DRAFT UPDATE:

MANUAL FOR STATE PAYMENT OF MEDICARE PREMIUMS

Updated Draft for Public Comment

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TABLE OF CONTENTS

CHAPTER 1 PROGRAM OVERVIEW AND POLICY

1.0 INTRODUCTION

The Medicaid statute requires states to pay Medicare Part A or Part B premiums for certain individuals dually eligible for Medicare and Medicaid (dually eligible individuals). Sections 1902(a)(10)(E) and 1905(p)(3)(A) of the Social Security Act ("the Act"). One way a state can fulfill this obligation for most dually eligible individuals is by entering into a buy-in agreement under section 1843 of the Act. The "state buy-in" program, administered by the Centers for Medicare & Medicaid Services (CMS) through authority delegated by the Department of Health and Human Services (HHS), provides a useful mechanism for states to pay Medicare premiums under Part A and/or Part B for certain individuals.

This chapter sets forth consolidated policy guidance regarding the state buy-in program, including:

- Introduction (section 1.0)
- Definitions (section 1.1)
- Background (section 1.2)
- Medicare eligibility and enrollment policy (section 1.3)
- Requirements For Enrolling Individuals Under Buy-In Agreements (section 1.4)
- Effect of buy-in on a beneficiary (section 1.5)
- Part B Buy-in Agreement Groups – General (section 1.6)
- Part A Buy-in Agreement Group – QMB Program (section 1.7)
- Conversion from Part A Group Payer to Part A State Buy-in Status (section 1.8)
- Federal Financial Participation (FFP) (section 1.9)
- Streamlined enrollment under a Buy-in agreement (section 1.10)
- Conditional Enrollment Process for QMBs to enroll in Premium-Part A (section 1.11)
- Policy regarding which entity initiates buy-in (section 1.12)
- Definition of Part B buy-in coverage period (section 1.13)
- Definition of Part A buy-in coverage period (section 1.14)
- Termination and withdrawal of Medicare Part A and/or B (section 1.15)

Chapter 1 applies to all states and the District of Columbia. Forthcoming chapter 7 applies to the U.S. territories identified in 42 CFR §§407.42 and 407.43.

NOTE: this chapter contains links to the SSA Program Operations Manual System (POMS) as of December 2019.[1]

1.1 DEFINITIONS

Buy-in agreement (agreement) means an agreement authorized by section 1843 of the Act, under which a state secures Premium-Part A or 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 1843 of the Act) are identified by the state and are composed of multiple Medicaid eligibility categories specified in the agreement.3See 42 CFR §§406.26 and 407.42.407.42.

Eligible individual (Part B) means an individual who is entitled to Medicare Part A or who is 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 5 years immediately preceding the month he or she 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 an individual who is entitled to have payment made on his or her behalf for Part A because he or she is:

- Age 65 and over and a fully insured individual for Social Security Retirement benefits (known as Old-Age Insurance Benefit Payments in section 202 of the Act) who receives these benefits or has not filed an application for these benefits but has filed an application for Part A; a qualified Railroad Retirement beneficiary; or has government-qualified employment (see section 210 of the Act; 42 CFR §406.5(a)(1)); or

- Under age 65 and entitled to Social Security Disability Benefits (see section 223 of the Act; 42 CFR §406.5(a)(2)); or

- Under age 65 and entitled to Medicare benefits on the basis of end stage renal disease

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[1] 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 State Medicaid Plan preprint form includes pages that reflect the method the state uses to pay Medicare Part A and B premiums for dually eligible individuals. See e.g., State Medicaid 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.

(ESRD) (see section 226A of the Act; 42 CFR §406.5(a)(3)).

General Enrollment Period (GEP) for Part B means the annual period (January through March, with coverage effective July 1) for individuals to apply for Part B if they 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 he or she 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); 42 CFR §408.80.

Initial Enrollment Period (IEP) means the 7-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 requirement 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 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 his or her IEP or reenrolls after termination of a coverage period. 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, the premium is limited to ten percent and is payable for twice the number of full 12 month periods determined under the regulations. 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); §406.20.

1.2 BACKGROUND

Medicare provides health coverage to individuals age 65 and older and certain persons under age 65 with disabilities or ESRD. Medicare Part A provides coverage generally of inpatient care, and most beneficiaries are entitled to these benefits based on eligibility for Social Security or RRB benefits. Some individuals are eligible to obtain entitlement to Part A benefits by paying a Part A premium (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).

The buy-in program was part of the original Medicare program first implemented in 1966. Under this program states, the District of Columbia (DC), and specified U.S. territories may enter into buy-in agreements to 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 agreement 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 an individual who is eligible for but not yet enrolled in Medicare, Part A or B buy-in enrolls the individual in Medicare 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 him or her for these costs through deductions from their monthly Social Security benefits (Old Age Insurance or Disability benefits or Supplement Security Income (SSI)) or through direct billing.

Low-income individuals who receive assistance with Medicare premiums save critical funds to use for other life's necessities, including food and housing. Upon enrollment in buy-in, individuals who were paying the Medicare premiums through deductions from their Social Security benefits see a notable increase in their monthly checks (the current year Part B base premium amount). Individuals without Medicare will be able to 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 to 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 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 Medicaid benefits by covering Medicare premium and cost-sharing costs through three Medicare Savings Program groups (QMB, Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI)). Federal matching funds are available to states for the cost of Medicare Parts A and B premiums and cost-sharing for certain Medicaid eligibility categories (see section 1.9).

1.3 MEDICARE ELIGIBILITY AND ENROLLMENT

Members of a buy-in group must be enrolled in buy-in if they meet the requirements for Medicare Parts A and/or B (an "eligible individual" as defined in section 1.1).

This section summarizes Medicare eligibility requirements and enrollment processes to help states understand which Medicaid recipients may qualify for Medicare and become dually entitled.

1.3.1 Premium-free Part A

Most individuals don't have to pay a monthly premium for Part A coverage. No Part A premium is required in cases where the individual or his/her spouse paid Medicare payroll taxes for a certain amount of time while working. This is sometimes called "Premium-free Part A." Most Medicare beneficiaries get Premium-free Part A.

An individual can get Premium-free Part A at age 65 if he/she:

- Already gets retirement benefits (Old Age Insurance Benefit Payments) from Social Security or the Railroad Retirement Board (RRB);
- Is eligible to get Social Security or RRB retirement benefits but hasn't 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 who is under age 65 can get Premium-free Part A if:

- He/she received Social Security or RRB Disability benefits for 24 months; or
- He/she has ESRD and has the requisite work credits to qualify for Social Security or RRB disability benefits (or is a spouse or dependent child of an individual who does).

NOTE: An individual who has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), will get Medicare Part A the month his or her Social Security Disability benefits begin.

1.3.2 Premium Part A

Certain individuals who lack the requisite Social Security work credits to qualify for Premium-free Part A, can enroll in Part A by paying a premium ("Premium-Part A"). See §§406.5(b) and 406.20.

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

- U.S. residents;
- Either: U.S. citizens or legal permanent residents who have resided in the U.S. continuously during the 5 years immediately preceding the month they applied for enrollment in Medicare;[4] and
- Are receiving benefits under Part B or are in the process of enrolling in it. See 42 CFR §406.20(b).

Individuals under age 65 qualify for Premium-Part A if they:

- Were entitled to Premium-free Part A on the basis of entitlement to Social Security disability benefits;
- Have lost entitlement to Premium-free Part A due to excess earnings; and
- Continue to have a qualifying disability. See 42 CFR §406.20(b).

NOTE: Individuals under age 65 who are eligible for Premium-Part A are not "eligible individuals" and are never eligible for state buy-in. As mentioned in section 1.6.2 of this manual, states pay the Part A premiums for Qualified Working Disabled Individuals (QDWI) individuals through the group payer arrangement.

Individuals may qualify to pay a reduced monthly Part A premium under certain circumstances.[5] See §406.32.

[4] The 5 years' continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. Reference POMS HI 00805.005A and GN 00303.800.

[5] Individuals may qualify for a reduced premium if they have obtained 30 work credits, were married for at least 1 year to a worker with at 30 work credits; married for at least one year to a worker who attained 30 work credits prior to their death; divorced from worker after 10 years of marriage and the worker attained 30 work credits at the time the divorce was final; divorced from 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. 42 CFR §406.32.

1.3.3 Medicare Part B Eligibility

All individuals eligible for Part B are charged a monthly premium through a deduction from their Social Security (Old Age, Disability, or SSI) benefits, RRB benefits, government retirement or SSDI benefits or a bill mailed directly by CMS.[6]

1.3.3.1 Part B for Individuals Eligible for Premium-Free Part A

Individuals who are entitled to Premium-free Part A are also eligible for Medicare Part B. See 42 CFR §407.10(a)(1).

Individuals who do not meet the requirements for Premium-free Part A are also eligible for Medicare Part B if they 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
- Either: U.S. citizens or legal permanent residents who have resided in the U.S. continuously during the 5 years immediately preceding the month of application for enrollment in Medicare.[7]

1.3.4 Medicare Enrollment

In the absence of a buy-in agreement, individuals must 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 Initial Enrollment Period (IEP). If they miss the IEP, they can only enroll during the annual General Enrollment Period (GEP) and may pay a premium increase for late enrollment. For an explanation of the premium surcharge 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 sign up, as described in Table 1.0 Medicare Enrollment.

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[6] 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.

[7] The 5 years' continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. Reference POMS HI 00805.005A and GN 00303.800.

Table 1.0 Medicare Enrollment

Automatic Enrollment	Individual Enrollment
Individuals automatically get Premium-free Part A (See §406.5(a); §406.10-15) if they are: • Individuals age 65 who are receiving Social Security or RRB Retirement benefits; or • Individuals under age 65 who receive Social Security or RRB Disability benefits for 24 months.	**Premium-free Part A:** Individuals must sign up for Medicare Premium-free Part A at SSA if they are: • Are age 65 and over and have not yet filed for Social Security or RRB benefits; • Qualify for Medicare based on having ESRD; or • Government employees who have paid the Medicare payroll tax for the required number of quarters.
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: • They do not pay a premium for Part A, which will start on the coverage date on the card; 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 on the card.	**Premium Part A:** In the absence of a buy-in agreement, individuals who qualify for Premium-Part A must sign-up for enrollment. 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 he or she is receiving Part B benefits or files an application to enroll. See 42 CFR §406.20(b). An individual can sign up for Medicare on the ssa.gov website, through SSA's toll-free number 1-800-772-1213, TTY 1-800-325-0778, or by making an appointment at their local Social Security Office.

1.3.5 Medicare Re-enrollment

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 pre-requisite for re-enrollment. See POMS HI 01001.345.

1.4 REQUIREMENTS FOR ENROLLING INDIVIDUALS UNDER BUY-IN AGREEMENTS

All states have buy-in agreements for Part B buy-in, and most have agreements for Part A buy-in. The agreements and related State Medicaid Plan pages identify the buy-in group 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, 407.48, and sections 1.13, 1.14, and 1.15. States must honor the applicable buy-in start and stop dates, even if buy-in processing is delayed. See chapter 2 of this manual for information regarding state and CMS processes to start and end buy-in.

NOTE: If SSA makes retroactive award of Social Security Disability, 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 disability 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. The state must enroll an individual even if he or she has not filed an application or does not wish to enroll. **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).

When a state anticipates or receives information that a current Medicaid recipient is newly eligible for Medicare, the state must promptly re-determine his/her eligibility. See 42 CFR §435.916(d). Eligibility for Medicare constitutes "a change in circumstances" that may affect an individual's Medicaid eligibility.[8] If the individual is determined eligible for a Medicaid category included in the state's buy-in group, the state must start paying the Part A or B premiums for him or her.

If an individual loses eligibility for one category of Medicaid included in the buy-in group, the state must determine whether 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 that determination, the state must maintain Medicaid coverage and must not terminate the individual from buy-in. Further, if the individual continues to qualify under another buy-in group category, buy-in coverage must continue without interruption.

Medicaid agencies must communicate all enrollment and disenrollment information through the established data exchange process directly with CMS. All state-submitted buy-in actions will be processed through the Third Party System (TPS). 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 of this manual for information about buy-in data exchanges.

1.5 EFFECT OF BUY-IN ON AN INDIVIDUAL

If an individual is not currently enrolled in Medicare, enrolling in buy-in enables the individual to enroll in Medicare and access Part A or B 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 he or she becomes eligible for state buy-in.

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

- If the beneficiary is receiving a Social Security benefit (OASDI or SSI), Office of Personnel Management (OPM) or RRB annuity, the Medicare Part B premium will no longer be deducted from the benefit, which will result in the beneficiary receiving a higher monthly benefit payment.

[8] 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.

- If the beneficiary was not receiving a Social Security benefit or an OPM or RRB annuity and received bills for Medicare Part A and/or Medicare Part B from CMS, direct billing will end.

Once buy-in coverage is effective, the beneficiary shall receive a refund for any premiums (including any late enrollment penalties) that were deducted from the benefit amount or paid directly by the beneficiary for any month the beneficiary is covered by 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 coverage will end only as provided in 42 CFR §407.48. In these instances, the beneficiary is entitled to keep any premium refunds received when coverage begins. The state must treat the individual as if they are eligible and may not attempt to recoup these amounts from the beneficiary.[9]

NOTE: The refund of Medicare premiums must not be considered income when determining eligibility for Medicaid or spend-down.

1.6 PART B BUY-IN AGREEMENT GROUPS – GENERAL

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.

[9] 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 §431.211-214, which require states to provide at least 10 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 (42 CFR §435.403(a)) and must continue to furnish Medicaid to all eligible individuals until they are found to be ineligible (42 CFR §435.930(b)). When a state receives information which suggests a beneficiary is not eligible for Medicaid, the state must promptly conduct a redetermination of eligibility for this beneficiary (42 CFR §435.916(d)(1)). This includes providing the beneficiary with an opportunity to demonstrate that the information received by the state is not accurate or that she or he otherwise remains eligible for coverage (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 §435 subpart J and 42 CFR §431 subpart E.

After numerous changes, federal buy-in law now allows states to select one of three Part B buy-in coverage groups. See section 1843 of the Act; 42 CFR §§407.42, 407.43. The buy-in groups are listed below, in order of narrowest to broadest. All of the groups include cash assistance and deemed cash assistance recipients, individuals for whom states with buy-in agreements must secure Part B coverage.[10]

- **Cash Assistance Recipients and Deemed Cash Assistance Recipients (Required Categories Only).**This group includes cash assistance recipients (i.e., SSI and optional state supplement program (SSP) recipients) and individuals who are "deemed" to be cash assistance recipients who are covered under the State Medicaid Plan as categorically needy.

- **Required Categories Plus Three Medicare Savings Program (MSP) Groups.** This group includes the Required Categories above, plus all individuals enrolled in three MSPs--Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs).[11]

- **All Medicaid Categories.** This group includes the Required Categories and the three MSP groups above, plus all other individuals who are eligible for Medicaid.

Since the enactment of the MSPs, CMS has deemed all buy-in agreements to include Part B buy-in for QMBs, SLMBs, and QIs.[12] As of December 2019, all states, DC, and certain territories have Part B buy-in agreements that include either the Required Categories Plus Three Medicare Savings Programs or All Medicaid Categories.

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[10] Note that the regulations at 42 CFR §§407.42 and 407.43 reference obsolete Medicaid categories, such as individuals receiving Aid to Families with Dependent Children (AFDC) or treated as though they were receiving it, and individuals who received aged, blind or disabled (ABD) assistance in August 1972 or would have had they applied or not been institutionalized. This manual does not include these categories in the buy-in groups since states no longer provide coverage under them.

[11] Note that states pay the Part A premiums for individuals who qualify for the Qualified Disabled Working Individuals program (QDWI) through the group payer arrangement.

[12] CMS (then 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, which was enacted in 1997. The State Plan Amendment pre-print (3.2 Coordination of Medicaid with Medicare and Other Insurance) treats QI the same as SLMB.

1.6.1 Cash Assistance and Deemed Cash Assistance (Required Categories Only) Recipients who Qualify for Mandatory Medicaid

Cash assistance includes monthly cash benefits for individuals 65 years old and older or who have blindness or disability under SSI or SSP (both required and optional). See Title XVI of the Act. Depending upon the state, individuals who receive SSI/SSP may be eligible for the mandatory aged, blind, and disabled (ABD) eligibility group with full Medicaid benefits. SSA notifies Medicaid agencies of individuals who are determined eligible for SSI (and SSP, in some cases) and may qualify for Medicare through the SSA systems such as the State Data Exchange (SDX). See section 2.4 for more information about SSA data sharing with states.

1.6.1.1 Supplemental Security Income (SSI) Program

In 1972, federal law consolidated the cash assistance programs targeted at individuals 65 years old and older or who have blindness or disability (also known as ABD) into one program, the SSI program, in the 50 states, the District of Columbia, and the Northern Mariana Islands. [13]

At the same time Congress created the SSI program, it enacted section 1634 of the Act, under which states have the option of contracting with SSA to determine Medicaid eligibility for individuals age 65 or older or who have blindness or disability, and for whom SSA has determined eligible for SSI ("1634" agreements). In states with 1634 agreements ("Auto-Accrete" states), SSI recipients are a mandatory ABD eligibility group with full Medicaid benefits. The majority of states are Auto-Accrete states.

The remainder of the states are known as "Alert" states. Alert states fall into two categories: "SSI criterion" states and "209(b)" states.

In "SSI criterion states," SSI recipients are a mandatory ABD eligibility group with full Medicaid benefits. However, these states remain responsible for making their own Medicaid determinations. They generally require only a signed state Medicaid application after SSA has approved an individual for SSI.

