

State Buy-In Manual Table of Contents

[U. S. Department of Health and Human Services](#)

[Health Care Financing Administration](#)

HCFA Pub. 24 (Basic) 9/96

The Electronic Publishing Unit makes every attempt to publish accurate and current information, however, we disclaim any liability or responsibility for any typographical errors, out of date information and/or other inaccuracies that may appear in this document.

eManual Contents			
<i>Please send comments to ePubs_updates@ifs.ohio.gov</i>			
<u>Forward</u>	<u>Chapter 1 - Background and Requirement</u>	<u>Chapter 2 - General Procedures</u>	<u>Chapter 3 - Data Exchange</u>
<u>Chapter 4 - Part B Buy-In System</u>	<u>Chapter 5 - Part B Transaction Codes</u>	<u>Chapter 6 - Part A Buy-In/Group Payer System</u>	<u>Chapter 7 - Part A Buy-In/Group Payer Transaction Codes</u>
<u>Chapter 8 - Premium Payments By States</u>			

FOREWORD

The State Buy-In Manual describes the policies and procedures governing the enrollment of individuals in the Part A and Part B State Buy-In program (including the Part A Group Payer program). Since the scope of the manual was expanded, the title of HCFA Publication 24 was changed from the State Buy-In Manual on Supplementary Medical Insurance Enrollment to the State Buy-In Manual. The manual is directed primarily to components within the State which administer the Buy-In Program.

The State Buy-In Manual (HCFA Publication 24) published in 1996, supersedes the State Buy-In Manual on Supplementary Medical Insurance Enrollment published in May 1983 and supersedes the 10 transmittals which were issued for that publication.

Future changes in policy and procedure will be incorporated directly into the State Buy-In Manual through the State Buy-In Manual transmittals. The transmittals will be numbered sequentially beginning with Transmittal No. 2.

Each entity which receives one or more copies of the State Buy-In Manual will receive the same number of copies of subsequent revisions to the State Buy-In Manual. Report any change of address for the manual to or request additional copies of the manual from the Health Care Financing Administration, Distribution Management Team - OFHR, 7500 Security Boulevard, Baltimore, MD. 21244-1850.

Chapter 1 Background and Requirement

(11-96)

100. General Description

Under a buy-in agreement, States may enroll people in the Premium Hospital Insurance Program (also referred to as Premium HI or Medicare Part A) and the Supplementary Medical Insurance Program (also referred to as SMI or Medicare Part B) and pay their premiums. The statutory authority for the Buy-In Program is §1843 of the Social Security Act.

The purpose of these arrangements is to permit the State, as part of its total assistance plan, to provide Medicare protection to certain groups of needy individuals. The arrangement also has the effect of transferring some medical costs for this population from the title XIX Medicaid program, which is partially State financed, to the title XVIII Medicare program, which is funded by the Federal government and by the payment of individual premiums. Federal financial participation (FFP) is available through the Medicaid program to assist the States with the premium payment for certain groups of recipients. (See §180.)

105. Medicare Entitlement

In order to be eligible for Part B buy-in, an individual must first be eligible to enroll in SMI.

The following people are eligible for SMI:

- People age 65 or over who have premium-free Medicare Part A (hospital insurance);
- All other people age 65 or over who are U.S. residents and either citizens or aliens lawfully admitted for permanent residence who have resided in the U.S. continuously during the 5 years immediately preceding the month they effectively apply for enrollment;
- People under age 65 who are eligible for premium-free HI because they have been entitled to monthly social security disability benefits under title II or railroad disability benefits for more than 24 months; and
- People who are eligible for premium-free HI because they have chronic renal disease.

In order to be included in a Part A buy-in agreement or group payer arrangement, an individual must be eligible to enroll in Premium Part A.

The following people are eligible for premium Part A:

- People age 65 or older who are not eligible for premium-free HI but are U.S. residents and either citizens or aliens lawfully admitted for permanent residence who have resided in the U.S. continuously during the 5 years immediately preceding the month they effectively applied for enrollment in Medicare. (These individuals may be eligible for payment of Part A premiums under either the State Buy-In Agreement or the Group Payer Program, depending upon the State in which they reside.)
- People under 65 who are eligible to enroll for premium HI under the Disabled Working Individual (DWI) program. These individuals are eligible for payment of Part A premiums only under the Group Payer program.

110. State Buy-In Agreements: Coverage Groups - General

(42 CFR 407.42 and 407.43)

Buy-In coverage groups include all individuals eligible to enroll in Medicare who are receiving or are eligible for a category of assistance under Medicaid as specified in the State's Buy-In Agreement or who are reported by the State to be a member of one of its coverage groups.

The State must buy-in for everyone who is a member of a buy-in coverage group which the State has elected to include in its Buy-In Agreement. The State cannot restrict buy-in coverage only to those individuals who incur medical expenses.

The State pays the Part A and/or Part B premium on behalf of each individual who is enrolled under a State Buy-In Agreement. Premiums paid under a State Buy-In Agreement are not subject to a premium surcharge for late enrollment. The monthly premium paid by the State on behalf of a cash assistance recipient, a deemed cash recipient, a Qualified Medicare Beneficiary (QMB), or a Specified Low Income Medicare Beneficiary (SLMB) is considered a vendor payment and is subject to the Federal matching formula applicable under title XIX of the Social Security Act. The Federal Medical Assistance Percentage (FMAP) is not applicable to the Medical Assistance Only (MAO) category of recipients. (See §180.)

A State may elect to enroll the following categories of Medicaid recipients in SMI under the State's Buy-In Agreement:

- Cash assistance recipients (and certain individuals who are deemed to be cash assistance recipients) who are covered under the State's Medicaid plan as categorically needy;
- Cash assistance recipients (and certain individuals who are deemed to be cash assistance recipients) who are covered under the State's Medicaid plan as categorically needy, QMBs, and SLMBs; or
- Cash assistance recipients (and certain individuals who are deemed to be cash assistance recipients) who are covered under the State's Medicaid plan as categorically needy, QMBs, SLMBs, and all other individuals who are eligible for Medicaid.

In addition, a State may elect to enroll QMBs in Premium Part A under its buy-in agreement.

115. Effect of Supplemental Security Income (SSI) On Part B State Buy-In Coverage Groups

The Supplemental Security Income (SSI) program which became effective January 1, 1974, replaced the State administered titles I, X, XIV, and XVI (aid to the aged, blind, and disabled). The federally administered title XVI (SSI) is effective in the District of Columbia, the Northern Mariana Islands and the 50 States. However, the State administered titles I, X, and XIV remain in effect in Puerto Rico, Guam, and the Virgin Islands.

Some States have entered into "1634 agreements" with the Social Security Administration (SSA). In these States, Medicaid eligibility standards are the same as SSI eligibility standards, making all SSI recipients who are eligible for SMI eligible for Medicaid and therefore eligible for Part B buy-in. Recipients of a State supplement are also eligible for both Medicaid and Part B buy-in. Recipients of SSI or federally administered supplement payments are automatically accreted to buy-in based upon their SSI status. States which have entered into a "1634 agreement" are referred to as "accrete" or "auto-accrete" States.

States with more restrictive eligibility standards for Medicaid are referred to as "209b" States or "SSI alert" States. These States make their own Part B buy-in determinations. The Health Care Financing Administration (HCFA) sends an SSI alert record to these States to notify them of an individual's SSI status.

A few States use SSI eligibility standards but have opted to make their own Medicaid eligibility and Part B buy-in eligibility determinations.

120. Part B State Buy-In Status By State

All State Buy-In Agreements were effective July 1, 1966, with the following exceptions: Alaska - October 1, 1982, Commonwealth of the Northern Mariana Islands - July 1, 1989, Louisiana - July 1, 1985, Oregon - January 1, 1984, and Wyoming - April 1, 1989. Wyoming's previous Buy-In Agreement was effective from July 1, 1966, through July 31, 1967.

A number of States which have bought in for all of their medical assistance recipients under title XIX do not provide title XIX approved medical assistance to the medically needy. In those States, the only non-cash recipients who are eligible for buy-in (the MAO category) are non-cash recipients who are categorically needy; e.g., certain institutionalized individuals.

The following chart shows States with 1634 agreements as accrete and those which are 209b as alert. Those using SSI standards but making their own buy-in determinations are shown as alert*. All States except Kentucky (180) include Part A of title IV (AFDC) in their buy-in coverage groups.

Part B State Buy-In Status By State					
AGENCY CODE	STATE	SSI STATUS ACCRETE OR ALERT	STATE SUPP. Man.	ADM. Opt.	TITLE XIX MA ONLY
010	Alabama (1)	Accrete	State	State	1/1/92
020	Alaska	Alert*	State	State	10/1/82
030	Arizona	Accrete	State	State	1/1/82
040	Arkansas	Accrete	Fed	N/A	1/1/70
050	California	Accrete	Fed	Fed	1/1/70
060	Colorado (2)	Accrete	State	State	3/1/69
640	Commonwealth of the No.	Alert	N/A	N/A	1/1/89
070	Connecticut	Alert	State	State	
080	Delaware	Accrete	Fed	Fed	
090	District of Columbia	Accrete	Fed	Fed	8/1/69
100	Florida	Accrete	Fed	State	2/1/70
110	Georgia	Accrete	Fed		4/1/68
650	Guam	I,IV,X,XIV,XIX			7/1/68
120	Hawaii	Alert	Fed	Fed	1/1/70
130	Idaho	Alert*	State	State	4/1/68-2/28/83
140	Illinois	Alert	State	State	
150	Indiana	Alert	State	State	1/1/70
160	Iowa	Accrete	Fed	Fed	1/1/70

170	Kansas	Alert*	Fed	N/A	4/1/68
180	Kentucky	Accrete	State	State	
190	Louisiana	Accrete	Fed	State	
200	Maine	Accrete	Fed	Fed	4/1/68-8/31/74
210	Maryland (3)	Alert*	Fed	State	1/1/72
220	Mass.-DMA (4)	Accrete	Fed	Fed	
22A	Mass.-Blind (4)	Accrete	Fed	Fed	
230	Michigan (5)	Accrete	Fed	Fed	8/1/81
240	Minnesota	Alert	State	State	
250	Mississippi (6)	Accrete	Fed	N/A	1/1/70
260	Missouri	Alert	State	State	
270	Montana	Accrete	Fed	Fed	3/1/70-2/28/92
280	Nebraska	Alert	State	State	4/1/68-3/31/69
290	Nevada	Alert*	Fed	Fed	5/1/69
300	New Hampshire	Alert	State	State	
310	New Jersey	Accrete	Fed	Fed	1/1/70
320	New Mexico	Accrete	State	State	1/1/70
330	New York (7)	Accrete	Fed	Fed	
340	No Carolina (8)	Accrete	State	State	1/1/70
350	North Dakota	Alert	State	State	
360	Ohio	Alert	Fed	State	4/1/68
370	Oklahoma	Alert	State	State	
380	Oregon	Alert	State	State	1/1/84
390	Pennsylvania	Accrete	Fed	Fed	
400	Puerto Rico				
410	Rhode Island	Accrete	Fed	Fed	
420	South Carolina	Accrete	State	State	7/1/68
430	South Dakota	Accrete	Fed	State	
440	Tennessee	Accrete	Fed	N/A	12/1/69-3/31/76

450	Texas	Accrete	N/A	N/A	4/1/68-6/30/90
460	Utah	Alert	Fed	Fed	10/1/71
470	Vermont (9)	Accrete	Fed	Fed	
480	Virgin Islands	I,IV,X,XIV,XIX			9/1/68-6/30/93
490	Virginia	Alert	State	State	9/1/69
500	Washington (10)	Accrete	Fed	Fed	5/1/68
510	West Virginia	Accrete	N/A	N/A	
520	Wisconsin (11)	Accrete	Fed	Fed	4/1/82-7/31/83
530	Wyoming	Accrete	State	State	4/1/89

Footnotes:

1. Alabama included MAO 1/1/70 - 9/30/86
2. Colorado - alert State 1/74-11/81
3. Maryland - alert State 1/74-12/74, accrete State 1/75-4/79
4. RSDI or RRB beneficiaries receiving cash assistance under Part A of title IV are not covered under buy-in in Massachusetts.
5. Michigan - accrete State 1/74-6/75, alert State 7/75-8/76
6. Mississippi - alert State 1/74-6/81
7. New York - alert State 9/80-7/82
8. North Carolina - alert State 1/74-12/94
9. Vermont - alert State 1/74-6/74
10. Washington - alert State 1/74-6/77
11. Wisconsin included RSDI and RRB beneficiaries receiving SSI or a State supplement under buy-in coverage effective 11/1/75. Beneficiaries receiving cash assistance under Part A of title IV are covered under buy-in effective 4/1/82.

Footnotes (to above table):

1. Alabama included MAO 1/1/70 - 9/30/86
2. Colorado - alert State 1/74-11/81
3. Maryland - alert State 1/74-12/74, accrete State 1/75-4/79
4. RSDI or RRB beneficiaries receiving cash assistance under Part A of title IV are not covered under buy-in in Massachusetts.
5. Michigan - accrete State 1/74-6/75, alert State 7/75-8/76
6. Mississippi - alert State 1/74-6/81
7. New York - alert State 9/80-7/82
8. North Carolina - alert State 1/74-12/94
9. Vermont - alert State 1/74-6/74
10. Washington - alert State 1/74-6/77

11. Wisconsin included RSDI and RRB beneficiaries receiving SSI or a State supplement under buy-in coverage effective 11/1/75. Beneficiaries receiving cash assistance under Part A of title IV are covered under buy-in effective 4/1/82.

125. Individuals in Title XIX Institutions

(FOR PART B STATE BUY-IN PURPOSES ONLY)

Generally, residents of public institutions throughout a full calendar month are ineligible for SSI. However, there are several exceptions to this rule. One of these exceptions is when the public institution is a medical treatment facility and Medicaid pays more than 50 percent of the cost of care.

In general, the SSI payment is limited to a maximum of \$30 per month (plus State supplemental payments, if any, less any countable income if:

- The individual is a resident through a month in either a public or private medical treatment institution; and
- Medicaid pays or is expected to pay over 50 percent of the cost of care for that month.

There are two exceptions to the payment limit:

- Individuals who participate in the work incentive in §1619 of the
- Social Security Act may receive the full SSI payment for the first 2 full months of institutionalization; and
- If a physician certifies that the recipient's stay in a medical facility is likely not to exceed 3 months, and the recipient needs to continue to maintain and provide for the expenses of the home to which to return, the recipient may receive the full SSI payment for the first 3 months of institutionalization.

If a State has included title XIX MAO in its buy-in agreement, the system will continue an individual on Part B buy-in if the beneficiary loses SSI or a federally administered State supplement and the living arrangement code changes to "D" (living in a title XIX institution). The third party system will convert the billing item from Federal jurisdiction to State jurisdiction. The State should verify continuing eligibility for this type case.

130. Deemed Cash Recipients

(FOR PART B STATE BUY-IN PURPOSES ONLY)

Some individuals lose their eligibility for cash assistance because of an increase in Social Security benefits, Department of Veterans Affairs (DVA) benefits, or earnings. Congress has determined that in certain cases, Medicaid benefits for these individuals should continue as if their cash assistance had continued. Eight specific laws cover these situations.

