMB in January, the state may either begin QMB coverage on February 1 (i.e., if state elects option one above) or March 1 (i.e., if the state elects option two above).

For QMB-plus individuals determined eligible at application, the separate full-benefit Medicaid coverage may be effective up to three months before the month of application, if the individual received Medicaid covered services and would have been eligible at the time the services were received, even though the same retroactive eligibility period does not apply to their QMB benefits. See 42 CFR § 435.915(a).

1.6.2.2 Specified Low-Income Medicare Beneficiary (SLMB) Program
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Under the SLMB eligibility group, state Medicaid programs pay the Medicare Part B premiums for individuals who:

- *Are entitled to Medicare Part A (see section 1.1 (including individuals age 65 and over who are entitled to Premium-Part A));*
- *Have income that exceeds 100 percent but is less than 120 percent of the FPL; and*
- *Have resources that do not exceed the full LIS resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the CPI.*[33]

See sections 1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii) of the Act.

Current federal income and asset limits for SLMB are available at https://www.medicaid.gov/medicaid/eligibility/medicaid-enrolleesAs described in section 1.6.2, states can modify their financial eligibility methodologies and requirements above the federal floor.

Unlike QMBs, the state is precluded from paying the Medicare Part A premiums for SLMBs. Some individuals who qualify for SLMB also qualify for a separate Medicaid eligibility group that entitles them to the full range of services provided under the state plan, in addition to

[33] Note that while full LIS and the MSP use the same resource standard, the resource exclusions applicable to determinations for these programs are not fully aligned. A detailed description of the asset exclusions applied by SSA during LIS eligibility determinations is available at SSA POMS HI 03030.20 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030020. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to adopt criteria that better align with those for LIS. For example, states can adopt LIS asset rules that exclude vehicles, the cash value of life insurance and $1,500/$3,000 of burial funds without verifying that such funds have been put in a burial trust.

assistance with the Medicare Part B premium.[34]

Coverage for an individual determined eligible under the SLMB group at application may be effective up to three months before the month of application if the individual received Medicaid covered services and would have been eligible at the time services were received. See 42 CFR § 435.916(a).

1.6.2.3 Qualifying Individuals (QI) Program
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Under the QI eligibility category, state Medicaid programs pay the Medicare Part B premiums for individuals who:

- *Are entitled to Medicare Part A (including individuals age 65 and over who are entitled to Premium-Part A);*
- *Have income that is at least 120 percent, but less than 135 percent, of the FPL; and*
- *Have resources that do not exceed the full LIS resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the CPI.*[44]

See sections 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) of the Act.

Current federal income and asset limits for QIs are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. As described in section 1.6.2, states can modify their financial eligibility methodologies and requirements above the federal floor.

Like SLMBs, the state is precluded from paying the Medicare Part A premiums for QIs. Similarly, QI determinations may be retroactive for a maximum of three months prior to the month of application within the same calendar year. Unlike QMB and SLMB, individuals who qualify for QI cannot be eligible for a separate eligibility group covered under the state plan. See section 1902(a)(10)(E)(iv).

State Medicaid programs pay for a QI's Medicare Part B premium to the extent their state Medicaid program has available funding. The federal government makes annual allotments to states to fund the Part B premiums. See 1933(g) of the Act.

1.6.3 All Medicaid Categories
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

In their buy-in agreements, states can elect a Part B buy-in group that includes all individuals eligible for Medicaid under the state plan. This "catch-all" group includes the cash assistance categories and three MSP categories above, plus all other individuals who are eligible for Medicaid, such as the poverty-level group for individuals 65 years old or older (sections 1902(a)(10)(A)(ii)(X); 1902(m)(1) of the Act); the medically needy (section 1902(a)(10)(C) of

[34] In 2018, 22 percent of SLMBs qualified for full-benefit Medicaid in addition to SLMB (sometimes referred to as "SLMB-plus"), while 78 percent of SLMBs qualified for SLMB alone (sometimes referred to as "SLMB-only").

the Act; 42 CFR § 435.301); and institutionalized individuals eligible under a special income level (section 1902(a)(10)(A)(ii)(V) of the Act; 42 CFR § 435.236).

Generally, the eligibility effective date for Medicaid categories is up to three months before the month of application if all eligibility criteria are met, with exception of the QMB program as described above. See 42 CFR § 435.915. The state is precluded from paying the Medicare Part A premiums for these Medicaid categories.

1.7 Part A Buy-in Agreement Group - Qualified Medicare Beneficiary (QMB) Program

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Starting January 1, 1990, CMS deemed all buy-in agreements (except in states that opted out), to include the payment of Part A premiums for individuals age 65 or over who meet the requirements for Premium-Part A and are otherwise eligible as QMBs. [35]

See section 1.3.2 for more information about eligibility for Premium-Part A and section 1.6.2.1 for more information about QMB.

The majority of states include the payment of premiums for Medicare Part A for QMBs in their agreements and are known as "Part A buy-in states." See section 1.2 for the advantages of a Part A buy-in agreement for states. States that do not include Premium-Part A for QMBs in their state buy-in agreements are known as "group payer states." See the table in appendix 1.D, which classifies states by whether they are a Part A buy-in state or a group payer state as of July 2020.

***NOTE:** States can choose to pay Part A premiums for QMBs through their buy-in agreements or a group payer arrangement. Federal law requires states to pay the Part A premium for QDWIs through the group payer arrangement.*

1.8 Conversion from Part A Group Payer to Part A Buy-in Status

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

A group payer state may elect to become a Part A buy-in state at any time. See 42 CFR § 406.26(a). Enrollments under a new buy-in agreement can be no earlier than the third month after the month in which the agreement is executed (i.e., formal notification is signed by the state and accepted by CMS). See 42 CFR § 406.26(b).

Interested states should contact the Medicare-Medicaid Coordination Office, who will then coordinate with the state's Center for Medicare and CHIP Services (CMCS) SPA Coordinator and the Division of Premium Billing and Collections in CMS' Office of Financial Management (see contact information in chapter 6).

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[35] CMS (then HCFA) stated, "we informed the States that we would consider all States to have requested modification of their buy-in agreements to cover Part A for QMBs, unless they notified us, by a specified date, that they did not wish to use the buy-in procedure." 56 Fed. Reg. 38074 at 38076 (August 12, 1991).

1.9 Federal Financial Participation (FFP) for Buy-in Categories
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States can receive FFP for individuals who are enrolled in the required categories described above and the relevant MSPs. Specifically, states can seek FFP for the state payment of:

- *Medicare Part B premiums, deductibles, coinsurance, and copays for cash assistance recipients (SSI/SSPs) and deemed recipients of cash assistance;*
- *Part A or B premiums, deductibles, coinsurance and copays for QMBs; and*
- *Part B premiums for SLMBs.*

The state's regular FMAP rate applies to these expenditures.[36]

For eligible individuals who are enrolled in any other category of Medicaid, FFP is not available for the state payment of Part B premiums. However, it may be cost-effective for states to include additional categories in their Part B buy-in coverage group since states cannot obtain FFP for state Medicaid expenditures that could have been paid for under Medicare Part B if the person had been enrolled in Part B. See 42 CFR § 431.625(d)(3).

State agencies report gross expenditures (total computable) and apply the applicable FMAP on the Quarterly Expenditure Report for Medical Assistance Payments (Form CMS-64).[37]

States should direct any questions about Form CMS-64 to the analyst within the CMCS Medicaid and CHIP Operations Group (MCOG), Division of Financial Operations (DFO) for their state.

1.10 Streamlined Enrollment Under a Buy-in Agreement
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in agreements permit states to enroll members of a buy-in group in Medicare Part A or B and agree to pay their premiums ***at any time of the year (without regard to enrollment periods).*** *CMS does not bill states for any applicable premium surcharges due to late enrollment. See sections 1843 and 1818(g) of the Act.*

In all states, SSA must first determine an individual eligible for Medicare before the state can enroll the individual in buy-in.

If a buy-in group member is neither entitled to Medicare Part A nor enrolled in Part B, *SSA has not yet determined the individual eligible for Medicare. The state should direct the individual to file for Medicare at the SSA Field Office (SSA FO) to enable the state to enroll the person in buy-in.*

If a buy-in group member is entitled to Medicare Part A or is enrolled in Part B, *SSA has*

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[36] Note: The federal government funds 100 percent of the Part B premiums for QIs through annual allotments made to states. See section 1933(g) of the Act.

[37] The expenditures for allowable Medicare Part A premiums are claimed on line 17.A of the Form CMS-64.9 or CMS-64.9P (whichever applies). The expenditures for allowable Medicare Part B premiums are claimed on line 17.B of the Form CMS-64.9 or CMS-64.9P.

established Medicare eligibility for this individual. The state should directly enroll the individual in buy-in without first sending them to file for Medicare at SSA. See section 1.3 for information regarding Medicare eligibility and enrollment.

Referring an individual to the SSA FO to file a Medicare application for the Part the individual is not already enrolled in is not appropriate. For example, if a member of a group is entitled to Premium-free Part A but is not enrolled in Part B, the state should directly enroll the individual in Part B buy-in without referring them to the SSA FO to file for Part B. Similarly, if a QMB-eligible individual is already enrolled in Part B, a Part A buy-in state should directly enroll that individual in Part A buy-in (without requiring the individual to first file for Part A at the SSA FO). As noted in section 1.11, in group payer states, individuals must always file for Premium-Part A at SSA before the state can enroll them in Part A buy-in.

1.11 Conditional Enrollment Process for QMBs to Enroll in Premium-Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Individuals must be entitled to Part A in order to qualify for the QMB program. However, individuals who qualify for the QMB program who are only eligible for Premium-Part A likely cannot afford to pay the Medicare Part A premium without assistance from the QMB program. This creates a predicament for low-income individuals, which SSA's "conditional" Part A enrollment process helps to address.

The conditional enrollment process allows an individual to apply for Premium-Part A at SSA on the condition that he or she only wants coverage if the state approves their QMB application. CMS considers a conditional Part A filing to be sufficient to fulfill the requirement for entitlement to Part A for the purpose of QMB eligibility under section 1905(p)(1)(A) of the Act. If an individual who conditionally files for Part A then applies for the QMB program with their state Medicaid program, the individual can effectively become simultaneously enrolled in Part A and the QMB program if the individual meets all other QMB eligibility requirements.

The conditional enrollment acts as a placeholder in SSA's system. Premium-Part A entitlement is only effective with the individual's enrollment in QMB. The Medicare Part A start date will reflect the QMB start date that the state reports to CMS. If the state does not determine the individual eligible for QMB, SSA will not establish Premium-Part A entitlement.

When processing the conditional Part A enrollment, SSA will refer the individual to the appropriate state Medicaid office to apply for the QMB program and may give the individual a screen shot of the application to bring to the state as proof of the conditional enrollment. The state can also query SSA's State Verification and Exchange System (SVES) to verify the conditional Part A enrollment. See SSA POMS HI 00801.140 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140 for more information about the conditional enrollment process.

In group payer states, Part A buy-in is always a two-step process. The state cannot determine an individual eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A entitlement. Individuals who do not file for Premium-Part A during their IEP can only file for Premium-Part A during the annual GEP (January through March). If an

individual enrolls in Premium-Part A during the GEP, QMB coverage starts July 1 of the calendar year (if the state determines the individual eligible for QMB before July 1), or a month later than July of that year (if the individual is determined eligible for QMB on July 1 or later).[38] *The state pays any premium surcharges.*

In Part A buy-in states, if an individual lacks Premium-free Part A, but is already enrolled in Part B (and otherwise qualifies for QMB), the state must enroll the individual in QMB and refrain from referring them to SSA to file for actual or conditional Part A. As mentioned in section 1.10, SSA has established Medicare Part A eligibility for this individual. Since individuals enrolled in Part B meet the requirements for Part A eligibility, they satisfy the requirement to be entitled to Part A for the purposes of the QMB eligibility determination. However, if a QMB applicant lacks Part A and Part B, the state cannot determine the individual eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A enrollment. A conditional Part A filing is sufficient to fulfill the requirement for entitlement to Part A as applicable for QMB coverage. Such individuals can conditionally enroll in Premium-Part A at any time of the year, with no state liability for premium surcharges.

1.12 Policy Regarding Which Entity Initiates Buy-in

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Depending upon the circumstances, CMS or the state will generally initiate buy-in enrollment ("accretion"). This section describes which entity initiates the accretion.

***NOTE:** Depending upon state procedures, the SSA FO can use a Public Welfare (PW) accretion to initiate Part B buy-in for individuals who file a Part B application and appear to qualify for Part B buy-in. Enrolling the individual in Part B through buy-in protects the beneficiary from paying premiums through deductions from SSA or RRB or by direct bill, which is mailed to the beneficiary by CMS. See chapter 2, section 2.8 for more information about PW accretions.*

1.12.1 Part B Buy-in for Cash-Related Recipients (SSI/SSPs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA regularly communicates with states regarding who is entitled to SSI and/or federally-administered SSPs through SSA data systems, such as the State Data Exchange (SDX). See chapter 2, section 2.4.2 for a list of SSA systems for states. In addition, SSA sends information to CMS about SSI/SSPs recipients who qualify for Medicare which, in turn, assists states in enrolling cash recipients in Part B buy-in. See chapter 2, section 2.5.1.1 for more information.

The state is responsible for accreting individuals the state has found eligible for Medicaid in the SSI criteria category to the state's buy-in rolls.

***In auto-accrete states and states with 1616 agreements,** CMS automatically accretes individuals in Part B buy-in only after SSA notifies CMS that the individual is entitled to SSI and eligible for Medicare. In states with 1616 agreements, CMS will auto-accrete individuals who receive SSI*

[38] If the state determines the individual eligible in June of that year, QMB coverage can start as early as July 1.

only, or SSI in combination with SSPs, or SSPs-only.

***NOTE:** Although CMS generally initiates auto-accretions for these individuals, the state is responsible for taking action to ensure all eligible individuals are enrolled in Part B buy-in.*

In alert states (SSI Criterion and 209(b) states (states that apply stricter eligibility criteria than SSI)), CMS sends states "SSI alert notification" records for SSI individuals who are also eligible for Medicare. The state is responsible for accreting individuals the state has found eligible for Medicaid in the SSI criteria category to the state's buy-in rolls.

States must always initiate:

- *Part A or B buy-in for QMBs;*
- *Part A buy-in for QDWIs;*
- *Part B buy-in for deemed recipients of cash assistance;*
- *Part B buy-in for SLMB and QI; and*
- *Part B buy-in for other full-benefit Medicaid recipients.*

1.13 Definition of Part B Buy-in Coverage Period (See Appendix 1.C)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

1.13.1 Beginning of Part B Buy-in Coverage (42 CFR § 407.47)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

For an individual enrolled in the Required Categories (i.e., cash assistance recipients or deemed recipients of cash assistance) or the three MSPs, Part B buy-in begins the later of:

- *The first month in which the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility for Medicare Part B; or*
- *The first month in which the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility for Medicare Part B; or*
- *The effective date of the buy-in agreement or modification that includes the buy-in group to which the individual belongs (defined as the third month after the document's execution).*

For an individual enrolled in one of the other Medicaid categories (e.g., the buy-in group includes all Medicaid categories), Part B buy-in begins the later of:

- *The second month after the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's Medicaid coverage) and eligibility for Medicare Part B; or*
- *The effective date of the buy-in agreement or modification that includes the buy-in group to which the individual belongs (defined as the third month after the document's execution).*

To determine the effective date of Part B buy-in, a state must consider all bases of membership in the buy-in group. If a state determines an individual eligible for QMB-plus or SLMB-plus, Part B buy-in begins the earlier of the buy-in effective date applicable to the Medicaid or MSP categories.

To illustrate, for a QMB-plus individual, the start of Part B buy-in coverage is often earlier than the QMB effective date. For example:

If an individual is enrolled in a required category (e.g., SSI) effective April 1 and the QMB effective date is August 1, Part B buy-in starts on April 1 (i.e., the buy-in start date for required categories).

If an individual is enrolled in one of the other Medicaid categories effective April 1 and the QMB effective date is August 1, Part B buy-in starts on June 1 (i.e., the buy-in start date for other Medicaid categories).

1.13.2 End of Part B Buy-in Coverage (42 CFR § 407.48)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part B buy-in coverage ends with the earliest of the events specified below:

- ***Death –*** *Coverage ends on the last day of the month in which the individual dies.*

- ***Loss of enrollment in Medicare Part A –*** *If an individual is under age 65 and is no longer enrolled in Medicare Part A (i.e., no longer qualifies for SSA Disability benefits), Part B buy-in ends on the last day of the last month for which the individual is enrolled in Part A.*

- ***Termination or modification of the buy-in agreement –*** *If the state's buy-in agreement is terminated or modified to restrict coverage to a narrower buy-in group, coverage for an individual ends on the last day of the last month for which the agreement is in effect or covers the broader group.*

- ***Loss of membership in the buy-in group –*** *The last day of the month in which the individual is enrolled in one or more Medicaid categories under the buy-in group.*

CMS may modify the effective date of the deletion requested by the state based on CMS system processing rules that limit the retroactivity of Part B deletions to two months prior to the "processing month." See 42 CFR § 407.48(c). To learn more about CMS processing limits intended to prevent excessive hardship for beneficiaries, see chapter 2, section 2.6.1.3.

States must redetermine eligibility and continue buy-in coverage without interruption if the individual qualifies for another Medicaid category covered under the buy-in agreement. See section 1.4 for state requirements when an individual loses eligibility for a buy-in group category.

1.14 Definition of Part A Buy-in Coverage Period (42 CFR § 406.26) (See Appendix 1.C)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

1.14.1 Beginning of Part A Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part A buy-in begins the later of:

- *The effective date of the buy-in agreement or modification that covers QMBs (defined as the third month after the document's execution); or*
- *The month the individual is enrolled in Premium-Part A and QMB. See appendix 1.C for the effective date of QMB.*

NOTE: *SSA's conditional enrollment process allows individuals to meet the eligibility criterion for the QMB program (entitlement in Part A), enabling states to determine them eligible for QMB and buy them into Part A. See section 1.11 for information about SSA's conditional enrollment process for QMB-eligible individuals.*

1.14.2 End of Part A Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part A buy-in coverage ends with the earliest of the events specified below:

- ***Death*** *– Coverage ends on the last day of the month in which the individual dies.*

- ***Enrollment in Premium-free Part A*** *– If an individual enrolls in Premium-free Part A, Part A buy-in coverage ends on the last day of the last month the individual is enrolled in Premium-Part A.*

- ***Termination of the Part A buy-in agreement*** *– If the state terminates its Part A buy-in agreement (i.e., removes the payment of Part A premiums for QMB from the buy-in agreement), coverage through the buy-in agreement will end. However, payment of the Part A premiums for QMB individuals must continue under the group payer arrangement.*

- ***Loss of QMB status*** *– The last day of the month in which the individual is enrolled in QMB.*

CMS may modify the effective date of the deletion requested by the state based on the CMS regulation that limits the Part A deletion date to the month CMS processes the deletion. See 42 CFR § 406.26. To learn more about CMS processing of Part A deletion requests for individuals who lose QMB status, see chapter 2, section 2.6.1.4.

1.15 Implications and Options for Beneficiaries When State Buy-in Coverage Ends

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

When a state stops paying the Part A or Part B premium for an individual, Medicare enrollment continues without interruption, with the beneficiary assuming responsibility for paying the premiums. See 42 CFR §§ 406.26(d) and 407.50(a).

- *Premiums paid under a state buy-in agreement: The beneficiary is deemed to have enrolled during the IEP and is liable for the standard base premium amount even if they had been paying a premium surcharge prior to enrollment in buy-in.*

- *Premiums paid under state group payer arrangement: The beneficiary becomes liable for the premium amount the state paid (i.e., the Medicare Part A premium may be subject to a premium surcharge if the state had been paying one).*

If the beneficiary receives Social Security (OASDI or SSI)RRBor Civil Service Retirement benefits, SSA will typically deduct the Part A and/or B premium amount for their monthly benefit payment. If the beneficiary does not receive Social Security, RRB or Civil Service Retirement benefits (or their benefit is less the premium amount owed), they will receive bills from CMS or SSA ("direct billing") for Medicare Part A and/or B premiums.[39] Once the state ends buy-in coverage, SSA will send the beneficiary a notice of state buy-in termination ("buy-out notice").

1.15.1 Voluntary Withdrawal (Termination) From Medicare

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The buy-out notice describes the option to withdraw from Medicare Part A and/or Part B and encloses a ***Request for Termination of Premium Hospital and/or Supplemental Medical Insurance*** *(Form CMS-1763) that the beneficiary can file to terminate Medicare coverage. See appendix 1.E for the process of voluntary termination when buy-in ends and appendix 1.F for copy of Form CMS-1763.*

- *If the beneficiary files Form CMS-1763 within 30 days of the buy-out notice date, Part A and/or B will generally terminate the month buy-in has ended.*

NOTE: *The notice may be dated after buy-in has already terminated.*

- *If the beneficiary files Form CMS-1763 during the six months following the loss of buy-in (group payer coverage), Medicare coverage ends at the end of the month in which the beneficiary filed the notice.*

- *If a beneficiary waits more than six months after buy-in (group payer) coverage ends to*

[39] Part B premiums are billed quarterly, whereas Part A alone and Part A and Part B combined are billed monthly. A grace period for premium payment extends until the end of the third month of unpaid premiums; after 90 days the direct billing notice will include a termination date of coverage.

file Form CMS-1763, coverage ends at the end of the month after the month in which the beneficiary notifies SSA or CMS that they wish to withdraw.

1.15.2 Options for Financial Relief from Retroactive Part B Premium Billing

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA may initially bill beneficiaries for Part B premium liability amounts of up to three months (current month plus two retroactive billing months) when Part B buy-in coverage ends. See 42 CFR § 407.48(c) and chapter 2, section 2.6.1.3. Beneficiaries have two options to obtain financial relief from retroactive Part B premium billing.

- *Premium Waiver - Beneficiaries who believe they cannot afford to pay the retroactive premiums can request a premium waiver by submitting a Request for Waiver of Overpayment Recovery, available at https://www.ssa.gov/forms/ssa-632-bk.pdf to their local SSA office. If SSA grants the waiver request and has already deducted retroactive Medicare premiums from the beneficiary's benefit payment, SSA will refund the waived amount to the beneficiary. See SSA POMS HI 00830.15 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830015 for more information about retroactive premium waivers.*

- *Installment Payments for Retroactive Premiums - Beneficiaries may request an installment plan from their local SSA office if they indicate they cannot afford to pay the retroactive premiums in one lump sum and a waiver is not possible. Installment payments must be at least $20 per month. For more information about installment payments, see SSA POMS HI 00830.060 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830060.*

Appendix 1.A Dual Eligibility Categories and Assistance with Medicare Part A and Part B Costs

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Category	*Monthly Income**	*Assets **	*Covers Part A premium (when applicable)*	*Covers Part B premium*	*Covers Parts A and B cost-sharing*	*Full-benefit Medicaid coverage***
QMB-only	*FPL ≤ 100%*	*≤3 times the SSI resource limit, adjusted based on the CPI*	*X*	*X*	*X****	
*QMB plus***	*FPL ≤ 100%*	*States determine resources criteria*	*X*	*X*	*X****	*X*
SLMB-only	*> 100% FPL < 120%*	*≤3 times the SSI resource limit, adjusted based on the CPI*		*X*		
*SLMB plus***	*> 100% FPL < 120%*	*≤3 times the SSI resource limit, adjusted based on the CPI*		*X*	*Depends on state plan******	*X*
QI	*≥ 120% FPL < 135%*	*<3 times the SSI resource limit, adjusted based on the CPI*		*X*		
QDWI	*≤200% FPL*	*≤2 times the SSI resource limit*	*X*			
*Full-benefit Medicaid (only)***	*Determined by state*	*Determined by state*		*Depends on state Buy-in Agreement********	*Depends on state plan******	*X*

** The income and asset limits for the MSPs are released annually by CMS. The income limit for QDWI includes an earned income disregard of $65. The asset limit calculation for QMBs, SLMBs, and QIs is three times the SSI resource limit, adjusted annually by increases in the CPI (effective January 1, 2010). States can effectively raise the federal floor for income and resources standards under the authority of section 1902(r)(2) of the Social Security Act, which generally permits state Medicaid agencies to disregard income and/or resources that are counted under certain standard financial eligibility methodologies. Some states have used the authority of section 1902(r)(2) of the Act to eliminate any resource criteria for the MSP groups.*

*** "Full-benefit" Medicaid coverage generally refers to coverage for a range of items and services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to when they qualify under certain eligibility categories included in the state plan. Individuals who are QMB/SLMB "plus" receive full-benefit Medicaid in addition to Medicare cost-sharing and premiums coverage. Individuals who receive full-benefit Medicaid only are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full-benefit Medicaid benefits, but not the QMB or SLMB programs*

**** While individuals enrolled in QMB do not pay Medicare deductibles, coinsurance, or copays, they may have a small Medicaid copay for certain Medicaid-covered services.*

***** States pay the Part B premiums if they include all Medicaid categories in their Part B buy-in coverage group.*

****** Beneficiary pays no more than the amount allowed by the state plan for services covered by both Medicare and Medicaid if the provider participates in Medicaid. Also, all Medicare providers (regardless of Medicaid participation) must accept the Medicare-allowed amount as payment in full for Part B services furnished to dual eligible beneficiaries.*

Appendix 1.B Dual Eligibility Category Descriptions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB-Only – also known as QMB "partial-benefit") *are enrolled in Medicare Part A (or if uninsured for Part A, have filed for Premium-Part A on a conditional basis), have income up to 100 percent of the federal poverty level (FPL) and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation, and are not otherwise eligible for full-benefit Medicaid coverage. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance and copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost-sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service.*

QMBs with full-benefit Medicaid (QMB-Plus – also known as QMB "full-benefit") *meet the QMB-related eligibility requirements described above and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to the coverage for Medicare premiums and cost-sharing described above, QMB-plus individuals receive the full range of Medicaid benefits applicable to the separate eligibility group for which they qualify. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance and copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost-sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service. QMBs with full-benefit Medicaid pay no more than the Medicaid coinsurance[40] (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover). These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan, unless the state chooses to pay these costs.*

Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB-Only – also known as SLMB "partial-benefit") *are enrolled in Part A and have income between 100 and 120 percent of the FPL, and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. Medicaid pays only the Medicare Part B premiums for this group.*

Specified Low-Income Medicare Beneficiaries (SLMBs) with full-benefit Medicaid (SLMB-Plus – also known as SLMB "full-benefit") *meet the SLMB-related eligibility requirements described above, and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to coverage for Medicare Part B premiums,*

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[40] States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR §§ 447.52 to 447.56.

these individuals receive full-benefit Medicaid coverage (i.e., the package of benefits provided to the separate Medicaid eligibility group for which they qualify). These individuals pay no more than the Medicaid coinsurance[41] (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover.) These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan, unless the state chooses to pay these costs.

***Qualifying Individuals (QIs)** are enrolled in Part A and have income of at least 120 but less than 135 percent of the FPL, and resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation. QIs may not be eligible for a separate eligibility group covered under the state plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available funding. The federal government makes annual allotments to states to fund the Part B premiums.*

***Qualified Disabled and Working Individuals (QDWIs – also known as QDWI "partial-benefit")** became eligible for Premium-free Part A by virtue of qualifying for Social Security Disability Insurance (SSDI) benefits, but lost those benefits, and consequently Premium-free Medicare Part A, because they returned to work. QDWIs have income that does not exceed 200 percent of the FPL, resources that do not exceed two times the SSI resource standard, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.*

***Full-benefit Medicaid Only:** These individuals are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB programs. Full-benefit Medicaid coverage refers to the package of services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to when they qualify under eligibility categories covered under a state's Medicaid program. Some of these coverage categories are ones states generally must cover (for example, SSI recipients) and some are ones states have the option to cover (for example, the "special income level" group for institutionalized individuals, home and community based services (HCBS) participants, and "medically needy" individuals). Some of the services covered by Medicaid are ones Medicare does not cover, such as certain long-term services and supports (LTSS), certain behavioral health, transportation, and vision services. Medicaid benefits vary by state. A full-benefit Medicaid beneficiary pays no more than the Medicaid coinsurance[42] (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover.) These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan, unless the state chooses to pay these costs.*

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[41] States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR §§ 447.52 to 447.56.

[42] States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR §§ 447.52 to 447.56.

Appendix 1.C Medicaid Effective Dates and Buy-in Start and Stop Dates

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Medicaid Category	***Medicaid category effective date is up to three months before the month of application*** ***42 CFR § 435.915(a)***	***Medicaid category effective date is the month after the eligibility requirements are met***** ***Section 1902(e)(8) of the Act***	***Part B buy-in starts the month an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(a)-(c)***	***Part B buy-in starts the second month after an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(d)***	***Part A buy-in starts the month an individual is enrolled in Medicare Part A and has QMB status***** ***42 CFR § 406.26(b)***	***Part B buy-in deletion due to loss of coverage group membership, is effective the month after coverage group membership ends ****** ***42 CFR § 407.48(c)***	***Part A buy-in deletion based on loss of QMB status is effective the month after QMB ends ******* ***42 CFR § 406.26 (c)(2)***
Cash assistance (SSI/SSPs) and deemed recipients of cash assistance who are categorically needy	*X*		*X*			*X*	
QMB		*X*	*X*		*X* *In Group Payer states only:* *As early as July 1 of any given year in which actual or conditional Part A application occurred*	*X*	*X*

Medicaid Category	***Medicaid category effective date is up to three months before the month of application*** ***42 CFR § 435.915(a)***	***Medicaid category effective date is the month after the eligibility requirements are met***** ***Section 1902(e)(8) of the Act***	***Part B buy-in starts the month an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(a)-(c)***	***Part B buy-in starts the second month after an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(d)***	***Part A buy-in starts the month an individual is enrolled in Medicare Part A and has QMB status**** ***42 CFR § 406.26(b)***	***Part B buy-in deletion due to loss of coverage group membership, is effective the month after coverage group membership ends ***** ***42 CFR § 407.48(c)***	***Part A buy-in deletion based on loss of QMB status is effective the month after QMB ends ****** ***42 CFR § 406.26 (c)(2)***
					during the GEP.		
SLMB	*X*		*X*			*X*	
QI	*X*		*X*			*X*	
Other Full-benefit Medicaid Eligibility Categories	*X*			*X*		*X*	

**This date applies if a buy-in agreement is already in effect; currently, all states include MSPs in their Part B buy-in agreements. Thirty-six states and DC have Part A buy-in agreements.*

*** An individual in a Group Payer state who must enroll in Premium-Part A but has missed their IEP, must enroll in Premium-Part A (conditionally or unconditionally) during the GEP. If the state determines the individual eligible for QMB in June of that year, QMB can start July 1.*

**** CMS may modify the effective date of the Part B deletion requested by the state because CMS limits the retroactivity of Part B deletions to two months prior to the "processing month." See chapter 2, section 2.6.1.3.*

***** CMS may modify the effective date of the Part A deletion requested by the state because CMS limits the Part A deletion date to the month CMS processes the deletion. See chapter 2, section 2.6.1.4.*

Appendix 1.D Classification of States by SSI and Part A Status as of July 2020
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

State	*SSI Status Accrete or Alert*	*Part A Buy-in*	*Part A Group Payer*[43]
Alabama	*Accrete*		*X*
Alaska	*Alert (SSI-criterion)*	*X*	
Arizona	*Accrete*		*X*
Arkansas	*Accrete*	*X*	
California	*Accrete*		*X*
Colorado	*Accrete*		*X*
Connecticut	*Alert (209b)*	*X*	
Delaware	*Accrete*	*X*	
District of Columbia	*Accrete*	*X*	
Florida	*Accrete*	*X*	
Georgia	*Accrete*	*X*	
Hawaii	*Alert (209b)*	*X*	
Idaho	*Alert (SSI-criterion)*	*X*	
Illinois	*Alert (209b)*		*X*
Indiana	*Accrete*	*X*	
Iowa	*Accrete*	*X*	
Kansas	*Alert (SSI-criterion)*		*X*
Kentucky	*Accrete*		*X*
Louisiana	*Accrete*	*X*	
Maine	*Accrete*	*X*	
Maryland	*Accrete*[44]	*X*	
Massachusetts	*Accrete*	*X*	
Michigan	*Accrete*	*X*	
Minnesota	*Alert (209b)*	*X*	
Mississippi	*Accrete*	*X*	
Missouri	*Alert (209b)*		*X*
Montana	*Accrete*	*X*	

[43] States can choose to pay Part A premiums for QMBs through their buy-in agreements or a group payer arrangement. Federal law requires states to pay the Part A premiums for QDWIs through the group payer arrangement.