[13] The Supplemental Security Income (SSI) program (also known as Title XVI), which became effective January 1, 1974, replaced the state-administered Titles I, X, XIV, and XVI (aid to the blind and disabled) which formed the basis for State Buy-In coverage groups between 7 /1/1966 and 12/31/1973. The federally administered Title XVI (SSI) is effective in the District of Columbia, the Northern Mariana Islands and the 50 states. The state-administered Titles I, X and XIV remain in effect in Puerto Rico, Guam, and the Virgin Islands.

209(b) states are excused from the requirement of providing Medicaid to all SSI recipients who are age 65 or older or who have blindness or a disability.[14] Section 209(b) states use a more restrictive standard for Medicaid eligibility than SSI and require a complete state application regardless of SSI status.

In Auto-Accrete states, CMS automatically enrolls SSI recipients who are Medicare-eligible in Part B buy-in. CMS sends Alert states information to identify SSI recipients who are Medicare-eligible, but Alert states, not SSA, determine Medicaid eligibility and initiate Part B buy-in enrollment. See section 2.5.1 of this manual for information about buy-in enrollment processes in Auto-Accrete and Alert states.

Appendix 1.C. classifies states by whether they are an Auto-Accrete or Alert state (including SSI criterion and 209(b)) as of December 2019.

1.6.1.2 State Supplement Programs (SSP)

Most states operate their own cash assistance programs—known as optional state supplement programs (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.[15] In other cases, individuals receive only an SSP payment if they otherwise qualify for SSI but for excess 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 the SSP. Other states perform determinations for their SSPs themselves. See SSA POMS SI 01401.001.

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[14] States that have elected this option are referred to as "209(b)" states after section 209(b) of the Social Security Act Amendments of 1972 which added section 1902(f) to the Act.

[15] In states where the grant-in-aid cash benefit rate in December 1973 exceeded the SSI Federal Benefit Rate of January 1974, the states were 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.

1.6.1.3 Deemed Cash Recipients

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/SSP. Federal law and regulations make these individuals mandatorily eligible for Medicaid.[16] These individuals must be included in state buy-in agreements.

1.6.2 Required Categories Plus Three Medicare Savings Program Eligibility Groups

Pursuant to section 1902(a)(10)(E) of the Act, states must assist low-income beneficiaries with their Medicare expenses through one of these Medicare Savings Programs (MSP):

1. Qualified Medicare Beneficiaries (QMBs)
2. Specified Low-Income Medicare Beneficiaries (SLMBs)
3. Qualifying Individuals (QI)
4. Qualified Working Disabled Individuals (QDWI)

In addition to the Required Categories (cash assistance-related and deemed cash assistance-related coverage categories described in section 1.6.1), states may cover MSP groups one through three above (QMBs, SLMBs and QIs) in their Part B buy-in agreements. The MSP pay the Part B premium, and depending upon the group, all other Medicare Parts A and B costs.

NOTE: States pay Part A premiums (but not Part B premiums) for QDWI. QDWIs were eligible for Premium-free Part A by virtue of qualifying for disability insurance benefits through the Social Security program, but lost those benefits, and consequently Premium-free Medicare Part A, because they returned to work. QDWIs have income up to 200% of the FPL, resources that do not exceed two times the SSI resource standard, and are not otherwise eligible for Medicaid. States cannot include the Part A premium payments for QDWIs in their buy-in agreements. States must pay the Part A premiums for QDWIs through the group payer process.

The SSI income and resource methodologies are used to determine financial eligibility for the MSPs. States can use less restrictive financial methodologies under section 1902(r)(2) of the Act in counting applicants' income and resources to expand eligibility

[16] The following categories are deemed SSI/SSP recipients: certain individuals (sometimes known as "Pickle" individuals) who used to qualify for both Social Security Disability benefits 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).

and also have the option to define family size for purposes of determining eligibility for the MSPs.

Depending upon the income and other characteristics of the individual, MSP enrollees may qualify for a "categorical" eligibility group covered under the individual's State Medicaid Plan and receive the full package of Medicaid benefits ("full duals") in addition to Medicare cost-sharing. During eligibility determinations, the state must typically consider an individual for all programs for which they may qualify, including categorical eligibility categories that provide full benefits and the MSP which help pay Medicare premiums/cost-sharing. 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).

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

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

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-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 Appendices 1.A and 1.B.

1.6.2.1 Qualified Medicare Beneficiaries (QMBs)

Under the QMB eligibility group, states must pay the Medicare Parts A and B cost-sharing expenses (i.e., monthly premiums, deductibles, coinsurance, co-payments,[17] and at state option, Part C premiums) for individuals who:

[17] Note that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay.

- Are entitled to Medicare Part A, including Premium-Part A;
- Have incomes that do not exceed 100 percent of the federal poverty level (FPL); and
- Have resources that do not exceed the full Low-Income Subsidy (LIS) resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the Consumer Price Index (CPI).[18]

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

Current income and asset limits for QMB are at: https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees.

The QMB program is a mandatory ABD eligibility group. Individuals who qualify for QMB often 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. In 2017, 78 percent of QMBs qualified for full Medicaid in addition to QMB (QMB-plus), while 28 percent of QMBs qualified for QMB alone (QMB-only).

QMB is effective the month following the month the individual is determined to be QMB-eligible. See section 1902(e)(8) of the Act. That said, CMS considers the "month the individual is determined to be QMB-eligible" to be the month that the individual is determined to meet all the requirements for QMB eligibility. For example, if an individual applies for Medicaid on January 1 and is determined to meet all of the requirements of eligibility at that time, even if the state makes this determination on February 15, the individual's QMB coverage may begin on February 1.

For QMB-plus individuals, their separate full Medicaid coverage may be effective up to three months before the month of application, even though their QMB coverage is prospective.

[18] Note that while full LIS and SLMB 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 in the SSA POMS HI 03030.20. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to better align MSP criteria with those used for LIS. For example, states could disregard the cash value of life insurance policies, or $1,500/$3,000 as a burial disregard without verifying that the funds have been put in a burial trust, to address the specific areas of misalignment.

1.6.2.2 Specified Low-Income Medicare Beneficiaries (SLMBs)

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

- Are entitled to Medicare Part A, including Premium-Part A;
- Have an income that exceeds 100 percent, but is less than or equal to 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.[19]

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

Current income and asset limits for SLMB are at: https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees.

Unlike QMBs, the state is precluded from paying the Medicare Part A premiums for SLMBs. Individuals who qualify for SLMB may 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 assistance with the Medicare Part B premium. In 2017, 22 percent of SLMBs qualified for full Medicaid in addition to SLMB (SLMB-plus), while 78 percent of SLMBs qualified for SLMB alone (SLMB-only).

A SLMB determination is effective up to three months before the month of application if all eligibility criteria are met. See 42 CFR §435.916.

1.6.2.3 Qualifying Individuals (QIs)

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

- Are entitled to Medicare Part A, including Premium-Part A;

[19] Note that while full LIS and SLMB 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 in the SSA POMS HI 03030.20. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to better align MSP criteria with those used for LIS. For example, states could disregard the cash value of life insurance policies, or $1,500/$3,000 as a burial disregard without verifying that the funds have been put in a burial trust, to address the specific areas of misalignment.

- Have an income that exceeds 120 percent but is less than or equal to 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.[20]

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

Current income and asset limits for QIs are at: https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees.

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. Unlike QMB and SLMB, individuals who qualify for QI cannot be eligible for a separate eligibility group covered under the State Medicaid 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.

1.6.3 All Other Medicaid Categories

In their 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 encompasses other Medicaid eligibility categories not included in the buy-in groups above, such as the poverty-level group (sections 1902(a)(10)(A)(ii)(X); 1902(m)(1) of the Act); the medically needy (section 1902(a)(10)(C) of the Act; 42 CFR §435.301); and institutionalized individuals under a special income level (section 1902(a)(10)(A)(ii)(V) of the Act; 42 CFR §435.236).

[20] Note that while full LIS and SLMB 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 in the SSA POMS HI 03030.20. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to better align MSP criteria with those used for LIS. For example, states could disregard the cash value of life insurance policies, or $1,500/$3,000 as a burial disregard without verifying that the funds have been put in a burial trust, to address the specific areas of misalignment.

Determinations under these categories are effective up to three months before the month of application if all eligibility criteria are met. See 42 CFR §435.916. 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 BENEFIARY (QMB) PROGRAM

Starting January 1, 1990, CMS deemed all agreements (except in states that opted out), to include the payment of Part A premiums for individuals who are otherwise eligible for the QMB program but who must pay a premium to enroll in Part A (Premium-Part A). [21]

Most individuals qualify for Premium-free Part A (i.e., those who have worked the requisite quarters to qualify for Social Security benefits). However, individuals who lack a sufficient work history can pay a monthly premium to enroll in Part A. Through QMB, states must pay the premium for the individuals who must pay a premium to enroll in Part A. See section 1.3.2 for more information about eligibility for Premium-Part A.

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 Appendix 1.C. table classifies states by whether they are a Part A buy-in state or a group payer state as of May 2019.

QMB is the only buy-in group for Part A buy-in. 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 STATE BUY-IN STATUS

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 CMCS SPA Coordinator in their CMS Regional Office, the Division

[21] 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).

of Premium Billing and Collections in CMS' Office of Financial Management (refer to contact information in chapter 6).

1.9 FEDERAL FINANCIAL PARTICIPATION (FFP) FOR BUY-IN GROUPS

States can obtain FFP funds for "eligible individuals" who are enrolled in the "Required Categories" and the three MSPs described in section 1.6. Specifically FFP funds are available for the state payment of:

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

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, states have an interest in ensuring Medicare Part B enrollment for such individuals since FFP is not available for Medicaid costs that Part B could have covered had individuals been had enrolled in it. 42 CFR §431.625(d)(3).

State agencies report gross expenditures (total computable) and apply the applicable Federal Medical Assistance Percentage (FMAP) on the Quarterly Expenditure Report for Medical Assistance Payments (Form CMS-64).[22]

States should direct any questions about form CMS-64 to the analyst within the Center for Medicaid and CHIP Services (CMCS), Regional Office Group (ROG), Division of Financial Operations (DFO) for their state.

1.10 STREAMLINED ENROLLMENT UNDER A BUY-IN AGREEMENT

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; 1818 (g) of the Act.

[22] 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.

If a buy-in group member is neither entitled to Medicare Part A nor receiving benefits under Part B, the individual must apply for Medicare at the SSA Field Office (SSA FO) before a state can enroll him or her in buy-in.

If a buy-in group member is entitled to Medicare Part A or receiving benefits under B, the state should directly enroll him or her in buy-in since SSA has already determined them eligible for Medicare. 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 enrolled in Premium-free Part A, the state should directly enroll him or her in Part B buy-in without referring the individual to the SSA FO to apply for Part B. Similarly, if a QMB-eligible individual is already enrolled in Part B, the state can directly enroll that individual in Part A buy-in (without requiring SSA to make a separate Part A determination). As noted in section 1.8, in group payer states, Part A application is required.

1.11 CONDITIONAL ENROLLMENT PROCESS FOR QMBS TO ENROLL IN PREMIUM-PART A

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

The "conditional enrollment" process allows individuals 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 and therefore becomes liable for the Part A premium. Conditional enrollment also acts as a placeholder in SSA's system. Actual Medicare entitlement will be effective only after SSA receives the state's Part A buy-in enrollment. The Medicare Part A start date will reflect the buy-in start date the state reported. With the conditional enrollment in Part A, individuals meet the eligibility criteria for the QMB program, enabling states to determine them eligible for QMB and begin paying the Part A premiums. If the state denies the QMB application, the individual will not be enrolled in Premium-Part A.

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 & Exchange System (SVES) to verify the conditional Part A enrollment. See POMS HI 801.140 for more information about the conditional enrollment process.

In group payer states, Part A buy-in is 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 enrollment. Individuals can only enroll in Premium-Part A during the annual GEP (if they missed their IEP). If the state determines the individual eligible for QMB in or before June of that year, QMB coverage can start no earlier than July 1.[23] The state must pay 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 him or her in QMB and refrain from referring him or her to SSA to file an actual or conditional Part A application. States must treat individuals enrolled in Part B as enrolled in 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 him or her in Part A buy-in until SSA establishes actual or conditional Part A enrollment. 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

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 section 2.8 of this manual for more information about PW accretions.

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

SSA regularly communicates with states regarding who is eligible for SSI and SSPs and Medicare through SSA data systems, such as the State Data Exchange (SDX). See section 2.4 of this manual for a list of SSA systems for states. In addition, SSA sends SSI/SSP information to CMS which, in turn, assists states in enrolling cash recipients in Part B buy-in. See section 2.5.1.1 of this manual for more information.

In auto-accrete states and states with 1616 agreements, CMS automatically accretes individuals in Part B buy-in if SSA determines them eligible for SSI and, thus, Medicaid. In states with 1616 agreements, CMS will auto-accrete individuals who receive SSI only, or SSI in combination with SSP or SSP-only.

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

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 may also be eligible for Medicare. The state is responsible for accreting the individual to buy-in if the state then determines them eligible for Medicaid.

1.12.2 Buy-in for Other Individuals

States must always initiate buy-in for all non-cash assistance-related Medicaid recipients.

This includes:

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

1.13 DEFINITION OF PART B BUY-IN COVERAGE PERIOD (SEE APPENDIX 1.A)

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

For an individual enrolled in the Required Categories (i.e., 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 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 QMB effective 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 QMB effective August 1, Part B buy-in starts on June 1 (i.e., the buy-in start date for other Medicaid categories).

See Appendix 1.B for the effective dates of buy-in group categories.

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

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 he/she 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 section 2.6.1.3.
    - States must re-determine eligibility and continue buy-in coverage without interruption if the individual qualifies for another Medicaid category covered under the buy-in agreement. See section 1.2 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.B.)

1.14.1 Beginning of Part A Buy-in Coverage

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.B for the effective date of QMB.

NOTE: SSA's "conditional enrollment" process allows individuals to meet the eligibility criterion for the QMB program (enrollment 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 to enroll.

1.14.2 End of Part A Buy-in Coverage

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 he/she 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 under the buy-in agreements ends on the last day of the last month in which the Part A buy-in agreement is in effect. 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 section 2.6.1.4.

1.15 TERMINATION AND WITHDRAWAL OF MEDICARE PART A OR MEDICARE PART B AFTER STATE BUY-IN COVERAGE ENDS

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), RRB or Civil Service Retirement benefits, SSA will typically deduct the Part A and/or B premium amount for their monthly benefit. If the beneficiary does not receive Social Security, RRB or Civil Service Retirement benefits (or their benefit less then premium amount owed), they will receive bills from CMS or SSA ("direct billing") for Medicare Part A and/or B premiums. [24]

1.15.1 Voluntary Withdrawal (Termination) From Medicare

Once the state ends buy-in coverage, the SSA will send the beneficiary a notice of state buy-in termination ("buy-out notice") with the option to withdraw from Medicare Part A and/or Part B.

The buy-out notice encloses a **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.C for process of voluntary termination when buy-in ends and 1.D. 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 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 file form 1763, coverage ends at the end of the month after the month in which the beneficiary notifies SSA or CMS that he/she wishes to withdraw.

[24] 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.

APPENDIX 1.A DUAL ELIGIBILITY CATEGORIES AND ASSISTANCE WITH MEDICARE PART A AND PART B COSTS

Category	Monthly Income as of 2019*	Assets as of 2019*	Covers Part A premium (when	Covers Part B premium	Covers Parts A & B cost sharing	Full Medicaid coverage**
QMB only	$FPL \leq 100\%$	<3 times the SSI resource limit, adjusted based on the Consumer Price Index (CPI)	X	X	X***	
QMB plus**	$FPL \leq 100\%$	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	$\geq 120\%\ FPL < 135\%$	<3 times the SSI resource limit, adjusted based on the CPI		X		
QDWI	$\leq 200\%\ FPL$	<2 the SSI resource limit	X			
Full Medicaid (only)**	Determined by state	Determined by state		Depends on State Plan	Depends on State Plan****	X

* The income and asset limits for the MSPs are released annually by the Centers for Medicare & Medicaid Services (CMS). The income limit for QDWI includes an earned income disregard of $65. The asset limit calculation for QMBs, SLMBs, and QIs is 3 times the SSI resource limit, adjusted annually by increases in the Consumer Price Index (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" 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. Individuals who are QMB/SLMB "plus" receive full Medicaid in addition to Medicare cost-sharing and premiums coverage. Individuals who receive full Medicaid only are enrolled in Medicare Part A and/or Part B, and qualify for full 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.

**** Beneficiary pays no more than amount allowed by the State Plan for services covered by both Medicare and 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.

**** Beneficiary pays no more than amount allowed by the State Plan for services covered by both Medicare and 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.

Dual Eligibility Category Descriptions

1. **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% 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 Medicaid benefits through the state. 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. 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.

2. **QMBs with full 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" eligibility group covered under the individual's State Medicaid Plan. In addition to the coverage for Medicare premiums and cost-sharing described above, QMB-Plus individuals are entitled to Medicaid coverage for the services included in the state plan coverage that corresponds 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. 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. For services that Medicare doesn't cover, but Medicaid does, Medicaid will cover the service, and pay the amount specified in the State Medicaid Plan.

3. **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% 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.

4. **Specified Low-Income Medicare Beneficiaries (SLMBs) with full 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" eligibility group covered under the individual's State Medicaid Plan. In addition to the coverage for Medicare Part B premiums, SLMB-

Plus individuals are entitled to coverage for the services included in the state plan coverage that corresponds to the separate eligibility group for which they qualify. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. Beneficiary pays no more than amount allowed by the state plan for services covered by both Medicare and Medicaid. For services that Medicare doesn't cover, but Medicaid does, Medicaid will cover the service and pay the amount specified in the state plan.