A. Section 249E of P.L. 92-603 (Social Security Amendments of 1972).

This provision mandates that any individual who is an SSI, State supplement, or cash assistance recipient under a State plan approved under titles I, X, XIV, XVI, or Part A of title IV for any month after August 1972 will be considered eligible for Medical assistance and buy-in coverage if:

- For August 1972, the individual was eligible for cash assistance under such plan for the State;
- For August 1972, the individual was entitled to monthly insurance benefits under title II of the Social Security Act; and
- For such month (after August 1972), the individual would be eligible for SSI, a State supplement, or cash assistance under a State plan if the 20 percent increase in monthly insurance benefits under title II of the act provided by P.L. 92-336 effective September 1972 were not applicable for such individual. (Although P.L. 92-603 provided for coverage under this provision only until September 1974, P.L. 93-66 extended this coverage through June 1975 and P.L. 94-48 extended this coverage indefinitely. It does not apply to title II increases for any month other than August 1972.)

This provision affects buy-in as follows:

- Buy-In coverage is affected primarily in those States which have bought in only for cash assistance recipients or which have included only the categorically needy in their title XIX plans. However, the provision could affect the month in which an individual's buy-in coverage begins in States which have bought in for title XIX MAO.
- If a person who has Medicaid as a result of this provision loses eligibility for some other reason; e.g., has an increase in resources, and subsequently reestablishes eligibility, the beneficiary should be placed on buy-in immediately. Because the individual is treated as a cash recipient, the normal 2 month waiting period is waived.
- Any cases that have been improperly deleted should be reaccreted to provide continuous buy-in coverage.
- State records should be annotated to indicate deemed cash pay status to prevent inappropriate deletion activity. Also, in order to provide a continuing record for the State's use in the monthly billing exchange, the State may use code 99 procedure to add a special alpha code in position 50 or earmark one of the alpha or numeric positions in the State welfare identification field. If the State decides to use a special code in position 50, it may wish to consider the letter Z for this purpose as HCFA will not use a code Z for any other reason.

B. Section 503 of P.L. 94-566.--Under this law, those recipients of SSI or State supplements who lose those payments due to cost of living increases in title II benefits, and would still be eligible for those payments were it not for the title II cost of living increases, will be treated as continuing to receive those payments for purposes of Medicaid eligibility and buy-in coverage. This law is effective with respect to Medicaid eligibility in July 1977, and thereafter, and applies to cost of living increases for June 1977 and all subsequent cost of living increases provided by §215(i) of the Social Security Act.

C. Section 1619 of Social Security Act.--This section provides continued Medicaid eligibility for certain disabled or blind persons who lose SSI benefits or State supplements because they are performing substantial gainful activity (SGA). Originally effective only through December 30, 1983, these provisions were extended through June 30, 1987, by §14 of P.L. 98-460 (Social Security Disability

Benefits Reform Act of 1984) and were made permanent by §2 of P.L. 96-643 (Employment Opportunity for Disabled Americans Act of 1986).

A disabled or blind individual may qualify for a special SSI or State supplemental monthly payment provided earnings and other income are within prescribed limits set forth in this law. This special payment is treated the same as the regular SSI and State supplement payment for purposes of Medicaid eligibility.

Medicaid eligibility is continued for blind and disabled persons who lose SSI or State supplement benefits because of their earnings and whose ability to continue employment or self-employment would be seriously impaired by termination of Medicaid and whose earnings are insufficient to provide the reasonable equivalent of the cash payments and Medicaid benefits (and in the case of determinations made under this law before October 1, 1981, title XX social services) which would be available to them in the absence of such earnings. These individuals will not receive any cash assistance but their Medicaid status as categorically needy cash assistance recipients will continue for buy-in purposes.

- D. Section 1902(e) of Social Security Act.--This section requires that when a family's AFDC is terminated because of increased earnings or hours of work, or both, Medicaid eligibility shall continue for 4 calendar months thereafter. Buy-in eligibility during that period is continued as though the family were still receiving AFDC.
- E. Section 2624 of P.L. 98-369 (Deficit Reduction Act of 1984).--This section specifies that, effective July 18, 1984, in situations where a family loses AFDC eligibility solely because a member of the family is no longer eligible for either the \$30 or the \$30 and one-third monthly earnings disregard, the family is deemed to be eligible for AFDC for Medicaid eligibility purposes only for a period of 9 months following the last month of actual AFDC eligibility and, at State option, for an additional period of up to 6 months. Section 2361 of P.L. 98-369 provides that certain medically verified pregnant women also are deemed to be receiving AFDC benefits.
- F. Section 2316 of P. L. 97-35.--This section requires that when an individual is denied a cash payment from the title IV-A State agency solely because the amount of the AFDC payment would be less than \$10, the individual must be deemed to be receiving AFDC.
- G. Section 20 of P.L. 98-378 (Child Support Enforcement Amendments of 1984). --This section requires States to continue to provide Medicaid benefits for 4 calendar months to a family which loses AFDC eligibility due to the collection or increased collection of support payments, provided the family received AFDC benefits in at least 3 of the 6 months preceding the month of AFDC ineligibility. This provision applies to families which become ineligible for AFDC benefits on or after August 16, 1984, and before October 1, 1988.
- H. Section 310(b) of P.L. 96-272 (Adoption Assistance and Child Welfare Act of 1980).--This section provides Medicaid eligibility and buy-in coverage for certain individuals who, in December 1978, were receiving a pension from DVA and were eligible for and receiving cash assistance under the Social Security Act. P.L. 96-272 also provided that recipients of benefits under Part E of title IV are deemed to be AFDC recipients and thus, eligible for Medicaid and buy-in.

The 2-month waiting period is not required for the beginning of buy-in coverage under subsections A through H.

135. Qualified Medicare Beneficiaries (QMBs)

Section 301 of the Medicare Catastrophic Coverage Act (MCCA) of 1988 mandated that the State Medicaid programs pay the Medicare cost sharing expenses (Medicare premiums, deductibles, and coinsurance) for a category of individuals known as QMB.

A QMB is an individual:

- Who is entitled to Medicare hospital insurance, Medicare Part A, including premium Part A, except when the premium Part A is based on the working disabled provisions. (See §150.)
- Whose income does not exceed 100 percent of the official poverty line as defined by the Executive Office of Management and Budget (EOMB) and revised annually under §673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981; and
- Whose resources do not exceed twice the SSI resource limit.

Buy-In (Part A and/or Part B) is effective with the first month for which a person is determined to have QMB status. (QMB eligibility cannot be made retroactive.) The buy-in effective date for a QMB can be no earlier than January 1989. However, a beneficiary who meets the requirements of a QMB may also qualify for buy-in for an earlier date as a member of another buy-in coverage group.

For SMI, QMBs are deemed to be included in all existing State Buy-In Agreements in the 50 States and the District of Columbia. The QMB program is optional in Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands even though they have buy-in agreements. The QMB program is also optional in American Samoa and Puerto Rico which do not have buy-in agreements.

The majority of States include the payment of Medicare premiums for premium HI in their State Buy-In Agreements. The remaining States use the group payer arrangement. Part A State buy-in follows the same principles as Part B buy-in, i.e., the State's accretion action can result in the creation of Part A Medicare entitlement if the beneficiary is enrolled in Medicare Part B. In States which pay the premiums under the group payer arrangement, the beneficiary must first enroll for Medicare Part A. This enrollment can be either an actual or a conditional enrollment. Refer to the chart in §140 and to Chapter VI.

140. Part A Status By State

(FOR QMBs ONLY)

Part A Status By State:

Part A Status By State			
AGENCY CODE	STATE	PART A BUY-IN	PART A GROUP PAYER
S01	Alabama		X
S02	Alaska	X	
S03	Arizona		X
S04	Arkansas	X	
S05	California		X
S06	Colorado		X
640	Comm. of No. Mariana Is.	N/A	N/A
S07	Connecticut	X	
S08	Delaware	X	
S09	District of Columbia	X	
S10	Florida	X	
S11	Georgia	X	
650	Guam	N/A	N/A
S12	Hawaii	X	
S13	Idaho	X	
S14	Illinois		X
S15	Indiana	X	
S16	Iowa	X	
S17	Kansas		X
S18	Kentucky		X
S19	Louisiana		X
S20	Maine	X	

S21	Maryland	X	
S22	Mass. DMA	X	
S2A	Mass. Blind	X	
S23	Michigan	X	
S24	Minnesota	X	
S25	Mississippi	X	
S26	Missouri		X
S27	Montana	X	
S28	Nebraska		X
S29	Nevada	X	
S30	New Hampshire	X	
S31	New Jersey		X
S32	New Mexico		X
S33	New York		X
S34	North Carolina	X	
S35	North Dakota	X	
S36	Ohio	X	
S37	Oklahoma	X	
S38	Oregon		X
S39	Pennsylvania	X	
S40	Puerto Rico	N/A	N/A
S41	Rhode Island	X	
S42	South Carolina		X
S43	South Dakota	X	
S44	Tennessee	X	
S45	Texas	X	
S46	Utah		X
S47	Vermont	X	
S48	Virgin Islands	N/A	N/A

S49	Virginia		X
S50	Washington	X	
S51	West Virginia	X	
S52	Wisconsin	X	
S53	Wyoming	X	

145. Specified Low Income Medicare Beneficiaries (SLMBs)

(FOR PART B STATE BUY-IN PURPOSES ONLY)

Section 4501 (b) of OBRA 1990 mandated that the State Medicaid programs pay the Medicare Part B premiums for a category of individuals known as SLMB. The SLMB program does not include State payment of Part A Medicare premiums.

A SLMB is an individual who meets all of the eligibility requirements for QMB status except for income in excess of the QMB income limit but not exceeding certain specified limits.

Buy-in is effective with the first month for which a person is a SLMB. A SLMB determination may be retroactive for a maximum of 3 months. The buy-in effective date for a SLMB can be no earlier than January 1993. However, a beneficiary who meets the requirements of a SLMB may also qualify for buy-in for an earlier date as a member of another buy-in coverage group.

SLMBs are deemed to be included in all existing State buy-in agreements in the 50 States and the District of Columbia. The SLMB program is optional in Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands even though they have buy-in agreements. The SLMB program is also optional in American Samoa and Puerto Rico which do not have buy-in agreements.

150. Qualified Disabled Working Individuals (QDWIs)

(FOR PART A GROUP PAYER PURPOSES ONLY)

Section 6408 of OBRA 1989 mandated that the State Medicaid programs pay the Medicare Part A premiums for a category of individuals known as QDWI. The QDWI program does not include State payment of Part B Medicare premiums.

A QDWI is an individual:

- Who lost premium-free HI solely because of work and is entitled to enroll in Part A under §1818A of the Social Security Act;
- Whose income does not exceed 200 percent of the official poverty line as defined by the EOMB and revised annually under §673(2) of OBRA 1981;
- Whose resources do not exceed twice the SSI resource limit; and
- Who is not otherwise eligible for Medicaid.

The State will pay the Part A premiums under the Part A group payer system rather than the Part A buy-in system. The beneficiary must be entitled to Medicare Part A before the State can pay the premium. Conditional Part A enrollment does not apply to the QDWI program.

State payment of Part A premiums is effective with the first month for which a person is a QDWI. The effective date for a QDWI can be no earlier than July 1990.

The QDWI program is mandatory in the 50 States and the District of Columbia. It is optional in Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, and Puerto Rico.

155. Reduced Part A Premiums

Section 13508 of P.L. 103-66 provides that an individual, age 65 or older, who is not insured for monthly title II benefits and/or premium-free HI or an individual who pays the Part A premium as a DWI who has at least 30 work credits under Social Security, is eligible for a reduction in the amount of the Part A premium effective with the January 1994 billing month. The Part A premium is reduced 25% in 1994 and is reduced by an additional 5% per year until the full reduction of 45% is reached in 1998. The following individuals may qualify for the reduced Part A premium based upon their relationship to a number holder (NH) who has 30 work credits:

- A spouse who has been married for at least 1 year to the NH who has 30 work credits;
- A widow(er) who was married to a NH who had 30 work credits if the marriage was in effect for at least 1 year prior to the NH's death; and
- A divorced spouse (including a surviving divorced spouse) who was married to the NH for at least 10 years if the NH had at least 30 work credits as of the date the divorce became final.

160. Definition of Coverage Period Under State Buy-In Agreement

- A. When Buy-In Coverage Period Begins (42 CFR 407.47).--If HCFA makes an accretion based on data contained in the SSI master record, the Part B buy-in coverage period begins with the first month for which HCFA determines the individual meets the eligibility requirements for inclusion in the coverage group. That is the first month the person is eligible for both Medicare and SSI or a federally administered State supplement and is a resident of the State.

If the State makes an accretion for a QMB, SLMB, or for a recipient of cash assistance (either SSI, a State supplement, or Part A of title IV), the Part B buy-in coverage period (or Part A in the case of a QMB) begins with the month reported by the State as the date the individual became a member of the coverage group.

For States which include non-cash title XIX MAO in their agreement, Part B buy-in coverage for an individual eligible for MAO begins the first day of the second month after the month in which the State makes the determination that the individual is eligible for medical assistance. However, buy-in coverage is continuous for an individual who loses eligibility for cash assistance but whose Medicaid eligibility continues without interruption. If an individual begins to receive cash for a month earlier than the month coverage as a MAO eligible would begin, the beginning date of buy-in coverage is the first month for which a cash payment was received.

HCFA will adjust a State submitted accretion to a later date if one of the following conditions exists:

- HCFA records show that the individual does not meet all the requirements for Medicare coverage; e.g., is not yet 65 on the requested accretion date;
- The accretion date submitted falls in the middle of a period of buy-in coverage for another State on HCFA's records; i.e., it is later than the accretion date and earlier than the deletion date; or
- The accretion date submitted is earlier than the effective date of the submitting State's Buy-In Agreement.

- B. When Buy-In Coverage Period Ends (42 CFR 407.48).--Buy-In coverage ends with the earliest of the events specified in the following paragraphs:

- Death.--Coverage ends on the last day of the month in which the individual dies.
- Loss of Entitlement to Hospital Insurance Benefits.--If an individual is under age 65 and loses entitlement to Hospital Insurance (HI), buy-in coverage ends on the last day of the last month for which he is entitled to HI benefits.
- Loss of Eligibility in Coverage Group.--If an individual loses eligibility for inclusion in the State's coverage group, buy-in coverage ends:
 1. On the last day of the last month for which the beneficiary is eligible for inclusion in the coverage group, if the State notifies HCFA within a reasonable time. (See subsection C.3.); or
 2. On the last day of the second month before the month in which HCFA receives a deletion notice which the State did not submit within a reasonable time. (See subsection C.3.) A deletion notice received by HCFA after the 25th day of the month will be considered to have been received in the following month.
- Termination or Modification of Buy-In Agreement.--If the State's Buy-In Agreement is terminated or modified to restrict coverage to a narrower coverage group, coverage ends on the last day of the last month for which the buy-in agreement is in effect or the last day of the last month for which the buy-in agreement included the broader buy-in coverage group.