[44] Although Maryland has a 1634 agreement, CMS does not auto-accrete SSI recipients who are Medicare-eligible in Part B buy-in. Instead, Maryland initiates Part B buy-in enrollment for Medicare-eligible SSI recipients.

State	*SSI Status Accrete or Alert*	*Part A Buy-in*	*Part A Group Payer*[43]
Nebraska	*Alert (SSI-criterion)*		*X*
Nevada	*Alert (SSI-criterion)*	*X*	
New Hampshire	*Alert (209b)*	*X*	
New Jersey	*Accrete*		*X*
New Mexico	*Accrete*		*X*
New York	*Accrete*	*X*	
North Carolina	*Accrete*	*X*	
North Dakota	*Alert (209b)*	*X*	
Ohio	*Accrete*	*X*	
Oklahoma	*Alert (209b)*	*X*	
Oregon	*Alert (SSI-criterion)*	*X*	
Pennsylvania	*Accrete*	*X*	
Rhode Island	*Accrete*	*X*	
South Carolina	*Accrete*		*X*
South Dakota	*Accrete*	*X*	
Tennessee	*Accrete*	*X*	
Texas	*Accrete*	*X*	
Utah	*Alert (SSI-criterion)*		*X*
Vermont	*Accrete*	*X*	
Virginia	*Alert (209b)*		*X*
Washington	*Accrete*	*X*	
West Virginia	*Accrete*	*X*	
Wisconsin	*Accrete*	*X*	
Wyoming	*Accrete*	*X*	

Appendix 1.E Implications and Options for Beneficiaries Who Lose Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Voluntary Termination/Withdrawal from Medicare Part A and/or B	
Process to terminate coverage *SSA POMS HI 00820.901 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600820901)*	• *The "buy-out" notice from SSA, includes the Request for Termination of Premium Hospital and/or Supplemental Medical Insurance (Form CMS-1763) that the beneficiary must file to terminate Medicare coverage. See Appendix 1.F for copy of Form CMS-1763* • *On the form the beneficiary must specify termination of Part A (Premium-HI Hospital Insurance) or both Premium-HI and Part B (SMI Medical Insurance)*
Terminating coverage when state buy-in ends *SSA POMS HI 00820.015 (Premium-Part A) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600820015)* *SSA POMS HI 00815.042 (Part B) (https://secure.ssa.gov/poms.nsf/lnx/0600815042)*	• *If the beneficiary files Form CMS-1763 to withdraw from Premium-Part A within 30 days of the buy-out notice date, Premium-Part A will terminate the month state buy-in ends*
Withdrawals after the state buy-in ends *SSA POMS HI 00820.015 (Premium-Part A) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600820015)* *SSA POMS HI 00815.042 (Part B) (https://secure.ssa.gov/poms.nsf/lnx/0600815042)*	• *If the beneficiary files Form CMS-1763 within six months after a state buy-out, but not within 30 days of the buy-out notice, Premium-Part A enrollment through the end of the month.*
Terminating coverage six months or more after state buy-in ends	• *If the beneficiary files Form CMS-1763 to withdraw from Premium-Part A more than six months after state buy-in ends, the Premium-Part A termination is effective at the end of the month after the month the beneficiary files for withdrawal.*

Voluntary Termination/Withdrawal from Medicare Part A and/or B	
	NOTE: *In group payer states, withdrawals after buy-out will be assigned a Premium A termination date equal to two months after the date of the requested month.*

Options for Financial Relief from Retroactive Part B Premium Billing	
Premium Waiver *SSA POMS HI 00830.015 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830015)*	• *If beneficiaries cannot afford to pay the retroactive premiums, they can request relief by submitting a Request for Waiver of Overpayment Recovery, available at https://www.ssa.gov/forms/ssa-632-bk.pdf, to their local SSA office. If SSA grants the waiver request and has already deducted retroactive Medicare premiums from the beneficiary's benefit payment, SSA will refund the waived amount to the beneficiary.*
Installment Payments for Retroactive Premiums *SSA POMS HI 00830.060 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830060)*	• *Beneficiaries may request an installment plan from their local SSA office if they indicate they cannot afford to pay the retroactive premiums in one lump sum, and a waiver is not possible. Installment payments must be at least $20 per month.*

Appendix 1.F Request for Termination of Premium Hospital and/or Supplemental Medical Insurance

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0025 (Expires: 05/21)

REQUEST FOR TERMINATION OF PREMIUM HOSPITAL AND/OR SUPPLEMENTARY MEDICAL INSURANCE

DO NOT WRITE IN THIS SPACE

The completion of this form is needed to document your voluntary request for termination of Medicare coverage as permitted under the Code of Federal Regulations. Section 1838(b) and 1818A(c)(2)(B) of the Social Security Act require filing of notice advising the Administration when termination of Medicare coverage is requested. While you are not required to give your reasons for requesting termination, the information given will be used to document your understanding of the effects of your request.

NAME OF ENROLLEE *(Please Print)*		MEDICARE NUMBER	
NAME OF PERSON, IF OTHER THAN ENROLLEE, WHO IS EXECUTING THIS REQUEST.	THIS IS A REQUEST FOR TERMINATION OF ☐ HOSPITAL INSURANCE ☐ MEDICAL INSURANCE	DATE SUPPLEMENTARY MEDICAL INSURANCE WILL END	DATE HOSPITAL INSURANCE WILL END

I request termination of my enrollment under the above sections of title XVIII of the Social Security Act, as amended, for the reason(s) stated below:

I UNDERSTAND THAT IF I AM REQUIRED TO PAY FOR MY HOSPITAL INSURANCE, THE TERMINATION OF MY SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WILL ALSO END MY HOSPITAL INSURANCE COVERAGE.

If this request has been signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses.	**SIGNATURE** *(Write in Ink)* **SIGN HERE**	
1. NAME OF WITNESS		
ADDRESS *(Number and Street, City, State and Zip Code)*	**MAILING ADDRESS** *(Number and Street)*	
2. NAME OF WITNESS	**CITY, STATE, ZIP CODE**	
ADDRESS *(Number and Street, City, State and Zip Code)*	**DATE** *(Month, Day and Year)*	**TELEPHONE NUMBER**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0025. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1763

State Buy-in Data Exchange Processes
Chapter 2

Table of Contents
(Rev. 4, 08-21-20)

Transmittals for Chapter 2

2.0 Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

State buy-in of Medicare premiums operates through a data exchange process among states, the Centers for Medicare & Medicaid Services (CMS), and the Social Security Administration (SSA).

This chapter describes:

- *The buy-in data exchange processes involving states, CMS, and SSA;*
- *State and CMS processes to start ("accrete"), change, and end ("delete") buy-in enrollment; and*
- *CMS buy-in system processing rules and tips for states.*

Chapter 3 contains buy-in file exchange layouts, and chapter 4 contains CMS system code definitions.

***NOTE:** This chapter contains links to the SSA Program Operations Manual System (POMS) and information on SSA data exchange applications as of July 2020.*[45]

2.1 Overview of State Buy-in Data Exchange

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States submit buy-in files to CMS' Third Party System (TPS) to identify individuals dually eligible for Medicare and Medicaid for whom the state will pay Part A and/or B premiums. In turn, TPS responds to state submissions with response files and a monthly billing file.

On a daily basis, TPS updates the CMS Enrollment Database (EDB) to record all state Medicaid recipients enrolled in, or being enrolled in, Medicare due to state buy-in. The EDB is the CMS authoritative source for Medicare enrollment information including demographic information, enrollment dates, state buy-in information, and Medicare managed care enrollment for all Medicare beneficiaries.

On a daily basis, TPS and EDB exchange data directly with SSA systems for storage in the Master Beneficiary Record (MBR), SSA's database that records Medicare and Social Security eligibility determinations and enrollment data. This CMS-SSA daily exchange may trigger updates to beneficiary data concerning buy-in enrollment, Medicare entitlement, and premium billing in either or both systems.

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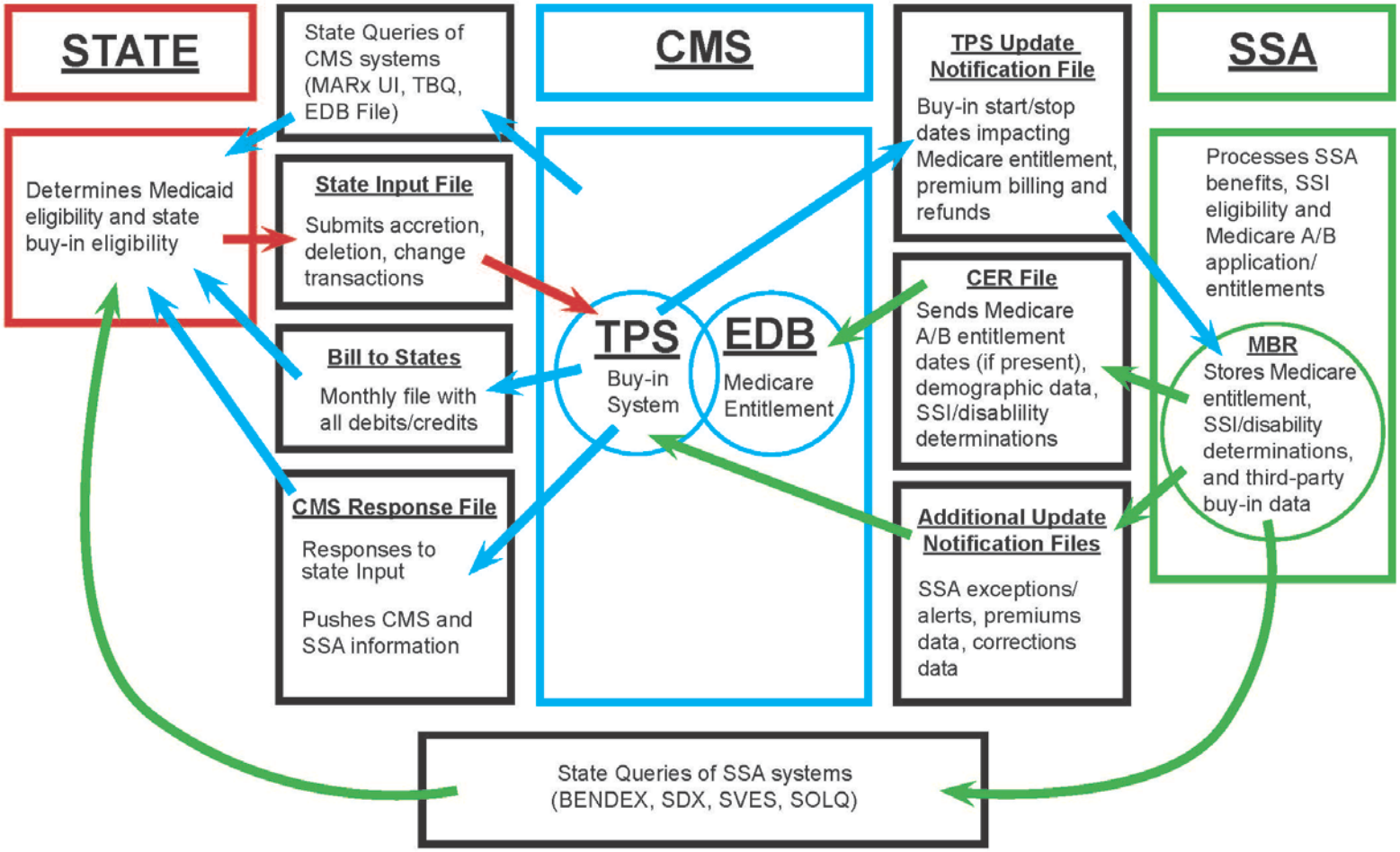
[45] As a courtesy to states, CMS provides links to the SSA POMS and other online SSA materials as of the time the manual was published. Changes may occur after release. For more information visit ssa.gov.

States can obtain information to support state buy-in operations and Medicaid eligibility and enrollment processes by querying these SSA and CMS databases in a variety of ways as described in section 2.4.



Glossary of Abbreviations

BENDEX - Beneficiary and Earnings Data Exchange
CER - Combined Exchange Record
EDB - Enrollment Database
MARx UI - Medicare Advantage Prescription Drug System User Interface
MBR - Master Beneficiary Record
SDX - State Data Exchange
SOLQ - State Online Query
SVES - State Verification and Exchange System
TBQ - Territories & States Beneficiary Query
TPS - Third Party System

2.2 Frequency of State-CMS File Exchange

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS encourages states to exchange buy-in data with TPS on a daily basis. Through March 2022, states can send input files to TPS as frequently as each business day (daily) and opt to receive one monthly response file or to receive daily response files, in addition to the monthly billing file.

Daily state-CMS buy-in exchange promotes efficiencies for states and allows beneficiaries to more quickly enroll in Medicare Part A and/or B, or stop paying Medicare premiums if they are already enrolled and had been paying them on their own.

Starting April 1, 2022, federal regulations at 42 CFR §§ 406.26 and 407.40 require all states to ***submit*** *and* ***receive*** *buy-in files on a daily basis. See the Interoperability and Patient Access final rule (CMS-9115-F), 85 Federal Register 25510 (May 1, 2020).*

NOTE: *States transitioning to daily* ***receipt*** *of CMS buy-in files should contact the MAPD Help Desk at mapdhelp@cms.hhs.gov to schedule the update. CMS may need to limit the number of states at any given time transitioning to* ***receiving*** *daily buy-in files given impacts to CMS systems.*

For CMS technical assistance to help shift to daily ***receipt*** *of buy-in files, states can contact the CMS Office of Financial Management (OFM)/Accounting Management Group (AMG)/Division of Premium Billing and Collections (DPBC) through the DPBC resource mailbox at DPBCStateBuy-In@cms.hhs.gov.*

Unlike the shift to daily ***receipt*** *of CMS buy-in files, a state's shift to* ***sending*** *daily buy-in files involves no federal system changes. States can, therefore, start to* ***send*** *daily files to CMS at any time.*

2.2.1 State Input Files

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Each state submits the buy-in input file to TPS through an electronic file transfer (EFT) exchange setup. The state's input file includes a record for each Medicare beneficiary for whom the Medicaid agency is accreting, deleting, or changing buy-in status and the state responsible for paying the Part A or B premiums.

In response, CMS returns an updated transaction record that provides data identifying, for each transaction on the state input file, whether CMS accepted, modified, or rejected it, as well as a Part A or Part B billing record showing the state's premium responsibility.

In addition, CMS may "push" new updates obtained from SSA to the state, for example, Supplemental Security Income (SSI) determinations or changes in the Health Insurance Claim Number (HICN).

NOTE: *The HICN or RRB claim numbers are preferred for state buy-in exchanges. CMS will accept the MBI, but will return only the HICN (or, for RRB beneficiaries, the converted RRB claim number, also known as pseudo HICN) on state buy-in response files.*

See chapter 3 for further details on CMS/state data exchange.

2.2.2 CMS Response to States (CMS Billing and Response Files)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*All states receive Part A and Part B monthly billing files from CMS containing all new and ongoing credit/debit billing records. In states that receive **only** monthly exchange files from CMS, CMS sends a monthly billing file containing all billing records and reply records, reflecting state, CMS, and SSA information received through the last business day of the month. In daily exchange states, CMS sends daily response files (or, as frequently as the state submits the input file), containing only reply records; the CMS monthly file includes only billing records. CMS will process each state input file on a flow basis, in the order they are received, by adding them to the input processing lineup for the next scheduled daily update run of TPS.*

The CMS reply records for state accretions and deletions will be one of the following types: An acknowledgement reply that TPS has accepted the accretion or deletion action, found in daily response files only;

- *A billing reply indicating the liability charges or refund resulting from an accepted accretion or deletion action, found in monthly response files only;*
- *A reject reply code describing the reason for the rejected accretion or deletion action; or*
- *An adjustment reply if CMS changes the date of the state transaction.*

TPS responses are differentiated by a Record Identification Code (RIC) value of A through F, each identifying a type of response. Chapter 3 contains a detailed description of the format for each RIC type included on daily response files and the monthly billing file.

RIC-A	*SSI Alert*
RIC-B	*Monthly Billing Records*
RIC-C	*Medicare Number Change Record*
RIC-D	*Date Change or Reply Record*
RIC-E	*Personal Characteristics Change Record*
RIC-F	*Reject Record*

2.3 Data Exchange Between CMS and SSA

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The Combined Exchange Record (CER) file daily exchange process between CMS and SSA eligibility systems is another integral part of buy-in data exchange.

Through CER file processing, CMS receives from SSA Medicare Part A and/or B entitlement dates, SSI and disability determinations, and demographic data. Once TPS completes its daily update of the EDB to reflect new state accretions, deletions, and changes, TPS also sends these update notifications to SSA systems for storage in its MBR database. CMS does so through its daily TPS Update Notification File transmission to SSA. If SSA systems receive and accept the records, the MBR will reflect updated enrollment information (e.g., newly enrolling buy-in coverage group members in Medicare Parts A or B) and trigger downstream premium billing actions (e.g., starting or stopping premium withholding and direct billing; issuing credits or debits for the beneficiary). SSA systems send MBR data on updated or new entitlement via the CER file to the EDB, which in turn updates the entitlement record.

In addition to state-initiated buy-in transactions, SSA may transmit data that causes CMS to perform buy-in actions for states. When the MBR is updated to reflect new or modified beneficiary information received by other parts of SSA, the SSA systems share these MBR updates with the EDB. For example, once SSA makes an SSI determination, SSA systems will share this information with the EDB via the CER file, and TPS will auto-accrete the beneficiary to Part B buy-in in an auto-accrete state or send an alert notification on behalf of the beneficiary to an alert state. See section 2.5.1.1 for more information about accretions for SSI individuals.

***NOTE:** When SSA's automated system cannot accept a buy-in record from CMS, Medicare entitlement will not update to the MBR. In these instances, SSA systems will generate a processing limitation/exception or return a deletion record to CMS. Both instances will require administrative (manual) action by CMS and/or SSA to correct.*

Discrepancies between the EDB and MBR are common in these cases. For example, TPS will continue to bill states for Part A and/or Part B premiums even if a beneficiary record does not yet show Medicare entitlement and/or may show beneficiary premium liability amounts (i.e., the record shows SSA deduction or direct billing status). If any of these situations are identified, the state should submit a resolution request to CMS' Offices of Hearings and Inquiries (OHI), Division of Medicare System Exceptions and Interfaces (DMSEI) for assistance (see chapter 6, section 6.2).

2.4 Federal Resources for States to Support Buy-in and Medicaid Operations

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States have a number of options to query an individual's HICN/MBI and Medicare entitlement status in CMS or SSA systems, or SSI status in SSA systems, in order to help the state correct and re-submit the buy-in accretion.

2.4.1 CMS Data Systems for States

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.4.1.1 Territories and States Beneficiary Query (TBQ) File
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The TBQ File supports a query process that includes Medicare Parts A, B, C, and D eligibility and enrollment data on the queried beneficiaries. States and territories may query CMS daily for Medicare beneficiary eligibility determinations. For additional information about your state's TBQ File, visit the CMS TBQ page at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/TerritoryBeneficiaryQuery.

2.4.1.2 Enrollment Database (EDB) File
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The EDB File supports a query process that includes Medicare Parts A and B eligibility and enrollment data on the queried beneficiaries. States and territories may query CMS daily for Medicare beneficiary eligibility determination. Note that CMS is not expanding access to new states; CMS will provide new states access to the TBQ.[46] For additional questions about your state's EDB File, contact the State Data Resource Center (SDRC) at http://statedataresourcecenter.com/.

2.4.1.3 Medicare Advantage Prescription Drug System User Interface (MARx UI)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The MARx UI system provides individual beneficiary look-up where users can find real-time data about a beneficiary who is enrolled in a Medicare Advantage and/or Prescription Drug plan, either currently, in the past, or in the future. Data fields include demographic data, Medicare Parts A and Part B Entitlement, Non-Entitlement, Enrollment, and Disenrollment codes, Low-Income Subsidy (LIS) status, and detailed health plan enrollment information at a beneficiary level. For information about accessing and using the MARx UI system, see the MAPD State User Guide at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/MAPD-State-User-Guide-Version-80.pdf. Note that data are only available for individuals enrolled in a Medicare plan; if they are not, the end-user will not find them in MARx and will need to check a different CMS system. For help, contact the MAPD Help Desk at mapdhelp@cms.hhs.gov or 1-800-927-8069; for more

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[46] CMS. (2019). *Data Disclosures and Data Use Agreements: States.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/States.html.

information about the MAPD Help Desk, visit their website at http://go.cms.gov/mapdhelpdesk.

2.4.1.4 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) File Exchange[47]
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The MMA File Exchange is the state's data exchange with CMS in which the state provides current information on updated full-benefit dually eligible and partial-benefit dually eligible beneficiary status (i.e., those who get Medicaid help with Medicare premiums, and often for cost-sharing), and CMS provides a response file with Medicare Parts A, B, C, and D enrollment and eligibility information. This is an operational exchange, but states may find information on the CMS response file useful for researching and trouble-shooting rejected records. For information about the MMA File Exchange, visit the CMS MMA page at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/StateMMAFile.html.

Information about the MMA File Exchange, TBQ File, and/or EDB File can also be found at Understanding CMS Data: An Overview of EDB, MMA, and TBQ Files on the SDRC[48] website at https://statedataresourcecenter.com/assets/files/Task12_Overview_Edited_SDRC_MMCO_Final508.pdf.

For technical help with the MMA File Exchange, MARx UI, TBQ File, and/or EDB File, contact the MAPD Help Desk at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/index or reference the MAPD State User Guide at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/MAPD-State-User-Guide-Version-80.pdf.

For questions regarding your CMS data agreement, status of exchanges and queries for your state/territory, or understanding the data in these files, contact SDRC at http://statedataresourcecenter.com/.

Section 2.4.1.5 provides further detail on the information provided in each file to help states

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[47] The "MMA file" is named after the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and is also referred to as the "State Phasedown file."

[48] In 2011, CMS established the SDRC to provide states with support, assistance, and guidance on how to request, access, and use Medicare data provided by CMS to support their dually eligible beneficiaries. The SDRC team consists of data experts who provide states with information and resources to help support their use of Medicare data for Medicare–Medicaid care coordination and program integrity purposes. States can locate SDRC resources on the SDRC website (http://www.StateDataResourceCenter.com), submit questions by phone at (877) 657-9889, or by email at SDRC@EconometricaInc.com.

identify Medicare eligibility within their population.

2.4.1.5 Table of CMS Files That Provide Data on Medicare Eligibility
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

File Element	*MMA*	*EDB*	*TBQ*	*MARx UI*
Beneficiary Name	*Yes*	*Yes*	*Yes*	*Yes*
Beneficiary Address	*No*	*Mailing*	*Mailing and residence*	*Yes*
Date of Birth	*Yes*	*Yes*	*Yes*	*Yes*
HICN, MBI, SSN	*HICN, MBI, SSN*	*HICN, MBI, SSN*	*HICN, MBI, SSN*	*MBI only* ***NOTE**: CMS has created an MBI Plan lookup tool in MARx that provides authorized users the ability to obtain an individual beneficiary's MBI.*[49]
Part A	*Yes*	*Yes*	*Yes*	*Yes*
Part B	*Yes*	*Yes*	*Yes*	*Yes*
Part C	*Yes*	*No*	*Yes*	*Yes*
Part D	*Yes*	*No*	*Yes*	*Yes*

[49] See the HPMS memo of May 19, 2020, on "Medicare Beneficiary Identifier (MBI) Plan Lookup Tool," available at: https://www.cms.gov/files/document/mbi-lookup-tool.pdf.

File Element	MMA	EDB	TBQ	MARx UI
Date of Disability	*No*	*Yes*	*No*	*Yes*
Dual Eligibility Status	*Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals (QIs), and other full-benefit dually eligible beneficiaries.*	*No*	*QMBs, SLMBs, QIs, and other full-benefit dually eligible beneficiaries.*	

2.4.2 SSA Data Systems for States

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

In addition to querying CMS data systems for correct HICN/MBI information, states can also query SSA systems. These queries include SSN verification and benefit information for Title II (Old Age, Survivors, and Disability Insurance (OASDI)) and Title XVI (SSI) of the Social Security Act ("the Act"), which can be used to support states' buy-in operations. Section 2.4.2.6 identifies the relevant SSA data exchanges, in the event a state prefers to leverage them. See SSA POMS GN 03314.155 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0203314155.

2.4.2.1 State Verification and Exchange System (SVES)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SVES is a batch query system that provides states and some federal agencies with a standardized method of SSN verification and uniform data response for Title II (OASDI) and Title XVI (SSI) of the Act. SVES also allows states to request information from other SSA exchange systems external to SVES (e.g., Beneficiary and Earnings Data Exchange (BENDEX), State Data Exchange (SDX)) via the SVES request.

SVES utilizes SSA's File Transfer Management System (CyberFusion) to receive and transmit files. States and, in some cases, federal agencies transmit files containing requests to SSA. SVES filters the files and routes the requests to the proper applications (e.g., BENDEX, SDX) for processing. For more details, see SSA's State Verification and Exchange System (SVES) and State Online Query (SOLQ) Manual at https://www.ssa.gov/dataexchange/documents/sves_solq_manual.pdf.

2.4.2.2 State Online Query (SOLQ)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SOLQ is an online version of SVES and allows states real-time access to SSA's SSN verification service and retrieval of OASDI or SSI data. For a full list of SOLQ/SOLQ-I record data elements, see Appendix J of SSA's State Verification and Exchange System (SVES) and State Online Query (SOLQ) Manual at https://www.ssa.gov/dataexchange/documents/sves_solq_manual.pdf. The manual also provides guidelines for requesting data from other SSA data exchange applications including BENDEX/Beneficiary Earnings Exchange Record (BEER) records, SDX records, prisoner data records, and 40 qualifying quarters records. In addition, the manual provides information about how states can obtain citizenship data to administer health care programs.

2.4.2.3 Beneficiary and Earnings Data Exchange (BENDEX)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

BENDEX is a batch data exchange from SSA that provides OASDI and earnings data to state agencies. BENDEX data is retrieved from the MBR. The primary purpose of the BENDEX is to assist states in administering the Temporary Assistance to Needy Families (TANF) program and their Medicaid programs.

BENDEX contains only those records on which the state has requested data exchange as a result of direct input by the state or as a by-product of a state buy-in action.

The BENDEX file provides OASDI benefit payment status, SSI payment status (if applicable), and Medicare enrollment dates (if applicable).

For more details, see the SSA's list of BENDEX data elements at https://www.ssa.gov/dataexchange/documents/Bendex%20record.pdf.

2.4.2.4 State Data Exchange (SDX)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SDX is a batch data exchange that provides SSI data to states that administer federally funded income or health maintenance programs. The SDX is created by SSA from the SSI record. The primary purpose of the SDX is to assist the states in administering Medicaid and State Supplemental Programs (SSPs).

SDX contains a record of all persons within the state who are eligible for the basic federal SSI payment or a federally-administered state supplement. It provides a method of identifying people who may be eligible for state buy-in. However, there is no indication of whether the individual has established eligibility for Medicare.

SDX also identifies all individuals who lose SSI regardless of whether they are on state buy-in. Loss of SSI constitutes a change in circumstances that may affect an individual's Medicaid eligibility and thus requires a redetermination. See 42 CFR § 435.916(d). See section 2.6.1.2 for more information about procedures when an individual loses SSI.

For more details, see the SDX record data elements at https://www.ssa.gov/dataexchange/documents/SDX%20record.pdf

2.4.2.5 Low-Income Subsidy (LIS)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Federal law requires SSA to transmit files containing data from LIS applications to states, and for states to use the data to initiate Medicare Savings Program (MSP) applications. States must treat the LIS "leads" data as an application for the MSP, as if it had been submitted directly by the applicant, even if SSA denied the applicant's LIS application. See sections 1144(c)(3) and 1935(a)(4) of the Act.

SSA sends daily files containing LIS application data and eligibility determinations to state Medicaid agencies. The files contain data for all LIS applications received, with limited exceptions. See SSA POMS HI 00815.024 at *https://secure.ssa.gov/poms.nsf/lnx/0600815024 for information about these exceptions. SSA LIS leads data files contain information about beneficiaries' LIS eligibility, as well as demographic, income, and resource information verified by SSA.*

For more details, see SSA's list of LIS record data elements at https://www.ssa.gov/dataexchange/documents/LIS%20record.pdf.

2.4.2.6: Table of SSA-State Data Exchanges
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Data Exchange	***Type***	***Description***	***Manual/Data Elements***
State Verification and Exchange System (SVES)	*Batch query*	*SVES draws upon BENDEX, SDX, prisoner data, and 40 qualifying quarters data.*	*SVES/SOLQ Manual (https://www.ssa.gov/dataexchange/documents/sves_solq_manual.pdf)*

Data Exchange	***Type***	***Description***	***Manual/Data Elements***
State Online Query (SOLQ)	*Individual query*	*Online version of SVES which allows states real-time access to SSA's SSN verification service and retrieval of OASDI or SSI data.*	*See above.*
State Data Exchange (SDX)	*Batch query*	*Eligibility data for the basic federal SSI payment or federally-administered SSPs. It provides a method of identifying people who may be eligible for state buy-in.*	*SDX record data elements (https://www.ssa.gov/dataexchange/documents/SDX%20record.pdf)*
Beneficiary and Earnings Data Exchange (BENDEX)	*Batch query*	*OASDI benefit payment status, SSI payment status, and Medicare enrollment dates. Data retrieved from MBR.*	*BENDEX data elements (https://www.ssa.gov/dataexchange/documents/Bendex%20record.pdf)*
LIS Leads	*Daily file*	*LIS*	*LIS record data elements at*

Data Exchange	Type	Description	Manual/Data Elements
Data	from SSA to state Medicaid agencies	application data and eligibility determinations.	https://www.ssa.gov/dataexchange/documents/LIS%20record.pdf.

2.5 Accretions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.5.1 Part B Buy-in Accretions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Each state is responsible for ensuring Part B buy-in enrollment for members of the buy-in coverage group identified in the state's buy-in agreement. CMS will generally initiate Part B buy-in enrollments for SSI eligible individuals residing in states with signed 1634 agreements, referred to as "SSI auto-accrete" states. Auto-accrete states make all buy-in eligibility determinations for non-SSI recipients and submit state accretion requests directly to CMS. Alert states are responsible for all buy-in eligibility determinations (i.e., for both SSI and non-SSI) and submit accretion requests directly to CMS. In limited circumstances, SSA can take steps to initiate Part B buy-in through the Public Welfare (PW) Accretion process for individuals who file a Medicare application and appear to qualify for Part B buy-in. See section 2.8.