5. **Qualifying Individuals (QIs)** are enrolled in Part A and have income between 120% and 135% of the FPL, and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. QIs may not be eligible for a separate eligibility group covered under the State Medicaid 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.

6. **Qualified Disabled and Working Individuals (QDWIs – also known as QDWI "partial benefit")** became eligible for Premium-free Part A by virtue of qualifying for disability insurance benefits through the Social Security program, but lost those benefits, and consequently Premium-free Medicare Part A, because they returned to work. QDWIs have income up to 200% 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.

7. **Full Medicaid Only:** These individuals are enrolled in Medicare Part A or Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB programs. "Full" 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, Supplemental Security Income (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), behavioral health, transportation, and vision services. Medicaid benefits vary by state. A full Medicaid beneficiary pays no more than amount allowed by the state plan for services covered both by Medicare and Medicaid. For services that Medicare doesn't cover, Medicaid will cover the service and pay the amount specified in the state plan.

APPENDIX 1.B MEDICAID EFFECTIVE DATES AND BUY-IN START AND STOP DATES

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 second month after the eligibility determination.**** **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/SSP) and deemed cash assistance who are categorically needy	X		X	X		X	
QMB		X	X		X Group Payer states only: As early as July 1 of any given year in which actual or conditional Part A application occurred during the GEP.	X	X
SLMB	X		X			X	
QI	X		X			X	
Other Full 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 as early as 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 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 section 2.6.1.4.

APPENDIX 1.C CLASSIFICATION OF STATES BY SSI AND PART A STATUS

STATE	SSI STATUS ACCRETE OR ALERT	PART A BUY-IN	PART A GROUP PAYER
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[25]	X	
Massachusetts	Accrete	X	
Michigan	Accrete	X	
Minnesota	Alert (209b)	X	
Mississippi	Accrete	X	

[25] 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
Missouri	Alert (209b)		X
Montana	Accrete	X	
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.D VOLUNTARY TERMINATION OF MEDICARE COVERAGE (WITHDRAWAL) FOR INDIVIDUALS WHO LOSE BUY-IN COVERAGE

Voluntary Termination/Withdrawal	Medicare Part A and/or Medicare Part B
Process to Terminate Coverage POMS HI 00820.901	• After receiving notice of buy-in termination from SSA, the beneficiary must file a Request for Termination of Premium Hospital and/or Supplemental Medical Insurance (Form CMS-1763). See Appendix 1.D. 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 POMS HI 0820.015 (Premium Part A) POMS HI 00815.042 (Part B)	• 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 Buy-in ends POMS HI 0820.015 (Premium Part A) POMS HI 00815.042 (Part B)	• If the beneficiary files From CMS 1763 within 6 months after a state buy-out, but *not within 30 days* of the buy-out notice, Premium Part A enrollment is effective to the end of the month.
Terminating coverage 6 months or more after buy-in ends	• If the beneficiary files Form CMS1763 to withdraw from Premium Part A more than 6 months after buy-in ends, the Premium Part A termination is effective at the end of the month after the month the beneficiary files for withdrawal. **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.

APPENDIX 1.E REQUEST FOR TERMINATION OF PREMIUM HOSPITAL AND/OR SUPPLEMENTAL MEDICAL INSURANCE

(Form CMS-1763)

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	DATE SUPPLEMENTARY MEDICAL INSURANCE WILL END	DATE HOSPITAL INSURANCE WILL END
	☐ HOSPITAL INSURANCE ☐ MEDICAL INSURANCE		

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

CHAPTER 2 STATE DATA EXCHANGE WITH MEDICARE

2.0 INTRODUCTION

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

This chapter provides information regarding:

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

Chapter 3 of this manual contains buy-in file exchange layouts, and chapter 4 includes 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 December 2019.[26]

2.1 OVERVIEW OF STATE BUY-IN DATA EXCHANGE

States submit files to the Third Party System (TPS) to identify individuals dually eligible for Medicare and Medicaid for whom the state will pay Parts A and/or B premiums. 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. In turn, TPS responds to state submissions and proactively transmits updates from CMS and SSA to states. See section 2.2.2 below.

On a daily basis, TPS and EDB exchange data directly with the Master Beneficiary Record (MBR), SSA's system that records Medicare and Social Security eligibility determinations and enrollment data.

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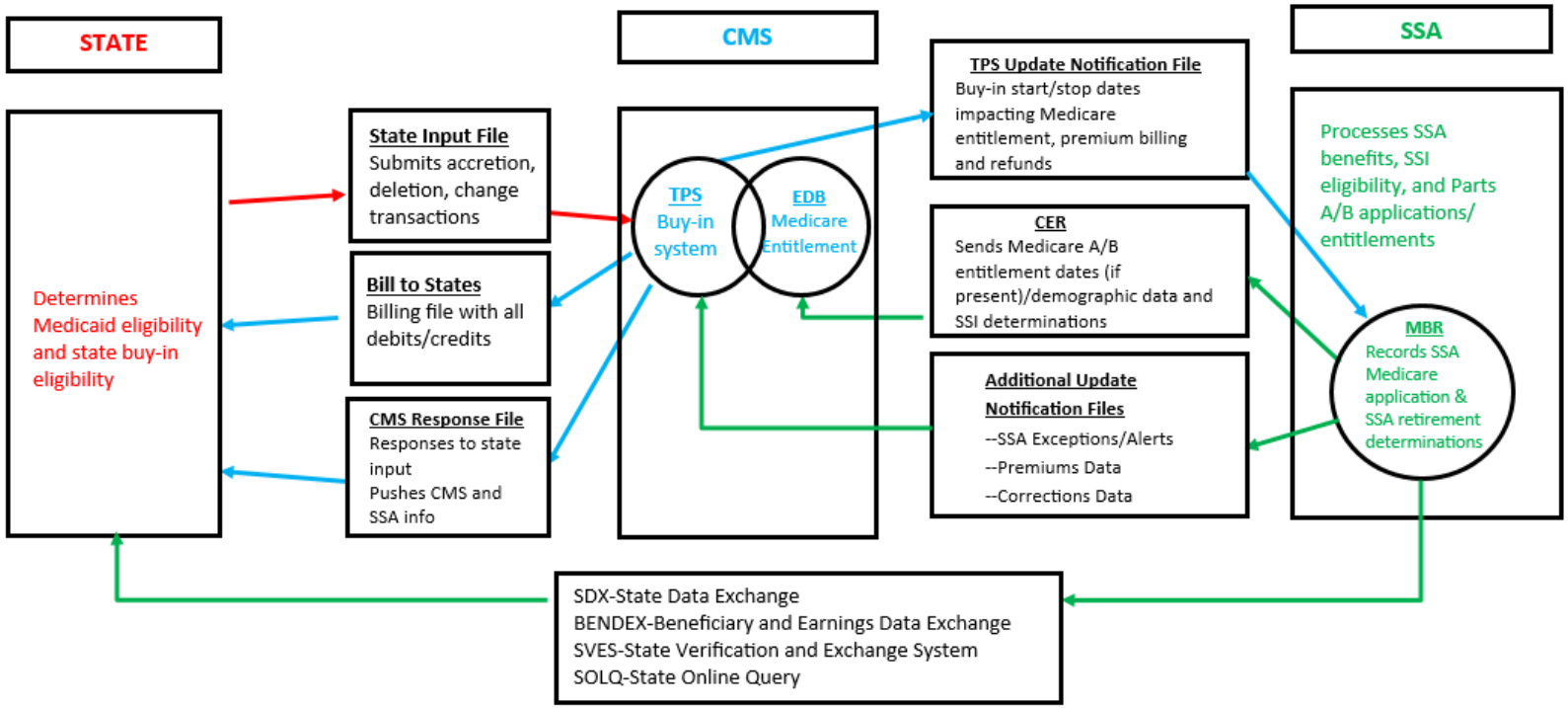
[26] As a courtesy to states, CMS provides links to the SSA POMS and other online SSA materials as of the time the manual was published. Changes may occur after release. For more information visit ssa.gov.

This daily exchange may trigger updates in either or both systems concerning buy-in enrollment, Medicare enrollment, and premium billing. States also rely on Medicare enrollment, SSA benefits, and demographic information from SSA systems to determine eligibility for Medicaid categories[27] included in the state's buy-in coverage group, among other things.

[27] 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.

Table 2.1 High-Level Overview of the State Buy-in Data Exchange



Glossary of Abbreviations

- **TPS** – Third Party System
- **EDB** – Enrollment Database
- **CER** – Combined Exchange Record
- **MBR** – Master Beneficiary Record
- **SDX** – State Data Exchange (Batch data from SSA)
- **BENDEX** – Beneficiary and Earnings Data Exchange (Batch response from SSA)
- **SVES** – State Verification and Exchange System (Batch)
- **SOLQ** – State Online Query (Individual query)

2.2 STATE BUY-IN DATA EXCHANGE WITH CMS

2.2.1 State Input

Each state must submit buy-in transactions to TPS (input files) for updating the EDB 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. The beneficiary record also identifies 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 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, the CMS file may "push" new updates obtained from SSA to the state, for example, 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, however, CMS will return only the HICN on state buy-in response files.

States must send buy-in files to TPS on at least a monthly basis, but **can elect to send files as frequently as each business day.**

CMS strongly encourages states to submit buy-in transactions to TPS on a daily basis to promote administrative efficiencies and allow beneficiaries to more quickly enroll in Medicare Parts A or B, or stop paying Medicare premiums if they are already enrolled and had been paying them on their own.

All states, regardless of their data exchange election, may submit buy-in input files to TPS as needed (e.g., monthly, weekly, or daily). See chapter 3 for further details on CMS/state data exchange.

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

All states receive Part A and Part B monthly billing files from CMS (CMS Billing Files) containing all new and ongoing credit/debit billing records. States that opt to receive **only** monthly exchange from CMS will find all response records in addition to billing records in these monthly files. Response records are based on state, CMS and SSA information received through the last business day of the month. States may opt to receive Part A and Part B daily response files (CMS Reply Files) from CMS each business day. Response files contain all response

records based on state, CMS, and SSA information received through the last business day of the month. For daily exchange states, daily response files, containing only response records, are sent in addition to monthly billing files containing only credit/debit records. **CMS strongly encourages states to opt to receive response files from TPS on a daily basis to promote administrative efficiencies.**

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 the Third Party System.

The CMS response records for state accretions and deletions will be one of the following types:

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

The TPS responses are differentiated by a Record Identification Code (RIC) value between A and F, each identifying a type of response. Chapter 3 contains a detailed description of the format for each RIC included on Daily Reply Files and Monthly Billing Files.

2.3 DATA EXCHANGE BETWEEN CMS AND SSA

In addition to state and CMS data exchanges, the Combined Exchange Record (CER) file daily exchange process between CMS and SSA eligibility systems also supports buy-in program operations.

Through CER file processing, CMS updates SSA regarding state liability for Medicare premiums and billing liability and receives from SSA Medicare Parts A or B enrollment dates and demographic data. Once the CMS TPS completes its daily update of the CMS EDB to reflect new state accretions, deletions, and changes, the CMS TPS also sends these update notifications to the SSA Master Beneficiary Record (MBR). CMS does so through its daily TPS Update Notification File transmission to SSA. If SSA systems receive and accept the records, the SSA 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). The SSA MBR then returns an updated or new entitlement CER to the CMS EDB, which in turn updates the entitlement record

In addition to state-initiated buy-in transactions, SSA may initiate buy-in actions, which CMS "forwards" to states. When the SSA MBR is updated to reflect new or modified beneficiary information received by other parts of SSA, the SSA MBR shares these updates with the CMS EDB. For example, once SSA makes an SSI determination, the SSA MBR will share this information with the CMS EDB, and the CMS 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 a buy-in transaction does not process through SSA's automated process, Medicare entitlement will not update to the MBR. In these instances, SSA systems will generate a processing limitation (exception) or return an update deletion record to CMS. Both instances will require administrative action by CMS and/or SSA, with related manual action 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, but the beneficiary record does not yet show Medicare entitlement and/or may show the premium liability amounts (if the record shows SSA deduction or direct billing status). Premiums continue to be paid the enrollee (due to individual's enrollment in Medicare). If any of these situations are identified, the state should submit a resolution requests to CMS' DMSEI for assistance (see section 6.2).

2.4 SSA DATA SYSTEMS FOR STATES

The TPS pushes SSA updates to states, but states can also leverage SSA systems data to support their Medicaid and buy-in operations. See SSA POMS GN 03314.155.

2.4.1 State Verification & Exchange System (SVES)

SVES is a batch query system that provides states and some federal agencies with a standardized method of Social Security Number (SSN) verification and uniform data response for Social Security Retirement, Survivors or Disability Insurance ((OASDI) Title 2 of the Social Security Act (the Act)) and SSI (Title 16 of the Act). SVES also allows states to request information from other SSA exchange systems external to SVES (e.g., Beneficiary & 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 those requests to the

proper applications (e.g., BENDEX, SDX) for processing. For more details, please see SSA's State Verification & Exchange System (SVES) and State Online Query (SOLQ) Manual.

2.4.2 State Online Query (SOLQ)

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 & Exchange System (SVES) and State Online Query (SOLQ) Manual.

2.4.3 Beneficiary & Earnings Data Exchange (BENDEX)

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 state direct input or as a by-product of a state buy-in action.

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

For more details, please see the SSA's list of BENDEX data elements on ssa.gov.

2.4.4 State Data Exchange (SDX)

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 the 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, please see the SDX record data elements.

2.5 ACCRETIONS

2.5.1 Part B Buy-in Accretions

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 Part B application and appear to qualify for Part B buy-in. See section 2.8.

2.5.1.1 Part B Buy-In for Cash-Related Recipients (SSI/SSPs)

SSA explores Medicare eligibility for all SSI (including federally-administered SSPs) applicants.[28]

Through the daily CER 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 identifies current SSI (and federally-administered SSP) recipients for Medicare screening as they approach their 65th birthday. These individuals:

  - Must be within 3 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,

[28] 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.). SI 00601.060.D.2.i.

- 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 5 years.

See SSA POMS HI 00810.010.

- 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 their State Supplementary Payment (SSP)

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

The effective date of the accretion will generally be the first month the individual is entitled to SSI (and/or a federally-administered SSP), and entitled to Medicare and a resident of the state.[29] Auto-accretions are made at any time of the year, without regard to Medicare Enrollment Periods or premium increases for late enrollment.

See the relevant QMB provisions at POMS HI 00801.139.

> **Systems Tip:** CMS notifies states of Part B auto-accretions with transaction **code 1180** in the Billing File (RIC B) sent to states (and in the daily reply files in a state that elects to receive the CMS files daily). 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-enrolls SSI (federally-administered SSP) recipients in Part B buy-in auto-accrete states, auto-accretion may omit SSI beneficiaries in limited instances. States should review SSA records (i.e., SDX) to identify SSI recipients and other covered members are accreted, and submit needed transactions to

[29] 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 states equitable relief from the imposition of retroactive Part B premiums in certain instances involving lengthy delays in Medicare eligibility determinations that to the extent that such delays would result in retroactive auto-accretions for that would cover periods for which it is too late for the state to obtain the benefits of Medicare coverage.

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 Public Welfare (PW) accretion during the initial Medicare development process when an individual files a new Part B application. See HI 00815.030 and section 2.8 for more information about PW accretions.

2.5.1.1.2 Alert States

Alert states are responsible for accreting all SSI (including SSP) 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's notified by SSA that the SSI individual may be eligible for a buy-in coverage group. States can also use information transmitted through SSA systems (i.e., SDX) 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/SSP effective date. Part B auto-accretions (Code 80) are processed daily and will establish Medicare entitlement without regard to Medicare enrollment periods or premium increases for late enrollment. Once the TPS shares the new accretion record with MBR, the MBR will update the Medicare entitlement record.

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

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 section 1.13 and Appendix 1.B. 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 the TPS share 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 Appendix 1.B for more information about the effective date of buy-in for QMB.

Systems Tip: Common codes used by states

- **Code 61** - state accretion action
- **Code 63** - identical to **code 61** but available for use by the state for special accretion actions or for monitoring specific coverage groups
- **Code 84** - 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 the SDX file

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

2.5.2 Part A Buy-in Accretions

States may accrete QMB-eligible beneficiaries to their Part A buy-in rolls through a buy-in agreement or a group payer arrangement. Residents of Part A buy-in states are not required to complete a separate application for Part A. Part A states may enroll individuals in Medicare Part A throughout the year and without regard to premium surcharges.

States that opted out of covering premiums for Part A in their buy-in agreements, called group payer states, pay the Part A premium for QMBs through the group payer arrangement. Residents of in these group payer states are required to complete a Medicare Part A application at SSA during the General Enrollment Period (GEP). (See section 1.11 on conditional enrollment, and important rules for QMB accretions in section 2.5.3). Group payer states are also responsible for paying applicable surcharges for late enrollments.

For a QDWI, states may cover premiums for enrollment in Medicare Part A only; however, the individuals must be enrolled in payable Part A and Part B prior to the state accreting the record to their buy-in account.

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

2.5.3 Important Processing Rules for QMB (MSP) Accretions

2.5.3.1 Required Steps For QMB, SLMB and QI Part B Buy-in Accretions

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 state accretion.

The state can add the appropriate BIEC to the billing record by using the code 99, update process. States are encouraged to verify Medicare Part A and Part B entitlements are present on the record in addition to Part B Buy-in before submitting the code 99. A code 99 action will always update prospectively. States are encouraged to verify entitlement dates for Medicare Part A and Part B are present on the EDB in addition to open Part B coverage prior to submitting the Code 99 to update the BIEC identifier. A code 99 update is always effective prospectively, effective with the billing month. A BIEC cannot be changed for a past period through the buy-in data exchange.