- C. Notification of Eligibility or Ineligibility for Coverage Under State Buy-In Agreement for Individuals for Whom State Makes Determination.--

1. Form of Notification.--A State must notify HCFA of individuals who are eligible or ineligible for coverage under the State's Buy-In Agreement. Notification is accomplished through the accretion and deletion of records submitted by the State in the monthly data exchange.
2. Notice of Eligibility.--It is limited to the effective date of the buy-in agreement (or relevant modification) or to the first month of eligibility in the coverage group as determined by the State and reported to HCFA in accordance with prescribed procedures (without regard to the retroactivity of such determination).
3. Notice of Ineligibility.--It is considered to be received by HCFA within a reasonable time:
 - If the deletion notice is received by HCFA no later than the 25th day of the second month after the month in which the individual no longer is a member of the State's coverage group except as specified in the following paragraph; or
 - If HCFA initially determined the individual's eligibility for inclusion in the State's coverage group, the deletion notice must be received by HCFA no later than the 25th day of the second month after the month in which HCFA sends a notice to the State that the individual no longer is receiving SSI or a federally administered State supplement.

D. Coverage Period for Guam and the Virgin Islands.--

1. When Buy-In Coverage Period Begins.--A buy-in coverage period begins with the month (equal to or later than the effective date of the State's buy-in agreement) reported to HCFA by the State as the date an eligible individual became a member of the coverage group. State submitted accretion dates are, however, subject to adjustment to a later date by HCFA if one of the following conditions exist:
 - HCFA records show that the individual does not meet all the requirements for Part B coverage; e.g., is not yet 65 on the requested accretion date;
 - The accretion date submitted falls in the middle of a period of buy-in coverage for another agency on HCFA's records; i.e., it is later than the accretion date and earlier than the deletion date; or
 - The accretion date submitted is earlier than the effective date of the submitting State's Buy-in Agreement.
2. When Buy-In Coverage Period Ends.--Buy-In coverage ends with the earliest of the events specified in the following paragraphs:
 - The month reported to HCFA by the State as the last month the individual was a member of the coverage group, but no earlier than 2 months prior to the month in which the State reports the deletion to HCFA. (A deletion notice received after the 25th day of the month is considered to have been received in the following month.);
 - The last month an individual, under age 65, is entitled to HI under Medicare; or
 - The month in which the individual dies.

165. Effect of State Buy-In On Individual

When an individual becomes a member of the State's coverage group and the State buys-in, a number of other records are affected. If the beneficiary is receiving a Social Security check or an RRB annuity, the SMI premium will no longer be deducted from the benefit resulting in a higher monthly payment. If the beneficiary was not receiving a Social Security check or an RRB annuity, but instead was being billed directly for HI and/or SMI, direct billing will cease. In both cases, the individual will receive a refund of any premiums deducted or paid for any month the beneficiary was on buy-in.

NOTE: The refund of Medicare premiums must not be considered income when determining eligibility for assistance or for spenddown. In the event that a State accretes an individual to buy-in with greater retroactivity than the individual was eligible for under the State's program, the individual beneficiary is entitled to keep the premium refund for these months and the State may not attempt to recoup its premium indebtedness from the beneficiary.

If the individual previously refused HI or SMI or withdrew from it, entitlement will be established or re-established effective with the first month the beneficiary was eligible for buy-in. When buy-in ends, the beneficiary has the option to then withdraw if the beneficiary does not want the coverage to continue. However, if the beneficiary does not withdraw, the premium will be the base rate even if the beneficiary had been paying a penalty premium for late enrollment prior to accretion to buy-in. If the beneficiary is a resident of a Part A group payer State and the Part A premium paid by the State for the beneficiary included the surcharge for late enrollment, the surcharge will be included in the premium bill which is sent to the beneficiary.

The State may report a simultaneous accretion/deletion in which both events occurred prior to the State's notice to HCFA. For example, the State may notify HCFA that an individual is to be both accreted as of a given month and deleted as of a specified later month (such later month being the month in which the State determined that the beneficiary became ineligible).

A closed period of buy-in coverage may be used by Part A or Part B buy-in States but cannot be used by Part A group payer States. When the reported deletion month does not represent a current item; i.e., when the effective deletion month is 3 or more months before the month in which HCFA received the prescribed notice of accretion and deletion, the enrollee is awarded a closed period of buy-in coverage and has buy-in coverage only for the months reported by the State.

The State is liable for premium payments only for those months, and the enrollee's current HI or SMI coverage status is not affected. When the enrollee had individual coverage and paid premiums for any of the months in the closed period, premiums for those months are refunded to the beneficiary.

If the individual does not have current HI or SMI coverage and the termination date of the closed period is 3 or more calendar months before the month of notice, the individual is not awarded individual coverage following the period of buy-in coverage, as would be normal after buy-in. However, the records are annotated to reflect the prior buy-in coverage. Also, if the individual enrolls for HI or SMI at a later date, only those months after the buy-in coverage period will be counted in determining the statutory premium increase for late enrollment.

If the enrollee has current coverage and is paying increased premiums, the premium rate will be adjusted to the standard premium amount for all months after the buy-in period. Any amount the beneficiary paid in excess of the standard premium will be refunded. The beneficiary also will have the right to re-enroll if the beneficiary terminates present coverage.

170. Termination and Withdrawal of HI Or SMI After State Buy-In Coverage Ends

When an individual's HI or SMI coverage under a State Buy-In Agreement ends, the beneficiary is deemed to have enrolled in the initial enrollment period (IEP). When an individual's HI coverage under a State group payer arrangement ends, enrollment continues under the same conditions as were applicable when the State paid the beneficiary's premium; i.e., the Part A premium may be subject to a penalty for late enrollment.

Any individual whose buy-in coverage has been terminated and who files a notice requesting termination of HI or SMI during the last month of buy-in coverage or during the 6 succeeding months will have HI or SMI terminated at the end of the month in which the beneficiary filed the notice. This provision is also applicable in Part A group payer States. This provision became effective April 1, 1981.

Effective July 1, 1987, if any individual waits more than 6 months after buy-in ends to request withdrawal from HI or SMI, coverage ends at the end of the month after the month in which the beneficiary notifies SSA or HCFA that he/she wishes to withdraw.

NOTE: States did not begin to pay Part A premiums until January 1, 1989.

If the beneficiary is billed directly for Part B premiums because he/she is not receiving Social Security or RRB benefits and does not pay the Part B premiums, Part B coverage ends at the end of the third month after the month in which the premium bill is sent. If the beneficiary is billed for Part A premiums and does not pay the Part A premiums, Part A coverage ends at the end of the third month after the month in which the premium bill is sent.

175. Equitable Relief After Termination of State Buy-In Coverage

Under current procedures an individual's HI coverage under Part A buy-in/group payer cannot be terminated any earlier than the update month. After HCFA receives a deletion notice from the State and it is processed to the Third Party Master, HCFA sends a notice (usually Form HCFA-L 1617) to the individual telling the individual that he/she is responsible for paying the Part A premium beginning with the month following the last month the State paid the Part A premium.

An individual's SMI coverage under State buy-in can be terminated retroactively for as many as 2 months before the State notifies HCFA that the beneficiary is no longer eligible. After HCFA processes the buy-in deletion notice, HCFA sends a notice (usually Form HCFA-L 1636) to the individual telling the individual that he/she is responsible for paying the SMI premiums beginning with the month following the last month of State buy-in coverage.

Due to administrative delays, the beneficiary may be in the third month after buy-in termination and owe 3 months of HI or SMI premiums before being notified that buy-in coverage has been terminated. Equitable relief can be granted to allow an individual's HI or SMI coverage to end effective with the termination of buy-in coverage (thus allowing the beneficiary to avoid entirely any premium liability) if all of the following conditions are met:

- The individual submits a written request to have HI or SMI coverage terminate effective with the end of buy-in coverage;
- Such request is filed within 30 days of the date of Form HCFA-L 1617 or Form HCFA-L 1636 or other such notice informing the beneficiary of the buy-in termination; and
- The individual certifies that he/she has incurred no medical services covered under HI or SMI (which ever is applicable) during the months after buy-in termination.

180. Federal Medical Assistance Percentage (FMAP)

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 HCFA-64). The expenditures for allowable Part A premiums are claimed on line 17.A of the Form HCFA 64.9 or 64.9P (whichever applies). The expenditures for allowable Part B premiums are claimed on line 17.B of the Form HCFA-64.9 or 64.9P. The premium payment made on behalf of a non-cash Medical Assistance recipient (MA Only) does not qualify for Federal matching.

States that cover the MAO in their buy-in agreement are required to identify these enrollees in accordance with the procedures outlined in §410. Failure to identify the MAO recipients may result in erroneous FMAP payments to the State for Part B premiums.

185. Part A Medicare Premium

Section 1818 of the Social Security Act specifies that the Secretary of the Department of Health and Human Services (DHSS) shall determine the amount of the monthly Part A premium to be paid on behalf of each individual who is not otherwise eligible for premium free HI but is enrolled for premium HI. Part A premiums paid on behalf of individuals enrolled in the State Buy-in Program as QMBs are not subject to a surcharge for late enrollment. Part A premiums paid on behalf of individuals enrolled in the State Group Payer Program as QMBs or QDWIs are subject to the late enrollment surcharge.

Chart of Monthly Part A Premium Amounts:

Chart of Monthly Part A Premium Amounts		
Effective Date	Base Rate	10% Surcharge
01/89 - 12/89	\$156.00	\$171.60
01/90 - 12/90	\$175.00	\$192.50
01/91 - 12/91	\$177.00	\$194.70
01/92 - 12/92	\$192.00	\$211.20
01/93 - 12/93	\$221.00	\$243.10
01/94 - 12/94	\$245.00	\$269.50
01/95 - 12/95	\$261.00	\$287.10
01/96 - 12/96	\$289.00	\$317.90
01/97 - 12/97	\$311.00	\$342.10

Section 13508 of P.L. 103-66 provides for reduced Part A premiums. The conditions under which the reduced Part A premium is applicable are described in §155. The Part A premium is reduced by 25% beginning in 1994 and is reduced by an additional 5% per year until the full reduction of 45% is reached in 1998.

Chart of Monthly Reduced Part A Premium Amounts:

Chart of Monthly Reduced 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

190. Part B Medicare Premium

Section 1839 of the Social Security Act specifies that the Secretary of DHSS shall determine the amount of the monthly Part B premium to be paid by or on behalf of each individual who is enrolled in the Supplementary Medical Insurance Program. 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. 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.

Chart of Monthly Part B Premium Amounts:

Chart of Monthly 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
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 -	\$43.80

* Due to Presidential price freeze

** Applicable to beneficiaries who have "Part B only" under a provision of the MCCA and was applicable only during 1989.

*** Section 103 of P.L. 100-360 set the Part B premium rate through 1995.

Chapter 2 General Procedures

(11-96)

200. Components Which Administer Buy-In Program

- A. HCFA Central Office (CO).--The Bureau of Program Operations (BPO), Office of Customer Communications (OCC), Entitlement and Premium Billing (EPB) has overall responsibility for the administration of the buy-in provisions of the Social Security Act. The address of this component is:

HCFA, BPO, OCC
Entitlement and Premium Billing
Mailstop N2-05-03
7500 Security Blvd.
Baltimore, Maryland 21244-1850

The responsibilities of EPB include the following:

- Establishment and coordination of methods and procedures pertinent to the third party buy-in operation;
- Providing assistance and training to States, Social Security Administration offices (SSO's), and HCFA regional offices (ROs); and
- Resolving buy-in problem cases which cannot be resolved by routine procedures.

The Third Party unit (TP), Division of Beneficiary Systems (DBS), BPO, receives and processes the monthly third party input files from the States. States must submit input files via the Network Data Mover (NDM). Files sent via NDM are transmitted over SSA's NDM facility.

The address of the TP unit is:

HCFA, BPO, DBS
Third Party
Mailstop N2-13-15
7500 Security Blvd.
Baltimore, MD 21244-1850

- The TP unit is also responsible for:
- The receipt, investigation and resolution of problem cases submitted by the States, the HCFA ROs, or the SSOs; and
- The investigation and resolution of selected computer generated exceptions from the monthly update.

Send all requests for resolution of problem cases and the related documentation to:

HCFA, BPO, TP
P.O. Box 11977
Baltimore, MD 21207-0977

- B. HCFA Regional Office (RO).--RO responsibility for State buy-in may reside in either the Division of Medicare or the Division of Medicaid since many buy-in issues affect both divisions. The responsibilities of the ROs include:

- Liaison with the States;
- Coordinating and implementing procedures within the region;
- Continuing assessment of the buy-in operation in the States; and
- Training of personnel in the States, SSOs, and Program Service Centers.

- C. Social Security Office (SSO).--The responsibilities of the SSO include:

- Assistance to beneficiaries;
- Assistance to the States in obtaining correct beneficiary identifying information;
- Providing buy-in training to welfare personnel; and
- Reporting trends and problems encountered in the buy-in process.

The additional responsibilities of the parallel SSO, which is the office servicing the State agency, include:

- Representing the SSA RO in negotiations with the State welfare office;
- Maintaining controls on problem cases forwarded to servicing SSOs because the cases cannot be resolved by the parallel SSO;
- Participating in buy-in meetings attended by personnel from the State, CO, and RO;
- Providing technical advice on buy-in procedures to other SSOs in the State; and
- Establishing rapport with the State to facilitate buy-in operations.

D. Social Security Central Office.--The responsibilities of SSA CO include the following:

- Establishment and maintenance of the Master Beneficiary Record (MBR) and the Supplemental Security Income (SSI) Record; and
- Data exchange with HCFA for the monthly third party update. This includes transmitting records to HCFA for inclusion in the third party update and annotating the MBR with buy-in data processed by HCFA during the third party update.

E. Social Security Program Service Centers (PSC).--The PSCs annotate the MBR with State buy-in transactions which could not be processed electronically by SSA's CO and assist with the resolution of problems pertaining to Medicare entitlement which may impact State buy-in.

F. The State.--The State is responsible for:

- Establishing internal procedures and systems to identify individuals eligible for buy-in, to communicate these data to HCFA, and to respond to action taken by HCFA on individual cases;
- Assisting the SSOs in resolving problem cases; and
- The timely payment of Medicare premiums on behalf of the individuals within its jurisdiction who are eligible for State buy-in.

205. Monthly Billing File (TPTAB)

A monthly billing file called Third Party Tape Agency Bills (TPTAB) is produced for each State at the conclusion of the monthly buy-in update. A separate billing file is prepared for Part A and Part B buy-in.

The TPTAB file contains a record of all transactions processed to the State's buy-in file during the update. This includes both accepted and rejected transactions and all on-going code 41 and code 91 items. Chapter III, contains a detailed description of the format of the billing file.

210. History File (TPFAB)

A file called Third Party File of Agency Buy-In (TPFAB) is produced upon request. A separate TPFAB file is produced for Part A and Part B buy-in. A State may request a history file once each 6 months. Submit requests for the TPFAB file through the HCFA RO.