2.5.1.1 Part B Buy-in for Cash Assistance Recipients (SSI/SSPs)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA explores Medicare eligibility for all SSI (including federally-administered SSPs) applicants.[50]

Through the daily CER file exchange, SSA notifies CMS about individuals who are entitled to SSI and found eligible for Medicare. CMS systems follow up with one of two actions.
In auto-accrete states, CMS systems will automatically accrete the individual to Part B buy-in and transmit an auto-accretion code to the state ***(code 1180).***

NOTE: *In auto-accrete states, an internal SSA process called the Medicare Attainment and Leads Process (MALP) identifies current SSI (and federally-administered SSPs) recipients for*

[50] SSA explores eligibility for all possible benefits, including Medicare, under the SSI applicant's SSN (this includes exploring under the SSN of a spouse, former spouse, or parent, etc.). SSA POMS SI 00601.060.D.2.i at https://secure.ssa.gov/poms.nsf/lnx/0500601060#d.

Medicare screening as they approach their 65th birthday. These individuals:

- *Must be within three months of the attainment of age 65, provided the SSI record is annotated to reflect that the individual has submitted proof of age (which meets the Title II proof of age requirements); and,*
- *Must have submitted proof of U.S. citizenship or proof that he/she has been lawfully admitted for permanent residence and has resided in the United States continuously for five years.*

See SSA POMS HI 00810.010 at https://secure.ssa.gov/poms.nsf/lnx/0600810010.

In alert states, CMS systems will transmit an SSI alert that a beneficiary in its jurisdiction is entitled to SSI benefits and may be eligible for buy-in ***(code 86bb).***

2.5.1.1.1 Auto-Accrete States and States with Federal Administration of SSPs
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

When CMS receives a record for an individual entitled to SSI (and/or federally-administered SSPs), TPS will auto-enroll the individual in Part B buy-in.

The effective date of the accretion will be the first month/year of the most recent continuous period the individual is entitled to SSI (and/orfederally-administered SSPs), entitled to Medicare, and a resident of the state.[51] CMS generates auto-accretions at any time of the year, without regard to Medicare enrollment periods or premium increases for late enrollment.

Systems Tip: *CMS notifies states of Part B auto-accretions with transaction* ***code 1180*** *in the monthly billing file (RIC-B) sent to states (or in the daily response files, RIC-D, sent to daily exchange states). The following month, the record will appear as an ongoing item* ***(code 41)*** *unless the item is deleted.*

NOTE*: States are responsible for ensuring that all eligible individuals are enrolled in buy-in. Although CMS auto-accretes SSI (federally-administered SSPs) recipients in auto-accrete states, auto-accretion may omit SSI beneficiaries in limited instances. States should review SSA records (i.e., SVES/SOLQ, SDX, or BENDEX) to identify SSI recipients and other covered members and submit needed transactions to CMS. A state-initiated SSI accretion* ***code 61*** *or* ***code 63*** *is processed in the same manner as any other state-initiated accretion.*
In addition, SSA can initiate Part B buy-in through the PW accretion process when an individual

[51] Pursuant to the court decision in NY State v. Sebelius (N.D. NY, June 22, 2009), available at https://www.govinfo.gov/content/pkg/USCOURTS-nynd-1_07-cv-01003/pdf/USCOURTS-nynd-1_07-cv-01003-0.pdf, CMS has in effect a policy under which states are granted states equitable relief from the imposition of retroactive Part B premiums in certain instances involving lengthy delays in Medicare eligibility determinations to the extent that such delays would result in retroactive auto-accretions that would cover periods for which it is too late to obtain the benefits of Medicare coverage.

files a new Medicare application. See SSA POMS HI 00815.030 at https://secure.ssa.gov/poms.nsf/lnx/0600815030 and section 2.8 for more information about PW accretions.

2.5.1.1.2 Alert States

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Alert states are responsible for accreting all SSI (SSPs) individuals in Part B buy-in if the state finds them eligible for a buy-in coverage group as part of a Medicaid eligibility determination.

To assist states with the identification of SSI recipients who are also eligible for Medicare, CMS sends SSI accretion alert records to states. CMS generates such SSI accretion alert notifications once it is notified by SSA that the SSI individual qualifies for Medicare and may be eligible for a buy-in coverage group. States can also use information transmitted through SSA systems (i.e., SVES/SOLQ, SDX, or BENDEX) to identify SSI recipients for the purpose of Medicaid eligibility determinations.

If the state determines that a Medicare-eligible individual is also eligible for a buy-in coverage group, it must submit a state accretion request to CMS. The effective date of the accretion will be the first month of buy-in eligibility based upon the SSI/SSPs effective date.

***Systems Tip:** SSI accretion alert records (RIC-A) contain a Part B transaction **(code 86)**. Once an alert state determines an SSI recipient eligible for a Part B buy-in coverage group, the state can accrete the individual to Part B buy-in (generally, **code 84**).*

2.5.1.2 Members of the Buy-in Coverage Group Who Do Not Receive Cash Assistance

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States must initiate Part B buy-in accretions for any member of the buy-in coverage group who does not receive cash assistance.

The effective date of the accretion will be based on the start date of the buy-in period, which differs depending upon the Medicaid eligibility category. See chapter 1, section 1.13 and chapter 1, appendix 1.C. States can submit a Part B buy-in accretion and establish Medicare entitlement at any time of the year, without regard to Medicare enrollment periods or premium increases for late enrollment if the individual is already enrolled in Part A or Part B. Once TPS shares the new accretion record with the MBR, the MBR will update the Medicare enrollment record.
The buy-in effective date is the first month the individual is eligible for buy-in. See chapter 1, appendix 1.C for more information about the effective dates for buy-in.

Systems Tip: Common codes used by states

- ***Code 61*** *- state accretion action;*
- ***Code 63*** *- identical to* ***code 61*** *but used for special accretion actions or monitoring specific coverage groups;*
- ***Code 84*** *- used by an alert state to accrete a beneficiary to Part B buy-in in response to a* ***code 86*** *accretion alert record or by an auto-accrete state to accrete a beneficiary based on an examination of the SDX file.*

See chapter 4 for detailed buy-in transaction code descriptions.

2.5.2 Part A Buy-in Accretions

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States may accrete QMB-eligible beneficiaries to their Part A buy-in rolls through a buy-in agreement or a group payer arrangement. For information about these options, see chapter 1, section 1.7 and chapter 2, section 2.5.3.3.

States pay Part A premiums for Qualified Disabled Working Individuals (QDWIs) only through the group payer arrangement. States may only cover Part A premiums for QDWIs; however, the individuals must be enrolled in Part B prior to the state accreting the record to their buy-in account. For more information about QDWIs, see chapter 1, section 1.6.2.

Each state is responsible for accreting individuals determined eligible for QMB or QDWI. CMS does not accrete beneficiaries to Part A buy-in except when requested to do so by the state in conjunction with a buy-in problem resolution request. See chapter 6.

For any accretion, the latest acceptable effective date a state may submit is one month prior to the current billing period. The accretion effective date may not be equal to or later than the current billing period. The current billing period is equal to the calendar month in which the accretion is processed plus two months. For example, any action processed in April is part of the June billing period. The latest accretion effective date a state may submit within the June billing period is May. Any accretion with an effective date of June submitted during the June billing period will be rejected. In other words, for any accretion processed in April (i.e., in the June billing period), the latest acceptable effective date a state may submit is May.

Systems Tip: *States use accretion* ***codes 61 and 63*** *for routine Part A accretions. The Buy-in Eligibility Code (BIEC) is* ***not*** *required for Part A billing records. States may submit a BIEC for Part A accretions and CMS will store the value in the beneficiary's EDB record; CMS, however, will not return a Part A BIEC reply.*

NOTE: *The Part A accretion BIEC will* ***not*** *update the Part B BIEC stored on the EDB.*

2.5.3 Important Processing Rules for MSP Accretions

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.5.3.1 Required Steps for QMB, SLMB, and QI Part B Buy-in Accretions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

To ensure a Part B accretion for a QMB, SLMB, or QI successfully updates through TPS, states should leave the Buy-in Eligibility Code (BIEC) blank in the initial state accretion. If the state buy-in system requires a BIEC code, states should use another code besides "P," "L," or "U" to avoid triggering a rejection.

The state can add the appropriate BIEC to the billing record by using the code 99 update process. CMS encourages states to verify Part B buy-in is present in CMS systems before submitting the ***code 99.*** *A* ***code 99*** *action will always update prospectively. States cannot change a BIEC for a past period through the buy-in data exchange.*

CMS will return a Part A or Part B ***code 21XX*** *series rejection, or sub-code C rejection record in reply to state accretion requests if the state accretion request includes the BIEC identifier. See chapter 4, section 4.7.1, for a description of the* ***code 21XX*** *rejection series.*

NOTE*: If a state determines an individual eligible for QMB-plus or SLMB-plus, Part B buy-in begins the earlier of the buy-in effective date applicable to the Medicaid or MSP categories. For QMB-plus individuals determined eligible at application, the separate full-benefit Medicaid coverage may be effective up to three months before the month of application, if the individual received Medicaid covered services and would have been eligible at the time the services were received, even though the same retroactive eligibility period does not apply to their QMB benefits. See 42 CFR § 435.915(a) and chapter 1, section 1.13.1. TPS will accept retroactive start dates for the Part B buy-in accretion as long as the BIEC identifier in the transaction is blank.*

2.5.3.2 Part B Before Part A Rule for QMB Accretions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

TPS will not accept a state's request for a ***Part A*** *accretion unless the EDB shows current Medicare Part A and* ***Part B*** *entitlement and open buy-in coverage. That is, if a state determines an individual eligible for QMB, the state or CMS must first accrete* ***Part B*** *before the state can accrete* ***Part A****. States may submit Part A and Part B accretions simultaneously in the same month or first submit a Part B accretion followed by a Part A accretion. The exception to this rule applies to QDWIs for which the state only pays premiums for Part A. TPS cannot accept a Part A accretion for QDWI records unless the EDB shows current Part B entitlement, but the beneficiary, not the state, is liable for the Part B premiums.*

NOTE: *TPS automatically sorts buy-in files so Part B actions process before Part A. To safeguard against TPS rejections for Part A and/or Part B, ensure the Part B accretion requests do not include the BIEC identifier.*

2.5.3.3 Part A Buy-in State v. Group Payer State Status
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state's payment arrangement status (i.e., Part A buy-in state or Part A group payer state) determines when a state can enroll QMB-eligible individuals in Medicare Part A. This status will also determine if the state will pay applicable surcharge amounts due to late enrollments or re-enrollments.

A Part A buy-in state can enroll a QMB individual in Part A buy-in at any time of year. If the individual is already enrolled in Part B and Part B buy-in is open, TPS will accept a state Part A buy-in accretion request. If the QMB individual lacks Parts A and B, the individual must first apply for Premium-Part A (conditionally or unconditionally) and for Part B at SSA before the state can submit the accretion to TPS. SSA will process the Premium-Part A enrollment without regard to Medicare enrollment periods and without premium increases for late enrollment.

A group payer state is limited in when it can enroll a QMB in Part A buy-in. The individual must first file a conditional or unconditional Part A application (and enroll in Part B if they are not already enrolled) during the General Enrollment Period (GEP) (January through March; coverage will be effective July 1). The ***code Z99*** *on the MBR represents conditional enrollment.*

The effective date associated with the ***code Z99*** *is July 1. Once the state determines the individual eligible for QMB, it can submit the accretion request with an effective date of July 1 at the earliest. If premium surcharge amounts for late enrollment apply, CMS will bill the state for them.*

See chapter 1, section 1.11 for more information.

2.5.4 CMS Adjustment of State Accretion Effective Date to Coincide with Medicare Entitlement Data
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All state-initiated accretion actions are screened against the EDB for the presence of Medicare entitlement. In those cases where entitlement exists, TPS compares the beneficiary's Medicare entitlement date established by SSA with the state buy-in effective date. If the state buy-in effective date precedes the individual's Medicare entitlement date, TPS will automatically adjust the state buy-in date to agree with the individual's Medicare entitlement date. For Part A accretions, the accretion cannot be earlier than both the Medicare Part B entitlement date on the EDB and the Part A entitlement or conditional enrollment (Z99) date.

NOTE: *Conditional Part A enrollment data are used by CMS in deriving Part A buy-in start dates, but do not appear in CMS response files. See chapter 4, section 4.7.1, transaction code*

21XX, sub-code C.

***Systems Tip:** The state will receive two reply records as a result of the adjustment to the state-submitted start date. The first record **(code 30XX)** will contain the effective date as submitted by the state. The second record will contain the adjusted effective date that corresponds to the individual's Medicare entitlement date. The transaction code in this record can be any one of the possible reply codes for a state-submitted accretion.*

***Example:** The state-initiated accretion record contains a state buy-in effective date of 03/2017. When the accretion is screened, CMS will examine the Medicare entitlement date. In this example, the EDB Medicare entitlement date is 04/2017.*

*The state will receive two reply records for this situation. The first record will be a **code 30XX**. This record will contain the state buy-in effective date of 3/2017 submitted by the state. The second record will be a **code 1161**. The state buy-in effective date contained in this record will be 04/2017.*

2.6 Deletions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.6.1 State-Initiated Deletions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.6.1.1 Medicare Parts A and B Deletions Based on Loss of Buy-in Coverage
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States should submit deletion actions promptly when the state determines the individual is no longer eligible for buy-in due to loss of membership in the buy-in coverage group. See sections 2.1.6.3 and 2.1.6.4 for guidance on how the end date is applied for a state deletion request.

***Systems Tip:** states use **code 51** - state deletion record for a beneficiary who is no longer a member of the state's coverage group - to delete a record from the state's account.*
*A state's deletion record will be **rejected** if:*

- *The deletion date is blank, incomplete, or otherwise in error.*
- *The deletion date, other than a death deletion, is **equal to or greater than** the billing month.*
- *The deletion date for a death deletion is **later than** the current (update) month.*

***NOTE:** See section 2.9 for information about state deletions for PW accretions.*

2.6.1.2 Special Procedures for an Individual Who Loses SSI
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

If a beneficiary loses SSI, a state must conduct a Medicaid redetermination to assess whether or not the individual qualifies for a different Medicaid category, including those encompassed by the state's buy-in coverage group.

CMS transmits an informational "SSI deletion alert" notification record ***(code 87)*** *to auto-accrete and alert states upon notification from SSA that a beneficiary has lost SSI eligibility.*

The alert is not a notification that CMS has deleted the record or that the state must submit a deletion transaction. Rather, the alert is intended to prompt the state to conduct a redetermination. While the state is making this determination, the state must maintain Medicaid coverage and must not terminate the individual from buy-in. If the state determines the individual eligible for another Medicaid category in the buy-in coverage group, the state should maintain buy-in coverage for the individual. ***States shall not delete individuals from buy-in unless the state redetermination finds the individual no longer qualifies as a member of the buy-in coverage group.*** *See chapter 1, section 1.4 for more information about redeterminations.*

Systems Tip: *If the state redetermination finds the individual no longer eligible as a member of the buy-in coverage group, the state should delete the individual using* ***code 51****. If the state redetermination shows the individual qualifies under another Medicaid category in the buy-in coverage group, the state should not submit a* ***code 51*** *deletion. Instead, the state should submit a* ***code 99*** *(change record) to change the BIEC in the state's billing record using the steps described in chapter 4.*

2.6.1.3 CMS Processing of Part B Deletions Because a Beneficiary is No Longer a Member of the State's Coverage Group

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*CMS will evaluate the requested stop date of all state deletion requests for Part B (****code 51*** *and, in some cases,* ***code 50****) based on loss of buy-in coverage group membership (this does not apply to* ***code 53****) and, where necessary, modify the deletion effective date based on the processing limitations below.*

- *The deletion regulations for Part B buy-in limit the retroactivity of Part B deletions to the CMS processing month minus two months. See 42 CFR § 407.48(c). This rule aims to prevent excessive hardship for beneficiaries when buy-in coverage ends by restricting retroactive liability to two months.*[52]

  NOTE*: In practice, SSA may initially bill beneficiaries for premium liability amounts of up to three months (current month plus two retroactive billing months) when buy-in*

[52] The retroactive liability may not extend to a point in time prior to the date of action in the notice which informed the beneficiary of their loss of Part B buy-in coverage through the Medicaid program. See 42 CFR 431.201, 435.917, 431.206, and 431.210 to 214.

coverage ends. The deletion regulation is also known as the "Commissioner's Decision" (CD) because it was issued in 1972 by SSA's commissioner, before the creation of its sister-agency, the Health Care Financing Administration (HCFA, now CMS).

- *CMS operates in alignment with SSA's Current Operating Month (COM) schedule, rather than by calendar month. COM dates vary each month and are determined by SSA. The COM dates provide the start and end dates for processing periods/months. For example, the August 2020[53] COM ran from July 24 through August 25. The September 2020 COM ran from August 26 through September 23.*

*CMS, in order to maintain synchronicity with SSA, processes **code 51** deletions according to the business day prior to the COM change date. This is necessary because the TPS daily exchange with SSA is not processed by SSA until the next business day.*

***Systems Tip:** CMS sends a copy of SSA's COM schedule to states on a quarterly basis to help the states determine the earliest deletion date.*

***NOTE:** The deletion cut-off of the 25th day of the month in 42 CFR § 407.48(c) no longer applies; SSA's COM schedule should be referenced, instead.*

The date of CMS processing depends upon the time of day received. Generally, TPS update processing begins at 11:00 a.m. (Eastern Time (ET))--and no earlier--every business day. Files received before daily processing begins are processed the same day. Processing may be delayed on rare occasions. Files received after daily processing begins (usually 11:00 a.m. ET) are processed in the next scheduled TPS daily run.

***Example:** State **code 51** deletion requests are received in the calendar month of August 2020. The TPS August 2020 COM is from July 24 through August 25, and the TPS September 2020 COM is from August 26 through September 23. TPS processing starts at 11:00 a.m. ET.*

*State **code 51** deletion requests received by TPS in August 2020 prior to 11:00 a.m. ET on the 25th had a processing month of August and may have an effective deletion date no earlier than June. If the state requested an effective date prior to June, CMS adjusted the deletion date, processing it as June (i.e., if the state requested an effective date of April, TPS automatically adjusted the effective date to June). The state remained liable for billing prior to and including June. CMS refunded the state for any premiums already billed for July through September (CMS bills one month prospective to the date the billing invoice is mailed) and the beneficiary became liable for those months.[54]*

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[53] Note: these dates are specific to 2020, and provided as illustrative examples. The specific dates will vary by calendar year.

[54] Note: CMS does not automatically bill the beneficiary for those months; instead, CMS notifies SSA. SSA may begin withholding the monthly premium from the person's benefits; if they do not, SSA would notify CMS to begin direct billing of the individual.

*State **code 51** deletion requests processed by TPS on or after August 26 (regardless of the time of day), had a processing month of September and an effective deletion date no earlier than July 2020. If the state requested an effective date prior to July, TPS automatically adjusted the deletion date, processing it as July (e.g., if the state requested an effective date of April, TPS automatically adjusted the effective date to July). The state remained liable for billing prior to, and including, July 2020. CMS refunded the state for any premiums already billed for August through September (CMS bills one month prospectively) and the beneficiary became liable for those months.*

2.6.1.4 CMS Processing of State-Initiated Part A Deletion Requests Based on Loss of QMB Status

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state must notify CMS through a Part A deletion request when an individual loses eligibility for QMB. Part A buy-in ends at the end of the month the deletion is processed, regardless of the date the individual lost QMB status. See 42 CFR § 406.26. Actions received on the last business day of a month are processed the next month. CMS will evaluate the requested effective date of all state Part A deletions and modify the deletion effective date based on these two rules.

Examples:

State Part A deletion requests received in August prior to 11:00 a.m. ET on the 31st may have an effective deletion date no earlier than August. If the state requests an effective date prior to August, CMS will adjust the deletion date, processing it as August (e.g., if the state requests an effective date of July, TPS automatically adjusts the effective date to August). The state remains liable for billing prior to and including August. CMS will refund the state for any premiums already billed for September (CMS bills one month prospectively) and the beneficiary becomes liable for that month.

State Part A deletion requests received in August after 11:00 a.m. ET on the 31st may be held until September. Those held until September may have an effective deletion date no earlier than September. If the state requests an effective date prior to September, TPS will automatically adjust the deletion date, processing it as September (e.g., if the state requested an effective date of August, TPS automatically adjusted the effective date to September). The state remains liable for billing prior to and including September. CMS will refund the state for any premiums already billed for October (CMS bills one month prospectively) and the beneficiary is liable for that month.

2.6.2 CMS-Initiated Deletions

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS will initiate a deletion action to terminate ongoing buy-in coverage or annul ("wipe-out") the entire buy-in coverage period in response to certain events. This section describes events that will cause CMS to delete ongoing buy-in billing records from a state's account.

2.6.2.1 Death of the Beneficiary
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA receives reports of death from a number of sources in the daily operation of its various programs. CMS receives death notifications in the CER file exchange with SSA, which will first trigger an update to the EDB, and then to TPS, to end buy-in coverage. CMS will delete the beneficiary from buy-in effective the last day of the beneficiary's month of death. In cases where the date of death is prior to the buy-in start date, the state will receive credit for the entire buy-in period.

***Systems Tip:** CMS sends **code 16bb**, notification of death, to the state on the next monthly billing file (and in the daily response files in a daily exchange state). The month and year of death reported by SSA are shown in the transaction effective date field.*

***NOTE:** In some instances, SSA may send a death notification to CMS in error. In these cases, the state should ask the beneficiary to submit proof of identity to SSA so it can remove the date of death from the MBR. The state may re-accrete the beneficiary to the buy-in rolls through the normal data exchange after SSA corrects the record in the MBR.*

2.6.2.2 Beneficiary's Loss of Medicare Eligibility
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA will end Medicare entitlement for a beneficiary for various reasons, such as the loss of entitlement to disability benefits, the receipt of a kidney transplant to treat End-Stage Renal Disease (ESRD), or failure to meet or provide documentation to meet citizenship or alien residency requirements.

In such cases, CMS will receive a Medicare termination notification from SSA in the CER file exchange, which will first trigger an update to EDB, and then to TPS, to end buy-in coverage. The buy-in end date associated with the deletion transaction will be the last month prior to the Medicare termination.

***Systems Tip:** CMS sends a **code 15bb** to the state on the next monthly billing file (and in the daily response files in a daily exchange state).*

2.6.2.3 Beneficiary Changes of State of Residency
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Membership in a buy-in coverage group derives from the receipt of Medicaid coverage. Loss of state residency will disqualify an individual for Medicaid and, thus, buy-in coverage.

2.6.2.4 Deletion as a Result of Another State's Accretion Action
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

If a beneficiary is enrolled in buy-in in one state ("former state") and CMS receives an accretion action from another state ("new state") for the same beneficiary, CMS assumes that the new state has jurisdiction over the record. When CMS processes the accretion from the new state, TPS will trigger a deletion to remove the records from the former state's buy-in rolls. The stop date in the deletion record is the month prior to the buy-in accretion in the new state.

Systems Tip: *CMS will send the former state a* ***code 1728*** *deletion record and reflect the new state in CMS records.*

2.6.2.5 Change of State Residence for SSI Recipients
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*When an SSI beneficiary moves to another state, SSA will process a change of state residency action to update the SSI record and the MBR, which then transmits the information to the EDB (via the CER file) to update the beneficiary's record. The change of residency update in EDB will cause CMS to delete the individual from the former state's account. The deletion (****code 1728****) effective date will be the last month of residency in the "former" state.*

- *If the beneficiary moves from one auto-accrete state to another auto-accrete state, CMS will auto-accrete the beneficiary in Part B in the new state. The effective date of the accretion is the start of the first continuous period of SSI entitlement. If the SSI record reflects earlier SSI coverage while the beneficiary resided in the former state, CMS will send the new state a* ***code 1180*** *followed by the sub-code A. Sub-code A alerts the state that CMS will also send a RIC-A record with the complete SSI data.*

- *If the beneficiary moves from an auto-accrete state to an alert state, or from one alert state to another alert state, CMS will transmit an SSI alert notification (****code 86bb****) to the new state,.*

  State Action: The former state should examine the Medicaid eligibility record for any beneficiary for whom it receives a ***code 1728*** *to ensure the state closed the beneficiary's Medicaid eligibility record. If the former state believes it should retain jurisdiction of the case, it must contact the new state to resolve jurisdictional issues.*

Systems Tip*: CMS will notify the former state of the deletion with a* ***code 1728*** *transaction in the billing/response files (i.e., positions 124 to 126 on the RIC-B record and positions 94-96 on the RIC-D record as described in chapter 3). The deletion date is the individual's last month of residency in the former state. Chapter 3 describes the record format and data fields for the* ***code 1167*** *accretion in the monthly billing file (RIC-B) and, for states receiving daily files,* ***code 1167***

*is also sent as a RIC-D record. The new state will receive either an SSI alert record **(code 86)** or an SSI accretion record **(code 1180),** if SSI entitlement continues.*

***NOTE:** Upon receipt of the deletion transaction from CMS, the former state should conduct a Medicaid redetermination to assess continued Medicaid eligibility, including state residency. If the beneficiary no longer resides in the state, the state should ensure that it has closed the Medicaid record to prevent a cycle of re-accretion and deletion actions between states. If the state finds the individual still resides in the state, it must contact the new state in order to resolve state residency.*

2.6.2.6 Beneficiary Becomes Entitled to Reduced or Premium-Free Part A
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part A buy-in will terminate when an individual obtains enough Social Security quarters to qualify for Premium-free Part A (either based on their own on their spouse's record). SSA will send a notification to CMS when coverage changes from Premium-Part A to a reduced premium or from reduced Premium-Part A to Premium-free Part A entitlement. Premium-based changes are received daily by CMS from SSA in the CER file exchange. Once EDB updates the new entitlement record, TPS will trigger the appropriate action(s).

In cases where Premium-Part A premium liability changes from the full premium to a reduced amount, TPS will generate a deletion to stop billing at the "previous rate" and re-accrete the record to begin state billing at the "new rate." In cases where the premium liability amount changes from reduced Premium-Part A to Premium-free Part A, TPS will send a deletion and stop billing the state for Part A. The deletion date in both instances is the month prior to the effective date of reduced or Premium-free Part A.

***Systems Tip:** CMS sends a **code 14bb** to the state to identify the deletion.*

2.6.2.7 Deletions from Other Sources
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS may be notified outside of the normal data exchange that a manual deletion action is required. CMS generally receives these requests from the state or from the SSA FO on the Form CMS-1957 "SSO Report of State Buy-in Problem," or Form SSA-5002-HB "Report of Contact," after a beneficiary reports information that indicates a change in residency or SSI entitlement. See chapter 6, section 6.6 for additional details.

2.7 Changes and Corrections
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.7.1 State Correction of a Previously Submitted State Accretion or Deletion Date
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.7.1.1 Adjustment to the Start Date for Ongoing (Code 41) Billing Items
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*The state may adjust the accretion date of an ongoing record or a new accretion to an earlier date by submitting a **code 61** transaction containing the new accretion date in the regular buy-in data exchange.*

***NOTE:** States should use a **code 61** to adjust a period to an earlier date with caution - only when the earlier date/period is contiguous with the current period.*

- *CMS will send the state a **code 4361, 4363, or 4384** to reflect that CMS has established an earlier period of state buy-in coverage in response to the state's retroactive accretion. If CMS establishes ongoing coverage, the state will receive a **code 1161, 1163, or 1184**.*

- *The state may not adjust an accretion date to a later date since this would disadvantage the beneficiary. CMS will reject the state accretion with a **code 2561,** duplicate accretion action.*

2.7.1.2 Adjustment of Accretion or Deletion Date - Closed Period of State Buy-in Coverage
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*The state may send CMS a simultaneous accretion/deletion action (**code 75**) to establish a closed period of state buy-in coverage separate from existing buy-in coverage already reflected in CMS systems. CMS will acknowledge the closed period request with a reply **code 4375**.*

The state is responsible for the accuracy of the dates submitted. The state cannot adjust the accretion date to a later date nor adjust the deletion date to an earlier date on a closed period of state buy-in coverage. Either action would disadvantage the beneficiary.

*If the simultaneous accretion/deletion action duplicates an existing period of coverage on the EDB, CMS will send the state a rejection **code 2575**.*

- *If a state receives this rejection code, it should not submit a **code 61** to change the accretion date on a closed period. The system interprets a **code 61** as a request to expand coverage. Not only will a **code 61** change the accretion date to afford greater coverage, it will also reopen the closed period and establish ongoing coverage.*
- *The state may adjust the deletion date for a closed period to an earlier date. For Part B, this may be no earlier than two months prior to the processing month in which the adjustment is processed and, for Part A, this may be no earlier than the calendar month in which the adjustment is processed, except in the case of death. A death case may be deleted retroactively to the month of death.*

*If the date of death (DOD) in the MBR conflicts with the date of death on a state request to correct an erroneous **code 16** death deletion, SSA will ask the state to provide corroborating evidence to support its request.*

- *To correct an erroneous death deletion, submit a buy-in problem resolution request to CMS. See chapter 6 for submission methods. A separate memorandum is required for each request.*

CMS will notify the state through the buy-in data exchange of an adjustment action that results in a debit or credit action.

- ***Code 4268** - acknowledgment of a state-submitted request to move an accretion date to a **later date** resulting in a **credit** to the state. CMS made this adjustment because it applied an incorrect accretion effective date.*
- ***Code 4269** - acknowledgment of a state-submitted request to move a deletion date to an **earlier date** resulting in a **credit** to the state. CMS made this adjustment because it applied an incorrect deletion date.*
- ***Code 4368** - acknowledgment of a state-submitted request to move an accretion date to an **earlier date** resulting in a **debit** to the state. CMS made this adjustment because it applied an incorrect accretion effective date.*
- ***Code 4369** - acknowledgment of a state-submitted request to move a deletion date to a **later date** resulting in a **debit** to the state. CMS made this adjustment because it applied an incorrect deletion date.*

2.7.2 State Request for Adjustment of SSI Actions Accreted by CMS
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

An auto-accrete state may identify items on its state buy-in account that conflict with state records or the SSA data in the SVES/SOLQ, SDX, or BENDEX.

Potential discrepancies between the EDB records and the state records or the SSA data are:

- *CMS newly auto-accreted the record to the state's buy-in account **(code 1180)** or the billing record shows ongoing buy-in **(code 41)**, but SSA has no record of the individual;*
- *SSA has a record of an individual age 65 or older in an auto-accrete state, but CMS has no record of the individual; or*
- *The effective date of the CMS-initiated accretion and the effective date of SSI eligibility differ.*

In the situations described above, examine SSA data exchanges before initiating a complaint. The SSI eligibility date and the state buy-in eligibility date can differ if:

- *The beneficiary was not eligible for Medicare at the time of SSI eligibility;*
- *The beneficiary changed legal residence after the individual established SSI eligibility; or*
- *The beneficiary's SSI status changed from conditional to ineligible or from ineligible to eligible, and SSA is processing a reinstatement.*

States can submit a State Buy-in Resolution request to correct an erroneous SSI-based accretion to DMSEI. See chapter 6 for instructions on how to submit buy-in cases for resolution.