CMS will return a Part A or Part B code 21** Series Rejection, or subcode C update rejection record in reply to state's accretion requests when if buy-BIEC

identifier is submitted in a state's accretion record if beneficiary's record does not meet the reflect Part A and Part B entitlements and open Part B Buy-in. in the previous paragraph. See chapter 3 for explanation of code 21** rejection series for state accretion requests.

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, the separate full Medicaid coverage may be effective up to three months before the month of application, even though their QMB coverage is prospective. See section 1.14.1. TPS will accept retroactive start dates for the B Buy-in accretion as long as the BEIC identifier in the transaction is blank.

2.5.3.2 Part B Before Part A Rule

The TPS will not accept a state's request for **Part A** accretion unless open the EDB shows current Medicare Part A and **Part B** entitlement and open buy-in coverage is present on the record. 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 can submit Part A and Part B accretions simultaneously in the same month or first submit Part B then Part A accretion transactions separately. The exception to this rule applies to QDWI for which the state only pays premiums for Part A.

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

2.5.3.3 Buy-in Can Be Used to Establish Medicare Enrollment

A primary function of the state buy-in process is to enroll or re-enroll individuals in Medicare Part A and/or Part B, without the individual needing to file a separate Medicare Part A application. States will enroll or re-enroll QMBs in Part B through a Part B buy-in accretion if the individual is already enrolled in Part A. Part A buy-in states will enroll or re-enroll QMBs in Part A through a Part A buy-in accretion if the individual is already enrolled in Part B. In these instances, states should not send the individual to SSA for a separate Medicare determination.

NOTE: Group payer states cannot enroll or re-enroll QMBs in Part A unless the individual has completed a Medicare Part A "conditional application" or is already enrolled in Part A; the Part A entitlement start date must be present on the CMS EDB first going. Individuals may enroll in Part A and pay their premiums or can submit a "conditional" application. A signed statement by

the individual is required to say, “I only want Part A if the state pays the premiums”. The code Z99 on the MBR represents “conditional” enrollment. The effective date associated with the code z99 is the earliest date the state can accrete Part A**.**

2.5.3.4 Part A Buy-in State v. Group Payer State Status

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.. As mentioned above, 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 or 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 can 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 GEP (January through March; coverage will be effective 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.

See section 1.12 for more information.

2.5.4 CMS Adjustment of State Accretion Effective Date to Coincide with Medicare Enrollment

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

Systems Tip: The state will receive two response records as a result of the adjustment to the state submitted start date. The first record will be a **code 30XX** that contains the effective date as submitted by the state. The second record will contain the adjusted effective date that corresponds to the individual's Medicare enrollment date. The transaction code in this record can be any one of the possible response 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 response records for this situation. The first record will be a **code 30XX**. This record will contain the state buy-in effective date 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

2.6.1 State-Initiated Deletions

2.6.1.1 Medicare Parts A and B Deletions Based on Loss of Buy-in Coverage

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 section 2.1.6.3 for guidance on how the end date is applied for a state deletion request.

Systems Tip: states use the following codes to delete a record from the state's account:

- **Code 51** - state deletion record for a beneficiary who is no longer a member of the state's coverage group.

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 2.8 for information about state deletions for PW accretions.

2.6.1.2 Special Procedures for An Individual Who Loses SSI

If a beneficiary loses SSI, a state must conduct a Medicaid redetermination to assess whether or not the individual qualifies for Medicaid coverage on another basis, including categories included in 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. 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 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 re-determination 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 (as 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

CMS will evaluate the requested stop date of all state deletion requests for Part B (code 51) based on loss of coverage group membership (does not apply to **code 50** or **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 **(code 51)** 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[30].

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 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[31] COM ran from July 27 through August 23. The September 2018 COM ran from August 24 through September 25.

  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) every business day. TPS daily processing will never start before 11:00 a.m. Files received before daily processing begins (usually 11:00 a.m.) will be processed the same day. Processing may be delayed on rare

[30] 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 431.210-214.

[31] Please note: these dates are specific to 2018, and provided as illustrative examples. The specific dates will vary by calendar year.

occasions. Files received after daily processing begins (usually 11:00 a.m. ET) will be processed in the next scheduled TPS daily run.

Example: State **code 51** deletion requests are received in the calendar month of August. The TPS August COM is from July 26 through August 22, and the TPS September COM is from. August 23 through September 24. TPS processing starts at 11:00 a.m. ET.

State **code 51** deletion requests received by the TPS in August 2018 prior to 11:00 a.m. ET on the 22nd 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. (e.g., if the state requested an effective date of April, the 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.[32]

- State **code 51** deletion requests processed by the TPS on or after August 23 (regardless of the time of day), will have a processing month of September and may have an effective deletion date no earlier than July 2018. If the state requested an effective date prior to July, the TPS automatically adjusted the deletion date, processing it as July (e.g., if the state requested an effective date of April, the TPS automatically adjusted the effective date to July). The state remained liable for billing prior to and including July 2018. 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.

[32] Please 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.

COM	Processing Dates	Earliest Deletion Date
August 2019	July 26 through August 22	June 2019
September 2019	August 23 through September 24	July 2019

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

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 will be 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 am ET on the 31st may have an effective deletion date no earlier than August. If the state requested an effective date prior to August, CMS adjusted the deletion date, processing it as August (e.g., if the state requested an effective date of July, the TPS automatically adjusted the effective date to August). The state remained liable for billing prior to and including August. CMS refunded the state for any premiums already billed for September (CMS bills one month prospectively) and the beneficiary became liable for that month.

  State Part A deletion requests received in August after 11:00 am 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 requested an effective date prior to September, the TPS automatically adjusted the deletion date, processing it as September (e.g., if the state requested an effective date of August, the TPS automatically adjusted the effective date to September). The state remained liable for billing prior to and including September. CMS refunded the state for any premiums already billed for October (CMS bills one month prospectively) and the beneficiary became liable for that month.

Calendar Month	Deletion Process Date	Deletion Date
September 2019	September 27, 2019	September 2019
September 2019	*September 30, 2019	October 2019

*assume this is the last business day of the month

2.6.2 CMS-Initiated Deletions

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

2.6.2.1 Death of the Beneficiary

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 trigger an update to the EDB, then to the TPS for the purpose of ending buy-in coverage. CMS will delete the beneficiary from buy-in effective with 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 received 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 reply files in a daily exchange state). The month and year of death reported by SSA are shown in the transaction effective date field.

NOTE: There are instances in which SSA will send a death notification in error. In these cases, the state should inform the beneficiary and request proof of identity to SSA. The state may re-accrete the beneficiary to the buy-in rolls through the normal data exchange after ensuring SSA removed the date of death from the MBR.

2.6.2.2 Beneficiary's Loss of Medicare Eligibility

In the course of reviewing its files of beneficiaries eligible for Medicare, SSA may determine that a beneficiary no longer meets all requirements for Medicare. Medicare entitlement can end 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 receives Medicare termination notification in the CER file exchange from SSA, which will trigger an update to EDB, then to TPS, for the purpose of ending buy-in coverage. The end date associated with the deletion transaction will be the last month and year prior to Medicare termination. Notifications are received in the CER file exchange.

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

2.6.2.3 Beneficiary Changes of State of Residency

Membership in a buy-in coverage group is premised on 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

If a beneficiary is enrolled in buy-in in one state and CMS receives an accretion action from another state for the same beneficiary, CMS assumes that the state which submits the latest accretion action is the state with 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 will reflect 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. The state associated with the new accretion request is reflected in this record.

2.6.2.5 Change of State Residence for SSI Recipients

When an SSI beneficiary moves to another state, SSA will process a change of a state residency action to update the SSI record and the MBD, which in turn transmits this information to the EDB to update the beneficiary's record. The change of **residency** update in EDB will trigger:

- CMS deletion of the individual from the "former" auto-accrete state's account. The deletion (code 1728) effective date will be the last month of residency in the "former" state.

- CMS will auto-accrete Part B to the "new" state's account, if the beneficiary moved from one auto-accrete state to another auto-accrete

state. The effective date of the accretion will be the first continuous period of SSI entitlement. If the SSI record received by CMS in the data exchange with SSA reflects earlier SSI coverage for the same state, the code 1180 will be followed by the sub code A. Sub code A alerts the state that it will also receive a RIC A record with the complete SSI data.

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

  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 which submitted the new accretion in order to resolve jurisdictional issues.

  Systems Tip: CMS will notify the "former" state of the deletion with a **code 1728** transaction. The deletion date will be the individual's last month of residency in the "former" state. The new state of residency, which can be an alert state or auto-accrete state, will receive either an SSI alert record **(code 86)** or an SSI accretion record **(code 1180)** if SSI entitlement continues.

  NOTE: The state with jurisdiction over the record should conduct a Medicaid redetermination to verify continued eligibility upon receipt of the deletion transaction from CMS. If the beneficiary no longer resides in the state, the state should ensure that Medicaid is closed 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 state which submitted the latest accretion in order to determine which state is responsible for the beneficiary's Medicaid eligibility record.

2.6.2.6 Beneficiary Becomes Entitled to Reduced or Premium-Free Part A

Part A buy-in will terminate when an individual obtains enough Social Security quarters to qualify for Premium-free Part A (either through their individual or spousal'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 in the CER file exchange daily. Once EDB updates the new entitlement record, TPS will trigger the appropriate action(s).

In cases where Premium-Part A is changed to a reduced premium liability 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, TPS will generate a deletion to the state's account to stop billing for Part A. The deletion date in both instances will always reflect 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

CMS may be notified outside of the normal data exchange that a manual deletion action is required. Deletion notifications are generally submitted to CMS by the SSA FO on the Form CMS-1957 "*SSO Report of State Buy-in Problem*," or form SSA-5002-HB, *Report of Contact*, or by the state. SSA sends these requests to CMS based on contact with the beneficiary. Action requests are due to change in residency or change in SSI entitlement.

When a request is submitted to the Division of Medicare Systems Exceptions and Inquiries (DMSEI; formerly Division of Ombudsman Exceptions (DOE), one of the following actions will be taken.

- If the form was not signed by the state, DMSEI will forward the deletion request directly to the state for processing.

- If the form is signed by the state or an authorized state contractor, DMSEI will process the deletion. Deletion actions processed by CMS will be identified in the state's billing file with **code 1759** (general deletion action) or **code 50** (special deletion record).

2.7 CHANGES AND CORRECTIONS

2.7.1 State Correction of a Previously Submitted State Accretion or Deletion Date on a TPS

2.7.1.1 Adjustment to the Start Date – for Ongoing (code 41) Billing Items

- 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: A **code 61** to adjust a period to an earlier date should be used with caution - only when the earlier date/period is contiguous with the current period.

- The state will receive a **code 4361, 4363, or 4384** which informs the state that an earlier period of state buy-in coverage, brought about by a retroactive state accretion, has been established. If ongoing coverage is established, the state will receive a **code 1161, 1163, or 1184**.

- The state may not adjust an accretion date to a later date. This would disadvantage the beneficiary. The item will be rejected with a **code 2561,** duplicate accretion action.

2.7.1.2 Adjustment of Accretion or Deletion Date - Closed Period of State Buy-in Coverage

- The state may undertake a simultaneous accretion/deletion action to establish a closed period of state buy-in coverage in addition to the coverage already on the master record. The simultaneous accretion/deletion action may be accomplished only by using a **code 75**. The closed period request will be acknowledged in the data exchange with a response **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 already established on the EDB, the state will receive 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 deletion date for a closed period may be adjusted to an earlier date; for Part B, this may be no earlier than 2 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) of the SSA MBR does not agree with the date of death on a 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.

The state will be notified in the regular data exchange of an adjustment action which 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. This adjustment was made because CMS accreted the beneficiary with an incorrect 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. This adjustment was made because CMS deleted the record with 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. This adjustment was made because CMS accreted the individual with an incorrect 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. The adjustment was made because CMS deleted the record with an incorrect deletion date.

2.7.2 State Request for Adjustment of SSI Actions Accreted by CMS

An auto-accrete state may identify items on its state buy-in account which do not agree with state records or the State Data Exchange (SDX).

Potential discrepancies between the EDB records and the state records or the SDX are:

- The record was newly auto-accreted to the state's buy-in account (code 1180) or billing record shows ongoing (**code 41)** and there is no record of the individual on the state's SDX;
- The individual is age 65 or older and is on the state's SDX record in an accrete state and there is no record of the individual on the state buy-in file; or
- The effective date of the CMS-initiated accretion and the effective date of SSI eligibility differs.

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

- The beneficiary was not eligible for health insurance at the time of SSI eligibility;
- The beneficiary changed legal residence after she or he 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 cases needing buy-in resolution.

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

- Buy-in coverage 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) due to 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

2.7.3.1 Medicare Part B

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

- A **code 99** can be used to add or change the individual's BIEC. The **code 99** update will be effective with the next billing cycle.
- A **code 99** submission with blanks in positions 71-72 **will not** eliminate an existing BIEC in the billing record.
- A **code 99** can be used to add or change a state welfare identification number. The **code 99** cannot be used to delete an existing state welfare identification number.
- A **code 99** 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 EDB TPS record (e.g., **code 41**).

2.7.3.2 Medicare Part A

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

The transaction code for the change record is 99. A **code 99** can only be applied to an open EDB TPS record (e.g., **code 41**).

2.7.4 CMS Response to a State-Initiated Change Record (Code 99)

State change records **(code 99)** are applied to existing open coverage billing records **(code 41)** if the change record matches the existing EDB record on Medicare number and state agency code. The change record will only be applied to an open coverage record. The state will not receive a response if the action is applied. If the change record does not match an existing TPS record on Medicare number and state Agency Code, CMS will reject the change record with the transaction **code 4999**.

If the state submits a Part B **code 99** with a BIEC of "L" (SLMB), "P" (QMB), 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 response **code 4999**.

2.8 SSA-INITIATED ACCRETIONS--PUBLIC WELFARE ACCRETION PROCEDURE (CODE 1167)

The Public Welfare (PW) accretion procedure is initiated by the SSA FO (and passed on to states by CMS) 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 section 1.5 for a list of state buy-in coverage groups. The purpose of the PW procedure is to establish Medicare Part B for the individual via state buy-in without any Part B premiums being deducted from the individual's check or the individual being placed in direct billing status for any period for which the state should pay the premium. SSA FOs may initiate a PW accretion at any time, not just during the Initial Enrollment Period or the GEP.

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 one of those groups before initiating a PW accretion.

Note: SSA FOs can use PW accretions for state buy-in coverage group individuals in alert states and for all individuals who do not receive SSI or a federally-administered

supplement in auto-accrete states. In auto-accrete states, individuals who receive SSI or a federally-administered state supplement are automatically determined eligible for Medicaid by SSA and accreted by CMS to Part B buy-in. In the event that CMS auto-accretion does not occur for an SSI recipient in an auto-accrete state, FOs can initiate a PW accretion for the individual. Instructions for processing of PW accretions requirements in auto-accrete states are in sections 2.8 and 2.9 below.

> **Systems Tip:** After SSA has established an MBR record for a beneficiary, SSA will transmit a PW accretion to CMS. CMS will use **code 1167** to accrete the individual to Part B buy-in in that state. If the individual is SSI-eligible, the state will receive either an SSI alert record **(code 86)** in auto-accrete state or an SSI accretion record **(code 1180)** in an alert state.

Chapter 3 describes the record format and provides an explanation of the data fields for the **code 1167** accretion. The state will receive a RIC B and possibly a RIC D record on this beneficiary.

2.9 ERRONEOUS PW ACCRETION - ALL STATES

If the state determines that a PW accretion **(code 1167)** was processed in error, 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 **(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 2 billing months, i.e., must be received by CMS prior to 11:00A.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, submit a **code 50** to CMS in the state's input file within the established timeframe. Include the information specified below in your request.
>
> - **Code 51** – state should submit a deletion request if the effective date of the PW accretion is correct and the state has determined the individual is not eligible for buy-in coverage. Code 51 deletions remain subject to the limitations of the Commissioner's Decision.
>
> - **Code 50** – state should submit a deletion or "wipe-out" action if the accretion date is incorrect or the PW was processed in error. Code 50 deletions submitted within the prescribed time frame (2 billing months)

are not subject to the limitations of the Commissioner's Decision.

Systems Tip: Code 75 may be used to establish a closed-period of buy-in coverage record.

CMS will process multiple transactions, e.g., code 61 and code 75 for the same individual if received in the same file. A deletion record should always precede a state accretion record **(code 61, code 63, or code 84)**.

2.10 PUBLIC WELFARE ACCRETION - AUTO-ACCRETE STATES

When a PW accretion is received by an auto-accrete state, the accretion should be for a non-cash recipient; i.e., a member of the state's Medical Assistance Only (MAO) coverage group. It is possible, however, that the PW can be for a cash-assistance (SSI) recipient whom CMS should have accreted to the buy-in as an auto-accretion action.

Auto-accrete states should compare all PW actions to the appropriate SDX file to identify those which should have been auto-accreted based on their SSI status. The chart below should be followed by all auto-accrete states to determine the proper notification procedure for resolution of PW issues. When using this chart, auto-accrete states should consider the following points when determining the validity of a PW especially if the individual is receiving SSI and the effective date of buy-in is earlier than the SSI entitlement date:

- If SSI is involved, the state can examine the SDX record for evidence of TANF eligibility and verify receipt by review of the TANF file.
- If the state buy-in agreement includes "MAO," the PW effective date could be related to state medical assistance eligibility prior to receipt of SSI benefits. The state should examine its Medicaid records to verify the initial date of Medicaid eligibility.