The TPFAB file contains a history of individuals who are, or were, on the State's buy-in rolls. Records are selected for the TPFAB file according to the agency code in the latest buy-in history field. Therefore, the State will not receive a record of everyone for whom it has paid premiums because some individuals will have established periods of buy-in coverage with more than one State and it is the last period of coverage which determines whether the record is selected. When a record is selected, the five most recent periods of buy-in coverage are included regardless of the agency of record for the four earlier periods. Chapter III, contains a detailed description of the history file.

215. State Data Exchange (SDX) File

The SDX file is produced for the States by the Social Security Administration (SSA). The SDX is created from the SSI record. The primary purpose of the SDX is to assist the States in administering Medicaid and the State supplemental programs.

The 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 buy-in. However, there is no indication of whether the individual has established eligibility for Medicare.

The SDX also identifies all individuals who lose SSI eligibility regardless of whether they are on buy-in. States should examine the reason for termination of SSI payments. In some cases, termination of SSI does not terminate Medicaid eligibility.

Detailed information about the SDX may be found in the Program Operations Manual System (POMS), in the section titled "SSI State Data Exchange" which is published by SSA and may be obtained through the SSA RO.

220. Beneficiary Data Exchange (BENDEX) File

The BENDEX file is produced for the States by the SSA. The BENDEX is created from the Master Beneficiary Record (MBR). The primary purpose of the BENDEX is to assist the States in administering the Aid to Families with Dependent Children (AFDC) program and the Medical Assistance program.

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

The BENDEX file provides title II SSA benefit payment status, title XVI SSI payment status (if applicable), and title XVIII Medicare entitlement dates (if applicable).

Detailed information about the BENDEX may be found in Program Operations Manual System (POMS) in the section titled "Beneficiary and Earnings Data Exchange (BENDEX) Handbook" which is published by SSA and may be obtained through the SSA RO.

225. Carrier Alphabetic State File (CASF)

The CASF is a formatted version of the BEST file. The State may convert the CASF to microfiche at its own expense. It is in alphabetic order and contains a record of health insurance beneficiaries living within a geographic entity. It is produced once every 6 months. A separate file is available for each State, the District of Columbia, Puerto Rico, and the Virgin Islands. American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands are included in the Hawaii file.

The CASF may be used by the State to obtain or verify incomplete identifying data such as the beneficiary's name, claim number, or date of birth. Direct all inquiries regarding the CASF to the HCFA RO.

- A. CASF Format.--Data on the CASF reflects the beneficiary's status at the time the data were selected from the Enrollment Data Base (EDB). The CASF cannot be used to determine current eligibility to either Part A or Part B benefits or as proof of current State buy-in. It can be used as a lead. The entry for each beneficiary is limited to one line of data reading from left to right as follows:

CASF Format		
Field Name	Positions	Remarks
Surname	12 positions	
Blank	1 position	
Given Name	10 positions	
Blank	1 position	
Middle Initial	1 position	
Blank	1 position	
Claim number	14 positions	SSA or RRB number
Blank	1 position	
Date of Birth	10 positions	MM-DD-CCYY
State Buy-in Indicator	1 position	"S" or blank
Sex Code	1 position	1-Male, 1-Female, 3-Unknown
RRB Indicator	1 position	"R" RRB jurisdiction or blank
ZIP Code	5 positions	
Blank	1 position	
Address	64 positions	First 64 characters of the address

Record Mark	1 position	
-------------	------------	--

230. Health Insurance Beneficiary State File (BEST)

The BEST is a cartridge file which contains data similar to the data on the CASF except that the BEST includes the beneficiary's own social security number (SSN). The BEST may be used in the same manner as the CASF. Direct all inquiries concerning the BEST to the HCFA RO. The data record for the BEST is as follows:

BEST Format		
Positions	Field Name	Remarks
1-12	Surname	
13-22	Given Name	
23	Middle Initial	
24-35*	Claim Number	SSA or RRB
36-43	Date of Birth	MMDDCCYY
44	State Buy-in Indicator	"S" or blank
45	Sex Code	1-Male, 2-Female, 3-Unknown
46	RRB Indicator	"R" RRB jurisdiction or blank
47-51	ZIP Code	
52-53	Blank	
54-119	Address	First 66 characters of the address
120-124	SSN	Beneficiary's own SSN in IBM packed decimal format
125	Record Mark	
<p>* For a railroad retirement beneficiary, positions 24 - 35 show the 1 to 3 character Railroad Board <u>prefix</u> followed by the 6 or 9 digit railroad claim number. The prefix indicates the type of railroad benefits to which the beneficiary may be entitled. The railroad number will be left justified in all cases, regardless of length.</p> <p>EXAMPLE: A000000bbbb or A000000000bb MA000000bbbb or MA000000000b WCA000000bbb or WCA000000000</p>		

235. Enrollment of Persons Who Refuse to Establish Medicare Eligibility

- A. State Initiated Enrollment.--If an individual refuses to cooperate with SSA to establish eligibility for Medicare Part B, the SSO will advise the local welfare office, so that the State can take any action that is appropriate to obtain the cooperation of the individual. The State may enroll the individual for Supplementary Medical Insurance (SMI) only. The individual must enroll for Hospital Insurance (HI).

In order to enroll the individual for SMI, 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. (See §105.)

The State must complete the application Form HCFA-4040, "Request for Enrollment in Supplementary Medical Insurance" which it can obtain from the SSO. Send the completed form and related proofs to the SSO which services the welfare recipient's address.

NOTE: Some SSOs use Form HCFA-18, "Application for Hospital Insurance" for all Medicare applications and do not stock Form HCFA-4040. Form HCFA-18 may be used to enroll for SMI.

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

- The welfare recipient's address since that is the address to which the Health Insurance card will be mailed; and
- The individual's SSN. If the individual does not have an SSN, contact the local SSO for assistance in obtaining an SSN for the person.

The enrollee need not sign the application. Instead the welfare officer should complete the signature block and annotate the form to show that the information on it was taken from welfare 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 certification which shows the date the welfare record was established and the documents which were used to establish the record; and
- Proof of citizenship and/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 certification which describes the evidence which was used to establish residency and/or citizenship.

After the SSA establishes the individual's Medicare record, the individual will be accreted to buy-in through the public welfare procedure.

- B. HCFA Initiated Enrollment.--If an individual who is eligible for SSI payments refuses to file an application to establish eligibility to Medicare, the SSO will complete an application to enroll the individual. The SSO will obtain proof of age and citizenship or obtain residency status from the SSI application. The file will be documented to show that the individual was asked to apply for Medicare but refused to do so.

For HCFA initiated accretions based on SSI eligibility in an auto-accrete State, the application is a device to establish the individual's eligibility for buy in. The State buy-in agreements do not require a formal application signed by the individual in order to establish eligibility for SMI and buy-in.

- C. Enrollment of Member of Coverage Group Who Failed to Establish Medicare Eligibility Prior to Death.--The procedures described in the preceding paragraphs may be used to establish Medicare eligibility for a member of a coverage group who died prior to establishing basic Medicare eligibility. Proof of death is required in addition to the documentation specified in the previous paragraphs of this section.

240. Extension of Time Limitation For Filing Part B Claim Due to Administrative Error

Section 1842(b) of the Social Security Act and 42 CFR 405.1667(b) and 405.1692(c) extend the time limitation for filing a Part B claim if:

1. Failure to submit the bill or request payment timely was due to the error or misrepresentation of an officer, employee, intermediary, carrier, or agent of the Department of Health and Human Services performing functions under title XVIII (Medicare) and acting within the scope of his, her, or its authority; and
2. The bill is submitted or payment is requested within 6 months after the month in which such error or misrepresentation is eliminated or corrected.

This extension of time is available to both accrete and alert States only when the factors in the above paragraph are met.

To qualify for an extension of the time limit on filing claims, it does not suffice that the State show that the delay in filing resulted from a retroactive buy-in accretion by the State. The State must show that the delay in accreting the individual resulted from inappropriate action or inaction in the administration of the Medicare program (i.e., error or misrepresentation by a party specified above) and that such action or inaction was not corrected until there were less than 6 full calendar months remaining before the expiration of the usual time limit on filing. Moreover, the fact that the time limit on filing precludes payment for a period of retroactive coverage does not absolve the State of responsibility for accreting the individual and paying the Part B premiums for that period.

In an accrete State, the failure of an otherwise eligible recipient to be enrolled in Part B and State buy-in is deemed to be the result of an administrative error whenever such error prevented the intermediary or carrier from processing a timely claim for Part B reimbursement. The time limitation for filing a claim for reimbursement will be extended to the close of the 6th month following the month in which the buy-in accretion notice is sent to the State. On claims filed timely; i.e., within the 6 month extension, Part B reimbursement may be paid for services received on or after the effective date of the SSI accretion. Any case of the type described in this paragraph identified by the State should be referred to the HCFA RO. The RO will verify the retroactivity of the buy-in action and inform the intermediary or carrier of the Part B entitlement. In a case in which the services are reimbursable on a reasonable cost basis and the time extension would go beyond the close of the second year after the expiration of the normal time limit, the RO will submit the case to HCFA's Division of Beneficiary and Insurance Issues, Bureau of Policy Development, in CO for evaluation.

245. Problem Cases - General

The monthly operation of the State buy-in program is accomplished through the automated data exchange among the States, SSA, and HCFA. The State must be able to process through the monthly data exchange:

- All routine accretions, including closed periods of buy-in coverage, using the accretion codes described in §§400, 500, 600, and 700 (with the exception of the code 64 which is optional for auto-accrete States);
- All routine deletions, using the deletion codes described in §§400, 500, 600 and 700 (with the exception of the code 81 which is optional for auto-accrete States); and
- All State initiated code 99 change records.

Problems do arise which cannot be resolved through the normal data exchange. These cases require clerical processing by HCFA. The majority of buy-in problems will be reported by a SSO or by individual States. However, other HCFA components, the ROs, or intermediaries and carriers may report buy-in problems.

The SSO generally will report a buy-in problem on the Form HCFA-1957 "SSO Report of State Buy-In Problem". (See §270.) The States generally design their own form letters or memoranda. (See §265.) A component is not restricted to a specific form when reporting a buy-in problem. The only requirement is that the reporting entity provide enough detail to enable staff in the TP unit to work the case. Refer to §200 for the address of the TP unit.

Report each problem case on a separate form.

The TP unit will attempt to resolve a problem case within three updates (approximately 90 days). Submit all second requests to the TP unit, clearly identified as "Second Request". Allow 30 days for the resolution of a second request. Submit all third requests to the attention of the Manager, Third Party unit. Include copies of the first and second requests including any correspondence received from the TP unit regarding the earlier request.

250. Refund of Medicare Premiums to Beneficiaries

Situations may arise when the State is paying the Medicare premium, yet the beneficiary has not received a refund of premiums paid by the beneficiary for the same period of time. The premiums may have been deducted from the title II check or may have been paid by the beneficiary as the result of a premium bill sent by HCFA. In nearly every situation, the failure to refund premiums occurs because SSA did not annotate the third party buy-in information to the MBR.

SSOs have access to HCFA's State buy-in information through the Health Insurance Online Query (HIQR). The HIQR provides both current and historic State buy-in coverage and the identity of the State(s) which paid the Medicare premiums. Whenever a beneficiary alleges that he/she did not receive a premium refund which was due, the SSO will verify the buy-in data on the HIQR. The SSO will contact the PSC and ask the PSC to annotate the buy-in data to the MBR, and to issue the appropriate Medicare premium refund(s) to the beneficiary. This type of case should not be referred to HCFA.

255. Cases Involving Duplicate Billing

If the State identifies a case in which HCFA has processed two accretion actions under different claim numbers, the case should be considered an error on the face of the record.

Prepare a memorandum or letter to the TP unit describing the duplicate billing situation and providing both claim numbers. The TP unit determines the correct claim number, combines the records, and adjusts the State's liability. There is no time limit to obtain an adjustment for duplicate billing.

Section 475 describes an interim duplicate billing situation which can result from a code 23 claim number change. Normally an interim duplicate billing situation does not require any action by the State.

260. State Correction of Beneficiary Name On Third Party Master Record

The only requests for a change of name on a third party master record which will be honored are those in which failure to change the name in the record will result in improper identification of the individual. A case of this nature requires verification by the SSO before it is submitted to the TP unit.

265. Request for Resolution of Buy-In Problem Cases By Memorandum

The State may initiate resolution of any nonroutine buy-in problem case which cannot be handled through the monthly data exchange by sending a memorandum or form letter designed by the State to the TP unit at the address in §200. Submit only one case per memorandum or letter.

The memorandum must include the following data:

- Date of request;
- State name and State code;
- Beneficiary's full name;
- Medicare claim number(s);
- SSI claim number, if applicable;
- Any other relevant claim numbers;
- Beneficiary's sex;
- Beneficiary's date of birth;
- State welfare identification number, if applicable;
- Accretion effective date for each period relevant to the buy-in problem;
- Deletion effective date for each period relevant to the buy-in problem; and
- Description of the problem. The description must be detailed enough so that the staff in TP unit will understand the nature of the problem from the State's perspective, and the type of corrective action the State believes should be taken.

NOTE: The TP unit cannot honor every request. If the unit cannot honor a State request, it will return the memorandum to the State with a brief explanation.

270. Resolution of Buy-In Problem Cases On Form Hcfa-1957, SSO Report of State Buy-In Problem

Form HCFA-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 SSO will have become aware of a problem through a beneficiary complaint.

Form HCFA-1957 is designed to accumulate the information needed to resolve the problem case. The completed form may be routed to the State or local welfare office or to the TP unit for resolution of the problem.

SSO completes Part I, Report of Problem by SSO, and Part II, SSI status at SSO, (if applicable). The SSO may need to contact the local welfare 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 Social Security, HCFA ROs, and each State. Usually the arrangements depend upon whether verification of buy-in status is to be obtained from the local welfare office (Part III) or the State (Part IV).

A. State Welfare Office Verification Required.--The State takes the following action when it receives Form HCFA-1957:

- Completes Part III (Report of buy-in status by Welfare Department) of Form HCFA-1957 or reviews Part III for correctness if arrangements coordinated through HCFA and SSA ROs call for Part III to be completed by SSO 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 HCFA-1957 based upon information contained in the State's records and the latest billing record received from HCFA; and
- Signs, dates, and returns the completed form to the parallel SSO.

NOTE: If the State has checked the block stating that it will submit an action to HCFA in a future data exchange, diary the case to ensure that the action is taken.

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 HCFA-1957 and request a correction or adjustment.

The parallel SSO will forward Form HCFA-1957 to the TP unit for necessary action.

B. Local Welfare Office Verification Required - State Verification Not Required.--SSO contacts the local welfare office for assistance in completing the following items on Form HCFA-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 individual currently or previously had buy-in coverage, SSO routes the Form HCFA-1957 to the TP unit for resolution.

RESERVED FOR HCFA 1957

275. Report of State Buy-In Problem Case By Railroad Retirement Board (RRB)

(FORM RL-380F)

RRB through its system of field offices, receives inquiries from Medicare beneficiaries 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 State Medicaid Agency in order to identify and resolve State buy-in problem cases affecting RRB Medicare beneficiaries.

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 expeditor's desk in Chicago is (312) 751-4744.