When DMSEI receives the request, it will conduct an investigation. If DMSEI determines:

- *Buy-in coverage was updated in error, the state will receive a **code 1750**, annulment of entire buy-in coverage period.*
- *Buy-in coverage start and/or stop date is incorrect, the state will receive a credit item **(code 4268)** based on the accretion date adjustment and/or deletion date adjustment.*

***Systems Tip:** States must contact CMS to manually correct discrepant records. See chapter 6 for instructions on how to submit buy-in cases needing resolution.*

2.7.3 State-Initiated Change Records
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.7.3.1 Medicare Part B
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state may change a beneficiary's BIEC and state welfare (Medicaid) identification number.

- *A state can use **code 99** to add or change the individual's BIEC. The **code 99** update will be effective with the next billing cycle.*
- *A state **code 99** submission with blanks in positions 71-72 **will not** eliminate an existing BIEC in the billing record.*
- *A state can use **code 99** to add or change a state welfare identification number, but cannot delete an existing state welfare identification number.*
- *A state **code 99** submission with blanks in positions 101-120 will not eliminate an existing state welfare identification number.*

*The record format is the same as the format for the state accretion or deletion action (State Agency Input Record) described in chapter 3. The transaction code for the change record is **code 99**. A **code 99** action can only be applied to an open TPS record (e.g., **code 41**).*

2.7.3.2 Medicare Part A
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state may change only the Client Identification Number on the Part A TPS record.

*The transaction code for the change record is **code 99** and can only apply to an open TPS record (e.g., **code 41**).*

2.7.4 CMS Reply to a State-Initiated Change Record (Code 99)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*CMS will apply state change records **(code 99)** to existing open coverage billing records **(code 41)** if the change record matches the existing EDB record on HICN/MBI and state agency code and the EDB shows an open coverage record. If CMS applies the change, it will not send the state a reply. Otherwise, CMS will reject the change record with the transaction **code 4999**.*

*If the state submits a Part B **code 99** with a BIEC of "P" (QMB), "L" (SLMB), or "U" (QI) and the EDB does not reflect a current Part A and Part B entitlement and open Part B buy-in, CMS will reject the transaction with a reply **code 4999**.*

2.8 SSA-Initiated Accretions - Public Welfare Accretion Procedure (Code 1167)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The SSA FO can start buy-in coverage through the PW accretion procedure when an individual files an application for Medicare and is, or will be, a member of a Part B buy-in coverage group in the state. See chapter 1, section 1.6, for a list of state buy-in coverage groups. The PW procedure allows the SSA FO to establish Part B through state buy-in, making the state responsible for paying the Part B premiums instead of the individual.

Each state should work with its SSA Regional Office to define the individuals for whom SSA FOs will initiate a PW accretion and the procedures to verify an individual's potential membership in the state's buy-in coverage group before initiating a PW accretion.

***Systems Tip:** After SSA establishes Medicare entitlement for a beneficiary who may be eligible for buy-in, SSA will transmit the PW accretion to CMS, which uses the **code 1167** to accrete the record to the state's Part B buy-in account. If the individual is SSI-eligible and resides in an alert state, CMS will send an SSI alert record (**code 86bb**).*

*SSA may use the PW accretion process for SSI-eligible individuals who are also eligible for Medicare in auto-accrete states, with the expectation that CMS will then auto-accrete (**code 1180**) these individuals in Part B buy-in. Depending on the timing of the SSI entitlement update from MBR to EDB, the state may first receive the PW accretion **code 1167** followed by **code 1180** (after deletion of the **code 1167**), or it may only receive **code 1180.** The state also receives a SSI alert record (**code 86bb)** for informational purposes.*

*Chapter 3 describes the record format and data fields for the **code 1167** accretion in CMS billing records (RIC-B and, for states receiving files daily, RIC-D).*

2.9 Erroneous PW Accretion - All States
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*If the state determines that a PW accretion (**code 1167**) was processed for an ineligible individual, the state may appeal the action. The state must react to the PW accretion before the end of the second month following the month in which the state received notification of the PW accretion on its billing file. If the state does not react within the established timeframe, the state becomes responsible for the premium liability until a state's deletion action is processed per the standards in section 2.6.1.3.*

***Example**: A state receives a PW accretion (**code 1167**) billing record on the monthly billing file sent by CMS February 1st. The state may submit a **code 50** deletion request to CMS within two billing months (i.e., must be received by CMS prior to 11:00 a.m. ET on April 30th or the last business day, if the last day of the month is a non-business day).*

***Systems Tip:** If a PW accretion is processed in error or the accretion date is incorrect, submit a **code 50** deletion or "wipe-out" to CMS in the state's input file within the established timeframe (two billing months). If the state submits the **code 50** after the two-month window, the deletion will be subject to the limitations of the Commissioner's Decision as if it were a **code 51** deletion. TPS will delete the **code 1167** open period and send a deletion reply **code 1750** with a modified effective end date as required by the Commissioner's Decision.*

*If the effective date of the PW accretion is correct, but the state has determined the individual is no longer eligible for buy-in coverage, the state should submit a **code 50** deletion request with the appropriate end date to establish a closed period of coverage.*

2.10 Enrollment of Persons Who Refuse to Establish Medicare Eligibility
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

If an individual refuses to cooperate with SSA to establish eligibility for Medicare Part B (Supplementary Medical Insurance (SMI)), the FO will advise the state Medicaid agency or the office delegated to perform Medicaid eligibility determinations so they can take any appropriate action to obtain the cooperation of the individual. The state may enroll the individual only in Medicare Part B. The individual must enroll in Medicare Part A.

In order to enroll the individual in Part B buy-in, the state must establish that the individual is a member of the state's coverage group and that the individual meets the requirements for Medicare entitlement.

The state must complete the application Form CMS-4040, "Request for Enrollment in Supplementary Medical Insurance" which it can obtain from the FO or from the CMS website under Medicare, CMS Forms at https://www.cms.gov/Medicare/CMS-Forms/CMS-

Forms/index.html. Send the completed form and related documentation to the FO which services the individual's address.

Most of the information which is requested on the application can be obtained from local county eligibility records. Enter the following:

- *The beneficiary's address, since that is the address to which the Medicare card will be mailed; and*

- *The beneficiary's HICN/MBI. If the individual does not have a HICN/MBI, contact the local FO for assistance in obtaining a HICN/MBI for the individual.*

The enrollee need not sign the application. Instead, the eligibility staff person should complete the signature block and annotate the form to show that the information on it was taken from local records.

The application also requests that the state submit the following documentation:

- *Proof of age. The state should submit a copy of the individual's birth certificate. If the birth certificate is not available, submit copies of the documents which were used to establish the date of birth in the Medicaid record; and*
- *Proof of citizenship or residency. If the individual was born in the United States no proof of citizenship or residency is required. If the individual was born outside the United States, the state should submit a copy of the evidence which was used to establish citizenship or residency.*

SSA makes the final determination of Medicare entitlement. *After SSA has established the Medicare record, SSA will accrete the individual to Part B buy-in through the PW procedure, accretion* ***code 1167.***

2.11 State Accretion Procedure to Establish a Closed Period of State Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

2.11.1 Medicare Part B

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*The Simultaneous Accretion/Deletion (SAD) transaction (**code 75**), also referred to as a "closed period," is available to states for the purpose of inserting a closed period of buy-in coverage. A state's buy-in request (**code 75**) must contain a start and stop date. Closed period insertions are common in SSA disability appeals cases involving individuals with past Medicaid entitlements. In these cases, SSA issues a retroactive SSI/SSDI award with a disability entitlement date more than 24 months in the past. In such cases, SSA will retroactively establish Part A entitlement (starting the 25th month after the disability entitlement date). States are required to pay Part B premiums for all periods for which an individual is eligible for buy-in under Medicaid and is*

Medicare entitled.

Example:

- *SSA established retroactive premium-free Medicare Part A and Part B effective 08/2017. The beneficiary is QMB beginning 09/2017.*
- *The individual has SSI entitlement from 05/2017 through 07/2017. The state submits a **code 75** with a start date of 05/2017 and a stop date of 08/2017.*

***Systems Tip:** Submit a **code 75** (closed period) to insert a limited buy-in coverage period. The **code 75** must provide the start date and stop date. Failure to send both the accretion start date and the deletion end date will result in a rejection. States may submit multiple requests for **code 75** actions on a single input file. Each discrete period must be represented by a separate input record with the same transaction code.*

- *A **code 4375** is returned to the state to acknowledge the successful update of a **code 75** request.*
- *The **code 75** must contain the proper Medicare identification information to allow the item to be processed in the month submitted. If the transaction record does not match the Medicare data on the EDB, it is automatically rejected.*

2.11.2 Medicare Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

There are situations where states fail to accrete eligible beneficiaries on a timely basis. That is, the beneficiary is not currently eligible as a QMB or a QDWI, but was eligible for one or more months in the past and should have been enrolled in Part A buy-in. This situation should occur infrequently.

*A Part A buy-in state may use the **code 75** to establish Medicare Part A state buy-in coverage for a closed or limited period of coverage. In rare instances, a closed period of Part A Buy-in coverage may be updated for group payer states. A request to update a closed period in group payer states may be directed to DMSEI (see chapter 6).*

State Input and CMS Response File Formats
Chapter 3

Table of Contents
(Rev. 4, 08-21-20)

Transmittals for Chapter 3

3.0 Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This chapter includes the formats for both state input files submitted to the Centers for Medicare & Medicaid Services (CMS) and CMS response files to states.

Special procedures have been developed for buy-in file exchange for U.S. territories and will be provided in a future chapter of this manual.

3.1 State Input

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state must submit files via an electronic file transmission (EFT) exchange setup (i.e., Connect:Direct or Cyberfusion) or a CMS secure internet exchange (i.e., GenTran or Tibco). The state input files containing the state buy-in accretion, deletion, and change records must be received by the CMS Central Office (CO) in Baltimore, Maryland ***no later than the close of business (COB) on the next to the last business day of the update month.*** *Saturdays, Sundays, and federal holidays are not considered business days. It is the state's responsibility to submit its files timely. If input files are not received by the next to the last business day of the update month, CMS CO shall assume that the state will not be submitting state buy-in input files for the month.* ***Files received after the next to the last business day of the update month may be treated as input for the next update month.***

3.2 CMS Output

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS updates the state's buy-in account based on transactions from the state, SSA, and CMS.

CMS then creates two billing files for each state agency, one for Part A and one for Part B buy-in records. States receive the response and billing files via their established EFT method.

The response and billing files are specified as record identification code (RIC) types:

RIC-A	*Supplemental Security Income (SSI) Alert*
RIC-B	*Monthly Billing Record*
RIC-C	*Medicare Number Change Record*
RIC-D	*Date Change or Reply Record*
RIC-E	*Personal Characteristics Change Record*

RIC-F	*Reject Record*

The RIC response file layouts are provided in section 3.5.

For states receiving only monthly files, *these files contain all RIC type records: -A, -B, -C, -D (date change only), -E, and -F.*

For states electing to receive daily response files *in addition to the monthly billing files, their response files contain all RIC-A, -C, -D, -E and -F type records but no RIC-B. Their monthly billing files contain all RIC-B and only RIC-B records, further segregated by Part A or Part B.*

***For the most up-to-date buy-in eligibility, enrollment, and billing information, CMS recommends that states accept daily response files. This will help to address errors sooner and minimize burden on the beneficiary. Effective April 1, 2022, federal regulations at 42 CFR §§ 406.26 and 407.40 require states to submit and receive files on a daily basis.*

In addition to the electronic billing file, the following paper documents are produced and mailed to the state (see chapter 5):

- *The Summary Accounting Statement (SAS) provides an analysis of the state's Medicare premium liability as of the most recent state buy-in update. See chapter 5, appendix 5.C for additional information.*
- *The Listed Agency Billing (LAB) summary sheet, an agency totals sheet, is a summary of selected state buy-in transaction codes contained on the state's billing file (see chapter 5, appendix 5.D).*

*The monthly billing file typically arrives in the state no later than the **1st business day** of the month following the update. If the file is not received by the **2nd** business day of the month, the state must notify CMS CO staff within the Office of Financial Management (OFM)/Accounting Management Group (AMG)/Division of Premium Billing and Collections (DPBC) so that CMS may initiate another transmission of the state's billing files (see chapter 6, section 6.1.1.1 for contact information).*

*The SAS and related documents are mailed separately and typically arrive in the state no later than the **20th of the month.** If the documents are not received by the 20th of the month, the state must notify DPBC staff so that duplicate documents may be mailed.*

3.3 Data Exchange Files - States to CMS

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

3.3.1 State Agency Buy-in Exchange Header Record

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state buy-in File Header Record is appended as the first record on all monthly submitted state input files sent to CMS.

Item	Field	Size	Position	Format	Description
1	File Type Identification, "PROD" or "TEST"	4	1-4	Alphabetic	Indicates the intent of the state buy-in file sent to CMS, identifying the file as either a test file, "TEST," or a production file, "PROD." This is a MANDATORY field value used by CMS during header/trailer security validation routines.
2	Filler	1	5	NA	Position reserved for future use.
3	File Creation Date, CCYYMMDD	8	6-13	Numeric	This represents the date on which the state generated the file to be sent to CMS. Enter an eight-position numeric date (e.g., enter November 1, 2019 as 20191101).
4	Filler	59	14-72	NA	Positions reserved for future use.
5	Agency Code	3	73-75	Alpha-numeric or Numeric	Enter the three-position alpha-numeric or numeric code of the state which has jurisdiction over the account associated with this file. This is a MANDATORY field value used by CMS during header/trailer security validation routines.
6	Record Identification Code, "H"	1	76	Alphabetic	"H" constant. The "H" identifies this record as the header record. This is a MANDATORY field value used by CMS during header/trailer security validation routines.

Item	Field	Size	Position	Format	Description
7	*Filler*	*44*	*77-120*	*NA*	*Positions reserved for future use.*

3.3.2 State Buy-in Exchange Input File

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	Field	Size	Position	Format	Description
1	*Medicare Number*	*12*	*1 - 12*	*Alpha-numeric*	*MANDATORY: The Medicare number should consist of a nine-position numeric value followed by an alpha-numeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This Medicare number is commonly referred to as the Health Insurance Claim Number (HICN). If the beneficiary is entitled under a RRB number, this field may consist of an 11-position alpha-numeric pseudo HICN, or a 10- or 11-position alpha-numeric value. The HICN or RRB claim numbers are preferred for state buy-in exchanges. CMS will accept the Medicare Beneficiary Identifier (MBI), however, CMS will return only the Medicare number on state buy-in response files.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
2	*Surname*	*24*	*13 - 36*	*Alpha-numeric*	*MANDATORY: Enter a maximum of 24 alpha-numeric characters. An exact match to the surname in CMS' systems is required on the first six characters.* ***Special instructions that apply to all of the name fields:*** *(1) retain blank spaces that are part of a compound name; (2) insert a single blank space between the name and suffixes, such as JR, SR, or III; (3) names may not include a period, although other punctuation marks (e.g., an apostrophe or hyphen) are allowed; and (4) all alphabetic characters must be capitalized or matching criteria will fail.*
3	*Given Name*	*15*	*37 - 51*	*Alpha-numeric*	*MANDATORY: Enter a maximum of 15 alpha-numeric characters. CMS requires an exact match on the first three characters. If this match fails, however, and CMS has only the first initial of the given name in its system, CMS will accept an exact match on the first character alone. See special instructions above.*
4	*Middle Initial*	*1*	*52*	*Alpha-numeric*	*Enter a one-position alpha-numeric character. Leave field blank if middle initial is unknown.*
5	*Sex Code*	*1*	*53*	*Alphabetic*	*Enter a one-position code: "M" = male, "F" = female. Leave field blank if unknown.*
6	*Date of Birth (CCYYMMDD)*	*8*	*54 - 61*	*Numeric*	*MANDATORY: Enter an eight-position numeric date (e.g., enter November 1, 1939 as 19391101).*

Item	Field	Size	Position	Format	Description
7	*Beneficiary's Social Security Number*	*9*	*62 - 70*	*Alpha-numeric*	*Enter the beneficiary's own SSN, if known. If unknown, leave blank.*
8	*Buy-in Eligibility Code*	*2*	*71 - 72*	*Alphabetic/ Blank*	*For Part B records only; if the state submits a Part A BIEC, it is recorded in EDB Part A records, but is never used by CMS. In position 71, leave blank or enter any code other than "P," "L," or "U." This will help to avoid triggering a rejection. Once Part B enrollment is established, the state can use the* ***code 99*** *procedures to update the BIEC once it verifies Part B buy-in is present in CMS systems. Position 72 is reserved for future expansion.*
9	*Agency Code*	*3*	*73 - 75*	*Alpha-numeric or Numeric*	*MANDATORY: Enter the three-position alpha-numeric or numeric code of the state which has jurisdiction over the account, indicating whether this is a Part A or Part B request.*
10	*Transaction Code*	*2*	*76 - 77*	*Numeric*	*MANDATORY: Enter the two-position numeric code which identifies the type of record conveyed by the transaction.* *Accretion action -* ***codes 61, 63, and 84.*** *Deletion action -* ***codes 50, 51, and 53.*** *Simultaneous accretion/deletion action (closed period) -* ***code 75.*** *State change record -* ***code 99.***

Item	Field	Size	Position	Format	Description
11	Filler	5	78 - 82		Positions reserved for future use.
12	Transaction Effective Date (CCYYMM)	6	83 - 88	Numeric	MANDATORY except for transaction **code 99:** Enter the date on which the accretion or deletion action is effective (e.g., enter April 2019 as 201904).
13	Code 75 Stop Date (CCYYMM)	6	89 - 94	Numeric	This field is used only in conjunction with the insertion of a closed period of buy-in coverage. Enter the date on which the closed period of buy-in coverage ends (e.g., enter June 1998 as 199806). Important: This field is to be used exclusively with transaction code 75.
14	Filler	6	95 - 100		Positions reserved for future use.
15	Agency Client Identification Number	20	101 - 120	Alpha-numeric	Enter the beneficiary's state client (or Medicaid) identification number or any other identifier of the state's choice. Any combination of not more than 20 alpha-numeric characters may be used. Packed fields cannot be accepted.

3.3.3 State Buy-in Exchange Trailer Record

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The State Buy-in File Trailer Record is appended as the last record on all submitted state input files sent to CMS.

Item	Field	Size	Position	Format	Description
1	Filler	72	1-72		Positions reserved for future use.

Item	Field	Size	Position	Format	Description
2	Agency Code	3	73-75	Alpha-numeric or Numeric	Enter the three-position alpha-numeric or numeric code of the state which has jurisdiction over the account associated with this file.
3	Record Identification Code	1	76	Alphabetic	"T" constant. The "T" identifies this record as the trailer record. This is a MANDATORY field value used by CMS during header/trailer security validation routines.
4	Filler	5	77-81		Positions reserved for future use.
5	Bill Month, CCYYMM	6	82-87	Numeric	A six-position numeric field that designates the billing cycle (year and month) in which the transactions should be processed. This date may be determined by adding two months to the current calendar month in which the file is being created.
6	Filler	1	88		Position reserved for future use.
7	total Number of Transaction Records Included	7	89-95	Numeric	This records total count must be zero-filled to the left when the count is less than seven positions (e.g., a count of 4,689 would be entered as "0004689"). This is a MANDATORY field value used by CMS during header/trailer security validation routines.
8	Filler	25	96-120		Positions reserved for future use.

The State Buy-in File Trailer Record is appended as the last record on all submitted state input files sent to CMS.

3.4 Matching State Input Records to the CMS Enrollment Database (EDB)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The EDB contains the current status of all individuals who are or were entitled to Medicare. When a state submits a state input record, the record is verified against the EDB to ensure it was submitted under the correct HICN/MBI.

3.4.1 State Input File Matching Criteria

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

In order for the CMS Third Party System (TPS) to process a state-submitted accretion request, the Medicare claim number and a required set of personal characteristics must match a record on the EDB. State-submitted deletion requests need only match on Medicare claim number.

The data fields utilized in the EDB matching routine are described below. Each accretion record submitted by the state must contain this identifying information:

- ***Capital Alphabetic Characters*** *- All alphabetic characters must be capitalized or matching criteria will fail.*

- ***Medicare Number*** *– The HICN is a nine-position SSN followed by a one or two-position alpha-numeric BIC. An RRB claim number may be submitted; however, the converted RRB claim number, or pseudo HICN, is preferred for state input files. See chapter 4, section 4.4 on converting RRB claim numbers to pseudo HICNs. CMS will accept the Medicare Beneficiary Identifier (MBI), however, CMS will return only the HICN or pseudo HICN on state buy-in response files.*

- ***Surname (Last Name)*** *- First six positions.*

  NOTE*: If JR or SR is part of the surname, include the JR or SR in the surname field of the accretion record. Failure to include the JR or SR may cause the record to reject. Normally, the JR or SR is separated from the surname proper with a single blank space.*

  Example: *FOX JR*

- ***Given (First) Name*** *- First three positions. If no match can be found on the first three positions, and CMS has only one character stored as the first name, TPS will accept a match on the first position only.*

- ***Date of Birth (DOB)*** *- An eight-position date of birth is required, YYYYMMDD. Although the first six positions for the year and month are used for matching, it is important that the day be included so that the correct Medicare entitlement date can be computed. If the accretion request fails the DOB matching criteria, review the state's record to ensure that the DOB in the accretion record matches the corresponding data in either CMS or SSA systems. If there is a discrepancy, correct and resubmit the record.*

The matching is done as follows:

- *If no equitable match is found on the EDB for the Medicare claim number submitted, the transaction request is rejected and returned to the agency.*

- *For an accretion request, a match is also required on the following set of personal characteristics:*

    - *The first six characters of the surname;*
    - *The first three characters of the first name (if no match on the first three characters, and CMS has only one character stored as the first name, TPS will accept a match on the first character only); and*
    - *The month and year of birth.*

    If an equitable match is found on the claim number but the request fails to match this set of EDB personal characteristics, the state request is rejected.

- *If the transaction matches the EDB on claim number and personal characteristics using the above criteria, but there is still a discrepancy in any of the personal characteristics, (i.e., full surname, full first name, middle initial, date of birth "day," or beneficiary SSN), the transaction is accepted and a personal characteristics change record (RIC-E) is returned to the state. CMS advises states to update the state beneficiary record with the personal characteristics from the EDB to use in subsequent transactions.*

3.5 Data Exchange Files - CMS to States

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

3.5.1 CMS/TPS Buy-in Exchange Header Record

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	*Field*	*Size*	*Position*	*Format*	*Description*
1	*File Type Identification, "PROD" or "TEST"*	*4*	*1-4*	*Alphabetic*	*Identifies the file as either a test file, "TEST," or a production file, "PROD."*
2	*Filler*	*1*	*5*		*Position reserved for future use.*
3	*File Creation Date, CCYYMMDD*	*8*	*6-13*	*Numeric*	*This represents the date on which CMS generated the file. An eight-position numeric date (e.g., November 1, 2019 would be 20191101).*
4	*Filler*	*59*	*14-72*	*NA*	*Positions reserved for future use.*
5	*Agency Code*	*3*	*73-75*	*Alpha-numeric*	*The three-position alpha-numeric or numeric code*

Item	Field	Size	Position	Format	Description
				or Numeric	*identifying the state which has jurisdiction over the account associated with this file, and identifying the file as being Part A or Part B.*
6	*Record Identification Code, "H"*	*1*	*76*	*Alphabetic*	*"H" constant. The "H" identifies this record as the header record.*
7	*Filler*	*5*	*77-81*	*NA*	*Positions reserved for future use.*
8	*Bill Month, CCYYMM*	*6*	*82-87*	*Numeric*	*A six-position numeric field that designates the billing period (year and month) for which the response is associated.*
9	*Filler*	*73*	*88-160*		*Positions reserved for future use.*

3.5.2 State Agency SSI Alert Record (RIC-A)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	Field	Size	Position	Format	Description
1	Medicare Number	12	1-12	Alpha-numeric	The beneficiary HICN, a nine-position numeric value followed by an alpha-numeric BIC. If the beneficiary is entitled under a RRB claim number, this field will contain an 11-position alpha-numeric pseudo HICN. Positions 11 and 12 may be blank. This field will convey the Medicare number from the EDB. CMS will not return the MBI in this state buy-in reply.
2	Surname	24	13-36	Alpha-numeric	A maximum of 24 alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.
3	Given Name	15	37-51	Alphabetic	A maximum of 15 alphabetic characters. The name will match the given name on the EDB. Any unused positions will be blank.
4	Middle Initial	1	52	Alphabetic	An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.
5	Sex Code	1	53	Alphabetic	A one-position alphabetic code (male = “M”, female = “F”).

Item	Field	Size	Position	Format	Description
6	Date of Birth	8	54-61	Numeric	An eight-position numeric field, CCYYMMDD. A date such as November 1, 1939 will be displayed as 19391101. The date of birth will match the date of birth on the EDB.
7	Beneficiary's Social Security Number	9	62-70	Numeric	A nine-position numeric field. The SSN will be extracted from the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.
8	Buy-in Eligibility Code	2	71-72	Alphabetic/ Blank	Position 71 is a one-position alphabetic code which describes the reason the beneficiary is eligible for buy-in. Position 72 is reserved for future expansion.
9	Agency Code	3	73-75	Alpha-numeric	A three-position alpha-numeric code that is based on the state code which appears in the SSI record furnished by SSA.
10	Record Identification Code "A"	1	76	Alphabetic	"A" constant. The "A" identifies this record as an SSI alert record.
11	Transaction Code	2	77-78	Numeric	Positions 77 and 78 will contain an "86" for an SSI accretion alert record or an "87" for an SSI deletion alert record.
12	Filler	3	79-81		Positions reserved for future use.

Item	Field	Size	Position	Format	Description
13	*SSI Start Date Month (CCYYMM)*	*6*	*82-87*	*Numeric*	*A six -position numeric field which contains the beginning date (year and month) of the most recent period of SSI entitlement. SSA furnishes this date for **code 86** records.*
14	*SSI Stop Date Month (CCYYMM)*	*6*	*88-93*	*Numeric*	*A six-position numeric field which contains the ending date (year and month) of the last period of SSI entitlement. SSA furnishes this date for **code 87** records.*
15	*Medicare Entitlement Date Month (CCYYMM)*	*6*	*94-99*	*Numeric*	*A six-position numeric field which indicates the year and month in which the beneficiary became entitled to Medicare Part B. This date is provided to assist the state in determining the effective date for buy-in coverage. This field is applicable to accretion alert records only.*
16	*Filler*	*27*	*100-126*		*Positions reserved for future use.*
17	*ZIP Code of Residence*	*9*	*127-135*	*Numeric*	*A nine-position numeric code that is reflected on the EDB. If the EDB only reflects the five-position zip code, the five positions will be reflected and the remaining positions will be blank.*
18	*County Code of Residence*	*3*	*136-138*	*Numeric*	*A three-position numeric code developed from the SSI record. SSA furnishes this code.*

Item	Field	Size	Position	Format	Description
19	*SSI Living Arrangement Code*	*1*	*139*	*Alphabetic*	*A one-position alphabetic code of "D" which indicates that the beneficiary is a resident of a Title XIX institution. This field may be blank.*
20	*SSI Status Code (SISC)*	*1*	*140*	*Alphabetic*	*A one-position alphabetic code which describes the beneficiary's SSI status.*
21	*Agency Client Identification Number*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice.*

3.5.3 Part A State Agency Billing Record (RIC-B)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	*Field*	*Size*	*Position*	*Format*	*Description*
1	*Medicare Number*	*12*	*1-12*	*Alpha-numeric*	*The beneficiary HICN, a nine-position numeric value followed by an alpha-numeric BIC. If the beneficiary is entitled under a RRB claim number, this field will contain an 11-position alpha-numeric pseudo HICN. Positions 11 and 12 may be blank. This field will convey the Medicare number from the EDB. CMS will not return the MBI in this state buy-in reply.*
2	*Surname*	*24*	*13-36*	*Alpha-numeric*	*A maximum of 24 alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.*
3	*Given Name*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The name will match the given name on the EDB. Any unused positions will be blank.*
4	*Middle Initial*	*1*	*52*	*Alphabetic*	*An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.*

Item	Field	Size	Position	Format	Description
5	*Sex Code*	*1*	*53*	*Alphabetic*	*A one position alphabetic code (male = "M," female = "F").*
6	*Date of Birth*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD. A date such as November 1, 1939 will be displayed as 19391101. The date of birth will match the date of birth on the EDB.*
7	*Beneficiary's Social Security Number*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The SSN will be extracted from the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.*
8	*Reduced Part A Indicator*	*1*	*71*	*Numeric or Alphabetic*	*The presence of a "1" in this position means that the reduced Part A premium rate applies; otherwise, it will be blank, unless the state submitted a buy-in eligibility code with their Part A buy-in. If so, the BIEC submitted for Part A will be displayed.*
9	*Part A Premium Surcharge Indicator*	*1*	*72*	*Numeric or Blank*	*The presence of a "1" in this position means that the Part A premium includes a 10% surcharge for late enrollment; otherwise, it is blank.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
10	*Agency Code*	*3*	*73-75*	*Alpha-numeric*	*A three-position alpha-numeric code, beginning with "S," assigned to the state which has jurisdiction over the account.*
11	*Record Identification Code "B"*	*1*	*76*	*Alphabetic*	*"B" constant. The "B" identifies this record as a billing record.*
12	*Transaction Code*	*4*	*77-80*	*Numeric*	*A two- or four-position numeric code. The first two positions reflect the type of action taken by CMS (e.g., accretion, deletion, or adjustment). The third and fourth positions contain either the incoming transaction code submitted by the state or a code generated internally by CMS if the action originated with CMS. This code could also be other than that submitted by the state if CMS processing requires additional delineation be shared with the state.*
13	*Transaction Sub-Code*	*1*	*81*	*Alphabetic*	*A one-position alphabetic code that further defines the transaction code.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
14	*Billing Period Start Date (CCYYMM)*	*6*	*82-87*	*Numeric*	*A six-position numeric field which contains the beginning date (year and month) used in the calculation of the refund or premium amount due for this transaction. For debit transactions, the billing period start date also represents the transaction effective date. For credit transactions, the transaction effective date is represented by the billing period start date minus one month. NOTE: the billing period start date and the billing period stop date are inclusive dates.*
15	*Billing Period Stop Date (CCYYMM)*	*6*	*88-93*	*Numeric*	*A six-position numeric field that contains the last date (year and month) used in the calculation of the refund or premium amount due for this transaction.* ***NOTE****: the billing period start date and the billing period stop date are inclusive dates.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
16	*Premium Amount Due or Refund*	*8*	*94-101*	*Numeric*	*An eight-position field with leading zeroes. On an accretion or ongoing billing record, this field will reflect a debit (i.e., the amount the state owes the federal government). On a deletion record, this field will reflect any credit (refund) due the state. On an adjustment record, the adjustment code in the transaction code field will indicate whether the field reflects a debit or a credit.*
17	*Bill Month (CCYYMM)*	*6*	*102-107*	*Numeric*	*A six-position numeric field that designates the billing period (year and month) in which the transaction was processed.*
18	*Current Monthly Premium Rate*	*6*	*108-113*	*Numeric*	*A six-position numeric field with leading zeroes which contains the current monthly Part A Medicare premium rate.*
19	*Filler*	*3*	*114-116*		*Positions reserved for future use.*
20	*Credit Indicator*	*1*	*117*	*Minus Sign or Blank*	*A minus sign (-) in this field means that the premium amount in positions 94 – 101 is a credit. A blank in this field means that the premium amount is a debit.*