2.11 ENROLLMENT OF PERSONS WHO REFUSE TO ESTABLISH MEDICARE ELIGIBILITY

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 for 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 proofs to the FO which services the individual's address.

Note: Some FOs use Form CMS-18F, "Application for Hospital Insurance" for all Medicare applications and do not stock Form CMS-4040. Form CMS-18F may be used to enroll for Medicare Part B.

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 Health Insurance card will be mailed; and

- The beneficiary's Medicare number. If the individual does not have a Medicare number, contact the local FO for assistance in obtaining a Medicare number 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.

In addition to completing the application the **state must submit proofs to substantiate the application**. These proofs include:

- 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.

The SSA makes the final determination of Medicare entitlement. After the SSA has established the Medicare record, the individual will be accreted to state buy-in through the PW procedure. The accretion **code is 1167.**

2.12 STATE ACCRETION PROCEDURE TO ESTABLISH A CLOSED PERIOD OF STATE BUY-IN COVERAGE

2.12.1 Medicare Part B

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.

For 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 submit 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 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 CMS EDB, it is automatically rejected.

2.12.2 Medicare Part A

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 put on the Part A rolls. 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 DSMEI (see chapter 6).

APPENDIX 2.A RESOLUTION OF PUBLIC WELFARE RECORDS RECEIVED BY AUTO-ACCRETE STATES

Related SDX	Current Pay Status	CN in Unearned Income Field	PW buy-in Date	Disposition
No	---	---	---	SSI not involved. Handle in accordance with procedures outlined in section 2.10.
Yes	No	---	---	SSI not involved. Handle in accordance with procedures outlined in section 2.10.
Yes	Yes	Yes	Yes	A code 1180 will usually follow a PW accretion in a subsequent billing month.
Yes	Yes	Yes	No	If the PW effective date is **later** than the SSI entitlement date, submit a **code 75** accretion to update a prior buy-in period. If the PW effective date is **earlier** than the SSI entitlement date, submit a **code 50** to remove the PW accretion. If the beneficiary has current buy-in coverage, submit a state accretion with the correct start date. If the beneficiary was eligible for coverage for a limited period, submit a **code 75** accretion.
Yes	Yes	No	Yes	Notify the SSA FO of the omission of the individual's Medicare number in the SSI record. If a **code 1180** action is not received within 60 days after initial notification, re-examine the SDX record to confirm SSA FO input of the claim number. If the unearned income field does not contain this number, submit a second request to the responsible SSA FO.
Yes	Yes	No	No	If the PW date is **later** than the SSI entitlement date, notify the FO of the omission of the individual's claim number in the SSI record. If a **code 1180** action is not received within 60 days after initial notification, reexamine the SDX record to confirm FO input of the claim number. If the PW effective date is **earlier** than the SSI entitlement date, notify the RO that the individual's Medicaid eligibility prior to receipt of SSI payments

Related SDX	Current Pay Status	CN in Unearned Income Field	PW buy-in Date	Disposition
				submit a **code 50** and a state accretion with the correct buy-in start date.
Yes	Yes	Yes	No	If the PW effective date is **later** than the SSI entitlement date, submit a **code 75** accretion to update a prior buy-in period. If the PW effective date is **earlier** than the SSI entitlement date, submit a **code 50** to remove the PW accretion. If the beneficiary has current buy-in coverage, submit a state accretion with the correct start date. If the beneficiary was eligible for coverage for a limited period, submit a **code 75** accretion.
99				This code is used by the state to add or update the buy-in eligibility code or the welfare identification number on an existing buy-in record on the TPS.

CHAPTER 3 STATE INPUT AND CMS RESPONSE FILE FORMATS

3.0 INTRODUCTION

This chapter includes the formats for both state input files submitted to CMS and CMS response files to states.

Special procedures have been developed for buy-in exchange for U.S. territories. See chapter 7 for more information.

3.1 STATE INPUT

The state must submit files via an electronic file transmission (EFT) exchange setup, i.e., Connect:Direct, Cyberfusion, or a CMS secure internet exchange (GenTran or Tibco). The state input files containing the state buy-in accretion, deletion, and change records must be received by 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 assumes that the state is not 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

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 billing files via its established EFT method.

The content of the monthly billing files depends on whether a state is receiving only monthly billing files or has elected to receive daily reply files in addition to the monthly billing files.

- For states electing to receive daily reply files in addition to the monthly billing files, their daily reply 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. These records are described by the Part A and Part B RIC response record layouts below.

- For states receiving only monthly billing files, these files contain all RIC type records: A, B, C, D, E, and F. These records are described by the Part A and Part B RIC response record layouts in chapter 3 of this manual.

**For the most up-to-date buy-in eligibility, enrollment, and billing information, CMS recommends that states accept daily reply files. This will help to address errors sooner and minimize burden on the beneficiary.

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

- The Summary Accounting Statement (SAS) (see Appendix 5.C) provides an analysis of the state's Medicare premium liability as of the most recent state buy-in update. An explanation of each item on the SAS is contained in section 5.2.
- The Listed Agency Billing (LAB), an agency totals sheet, is a summary of selected state buy-in transaction codes contained on the agency's billing file (see Appendix 5.D).

The monthly billing file will typically arrive 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 DPBC/AMG/OFM so that CMS may initiate another transmission of the state's billing files (see section 6.1.1 for contact information).

The SAS and related documents are mailed out 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 CMS CO staff within DPBC/AMG/OFM so that duplicate documents may be mailed.

3.3 DATA EXCHANGE FILES–STATES TO CMS

3.3.1 State Agency Buy-in Exchange Header Record

The state buy-in File Header Record is appended as the first record on all monthly submitted state transaction request 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

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

3.3.2 State Agency Buy-in Exchange Input File

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, commonly referred to as the RRB claim number. 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 HICN on state buy-in response files.
2	Surname	24	13 - 36	Alpha-Numeric	MANDATORY: Enter a maximum of twenty-four alpha-numeric characters. Leave blank any position that contains a blank as a normal part of a compound surname. Separate designations such as Jr, Sr, II, or III

Item	Field	Size	Position	Format	Description
					from the surname with a single blank space. Special characters such as the apostrophe and hyphen are acceptable as part of the surname, however, remove any period and leave that position blank.
3	Given Name	15	37 - 51	Alpha-Numeric	MANDATORY: Enter a maximum of fifteen alpha-numeric characters. Apply the same format considerations as applies to the surname. Leave blank any positions that are not required.
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, 1909 as 19091101.
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	For Part B records only; if the state submits a Part A BIEC, it is recorded in CMS Part A database

Item	Field	Size	Position	Format	Description
					records, but is never used by CMS nor returned to the state in any Part A response. Enter, in position 71, 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	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 a 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 are not acceptable.

3.3.3 State Buy-in Exchange Trailer Record

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

Item	Field	Size	Position	Format	Description
1	Filler	72	1-72		Positions reserved for future use.
2	Agency Code	3	73-75	Alpha-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 2 months to the current calendar month in which the file is being created.
6	Filler	1	88		Position reserved for future use.

Item	Field	Size	Position	Format	Description
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 7 positions; i.e., 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.

3.4 MATCHING STATE INPUT RECORDS TO THE CMS ENROLLMENT DATABASE (EDB)

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 Medicare number.

Note: The EDB does not maintain a record of conditional Part A enrollment. Conditional Part A enrollments are maintained internally by CMS as informational records in the TPS.

3.4.1 Third Party Transaction Matching Criteria

In order for the CMS Third Party System 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 Alpha-Numeric Characters** - All alpha-numeric characters must be capitalized or matching criteria will fail.

- **Medicare Number** - Nine-position SSN (or alpha-numeric number if beneficiary is entitled under a RRB number) followed by a one or two-position alpha-numeric Beneficiary Identification Code (BIC). This is

referred to as a HICN, or health insurance claim number. An accretion record for an RRB beneficiary may be submitted with an unconverted RRB number. 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 HICN on state buy-in response files.

- **Surname** - 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. Special characters, specifically an apostrophe or hyphen, will not cause matching criteria to fail; periods, however, are not acceptable.

  Example: FOX JR

- **First Name** - First three positions.

- **Date of Birth** - An eight position date of birth is required, yyyymmdd. Although the first six positions for 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.

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, a match is also required on the following set of personal characteristics:
  - the first 6 characters of the surname;
  - the first 3 characters of the first name; and
  - the month and year of birth.

  If an equitable match is found on claim number but the request fails to match this set of EDB personal characteristics, the request is rejected and returned to the agency.
- If the transaction matches the EDB on claim number and personal characteristics using the above criteria but there is still some 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, but an additional record (RIC E) with the EDB personal characteristics is returned to the agency. It is recommended that the state update their beneficiary record with the personal characteristics from this record and use these new EDB personal characteristics in subsequent transactions.

3.5 DATA EXCHANGE FILES - CMS TO STATES

3.5.1 CMS/TPS Buy-in Exchange Header Record

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 or Numeric	The three-position alpha-numeric or numeric code 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.

Item	Field	Size	Position	Format	Description
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)

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 beneficiary identification code (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.
2	Surname	24	13-36	Alpha-Numeric	A maximum of twenty-four alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.

Item	Field	Size	Position	Format	Description
3	Given Name	15	37-51	Alphabetic	A maximum of fifteen 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 alpha 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, 1909 will be displayed as 19091101. 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	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 numeric code that is based on the state code which appears

Item	Field	Size	Position	Format	Description
					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.
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 attained age 65 or 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

Item	Field	Size	Position	Format	Description
					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, that 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.
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, if known.

3.5.3 Part A State Agency Billing Record (RIC B)

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 beneficiary identification code (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 response.
2	Surname	24	13-36	Alpha-Numeric	A maximum of twenty-four 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 fifteen 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 alpha 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, 1909 will be displayed as 19091101. 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	The presence of a "1" in this position means that the reduced Part A premium rate applies; otherwise, it is blank.
9	Part A Premium Surcharge Indicator	1	72	Numeric	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.
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

Item	Field	Size	Position	Format	Description
					two positions reflect the type of action taken by CMS, e.g., accretion, deletion, 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 if a code 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.
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.

Item	Field	Size	Position	Format	Description
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.
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.

Item	Field	Size	Position	Format	Description
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.
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 responses 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.

Item	Field	Size	Position	Format	Description
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)

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 beneficiary identification code (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 response.
2	Surname	24	13-36	Alpha-Numeric	A maximum of twenty-four 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 fifteen alphabetic characters. The name will match the given name on the EDB. Any

Item	Field	Size	Position	Format	Description
					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 alpha 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, 1909 will be displayed as 19091101. 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. 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 "B"	1	76	Alphabetic	"B" constant. The "B" identifies this record as a billing record.
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, 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 if 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.
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

Item	Field	Size	Position	Format	Description
					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.
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.

Item	Field	Size	Position	Format	Description
17	Current Monthly Premium Rate ($$$$¢¢)	6	108-113	Numeric	A six-position numeric field with leading zeroes which contains the current monthly Part B Medicare premium rate.
18	Reduced Monthly Premium Amount ($$$$¢¢)	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 the BIPA 606. 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

Item	Field	Size	Position	Format	Description
					premium amount is a debit.
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 responses 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)

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 beneficiary identification code (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 response.
2	Surname	24	13-36	Alpha-Numeric	A maximum of twenty-four 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 fifteen 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 alpha 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, 1909 will be displayed as 19091101. 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	A three-position alpha-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.
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

Item	Field	Size	Position	Format	Description
					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 social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) and an alpha-numeric beneficiary identification code (BIC).
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 response to a state-initiated transaction request.
15	Filler	7	112-118		Positions reserved for future use.
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.

Item	Field	Size	Position	Format	Description
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)

Reply records generated only for states receiving daily response files.

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 beneficiary identification code (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 response.
2	Surname	24	13-36	Alpha-Numeric	A maximum of twenty-four alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.

Item	Field	Size	Position	Format	Description
3	Given Name	15	37-51	Alphabetic	A maximum of fifteen 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 alpha 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, 1909 will be displayed as 19091101. 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 Reduced Part A Indicator	1	71	Numeric	When the transaction code in position 77-78 is "30," this field will be blank. For states receiving daily files, when the transaction response code is not "30," the presence of a "1" in this position means the reduced Part A

Item	Field	Size	Position	Format	Description
					premium rate applies; otherwise, it is blank.
9	Filler or Part A Premium Surcharge Indicator	1	72	Numeric	When the transaction code in position 77-78 is "30", this field will be blank. For states receiving daily files, when the transaction response 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.
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 response code is not "30," a reply record.
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

Item	Field	Size	Position	Format	Description
					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 this is not a code 30 response, the first two positions convey CMS's response 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.
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 response 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

Item	Field	Size	Position	Format	Description
					states receiving daily files, when the transaction response 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 response. 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.
15	Filler or Billing Period Stop Date (CCYYMM)	6	88-93	Numeric	When the transaction response code is "30," this field will be blank. For those states receiving daily files, when the transaction response 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.

Item	Field	Size	Position	Format	Description
16	Filler or Code 1728 Accretion state Agency Code	3	94-96	Alpha-Numeric	When the transaction response code is "30," this field will be blank. For those states receiving daily files: when the transaction response 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 responses 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.
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.

Item	Field	Size	Position	Format	Description
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)

Reply records generated only for states receiving daily response files.

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 beneficiary identification code (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 response.
2	Surname	24	13-36	Alpha-Numeric	A maximum of twenty-four alpha-numeric characters. The name will match the surname on the EDB. Any unused positions will be blank.

Item	Field	Size	Position	Format	Description
3	Given Name	15	37-51	Alphabetic	A maximum of fifteen 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 alpha 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, 1909 will be displayed as 19091101. 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	When the transaction code in position 77-78 is "30," this field will be blank. For states receiving daily files: when the transaction response code is not "30," a one-position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An

Item	Field	Size	Position	Format	Description
					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	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 response 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 states receiving daily response files when this is not a code 30 response, CMS's response to the state's accretion or deletion record. The last two positions contain the same transaction code as was present on the state input record. For these daily exchange states, the two

Item	Field	Size	Position	Format	Description
					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.
13	Billing Period Start Date (CCYYMM)	6	82-87	Numeric	A six-position numeric date field. When the transaction response 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 response code is not “30,” this field contains the beginning date (year and month) used in calculating the refund or premium amount for this transaction response. 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

Item	Field	Size	Position	Format	Description
					stop dates are inclusive dates.
14	Filler or Billing Period Stop Date (CCYYMM)	6	88-93	Numeric	When the transaction response code is "30" this field will be blank. For those states receiving daily files: when the transaction response 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 response code is "30" this field will be blank. For those states receiving daily files: when the transaction response code is not "30," this field will be a three-position numeric state agency code provided in all code 1728 deletion responses 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 response code is "30," this field will be blank. For those states receiving daily files: when the transaction response 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 the BIPA 606. 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)

This response 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 beneficiary identification code (BIC). Positions 11 and 12 may be blank. 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, commonly referred to as the RRB claim number. 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 twenty-four 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 fifteen 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 alpha 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. A date such as 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.
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.

Item	Field	Size	Position	Format	Description
8	Filler	2	71-72		Positions reserved for future use.
9	Agency Code	3	73-75	Alpha-Numeric	A three-position alpha-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.
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

Item	Field	Size	Position	Format	Description
					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.
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)

This response 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, it is important to return the primary field values exactly as they were submitted on the state record.

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

Item	Field	Size	Position	Format	Description
					beneficiary identification code (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, or a ten- or eleven-position alpha-numeric value, commonly referred to as the RRB claim number. 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 twenty-four 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 fifteen 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 alpha code (male “M,” female “F”)

Item	Field	Size	Position	Format	Description
6	Date of Birth from state record	8	54-61	Numeric	An eight-position numeric field, CCYYMMDD. A date such as November 1, 1909 will be displayed as 19091101. 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	Applicable to Part B buy-in only. 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. The value in this field will be the value submitted by the state on the incoming transaction.
9	Agency Code	3	73-75	Alpha-Numeric	A three-position alphanumeric 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

Item	Field	Size	Position	Format	Description
					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.
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 responses 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 response

Item	Field	Size	Position	Format	Description
					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.
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

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.

Item	Field	Size	Position	Format	Description
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.
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 Claim Personal Characteristics Change type records

Item	Field	Size	Position	Format	Description
					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.
12	Filler	25	48-72		Positions reserved for future use.
13	Agency Code	3	73-75	Alpha-Numeric	The three-position alphanumeric 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 response is associated.
17	Filler	1	88		Position reserved for future use.

Item	Field	Size	Position	Format	Description
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 thru F, included within this CMS daily or monthly response file.
19	Filler	65	96-160		Positions reserved for future use.

CHAPTER 4 BUY-IN CODE DESCRIPTIONS

4.0 INTRODUCTION

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 (BIEC)--POSITION 71 ON STATE AGENCY INPUT FILE AND CMS RESPONSE FILES

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 will only apply prospectively, which means the updated BIEC will be reflected in a subsequent billing period; e.g., if a **code 99** is updated in March, the updated BIEC will be reflected in the state's Part B billing file in May.

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

Buy-in Eligibility Code	Description	Notes (as applicable)
Mandatory		
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.
M	Entitled to Medical Assistance Only (MAO) – (non-cash recipients who are not QMBs)	All states that include Title XIX MAO recipients in their state buy-in agreement must identify and maintain identification of members of this coverage group within the EDB.
P	Qualified Medicare Beneficiary (QMB)	All states must cover QMBs. States must identify and maintain identification of members of this coverage group within the EDB.
U	Qualifying Individual (QI)	All states must cover QIs. States must identify and maintain identification of members of this coverage group within the EDB.
Optional		
Z	Deemed Categorically Needy	
CMS-Generated Codes (These codes are based on 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	
H	Aged, blind, or disabled recipient of a one-time payment	

4.2 AGENCY CODES FOR STATE BUY-IN (POSITIONS 73-75)

CMS assigns Agency codes to all Third Party Premium Payers, including states and US territories. All states have two assigned agency codes, one for Part A transactions and one for Part B transactions. Each third party billing action must include an agency code in order to identify the state and the account to which the action applies.