UNITED STATE OF AMERICA RAILROAD RETIRMENT BOARD RESERVED FOR RL-380F

Chapter 3 Data Exchange

310 State Agency Input Record

(Rev. 1, 10-01-03)

STATE AGENCY TO CMS			
FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Buy-In Eligibility Code	2
9.	73 - 75	Agency Code	3
10.	76 - 77	Transaction Code	2
11.	78 - 82	Filler	5
12.	83 - 88	Transaction Effective Date (CCYYMM)	6
13.	89 - 94	Code 75 Stop Date (CCYYMM)	6
14.	95 - 100	Filler	6
15.	101 - 120	Agency Client Identification Number	20

State Agency Input Record Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - The claim number must consist of a nine-position social security number or pseudo social security claim number (if the beneficiary is entitled under a railroad retirement claim number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank.
2. SURNAME (Positions 13-36) - Enter a maximum of twenty-four alphanumeric 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 from the surname with a single blank space. Leave blank any position that contains a special character as the apostrophe, hyphen, or period as a normal part of the surname.
3. GIVEN NAME (Positions 37-51) - Enter a maximum of fifteen alphanumeric characters. Apply the same format considerations as apply to the surname. Leave blank any positions that are not required.
4. MIDDLE INITIAL (Position 52) - Enter a one position alphanumeric character. Leave field blank if middle initial is unknown.

5. SEX CODE (Position 53) - Enter a one position code "M" male, "F" female. Leave field blank if unknown.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - Enter an eight position numeric date, e.g., enter November 1,1909 as 19091101.
7. BENEFICIARY'S SOCIAL SECURITY NUMBER (Positions 62-70) - Enter the beneficiary's own social security number if known. If unknown, leave blank.
8. BUY-IN ELIGIBILITY CODE (Positions 71-72) - 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 (Positions 73-75) - Enter the three position alphanumeric or numeric code of the entity which has jurisdiction over the account. Without this code the transaction may be lost.
10. TRANSACTION CODE (Positions 76-77) - Enter the two position numeric code which identifies the type of record conveyed by the transaction.
11. FILLER (Positions 78-82) - Positions reserved for future use.
12. TRANSACTION EFFECTIVE DATE CCYYMM (Positions 83-88) - Enter the date on which the accretion or deletion action is effective, e.g., enter April 1999 as 199904.
13. CODE 75 STOP DATE CCYYMM (Positions 89-94) - This field is used only in conjunction with a closed period of buy-in coverage. Enter the date on which the closed period of buy-in coverage ended, e.g., enter June 1998 as 199806.
14. FILLER (Positions 95-100) - Positions reserved for future use.
15. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 101-120) - Enter the beneficiary's State welfare identification number or any other identifier of the State's choice. Any combination of not more than 20 alphanumeric characters may be used. Packed fields are not acceptable.

315 State Agency SSI Alert Record (RIC A)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Buy-In Eligibility Code	2
9.	73 - 75	Agency Code	3
10.	76	Record Identification Code "A"	1
11.	77 - 78	Transaction Code	2
12.	79 - 81	Filler	3
13.	82 - 87	SSI Start Date (CCYYMM)	6
14.	88 - 93	SSI Stop Date (CCYYMM)	6
15.	94 - 99	Medicare Entitlement Date (CCYYMM)	6
16.	100 - 126	Filler	27
17.	127 - 135	ZIP Code of Residence	9
18.	136 - 138	County Code of Residence	3
19.	139	SSI Living Arrangement Code	1
20.	140	SSI Status Code (SISC)	1
21.	141 - 160	Filler	20

State Agency SSI Alert Record (RIC A) Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This field will convey the Medicare claim number from the EDB.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The name will match the surname on the EDB. Any unused positions will be blank.
3. GIVEN NAME (Positions 37-51) - 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 (Position 52) - An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.
5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F")
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field. 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 (Positions 62-70) - A nine position numeric field. The SSN will be extracted from the EDB.
8. BUY-IN ELIGIBILITY CODE (Positions 71-72) - A one position alphabetic code that describes the reason the beneficiary is eligible for SSI benefits. An additional position (position 72) has been allocated for expansion.
9. AGENCY CODE (Positions 73-75) - A three position alphanumeric code that is based on the State code which appears in the SSI record furnished by SSA.
10. RECORD IDENTIFICATION CODE (Position 76) - "A" constant. The "A" identifies this record as an SSI alert record.
11. TRANSACTION CODE (Positions 77-78) - Positions 77 and 78 will contain an "86" for an SSI accretion alert record or an "87" for an SSI deletion alert record. Positions 79 and 80 will be blank.
12. FILLER (Position 79-81) - Positions reserved for future use.
13. SSI START DATE CCYYMM (Positions 82-87) - A six position numeric field which contains 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 CCYYMM (Positions 88-93) - 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 CCYYMM (Positions 94-99) - A six position numeric field which indicates the year and month in which the beneficiary attained age 65 or became entitled to Medicare Part A. This date is provided to assist the State in determining the effective date for buy-in coverage. This field is applicable to accretion alert records only.
16. FILLER (Positions 100-126) - Positions reserved for future use.
17. ZIP CODE OF RESIDENCE (Positions 127-135) - 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 (Positions 136-138) - A three position code developed from the SSI record. SSA furnishes this code.
19. SSI LIVING ARRANGEMENT CODE (Position 139) - 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) (Position 140) - A one position alphabetic code which describes the beneficiary's SSI status.

21. FILLER (Positions 141-160) - Positions reserved for future use.

320 Part A State Agency Billing Record (RIC B)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71	Reduced Part A Indicator	1
9.	72	Part A Premium Surcharge Indicator	1
10.	73 - 75	Agency Code	3
11.	76	Record Identification Code "B"	1
12.	77 - 80	Transaction Code	4
13.	81	Transaction Sub-code	1
14.	82 - 87	Billing Period Start Date (CCYYMM)	6
15.	88 - 93	Billing Period Stop Date (CCYYMM)	6
16.	94 - 101	Premium Amount Due or Refund (\$\$\$\$\$c)	8
17.	102 - 107	Bill Date (CCYYMM)	6
18.	108 - 113	Current Monthly Premium Rate (\$\$\$\$c)	6
19.	114 - 116	Filler	3
20.	117	Credit Indicator	1
21.	118 - 126	Filler	9
22.	127 - 135	ZIP Code of Residence	9
23.	136 - 138	County Code of Residence	3
24.	139 - 140	Filler	2

25.	141 - 160	Agency Client Identification Number	20
-----	-----------	-------------------------------------	----

Part A State Agency Billing Record (RIC B) Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This field will convey the Medicare claim number from the EDB.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The name will match the surname on the EDB. Any unused positions will be blank.
3. GIVEN NAME (Positions 37-51) - 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 (Position 52) - An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.
5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F"). The sex code will be the sex code that appears on the EDB.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field. 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 (Positions 62-70) - A nine position numeric field. The SSN will be extracted from the EDB.
8. REDUCED PART A INDICATOR (Position 71) - 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 (Position 72) - 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 (Positions 73-75) - A three position alphanumeric code, beginning with "S", assigned to the entity which has jurisdiction over the account.
11. RECORD IDENTIFICATION CODE (Position 76) - "B" constant. The "B" identifies this record as a billing record.
12. TRANSACTION CODE (Positions 77-80) - A 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.
13. TRANSACTION SUB-CODE (Position 81) - A one position alpha code that further defines the transaction code.
14. BILLING PERIOD START DATE CCYYMM (Positions 82-87) - 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. (NOTE: the billing period start date and the billing period stop date are inclusive dates.)
15. BILLING PERIOD STOP DATE CCYYMM (Positions 88-93) - 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 \$\$\$\$\$\$cc (Positions 94-101) - 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. The Credit Indicator in position 117, when present, means that the premium amount is a credit. Where the Credit Indicator field is blank, it means that the premium amount is a debit.

17. BILL DATE CCYYMM (Positions 102-107) - A six position numeric field that designates the billing file (year and month) on which the transaction appears.
18. URRENT MONTHLY PREMIUM RATE \$\$\$\$cc (Positions 108-113) - A six position numeric field with leading zeroes which contains the current monthly Part A Medicare premium rate.
19. FILLER (Positions 114-116) - Positions reserved for future use.
20. CREDIT INDICATOR (Position 117) - 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 (Positions 118-126) - Positions reserved for future use.
22. ZIP CODE OF RESIDENCE (Positions 127-135) - 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 (Positions 136-138) - A three position code developed from the EDB. The field may be blank.
24. FILLER (Positions 139-140) - Positions reserved for future use.
25. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client (or welfare) identification number or any other identifier of the State's choice.

325 Part B State Agency Billing Record (RIC B)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Buy-In Eligibility Code	2
9.	73 - 75	Agency Code	3
10.	76	"B"Record Identification Code	1
11.	77 - 80	Transaction Code	4
12.	81	Transaction Sub-Code	1
13.	82 - 87	Billing Period Start Date (CCYYMM)	6
14.	88 - 93	Billing Period Stop Date (CCYYMM)	6
15.	94 - 101	Premium Amount Due or Refund(\$\$\$\$\$c¢)	8
16.	102 - 107	Bill Date (CCYYMM)	6
17.	108 - 113	Current Monthly Premium Rate (\$\$\$\$c¢)	6
18.	114 - 119	Reduced Monthly Premium Amt (\$\$\$\$c¢)	6
19.	120 - 122	Filler	3
20.	123	Credit Indicator	1
21.	124 - 126	Filler	3
22.	127 - 135	ZIP Code of Residence	9
23.	136 - 138	County Code of Residence	3

24.	139	Filler	1
25.	140	SSI Status Code (SISC)	1
26.	141 - 160	Agency Client Identification Number	20

Part B State Agency Billing Record (RIC B) Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number or pseudo social security claim number (if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This field will convey the Medicare claim number from the EDB.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The name will match the surname on the EDB. Any unused positions will be blank.
3. GIVEN NAME (Positions 37-51) - 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 (Position 52) - An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.
5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F"). The sex code will be the sex code that appears on the EDB.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field. 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 (Positions 62-70) - A nine position numeric field. The SSN will be extracted from the EDB.
8. BUY-IN ELIGIBILITY CODE (Positions 71-72) - Applicable to Part B buy-in only. Currently, it is a one position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An additional field (position 72) has been allocated for expansion.
9. AGENCY CODE (Positions 73-75) - A three position alphanumeric code assigned to the entity which has jurisdiction over the account.
10. RECORD IDENTIFICATION CODE (Position 76) - "B" constant. The "B" identifies this record as a billing record.
11. TRANSACTION CODE (Positions 77-80) - A 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.
12. TRANSACTION SUB-CODE (Position 81) - A one position alpha code that further defines the transaction code.
13. BILLING PERIOD START DATE CCYYMM (Positions 82-87) - A six position numeric field that contains beginning 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 billing period stop date are inclusive dates.
14. BILLING PERIOD STOP DATE CCYYMM (Positions 88-93) - 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 billing period stop date are inclusive dates.)
15. PREMIUM AMOUNT DUE OR REFUND \$\$\$\$\$c (Positions 94-101) - 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. The Credit Indicator in position 123, when

present, means that the premium amount is a credit. Where the Credit Indicator field is blank, it means that the premium amount is a debit.

16. BILL DATE CCYYMM (Positions 102-107) - A six position numeric field that designates the billing file (year and month) on which the transaction appears.
17. CURRENT MONTHLY PREMIUM RATE \$\$\$\$cc (Positions 108-113) - A six position numeric field with leading zeroes which contains the current monthly Part B Medicare premium rate.
18. REDUCED MONTHLY PREMIUM AMOUNT \$\$\$\$cc (Positions 114-119) - A six position numeric field with leading zeroes. This field 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. FILLER (Positions 120-122) - Positions reserved for future use.
20. CREDIT INDICATOR (Position 123) - 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 (Positions 124-126) - Positions reserved for future use.
22. ZIP CODE OF RESIDENCE (Positions 127-135) - 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 (Positions 136-138) - A three position code developed from the EDB record. The field may be blank.
24. FILLER (Position 139) - Position reserved for future use.
25. SSI STATUS CODE (SISC) (Position 140) - A one position alphabetic code which describes the beneficiary's SSI status (if applicable).
26. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client (or welfare) identification number or any other identifier of the State's choice.

330 Medicare Claim Number Change Record (RIC C)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Filler	2
9.	73 - 75	Agency Code	3
10.	76	Record Identification Code "C"	1
11.	77 - 80	Transaction Code	4
12.	81 - 93	Filler	13
13.	94 - 105	Active Medicare Claim Number	12
14.	106 - 118	Filler	13
15.	119 - 126	Reply Date (CCYYMMDD)	8
16.	127 - 140	Filler	13
17.	141 - 160	Agency Client Identification Number	20

Medicare Claim Number Change Record (RIC C) Explanation of Fields

- MEDICARE CLAIM NUMBER [INACTIVE NUMBER] (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. The claim number in this field will be the claim number submitted by the State on an incoming transaction or will be the claim number of record on the EDB prior to the claim number change.
- SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The surname in this field will be the surname submitted by the State on an incoming transaction or will be the surname of record on the EDB when the claim number change is applied to an existing master record. Any unused positions will be blank.
- GIVEN NAME (Positions 37-51) - A maximum of fifteen alphabetic characters. The given name in this field will be the given name submitted by the State on an incoming transaction or will be the given name of record on the EDB when the claim number change is applied to an existing master record. Any unused positions will be blank.

4. MIDDLE INITIAL (Position 52) - An alphabetic character which will be the middle initial submitted by the State on an incoming transaction or will be the middle initial of record on the EDB when the claim number change is applied to an existing master record. This field may be blank.
5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F") which will be the sex code submitted by the State on an incoming transaction or will be the sex code of record on the EDB when the claim number change is applied to an existing master record.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field which will be the date of birth submitted by the State on an incoming transaction or will be the date of birth of record on the EDB when the claim number change is applied to an existing master record.
7. BENEFICIARY'S SOCIAL SECURITY NUMBER (Positions 62-70) - A nine position numeric field. The SSN will be the SSN submitted by the State on an incoming transaction or will be the SSN of record on the EDB when the claim number change is applied to an existing master record.
8. FILLER (Positions 71-72) - Positions reserved for future use.
9. AGENCY CODE (Positions 73-75) - A three position alphanumeric code assigned to the entity which has jurisdiction over the account.
10. RECORD IDENTIFICATION CODE (Position 76) - "C" constant. The "C" identifies this record as a Medicare claim number change record.
11. TRANSACTION CODE (Positions 77-80) - Positions 77 and 78 will contain a "23" for a full claim number change or a BIC only change. Positions 79 and 80 will be blank if the claim number change is applied to an ongoing record. If the claim number change is applied to an incoming transaction, positions 79 and 80 will contain the twoposition transaction code that is contained in the input record.
12. FILLER (Positions 81-93) - Positions reserved for future use.
13. ACTIVE MEDICARE CLAIM NUMBER (Positions 94-105) - 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. FILLER (Positions 106-118) - Positions reserved for future use.
15. REPLY DATE CCYYMMDD (Positions 119-126) - An eight position numeric field. This is the date on which CMS created the RIC C record.
16. FILLER (Positions 127-140) - Positions reserved for future use.
17. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client or (welfare) identification number or any other identifier of the State's choice.