Item	Field	Size	Position	Format	Description
21	*Filler*	*6*	*118-123*		*Positions reserved for future use.*
22	*Code 1728 Accretion State Agency Code*	*3*	*124-126*	*Alpha-numeric*	*A three-position alpha-numeric state agency code, beginning with "S," will be provided in **code 1728** deletion replies identifying the accreting state which now claims buy-in jurisdiction for this beneficiary. Otherwise, this field will remain blank.*
23	*ZIP Code of Residence*	*9*	*127-135*	*Numeric*	*A nine-position numeric code that is reflected on the EDB. If the EDB only reflects the five-position zip code, the five positions will be reflected and the remaining positions will be blank.*
24	*County Code of Residence*	*3*	*136-138*	*Numeric*	*A three-position numeric code developed from the EDB. The field may be blank.*
25	*Filler*	*2*	*139-140*		*Positions reserved for future use.*
26	*Agency Client Identification Number*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice.*

3.5.4 Part B State Agency Billing Record (RIC-B)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	Field	Size	Position	Format	Description
1	*Medicare Number*	*12*	*1-12*	*Alpha-numeric*	*The beneficiary HICN, a nine-position numeric value followed by an alpha-numeric BIC. If the beneficiary is entitled under a RRB number, this field will contain an 11-position alpha-numeric pseudo HICN. Positions 11 and 12 may be blank. This field will convey the Medicare number from the EDB. CMS will not return the MBI in this state buy-in reply.*
2	*Surname*	*24*	*13-36*	*Alpha-numeric*	*A maximum of twenty-four (24) alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.*
3	*Given Name*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The name will match the given name on the EDB. Any unused positions will be blank.*
4	*Middle Initial*	*1*	*52*	*Alphabetic*	*An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
5	*Sex Code*	*1*	*53*	*Alphabetic*	*A one-position alphabetic code (male = "M," female = "F").*
6	*Date of Birth*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD. A date such as November 1, 1939 will be displayed as 19391101. The date of birth will match the date of birth on the EDB.*
7	*Beneficiary's Social Security Number*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The SSN will be extracted from the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.*
8	*Buy-in Eligibility Code*	*2*	*71-72*	*Alphabetic/ Blank*	*Applicable to Part B buy-in only. Position 71 is a one-position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An additional field (position 72) has been allocated for expansion.*
9	*Agency Code*	*3*	*73-75*	*Numeric*	*A three-position numeric code assigned to the state which has jurisdiction over the account.*
10	*Record Identification Code "B"*	*1*	*76*	*Alphabetic*	*"B" constant. The "B" identifies this record as a billing record.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
11	*Transaction Code*	*4*	*77-80*	*Numeric*	*A two- or four-position numeric code. The first two positions reflect the type of action taken by CMS (e.g., accretion, deletion, or adjustment). The third and fourth positions contain either the incoming transaction code submitted by the state or a code generated internally by CMS if the action originated with CMS. This could also be a code other than that submitted by the state if CMS processing requires additional delineation be shared with the state.*
12	*Transaction Sub-Code*	*1*	*81*	*Alphabetic*	*A one-position alphabetic code that further defines the transaction code.*

Item	Field	Size	Position	Format	Description
13	*Billing Period Start Date (CCYYMM)*	*6*	*82-87*	*Numeric*	*A six-position numeric field which contains the beginning date (year and month) used in the calculation of the refund or premium amount due for this transaction. For debit transactions, the billing period start date also represents the transaction effective date. For credit transactions, the transaction effective date is represented by the billing period start date minus one month. NOTE: the billing period start date and the billing period stop date are inclusive dates.*
14	*Billing Period Stop Date (CCYYMM)*	*6*	*88-93*	*Numeric*	*A six-position numeric field that contains the last date (year and month) used in the calculation of the refund or premium amount due for this transaction. NOTE: the billing period start date and the billing period stop date are inclusive dates.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
15	*Premium Amount Due or Refund ($$$$$$¢¢)*	*8*	*94-101*	*Numeric*	*An eight-position field with leading zeroes. On an accretion or ongoing billing record, this field will reflect a debit (i.e., the amount the state owes the federal government). On a deletion record, this field will reflect any credit (refund) due the state. On an adjustment record, the adjustment code in the transaction code field will determine whether the field reflects a debit or a credit.*
16	*Bill Month (CCYYMM)*	*6*	*102-107*	*Numeric*	*A six-position numeric field that designates the billing period (year and month) in which the transaction was processed.*
17	*Current Monthly Premium Rate ($$$$¢¢)*	*6*	*108-113*	*Numeric*	*A six-position numeric field with leading zeroes which contains the current monthly Part B Medicare premium rate.*

Item	Field	Size	Position	Format	Description
18	*Reduced Monthly Premium Amount ($$$$¢¢)*	*6*	*114-119*	*Numeric*	*A six-position numeric field with leading zeroes which specifies the amount of the monthly premium reduction under the provisions of section 1854(f)(1) of the Social Security Act. This is the amount of the* ***reduction,*** *not the new premium rate.*
19	*Part B Penalty Surcharge Code*	*3*	*120-122*	*Numeric-Signed*	*A three-position numeric-signed field. The presence of a value greater than zero in this position means that the Part B premium includes a surcharge for late enrollment. The numeric value provided represents the percentage of monthly surcharge assessed; for example, "01{" represents a 10% surcharge, whereas "13{" represents a 130% surcharge, and "00{" represents 0% or no surcharge has been applied.*
20	*Credit Indicator*	*1*	*123*	*Minus Sign or Blank*	*A minus sign (-) in this field means that the premium amount in positions 94 – 101 is a credit. A blank in this field means that the premium amount is a debit.*

Item	Field	Size	Position	Format	Description
21	*Code 1728 Accretion State Agency Code*	*3*	*124-126*	*Numeric*	*A three-position numeric state agency code will be provided in all **code 1728** deletion replies identifying the accreting state which now claims buy-in jurisdiction for this beneficiary. Otherwise, this field will remain blank.*
22	*ZIP Code of Residence*	*9*	*127-135*	*Numeric*	*A nine-position numeric code that is reflected on the EDB. If the EDB only reflects the five-position zip code, the five positions will be reflected and the remaining positions will be blank.*
23	*County Code of Residence*	*3*	*136-138*	*Numeric*	*A three-position numeric code developed from the EDB. The field may be blank.*
24	*Filler*	*1*	*139*		*Position reserved for future use.*
25	*SSI Status Code (SISC)*	*1*	*140*	*Alphabetic*	*A one-position alphabetic code which describes the beneficiary's SSI status (if applicable).*
26	*Agency Client Identification Number*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice.*

3.5.5 Medicare Number Change Record (RIC-C)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	*Field*	*Size*	*Position*	*Format*	*Description*
1	*Medicare Number*	*12*	*1-12*	*Alpha-numeric*	*The beneficiary HICN, a nine-position numeric value followed by an alpha-numeric BIC. If the beneficiary is entitled under a RRB claim number, this field will contain an 11-position alpha-numeric pseudo HICN. Positions 11 and 12 may be blank. This field will convey the Medicare number from the EDB. CMS will not return the MBI in this state buy-in reply.*
2	*Surname*	*24*	*13-36*	*Alpha-numeric*	*A maximum of 24 alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.*
3	*Given Name*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The name will match the given name on the EDB. Any unused positions will be blank.*
4	*Middle Initial*	*1*	*52*	*Alphabetic*	*An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
5	*Sex Code*	*1*	*53*	*Alphabetic*	*A one-position alphabetic code (male = "M," female = "F").*
6	*Date of Birth*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD. A date such as November 1, 1939 will be displayed as 19391101. The date of birth will match the date of birth on the EDB.*
7	*Beneficiary's Social Security Number*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The SSN will be extracted from the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.*
8	*Filler*	*2*	*71-72*		*Positions reserved for future use.*
9	*Agency Code*	*3*	*73-75*	*Alpha-numeric or Numeric*	*A three-position alpha-numeric or numeric code assigned to the state which has jurisdiction over the account.*
10	*Record Identification Code "C"*	*1*	*76*	*Alphabetic*	*"C" constant. The "C" identifies this record as a Medicare claim number change record.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
11	*Transaction Code*	*4*	*77-80*	*Numeric*	*Positions 77 and 78 will contain a "23" for a full claim number change or a BIC-only change. Positions 79 and 80 will be blank if the claim number change is applied to an ongoing record. If the claim number change is applied to an incoming transaction, positions 79 and 80 will contain the two-position transaction code that is contained in the input record.*
12	*Filler*	*13*	*81-93*		*Positions reserved for future use.*
13	*Active Medicare Claim Number*	*12*	*94-105*	*Alpha-numeric*	*The claim number to which the record is being cross-referred will consist of a nine-position numeric value and an alpha-numeric BIC (or pseudo HICN if the beneficiary is entitled under a RRB claim number).*
14	*Transaction Effective Date (CCYYMM)*	*6*	*106-111*	*Numeric*	*The date on which the claim number change became effective. This field may be left blank, unless the record is generated as a reply to a state-initiated transaction request.*
15	*Filler*	*7*	*112-118*		*Positions reserved for future use.*

Item	Field	Size	Position	Format	Description
16	*Reply Date (CCYYMMDD)*	*8*	*119-126*	*Numeric*	*An eight-position numeric field. This is the date on which CMS created the RIC-C record.*
17	*Filler*	*14*	*127-140*		*Positions reserved for future use.*
18	*Agency Client Identification Number*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice.*

3.5.6 Part A State Agency Date Change or Reply Record (RIC-D)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All states receive date change records, but reply records are generated only for states receiving daily response files. RIC-D reply records provide notification of actions that will affect billing and are, therefore, considered a pre-billing notification.

Item	Field	Size	Position	Format	Description
1	*Medicare Number*	*12*	*1-12*	*Alpha-numeric*	*The beneficiary HICN, a nine-position numeric value followed by an alpha-numeric BIC. If the beneficiary is entitled under a RRB claim number, this field will contain an 11-position alpha-numeric pseudo HICN. Positions 11 and 12 may be blank. This field will convey the Medicare number from the EDB. CMS will not return the MBI in this state buy-in reply.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
2	*Surname*	*24*	*13-36*	*Alpha-numeric*	*A maximum of 24 alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.*
3	*Given Name*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The name will match the given name on the EDB. Any unused positions will be blank.*
4	*Middle Initial*	*1*	*52*	*Alphabetic*	*An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.*
5	*Sex Code*	*1*	*53*	*Alphabetic*	*A one-position alphabetic code (male = "M," female = "F").*
6	*Date of Birth*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD. A date such as November 1, 1939 will be displayed as 19391101. The date of birth will match the date of birth on the EDB.*
7	*Beneficiary's Social Security Number*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The SSN will be extracted from the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
8	*Filler or Reduced Part A Indicator*	*1*	*71*	*Numeric or Alphabetic*	*When the transaction code in position 77-78 is "30," this field will be blank. For states receiving daily files, when the transaction reply code is not "30," the presence of a "1" in this position means the reduced Part A premium rate applies; otherwise, it will be blank, unless the state submitted a buy-in eligibility code with their Part A buy-in. If so, the BIEC submitted for Part A will be displayed.*
9	*Filler or Part A Premium Surcharge Indicator*	*1*	*72*	*Numeric or Blank*	*When the transaction code in position 77-78 is "30," this field will be blank. For states receiving daily files, when the transaction reply code is not "30," the presence of a "1" in this position means the Part A premium includes a 10% surcharge for late enrollment; otherwise, it is blank.*
10	*Agency Code*	*3*	*73-75*	*Alpha-numeric*	*A three-position alpha-numeric code, beginning with "S," assigned to the state which has jurisdiction over the account.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
11	*Record Identification Code "D"*	*1*	*76*	*Alphabetic*	*"D" constant. The "D" identifies this record as a date change record or, for states receiving daily response files, when the transaction reply code is not "30," a reply record.*

Item	Field	Size	Position	Format	Description
12	Transaction Code	4	77-80	Numeric	A two- or four-position numeric code. When CMS must adjust the effective date of an incoming accretion transaction to a later date to conform to the Medicare entitlement date, the first two positions contain the value of “30.” The last two positions will contain the same transaction code as was present on the state input record. For states receiving daily response files, when the transaction reply code is not “30,” the first two positions convey CMS' reply to a state's accretion or deletion request. The last two positions will contain the same transaction code as was present on the state input record. For these daily exchange states, the two- or four-position transaction code may also convey that CMS processed a debit or credit billing action, received from another source, on behalf of the state.
13	Transaction Sub-Code	1	81	Alphabetic	A one-position alphabetic code that further defines the transaction code.

Item	*Field*	*Size*	*Position*	*Format*	*Description*
14	*Transaction Date from state record or the Billing Period Start Date (CCYYMM)*	*6*	*82-87*	*Numeric*	*A six-position numeric date field. When the transaction reply code is "30," this field contains the accretion transaction effective date submitted by the state, the date which CMS adjusted to a later date. The resulting adjusted date is reflected on an accompanying billing record. For those states receiving daily files, when the transaction reply code is not "30," this field contains the beginning date (year and month) used in calculating a refund or debit premium amount for this transaction reply. For debits, the billing period start date also represents the applied transaction effective date. For credits, the transaction effective date is equivalent to the billing period start date minus one month. NOTE: the billing period start and stop dates are inclusive dates.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
15	*Filler or Billing Period Stop Date (CCYYMM)*	*6*	*88-93*	*Numeric*	*When the transaction reply code is "30," this field will be blank. For those states receiving daily files, when the transaction reply code is not "30," this field will be a six-position numeric field that contains the last date (year and month) used in calculating the refund or premium amount for this transaction. NOTE: the billing period start date and the billing period stop date are inclusive dates.*
16	*Filler or Code 1728 Accretion State Agency Code*	*3*	*94-96*	*Alpha-numeric*	*When the transaction reply code is "30," this field will be blank. For those states receiving daily files, when the transaction reply code is not "30," this field will be a three-position alpha-numeric state agency code, beginning with "S," provided in all* ***code 1728*** *deletion replies identifying the accreting state which now claims buy-in jurisdiction for this beneficiary. Otherwise, this field will remain blank.*
17	*Filler*	*22*	*97-118*		*Positions reserved for future use.*

Item	Field	Size	Position	Format	Description
18	*Reply Date (CCYYMMDD)*	*8*	*119-126*	*Numeric*	*An eight-position numeric field. This is the date on which CMS created the RIC-D record.*
19	*ZIP Code of Residence*	*9*	*127-135*	*Numeric*	*A nine-position numeric code that is reflected on the EDB. If the EDB only reflects the five-position zip code, the five positions will be reflected and the remaining positions will be blank.*
20	*County Code of Residence*	*3*	*136-138*	*Numeric*	*A three-position numeric code developed from the EDB. The field may be blank.*
21	*Filler*	*2*	*139-140*		*Positions reserved for future use.*
22	*Agency Client Identification Number*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice.*

3.5.7 Part B State Agency Date Change or Reply Record (RIC-D)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All states receive date change records, but reply records are generated only for states receiving daily response files. Reply records provide notification of actions that will affect billing and are, therefore, considered a pre-billing notification.

Item	*Field*	*Size*	*Position*	*Format*	*Description*
1	*Medicare Number*	*12*	*1-12*	*Alpha-numeric*	*The beneficiary HICN, a nine-position numeric value followed by an alpha-numeric BIC. If the beneficiary is entitled under a RRB claim number, this field will contain an 11-position alpha-numeric pseudo HICN. Positions 11 and 12 may be blank. This field will convey the Medicare number from the EDB. CMS will not return the MBI in this state buy-in reply.*
2	*Surname*	*24*	*13-36*	*Alpha-numeric*	*A maximum of 24 alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.*
3	*Given Name*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The name will match the given name on the EDB. Any unused positions will be blank.*
4	*Middle Initial*	*1*	*52*	*Alphabetic*	*An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.*
5	*Sex Code*	*1*	*53*	*Alphabetic*	*A one-position alphabetic code (male = "M," female = "F").*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
6	*Date of Birth*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD. A date such as November 1, 1939 will be displayed as 19391101. The date of birth will match the date of birth on the EDB.*
7	*Beneficiary's Social Security Number*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The SSN will be extracted from the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.*
8	*Filler or Buy-in Eligibility Code*	*2*	*71-72*	*Alphabetic/ Blank*	*When the transaction code in position 77-78 is "30," position 71 will be blank. For states receiving daily files, when the transaction reply code is not "30," position 71 will be a one-position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An additional field (position 72) has been allocated for expansion.*
9	*Agency Code*	*3*	*73-75*	*Numeric*	*A three-position numeric code assigned to the state which has jurisdiction over the account.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
10	*Record Identification Code*	*1*	*76*	*Alphabetic*	*"D" constant. The "D" identifies this record as a date change record or, for states receiving daily response files, when the transaction reply code is not "30," a reply record.*
11	*Transaction Code*	*4*	*77-80*	*Numeric*	*A two- or four-position numeric code. When CMS must adjust the effective date of an incoming accretion transaction to a later date to conform to the Medicare entitlement date, the first two positions contain the value of "30." The last two positions will contain the same transaction code as was present on the state input record. For these daily exchange states, the two- or four-position transaction code may also convey that CMS processed a debit or credit billing action, received from another source, on behalf of the state.*
12	*Transaction Sub-Code*	*1*	*81*	*Alphabetic*	*A one-position alphabetic code that further defines the transaction code.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
13	*Billing Period Start Date (CCYYMM)*	*6*	*82-87*	*Numeric*	*A six-position numeric date field. When the transaction reply code is "30," this field contains the accretion transaction effective date submitted by the state, the date which CMS adjusts to a later date. The resulting adjusted date is reflected on an accompanying billing record. For those states receiving daily files, when the transaction reply code is not "30," this field contains the beginning date (year and month) used in calculating the refund or premium amount for this transaction reply. For debits, the billing period start date also represents the applied transaction effective date. For credits, the transaction effective date is equivalent to the billing period start date minus one month. NOTE: the billing period start and stop dates are inclusive dates.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
14	*Filler or Billing Period Stop Date (CCYYMM)*	*6*	*88-93*	*Numeric*	*When the transaction reply code is "30," this field will be blank. For those states receiving daily files, when the transaction reply code is not "30," this field will be a six-position numeric field that contains the last date (year and month) used in calculating the refund or premium amount for this transaction.* ***NOTE****: the billing period start date and the billing period stop date are inclusive dates.*
15	*Code 1728 Accretion State Agency Code*	*3*	*94-96*	*Numeric*	*When the transaction reply code is "30," this field will be blank. For those states receiving daily files, when the transaction reply code is not "30," this field will be a three-position numeric state agency code provided in all* ***code 1728*** *deletion replies identifying the accreting state which now claims buy-in jurisdiction for this beneficiary. Otherwise, this field will remain blank.*
16	*Filler*	*11*	*97-107*		*Positions reserved for future use.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
17	*Filler or Reduced Monthly Premium Amount*	*6*	*108-113*	*Numeric-Signed*	*When the transaction reply code is "30," this field will be blank. For those states receiving daily files, when the transaction reply code is not "30," this will be a six-position numeric-signed field with leading zeroes. This field specifies the amount of the monthly premium reduction to be applied under the provisions of section 1854(f)(1) of the Social Security Act. This will be the amount of the* ***reduction****, not the new premium rate.*
18	*Filler*	*5*	*114-118*		*Positions reserved for future use.*
19	*Reply Date (CCYYMMDD)*	*8*	*119-126*	*Numeric*	*An eight-position numeric field. This is the date on which CMS created the RIC-D record.*
20	*Zip Code of Residence*	*9*	*127-135*	*Numeric*	*A nine-position numeric code that is reflected on the EDB. If the EDB only reflects the five-position zip code, the five positions will be reflected and the remaining positions will be blank.*
21	*County Code of Residence*	*3*	*136-138*	*Numeric*	*A three-position numeric code developed from the EDB. The field may be blank.*

Item	Field	Size	Position	Format	Description
22	*Filler*	*2*	*139-140*		*Positions reserved for future use.*
23	*Agency Client Identification Code*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice.*

3.5.8 Personal Characteristics Change Record (RIC-E)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This reply record is designed to demonstrate that the information provided by the state differs in some fashion to the information stored on the EDB. Thus, state record information is displayed as provided in the first set of field values, and CMS EDB information is displayed in the second set of field values.

Item	Field	Size	Position	Format	Description
1	*Medicare Number from State Record*	*12*	*1-12*	*Alpha-numeric*	*The Medicare number will consist of a nine-position numeric value followed by an alpha-numeric BIC. Positions 11 and 12 may be blank. If the beneficiary is entitled under a RRB claim number, this field may consist of an 11-position alpha-numeric pseudo HICN. The value in this field will be the value submitted by the state on the incoming transaction.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
2	*Surname from State Record*	*24*	*13-36*	*Alpha-numeric*	*A maximum of 24 alpha-numeric characters. The value in this field will be the value submitted by the state on the incoming transaction.*
3	*Given Name from State Record*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The value in this field will be the value submitted by the state on the incoming transaction.*
4	*Middle Initial from State Record*	*1*	*52*	*Alphabetic*	*An alphabetic character. The value in this field will be the value submitted by the state on the incoming transaction.*
5	*Sex Code from State Record*	*1*	*53*	*Alphabetic*	*A one-position alphabetic code (male = "M," female = "F"). The value in this field will be the value submitted by the state on the incoming transaction.*
6	*Date of Birth from State Record*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD (e.g., November 1, 2019 will be displayed as 20191101). The value in this field will be the value submitted by the state on the incoming transaction.*

Item	Field	Size	Position	Format	Description
7	*Beneficiary's Social Security Number from State Record*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The value in this field will be the value submitted by the state on the incoming transaction.*
8	*Filler*	*2*	*71-72*		*Positions reserved for future use.*
9	*Agency Code*	*3*	*73-75*	*Alpha-numeric or Numeric*	*A three-position alpha-numeric or numeric code assigned to the state which has jurisdiction over the account.*
10	*Record Identification Code "E"*	*1*	*76*	*Alphabetic*	*"E" constant. The "E" identifies this record as a personal characteristics change record.*
11	*Filler*	*5*	*77-81*	*Numeric*	*Positions reserved for future use.*
12	*Surname from CMS Records*	*24*	*82-105*	*Alpha-Numeric*	*A twenty-four-position alpha-numeric field that will convey the beneficiary's surname exactly as it is appears on the EDB. Any unused positions will be blank.*
13	*Given Name from CMS Records*	*15*	*106-120*	*Alphabetic*	*A fifteen-position alphabetic field that will convey the beneficiary's given name exactly as it appears on the EDB. Any unused positions will be blank.*

Item	Field	Size	Position	Format	Description
14	*Middle Initial from CMS Records*	*1*	*121*	*Alphabetic*	*A one-position alphabetic field that will convey the beneficiary's middle initial exactly as it appears on the EDB.*
15	*Sex Code from CMS Records*	*1*	*122*	*Alphabetic*	*A one-position alphabetic code (male = "M," female = "F") which will convey the beneficiary's sex code as it appears on the EDB.*
16	*Date of Birth from CMS Records (CCYYMMDD)*	*8*	*123-130*	*Numeric*	*An eight-position numeric field that will convey the beneficiary's date of birth exactly as it appears on the EDB.*
17	*Beneficiary's Social Security Number from CMS Records*	*9*	*131-139*	*Numeric*	*A nine-position numeric field that will convey the beneficiary's own SSN exactly as it appears on the EDB. This field may be blank if the EDB does not currently have the beneficiary's SSN.*
18	*Filler*	*1*	*140*		*Position reserved for future use.*
19	*Agency Client Identification Number from State Record*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice. The value in this field will be the value submitted by the state on the incoming transaction.*

3.5.9 State Agency Reject Record (RIC-F)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This reply record is designed to indicate that an action submitted by the state could not be processed. This may be because the beneficiary record could not be located on the EDB. In any event, CMS could not process the request as presented. Thus, CMS returns the primary field values exactly as they were submitted on the state input file.

Item	Field	Size	Position	Format	Description
1	*Medicare Number from State Record*	*12*	*1-12*	*Alpha-numeric*	*The Medicare number will consist of a nine-position numeric value followed by an alpha-numeric BIC. Positions 11 and 12 may be blank. If the beneficiary is entitled under a RRB number, this field may consist of an eleven-position alpha-numeric pseudo HICN. The value in this field will be the value submitted by the state on the incoming transaction.*
2	*Surname from State Record*	*24*	*13-36*	*Alpha-numeric*	*A maximum of 24 alpha-numeric characters. The value in this field will be the value submitted by the state on the incoming transaction.*
3	*Given Name from State Record*	*15*	*37-51*	*Alphabetic*	*A maximum of 15 alphabetic characters. The value in this field will be the value submitted by the state on the incoming transaction.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
4	*Middle Initial from State Record*	*1*	*52*	*Alphabetic*	*An alphabetic character. The value in this field will be the value submitted by the state on the incoming transaction.*
5	*Sex Code from State record*	*1*	*53*	*Alphabetic*	*A one position alphabetic code (male = "M," female = "F")*
6	*Date of Birth from State record*	*8*	*54-61*	*Numeric*	*An eight-position numeric field, CCYYMMDD (e.g., November 1, 1939 will be displayed as 19391101). The value in this field will be the value submitted by the state on the incoming transaction.*
7	*Beneficiary's Social Security Number from State Record*	*9*	*62-70*	*Numeric*	*A nine-position numeric field. The value in this field will be the value submitted by the state on the incoming transaction.*
8	*Buy-in Eligibility Code from State Record*	*2*	*71-72*	*Alphabetic/Blank*	*Applicable to Part B buy-in only. Position 71 is a one-position alphabetic code that describes the reason the beneficiary is eligible for buy-in. The value in this field will be the value submitted by the state on the incoming transaction. An additional field (position 72) has been allocated for expansion.*

Item	*Field*	*Size*	*Position*	*Format*	*Description*
9	*Agency Code*	*3*	*73-75*	*Alpha-numeric or Numeric*	*A three-position alpha-numeric or numeric code assigned to the state which has jurisdiction over the account.*
10	*Record Identification Code*	*1*	*76*	*Alphabetic*	*"F" constant. The "F" identifies this record as a state agency reject record.*
11	*Transaction Code*	*4*	*77-80*	*Numeric*	*A four-position numeric code. The first two positions of the code convey the reason that CMS rejected the state's accretion or deletion record. The last two positions contain the transaction code from the state input record.*
12	*Transaction Sub-Code*	*1*	*81*	*Alphabetic*	*A one-position alphabetic code that further defines the transaction code.*
13	*Transaction Effective Date from State Record (CCYYMM)*	*6*	*82-87*	*Numeric*	*A six-position numeric field that contains the transaction effective date (year and month) from the state input record.*

Item	Field	Size	Position	Format	Description
14	*Code 75 Stop Date from State Record (CCYYMM)*	*6*	*88-93*	*Numeric*	*A six-position numeric field that contains the date (year and month) of the last month for which the state claimed jurisdiction within a proposed closed period of buy-in coverage, taken from the state input record. Important: This field is used exclusively with transaction **code 75**. For all other RIC-F replies, this field should be blank.*
15	*Filler*	*3*	*94-96*		*Positions reserved for future use.*
16	*Additional Date (CCYYMM)*	*6*	*97-102*	*Numeric*	*In most situations, this field will be blank. However, for certain transaction codes, a date will be furnished in order to provide a more comprehensive reply to the state; for example, the beneficiary date of death as it appears on the EDB. The date will be a six-position numeric field.*
17	*Filler*	*16*	*103-118*		*Positions reserved for future use.*
18	*Reply Date (CCYYMMDD)*	*8*	*119-126*	*Numeric*	*An eight-position numeric field. This is the date on which CMS created the RIC-F record.*
19	*Filler*	*14*	*127-140*		*Positions reserved for future use.*

Item	Field	Size	Position	Format	Description
20	*Agency Client Identification Number from state Record*	*20*	*141-160*	*Alpha-numeric*	*The beneficiary's client (or Medicaid) identification number or any other identifier of the state's choice. The value in this field will be the value submitted by the state on the incoming transaction.*

3.5.10 CMS/TPS Buy-in Exchange Trailer Record

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Item	Field	Size	Position	Format	Description
1	*Total RIC-A Records*	*7*	*1-7*	*Numeric*	*A seven-position numeric value, zero-filled to the left, representing the total number of RIC-A SSI Alert type records included in this CMS response file.*
2	*Filler*	*1*	*8*		*Position reserved for future use.*
3	*Total RIC-B Records*	*7*	*9-15*	*Numeric*	*A seven-position numeric value, zero-filled to the left, representing the total number of RIC-B Billing type records included in this CMS response file.*
4	*Filler*	*1*	*16*		*Position reserved for future use.*

Item	Field	Size	Position	Format	Description
5	Total RIC-C Records	7	17-23	Numeric	A seven-position numeric value, zero-filled to the left, representing the total number of RIC-C Claim Number Change type records included in this CMS response file.
6	Filler	1	24		Position reserved for future use.
7	Total RIC-D Records	7	25-31	Numeric	A seven-position numeric value, zero-filled to the left, representing the total number of RIC-D Reply or Date Change type records included in this CMS response file.
8	Filler	1	32		Position reserved for future use.
9	Total RIC-E Records	7	33-39	Numeric	A seven-position numeric value, zero-filled to the left, representing the total number of RIC-E Personal Characteristics Change type records included in this CMS response file.
10	Filler	1	40		Position reserved for future use.
11	Total RIC-F Records	7	41-47	Numeric	A seven-position numeric value, zero-filled to the left, representing the total number of RIC-F Rejection type records included in this CMS response file.

Item	Field	Size	Position	Format	Description
12	Filler	25	48-72		Positions reserved for future use.
13	Agency Code	3	73-75	Alpha-numeric or Numeric	The three-position alpha-numeric or numeric code of the state which has jurisdiction over the account associated with this file.
14	Record Identification Code	1	76	Alphabetic	"T" constant. The "T" identifies this record as the trailer record.
15	Filler	5	77-81		Positions reserved for future use.
16	Bill Month (CCYYMM)	6	82-87	Numeric	A six-position numeric field that designates the billing file (year and month) for which the reply is associated.
17	Filler	1	88		Position reserved for future use.
18	Total Number of Transaction Records on File	7	89-95	Numeric	A seven-position numeric value, zero-filled to the left, representing the total number of transaction records, RICs A through F, included within this CMS daily or monthly response file.
19	Filler	65	96-160		Positions reserved for future use.

Buy-in Code Descriptions
Chapter 4

Table of Contents
(Rev. 4, 08-21-20)

Transmittals for Chapter 4

4.0 Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This chapter contains descriptions of codes used in the buy-in file exchange between states and CMS. The buy-in file layouts are set forth in chapter 3.