The unique assigned three-position agency code identifies: 1) the type of organization; 2) the type of account; and 3) the specific organization itself.

- **Initial character, first position**, identifies type of organization, and type of account:

  Alpha S=Part A buy-in or Group Payer state

  Numeric 0 thru 6=Part B buy-in state or territory

- **Numeric values in positions 2 and 3** further identify the specific organization associated with that account.

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

PART A AGENCY CODE	PART B AGENCY CODE	STATE
S09	090	District of Columbia
S10	100	Florida
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
S32	320	New Mexico
S33	330	New York
S34	340	North Carolina
S35	350	North Dakota

	PART A AGENCY CODE	PART B AGENCY CODE	STATE
	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
	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)

It is important to distinguish between the beneficiary's SSN and the beneficiary's claim number. The beneficiary's SSN is the number assigned to an individual by Social Security and is used throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program.

The HICN is the number on which Medicare entitlement has been established. It includes the nine-digit SSN combined with a one or two position alpha-numeric suffix known as the beneficiary identification code (BIC), which 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.

The area numbers range from 001 through 763. All groups except 00 are possible. The serial portion is a consecutive numeric series from 0001 through 9999 within each group.

The first position of the BIC must always be an alpha character, e.g., 000-00-0000A. The second position of the BIC may be alpha or numeric, e.g., 000-00-0000J1. If the second position of the BIC is numeric, it is referred to as a subscript. The table of BICs for Social Security beneficiaries is in section 4.4 below.

Effective January 1983, newly retired federal employees became entitled to Medicare benefits. These Medicare qualified federal employees (MQFE) are assigned a unique BIC which is different from the BIC assigned to Social Security beneficiaries. The table of BICS for MQGEs is in section 4.5 below.

4.4 TABLE OF BENEFICIARY IDENTIFICATION CODES (BIC)

	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
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 3 QCs)**	J1	---	---	---	---
Entitled to HIB* (3 QCs or more)**	J2	---	---	---	---
Not entitled to HIB* (less than 3 QCs)**	J3	---	---	---	---
Not entitled to HIB* (3 QCs or more)**	J4	---	---	---	---
Wife entitled to HIB* (less than 3 QCs)**	K1	K5	K9	KD	KH
Wife entitled to HIB* (3QCs or more)**	K2	K6	KA	KE	KJ
Wife not entitled to HIB* (less than 3 QCs)**	K3	K7	KB	KF	KL

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Wife not entitled to HIB* (3QCs 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
Disabled widower	W1	W3	W5	WB	WG
Disabled surviving divorced wife	W6	W7	W8	WC	WJ

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Disabled surviving divorced husband	WR	WT	---	---	---

* HIB – Hospital Insurance benefits

**QC – quarters of coverage for Title II

***SMIB – Supplementary Medical Insurance benefits

4.5 TABLE OF BENEFICIARY IDENTIFICATION CODES (BIC) FOR MEDICARE QUALIFIED GOVERNMENT EMPLOYEES (MQGE)

	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
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

	1ST Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
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)				
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.

4.6 RAILROAD RETIREMENT BOARD CLAIM NUMBERS

An individual whose primary employment was with 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 may be either a six or nine digit number with an alphabetic prefix.

The dependents of an individual whose primary employment was with the railroad may receive benefits from the RRB. Due to limitations in the RRB claim number structure, the RRB **Medicare claim number** for all members of a family may not be based on the same six or nine digit number. It is imperative that the state ask each RRB beneficiary for his/her RRB **Medicare claim number** rather than for his/her RRB claim number.

The state may submit an accretion record for a RRB beneficiary with either the RRB Medicare claim number or the pseudo social security claim number (the RRB Medicare claim number is preferred). In order to process data through an EDB system, the data must be consistent in format. CMS will convert the RRB Medicare claim number to a pseudo social security claim number and send a claim number change record to the state.

A deletion record for a railroad board beneficiary **must** be submitted with the pseudo social security claim number.

Convert an RRB claim number to a pseudo social security claim number 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 4.7).
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 to the front end of the six digit RR number thereby creating a nine-digit pseudo SSN. **IMPORTANT: The first zero in this type of conversion must always be zoned with a plus sign. The hexadecimal representation for a plus zoned zero is "C0."**

   Example: RRB Claim Number WA123456
   Pseudo SSA Claim Number 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. At the present time, there are no claim numbers which begin with 8 or 9.

Numeric	Alpha	Numeric	Alpha
0	0 (Zoned Plus)	4	D

1	A	5	E
2	B	6	F
3	C	7	G

Example: RRB Claim Number A321549876
Pseudo SSA Claim Number C2154987610

4.7 TABLE OF RRB PREFIXES AND EQUIVALENT SSA BICS

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

RRB Claim Prefix	SSA BIC	Type RRB Beneficiary
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 surviving spouse

*WCD and WCA have two designations each.

4.8 CMS-INITIATED ALPHA-NUMERIC CHARACTER CHANGES

CMS notifies the state in the regular billing file of any changes in the beneficiary's Medicare number and/or beneficiary identification code (BIC). A Medicare number and/or BIC change may be applied to an ongoing buy-in record or to a state-initiated action as it is processed by CMS.

A Medicare number and BIC change will occur when an individual becomes entitled to benefits on another social security record. For example, a woman may be on the rolls under her own Medicare 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 generate a transaction code 23bb Medicare number/BIC or BIC only change record to the state when the TPS receives notification from internal systems of the BIC or Medicare number change. The code 23bb transaction also indicates that the change was for an existing open master record (code 41) which will be contained in the billing file in proper sequence under the new Medicare number.

As a result of the code 23bb, a state could receive two open master records on the billing file under the new Medicare number. It is possible to receive two code 41 items. The duplicate billing situation occurs because the individual was accreted under two different Medicare numbers and now has been identified by the code 23bb action.

If the state receives this condition in the billing file, it should not initiate any action as CMS will automatically institute corrective action to consolidate the duplicate master records.

Generally, this corrective action is accomplished in the next billing month. However if clerical action is required, an additional month's delay can be expected. 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, prepare a memo or letter to CMS (see chapter 6) describing the situation. There is no time limit to obtain an adjustment for duplicate billing.

States can 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 responses 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 response 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. Therefore, the state can receive a transaction response **code 2399**.

The record format for all transaction **code 23** responses is contained in section 4.9 below.

4.9 BUY-IN TRANSACTION CODES - POSITIONS 77-81

The transaction codes used by CMS consist of not less than two and no more than four numerals which appear in positions 77 through 80 of the record. If CMS is transmitting a two-position transaction code, positions 79 through 80 will be blank. Certain CMS disposition codes are enhanced by an alphabetic sub-code. When a sub-code is appropriate, it appears in position 81 of the record. An explanation of the sub-code is included with the explanation of the transaction code.

Most transaction codes require no further action on the part of the state. There are instances, however, when additional action by the state is appropriate. Recommended state action is provided along with the explanation of the transaction code.

The transaction codes are listed in numerical order.

For ease of understanding, codes are illustrated as follows: For 11XX – the XX indicate that the code 11 is a prefix code. The XX represent the last two numeric positions that will be defined in the rows that follow. For 23bb – the bb indicates that the state can receive this transaction code followed by two blank spaces. Any code displayed in this section followed by the bb is a valid two-position transaction code.

TRANSACTION CODE	DEFINITION
11XX	CMS uses the code 11 series to inform the state of new accretions to the state's buy-in account. The code 11 is followed by a two-digit numeric code that identifies the source of the transaction or the reason that a specific adjustment action was taken by the Third Party System (TPS) prior to accreting the item to the TPS. The accretion results in a debit action to the state. In the following month, the item will appear on the state's bill as a code 41 (ongoing item). The state is liable for the individual's Medicare Part A and/or B premium and will be billed monthly until the individual is deleted from the state's account.
1125	The code 1125 informs the state that the effective date in an accretion submitted by the state was adjusted by the TPS to a later date. The adjustment was necessary because the EDB showed a closed period of coverage for the same state that ended later than the accretion date on the state input record. The state accretion was adjusted to the first month after the deletion date on record for the closed period. The following month the item will appear on the state's bill as a code 41 (ongoing item) unless the item is deleted.
1161 1163	The code 1161 or 1163 informs the state that an accretion it submitted has been added to the EDB. The accretion date is the same as reported on the state input record except when a code 30 action is present. Next month the item will appear on the state's bill as a code 41 (ongoing item) unless the item is deleted.
1165	The code 1165 informs the state that CMS submitted a Part A or B buy-in accretion manually on their behalf (based on a state request or SSA submission of a form CMS-1957 reporting a problem case). In limited cases, an accretion can be submitted manually to resolve a computer exception that impeded the state's initial accretion request from updating. If the SSA submits a form CMS-1957 requesting a Part A accretion, the request must be

TRANSACTION CODE	DEFINITION
	accompanied by a letter from the state confirming that the beneficiary qualifies as a QMB or QDWI. The following month, the item will appear on the state's bill as a code 41 (ongoing item) unless the item is deleted. *State Action* - Examine state records to verify the correctness of the accretion. If, after investigation, the state does not agree with the accretion, the state has 2 months following the month in which it received code 1165 to submit a code 50 deletion or "wipe-out" action to annul the accretion or establish a closed period of buy-in coverage. Code 50 deletions submitted within the prescribed time frame (2 billing months) are not subject to the limitations of the Commissioner's Decision. If the code 50 is submitted beyond the two-month rule, the code 1165 open period will be deleted as a code 51 and the deletion response code will be 1751. Part A deletions will occur in the current month and Part B deletions will be in accordance with CMS processing of code 51 deletions. See section 2.6.1. If the accretion date is incorrect, annul the transaction within the 2-month time limitation and re-accrete the record with the correct effective date.
1167 (Part B only)	The code 1167 informs the state that a SSA field office submitted a Public Welfare (PW) Part B accretion that was processed by the TPS. *State Action* - Examine state record to verify the correctness of the accretion. If the state does not agree with the accretion, the state has 2 months following the month in which it received notification of the code 1167 to submit a code 50 deletion or "wipe-out" action in order to annul the accretion or establish a closed period of buy-in coverage. Code 50 deletions submitted within the prescribed time frame (2 billing months) are not subject to the limitations of the Commissioner's Decision. If the code 50 is submitted beyond the 2-month rule, the code 1167 open period will be deleted as a code 51 with a deletion

TRANSACTION CODE	DEFINITION
	response code of 1751 in accordance with CMS processing of code 51 deletions. See section 2.6.1. If the accretion date is incorrect, annul the record within the 2-month limitation and re-accrete the record with the correct effective date.
1180 (Part B only)	The code 1180 informs the state which has a signed 1634 agreement (Auto-Accrete state) that CMS has established a state buy-in record for a Supplemental Security Income (SSI) recipient. The effective date of the accretion will generally be the first continuous period of buy-in eligibility based upon the most recent period of SSI or a federally-administered state supplement (SSP).[33] The following month the item will appear on the state's bill 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/SSP 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/SSP entitlement, the state will submit a simultaneous accretion/deletion record (code 75) to add a closed period of buy-in coverage for that time. *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 the SDX file to confirm the appropriate buy-in coverage period(s), particularly if CMS sent

[33] 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 for the State to obtain the benefits of Medicare coverage.

TRANSACTION CODE	DEFINITION
	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 record from CMS, or by an auto-accrete state based on an examination of the SDX file. 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 bill as a code 41 (ongoing item) unless the item is deleted.
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 SSO 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 another code 16. 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.

TRANSACTION CODE	DEFINITION
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.
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 the 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 new state of residency which submitted the new accretion in order to resolve jurisdictional issues (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, a code 1167 transaction. If the code 50 was submitted within 2 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 submitted by the state. If the code 50 was not submitted timely (2 billing months) TPS will process the deletion as a code 51 and the deletion response record will be a code 1751. 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

TRANSACTION CODE	DEFINITION
	effective date in accordance with CMS processing of code 51 deletions. See section 2.6.1. Note that for all TPS credit transaction responses, the transaction effective date can be derived from the TPS response record as the billing period start date minus one month.
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.
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 a form CMS-1957 reporting a problem case or by a form CMS-1957 submitted by an SSO (which should be extremely rare and must be supported by documentation from the state.) Occasionally, the code 1759 may reflect a deletion date that exceeds the normal 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 that claim number. *State Action* - Examine the claim number in the deletion record to check for any input keying errors. The claim number in the deletion record must match a corresponding record on the TPS *exactly* in order for the transaction to be applied. If the claim number 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 claim number change. If the claim number is correct, examine previous TPS response files to

TRANSACTION CODE	DEFINITION
	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 claim number on the EDB. The claim number may be absent from the EDB or the claim number in the accretion may contain blanks, alpha characters or special non-numeric characters in positions that should be numeric. *Sub-code B* The claim number on the accretion matches a claim number on the EDB record, however, required matching personal characteristics differ. *Sub-code C* Part A entitlement issues that may include the following: • the beneficiary is entitled to Premium-free Part A; • the beneficiary does not have Premium-Part A entitlement; or • the beneficiary resides in a group payer state and does not have conditional enrollment status. Part B - The claim number in the accretion matches a record on the EDB, however, the accretion is for a SLMB (buy-in eligibility code “L”), a QMB (buy-in eligibility code “P”), or a QI (buy-in eligibility code “U”) and the EDB does not reflect Medicare Part A entitlement.

TRANSACTION CODE	DEFINITION
	Sub-code D Part A - There is no record of Medicare Part B buy-in for the beneficiary. The state cannot pay the Part A premium for a QMB beneficiary unless the state is paying the Part B premium, with the exception of a Qualified Working Disabled Individual (QWDI). Part B - The state's transaction matches the EDB on name and claim number, however, the beneficiary does not have Medicare entitlement. Although the beneficiary may have previously had Medicare entitlement or may have future Medicare entitlement, there is no Medicare entitlement for the period of time that the state is attempting to buy-in. *Sub-code E* - The state's transaction matches the EDB on name and claim number, however, the beneficiary does not have Medicare entitlement. Although the beneficiary may have previously had Medicare entitlement or may have future Medicare entitlement, there is no Medicare entitlement for the period of time that the state is attempting to buy-in. *State Action – Sub-codes A and B* Examine the state's record to ensure that the claim number, name (surname, first name, middle initial) date of birth (month, day, year) and sex code in the accretion record match the corresponding data on the state's record. If there is a discrepancy, correct the appropriate field(s) and resubmit the accretion. If the input record and the state's record are in agreement, examine the Medicare eligibility data on the various federal files that the state receives or has access to and correct the input record. *State Action – Sub-code C* Part A - If the beneficiary has Premium-free Part A, no further action is necessary. If the beneficiary resides in a group payer state and does not have Premium-free Part A and has not enrolled conditionally for Medicare Part A, advise the beneficiary of the need to contact the SSA during the next general enrollment period (GEP) to enroll.

TRANSACTION CODE	DEFINITION
	Part B - If the beneficiary is eligible for state buy-in, re-submit the transaction without the QMB, SLMB, or QI buy-in eligibility code in position(s) 71-72. The state may follow up later with a **code 99** change request to update the BIEC after CMS receives Part A Medicare entitlement details from SSA, usually within two weeks of the Part B accretion. *State Action – Sub-code D* Part A - If the beneficiary is eligible for Part B buy-in, accrete the beneficiary to the Third Party System. After the Part B accretion is accepted by the TPS, submit the Part A accretion. Part B - The Medicare number in the accretion record matches a record in the EDB, however, the accretion is for a QDWI. The state may not pay the Part B Medicare premium through state buy-in for a QDWI. The state may only pay the Part A Medicare premium. *State Action – Sub-code E* Part A - This condition occurs when the beneficiary's Medicare entitlement terminated due to the cessation of disability (option code C) or termination of benefits under the end stage renal disease program (option code S). It can also occur when there was an invalid Medicare enrollment (option codes F or X) or if there is no Medicare entitlement on the Entitlement Data Base. If the state believes that the beneficiary should be entitled to Medicare, submit a state buy-in resolution request to CMS (see chapter 6). Part B - The state's transaction matches the EDB on name and Medicare number, however, the beneficiary does not have Medicare entitlement. Although the beneficiary may have previously had Medicare entitlement, there is no Medicare entitlement for the period of time that the state is attempting to buy-in. *State Action* - If the state believes that the beneficiary should be entitled to Medicare, submit a state buy-in resolution request to CMS (see chapter 6).

TRANSACTION CODE	DEFINITION
23XX	The **code 23** series inform the state that the claim number and/or Beneficiary Identification Code (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 claim number in the state's records and report all future actions under the correct claim number.
23bb	This code informs the state that a claim number change was processed to an ongoing buy-in record.
2350 2351 2353	These **codes (2350-2353)** inform the state that a claim number change was processed to a deletion record.
2361 2363 2375 2384 (Part B only)	These **codes (2361-2384)** inform the state that a claim number change was processed to an accretion or to a simultaneous accretion/deletion record.
2399	This code informs the state that a claim number 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***.**

TRANSACTION CODE	DEFINITION
2450 2451 2453	These **codes (2450-2453)** inform the state that the deletion record it submitted was rejected.
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 the 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 impossible 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**.
29XX	This code series informs the state that the accretion or simultaneous accretion/deletion action it submitted was rejected

TRANSACTION CODE	DEFINITION
2961 2963 2975 2984	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 Master Beneficiary Record (MBR). If the beneficiary is alive, the beneficiary must contact the SSO 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, the 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.
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 the TPS. The adjustment may be applied to an open or a closed record. Adjustments are made for a variety of reasons such as a

TRANSACTION CODE	DEFINITION
	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 the TPS for the beneficiary.
42bb	This code informs the state of a credit adjustment issued in response to duplicate billing records in the 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 that for all CMS credit transaction responses, the transaction effective date can be derived from the TPS response 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 the TPS was notified of a change to the beneficiary's Medicare entitlement date. The buy-in effective date on the 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.
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.