335 Part A State Agency Reply Record (RIC D)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71	Reduced Part A Indicator	1
9.	72	Part A Premium Surcharge Indicator	1
10.	73 - 75	Agency Code	3
11.	76	Record Identification Code "D"	1
12.	77 - 80	Transaction Code	4
13.	81	Transaction Sub-code	1
14.	82 - 87	Billing Period Start Date (CCYYMM)	6
15.	88 - 93	Billing Period Stop Date (CCYYMM)	6
16.	94 - 118	Filler	25
17.	119 - 126	Reply Date (CCYYMMDD)	8
18.	127 - 135	ZIP Code of Residence	9
19.	136 - 138	County Code of Residence	3
20.	139 - 140	Filler	2
21.	141 - 160	Agency Client Identification Number	20

Part A State Agency Reply Record (RIC D) Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This field will convey the Medicare claim number from the EDB.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The name will match the surname on the EDB. Any unused positions will be blank.

3. GIVEN NAME (Positions 37-51) - 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 (Position 52) - An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.
5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F"). The sex code will match the sex code that appears on the EDB.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field. 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 (Positions 62-70) - A nine position numeric field. The SSN will be extracted from the EDB.
8. REDUCED PART A INDICATOR (Positions 71) - 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 (Position 72) - 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 (Positions 73-75) - A three position alphanumeric code, beginning with "S" assigned to the entity which has jurisdiction over the account.
11. RECORD IDENTIFICATION CODE (Position 76) - "D" constant. The "D" identifies this record as a reply record.
12. TRANSACTION CODE (Positions 77-80) - A four position numeric code. The first two positions convey 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. In the event that CMS must adjust the start date and/or stop date of the incoming transaction, the transaction code will reflect the adjustment.
13. TRANSACTION SUB-CODE (Position 81) - A one position alpha code that further defines the transaction code.
14. BILLING PERIOD START DATE CCYYMM (Positions 82-87) - A six position numeric field which contains beginning date or accretion date (year and month) of the transaction.
15. BILLING PERIOD STOP DATE CCYYMM (Positions 88-93) - A six position numeric field that contains the ending date or deletion date (year and month) of the transaction.
16. FILLER (Positions 94-118) - Positions reserved for future use.
17. REPLY DATE CCYYMMDD (Positions 119-126) - An eight position numeric field. This is the date on which CMS created the RIC D record.
18. ZIP CODE OF RESIDENCE (Positions 127-135) - A nine position numeric code that will display the zip code as carried on the EDB. .
19. COUNTY CODE OF RESIDENCE (Positions 136-138) - A three position code developed from the EDB. The field may be blank.
20. FILLER (Positions 139-140) - Positions reserved for future use.
21. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client (or welfare) identification number or any other identifier of the State's choice.

340 Part B State Agency Reply Record (RIC D)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Buy-In Eligibility Code	2
9.	73 - 75	Agency Code	3
10.	76	Record Identification Code "D"	1
11.	77 - 80	Transaction Code	4
12.	81	Transaction Sub-code	1
13.	82 - 87	Billing Period Start Date (CCYYMM)	6
14.	88 - 93	Billing Period Stop Date (CCYYMM)	6
15.	94 - 118	Filler	25
16.	119 - 126	Reply Date (CCYYMMDD)	8
17.	127 - 135	ZIP Code of Residence	9
18.	136 - 138	County Code of Residence	3
19.	139	Filler	1
20.	140	SSI Status Code (SISC)	1
21.	141 - 160	Agency Client Identification Number	20

Part B State Agency Reply Record (ric D) Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This field will convey the Medicare claim number from the EDB.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The name will match the surname on the EDB. Any unused positions will be blank.
3. GIVEN NAME (Positions 37-51) - 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 (Position 52) - An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.

5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F"). The sex code will match the sex code that appears on the EDB.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field. 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 (Positions 62-70) - A nine position numeric field. The SSN will be extracted from the EDB.
8. BUY-IN ELIGIBILITY CODE (Positions 71-72) - Applicable to Part B buy-in only. Currently, it is a one position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An additional field (position 72) has been allocated for expansion.
9. AGENCY CODE (Positions 73-75) - A three position alphanumeric code assigned to the entity which has jurisdiction over the account.
10. RECORD IDENTIFICATION CODE (Position 76) - "D" constant. The "D" identifies this record as a reply record.
11. TRANSACTION CODE (Positions 77-80) - A four position numeric code. The first two positions convey 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. In the event that CMS must adjust the start date and/or stop date of the incoming transaction, the transaction code will reflect the adjustment.
12. TRANSACTION SUB-CODE (Position 81) - A one position alpha code that further defines the transaction code.
13. BILLING PERIOD START DATE CCYYMM (Positions 82-87) - A six position numeric field which contains beginning date or accretion date (year and month) of the transaction.
14. BILLING PERIOD STOP DATE CCYYMM (Positions 88-93) - A six position numeric field that contains the ending date or deletion date (year and month) of the transaction.
15. FILLER (Positions 94-118) - Positions reserved for future use.
16. REPLY DATE CCYYMMDD (Positions 119-126) - An eight position numeric field. This is the date on which CMS created the RIC D record.
17. ZIP CODE OF RESIDENCE (Positions 127-135) - A nine position numeric code that will display the zip code as carried on the EDB. .
18. COUNTY CODE OF RESIDENCE (Positions 136-138) - A three position code developed from the EDB record. The field may be blank.
19. FILLER (Positions 139) - Position reserved for future use.
20. SSI STATUS CODE (SISC) (Position 140) - A one-position alphabetic code which describes the beneficiary's SSI status (if applicable).
21. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client (or welfare) identification number or any other identifier of the State's choice.

345 Personal Characteristics Change Record (RIC E)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Filler	2
9.	73 - 75	Agency Code	3
10.	76	Record Identification Code "E"	1
11.	77 - 81	Filler	5
12.	82 - 105	Surname from CMS Records	24
13.	106 - 120	Given Name from CMS Records	15
14.	121	Middle Initial from CMS Records	1
15.	122	Sex Code from CMS Records	1
16.	123 - 130	Date of Birth (CCYYMMDD) from CMS Records	8
17.	131 -139	Beneficiary's Social Security Number from CMS Records	9
18.	140	Filler	1
19.	141 - 160	Agency Client Identification Number	20

Personal Characteristics Change Record (RIC E) Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Position 12 may be blank. The claim number in this field will be the claim number submitted by the State on the incoming transaction.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The surname in this field will be the surname submitted by the State on an incoming transaction. Any unused positions will be blank.
3. GIVEN NAME (Positions 37-51) - A maximum of fifteen alphabetic characters. The given name in this field will be the given name submitted by the State on an incoming transaction. Any unused positions will be blank.
4. MIDDLE INITIAL (Position 52) - An alphabetic character. The middle initial will be the middle initial submitted by the State on an incoming transaction. This field may be blank.

5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F"). The sex code will be the sex code submitted by the State on an incoming transaction.
6. DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field. The date of birth in this field will be the date of birth submitted by the State on an incoming transaction. A date such as November 1,1909 will be displayed as 19091101.
7. BENEFICIARY'S SOCIAL SECURITY NUMBER (Positions 62-70) - A nine position numeric field. The SSN will be the SSN submitted by the State on the incoming transaction.
8. FILLER (Positions 71-72) - Positions reserved for future use.
9. AGENCY CODE (Positions 73-75) - A three position alphanumeric code assigned to the entity which has jurisdiction over the account.
10. RECORD IDENTIFICATION CODE (Position 76) - "E" constant. The "E" identifies this record as a personal characteristics change record.
11. FILLER (Positions 77-81) - Positions reserved for future use.
12. SURNAME FROM CMS RECORDS (Positions 82-105) - 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 (Positions 106-120) - A fifteen position alpha field that will convey the beneficiary's given name exactly as it is appears on the EDB. Any unused positions will be blank.
14. MIDDLE INITIAL FROM CMS RECORDS (Position 121) - A one position alpha field that will convey the beneficiary's middle initial exactly as it appears on the EDB. The field may be blank.
15. SEX CODE FROM CMS RECORDS (Position 122) - A one position alpha code (male "M", female "F") which will convey the beneficiary's sex code as it appears on the EDB.
16. DATE OF BIRTH FROM CMS RECORDS CCYYMMDD (Positions 123-130) - 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 (Positions 131-139) - A nine position numeric field that will convey the beneficiary's own social security number exactly as it appears on the EDB.
18. FILLER (Position 140) - A one-position field reserved for future use.
19. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client (or welfare) identification number or any other identifier of the State's choice.

350 State Agency Reject Record (RIC F)

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 70	Beneficiary's Social Security Number	9
8.	71 - 72	Buy-In Eligibility Code	2
9.	73 - 75	Agency Code	3
10.	76	Record Identification Code "F"	1
11.	77 - 80	Transaction Code	4
12.	81	Transaction Sub-code	1
13.	82 - 87	Billing Period Start Date (CCYYMM)	6
14.	88 - 93	Billing Period Stop Date (CCYYMM)	6
15.	94 - 96	Filler	3
16.	97 - 102	Additional Date (CCYYMM)	6
17.	103 - 118	Filler	16
18.	119 - 126	Reply Date (CCYYMM)	8
19.	127 - 140	Filler	14
20.	141 - 160	Agency Client Identification Number	20

State Agency Reject Record (ric F) Explanation of Fields

- MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB number) followed by an alphanumeric beneficiary identification code (BIC). Position 12 may be blank. The claim number in the reject record will be the claim number submitted by the State.
- SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. Any unused positions will be blank. The surname will be the surname submitted by the State.
- GIVEN NAME (Positions 37-51) - A maximum of fifteen alphabetic characters. Any unused positions will be blank. The given name will be the given name submitted by the State
- MIDDLE INITIAL (Position 52) - An alphabetic character submitted by the State. If the beneficiary's middle initial was not included on the input record, the field will be blank.
- SEX CODE (Position 53) - A one position alpha code (male "M", female "F") submitted by the State.
- DATE OF BIRTH CCYYMMDD (Positions 54-61) - An eight position numeric field submitted by the State.

7. BENEFICIARY'S SOCIAL SECURITY NUMBER (Positions 62-70) - A nine position numeric field submitted by the State. If the State does not submit an SSN, the field will be blank.
8. BUY-IN ELIGIBILITY CODE (Positions 71-72) - Applicable to Part B buy-in only. Currently, it is a one position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An additional field (position 72) has been allocated for expansion. This field will reflect the buy-in eligibility code from the State input record. This field will be blank on Part A reject records.
9. AGENCY CODE (Positions 73-75) - A three position alphanumeric or numeric code assigned to the entity which has jurisdiction over the account.
10. RECORD IDENTIFICATION CODE (Position 76) - "F" constant. The "F" identifies this record as a State agency reject record.
11. TRANSACTION CODE (Positions 77-80) - A four position numeric code. The first two positions of the code convey the reason that CMS rejected the State's accretion or deletion record. The last two positions contain the transaction code from the State input record.
12. TRANSACTION SUB-CODE (Position 81) - A one position alpha code that further defines the transaction code.
13. BILLING PERIOD START DATE CCYYMM (Positions 82-87) - A six position numeric field that contains the beginning date or accretion date (year and month) from the State input record.
14. BILLING PERIOD STOP DATE CCYYMM (Positions 88-93) - A six position numeric field that contains the ending date or deletion date (year and month) from the State input record.
15. FILLER (Positions 94-96) - Positions reserved for future use.
16. ADDITIONAL DATE CCYYMM (Positions 97-102) - 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 to the State. The date will be a six position numeric field.
17. FILLER (Positions 103-118) - Positions reserved for future use.
18. REPLY DATE CCYYMMDD (Positions 119-126) - An eight position numeric field. This is the date on which CMS created the RIC F record.
19. FILLER (Positions 127-140) - Positions reserved for future use.
20. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 141-160) - The beneficiary's client or (welfare) identification number or any other identifier of the State's choice.

355 Third Party Control Record

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 7	Total RIC A Records (SSI Alert Records)	7
2.	8	Filler (Blank)	1
3.	9 - 15	Total RIC B Records (CMS Billing Records)	7
4.	16	Filler (Blank)	1
5.	17 -23	Total RIC C Records (Claim Number Change Records)	7
6.	24	Filler (Blank)	1
7.	25 - 31	Total RIC D Records (CMS Reject Records)	7
8.	32	Filler (Blank)	1
9.	33 - 39	Total RIC E Records (Personal Characteristics Change Records)	7
10.	40	Filler (Blank)	1
11.	41 - 47	Total RIC F Records (CMS Reject Records)	7
12.	48 - 72	Filler (Blanks)	25
13.	73 - 75	Agency Code	3
14.	76	Record Identification Code "T" Constant, Batch Control Record	1
15.	77 - 81	Filler (Blanks)	5
16.	82 - 87	Billing Cycle (CCYYMM)	6
17.	88	Filler (Blank)	1
18.	89 - 95	Total Number of Records on the File	7
19.	96 - 160	Filler (Blanks)	105

Third Party Control Record

- The Batch Control Record is appended to the end of the monthly agency-billing file. This record contains a count of the records on that file by record identification codes (RIC).
- The Batch Control Record is a 160 position fixed length record.
- Totals are zero filled to the left when the count is less than 7 positions.

- Last block of data may be 9s padded.