4.1 State Buy-in Eligibility Codes (BIECs) - Position 71 on State Agency Input File and CMS Response Files

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in Eligibility Codes (BIECs) provide states with a method for identifying specific Medicaid categories included in the state's Medicare buy-in accounts. States and CMS can populate the BIEC data field, but the ***states are responsible for maintaining its accuracy****.*

States can change the BIEC or add a new one for an individual record by using the ***code 99*** *transaction. These* ***code 99*** *changes only apply prospectively, meaning they take effect in a subsequent billing period (e.g., if the state submits a* ***code 99*** *for a record in March, the updated BIEC will first appear in the state's May billing file from CMS).*

NOTE: *States can submit a record with a blank BIEC field, but once a BIEC field is populated, it cannot be changed back to a blank field. States cannot use a* ***code 99*** *to delete a BIEC. A* ***code 99*** *record with a blank will not eliminate an existing BIEC on the Enrollment Database (EDB). If the state decides to use a BIEC of its own design, it must be an alphabetic character.*

4.1.1 Table of Buy-in Eligibility Codes

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in Eligibility Code	***Description***	***Notes (as applicable)***
Mandatory Codes		
P	*Qualified Medicare Beneficiary (QMB)*	*All states must cover QMBs. States must identify and maintain identification of members of this coverage group for CMS to update the EDB.*
L	*Specified Low-Income Medicare Beneficiary (SLMB)*	*All states must cover SLMBs. States must identify and maintain identification of members of this coverage group within the EDB.*

Buy-in Eligibility Code	***Description***	***Notes (as applicable)***
U	*Qualifying Individual (QI)*	*All states must cover QIs. States must identify and maintain identification of members of this coverage group for CMS to update the EDB.*
M	*Full-benefit dual eligible individuals who do not receive (or are not deemed to receive) cash assistance (also known as Medical Assistance Only (MAO))*	*All states that include full-benefit dual eligible individuals without cash assistance in their state buy-in agreement must identify and maintain identification of members of this coverage group for CMS to update the EDB. See chapter 1, section 1.6.3 for a description of "all other Medicaid categories."*
Optional		
Z	*Deemed Categorically Needy*	
CMS-Generated Codes (These codes are based on Supplemental Security Income (SSI) records.)		
A	*Aged recipient of Federal SSI payments*	
B	*Blind recipient of Federal SSI payments*	
D	*Disabled recipient of Federal SSI payments*	
E	*Aged recipient of supplemental payment administered by SSA*	
F	*Blind recipient of supplemental payment administered by SSA*	
G	*Disabled recipient of supplemental payment administered by SSA*	

Buy-in Eligibility Code	Description	Notes (as applicable)
H	Aged, blind, or disabled recipient of a one-time payment	

4.2 Agency Codes for State Buy-in (Positions 73-75)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS assigns agency codes to all Third Party Premium Payers, including states and U.S. territories. All states have two assigned agency codes – one for Part A transactions and one for Part B transactions. The first position in state agency codes for Part A buy-in transactions is "S" and the first position for Part B buy-in transactions is a number from 0 through 6. Each third party billing action must include an agency code to identify the state and type of transaction.

4.2.1 Table of State Agency Codes

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

PART A AGENCY CODE	PART B AGENCY CODE	STATE
S01	010	Alabama
S02	020	Alaska
S03	030	Arizona
S04	040	Arkansas
S05	050	California
S06	060	Colorado
S07	070	Connecticut
S08	080	Delaware
S09	090	District of Columbia
S10	100	Florida

PART A AGENCY CODE	***PART B AGENCY CODE***	***STATE***
S11	*110*	*Georgia*
S12	*120*	*Hawaii*
S13	*130*	*Idaho*
S14	*140*	*Illinois*
S15	*150*	*Indiana*
S16	*160*	*Iowa*
S17	*170*	*Kansas*
S18	*180*	*Kentucky*
S19	*190*	*Louisiana*
S20	*200*	*Maine*
S21	*210*	*Maryland*
S22	*220*	*Massachusetts*
S23	*230*	*Michigan*
S24	*240*	*Minnesota*
S25	*250*	*Mississippi*
S26	*260*	*Missouri*
S27	*270*	*Montana*
S28	*280*	*Nebraska*
S29	*290*	*Nevada*
S30	*300*	*New Hampshire*
S31	*310*	*New Jersey*

PART A AGENCY CODE	***PART B AGENCY CODE***	***STATE***
S32	*320*	*New Mexico*
S33	*330*	*New York*
S34	*340*	*North Carolina*
S35	*350*	*North Dakota*
S36	*360*	*Ohio*
S37	*370*	*Oklahoma*
S38	*380*	*Oregon*
S39	*390*	*Pennsylvania*
*S40**	*400*	*Puerto Rico*
S41	*410*	*Rhode Island*
S42	*420*	*South Carolina*
S43	*430*	*South Dakota*
S44	*440*	*Tennessee*
S45	*450*	*Texas*
S46	*460*	*Utah*
S47	*470*	*Vermont*
*S48***	*480*	*Virgin Islands*
S49	*490*	*Virginia*
S50	*500*	*Washington*
S51	*510*	*West Virginia*
S52	*520*	*Wisconsin*

PART A AGENCY CODE	PART B AGENCY CODE	STATE
S53	530	Wyoming
S64**	640	Commonwealth of the Northern Mariana Islands
S65**	650	Guam

** Puerto Rico does not have a state buy-in agreement.*

*** The Virgin Islands, Commonwealth of the Northern Mariana Islands, and Guam have elected not to cover QMBs.*

4.3 Health Insurance Claim Numbers (HICNs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The Third Party System (TPS) continues to classify buy-in records by the HICN, but can recognize and accept the Medicare Beneficiary Indicator (MBI) on the state input file. TPS will only provide the HICN on the response file to the state.

It is important to distinguish the beneficiary's Social Security Number (SSN) from the beneficiary's HICN. The Social Security Administration (SSA) assigns each individual a SSN to record and track earnings and work credits for Social Security benefits.

The HICN is the number identifying Medicare entitlement for an individual. It includes the nine-digit SSN combined with a one- or two-position alpha-numeric suffix known as the beneficiary identification code (BIC). The BIC designates the type of benefits the individual is receiving, such as wage earner's, spouse's, or child's benefits. The nine-digit SSN is divided into three parts and is usually separated by hyphens (-). From left to right, the three parts are referred to as area, group, and serial.

*Prior to June 25, 2011, the area number was derived from the ZIP Code in the mailing address the individual provided on their initial application for an SSN card. On June 25, 2011, SSA began randomizing the assignment of SSNs, thereby making available all numbers from **001-899** (with the exception of 666) for area assignment nationwide, regardless of the mailing address of the applicant. Numbers **900-999** were reserved for IRS Individual Taxpayer Identification Numbers (ITINs) and are, therefore, not available for the area series.*
*Group numbers range from **01-99**.*

*Serial numbers range from **0001- 9999** within each group.*
The first position of the BIC must always be an alphabetic character (e.g., 000-00-0000A). The

second position of the BIC may be alphabetic or numeric (e.g., 000-00-0000J1). If the second position of the BIC is numeric, it is referred to as a subscript. Section 4.3.1 provides a table of BICs for Social Security beneficiaries.
Effective January 1983, newly retired federal employees became entitled to Medicare benefits. These Medicare-qualified federal employees (MQFE) receive a BIC unique to this group. Section 4.3.2 includes the table of BICs for MQGEs.

4.3.1 Table of Beneficiary Identification Codes (BICs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

	1st Claimant	*2nd Claimant*	*3rd Claimant*	*4th Claimant*	*5th Claimant*
Primary Claimant	*A*	*---*	*---*	*---*	*---*
Wife age 62 or older	*B*	*B3*	*B8*	*BA*	*BD*
Wife under age 62	*B2*	*B5*	*B7*	*BK*	*BL*
Divorced Wife age 62 or older	*B6*	*B9*	*BN*	*BP*	*BQ*
Young Husband	*BY*	*BW*	*---*	*---*	*---*
Child	*C (Oldest child will have highest subscript; subscripts disabled or will descend to C1 for youngest child. If there are (student child) more than nine children, there will be an alphabetic subscript beginning with CA for the 10th child.)*				
Widow age 60 or older	*D*	*D2*	*D8*	*DD*	*DG*
Widow Remarried after age 60	*D4*	*D9*	*DA*	*DL*	*DN*

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Surviving Divorced Wife aged 60 or older	D6	D7	DV	DW	DY
Surviving Divorced Husband	DC	DM	DS	DX	DZ
Mother	E	E2	E7	E8	EA
Surviving Divorced Mother	E1	E3	EB	EC	ED
Husband age 62 or older	B1	B4	BG	BH	BJ
Divorced Husband	BR	BT	---	---	---
Widower age 60 or older	D1	D3	DH	DJ	DK
Widower Remarried	D5	DP	DQ	DR	DT
Widowed Father	E4	E6	EF	EG	EH
Surviving Divorced Father	E5	E9	EJ	EK	EM
Father	F1	F7	---	---	---
Mother	F2	F8	---	---	---
Stepfather	F3	---	---	---	---

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Stepmother	*F4*	---	---	---	---
Adopting Father	*F5*	---	---	---	---
Adopting Mother	*F6*	---	---	---	---
Entitled to HIB* (less than 30 QCs)*	*J1*	---	---	---	---
Entitled to HIB* (30 QCs or more)*	*J2*	---	---	---	---
Not Entitled to HIB* (less than 30 QCs)*	*J3*	---	---	---	---
Not Entitled to HIB* (30 QCs or more)*	*J4*	---	---	---	---
Wife Entitled to HIB* (less than 30 QCs)*	*K1*	*K5*	*K9*	*KD*	*KH*
Wife Entitled to HIB* (30 QCs or more)*	*K2*	*K6*	*KA*	*KE*	*KJ*
Wife not Entitled to	*K3*	*K7*	*KB*	*KF*	*KL*

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
HIB* (less than 30 QCs)**					
Wife not Entitled to HIB* (30 QCs or more)**	K4	K8	KC	KG	KM
Black Lung Miner	LM	---	---	---	---
Black Lung Miner's Widow	LW	---	---	---	---
Uninsured (not entitled to HIB,* qualified for SMIB)***	M	---	---	---	---
Insured (qualified for HIB,* but requested only SMIB)***	M1	---	---	---	---
Uninsured (entitled to HIB* under deemed insured provision)	T	---	---	---	---
Disabled Widow	W	W2	W4	W9	WF

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Disabled Widower	W1	W3	W5	WB	WG
Disabled Surviving Divorced Wife	W6	W7	W8	WC	WJ
Disabled Surviving Divorced Husband	WR	WT	---	---	---

** HIB – Hospital Insurance Benefits (Medicare Part A)*

***QC – quarters of coverage for Title II*

****SMIB – Supplementary Medical Insurance Benefits (Medicare Part B)*

4.3.2 Table of Beneficiary Identification Codes (BICs) for Medicare Qualified Government Employees (MQGEs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

	1ST Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Number Holder (Primary)	TA	---	---	---	---
ESRD Wife*	TB	TG	TH	TJ	TK
ESRD Husband*	TB	TG	---	---	---
Aged Wife	TB	TG	TH	TJ	TK
Aged Husband	TB	TG	TH	TJ	TK
Divorced Wife	TB	TG	TH	TJ	TK
Divorced Husband	TB	TG	---	---	---
ESRD Widow*	TE	TR	TS	TT	TU

	1ST Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
ESRD Widower*	TE	TR	TS	TT	TU
Surviving Divorced ESRD Wife*	TE	TR	TS	TT	TU
Surviving Divorced ESRD Husband*	TE	TR	TS	TT	TU
Aged Widow	TD	TL	TM	TN	TP
Aged Widower	TD	TL	TM	TN	TP
Remarried Widow	TD	TL	TM	TN	TP
Remarried Widower	TD	TL	TM	TN	TP
Surviving Divorced Aged Wife	TD	TL	TM	TN	TP
Surviving Divorced Aged Husband	TD	TL	TM	TN	TP
Father	TF	TF	---	---	---
Mother	TQ	TQ	---	---	---
Stepfather	TF	---	---	---	---
Stepmother	TQ	---	---	---	---
Adopting Father	TF	---	---	---	---
Adopting Mother	TQ	---	---	---	---
Child (Disabled/ESRD)*	TC (Additional children T2 – T9)				

	1ST Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Disabled Widow	TW	TX	TY	TZ	TV
Disabled Widower	TW	TX	TY	TZ	TV
Disabled Surviving Divorced Wife	TW	TX	TY	TZ	TV
Disabled Surviving Divorced Husband	TW	TX	---	---	---

**End-stage renal disease claimant under age 65.*

4.4 Railroad Retirement Board (RRB) Claim Numbers

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

An individual who primarily worked in the U.S. railroad will receive retirement benefits based on a RRB claim number rather than on a social security claim number. A RRB claim number is either a six- or nine-digit number with an alphabetic prefix. Although the RRB ended the assignment of six-digit numbers for most beneficiaries in 1964, there remains a small number of survivors who have the six-digit claim number. The RRB does continue to issue six-digit claim numbers to Canadian beneficiaries who do not have a SSN.

The dependents of an individual who primarily worked in the railroad may receive benefits from the RRB. The dependents will have an alphabetic prefix before the six- or nine-digit number, as well. See Table 4.5.

The RRB Medicare claim number, also known as RRB HICN, is always the same number as the RRB claim number for the railroad employee. For a dependent, however, the RRB HICN is not always the same number as the RRB claim number. Since the RRB HICN has been replaced on the Medicare card with the MBI, dependent RRB beneficiaries may not know their RRB HICN. In these instances, states may submit buy-in transactions using the MBI, instead.
CMS prefers that states submit an accretion record for a RRB beneficiary with the pseudo HICN since the EDB stores the data in this format. If a state submits the RRB claim number, CMS will convert it to a pseudo HICN and send a claim number change record to the state.

***NOTE:** States must submit deletion records for RRB beneficiaries using the pseudo HICN. Convert an RRB claim number to a pseudo HICN in the following manner:*

1. *Convert the RRB claim number prefix to the appropriate two-digit SSA BIC according to*

the format contained in the Table of RRB Prefixes and Equivalent SSA BICs (see section 4.5).

2. *Place the two-digit SSA BIC at the end of the RRB claim number and drop the alphabetic RRB prefix.*
3. *If the numeric portion of the original RRB claim number consists of a six-digit number, three zeroes (000) must be added as a prefix to the six-digit RRB claim number, thereby creating a nine-digit pseudo HICN.* ***NOTE: The first zero in this type of conversion must always be zoned as a signed field. The hexadecimal representation for a positive-zoned zero is "C0."***

   Example: *RRB Claim Number WA123456*
   Pseudo HICN 00012345616 (First zero must be zoned plus.)

4. *If the numeric portion of the original RRB claim number consists of nine digits, convert the first digit to an alphabetic character according to the table below. At the present time, there are no claim numbers which begin with 8 or 9.*

4.4.1 Conversion Table for Nine-Digit Numeric Portion of RRB Claim Number

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Numeric	***Alphabetic or Numeric***	***Numeric***	***Alphabetic***
0	*0 (Zoned Plus)*	*4*	*D*
1	*A*	*5*	*E*
2	*B*	*6*	*F*
3	*C*	*7*	*G*

Example: *RRB Claim Number A321549876*
Pseudo HICN C2154987610

4.5 Table of RRB Prefixes and Equivalent SSA BICs

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

RRB Claim Prefix	***SSA BIC***	***RRB Beneficiary Type***
A	*10*	*Retirement – employee or annuitant*

RRB Claim Prefix	*SSA BIC*	*RRB Beneficiary Type*
H	*80*	*RR pensioner (age or disability)*
MA	*14*	*Spouse of RR employee or annuitant (husband or wife)*
MH	*84*	*Spouse of RR pensioner*
*WCD**	*43*	*Child of RR employee*
*WCA**	*13*	*Child of RR annuitant*
CA	*17*	*Disabled adult child of RR annuitant*
WD	*46*	*Widow or widower of an RR employee*
WA	*16*	*Widow or widower of an RR annuitant*
WH	*86*	*Widow or widower of an RR pensioner*
*WCD**	*43*	*Widow of employee with a child in her care*
*WCA**	*13*	*Widow of annuitant with a child in her care*
WCH	*83*	*Widow of pensioner with a child in her care*
PD	*45d*	*Parent of RR employee*
PA	*15*	*Parent of RR annuitant*
PH	*85*	*Parent of RR pensioner*
JA	*11*	*Survivor joint annuitant – an annuitant who has taken a reduced amount to guarantee payments to a*

RRB Claim Prefix	*SSA BIC*	*RRB Beneficiary Type*
		surviving spouse

**WCD and WCA have two designations each.*

4.6 CMS-Initiated Alpha-numeric Character Changes to the HICN/MBI

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS notifies the state in the regular monthly billing file of any changes in the beneficiary's Medicare number and/or BIC. CMS may process a Medicare number and/or BIC change for an ongoing buy-in record or to a state-initiated transaction.

A Medicare number and BIC change can occur when an individual becomes entitled to benefits on another social security record. For example, a woman may first be entitled to Medicare under her own number as an uninsured individual. She may then become entitled as a wife or widow on a spouse's Medicare number.

A BIC change will occur, for example, when a beneficiary's status on his/her account changes from uninsured, BIC M or BIC T, to insured BIC A. Another common example occurs when a woman's status changes from wife, BIC B, to widow, BIC D.

*CMS will send a transaction **code 23bb** Medicare number/BIC or BIC-only change record to the state when the Third Party System (TPS) receives notification from internal systems of the BIC or Medicare number change. The **code 23bb** transaction also indicates that the change applies to an existing open master record **(code 41)**, contained in the billing file in proper sequence under the new Medicare number.*

***NOTE:** In rare instances, SSA may have erroneously created two different Medicare claim numbers (HICN or MBI) for the same beneficiary causing the EDB to create two master records for the beneficiary. Once CMS learns of the error, CMS will deactivate one of the HICNs/MBIs and consolidate the records.*

*If the state detects this error in the billing file, it should not initiate any action as CMS will automatically institute corrective action to consolidate the duplicate master records in the next billing month. If CMS must take manual action, however, the correction may take an additional month. The state will receive a transaction **code 42** credit item refunding premiums for any overlapping periods of buy-in coverage. If the state does not receive the **code 42** credit action within two billing months from the billing month in which the duplicate items appeared, send the record to CMS (see chapter 6) describing the situation. States have no time limit to obtain an adjustment for duplicate billing.*

*States may receive Medicare number/BIC or BIC-only change records on any state-initiated action (accretions, deletions, **code 99s**).*

- *For state accretion or deletion requests that require either type of change, the state can receive the following reply codes from CMS:*
  - *2361*
  - *2363*
  - *2375*
  - *2384*
  - *2350*
  - *2351*
  - *2353*
- *In addition to the transaction **code 23XX** record (XX represents state input code), CMS will send a reply record for the requested action to the state under the new Medicare number.*
- *The **code 99** request (state change record) can also require a Medicare number change action by CMS, which would trigger a reply **code 2399**.*

*Section 4.7 contains the record format for all transaction **code 23** replies.*

4.7 CMS Buy-in Transaction Codes - Positions 77-81

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS buy-in transaction codes consist of not less than two and no more than four numerals which appear in positions 77 through 80 of the record. When CMS transmits a two-position transaction code, positions 79 through 80 are blank. Certain CMS disposition codes are enhanced by an alphabetic sub-code. If a sub-code applies, it appears in position 81 of the record. An explanation of the sub-code appears with the explanation of the transaction code.

Many CMS transaction codes convey information only to the state, but some codes aim to prompt state action as described in the table below.

***NOTE:** The table below represents the last two positions in a code series as "XX." For example, for the 11XX series– the XX indicate that the **code 11** is a prefix code and XX are placeholders. For **code 23bb** – the bb indicates that two blank spaces may follow the CMS transaction code. Any code displayed in this section followed by the bb is a valid two-position transaction code.*

4.7.1 Table of CMS Buy-in Transaction Codes

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Transaction Code	***Definition/State Action***
11XX	*CMS uses the **code 11** series to inform the state of new state buy-in accretions. A two-digit numeric code following the **code 11**identifies the source of the transaction or the reason that TPS took an action prior to accreting the item to TPS. The accretion establishes state liability for the individual's Medicare Part A and/or B premiums, resulting in a CMS debit action for the state. In subsequent months (as long as the individual remains enrolled in buy-in), the item will appear on the state's monthly billing file as a **code 41** (ongoing item).*
1125	*The **code 1125** informs the state that TPS adjusted the accretion effective date in the state input record because the EDB shows a closed period of coverage for the same state that ended after the state-submitted accretion date. TPS has adjusted the accretion start date to the first month after the deletion date on the record for the closed period. The following month the item will appear on the state's billing file as a **code 41** (ongoing item) unless the item is deleted.*
1161 *1163*	*The **code 1161 or 1163** informs the state that CMS accepted the accretion in the state input record and added it to the EDB. The EDB accretion date is the same as the state input record unless a **code 30** action applies. The item will appear on the state's billing file as a **code 41** (ongoing item) the next month unless the item is deleted.*

Transaction Code	***Definition/State Action***
1165	*The **code 1165** informs the state that CMS initiated a Part A or B buy-in accretion on the state's behalf because (1) the state requested manual action by CMS to address a system limitation that prevented CMS from accepting the state accretion; or (2) SSA submitted a Form CMS-1957 requesting a Part A accretion, because the beneficiary qualifies as a QMB or Qualified Disabled Working Individual (QDWI). The following month, the item will appear on the state's monthly billing file as a **code 41** (ongoing item) unless the item is deleted.* ***State Action** - States should confirm the accuracy of the buy-in transaction. If state records don't support the accretion, states should submit a **code 50** deletion, or "wipe-out" action, within two months of the receipt of the **code 1165** to annul the accretion or establish a closed period of buy-in coverage.* *If the accretion date is incorrect, annul the transaction within the two-month window and re-accrete the record with the correct effective date.* *If the state submits the **code 50** after the two-month window, TPS will delete the **code 1165** open period and send a deletion reply **code 1750.** TPS will effectuate Part A deletions in the current month and Part B deletions as described in chapter 2, section 2.6.1.*

Transaction Code	***Definition/State Action***
1167 (Part B only)	*The **code 1167** informs the state that TPS processed a Part B accretion first initiated by an SSA Field Office (FO) through the Public Welfare (PW) process.* ***State Action** - States should confirm the accuracy of the buy-in transaction. If state records don't support the accretion, states should submit a **code 50** deletion, or "wipe-out" action, within two months of the receipt of the **code 1167** to annul the accretion or establish a closed period of buy-in coverage.* *If the accretion date is incorrect, states should annul the record within the two-month limitation and re-accrete the record with the correct effective date.* *If the state submits the **code 50** after the two-month window, TPS will delete the **code 1167** open period and send a deletion reply **code 1750** with a modified effective end date as required by the Commissioner's Decision. See chapter 2, section 2.6.1.*

Transaction Code	***Definition/State Action***
1180 (Part B only)	*The **code 1180** informs an auto-accrete state that CMS has initiated a Part B accretion (auto-accretion) for a SSI recipient who also qualifies for Medicare. The effective date of the auto-accretion is generally the first continuous period of buy-in eligibility based upon the most recent period of SSI or federally-administered state supplement (SSPs).[55] The following month the item will appear on the state's billing file as a **code 41** (ongoing item) unless the item is deleted.* ***Sub-code A** - If the SSI record received by CMS in the data exchange with SSA reflects past SSI/SSPs entitlement while the individual was a resident of the state, CMS will follow up the **code 1180** with the sub-code A to alert the state that CMS will also send the state a RIC-A record with the complete SSI data. The state will review the SSI record, and if it determines that the beneficiary was eligible for buy-in coverage during a prior period of SSI/SSPs entitlement, the state should submit a simultaneous accretion/deletion record **(code 75)** to add a closed period of buy-in coverage for that period.* ***State Action** - TPS establishes the effective date of the accretion beginning with the first month of the most recent period of continuous SSI or a federally-administered state supplement payment status of C01 on the Social Security record. However, it is imperative for the state to review SSA data to confirm the appropriate buy-in coverage period(s), particularly if CMS sent the state a RIC-A record to reflect prior SSI entitlement for the individual.*
1184 (Part B Only)	*The **code 1184** informs the state that a Part B accretion has been added to the EDB, either by an alert state in response to a **code 86** accretion alert from CMS, or by an auto-accrete state based on an examination of SSA data. The effective date is the same as reported on the state input record except when a **code 30** action is present. The following month, the item will appear on the state's billing file as a **code 41** (ongoing item) unless the item is deleted.*

[55] Pursuant to the court decision in NY State v. Sebelius (N.D. NY, June 22, 2009), CMS has in effect a policy under which states are granted equitable relief from the imposition of retroactive Part B premiums in instances involving lengthy delays in Medicare eligibility determinations to the extent that such delays would result in retroactive auto-accretions that would cover periods for which it is too late to obtain the benefits of Medicare coverage.

Transaction Code	***Definition/State Action***
14bb	*This code informs the state that CMS has deleted the Part A or Part B record as the result of an internal systems adjustment. These occurrences are rare. This code is also used to delete the Part A record because the beneficiary has obtained entitlement to Premium-free Part A.*
15bb	*This code informs the state that the individual was deleted from the state's buy-in account because the SSA record indicates that the individual does not currently meet all the requirements for Medicare (such as age, citizenship or residency, or continuation of disability or end-stage renal disease).* ***State Action*** *- If the state has reason to believe that the individual does meet the requirements for Medicare, refer the individual to the SSA Field Office (FO) to re-establish Medicare entitlement. If Medicare entitlement is re-established, re-accrete the record.*
16bb	*This code informs the state that according to SSA/CMS records, the beneficiary is deceased. CMS has deleted the beneficiary from the state's buy-in account.* ***State Action*** *- If the state believes that the individual is alive, obtain corroboration from the SSA. The state may then re-accrete the individual to state buy-in through the automated data exchange process. If the SSA records have not been corrected, the state's re-accretion will reject with a* ***code 29XX****. If the state agrees with the fact of death, but disagrees with the date of death, obtain corroboration from the SSA before sending a memorandum to CMS requesting an adjustment to the deletion date.*
17XX	*CMS uses the* ***code 17*** *series to inform the state of new record* ***deletions*** *from the state's buy-in account. The* ***code 17*** *is followed by a two-digit numeric code that identifies the reason for the deletion. The deletion may trigger a credit action to the state. The state's liability for the individual's Medicare Part A and/or B premium(s) ends with the month in which the buy-in deletion is effective. If the record is annulled, the state will not have any premium liability for the period.*

Transaction Code	***Definition/State Action***
1728	*This code informs the state that a beneficiary was deleted from the state's buy-in account because another state submitted an accretion that was accepted by TPS or because the SSI record shows that the beneficiary's state of residence changed.* ***State Action*** *- The state should examine the Medicaid eligibility record for any beneficiary for whom it receives a* ***code 1728*** *to ensure that the state's Medicaid eligibility record has been closed. This will prevent a cycle of accretion and deletion actions between states. If the state that received the* ***code 1728*** *believes it should retain jurisdiction of the case, it must contact the state that submitted the new accretion in order to resolve jurisdictional issues (i.e., to determine in which state the individual currently resides). States receiving the* ***code 1728*** *deletion will find the Agency Code for the state accreting the beneficiary in position(s) 124-126 of the RIC-B billing record. In addition, daily states receiving a RIC-D will find the state accreting the beneficiary in position(s) 94-96 of the reply record.*
1750	*This code informs the state that CMS has processed a* ***code 50*** *to annul or establish a closed period of Part A or Part B buy-in coverage for a* ***code 1165*** *transaction or, for Part B only, a* ***code 1167*** *transaction. If the* ***code 50*** *was submitted within two months of the month in which the state received the* ***code 1165 or 1167****, the* ***code 1750*** *will credit the state for premiums billed past the accepted transaction effective date as supplied in the* ***code 50*** *transaction submitted by the state. If the* ***code 50*** *was not submitted within two billing months, TPS will send a deletion reply* ***code 1750*** *with a modified effective end date as required by the Commissioner's Decision. The state will be credited for Part A premiums billed as a current month deletion and for Part B premiums billed past the derived transaction effective date. See chapter 2, section 2.6.1.* ***NOTE:*** *For all TPS credit transaction replies, the transaction effective date can be derived from TPS reply record as the billing period start date minus one month.*

Transaction Code	***Definition/State Action***
1751	*This code informs the state that the beneficiary was deleted from the state's buy-in account based on a deletion record submitted by the state. The retroactivity on a **code 1751** is limited to the current month for Part A and by the Commissioner's Decision for Part B.* *If Part B coverage is closed by **code 1751** and Part A coverage is open, CMS will automatically close Part A with **code 1751**, as well. In rare instances where one state has Part A buy-in on record and a second state has Part B buy-in on record, if the second state closes Part B coverage, CMS automatically closes the Part A coverage in the first state. In this case, both states will receive **code 1751**.*
1753	*This code informs the state that the beneficiary was deleted from the state's buy-in account based on a death deletion record submitted by the state.*
1759	*This code informs the state that the beneficiary was deleted from the state's buy-in account by a clerical action by CMS based on a state request or SSA submission of Form CMS-1957 reporting a problem case. Occasionally, the **code 1759** may reflect a deletion date that exceeds the deletion rules for a Part A buy-in deletion action or the limitations of the Commissioner's Decision for a Part B buy-in deletion action.*
20XX *2050* *2051* *2053*	*This code series informs the state that CMS rejected a deletion request because it has no record of buy-in coverage in the state for the identified HICN/MBI.* ***State Action** - Examine the HICN/MBI in the deletion record to rule out any input keying errors. The HICN/MBI in the deletion record must match a corresponding record on TPS <u>exactly</u> in order for the transaction to be applied. If the HICN/MBI was keyed correctly, review the case to ensure that the state did not previously delete the record or that the state did not fail to process a prior **code 23** HICN/MBI change. If the HICN/MBI is correct, examine previous TPS reply files to determine if a **code 1728** was received transferring jurisdiction to another state.*

21XX *2161* *2163* *2175* *2184 (Part B Only)*	*This code series informs the state that the accretion or simultaneous accretion/deletion records it submitted cannot be matched to a record on the EDB, or other criteria present in the request cannot be processed. The **code 21** is followed by the two-digit numeric accretion code submitted by the state. Each **code 21** contains an alphabetic sub-code in position 81 that further defines the reject.* ***Sub-code A*** *There is no record of the HICN/MBI on the EDB. The HICN/MBI may be absent from the EDB, it may contain blanks, alphabetic characters, or special non-numeric characters in positions that should be numeric, or it does not include an alphabetic BIC.* ***State Action -** Look up the correct HICN/MBI in CMS or SSA data systems made available to the state. Resubmit the record with the correct HICN/MBI.* ***Sub-code B*** *The HICN/MBI on the accretion matches a HICN/MBI on the EDB record, however, required matching personal characteristics differ.* ***NOTE:** CMS data may differ from SSA data since CMS sometimes shortens the beneficiary's first name to the first initial.* ***State Action -** Research in the EDB and resubmit the record with data that matches what is in the EDB using the following guide:* *Name* • *Surname (last name) mismatches: CMS requires an exact match on the first six characters. If the name as recorded in the EDB is incorrect, the state or the beneficiary should contact SSA to correct. SSA will then automatically update CMS' systems. This should be a rare occurrence.* • *Given (first) name mismatches: CMS requires an exact match on the first three characters. If this fails, however, and CMS has only the first initial of the given name in its system, CMS will accept an exact match on the first*

	character alone. • *Suffix mismatches: If JR or SR is part of the surname, include the JR or SR in the surname field of the accretion record. Failure to include the JR or SR may cause the record to reject.* • *Special instructions that apply to all name fields**:** (1) Retain blank spaces that are part of a compound name; (2) Insert a single blank space between the name and suffixes, such as JR, SR, or III; (3) Names may not include a period, although other punctuation marks (e.g., an apostrophe or hyphen) are allowed; and (4) All alphabetic characters must be capitalized or matching criteria will fail.* *Date of Birth* *Month and year of birth mismatch: CMS requires an exact match on the four-position year and two-position month. Review the state's record to ensure that DOB in the accretion record matches the corresponding data in CMS and SSA systems. If there is a discrepancy, correct and resubmit the record.* ***Sub-code C*** *Part A* 1. *The beneficiary may be entitled to Premium-free Part A.* ***State Action** - Check SSA systems to determine if the beneficiary is entitled to Premium-free Part A. If so, the beneficiary is not eligible for Part A buy-in. Do not resubmit this record. If the beneficiary is not entitled to Premium-free Part A, see state action under #2 below.* 2. *CMS records do not show Premium-Part A entitlement or conditional Part A enrollment **(code Z99)**, causing CMS to reject the buy-in enrollment.* ***State Action** -* *Part A buy-in states: states can accrete beneficiaries to Part A buy-in without sending the individual to SSA to file for conditional Part A if the beneficiary is already enrolled in Part B. If CMS rejects this request, submit it to the DMSEI*

	resource mailbox at statebuy-in@cms.hhs.gov for manual processing. *Part A group payer states: if a **code Z99** does not appear in SSA systems, refer the individual to SSA to file for conditional Part A during the General Enrollment Period (January through March with coverage effective July 1). Once the individual is enrolled in conditional Part A, the state can resubmit the Part A buy-in record.* *Part B* *CMS rejected the record because it contains a BIEC for an MSP group (i.e., "P" for QMB, "L" for SLMB, or "U" for QI) in position 71 of the input record. The CMS system may not process records with these three BIECs (if no Part A entitlement on record). In this case, states should use the workaround described below.* ***State Action** - Resubmit the Part B accretion record, leaving the BIEC blank. If your state system requires a BIEC value, use another code besides "P," "L," or "U" to avoid triggering a rejection.* *Use the **code 99** procedures to update the BIEC after 5-7 business days. If the **code 99** rejects, wait three business days and resubmit the request.* ***Sub-code D*** *Part A - For a QMB-eligible individual, CMS has no record of Part B buy-in, which is a prerequisite for Part A buy-in.* ***State Action –**If the state has not yet submitted a Part B accretion record for the beneficiary, submit the Part B buy-in record and then resubmit the Part A buy-in accretion.* *If CMS rejected a state Part B buy-in accretion record, correct the Part B buy-in error. Once you verify that Part B buy-in is present in CMS systems, resubmit the Part A buy-in accretion.* *Part B - CMS data indicate this individual may be eligible for QDWI (i.e., CMS data show they have a disability but lost Premium-free Part A and Social Security disability benefits*