TRANSACTION CODE	DEFINITION
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 the TPS response record billing period start date.
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 the 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 that bene record already shows open ongoing coverage, CMS will continue to send

TRANSACTION CODE	DEFINITION
	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 606 reduced rate is involved If new coverage is being established an "1165" will accompany the 4365. The part(s) billed at a different rate will be billed as a 4365 closed period of coverage.
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 606 reduced rate 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 the TPS.

TRANSACTION CODE	DEFINITION
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**.
44	<u>Part A</u> 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 Part A premium rate) if the 10% premium surcharge is removed from the beneficiary's record. <u>Part B</u> 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 BIPA 606.
45	<u>Part A</u> 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. <u>Part B</u> 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

TRANSACTION CODE	DEFINITION
	the Part B premium. The Group Health Plan subsequently decreased or eliminated the premium reduction.
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 claim number or state agency code in the **code 99** did not match a record on the TPS. This reject code is also used if the state submits a **code 99** record with a Part B buy-in eligibility code of "L," "P," 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 field office. 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 2 updates have elapsed, the **code 50** will be processed as 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 response **code 1751**. The **code 50** will be rejected only if the state attempts to apply the **code 50** against any codes other than the **code 1165** and **code 1167**. If the state is annulling coverage, the effective date of the code 50 deletion must be 1 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
51	Part A **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 December 2018 or January 2019. If the state submits a retroactive deletion date, the TPS adjusts the deletion date so that it conforms to the update month. Part B 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 section 2.6.1.3.
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	The state 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 B buy-in for QMBs (or Part A accretions for QDWIs). To ensure the appropriate effective dates for QMBs and QDWIs buy-in accretions, states should follow procedures in section 2.5.
63	States use this is 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 the 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.
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

TRANSACTION CODE	DEFINITION
	accuracy of the dates in the simultaneous accretion/deletion record. When the simultaneous accretion/deletion is accepted by the 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 the SDX file. The state is responsible for the accuracy of the accretion. When the accretion is accepted by the 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, after a beneficiary already accreted to the buy-in rolls subsequently becomes eligible for SSI benefits. The 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
87bb (Part B only)	CMS uses this code to inform both the SSI alert state and the SSI 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 no longer is eligible for buy-in, submit a deletion record.
99	This code is used by the state to correct the buy-in eligibility code or the welfare identification number on an existing buy-in record on the TPS.

4.10 SUPPLEMENTAL SECURITY INCOME (SSI) STATUS CODES

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 the TPS.

4.10.1 SSI Status Codes – Accretion

The status codes for SSI accretion or SSI accretion alert records are:

- "C" – conditionally eligible for SSI.
- "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.

4.10.2 SSI Status Codes – Deletion

The status codes for SSI deletion or SSI deletion alert records are:

- "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 SDX record 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.

CHAPTER 5 PREMIUM BILLING

5.0 BACKGROUND

The Federal Claims Collection Act (FCCA) of 1966 (Title 31 - USC 951-953), now codified as Title 31 - USC 3711, and as implemented by 4 CFR, Chapter II, Parts 101-105, provides CMS the authority to establish payment due dates for premium payments billed and collected from state Medicaid agencies (vendor payments) and, also provides for assessing interest on debts not paid timely. Departmental regulations implementing the FCCA are located in 45 CFR Part 30. CMS regulations implementing the FCCA include 42 CFR §401, 42 CFR §102.3, 42 CFR §§401.601 and 401.607(a)(2). The regulations give CMS the authority to recover amounts due from debtors including interest by direct collection or offset against funds owed the debtor.

5.1 STATE BILLING FOR MEDICARE PART A AND PART B PREMIUMS

The state Part A and Part B Medicare premium liability is calculated by CMS once a month at the conclusion of the third party monthly update. CMS prepares a separate Part A and Part B Medicare premium liability Summary Accounting Statement (SAS) for each state.

The SAS is mailed around the 10th of every month. Since CMS bills the states prospectively, the SAS represents premiums for Medicare coverage for the following month, e.g., the SAS created during May's third party monthly update is mailed to the states on June 10th and contains the state's Part A and Part B Medicare premium liability amounts for the month of July. The payment due date would be July 1.

Payments are due the 1st day of each month, item is shown on line 3 of the SAS. CMS has established an **unofficial** grace period which gives the states until the 25th day of the month to pay its liability. If the 25th day of the month falls on a federal holiday, payments for premium liability is due no later than close of business, on the last business day **prior** to the 25th. A Medicare premium liability is considered paid when the total amount due is **received** by CMS.

Any Medicare premium liability amount that remains unpaid at the end of the grace period (25th day of the month) in the month in which payment is due will be considered a late payment and will be subject to an assessment of interest and offset against the state's Medicaid Grant Award.

A state (including the District of Columbia (DC) and participating U.S. territories) may appeal if the state disagrees with the amount of their Part A and/or Part B Medicare premium liability, the amount of interest assessed, or offset amount against the Medicaid

Grant Award. CMS must receive the appeals requests within 90 days after the bill date on the disputed SAS billing notice, the state must submit a written request for review along with documentation to support their position via postal mail, fax, or email to the Director of the Division of Premium Billing & Collections (DPBC) at:

Postal mail:
CMS, OFM, AMG
Division of Premium Billing & Collections
Mailstop C3-13-08
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Fax number: (410) 786-7030
Type 'Appeal Request' and the <*state's name*> in the subject line of the fax cover page.

E-mail: 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 appeal request, the Director of DPBC will send a letter of acknowledgement to the requesting state to confirm receipt. CMS will evaluate the request and the evidence submitted and will send a written response to the state with the decision issued.

In order to avoid interest assessment and offset against the state's Medicaid Grant Award, the state must continue to make their Medicare premium payments timely while CMS reviews the request.

CMS will evaluate the evidence submitted. If CMS determines that a credit is due to the state, the credit amount will be reflected as an adjustment on line 2 of a **subsequent** SAS.

If a state disagrees with the amount of Part A and/or Part B billed for a specific health insurance claim number, the state should submit the item directly to the CMS DMSEI in accordance with the State buy-in problem resolution request procedures in chapter 6. In order to avoid an interest assessment and possible offset against the Medicaid Grant Award, the state must pay the total amount reflected on line 3 of the SAS while CMS reviews the problem case request.

5.2 SUMMARY ACCOUNTING STATEMENT – BILLING NOTICE

A separate Part A and Part B Medicare premium liability SAS, also called the "bill", is prepared for each state once a month.

The SAS contains the following information:

Name of Organization	**State name**
Agency Code	3 position state code
Billing Period	Month and year for which premiums are due
Date of Bill	Month, day, and year on which the bill was created
Previous Balance (Line 1)	This entry reflects either the premium amount due CMS (debit) or the premium amount due the state (credit). This figure is the same as the total balance (line 6) on the **previous** month's SAS. A credit balance is annotated CR.
Adjustments (Line 2)	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 SAS. A credit balance is annotated CR. If the adjustment is a debit amount which is the result of a **billing adjustment**, the debit amount must be paid in addition to the current month's premium liability shown on line 3.
Current Month's Liability - Payable by (MM/DD/YYYY) (Line 3)	"Payable by" date is the first day of the month of the billing period. This entry reflects the net premium liability (debit or credit) for all items processed in the current billing period. It includes all ongoing items (codes 41), accretions, deletions, and adjustment processed in the current billing period but does **not** include the debit or credit adjustments shown on line 2. If the state's buy-in Agreement covers title XIX Medical Assistance Only (MAO) beneficiaries, an asterisk (*) appears to the right of the current month's premium liability. This asterisk refers to the premium amount which appears in the space immediately below Line 6. The premiums identified by the asterisk represent that portion of the current month's premium liability which appears to qualify for Federal Matching Payments (FMAP) under the Medicaid program. This is the amount that is used to compute the allowable Part B premiums claimed on line 17.B of Form CMS 64.9 or 64.9P.
Payments Received (Line 4)	This entry reflects the receipt date and payment amount for each payment received from the state which was not previously posted to the state's account
Premiums Collected through Offset (Line 5)	This entry reflects the amount of overdue premiums which will be offset against the state's Medicaid Grant Award. If line is blank, no premiums will be collected through offset.

Total Balance (Line 6)	This entry reflects the premium amount due to CMS (debit) or amount due the state (credit).

5.3 AGENCY TOTAL SHEET

An Agency Total Sheet is enclosed with each state's Summary Accounting statement every month. The Agency Total Sheet will **only** reflect items processed on the third party **monthly** update billing file. For states that exchange data on a daily basis with CMS, the daily reply files will **not** be reflected on the Agency Total Sheet.

The Agency Total Sheet provides data on the number of files processed on the third party monthly billing file along with all credits and debits to the state. The number of files processed and the monetary amount associated with the debits and credits are also displayed for each code. See Appendix 5D.

5.4 CREDITING OF STATE PAYMENTS FOR MEDICARE PART A AND PART B PREMIUMS

State remittances are credited in the following manner:

- Medicare premium payments are applied to that portion of the Medicare premium liability which represents the MAO population, i.e., individuals whose Medicare premiums are not eligible for FMAP under the Medicaid program; and
- Any amount remaining is applied to Medicare premiums owed for individuals whose Medicare premiums qualify for FMAP, i.e., cash and deemed cash eligible.

When a state Medicare premium payment is received late (after the Medicare premium amount is collected by offset) CMS will credit the late Medicare premium payment to the Medicare premium liability for the following month. For example, if the Medicare premium payment due date was June 1st, with unofficial grace period through the 25th, and the payment was received July 1st, the late payment will be credited toward the July premium liability amount. Due to CMS' policy of prospective billing, the late payment will be reflected on the September bill. The SAS prepared during the July third party monthly update is for the billing month of September. The September bill will reflect all Medicare premium payments credited during the month of July including late payments received after the 25th day of the month and unpaid Medicare premiums which will be offset against the Medicaid Grant Award.

5.5 INTEREST ASSESSMENT

Interest is assessed on Medicare premium arrearages which arise from one of the following situations:

- State Medicare premium payments which are less than the total amount billed on the SAS; or
- State Medicare premium payments received after the unofficial grace period

during the month in which the premiums are due.

Interest is assessed in 30-day increments. The assessment on overdue Medicare premiums begins with the first day of the billing month and ends with the day/month CMS receives the state's Medicare premium payment **or** the day/month CMS initiates offset to the state's Medicaid Grant Award.

The interest rate for overdue Part A and Part B Medicare premiums is the SMI trust fund rate as computed for new investments in accordance with section 1841(c) of the Act and 42 U.S.C. 1395(c). This rate approximates the actual loss to the SMI trust fund and is derived from the average yield on all marketable obligations to the U.S. Department of the Treasury as of the last day of the month.

The amount of overdue Part A and/or Part B Medicare premiums collected through offset against the Medicaid Grant Award will be reflected on a subsequent SAS. The Medicaid Grant Award will show the amount of unpaid Part A and/or Part B Medicare premiums including the accrued interest which is being offset. See section 5.8.

5.6 OFFSET AGAINST THE STATE MEDICAID GRANT AWARD

A state’s Medicaid Grant Award will be offset immediately for any Part A and/or Part B Medicare premium amount(s) which remain unpaid beyond the grace period together with any accrued interest beginning with the first day of the month for which the premiums are due thru the date the actual offset is initiated by CMS. The offset for Part A and/or Part B Medicare premiums and interest collected against funds due to the state as part of its grant award is not a disallowance of federal financial participation; instead, the offset will be treated as an accounting adjustment which reduces the actual money amount owed to a state.

5.7 METHODS STATES MAY USE TO PAY MEDICARE PREMIUMS

States must use one of the following electronic funds transfer methods to pay the Medicare premiums on behalf of Medicare beneficiaries on the state buy-in rolls:

- The U.S. Department of the Treasury Internet Collections Application (PAY.GOV)
- The U.S. Department of the Treasury electronic funds transfer service system, known as the Treasury Financial Communications System (TFCS)/Fedwire

CMS will continue to compute the Part A and Part B Medicare premium liability amounts for each state and mail the Summary Accounting statement - Billing Notice and the Agency Total Sheet monthly.

The following sections describe the procedures for remitting state buy-in Medicare premium payments.

5.8 THE U.S. DEPARTMENT OF THE TREASURY INTERNET COLLECTION APPLICATION (PAY.GOV)

5.8.1 PAY.GOV Background

PAY.GOV was developed by the U.S. Department of the Treasury to meet the Financial Management Service commitment to process collections electronically using Internet technologies. PAY.GOV is a secure, government-wide collection portal. This application is Web-based allowing customers to access the portal from any computer with Internet access. PAY.GOV is a secure and easy way to make payments at no cost to the user.

5.8.2 PAY.GOV Instructions

A user ID and password are required to access the CMS Medicare Part A and Part B Payment Form on PAY.GOV. States electing to use PAY.GOV must first enroll with PAY.GOV through CMS. As part of the enrollment process, CMS will facilitate and authorize the U.S. Department of the Treasury to issue each state a user ID and password. To set up a user ID and password, contact the CMS buy-in analysts servicing your state.

When states pay their Medicare Part A and Part B bills using PAY.GOV, the payment will be processed by an Automated Clearing House (ACH) Direct Debit. The state's commercial banking account is debited and the funds collected are directly deposited into an account at the Department of the Treasury on behalf of CMS. A direct debit transaction must be received before 8:55 PM Eastern Time (ET) if settlement is to occur as early as the next business day. If the U.S. Department of the Treasury's designated depository is closed following the date of payment (including weekends and some holidays), the deposit date will occur the next day the U.S. Department of the Treasury depository is open. All PAY.GOV ACH collections are processed through the Federal Reserve Bank of Cleveland.

PAY.GOV also provides customer service representatives; therefore, if you have any questions on how to access the Web site, forms or payment processing or you need additional information, you can contact a PAY.GOV customer service representative at the telephone numbers provided below or you can go to https://www.pay.gov.

Phone: 1 (800) 624-1373 Option #2
Fax: 1 (216) 579-2813

Email: pay.gov.clev@clev.frb.org Hours (EST): 6:00 AM – 8:00 PM

5.9 THE U.S. DEPARTMENT OF THE TREASURY FINANCIAL COMMUNICATIONS SYSTEM (TFCS)/FEDWIRE

5.9.1 TFCS/Fedwire Procedures

States electing to use TFCS, also referred to as Fedwire, must adhere exactly to the procedures to ensure timely and accurate payment of the Medicare premium liability.

The U.S. Department of the Treasury has established a computer interface system known as TFCS with the Federal Reserve Bank of Cleveland. The system provides the Treasury with on-line access to the Federal Reserve Bank of Cleveland and utilizes the Federal Reserve Communication System (FRCS/Fedwire System) with access to all other Federal Reserve Banks, their branches, member banks, and correspondents of member banks.

By employing this interconnected banking network, the U.S. Department of the Treasury can receive, in a matter of minutes, deposits originating from commercial banks and can generate payments from federal agencies to recipient organizations. Since TFCS consists entirely of electronic funds transfers, checks and the accompanying collection time are completely eliminated, providing the recipient with the available funds on the actual payment date.

Commercial bank members of the Federal Reserve System are connected to Fedwire through their Federal Reserve district banks. These member banks also act as correspondents for the non-member commercial banks. This allows funds movement to and from all banking institutions.

5.9.2 TFCS/Fedwire Description

The state notifies its commercial bank to electronically transfer funds to the U.S. Department of the Treasury. Regardless of the state's banking status with the Federal Reserve Communication System (an on-line member, off-line member, or not a member), the state must furnish its bank with the specific information listed in section 5.9.4 in order to complete the transaction.

If the state's commercial bank is an on-line member of the Federal Reserve System, the bank prepares the standard electronic funds transfer message and enters it into the Fedwire system. If the state's commercial bank is a member of the Federal Reserve Communication System but off-line, the bank initiates the electronic funds transfer by contacting its servicing Federal Reserve Bank. If the

commercial bank is not a member of the Federal Reserve Communication System, it can initiate the electronic funds transfer through a correspondent member bank.

The electronic funds transfer flows through the commercial bank's servicing Federal Reserve Bank to the U.S. Department of the Treasury's account at the Federal Reserve Bank of New York. Through a computer-to-computer link, information on all electronic funds transfer transmitted to an account at the U.S. Department of the Treasury in Washington, D.C., from the New York Federal Reserve Bank then to selected government agencies including CMS. As deposit data are received by the U.S. Department of the Treasury's computer, the deposits are categorized and maintained according to the receiving federal agency location code as indicated on the electronic funds transfer message. Upon receipt of the deposit information, CMS makes entries to accounts receivable records maintained for each Part A and Part B buy-in state. Separate accounts receivable records are maintained for Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) premiums. CMS will not send an acknowledgement of receipt of the electronic funds deposit message to the state since the payment(s) will be reflected on the next month's Summary Accounting statement - Billing Notice. (See section 5.9.3 below regarding deposit receipts the state should obtain from its bank.)

5.9.3 TFCS/FEDWIRE General Information

Most banks sending electronic funds transfers on behalf of a state will provide the state, on request, a record of each transaction. For auditing purposes, each state should make arrangements with their banks to receive a record of each transaction.