360 Third Party History File

(Rev. 1, 10-01-03)

FIELD NUMBER	POSITION	FIELD NAME	NUMBER OF POSITIONS
1.	1 - 12	Medicare Claim Number	12
2.	13 - 36	Surname	24
3.	37 - 51	Given Name	15
4.	52	Middle Initial	1
5.	53	Sex Code	1
6.	54 - 61	Date of Birth (CCYYMMDD)	8
7.	62 - 64	Agency Code	3
8.	65 - 84	Agency Client Identification Number	20
9.	85	Number of History Fields	1
10.	86 - 88	Current History Agency Code	3
11.	89 - 94	Current History Start Date (CCYYMM)	6
12.	95 - 100	Current History Stop Date (CCYYMM)	6
13.	101 - 102	Current History Transaction Code	2
14.	103 - 106	Filler	4
15.	107 - 108	Current History Buy-In Eligibility Code	2
16.	109 - 114	Current History Reduced Premium Amount (\$\$\$\$ cc)	6
17.	115 - 120	Filler	6
18.	121 - 123	First Prior History Agency Code	3
19.	124 - 129	First Prior History Start Date (CCYYMM)	6
20.	130 - 135	First Prior History Stop Date (CCYYMM)	6
21.	136 - 139	Filler	4
22.	140 - 141	First Prior History Buy-In Eligibility Code	2
23.	142 - 147	First Prior History Reduced Premium Amount (\$\$\$\$ cc)	6
24.	148 - 153	Filler	6
25.	154 - 185	Second Prior History	32

26.	186 - 218	Third Prior History	33
27.	219 - 251	Fourth Prior History	33
28.	252 - 288	Filler	37

Third Party History File Explanation of Fields

1. MEDICARE CLAIM NUMBER (Positions 1-12) - A nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a RRB claim number) followed by an alphanumeric beneficiary identification code (BIC). Positions 11 and 12 may be blank. This field will convey the Medicare claim number from the EDB.
2. SURNAME (Positions 13-36) - A maximum of twenty-four alphanumeric characters. The name will match the surname on the EDB. Any unused positions will be blank.
3. GIVEN NAME (Positions 37-51) - 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 (Position 52) - An alphabetic character. If the beneficiary's middle initial is not reflected on the EDB, the field will be blank.
5. SEX CODE (Position 53) - A one position alpha code (male "M", female "F").
6. DATE OF BIRTH (CCYYMMDD) (Positions 54-61) - An eight position numeric field. 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. AGENCY CODE (Positions 62-64) - A three position alphanumeric code assigned to the entity which has jurisdiction over the account.
8. AGENCY CLIENT IDENTIFICATION NUMBER (Positions 65-84) - The beneficiary's client (or welfare) identification number or any other identifier of the State's choice.
9. NUMBER OF HISTORY FIELDS (Position 85) - The number of history fields contained on the history file.
10. CURRENT HISTORY AGENCY CODE (Positions 86-88) - A three position alphanumeric code assigned to the entity which has jurisdiction over the data reflected in this history period.
11. CURRENT HISTORY START DATE (CCYYMM) (Positions 89-94) - A six position numeric field which contains the beginning date or accretion date (year and month) of the transaction
12. URRENT HISTORY STOP DATE (CCYYMM) (Positions 95-100) - A six position numeric field that contains the ending date or deletion date (year and month) of the transaction
13. CURRENT HISTORY TRANSACTION CODE (Positions 101-102) - A two position numeric field which contains the last transaction code posted to this coverage period. The field will reflect code 41 for an ongoing billing record.
14. FILLER (Positions 103-106) - Reserved for future use.
15. CURRENT HISTORY BUY-IN ELIGIBILITY CODE (Positions 107-108) - Applicable to Part B buy-in records only. Currently a one position alphabetic code that describes the reason the beneficiary is eligible for buy-in. An additional field has been allocated for expansion.
16. CURRENT HISTORY REDUCED PREMIUM AMOUNT (\$\$\$\$cc) (Positions 109-114) - Amount of monthly premium reduction if applicable.
17. FILLER (Positions 115-120) - Reserved for future use.
18. FIRST PRIOR HISTORY AGENCY CODE (Positions 121-123) - A three position numeric or alphanumeric code assigned to the entity that had jurisdiction over this account in this coverage period. If the agency code begins with "A", "B", "J", "K" or "X", a formal third party group paid the premiums. If the agency code begins with a "7", the premiums were deducted from the beneficiary's federal civil

service retirement annuity. All other three position numbers or "S" followed by two numbers indicate a State Agency.

19. FIRST PRIOR HISTORY START DATE (CCYYMM) (Positions 124-129) - A six position numeric field that contains the beginning date or accretion date (year and month) of the transaction.
20. FIRST PRIOR HISTORY STOP DATE (CCYYMM) (Positions 130-135) -A six position numeric field that contains the ending date or deletion date (year and month) of the transaction.
21. FILLER (Position 136-139) - Reserved for future use.
22. FIRST PRIOR HISTORY BUY-IN ELIGIBILITY CODE (Positions 140-141) Applicable to Part B buy-in records only. Currently a one position alphabetic code that describes the reason the beneficiary was eligible for buy-in. An additional field has been allocated for expansion.
23. FIRST PRIOR HISTORY REDUCED PREMIUM AMOUNT \$\$\$\$cc (Positions 142-147) - Amount of monthly premium reduction for first prior history, if applicable.
24. FILLER (Position 148-153) - Reserved for future use.
25. SECOND PRIOR HISTORY (Positions 154-185) - The format is identical to the First Prior History.
26. THIRD PRIOR HISTORY (Positions 186-218) - The format is identical to the First Prior History.
27. FOURTH PRIOR HISTORY (Positions 219-251) - The format is identical to the First Prior History.
28. FILLER (Positions 252-288) - Reserved for future use.

Chapter 4 Part B Buy-In System

400. General Systems Description

The month to month operation of the buy-in program is accomplished through an automated exchange of data among the States, HCFA and SSA. Chapter III (Data Exchange) describes in detail the format of the State input records and the HCFA output records.

HCFA maintains a master file of all individuals who are, or were, on buy-in. Data concerning buy-in eligibility are sent to HCFA by the States and by SSA which maintains the Master Beneficiary Record (MBR) and the Supplementary Security Income Record (SSIR). Approximately the 25th of each month, HCFA updates the buy-in master file with accretion, deletion and change records which have accumulated since the last update.

Prior to January 1974, the States made all Medicaid eligibility determinations. When the SSI program was implemented in January 1974, the States were given the option of entering into a "1634 Agreement" with SSA. The 1634 Agreement, which derives its name from that section of the Social Security Act, authorizes the Secretary of Health and Human Services to determine Medicaid eligibility for the aged, blind, or disabled based upon the individual's entitlement to SSI benefits.

A number of States entered into 1634 Agreements and as a consequence became automatic accrete (auto-accrete) States for purposes of State buy-in. Each month, SSA transmits data exchange records for SSI recipients to the buy-in system. Based upon information contained in the data exchange records, HCFA would accrete or delete individuals to the buy-in rolls. Effective November 1986, auto-accrete States were given the option to accrete or delete SSI recipients through the HCFA/State data exchange.

Effective November 1992 HCFA modified the Part B buy-in system in order to bring the buy-in program into compliance with Medicaid regulations regarding redeterminations and appeals. As a result of this modification, the beneficiary is not deleted from the State buy-in rolls when the SSI benefits are terminated. Instead, the beneficiary remains on the buy-in rolls under State jurisdiction. The State will redetermine the beneficiary's Medicaid eligibility. If the State determines that the beneficiary is no longer eligible for State buy-in, the State will delete the beneficiary from the buy-in rolls.

States which entered into 1634 Agreements continue to be responsible for the Medicaid eligibility determinations for all other groups of individuals specified in the buy-in agreement.

States which did not enter into 1634 Agreements continue to make their own Medicaid eligibility determinations. A State may use the SSI standard or may establish its own eligibility standard. States which did not enter into a 1634 Agreement are known as SSI alert States for purposes of State buy-in and make their own accretion and deletion determinations. When the data exchange records for SSI recipients residing in alert States are transmitted from SSA to HCFA, HCFA prepares accretion or deletion alert records. The accretion and deletion alert records are transmitted to the States for appropriate action.

A State must notify the SSA RO in writing if it wants to enter into a 1634 Agreement or terminate an existing agreement. The SSA RO will contact the HCFA RO which will contact HCFA CO so that a realistic time frame can be established for the change. Modifications are required in the Third Party System whenever a State enters into or terminates a 1634 Agreement.

405. State Initiated Accretions

Accrete States are responsible for accreting those groups of individuals specified in the buy-in agreement, with the exception of SSI recipients. HCFA is responsible for accreting SSI recipients. However, HCFA has given auto-accrete States the option to accrete SSI recipients who were not accreted through SSA/HCFA data exchange. (See §457.)

Alert States have accretion responsibility for all coverage groups specified in the buy-in agreement. To assist alert States in identifying SSI recipients who are eligible for Medicare, HCFA provides accretion alert records to the State on a monthly basis. These alert records contain a transaction code 86. Chapter III describes the record format and provides an explanation of the data fields.

The record format for State initiated accretions is contained in Chapter III.

The accretion codes listed below are for use by any State. A brief explanation is provided. Refer to Chapter V for a detailed description.

- Code 61 - normal accretion action;
- Code 62 - special accretion action by the State after verification of Medicare entitlement by the SSA district office;
- Code 63 - identical to code 61 but available for use by the State for special accretion actions or for monitoring specific coverage groups;
- Code 64 - an optional accretion code to be used only by an auto-accrete State to accrete an SSI recipient who was not accreted through the automated SSA/HCFA data exchange; and
- Code 84 - designed for alert States to use when accreting individuals who are SSI recipients for whom the State had received the code 86 alert record.

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

There are situations where States fail to accrete eligible individuals on a timely basis. That is, the individual was eligible for one or more months in the past for which the State failed to pay the Medicare premium. Utilize the following accretion/deletion codes to establish the closed period of buy-in coverage. Submit both the accretion and deletion record in the same update month.

Failure to send both the accretion and the deletion will result in a reject. The code 75 and code 76 are never processed independently of each other. Only one pair of code 75-76 records may be submitted per beneficiary during an update month. The code 75/76 records will be rejected if more than one pair is submitted for a beneficiary during an update month. The record format for the simultaneous accretion/deletion is the same as the format for any regular accretion or deletion.

1. Code 75 - the accretion action to establish the start date
2. Code 76 - the deletion action to establish the stop date

An accretion record submitted by the State will be rejected if:

- The accretion date (positions 64-67) is blank, incomplete, or other-wise in error;
- The accretion date is later than the billing month. For example, if an accretion is submitted in the April update, the accretion date cannot be later than June of the same year.

410. Mandatory and Optional Use of Buy-In Eligibility Codes

The buy-in eligibility codes are designed to provide State agencies with a method of identifying the specific category of assistance for each individual enrolled in the buy-in program and are used for statistical purposes. The States are responsible for maintaining the accuracy of the codes. The buy-in eligibility code is housed in position 50 on the buy-in record. The field may be maintained via the code 99 procedure. (See §435).

Due to the accounting routines in the buy-in system for Federal Medical Assistance Percentage (FMAP), all States are required to identify those individuals who are members of the State's noncash assistance coverage group (title XIX Medical Assistance Only).

A. Mandatory Buy-In Eligibility Codes for States.--

1. Medical Assistance Only (MAO).--

- All States that include title XIX MAO recipients in their buy-in agreement must identify and maintain identification of members of this coverage group on the buy-in master record.
- Use the buy-in eligibility code of "M" for the MAO coverage group.

2. Qualified Medicare Beneficiaries (QMB).--

- Effective January 1, 1989, under the provisions of the Medicare Catastrophic Coverage Act (MCCA) of 1988, all States must cover a category of individuals known as Qualified Medicare Beneficiaries (QMBs). (This provision was not repealed when other provisions of the MCCA were repealed in 1989). States must identify members of this coverage group on the buy-in record.
- Use the buy-in eligibility code of "P" for the QMB coverage group.

3. Specified Low Income Medicare Beneficiaries (SLMB).--

- Effective January 1, 1993, all States must cover a category of individuals known as Specified Low Income Medicare Beneficiaries (SLMBs). States must identify members of this coverage group on the buy-in master record.
- Use the buy-in eligibility code of "L" for the SLMB coverage group.

B. Optional Buy-In Eligibility Codes for States.--

- The buy-in eligibility codes of "L", "M" and "P" are restricted to the situations described in the preceding paragraphs.
- The States should use the optional eligibility codes in §540 for their other coverage groups.

C. HCFA Use of Buy-In Eligibility Codes.--

- HCFA includes a buy-in eligibility code in each SSI accretion or SSI accretion alert record. The codes used by HCFA are described in §540.
- States may change the HCFA generated buy-in eligibility code using the code 99 procedure. (See §435.) A code 99 can be used to add or change a buy-in eligibility code. It cannot be used to delete a buy-in eligibility code. A code 99 record with a blank in position 50 will not eliminate an existing buy-in eligibility code.
- If the State decides to use a buy-in eligibility code of its own design, it must be an alphabetic character.

415. Matching Accretion Records to the Enrollment Data Base

HCFA maintains the Enrollment Data Base (EDB) file which contains the current status of all individuals who are or were entitled to Medicare.

When a State submits a buy-in accretion record, the accretion is verified against the EDB to ensure that the accretion was submitted under the correct 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:

- Medicare Claim Number.--Nine position social security claim number (or pseudo social security claim number if beneficiary is entitled under a Railroad Retirement Board number) followed by a one or two position alpha-numeric Beneficiary Identification Code (BIC). An accretion record for an RRB annuitant may be submitted with an unconverted RRB claim number. A detailed description of the RRB claim number is contained in §375.
- 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. Do not use any special characters such as a period, comma, or hyphen.

EXAMPLE: Fox Jr

NOTE: There may be records on the Part B buy-in file in which there are special characters in the surname. Generally these are records which were accreted directly from the MBR interface for SSI recipients in auto-accute states. Those records are not edited against the EDB. If the State encounters a record of this type, do not include any special characters in any subsequent accretion record.

- First Name - First three positions.
- Sex Code - One position.
- Date of Birth - All six positions. Although only month and year are used for matching, it is important that the day be included so that the correct Medicare entitlement date can be computed.

420. State Initiated Deletions

States have deletion responsibility for all code 41 records which appear on the State's buy-in account. However, there are situations under which HCFA will delete code 41 records for the State. (See §450.)

States are required to submit deletion actions on code 41 records within a specified time frame when Medicaid eligibility has been terminated by the State. (See Commissioner's Decision §430.)

In alert States where buy-in accretion and deletion responsibility rests with the States, HCFA provides informational SSI alert records to assist the State in making timely buy-in determinations. For potential buy-in deletions, HCFA generates a deletion alert record, code 87, on a monthly basis to alert States. This record is generated only when the buy-in system is notified that SSI has been terminated and the individual currently is a code 41. The format of the code 87 deletion alert record is described in Chapter III.

In auto-accrete States, all code 91 records are under HCFA jurisdiction. Effective November 1992, whenever HCFA is notified that a beneficiary has lost eligibility to SSI benefits, the beneficiary is not deleted from the buy-in rolls. Instead, the jurisdiction of the buy-in record is transferred to the State via the code 1190 procedure. The State will make a Medicaid eligibility redetermination and will delete the beneficiary from buy-in only if the beneficiary is no longer eligible for buy in. (See §462.)

Accrete States are responsible for code 41 records regardless of whether the item was originally accreted by the State or the item became a code 41 as a result of a transfer of jurisdiction from HCFA to the State. (See §462.)

The deletion codes listed below are for use by the State and each should be used for the proper reason. (Chapter V provides a full explanation of these codes.) The format of the State initiated deletion record is contained in Chapter III.

- Code 50 - special deletion action used only to delete a code 1165 HCFA accretion action.
- Code 51 - normal deletion for an individual who is no longer a member of the State's coverage group.
- Code 53 - a death deletion.
- Code 76 - deletion action which must be submitted in conjunction with the code 75 accretion record to establish a closed period of buy-in coverage.
- Code 81 - an optional deletion code to be used only by an auto-accrete State to delete a code 91 record for an individual who is no longer entitled to SSI benefits but who was not deleted from buy-in through the automated SSA/HCFA data exchange.

A buy-in deletion record submitted by the State will be rejected if:

- The deletion date (positions 64-67) 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 update month.

The State's liability for the individual's Part B premium includes the month in which the buy-in deletion is effective.

425. State Correction of a Previously Submitted State Accretion or Deletion Date On a Third Party Master Record

Adjustment of Accretion Date - Ongoing Code 41

- The State may adjust the accretion date of an ongoing code 41 to an earlier date by submitting a code 61 transaction containing the new accretion date in the regular monthly data exchange.
- If there is no prior intervening period of coverage, the State will receive a code 4368 showing the new accretion date.
- If there is an intervening action, the State will receive a code 3261 indicating that additional action is required by HCFA. HCFA will either:
 1. Establish one or more closed periods of buy-in coverage for which the State will receive one or more pairs of transaction codes 1172 and 1772 in the regular monthly data exchange, or
 2. Notify the State on a paper document that the accretion date cannot be adjusted.
- 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.