Transaction Code	***Definition/State Action***
	because they returned to work). States may pay the Part A premium for QDWIs, but may not pay the Part B premium. ***State Action*** *- Do not resubmit the Part B Buy-in record if the state agrees the individual is a QDWI.* *If the state believes the individual is not a QDWI, submit the accretion request to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for assistance.* ***Sub-code E*** *Part A - For a QMB-eligible individual, CMS does not yet have Part A or Part B entitlement history or the CMS system shows a closed period (i.e., both start and termination dates appear) of Medicare Part A entitlement. CMS systems may reject such requests in some instances.* ***State Action*** *- Submit the accretion request to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for manual processing.* *Part B - CMS does not yet have Part B entitlement history or the CMS system shows a closed period (i.e., both start and termination dates appear) of Medicare Part B entitlement. CMS systems may reject such requests in some instances.* ***State Action*** *- Submit the accretion request to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for manual processing.*
23XX	*The* ***code 23*** *series inform the state that the HICN/MBI and/or BIC have been changed. A* ***code 23*** *may be applied to an accretion, deletion, state change record, or to an ongoing* ***code 41*** *billing record.* ***State Action*** *- Change the HICN/MBI in the state's records and report all future actions under the correct HICN/MBI.*
23bb	*This code informs the state that a HICN/MBI change was processed to an ongoing buy-in record.*

Transaction Code	***Definition/State Action***
2350 *2351* *2353*	*These **codes (2350-2353)** inform the state that a HICN/MBI change was processed to a deletion record.*
2361 *2363* *2375* *2384 (Part B only)*	*These **codes (2361-2384)** inform the state that a HICN/MBI change was processed to an accretion or to a simultaneous accretion/deletion record.*
2399	*This code informs the state that a HICN/MBI change was processed to a state-submitted change record.*
24XX	*The **code 24** series informs the state that the accretion or deletion action it submitted was rejected because the effective date was blank, incomplete, or otherwise in error.* *An accretion action will be rejected if the effective date is equal to or later than the billing month. A deletion action, other than a death deletion, will be rejected if the effective date is equal to or greater than the billing month.* *A death deletion **(code 53)** will be rejected if the effective date (i.e., date of death) is later than the update month.*
2450 *2451* *2453*	*These **codes (2450-2453)** inform the state that the deletion record it submitted was rejected.*

Transaction Code	***Definition/State Action***
2461 *2463* *2475* *2484 (Part B only)*	*These **codes (2461-2484)** inform the state that the accretion record or simultaneous accretion/deletion record it submitted was rejected.*
25XX	*This code series informs the state that the accretion or simultaneous accretion/deletion it submitted was rejected because it duplicates a transaction previously processed by TPS. In all instances, it duplicates a transaction previously submitted by the same state.*
2561 *2563* *2575* *2584 (Part B only)*	*These codes inform the state that the accretion or simultaneous accretion/deletion record it submitted duplicates an existing accretion.*
27XX	*This code series informs the state that its intended action was rejected because the transaction contained an invalid transaction code. The input code may be blank, may contain alphabetic characters, or may contain a combination of numerals that do not correspond to established state input codes. If a transaction code is used improperly (e.g., if a **code 50** is submitted to delete a code other than a **code 1165 or 1167**, the transaction will reject as a **code 2750)**. The reject displays the erroneous input code immediately following the **code 27**.*

Transaction Code	***Definition/State Action***
29XX *2961* *2963* *2975* *2984*	*This code series informs the state that the accretion or simultaneous accretion/deletion action it submitted was rejected because there is a death deletion on the EDB which is at least one month earlier than the accretion effective date. The **code 29** may apply to a new accretion or to a re-accretion. The month and year of death will appear in positions 97 through 102 of the reject record.* ***State Action** - If investigation establishes that the beneficiary died later than the date of death on SSA/CMS records, the state must contact SSA to correct the date of death on the MBR. If the beneficiary is alive, the beneficiary must contact the SSA FO to remove the date of death on the MBR. When the date is corrected in or removed from the MBR, the updated information will be reflected on the EDB. After the MBR is updated/corrected, resubmit the buy-in accretion through the automated data exchange process.*
30XX *3061* *3063* *3075* *3084 (Part B only)*	*This **code series (3061-3084)** informs the state that the effective date in the state's accretion record required adjustment to a later effective date to conform to the Medicare entitlement date or to conform to an already established closed period of coverage for the same state. As a result of this adjustment action, TPS will create two records from the state accretion record: the first record is a **code 30XX** that contains the effective date as submitted by the state; and the second record contains the adjusted effective date that corresponds to the individual's Medicare entitlement date, or the earliest eligible start date in relation to an existing closed coverage period for the same state.*
41bb	*This code informs the state of the ongoing buy-in enrollment of a beneficiary. The state is responsible for paying the beneficiary's Part A or B premium and has deletion responsibility if the beneficiary is no longer eligible for buy-in. The **code 41** also means that there has not been a change in the beneficiary's buy-in status since the last billing record.*

Transaction Code	***Definition/State Action***
42XX	*This code series informs the state of a credit adjustment to the state's premium liability. Credit actions result from an adjustment to either the buy-in accretion date or the deletion date on TPS. The adjustment may be applied to an open or a closed record. Adjustments are made for a variety of reasons, such as a notification from SSA of a correction to Medicare entitlement or termination dates, a correction in the date of death, or the identification of duplicate billing records on TPS for the beneficiary.*
42bb	*This code informs the state of a credit adjustment issued in response to duplicate billing records in TPS for one or more months of buy-in coverage. The duplicate premiums are refunded to the state as a credit adjustment. CMS may also generate a* ***code 42bb*** *credit as the result of a TPS recovery action to correct a program error or to adjust a billing record that requires a corrective action that cannot be defined with one of the sub-codes. The transaction start date and stop date fields will be populated to indicate the period of coverage for which a credit adjustment is warranted.* ***NOTE:*** *For all CMS credit transaction replies, the transaction effective date can be derived from TPS reply record as the billing period start date minus one month.*
4211	*This code informs the state that the buy-in accretion date on an ongoing record was adjusted to a later date. The adjustment was necessary because TPS was notified of a change to the beneficiary's Medicare entitlement date. The buy-in effective date on TPS was earlier than the corrected Medicare entitlement date.*
4214	*This code informs the state that the deletion date on an established record was adjusted to an earlier date.*
4215	*This code informs the state that the deletion date on an established record was adjusted to an earlier date because the individual did not meet all the requirements for Medicare and should have been terminated prior to the deletion date previously recorded.*
4216	*This code informs the state that the date of death in an established record was incorrect and has been adjusted to an earlier date.*

Transaction Code	***Definition/State Action***
4268	*This code informs the state that CMS used a clerical action to adjust an accretion to a later date, resulting in a credit to the state.*
4269	*This code informs the state that CMS used a clerical action to adjust the record to an earlier date, resulting in a credit to the state.*
43XX	*This code series informs the state of a debit action. Debit actions can result from a request to establish a retroactive accretion for an ongoing record or to insert a past period of closed coverage. Most adjustments stem from state requests to expand coverage. Other adjustments to ongoing buy-in records are related to SSI changes or a TPS recovery action to correct a program error.*
43bb	*This code informs the state of a debit adjustment generated to correct billing errors related to a TPS recovery action to correct a program error or to adjust a record that requires a corrective action that cannot be defined with one of the sub-codes. The transaction start date and stop date fields will be populated to indicate the period of coverage for which a debit adjustment is warranted. The transaction effective date can be derived as being equal to TPS reply record billing period start date.*

Transaction Code	***Definition/State Action***
4325	*Part A* *This code informs the state that a period of third party coverage, accreted with an adjusted start date, involved periods with different premium rates. This transaction code will be accompanied by a **code 1125**. The part(s) billed at a different rate will be billed as a **code 43** closed period of coverage.* *Part B* *The **code 4325** informs the state that an earlier period of buy-in coverage, brought about by a retroactive state accretion, has been established for the state; however, the effective date of the accretion submitted by the state was adjusted by TPS to a later date.* *In other words, a defined period of state buy-in coverage (specific coverage start and end dates) has been inserted into an existing beneficiary coverage history. A **code 4325** does not indicate the establishment of new open coverage. However, if the beneficiary record already shows open ongoing buy-in coverage, CMS will continue to send **code 41** ongoing billing records each month so long as ongoing coverage continues.*
4361 *4363* *4384 (Part B only)*	*These **codes (4361-4384)** inform the state that an earlier period of buy-in coverage resulting from a retroactive state accretion, has been established for the state. A state may receive one or more **code 4361, 4363 or 4384** records from a single input record. These codes always refer to earlier coverage. If ongoing coverage is established, the state will also receive a **code 1161, 1163** or, for Part B, **1184.***
4365	*This code informs the state that a period of CMS-accreted coverage previously billed at one rate was billed for another rate for a different period or a new period being accreted spanned periods with different premium rates. Usually a reduced rate (as set forth under the provisions of section 1854(f)(1) of the Social Security Act) is involved. If new coverage is being established, a **code 1165** will accompany the **code 4365**. The part(s) billed at a different rate will be billed as a **code 4365** closed period of coverage.*

Transaction Code	***Definition/State Action***
4367 (Part B only)	*This code informs the state that a period of PW coverage previously billed at one rate was billed for another rate for a different period or a new period being accreted spanned periods with different premium rates. Usually a reduced rate (as set forth under the provisions of section 1854(f)(1) of the Social Security Act) is involved. If new coverage is being established, a **code 1167** will accompany the **code 4367**. The part(s) billed at a different rate will be billed as a **code 4367** closed period of coverage.*
4368	*This code informs the state that the accretion date on a TPS record was adjusted to an earlier date resulting in a debit to the state. The adjustment is the result of a CMS clerical action.*
4369	*This code informs the state that the deletion date on a TPS record was adjusted to a later date resulting in a debit to the state. The adjustment is the result of a CMS clerical action.*
4375	*This code informs the state that a simultaneous accretion/deletion (closed period of buy-in coverage) has been added to TPS.*
4380 (Part B only)	*This code informs the state that an earlier period of buy-in coverage, brought about by a retroactive SSI accretion, has been established. A state may receive one or more **code 4380** records. The **code 4380** always refers to earlier coverage. If ongoing coverage is established, the state will receive a **code 1180**.*

Transaction Code	*Definition/State Action*
44	*Part A* *This code informs the state that the Part A premium rate was decreased resulting in a credit to the state. A reduced Part A premium will apply if the beneficiary earned at least 30 work credits under Social Security (P.L. 103-66) but does not have enough work credits to be eligible for Premium-free Part A. In the Part A Group Payer states, the premium will revert to the base rate (or to the reduced Premium-Part A premium rate) once the 10% premium surcharge, if applicable, expires.* *Part B* *This code informs the state that the monthly Part B premium was reduced resulting in a credit to the state. The beneficiary is or was a member of a group health plan that offered a reduction in the Part B premium in accordance with the provisions of section 1854(f)(1) of the Social Security Act.*
45	*Part A* *This code informs the state that the Part A premium rate was increased resulting in a debit to the state. The Part A premium will increase if the initial Part A premium for the beneficiary was erroneously established at the reduced Part A premium rate and the premium was subsequently increased to the base rate. The premium rate increase will also occur if the initial Part A premium, for a beneficiary who resides in a Part A Group Payer state, failed to include a premium surcharge and the surcharge was subsequently added to the record.* *Part B* *This code informs the state of an increase in the monthly Part B premium rate resulting in a debit to the state. The beneficiary is or was a member of a group health plan that offered a reduction in the Part B premium. The group health plan subsequently decreased or eliminated the premium reduction.*

Transaction Code	***Definition/State Action***
4999	*This code informs the state that a request to correct the buy-in eligibility code or welfare identification number on a TPS record was rejected because the HICN/MBI or state agency code in the **code 99** did not match a record on TPS.* *This reject code is also used if the state submits a **code 99** record with a Part B buy-in eligibility code of "P," "L," or "U" (all of which require Medicare Part A entitlement) and the EDB does not currently reflect Medicare Part A.*
50	*States use this deletion code to delete or annul a **code 1165** or, for Part B, **code 1167** accretion posted to the state's buy-in account by CMS either as the result of a clerical action **(code 1165)** or a PW accretion **(code 1167)** initiated by the SSA FO. The **code 50** may be used either to annul buy-in coverage or to enter a termination date that will establish a closed period of coverage. The **code 50** must be sent to CMS no later than the second month following the month in which the state receives the **code 1165** or **code 1167** accretion. For example, if the accretion is processed in the April update, the state will receive the transaction in May. If the state determines that it should submit a **code 50**, the state must submit the **code 50** no later than the July update. If the state submits the **code 50** after more than two updates have elapsed, the **code 50** will be processed as if it was a **code 51** current month deletion for Part A and in accordance with the limitation imposed by the Commissioner's Decision for Part B with a deletion reply **code 1750**. The **code 50** will be rejected only if the state attempts to apply the **code 50** against any codes other than the **code 1165** or **code 1167**.* *If the state is annulling coverage, the effective date of the **code 50** deletion must be one month prior to the accretion date contained in the **code 1165** or **code 1167**. If the state is establishing a closed period of coverage, the effective date of the **code 50** deletion must be the last month in which the individual was a member of the state's coverage group.*

Transaction Code	***Definition/State Action***
51	*<u>Part A</u>* ***States*** *use this code to* ***delete*** *a beneficiary who is no longer a QMB. Do not use this code for death deletions. The retroactivity of a* ***code 51*** *deletion is limited to the update month or the update month plus one month. For example, a* ***code 51*** *deletion processed in the December 2018 update may terminate an individual's coverage in December 2018 or January 2019. If the state submits a retroactive deletion date, TPS adjusts the deletion date so that it conforms to the update month.* *<u>Part B</u>* *States use this code to delete a beneficiary from the state's buy-in account because the beneficiary is no longer a member of the state's coverage group. Do not use this code for death deletions. The retroactivity of a* ***code 51*** *deletion is limited in accordance with CMS processing of* ***code 51*** *deletions. See chapter 2, section 2.6.1.*
53	*The state uses this code to* ***delete*** *an individual who is deceased. The effective date of the deletion must be the month and year of death.*
61	*States uses this code to* ***accrete*** *a beneficiary to the state's buy-in account. TPS will accept Part B buy-in retroactive to the individual's initial eligibility for buy-in, except for QMBs. TPS will not accept retroactive accretions for Part A or Part B buy-in for QMBs (or Part A accretions for QDWIs). To ensure the appropriate buy-in accretion effective dates for QMBs and QDWIs, states should follow procedures in chapter 2, section 2.5.*
63	*States use this code to identify accretion records for subsequent state analysis. The* ***code 63*** *is processed in exactly the same manner as the* ***code 61****. The state is responsible for the accuracy of the accretion. When the accretion is accepted by TPS, the accretion date cannot be adjusted to a later date even if the state later determines that the accretion date it submitted is incorrect.*

Transaction Code	***Definition/State Action***
75	*States use this code to designate a request for a **simultaneous accretion/deletion** action to establish a closed period of buy-in coverage for a beneficiary. The state is responsible for the accuracy of the dates in the simultaneous accretion/deletion record. When the simultaneous accretion/deletion is accepted by TPS, the accretion date cannot be adjusted to a later date and the deletion date cannot be adjusted to an earlier date even if the state later determines that the date it submitted is incorrect.* *The **code 75** is restricted to Part A buy-in states. The **code 75** should be used infrequently.*
84 (Part B only)	*This code is used by an alert state to accrete a beneficiary to the buy-in account in response to a **code 86** accretion alert record or by an auto-accrete state to accrete a beneficiary based on an examination of SSA data. The state is responsible for the accuracy of the accretion. When the accretion is accepted by TPS, the accretion date cannot be adjusted to a later date even if the state later determines that the accretion date it submitted is incorrect.*
86bb (Part B only)	*CMS uses this code to inform the SSI alert state that a beneficiary in its jurisdiction is entitled to SSI benefits and may be eligible for buy-in. It may also be sent to an auto-accrete state for informational purposes if a beneficiary already accreted to the buy-in rolls subsequently becomes eligible for SSI benefits. TPS will not delete and re-accrete the buy-in record in such cases.* *The beneficiary's SSI and Medicare entitlement dates are contained in the record.* *An auto-accrete state may receive a **code 86** record in conjunction with a **code 1180** record.* ***State Action** - If the state determines that the beneficiary is eligible for buy-in, the state should accrete with a **code 84**. The state may use the **code 61 or code 63** in lieu of the **code 84**. The auto-accrete state should use the **code 75**, simultaneous accretion/deletion action, to establish additional buy-in coverage.*

Transaction Code	*Definition/State Action*
87bb (Part B only)	*CMS uses this code to inform both the alert state and the auto-accrete state that SSI entitlement has terminated for the beneficiary.* ***State Action** - Determine the individual's continuing eligibility for buy-in. If the individual remains eligible, no action is necessary. If the individual is no longer eligible for buy-in, submit a deletion record.*
99	*This code is used by the state to correct the BIEC or the welfare identification number on an existing buy-in record on TPS.*

4.8 Supplemental Security Income (SSI) Status Codes
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS includes the individual's SSI status in each SSI accretion, SSI accretion alert, SSI deletion or SSI deletion alert record that the states receive from TPS. See chapter 1, section 1.4 for information on requirements for redetermining Medicaid eligibility when there is a change in circumstance, including SSI status as indicated below.

4.8.1 SSI Status Codes - Accretion
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The status codes for SSI accretion or SSI accretion alert records are:

- *"C" – conditionally eligible for SSI.*[56]
- *"E" – eligible for SSI and may or may not be receiving a federally-administered state supplementary payment.*
- *"M" – special SSI payment for individuals engaged in substantial gainful activity.*
- *"S" – eligible for SSI and is receiving a federally-administered state supplementary payment only.*

4.8.2 SSI Status Codes - Deletion
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

[56] For information about conditional SSI benefits, see SSA POMS SI 01150.200 at https://secure.ssa.gov/poms.nsf/lnx/0501150200.

These status codes for SSI deletion or SSI deletion alert records should prompt states to follow the special procedures in chapter 2, section 2.6.1.2 regarding Medicaid eligibility redetermination after loss of SSI:

- *"B" – SSI terminated due to cost of living increase in Social Security benefits- Medicaid eligibility is retained.*
- *"G" – SSI terminated because individual is engaging in substantial gainful activity – Medicaid eligibility is retained.*
- *"T" – SSI terminated for a reason other than the codes described in this section. The SSA data exchanges for states (SVES/SOLQ, SDX, BENDEX) will provide the precise reason for termination.*
- *"U" – SSI terminated because the individual is reported to have died but the date of death has not been verified.*
- *"W" – State withdrawal of agreement for federally-administered state supplemental payments.*
- *"Y" – SSI terminated because the individual has excess income.*
- *"Z" – SSI terminated because the individual has excess resources.*

Premium Billing
Chapter 5

Table of Contents
(Rev. 4, 08-21-20)

Transmittals for Chapter 5

5.0 Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The Centers for Medicare & Medicaid Services (CMS) administers Medicare premium billing and collections related to the state payment of Medicare premiums for individuals dually eligible for Medicare and Medicaid (also known as state buy-in). Federal law authorizes CMS to establish due dates for premiums owed by state Medicaid agencies and to assess interest on outstanding balances. See the Federal Claims Collection Act of 1966, Pub. L. 104-134, codified at Title 31 USC 3711; 42 CFR § 401(f). CMS can recover amounts due from states, including interest, by direct collection or through offsets against Medicaid payments to states (specifically, State Medicaid Grants). See 42 CFR §§ 401.607 and 408.6(c)(4).

This chapter describes state buy-in billing and collections procedures for states.

5.1 State Billing for Medicare Part A and Part B Premiums

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

On or before the 10th of each month, CMS sends (via US Postal Service and email) each state a bill called the Summary Accounting Statement (SAS) that CMS produces at the end of the prior month (update month). See appendix 5.C for a sample SAS and a detailed explanation of the SAS.

The SAS reflects the state's Medicare premium liability for the upcoming month (billing month). The SAS gives the first of the billing month as the "payable by" date (due date), but CMS grants states a "grace period" up to the 25th day of that month.[57]

For example, on or before June 10th, CMS mails the state its SAS created after the end of the update month of May. The SAS contains the state's Medicare Part A or Part B premium liability for the month of July. The SAS gives July 1st as the due date and the grace period lasts up to July 25.

CMS considers a state's Medicare premium liability to be satisfied once CMS receives the full amount due. If outstanding balances remain after the grace period, they are assessed interest and subject to collection through offset against the state's Medicaid Grant Award.

A state Medicaid agency may appeal if it disagrees with the amount of their Medicare premium liability, the amount of interest assessed, or the amount of the offset against the Medicaid Grant Award. CMS must receive the appeal within 90 days of the billing date on the disputed SAS billing notice. The state can submit a written request for review along with supporting documentation to the Director of the Division of Premium Billing and Collections (DPBC)

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[57] If the 25th day of the month falls on a federal holiday or weekend, states must pay their premium liability no later than close of business on the last business day prior to the 25th.

through:

Mail:
CMS, OFM, AMG
Division of Premium Billing and Collections
Mailstop C3-13-08
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Email: DPBCStateBuy-in@cms.hhs.gov
Type 'Appeal Request' and <state's name> in the subject line of the email.

Within 30 days of receipt of the state's appeal request, the Director of DPBC will send the state a written acknowledgement confirming receipt. Pending the appeal, the state should pay the disputed amount to avoid further interest charges and a possible offset.

CMS will send a written response to the state to communicate its decision. If CMS determines that it owes the state a credit, the credit will appear as an adjustment in a subsequent SAS.

***NOTE:** If a state disagrees with the premium amount billed for a specific Health Insurance Claim Number (HICN), the state should submit the record directly to the CMS Division of Medicare Systems Exceptions and Inquiries (DMSEI) in accordance with procedures in chapter 6. To avoid interest assessment and possible offset, the state should pay the disputed amount while CMS reviews the state's request.*

5.2 Listed Agency Billing (LAB) - Summary Sheet
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

*A LAB summary sheet is enclosed with each monthly SAS. The LAB summary sheet will **only** reflect items included in the monthly billing file (RIC-B). For states that receive daily buy-in response files, reply records (RIC-D) are **not** be reflected on the LAB summary sheet. For states that do not receive daily reply files, all records processed in the update month are reflected on the LAB summary sheet.*

More specifically, the LAB summary sheet provides a breakdown of the number of records and the credits and debits associated with each transaction code. See appendix 5.D for a sample Agency LAB summary sheet.

5.3 Crediting of State Payments for Medicare Part A and Part B Premiums
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS applies Medicare premium payments to the most current unpaid Medicare premium liability.

CMS may collect past due premiums through offset against the state's Medicaid Grant Award

during the following update month. For example: for the June billing month, the Medicare premium payment due date is June 1st, with the grace period through June 25th. If, after June 25th, a balance remains unpaid, CMS considers the unpaid balance as past due and collects it through offset within the update month of July. CMS will credit the collection to the corresponding billing month of September and the collection will be on the September SAS.

5.4 Interest Assessment

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS assesses interest on past due Medicare premium amounts when the month's premium liability is not paid in full by the end of the grace period.

CMS assesses interest in 30-day increments. *Interest assessment on Medicare premiums that remain unpaid by the end of the grace period in which they were due begins with the first day of the billing month and is calculated on a 30-day basis.*

The interest rate for past due Part A and Part B Medicare premiums is the Federal Supplementary Medical Insurance (SMI) Trust fund rate as computed for new investments in accordance with section 1841(c) of the Social Security Act ("the Act"). This rate approximates the actual loss to the SMI trust fund and derives from the average yield on all marketable obligations to the U.S. Department of the Treasury as of the last day of the month.

5.5 Offset Against Medicaid Grant Award

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS will offset the state's Medicaid Grant Award for the interest assessed on amounts not paid by the end of the grace period and past due Medicare premiums (i.e., premiums not paid by the end of the month).

A subsequent SAS will show the amount of past due premiums collected through offset. The state's Medicaid Grant Award will reflect the amount of the offset.

The offset does not constitute a disallowance of FFP. The offset is an accounting adjustment that reduces the amount owed by CMS to the state.

5.6 Methods States May Use to Pay Medicare Premiums

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States can use either of the following electronic funds transfer methods to pay the Medicare premiums on behalf of dually eligible beneficiaries:

- *The U.S. Department of the Treasury ("the Treasury") Internet Collections Application (Pay.gov); or*

- *The Treasury's electronic funds transfer service system, the Fedwire.*

5.6.1 Pay.gov
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

5.6.1.1 Pay.gov Background
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The Treasury developed Pay.gov to meet its commitment to process collections electronically using internet technologies. Pay.gov is a secure, web-based collection portal and states can use it to make Medicare premium payments to CMS. Users can access the portal from any computer with internet access.

When states pay their Medicare premiums using Pay.gov, the transactions are processed as an Automated Clearing House (ACH) direct payment debit. ACH collections are processed by the Federal Reserve Bank of Cleveland with settlement usually occurring the next business day.

5.6.1.2 Pay.gov Instructions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Pay.gov requires a user ID and password to access the CMS Medicare Part A and Part B Payment forms on the portal. States electing to use Pay.gov must first enroll through CMS. As part of the enrollment process, CMS will facilitate and authorize the Treasury to issue each state a user ID and password. To set up a user ID and password, send an email to DPBC resource mailbox at DPBCStateBuy-in@cms.hhs.gov.

Pay.gov provides customer service to states concerning use of the portal, payment processing, and other topics. States can contact a Pay.gov customer service representative at https://www.pay.gov or by using the contact information provided below.

Phone: 1 (800) 624-1373 Option #2
Fax: 1 (216) 579-2813
Email: pay.gov.clev@clev.frb.org
Hours (ET): 7:00 a.m. – 7:00 p.m.

5.6.2 Fedwire
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

5.6.2.1 Fedwire Background
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)
Fedwire (formally known as the Fedwire Funds Service) is a real-time funds transfer system operated by the United States Federal Reserve Banks that allows financial institutions to

electronically transfer funds between its participants.

When states pay their Medicare premiums using Fedwire, the settlement of funds is immediate, final, and irrevocable.

5.6.2.2 Fedwire Instructions

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The information below is required to successfully transmit a Medicare premium payments to CMS via Fedwire:

Fedwire Field Name	***Information Needed***
Amount: *(Format must be properly punctuated with a dollar sign, comma(s), and decimal point -* *(e.g., $999,999.99).)*	*Enter payment amount.*
Sending Bank Routing Number:	*Enter sending bank's routing number*
Receiver ABA Number:	*021030004*
Receiver ABA Short Name:	*TREAS NYC*
Beneficiary Account Number: *(CMS Agency Location Code (ALC))*	*875050080000*
U.S. Agency Name:	*CMS*
Originator:	*Input state name*
Originator to Beneficiary information:	• *Enter the three-character agency code that CMS assigned to the state* • *Enter corresponding Medicare Program:* o *if agency code starts with "S", corresponding Medicare Program is Medicare Part A;* o *if agency code is all numbers, corresponding Medicare Program is Medicare Part B* ***IMPORTANT:*** *If the state combines the Medicare*

Fedwire Field Name	*Information Needed*
	Part A and Part B premiums into one payment, the electronic funds transfer transmission must specify the amount that applies to the Part A premium liability and the amount that applies to the Part B premium liability. If no designation appears, CMS will apply the total premium payment to the Part B premium payment which could result in an offset of the Part A premium liability amount.

Appendix 5.A Medicare Part A Premium Amount

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Section 1818 of the Act specifies that the Secretary of Health and Human Services shall determine the amount of the monthly Medicare Part A premium to be paid on behalf of each individual who is entitled to Premium-Part A. See 42 CFR § 406.32(d). Surcharges for late enrollment do not apply to the payment of Medicare Part A premiums on behalf of QMBs in Part A buy-in states. A ten percent surcharge for late enrollment, if applicable, applies to Medicare Part A premiums paid on behalf of QMBs in group payer states and on behalf of QDWIs in all states as they must use the group payer arrangement to pay QDWI premiums. For a description of the Part A premium surcharge, see chapter 1, section 1.1.

Monthly Medicare Part A Premium Amounts

Effective Date	*Part A Premium Base Rate*	*10% Surcharge*
01/89 - 12/89	*$156.00*	*$171.60*
01/90 - 12/90	*$175.00*	*$192.50*
01/91 - 12/91	*$177.00*	*$194.70*
01/92 - 12/92	*$192.00*	*$211.20*
01/93 - 12/93	*$221.00*	*$243.10*
01/94 - 12/94	*$245.00*	*$269.50*
01/95 - 12/95	*$261.00*	*$287.10*

Effective Date	*Part A Premium Base Rate*	*10% Surcharge*
01/96 - 12/96	*$289.00*	*$317.90*
01/97 - 12/97	*$311.00*	*$342.10*
01/98 - 12/99	*$309.00*	*$339.90*
01/00 - 12/00	*$301.00*	*$331.10*
01/01 - 12/01	*$300.00*	*$330.00*
01/02 - 12/02	*$319.00*	*$350.90*
01/03 - 12/03	*$316.00*	*$347.60*
01/04 - 12/04	*$343.00*	*$377.30*
01/05 - 12/05	*$375.00*	*$412.50*
01/06 - 12/06	*$393.00*	*$432.30*
01/07 - 12/07	*$410.00*	*$451.00*
01/08 - 12/08	*$423.00*	*$465.30*
01/09 - 12/09	*$443.00*	*$487.30*
01/10 - 12/10	*$461.00*	*$507.10*
01/11- 12/11	*$450.00*	*$495.00*
01/12 - 12/12	*$451.00*	*$496.10*
01/13 - 12/13	*$441.00*	*$485.10*
01/14 - 12/14	*$426.00*	*$468.60*
01/15 - 12/15	*$407.00*	*$447.70*
01/16 - 12/16	*$411.00*	*$452.10*
01/17 - 12/17	*$413.00*	*$454.30*

Effective Date	*Part A Premium Base Rate*	*10% Surcharge*
01/18 - 12/18	*$422.00*	*$464.20*
01/19 - 12/19	*$437.00*	*$480.70*
01/20 - 12/20	*$458.00*	*$503.80*

Section 1818(d) of the Act provides for reduced Medicare Part A premiums for individuals who have at least 30 Social Security work credits.