The operating hours of the Fedwire System are 9:00 a.m. to 4:30 p.m. Eastern Time (ET). If possible, process all electronic funds transfers by 10:00 a.m. ET, in order to ensure that the Federal Reserve Bank of New York receives the transfer the same day. Medicare Premium payments are considered paid as of the date the funds are deposited in CMS's account.

5.9.4 Instructions for the Payment of Medicare Premiums Using TFCS/Fedwire

The following instructions for electronic funds transfer to a U. S. Department of the Treasury account at the Federal Reserve Bank of New York should be given to the commercial bank which will handle the electronic funds transfer for the state. Care must be exercised in making the transfer. The format of the Electronic Funds Transfer Message may vary, but the following information is critical. Failure to include critical fields may delay crediting of the electronic funds transfer payment.

5.9.4.1 Critical Fields

- **Nine digit U.S. Department of the Treasury Routing Code and Name:**
  021030004 TREAS NYC
- **CMS Agency Location Code:**
  75050080
- **U.S. Agency Name**
  "DHHS, CMS" is the abbreviation for the Department of Health and Human Services, Centers for Medicare & Medicaid Services
- **Type of Payment:**
  Medicare Part A Premiums or Medicare Part B Premiums (Example: Medicare Part A Premiums)
- **Amount of Transfer:**
  Must include the dollar sign and the appropriate punctuation including cents, digits (Example: $9,999,999.99)
  NOTE: If the Medicare Part A and Part B premiums are combined in one payment, the electronic funds transfer transmission must specify which amount should be applied to the Part A premium liability and which amount should be applied to the Part B premium liability. If no designation is provided, the total premium payment will be applied to the Part B premium payment. This may result in an offset for the Part A premium liability amount.
- **Name of the state making the electronic transfer:**
  (Example: Maryland)
- **Three-position CMS assigned state agency code:**
  NOTE: There are separate state agency codes for Part A and Part B premium payments.
- **The state agency code must agree with the type of payment:**
  (Example: S21)

5.9.5 CMS Policy on Medicare Premium Payments Made by TFCS/Fedwire

State buy-in Medicare premium payments are considered paid as of the **date the funds are deposited into CMS's account.**

If a problem occurs with an electronic funds transfer, the deposit may be delayed. The delay could cause the receipt date to be later than the date the transfer was made. In such a case, submit evidence to CMS at the address shown in section 5.1. Include the date and time the wire deposit message was sent and a copy of the text of the message sent by the bank.

CMS will apply the following criteria in evaluating the evidence:

- **Critical Errors** - The nine-digit U.S. Department of the Treasury Code,

the U.S. Department of the Treasury's name, and the CMS Agency Location Code must have been completed correctly per section 5.9.4.1. **The wire must have been sent by 10:00 a.m. ET in order to be considered received on the day it was transmitted.**

- **Non-critical Errors** -The other items in the wire deposit message must be correct to a reasonable extent as determined by CMS.

If the evidence is conclusive in the state's favor, CMS will consider the deposit paid as of the date sent.

APPENDIX 5.A MEDICARE PART A PREMIUM AMOUNT

Section 1818 of the Act specifies the Secretary of the 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 not otherwise eligible for Premium-free Part A but is enrolled for Premium-Part A. Medicare Part A premiums paid on behalf of beneficiaries enrolled in the state buy-in program as QMBs are not subject to a surcharge for late enrollment. Medicare Part A premiums paid on behalf of beneficiaries enrolled in the state group payer arrangement as QMBs or QDWIs **are** subject to the late enrollment surcharge.

Monthly Medicare Part A Premium Amounts

Effective Date		
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
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

Effective Date		
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
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	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

Effective Date	Reduced Rate	10% Surcharge
01/07- 12/07	$226.00	$248.00
01/08- 12/08	$233.00	$256.30
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

Section 1839 of the Act specifies that the Secretary of Health and Human Services shall determine the amount of the 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 the state buy-in program 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 Amounts

Effective Date	Amount
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	Amount
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
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

Effective Date	Amount
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 - EXHIBIT

CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY ACCOUNTING STATEMENT

BILLING NOTICE

NAME OF ORGANIZATION	**AGENCY CODE**	**BILLING PERIOD**
	DATE OF BILL	

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

2. ADJUSTMENTS

3. CURRENT MONTH'S LIABILITY -- PAYABLE BY

4. PAYMENTS RECEIVED

5. PREMIUMS COLLECTED THROUGH OFFSET

6. TOTAL BALANCE

SEE ATTACHMENTS (S)

ENTRIES ON THIS FORM ARE EXPLAINED IN THE .....

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

APPENDIX 5.D AGENCY TOTAL SHEET – EXHIBIT

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	

CHAPTER 6 PROBLEM CASES AND RESOURCES

6.0 INTRODUCTION

This chapter identifies key federal components that administer the state buy-in program, as well as resources and procedures for states that identify problems with buy-in for specific individuals or transactions.

6.1 FEDERAL AND STATE COMPONENTS THAT ADMINISTER THE STATE BUY-IN PROGRAM

6.1.1 Centers for Medicare & Medicaid Services (CMS) Central Office (CO) Baltimore, MD

6.1.1.1 The Office of Financial Management (OFM)

The Office of Financial Management (OFM), Accounting Management Group (AMG), Division of Premium Billing & Collections (DPBC) has overall responsibility for the administration of the state buy-in programs including billing, collections, and general program policy.

Requests may be submitted by email to the OFM resource mailbox at: DPBCstatebuy-in@cms.hhs.gov.

DPBC's mailing address is:

CMS, OFM, AMG
Division of Premium Billing & Collections
Mailstop C3-18-08
7500 Security Blvd.
Baltimore, Maryland 21244-1850

DPBC's responsibilities include:

- Serving as 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 SSA operational and policy components, state Medicaid agencies, RRB and CMS ROs; and
- Analyzing proposed and new legislation to determine impact on the state buy-in program.

6.1.1.2 The Office of Information Technology (OIT)

The Office of Information Technology (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.

Requests may be submitted 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 primary point of contact for general Third Party System (TPS) systems-related questions;
- Managing the daily and monthly operations of the 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)

The Offices of Hearings and Inquiries (OHI), Medicare Ombudsman Group (MOG), Division of Medicare Systems Exceptions and Inquiries (DMSEIDMSEI), formerly Division of Ombudsman Exceptions (DOE), has overall responsibility for the resolution of processing exceptions that states cannot correct through the data exchange. State problem requests should be submitted to DMSEI. See section 6.2 for information on how to submit a state buy-in problem resolution request.

Requests may be directed to DMSEI by email through the CMS State Buy-in resource mailbox at: statebuy-in@cms.hhs.gov.

DMSEI's mailing address is:

CMS, OHI, DMSEI
State Buy-In
P.O. Box 11977
Baltimore, MD 21207

6.1.1.4 The Center for Medicaid and CHIP Services (CMCS)

The Center for Medicaid and CHIP Services (CMCS), Children and Adults Health Programs Group, Division of Medicaid Eligibility Policy (DMEP) has overall responsibility for Medicaid eligibility related policy.

DMEP's mailing address is:

CMS, CMCS, CAHPG, DMEP
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)

The Medicare-Medicaid Coordination Office (MMCO), Program Alignment Group, 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 CMS Regional Office (RO)

The CMS RO responsibility for the state buy-in program may reside with either Medicare or Medicaid component of the RO. The state buy-in program is a cross-cutting program which impacts both Medicare and Medicaid programs. Each RO

will determine where the program can be most effectively administered. The ROs are responsible for liaison with the states, assessment of the state buy-in operation within the states, and coordination and implementation of procedures within the region (https://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/index.html).

Reminder: CMS policy requires all electronic communications containing Personally Identifiable Information (PII) to be encrypted or sent through a secured data exchange.

6.1.3 Social Security Administration (SSA) Field Office (FO) (or District Office (DO))

The responsibilities of the SSA FO/DO include assistance to beneficiaries, assistance to the states on state buy-in related issues, and the reporting of trends and problems encountered in the state buy-in process.

The additional responsibilities of the **parallel FO/DO** which is the office servicing the state Medicaid agency, include establishing rapport with the state to facilitate state buy-in operations as liaison, participating in state buy-in meetings attended by personnel from the State, CO and the RO, participating in state buy-in meetings attended by personnel from the state, CO and the RO, providing technical assistance on state buy-in procedures to other FOs/DOs within the state, and maintaining control on the problem cases forwarded to servicing FO/DOs because the cases cannot be resolved by the parallel FO/DO.

6.1.4 Social Security Central Office Baltimore, MD

The responsibilities of the SSA CO include the establishment and maintenance of the Master Beneficiary Record (MBR) and the Supplemental Security Income (SSI) Record, and the data exchange with CMS for third party data. This includes transmitting records to CMS for inclusion in the third party update and annotating the MBR with state buy-in data processed by CMS during the third party update.

6.1.5 Social Security Program Service Centers (PSC)

The PSCs annotate the MBR with state buy-in transactions which could not be processed electronically in the data exchange between CMS and SSA and assist with the resolution of problems pertaining to Medicare entitlement which may impact state buy-in.

6.1.6 Railroad Retirement Board (RRB)

The RRB annotates its master file with state buy-in data processed by CMS for RRB annuitants during the third party update and assists with the resolution of problems pertaining to Medicare entitlement which may impact state buy-in.

6.1.7 The State Medicaid Agency

The responsibilities of the state Medicaid agency include:

- Establishing internal procedures and systems to identify individuals who are eligible for state buy-in;
- Communicating this data to CMS;
- Respond to action taken by CMS on individual cases;
- Timely payment of Medicare premiums on behalf of the individuals within its jurisdiction who are eligible for state buy-in; and
- Assisting the FOs in resolving inquiries on behalf of individuals who are or may be eligible for state buy-in.

6.2 PROBLEM CASES – GENERAL

If after two attempts to correct a processing error through the data exchange the issue remains, a state buy-in problem resolution request can be reported to DMSEI by email, fax, or (if expedited resolution is required) by phone. Only individuals approved by their state Medicaid director may submit requests to or communicate with DMSEI about buy-in records. OFM DBPC maintains a list of approved individuals; states may add additional individuals by sending documentation of the state Medicaid director approval to OFM DBPC.

All necessary steps to investigate the problem and resolve the issue(s) will be taken including working collaboratively with SSA to correct issues that are outside of CMS' control.

Types of issues handled by DMSEI:

- Corrections to Medicare Part A and Part B entitlements;
- Billing adjustments to correct duplicate billing items and other billing errors;
- Providing technical assistance and ensuring best practices;
- Identification and corrections of systems-related processing errors; and
- Other issues as they arise.

A. The following information is required to identify and process a case.

- Beneficiary's Name;
- Beneficiary's Health Insurance Claim number or Medicare Beneficiary Identifier (MBI);
- Beneficiary's own SSN;
- Rejection code and alphabetic sub code, if applicable;

NOTE: Resolution requests submitted without the rejection code will be returned to sender with a note to identify the rejection type.

- Relief request or expectation

❑ All requests (mail, email and fax) must include the name, title, organization, address, and telephone number of the requestor.

❑ Phone

Contact the CMS buy-in analyst assigned to you in your Regional Office. Please restrict phone contact where possible to cases which require to be expedited, e.g., Congressional and other urgent matters. If you need a copy of current State Contacts listing, send a request to at statebuy-in@cms.hhs.gov.

❑ Email

B. To submit a buy-in problem resolution request by e-mail follow the steps below:

1. Direct e-mail to CMS state buy-in resource mailbox at statebuy-in@cms.hhs.gov;
2. Indicate "buy-in - <name of the state>" (e.g., buy-in - Oregon), in subject line. The name of the state name should be spelled out; do not abbreviate state name.
3. In the email cover include the information indicated under section C above.

Please allow 30 business days for processing.

If after 30 business days the problem/issue remains, submit a follow-up or 'second request' to the DMSEI.

C. To submit a 'second request,' follow the steps below:

1. Follow step "1" under section C above;
2. Indicate "second request" and <name of the state> in the e-mail subject line. The name of the state name should be spelled out; do not abbreviate state name.
3. Attach a copy of original e-mail request;
4. CC Nicole Jones at Nicole.Jones@cms.hhs.gov.Nicole.Jones@cms.hhs.gov.

D. If after 60 business days the problem/issue remains, submit an inquiry to DMSEI director, James Johnston.

1. Submit the request to the CMS state Buy-In resource mailbox at statebuy-in@cms.hhs.gov
2. Indicate "DMSEI Director" in the subject line of the e-mail; and

3. Attach copy of initial and 30-day follow-up e-mail requests.

Note: CMS policy requires all electronic communications containing Personally Identifiable Information (PII) to be encrypted or sent through a secured data exchange.

6.3 REFUND OF MEDICARE PREMIUMS TO INDIVIDUALS

Situations may arise when the state is paying Medicare premium for which the beneficiary has not received a refund of premiums paid out of pocket for the same period of time. The premiums may have been deducted from the SSA benefit check or may have been paid by the beneficiary as the result of a premium billing (CMS-500) by CMS. In nearly every situation, the failure to refund premiums occurred because SSA's records did not reflect state buy-in coverage.

States should refer these cases to DMSEI which can forward them to the appropriate SSA Program Service Center (PSC), if necessary. PSCs have access to CMS' third party billing master 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. When an individual alleges that he or she didn't receive a premium refund which was due, the PSC will verify the state buy-in data on the HIQR. The PSC should update the MBR and issue the appropriate Medicare premium refund to the individual.

6.4 CASES INVOLVING DUPLICATE BILLING

Occasionally, a beneficiary will have more than one Medicare entitlement record. If the state identifies such a case and buy-in coverage is present on both, the case should be sent to DMSEI for correction. The DMSEI will cross-reference the records. When the correction is outside of CMS' control the record will be referred to the agency with jurisdiction over Medicare entitlement, i.e., SSA or RRB.

6.5 CORRECTION OF DEMOGRAPHIC DATA ON THE THIRD PARTY MASTER RECORD

All demographic data on the third party master are derived from the CMS Enrollment Database (EDB), whose data originates with 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 correction is outside CMS' control the action will be referred to the agency with jurisdiction over Medicare entitlement, i.e., SSA or RRB.

6.6 RESOLUTION OF STATE BUY-IN PROBLEM CASES ON FORM CMS-1957, FO REPORT OF STATE BUY-IN PROBLEM

Form CMS-1957, SSO Report of State Buy-in Problem, was developed to facilitate the resolution of problem cases relating to state buy-in. In most instances the FO will have become aware of a problem through a beneficiary complaint. A sample of the form is in Appendix 6.A; the form is available on-line at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS017354 .

Form CMS-1957 is designed to accumulate the information needed to resolve the problem case. The completed form may be routed to the state or local eligibility office or to the DMSEI for resolution of the problem.

FO completes Part I, Report of Problem by SSO, and Part II, SSI status at FO (if applicable). The FO may need to contact the local eligibility office in order to be able to complete the identification block in 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. Usually the arrangements depend upon whether verification of state buy-in status is to be obtained from the local eligibility office (Part 3) or the state (Part 4) of the CMS Form 1957.

6.6.1 State Eligibility Office Verification Required

The state takes the following action when it receives Form CMS-1957:

- Completes Part III (Report of state buy-in status by Welfare Department) of Form CMS-1957 or reviews Part III for correctness if arrangements coordinated through state and SSA ROs call for Part III to be completed by SSA FO from information it obtains from the local welfare office;
- Reviews the accuracy of the information in the identification block on the upper right hand side of the form;
- Completes Part IV (Information from State’s Records or Actions Being Taken by state), on Form CMS-1957 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 which requires an adjustment of the accretion or deletion date, for example, the state may explain the problem in Part IV of Form CMS-1957 and request a correction or adjustment.

The parallel FO will forward Form CMS-1957 to the DMSEI for necessary action.

6.6.2 Local Eligibility Office Verification Required - State Verification Not Required

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 III, Report of buy-in Status by Welfare Department (leave Part IV blank).

If Part III shows that the beneficiary currently or previously had state buy-in coverage, FO routes the Form CMS-1957 to the DMSEI for resolution.

6.7 REPORT OF STATE BUY-IN PROBLEM CASE BY RAILROAD RETIREMENT BOARD (RRB) (FORM RL-380F)

RRB receives inquiries from Medicare beneficiaries (through its system of field offices) who allege that the Part B Medicare premium is being deducted from RRB annuity even though the beneficiary believes that the premium should be paid by the state Medicaid agency. Form RL-380F was developed to facilitate direct communication between RRB and the state Medicaid agencies in order to identify and resolve state buy-in problem cases affecting RRB Medicare beneficiaries. See Appendix 6.B.

The responsibility for state buy-in accretion and deletion activity is the responsibility of the state Medicaid agency. Exchange of information on Form RL-380F does not change any of the procedures currently in effect concerning the resolution of state buy-in problem cases. RRB will neither begin nor terminate Medicare premium deductions from the beneficiary's benefit check based upon the state’s response on Form RL-380F **unless** the state's response shows that the state has been paying the Medicare premium and the RRB can locate the record on the Third Party Master record.

If the local RRB field office is unable to resolve an issue for the state regarding the beneficiary’s Medicare entitlement, the state may contact the RRB in Chicago. The telephone number for the RRB in Chicago is (877) 772-5772 or (312) 751-3376.

APPENDIX 6.A SSO REPORT OF STATE BUY-IN PROBLEM (FORM CMS-1957)

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 ☐
Federal Admin. State Supp. ☐

Start Date

Stop Date

(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

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 0938-0035. The time required to complete this information collection is estimated to average 17.5 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 time 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-1957 (04/2018)

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)

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.

RL-380F (05-18)

CHAPTER 7 PROVISIONS SPECIFIC TO U.S. TERRITORIES

NOTE: Placeholder for future chapter on how U.S. territories pay for Medicare premiums.