Monthly Reduced Medicare Part A Premium Amounts

Effective Date	*Part A Premium Reduced Rate*	*10% Surcharge*
01/94 - 12/94	*$184.00*	*$202.40*
01/95 - 12/95	*$183.00*	*$201.30*
01/96 - 12/96	*$188.00*	*$206.80*
01/97 - 12/97	*$187.00*	*$205.70*
01/98 - 12/99	*$170.00*	*$187.00*
01/00 - 12/00	*$166.00*	*$182.60*
01/01 - 12/01	*$165.00*	*$181.50*
01/02 - 12/02	*$175.00*	*$192.50*
01/03 - 12/03	*$174.00*	*$191.40*
01/04 - 12/04	*$189.00*	*$207.90*
01/05 - 12/05	*$206.00*	*$226.60*
01/06 - 12/06	*$216.00*	*$237.60*
01/07 - 12/07	*$226.00*	*$248.00*
01/08 - 12/08	*$233.00*	*$256.30*

Effective Date	*Part A Premium Reduced Rate*	*10% Surcharge*
01/09 - 12/09	*$244.00*	*$268.40*
01/10 - 12/10	*$254.00*	*$279.40*
01/11 - 12/11	*$248.00*	*$272.80*
01/12 - 12/12	*$248.00*	*$272.80*
01/13 - 12/13	*$243.00*	*$267.30*
01/14 - 12/14	*$234.00*	*$257.40*
01/15 - 12/15	*$224.00*	*$246.40*
01/16 - 12/16	*$226.00*	*$246.40*
01/17 - 12/17	*$227.00*	*$249.70*
01/18 - 12/18	*$232.00*	*$255.20*
01/19 - 12/19	*$240.00*	*$264.00*
01/20 - 12/20	*$252.00*	*$277.20*

Appendix 5.B Medicare Part B Premium Amount

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Section 1839 of the Act specifies that the Secretary of Health and Human Services shall determine the amount of the standard monthly Medicare Part B premium to be paid by or on behalf of each individual who is enrolled in Medicare Part B. From July 1966 through December 1983, the premium period usually spanned July through the following June. Beginning in January 1984, the premium period became January through December. Medicare Part B premiums paid on behalf of individuals enrolled in Part B buy-in are not subject to a surcharge for late enrollment. The following table reflects the premium amounts in effect since the beginning of the Medicare program.

Monthly Medicare Part B Premium Rates

Effective Date	*Part B Premium Base Rate*
7/66 - 3/68	*$3.00*
4/68 - 6/70	*$4.00*
7/70 - 6/71	*$5.30*
7/71 - 6/72	*$5.60*
7/72 - 7/73	*$5.80*
*8/73 - Only**	*$6.10*
9/73 - 6/74	*$6.30*
7/74 - 6/76	*$6.70*
7/76 - 6/77	*$7.20*
7/77 - 6/78	*$7.70*
7/78 - 6/79	*$8.20*
7/79 - 6/80	*$8.70*
7/80 - 6/81	*$9.60*
7/81 - 6/82	*$11.00*
7/82 - 12/83	*$12.20*
1/84 - 12/84	*$14.60*
1/85 - 12/86	*$15.50*
1/87 - 12/87	*$17.90*
1/88 - 12/88	*$24.80*
1/89 - 12/89	*$31.90*

Effective Date	*Part B Premium Base Rate*
*1/89 - 12/89***	*$27.90*
1/90 - 12/90	*$28.60*
*1/91 - 12/91****	*$29.90*
1/92 - 12/92	*$31.80*
1/93 - 12/93	*$36.60*
1/94 - 12/94	*$41.10*
1/95 - 12/95	*$46.10*
1/96 - 12/96	*$42.50*
1/97 - 12/97	*$43.80*
1/98 - 12/98	*$43.80*
1/99 - 12/99	*$45.50*
1/00 - 12/00	*$45.50*
1/01 - 12/01	*$50.00*
1/02 - 12/02	*$54.00*
1/03 - 12/03	*$58.70*
1/04 - 12/04	*$66.60*
1/05 - 12/05	*$78.20*
1/06 - 12/06	*$88.50*
1/07 - 12/07	*$93.50*
1/08 – 12/08	*$96.40*
1/09 – 12/09	*$96.40*

Effective Date	*Part B Premium Base Rate*
1/10 – 12/10	*$110.50*
1/11 – 12/11	*$115.40*
1/12 – 12/12	*$99.90*
1/13 – 12/13	*$104.90*
1/14 – 12/14	*$104.90*
1/15 – 12/15	*$104.90*
1/16 – 12/16	*$121.80*
1/17 – 12/17	*$134.00*
1/18 – 12/18	*$134.00*
1/19 – 12/19	*$135.50*
1/20 – 12/20	*$144.60*

**Due to Presidential price freeze*
***Applicable to beneficiaries who have "Medicare Part B only" under a provision of the Medicare Catastrophic Coverage Act (MCCA) and was applicable only during 1989.*
****Section 103 of P.L. 100-360 set the Medicare Part B premium rate through 1995.*

Appendix 5.C Summary Accounting Statement

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

State Buy-in (SBI)—Explanation of the Summary Accounting Statement (SAS)

CENTERS FOR MEDICARE & MEDICAID SERVICES
SUMMARY ACCOUNTING STATEMENT
BILLING NOTICE

A SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS

NAME OF ORGANIZATION	AGENCY CODE	BILLING PERIOD	DATE OF BILL
B	C	D JUN 2020	E 05/15/2020

This statement contains billing for items processed through this period only. It does not include remittances or billing for items received too late for processing, or items under investigation. Such items will be included in a later billing.

1. PREVIOUS BALANCE		1	$63,003,916.70
2. ADJUSTMENTS		2	$0.00
3. CURRENT MONTH'S LIABILITY-PAYABLE BY	06/01/2020	3	$31,931,308.20 *
4. PAYMENTS RECEIVED RECEIVED 04/23/2020 $31,576,990.40		4	$31,576,990.40 CR
5.		5	
6. TOTAL BALANCE		6	$63,358,234.50

☐ SEE ATTACHMENT (S)

* $30,834,163.00 REPORT ON FORM CMS-64.9 CASH/DEEMED CASH

ENTRIES ON THIS FORM ARE EXPLAINED IN THE STATE BUYIN MANUAL.
FOLLOWING ARE THE ELECTRONIC FUNDS TRANSFER METHODS AGENCIES SHOULD USE TO PAY THE MEDICARE PREMIUMS AND/OR STATE PHASED-DOWN CONTRIBUTIONS:

1. THE U.S. DEPARTMENT OF THE TREASURY'S INTERNET COLLECTIONS APPLICATION KNOWN AS PAY.GOV
2. THE U.S. DEPARTMENT OF THE TREASURY'S ELECTRONIC TRANSFER OF MONIES SYSTEM KNOWN AS THE TREASURY FINANCIAL COMMUNICATIONS SYSTEM (TFCS) OR FEDWIRE

SEE THE MANUAL NAMED ABOVE FOR COMPLETE INSTRUCTIONS.

FAILURE TO COMPLY WITH THESE INSTRUCTIONS COULD DELAY THE PROPER CREDITING OF YOUR PAYMENT.

CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MD 21244-1850

A Medicare Program
Name of Medicare program

B Name of Organization
The state name

C Agency Code
Three-character organization identifier assigned by CMS

D Billing Period
The month and year of premium coverage. Also, month and year in which premiums are due.

E Date of Bill
The date the SAS was created

1 Previous Balance
This amount is carried forward from the Total Balance (Line 6) on the previous month's SAS. "CR" denotes a credit balance.

2 Adjustments
This entry reflects a debit or credit adjustment to the total balance (Line 6) on the prior month's bill. It may also reflect a debit or credit adjustment to correct a payment amount recorded as payments received (Line 4) on a prior month's bill. "CR" denotes a credit balance. If the adjustment reflects a debit amount that resulted from a billing adjustment, the state must pay the debit amount in addition to the current month's premium liability (Line 3).

3 Current Month's Liability—Payable by (MM/DD/YYYY)
This entry contains the due date for payments (see section 5.1 of the Manual for State Payment of Medicare Premiums for an explanation of the due date) and the net premium liability (debit or credit) for all items processed for the billing month, including ongoing items, accretions, deletions, and adjustments. It **does not** include the debit or credit adjustments (Line 2).

If the state's buy-in agreement includes all individuals eligible for Medicaid under the state plan (including the categories also known as Medical Assistance Only), an asterisk (*) appears to the right of the current month's premium liability. This asterisk also appears next to the current month's premium liability which appears to qualify for Federal Financial Participation (FFP) under the Medicaid program in the row below Line 6. It is used to compute the allowable Part B premiums claimed on line 17.B of Form CMS 64.9 or 64.9P.

4 Payments Received
This entry reflects the receipt date and payment amount for each payment received from the state that had not previously posted to the state's account.

5 Premiums Collected through Offset
This entry reflects the amount of unpaid premiums that CMS has offset against the state's Award. If the line is blank, CMS did not recover premiums through offset.

6 Total Balance
This entry reflects the cumulative net billing and collection activity at the end of the billing period. "CR" denotes a credit balance.

Appendix 5.D Listed Agency Billing (LAB) - Summary Sheet
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

LAB LISTING FOR AGENCY CODE 000 (state name)

mm/03/yyyy

TOTAL ITEMS PROCESSED –

DEBIT		CREDIT			MISC.	
ITEMS	MONEY	ITEMS	MONEY		ITEMS	MONEY
CODE 11		CODE 14		CODE 20		
CODE 41		CODE 15		CODE 21		
CODE 43		CODE 16		CODE 22		
CODE 45		CODE 17		CODE 23		
TOTAL		CODE 42		CODE 24		
		CODE 44		CODE 25		
		TOTAL		CODE 26		
				CODE 27		
				CODE 28		
				CODE 29		
				CODE 30		
				CODE 49		
				CODE 86		
				CODE 87		
				TOTAL		

Problem Cases and Resources
Chapter 6

Table of Contents
(Rev.4, 08-21-20)

Transmittals for Chapter 6

6.0 Introduction
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This chapter identifies key federal components that administer the state buy-in program, as well as resources and procedures for states to address problems with buy-in for specific individuals or transactions.

***NOTE:** The Centers for Medicare & Medicaid Services (CMS) will only accept electronic communications containing Personally Identifiable Information (PII) that are encrypted or sent through a secure data exchange.*

6.1 Federal and State Components That Administer the State Buy-in Program
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

6.1.1 CMS Central Office (CO) Baltimore, MD
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

6.1.1.1 The Office of Financial Management (OFM)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

OFM, Accounting Management Group (AMG), Division of Premium Billing and Collections (DPBC) has overall responsibility for the administration of the state buy-in program including billing, collections, and general program policy.

States may submit inquiries by email to the DPBC resource mailbox at DPBCStateBuy-in@cms.hhs.gov.

DPBC's mailing address is:

CMS, OFM, AMG
Division of Premium Billing and Collections
Mailstop C3-18-08
7500 Security Blvd.
Baltimore, Maryland 21244-1850

DPBC's responsibilities include:

- *Serving as a primary point of contact for general state buy-in policy and operational related questions;*
- *Planning, developing, analyzing, and issuing operational policy and systems business requirements to administer third party premium collection programs;*
- *Working closely with Social Security Administration (SSA) operational and policy components, state Medicaid agencies, the Railroad Retirement Board (RRB), and CMS Regional Offices (ROs); and*
- *Analyzing proposed and new legislation to determine their impact on the state buy-in*

program.

6.1.1.2 The Office of Information Technology (OIT)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

OIT, Enterprise Systems Solutions Group (ESSG), Division of Medicare Systems Support (DMSS) has overall responsibility for the data processing of the state buy-in files.

States may submit inquiries by email to the OIT resource mailbox at MepbsEDBSSstaff@cms.hhs.gov.

DMSS' mailing address is:

CMS, OIT, ESSG
Division of Medicare Systems Support
Mailstop N3-17-07
7500 Security Blvd.
Baltimore, MD 21244-1850

DMSS' responsibilities include:

- *Serving as a primary point of contact for general Third Party System (TPS) systems-related questions;*
- *Managing the daily and monthly operations of TPS;*
- *Coordinating the maintenance and analysis of TPS system operations with the assistance of contractor support staff;*
- *Coordinating TPS, state Medicaid agency, and Third Party Formal Group daily and monthly data exchanges; and*
- *Coordinating the distribution of TPS monthly billing statements and related data and statistics.*

6.1.1.3 The Offices of Hearings and Inquiries (OHI)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

OHI, Medicare Ombudsman Group (MOG), Division of Medicare Systems Exceptions and Inquiries (DMSEI) (formerly Division of Ombudsman Exceptions (DOE)) has overall responsibility for the resolution of processing exceptions that states cannot correct through the data exchange process. See section 6.2 for information on how to submit a state buy-in problem resolution inquiry.

States may submit inquiries by email to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov.

DMSEI's mailing address is:

CMS, OHI, MOG

Division of Medicare Systems Exceptions and Inquiries
State Buy-in
P.O. Box 11977
Baltimore, MD 21207

Contact the CMS buy-in analyst assigned to your region. Please restrict phone contact to cases that need to be expedited (e.g., congressional and other urgent matters). Please send an email to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov to request a copy of the current state contacts list.

6.1.1.4 The Center for Medicaid and CHIP Services (CMCS)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMCS, Children and Adults Health Programs Group (CAHPG), Division of Medicaid Eligibility Policy (DMEP) has overall responsibility for Medicaid eligibility policy.

DMEP's mailing address is:

CMS, CMCS, CAHPG
Division of Medicaid Eligibility Policy
Mailstop S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1855

CMCS, Financial Management Group (FMG), Division of Financial Operations (DFO) has overall responsibility for the offsets against the Medicaid Grant Award and the Quarterly Expenditure Report for Medical Assistance Payments (Form CMS-64).

DFO's mailing address is:

CMS, CMCS, FMG
Division of Financial Operations
Mailstop S3-13-15
7500 Security Blvd.
Baltimore, MD 21244-1850

6.1.1.5 The Medicare-Medicaid Coordination Office (MMCO)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

MMCO, Program Alignment Group (PAG), works to coordinate components within CMS on issues affecting individuals dually eligible for both Medicare and Medicaid.

States interested in entering into a Part A buy-in agreement with CMS should contact the MMCO resource mailbox at ModernizetheMSPs@cms.hhs.gov.

6.1.2 Social Security Administration (SSA) Field Office (FO) or District Office (DO)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The responsibilities of the SSA Field Office (FO) or District Office (DO) include accepting Medicare applications, initiating buy-in for certain low-income beneficiaries, and assisting beneficiaries and states agencies with buy-in problems.

The responsibilities of the parallel FO/DO, the lead SSA FO/DO servicing the state Medicaid agency, include liaising with Medicaid buy-in operations personnel, providing technical assistance to other SSA FOs/DOs within the state, and overseeing the resolution of problem cases forwarded to servicing FOs/DOs.

6.1.3 CMS Office of Program Operations and Local Engagement (OPOLE)/CMCS Medicaid and CHIP Operations Group (MCOG)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Responsibilities for the state buy-in program may reside with either the Medicare (OPOLE) or Medicaid (CMCS/MCOG) component of the regional office. Each regional office determines where the program can be most effectively administered and is responsible for liaising with the states, assessing state buy-in operations, and coordinating and implementing procedures within the region (https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices).

6.1.4 Social Security Administration (SSA) Central Office (CO), Baltimore, MD

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The responsibilities of the SSA CO include the establishment and maintenance of the Master Beneficiary Record (MBR) and the Supplemental Security Income Record (SSR), and the daily exchange of new and updated Medicare entitlement and buy-in data with CMS. For more information about the exchange of buy-in data between CMS and SSA, see chapter 2, section 2.3.

6.1.5 Social Security Administration (SSA) Program Service Centers (PSCs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The SSA PSCs resolve problems pertaining to Medicare entitlement that impact state buy-in and annotate the MBR for state buy-in transactions that generate errors in automated systems and require manual processing.

6.1.6 Railroad Retirement Board (RRB)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The RRB annotates its master eligibility file with state buy-in data processed by CMS for RRB annuitants and assists with the resolution of problems pertaining to Medicare entitlement that may impact state buy-in.

6.1.7 The State Medicaid Agency

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The responsibilities of the state Medicaid agency include:

- *Conducting Medicaid eligibility determinations and redeterminations;*
- *Establishing internal procedures and systems to identify individuals who are eligible for state buy-in;*
- *Communicating these data to CMS;*
- *Responding to buy-in actions taken by CMS for beneficiaries;*
- *Making timely payments of Medicare premiums on behalf of state residents; and*
- *Assisting the SSA FOs in resolving inquiries on behalf of individuals who are, or may be, eligible for state buy-in.*

6.2 Problem Cases - General

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

If a state receives a processing error through the data exchange and the problem persists after two attempts by the state to resolve it, the state should send a problem resolution request to DMSEI via email, or, if expedited resolution is required, by phone. For DMSEI's contact information, see section 6.1.1.3.

Only individuals approved by their state Medicaid director may submit inquiries to or communicate with DMSEI about buy-in records. DPBC maintains a list of approved individuals; states may add additional individuals by sending documentation of the state Medicaid director approval to DPBC. For DPBC's contact information, see section 6.1.1.1.

CMS will take all necessary steps to investigate and resolve state problem resolution requests, including working collaboratively with SSA to correct issues that require SSA action to address.

DMSEI can assist states with:

- *Corrections to Medicare Part A and Part B entitlements;*
- *Billing adjustments to correct duplicate billing and other beneficiary-level billing items;*
- *Buy-in updates including accretions, deletions, and change record updates when the state is unable to clear the exception;*
- *Technical assistance and guidance to states on submitting accurate buy-in transactions;*
- *Identification and corrections of systems-related processing errors; and*
- *Other issues as they arise.*

***NOTE:** CMS will only accept electronic communications containing PII that are encrypted or sent through a secure data exchange. The following information is required to identify and process a case:*

- *Beneficiary's name;*
- *Beneficiary's Health Insurance Claim Number (HICN) or Medicare Beneficiary*

Identifier (MBI);

- *Beneficiary's own SSN;*
- *Rejection code and alphabetic sub-code, if applicable;*
- *Relief and/or assistance requested; and*
- *Requestor's name, title, organization, address, and telephone number.*

To submit a buy-in problem resolution inquiry via email, follow the steps below:

1. *Email the DMSEI resource mailbox at statebuy-in@cms.hhs.gov.*
2. *Indicate "buy-in inquiry - <name of the state>" (e.g., buy-in inquiry - Oregon), in the subject line. The name of the state should be spelled out; please do not abbreviate.*
3. *Include the information indicated under NOTE above in the email cover.*

Please allow 30 business days for processing.

If after 30 business days the problem/issue remains, submit a 'follow-up inquiry' to the DMSEI division director.

To submit a "follow-up inquiry," follow the steps below:

1. *Email the DMSEI resource mailbox at statebuy-in@cms.hhs.gov.*
2. *Indicate "follow-up inquiry" and <name of the state> in the email subject line. The name of the state should be spelled out; please do not abbreviate.*
3. *Also include "DMSEI Director" in the subject line of the email.*
4. *Attach a copy of the original email inquiry.*

6.3 Refund of Medicare Premiums to Individuals

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Once TPS accepts a state accretion request for an individual who is already enrolled in Medicare, CMS will notify SSA to update its records to show the state as the responsible party for premium billing (instead of the individual) effective with the buy-in start date. The federal government generally stops billing the individual upon notification from CMS. Individuals will receive a refund of any premiums deducted or paid for any month they were enrolled in buy-in.

See SSA POMS HI 00815.039 at https://secure.ssa.gov/poms.nsf/lnx/0600815039.

On rare occasions, federal systems may experience delays in updating SSA's billing record, resulting in the federal government simultaneously billing both the beneficiary and the state for premiums after the buy-in effective date. States should refer these cases to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov. DMSEI can work with SSA to resolve these issues.

SSA has access to CMS' third party billing master record through the MBR Health Insurance Query Response (HIQR). The HIQR provides current and prior state buy-in coverage periods

and the state agency code(s) for each period. If individuals claims they did not receive a premium refund owed to them, SSA can verify the beneficiary's buy-in status on the HIQR, correct the beneficiary record in the MBR and issue outstanding refunds to the individual.

6.4 Cases Involving Duplicate Billing

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

A beneficiary should have only one active Medicare entitlement record, but beneficiaries may have more than one record in rare instances (see chapter 4, section 4.6). If a state detects this error in the billing file, it should not attempt to resolve it since CMS will automatically consolidate the duplicate master records in the next billing month. If automated processes do not resolve issue, CMS may need to take manual action. Submit an inquiry regarding the duplicate billing records to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov. CMS has no time limit on accepting or granting state requests for duplicate billing adjustments. When resolving duplicate billing cases requires changing the individual's Medicare entitlement data, CMS will refer the case to the federal entity with jurisdiction over the individual's Medicare entitlement record (i.e., SSA or RRB.)

6.5 Correction of Demographic Data on the Third Party Master Record

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All demographic data in TPS derives from the CMS Enrollment Database (EDB), which originates from SSA. If the name or any other demographic information appears to be incorrect, send a buy-in resolution request to DMSEI. Submit documentation to substantiate a request for a name change or a change to any other demographic field. When the correction requires adjustment of the individual's Medicare entitlement status, CMS will refer the case to the federal entity with jurisdiction over the individual's Medicare entitlement (i.e., SSA or RRB.)

6.6 Resolution of State Buy-in Problems Received by the SSA Field Office (FO) Using Form CMS-1957

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The SSO Report of State Buy-in Problem (Form CMS-1957) facilitates the resolution of problem buy-in cases received by the FO. In most instances, the local FO will learn about a problem through a beneficiary complaint. A sample of the form is in appendix 6.A.

Form CMS-1957 is designed to collect the information needed to resolve the problem case. SSA will route the completed form to the state Medicaid agency, the local eligibility office, or to DMSEI for resolution of the problem.

The FO completes Part 1 (Report of Problem by SSO) and Part 2 (SSI status at FO), if applicable. The FO may need to contact the local eligibility office in order to complete the identification block on the upper right hand side of the form. Subsequent processing of the form will depend upon arrangements negotiated among SSA, CMS ROs, and each state, including whether the local eligibility office or the state Medicaid agency will verify the beneficiary's buy-

in status.

6.6.1 State Eligibility Office Verification Required
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The state takes the following actions when it receives Form CMS-1957:

- *Completes Part 3 (Report of Buy-in Status by Welfare Department) or reviews Part 3 for accuracy if the parties arranged for the FO to complete this section from information obtained from the local eligibility office;*
- *Reviews the accuracy of the information in the identification block on the upper right hand side of the form;*
- *Completes Part 4 (Information from State's records and/or actions being taken by State) based upon information contained in the state's records and the latest billing record received from CMS; and*
- *Signs, dates, and returns the completed form to the parallel FO.*

If the state receives an inquiry on an item that requires an adjustment of the accretion or deletion date, for example, the state may explain the problem in Part 4 and request a correction or adjustment.

The parallel FO will forward Form CMS-1957 to DMSEI for necessary action.

6.6.2 Local Eligibility Office Verification Required - State Verification Not Required
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The FO contacts the local eligibility office for assistance in completing the following items on

Form CMS-1957:

- *The identification block in the upper right hand side of the form; and*
- *Part 3 (Report of Buy-in Status by Welfare Department).*

Please leave Part 4 blank.

If Part 3 shows that the beneficiary currently or previously had state buy-in coverage, the FO will route the Form CMS-1957 to DMSEI for resolution.

6.7 Report of State Buy-in Problem Case by RRB (Form RL-380F)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States have the responsibility to submit buy-in transactions to CMS for RRB beneficiaries who are enrolled in buy-in. On occasion, the RRB receives complaints from Medicare beneficiaries (through its system of field offices), claiming that they are paying the Part B Medicare premium through deductions from their RRB annuity even though they are enrolled in Part B buy-in.

The RRB Report of State Buy-in Problem (Form RL-380F) helps to facilitate direct communication between the RRB and the state Medicaid agencies to resolve state buy-in problems for RRB Medicare beneficiaries. A sample of the form is included in appendix 6.B. The RRB will neither begin nor terminate Medicare premium deductions from the beneficiary's benefit check ***unless*** *the state's response shows that the state is liable for the Medicare premiums and the RRB can locate the record on TPS.*

The Form RL-380-F provides state Medicaid agencies the individual's correct identifying information (from RRB's Medicare Information Recorded, Transmitted, Edited, and Logged (MIRTEL) Online Inquiry (MOLI)) for the state to investigate the case. When the state Medicaid agency or local eligibility office receives the Form RL-380-F, it should:

- *Use the identifying information to investigate and verify the individual's buy-in status;*
- *Verify the beneficiary data, correct any errors and reprocess the record; and*
- *Advise RRB of the appropriate buy-in action.*

If the local RRB field office cannot resolve an issue regarding the beneficiary's Medicare entitlement, the state may contact the RRB in Chicago at (877) 772-5772 or (312) 751-3376.

Appendix 6.A SSO Report of State Buy-in Problem (Form CMS-1957)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0035

SSO REPORT OF STATE BUY-IN PROBLEM

To:

CMS
P.O. Box 11977
Baltimore, Maryland 21207-0977

From:

IDENTIFICATION

Name

Medicare Beneficiary Identifier

Railroad Retirement Board (RRB) Number | Sex ☐ M ☐ F

Welfare ID Number | Social Security Number (BOAN)

State and County of Residence

Claimant's Mailing Address

PART 1 Report of Problem by SSO

☐ A. Part B Claim Denied Carrier Name

☐ B. Premium being deducted from beneficiary check

☐ C. Being billed for premiums

☐ D. Individual received Part B Termination Notice

☐ E. Other *(Explain—Give Form numbers if applicable)*

PART 2 SSI Status at SSO

Receiving:

Federal SSI Check ☐ Start Date Stop Date

Federal Admin. State Supp. ☐

(Attach SSR & HMQ Printouts)

Signature of SSO Representative | Title | Date

PART 3 Report of Buy-In Status by Welfare Department *(Check and Complete Applicable Items)*

ACCORDING TO _____ WELFARE OFFICE, THE INDIVIDUAL IDENTIFIED ABOVE,

☐ 1. Has never been eligible for State buy-in.

☐ 2. Has been continuously eligible for State buy-in beginning (Mo., Yr.) _____

☐ 3. Has been eligible for State buy-in only for months of _____ through _____ (Inclusive) | If eligibility ended because of death, give date of death.

PART 4 Information from State's records and/or actions being taken by State

☐ 1. Individual is shown on State's bill as Code 41 continuing item beginning (Mo., Yr.) _____

☐ 2. Individual is shown on State's bill as other code. (Show code) _____

☐ 3. State will submit (Show code) _____ in the monthly data exchange (Show month) _____

Accretion Effective (Mo., Yr.) _____ Deletion Effective (Mo., Yr.) _____

☐ 4. Other

☐ CONTINUED ON REVERSE

Dept. of Public Welfare Signature | Title | Date

PRIVACY ACT STATEMENT

Section 1320.6 of title 5 to the U.S. Code authorizes collection of this information. The primary use of this information is to process changes to Hospital Insurance (HI)/Supplemental Medical Insurance (SMI) premium payments by third parties (such as State agencies, or private groups) on behalf of Medicare beneficiaries; for billing third parties; and for enrolling individuals for SMI coverage under State buy-in agreements.

Disclosure of the information may be made to State welfare departments pursuant to agreements with the Department of Health and Human Services for enrollment of welfare recipients for medical insurance under section 1843 of the Social Security Act or a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual.

Furnishing the information on this form including your Social Security Number, is voluntary but failure to do so may result in disapproval of this request.

Appendix 6.B RRB Report of State Buy-in Problem (Form RL-380F)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Form Approved
OMB No. 3220-0185

UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
OFFICE OF PROGRAMS/POLICY & SYSTEMS
844 NORTH RUSH STREET
CHICAGO, IL 60611-1275
WWW.RRB.GOV

OFFICE HOURS: M-T-TH-F 9:00 AM TO 3:30 PM
WEDS. 9:00 AM TO 12:00 PM - CLOSED FEDERAL HOLIDAYS

TOLL-FREE NUMBER: 1-877-772-5772

Send reply to: U.S. RAILROAD RETIREMENT BOARD Office of Programs/Policy & Systems 844 North Rush Street Chicago, IL 60611-1275	RRB Claim Number Medicare Number Part A Effective Date / Part B Effective Date Beneficiary's Own Social Security Number Beneficiary's DOB / Sex: Male ☐ Female ☐
Report of Problem: ☐ Buy-in Accretion Alleged ☐ Buy-in Deletion Alleged ☐ Other:	Social Security Claim Number Medicaid Number Beneficiary's Name Beneficiary's Address:
Signature of RRB Employee	Title
Telephone Number	Date

Information from State Records or Action Being Taken by State

Read the important notice on the next page.

To be completed by State Representative

1. ☐ State has been paying Medicare premium since _____ (Month/Year).
2. ☐ State paid Medicare premium from _____ (Month/Year) through _____ (Month/Year).
3. ☐ Beneficiary died _____ (Month/Year).

RL-380F (05-18)

Form Approved
OMB No. 3220-0185

4. ☐ Medicare number under which state paid premium (if different from RRB Medicare claim number)
_____.

5. ☐ State will submit a buy-in accretion effective _____ (Month/Year) in the _____ (Month/Year) data exchange with CMS.

6. ☐ State will submit a buy-in deletion effective _____ (Month/Year) in the _____ (Month/Year) data exchange with CMS.

7. ☐ Buy-in problem case on this beneficiary was submitted to CMS on _____ (Month/Year). Allow _____ days for resolution.

8. ☐ Beneficiary never eligible for buy-in.

9. ☐ State has no record of this beneficiary. Beneficiary should contact the following office and file a Medicaid application.

_____

_____

10. ☐ RRB inquiry has been referred to the office listed in item 9 above.

11. ☐ Other:

_____

_____

_____

Signature of State Representative	Title	
Printed Name	Telephone Number	Date

Return this form to the Railroad Retirement Board at the address shown on the first page.

Paperwork Reduction Act Notice

This notice is given under the Paperwork Reduction Act of 1995. Under Section 7(d) of the Railroad Retirement Act (RRA), the Railroad Retirement Board (RRB) is authorized to collect the information requested on this form. The information is needed by the RRB to determine the eligibility of an individual receiving benefits under the RRA for the payment of his or her Medicare medical insurance (Part B) premiums by the State. The information is also used by the RRB to determine if we should stop premium deductions for Medicare medical insurance from the benefits paid to the individual. Your obligation to provide us with this information is required under the law.

We estimate this form takes an average of 10 minutes to complete, including the time for getting the needed data and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.