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

- The State cannot adjust the accretion or deletion date on a closed period of buy-in coverage in the regular monthly data exchange.
- The State may undertake a simultaneous accretion/deletion action to establish a closed period of buy-in coverage in addition to the coverage already on the master record. The simultaneous accretion/deletion action may be accomplished only by means of paired transactions: code 75 for the accretion and code 76 for the deletion. The simultaneous accretion/deletion request will be acknowledged in the data exchange with the codes 1175 and 1776 if the records are processed electronically.

If there is an intervening action, the State will receive the codes 3275 and 3276 indicating that additional action is required by HCFA. HCFA will either:

1. Establish one or more closed periods of buy-in coverage for which the State will receive one or more pairs of transaction codes 1172-1772 (history insertion records); or
 2. Reject the transaction with the codes 2875-2876 because the period of coverage requested by the State is entirely within a buy-in coverage period already established on the TPM.
- Do 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 on-going coverage. The code 75/76 procedure should be followed for expanding the coverage period.
 - The deletion date for a closed period may be adjusted to an earlier date but no earlier than 2 months prior to the month in which the adjustment is requested except in the case of death. A death case may be deleted retroactively to the month of death.

A request to correct an erroneous code 16 death deletion must include corroborating evidence from the SSO.

- Correction of a deletion date must be requested by memorandum or letter addressed to the HCFA at the P.O. Box in §200. A separate memorandum is required for each request.

The State will be notified in the regular monthly 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, providing HCFA had accreted the individual 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.
- Code 4368 - acknowledgment of a State submitted request to move an accretion date to an earlier date resulting in a debit to the State.
- Code 4369 - acknowledgment of a State submitted request to move a deletion date to a later date resulting in a debit to the State.

430. Commissioner's Decision

When the "buy-in program" was implemented in July 1966 States were allowed to delete individuals on a retroactive basis and could annul a person's entire buy-in coverage period if the State determined that the individual should not have been enrolled in the buy-in program. When the State deleted the individual, the State received the entire amount of premiums paid as a credit to the State's account. As a result, the individual was held responsible for the entire premium amount. In effect, a hardship condition was placed on the individual when SSA withheld monies from the individual's Social Security benefit check to recover the premiums which, in many instances, were substantial. In 1972, the Commissioner of the Social Security Administration issued a regulation to prevent this hardship on the individual. The regulation, commonly referred to as the "Commissioner's Decision", limits the retroactivity of the deletion date to 2 months from the month in which the buy-in system receives the deletion request. For example, the State submits a deletion action to HCFA in August 1996, the deletion date cannot be earlier than June 1996. If the State had entered a date earlier than June 1996 (e.g., April 1996) the buy-in system would automatically adjust the deletion date to conform to the 2 month retroactive deletion rule and the deletion date would be processed with an effective date of June 1996.

435. State-Initiated Change Record

The State may change the following personal characteristics on the buy-in master record:

- Sex code;
- Buy-in eligibility code; and
- State welfare identification number.

The record format is the same as the format for the State accretion or deletion action described in Chapter III. The transaction code for the change record is code 99.

A code 99 action can be applied to an open master (code 41 or code 91) or to a closed master record.

NOTE: A code 99 can be used to add or change a buy-in eligibility code. It cannot be used to delete a buy-in eligibility code. A code 99 with a blank in position 50 will not eliminate an existing buy-in eligibility code.

440. HCFA Response to State Initiated Accretions and Deletions

The HCFA Third Party System (TPS) will provide a response record for each State initiated accretion or deletion record. The record format for these response actions is contained in Chapter III.

The HCFA response records for State accretions and deletions will be one of the following types:

- An acknowledgement response that the TPS has accepted the accretion or deletion action.
- A reject response with a definitive code describing the reason for the rejected accretion or deletion action.
- An interim response record for the accretion or deletion action that requires additional electronic or clerical investigation before the transaction can be completed. Generally, an electronic response will be made in the next monthly operation indicating the final disposition of the original request. An electronic response record is not generated in a few situations. In rare instances, the State may receive a paper document explaining why the original request could not be completed.

The HCFA response is contained in a four position transaction code field (positions 60-63) of the billing record.

- Chapter V lists all transaction codes in numerical order and provides a definition for each code. A brief synopsis of the codes is given in the following paragraphs for reference purposes only.
- The first two positions of the transaction code field contain the type of response the TPS generated for the accretion or deletion request.
- The last two positions of the transaction code field contain the State input code. However, there are certain conditions where HCFA may change the State accretion input code to reflect an adjustment made to the accretion request.
- In the majority of situations, there will be only one response record for each action submitted by the State. However, there are instances where intervening transactions generate multiple responses to the State. Examples of multiple events are described in Chapter V.
- The transaction code field always contains four numeric characters when HCFA responds to a valid accretion or deletion action submitted by the State.
- When HCFA transmits an ongoing buy-in record or certain HCFA initiated actions, the last two positions will be blank. Chapter V lists all transaction codes in numeric order and identifies those codes which are blank in the last two positions by displaying the blank indicator (bb) immediately after the two position numeric code.
- In the subsequent paragraphs of this section, the explanation of HCFA response codes will, for ease of expression, list the State input code as "XX." If "XX" is not shown as part of the HCFA response code but numerics appear, the response record will carry the numerics shown and not the State input code. This change to the State code results from a HCFA adjustment to the accretion date submitted by the State.

Acknowledgement codes for State initiated accretions and deletions (input codes 61, 62, 63, 64, 84) are listed below. They inform the State that the accretion has been completed.

11XX - beneficiary has been accreted to State buy-in (code 11 is always followed by a two digit explanatory code).

1125 - accretion adjusted to a later date (a closed period of coverage which overlaps the accretion date, is on record for the State submitting the accretion).

1128 - accretion adjusted to a later date (a closed period of coverage which overlaps the accretion date, is on record for a different State).

4368 - accretion adjusted to an earlier date resulting in a debit to the State.

Reject codes for State initiated accretions (input codes 61, 62, 63, 64, 84) are listed below. Accretion actions can be rejected for numerous reasons. States should examine the reason for the reject action and ensure that

all other data contained in the record is valid. The following HCFA reject codes notify the States that the accretion action could not be accomplished. Some of the reject codes have an additional explanation which is identified by the presence of data in the subcode field of the response record. The subcode is in position 51 of the billing record.

18XX - beneficiary does not have Medicare entitlement, however, the SSO is developing a claim for Medicare which may result in a code 1167 or 1180 accretion within the next several months.

19XX - beneficiary's application for Medicare was denied.

21XX - (subcode) accretion failed to match the EDB.

22XX - beneficiary does not have Medicare entitlement, however, the beneficiary is receiving Social Security disability benefits and may be entitled to Medicare at a future date.

24XX - the effective date is invalid.

25XX - (subcode) accretion duplicates an existing master record.

27XX - the accretion contained an impossible code.

29XX - (subcode) there is a death deletion on the TPM which conflicts with the accretion.

33XX - the beneficiary is on the TPM as a code 91 (SSI) for another State.

3662 - (applies only to State input code 62) the accretion did not match the EDB.

Interim codes from HCFA for State initiated accretions (input codes 61, 62, 63, 64, 84) are listed below. The HCFA interim codes inform the State that the action requested cannot be accomplished in the month that the item was submitted. In most cases, a definitive response will be generated the following month. In other situations, the State will receive a response explaining why the action requested by the State cannot be taken.

31XX - the accretion encountered a cross-reference action on the TPM and must be swung to the new location or, the TPS encountered an inactive master record which must be retrieved before the current transaction can be processed.

32XX - the coverage requested in the accretion is prior to existing coverage in the current history field on the TPM.

The acknowledgement code for State-initiated deletions (input codes 50, 51, 53, 81) is a code 17XX. The response code tells the State that the deletion has been processed.

The reject codes for State initiated deletions (input codes 50, 51, 53, 81) are listed below. A deletion request can be rejected for numerous reasons. States should examine the reason for the reject action and ensure that all other data fields are correct before the deletion action is resubmitted.

20XX - there is no record of buy-in coverage under the claim number submitted or there is a record but jurisdiction rests with another State.

24XX - the effective date is invalid.

25XX - (subcode) duplicates an existing master record.

2750 - (applies only to State deletion code 50) the deletion was not submitted within the proper timeframe, or the accretion action which the State is attempting to delete did not result from a code 1165.

34XX - the deletion code is incorrect, the beneficiary is on the TPM as a code 91 (SSI) for the State which submitted the deletion.

The interim code from HCFA for State initiated deletions (input codes 50, 51, 53, 81) is code 31XX. The "XX" represents the State input code. The code 31XX interim response code in this instance usually means that the incoming State transaction encountered a cross-reference action and the incoming transaction must be swung to the new location. The number of interim responses from HCFA for a State deletion is minimal as most deletions are either accepted or rejected.

442. Adjustment of State Accretion Effective Date for Aged or Disabled Individuals

All State submitted accretion actions are screened to the EDB for presence of Medicare entitlement. In those cases where entitlement exists, the individual'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.

The method used by HCFA is the creation of an additional response record in addition to the required response for the State accretion request. One of the HCFA response records always will be a code 30XX. The other record will be any valid HCFA response code for an accretion request.

The examples provided below illustrate the adjustment method for aged and disabled cases.

Adjustment for an Aged Individual

The State-initiated accretion record contains a buy-in effective date of 3/94 and the date of birth in the accretion record is 3/15/29 which indicates that attainment of age 65 is 3/94. When the State accretion is screened to the EDB, HCFA will examine the date of birth and Medicare entitlement date in both records. In this example, the EDB date of birth is 10/29/29; therefore, the Medicare entitlement date is 10/94.

The State will receive two response records for this situation. The first record will be a code 30XX. This record will contain the date of birth and buy-in effective date submitted by the State. The second record (if accreted) will be a code 11XX. The buy-in effective date contained in this record will be 10/94. The date of birth field will contain the EDB date of birth which in this example is 10/29/29. This corrected date of birth will convey a "zoned plus" in the last position of the year for easy identification by the State. In this case the date of birth will appear as 10/29/2I. The TPM record will maintain the corrected date of birth as all numerics (10/29/29).

Adjustment for a Disabled Individual

The same processing routines are performed for disabled individuals except that the date of birth is not used in determining the Medicare entitlement date. However, the date of birth field may be corrected if the State's date of birth does not agree with the EDB.

The State-initiated accretion contains a buy-in effective date of 12/92. The EDB reflects a Medicare entitlement date of 2/93.

The State will receive two response records for this situation. The first response record will be the code 30XX which contains the State's buy-in effective date and the date of birth submitted by the State. The second record (if accreted) will be a code 11XX. The buy-in effective date will be 2/93. The date of birth may be the same as submitted but could be corrected to agree with HCFA records. If the last position of year is "zoned plus" a correction action was taken but it has no bearing on the individual's Medicare entitlement date.

In certain situations the adjustment action taken by HCFA may result in a reject of the request based solely on the adjusted buy-in effective date. The reason that this situation can occur is one of timing.

- If the State receives a code 30XX record, it is possible for the second record to be a code 24XX.
- In this situation, the adjusted buy-in effective date in the code 24XX record will always be a future date. That is, the effective date is beyond the current billing month and therefore cannot be accreted. Whenever a State receives this type of adjustment/reject action it should resubmit the accretion request at the appropriate time.

445. HCFA Response to a State Initiated Simultaneous Accretion/Deletion Action

(Code 75/76)

The unique simultaneous accretion/deletion action (codes 75, 76) is available to States to establish a closed period of buy-in coverage. Special processing of codes 75 and 76 by HCFA is described in subsequent paragraphs.

The State input code 75 must always be accompanied by a code 76.

Only one pair of codes 75/76 for an individual can be processed by HCFA in a given monthly operation.

The code 75 (accretion portion) must contain the proper Medicare identification information to allow the item to be processed in the month submitted. If the code 75 record does not match on Medicare data, it is automatically rejected. The code 76 also will be rejected.

The following HCFA response codes inform the State of the action taken on a code 75/76 request.

- The acknowledgement codes for a completed action by HCFA are 1175 and 1776.
- The reject codes, if HCFA is unable to take the requested action, are:
 - 2175 - 2076
 - 2475 - 2476
 - 2775 - 2776
 - 2875 - 2876
 - 2975 - 2976
- The HCFA interim response codes are:
 - 3175-3176
 - 3275-3276

447. HCFA Response to a State-Initiated Change Record

(Code 99)

State change records (code 99) are applied to existing TPM records if the change record matches the existing master record on claim number and State agency code.

If the master record is an ongoing item (code 41 or code 91), the change record will be applied. The State will receive only the code 41 or code 91 record but it will reflect the change.

If the master record is not ongoing; i.e., is a closed master, the change record will be applied and the State will not receive any communication.

If the change record does not match an existing master record on claim number and/or State agency code, HCFA will reject the change record with a response code 4999.

If the State submitted a buy-in eligibility code of "L" (SLMB) or "P" (QMB) and the EDB does not contain current Part A entitlement, HCFA will reject the transaction with a response code 4999.

450. HCFA Initiated Deletions of Code 41 (State Responsibility) Items

A. Death Deletions-Code 16.--

- SSA receives reports of death from a number of sources in the daily operation of its various programs. If a report of death is received for an individual who is on buy-in, SSA sends a death deletion record to the HCFA TPS in the regular monthly data exchange.
- The TPS deletes the individual from buy-in effective with the month of death. HCFA sends a code 16 death deletion notification to the State on the billing file. The month and year of death are shown in the transaction effective date field. The transaction code field contains "16bb."
- There are instances in which, despite the notification of death from SSA, the beneficiary is alive. The State may reaccrete the beneficiary to the buy-in rolls through the normal data exchange after ensuring that SSA has removed the date of death from the MBR.

B. Individual's Loss of Medicare Eligibility - Code 15.--

- SSA, in the course of reviewing its files of Medicare eligibles, may determine that an individual does not currently meet all the requirements for Medicare. Among the reasons are a determination that the individual has not attained age 65, or that entitlement to disability benefits has ceased, or that requirements for citizenship or alien residency have not been met.
- SSA will send a deletion record to the TPS in the regular monthly data exchange. The TPS will delete the individual from buy-in effective with the month and year of Medicare termination. The transaction code field will contain "15bb."

C. Deletion as The Result of Another State's Accretion Action - Code 1728.--

- If an individual is on the buy-in rolls and another State submits an accretion action for the same individual, the original State will receive a code 1728 deletion. It is assumed that the State which submits the latest accretion action is the State which has jurisdiction. The deletion date will be the month prior to the month that the new State assumed jurisdiction.
- The State should examine the Medicaid record for any individual for whom it receives a code 1728 record to ensure that the State's Medicaid eligibility record has been closed. This will prevent a cycle of reaccretion and deletion actions between States. If the State which received the code 1728 believes it is responsible for the beneficiary's Medicaid eligibility, 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.

D. Deletions From Other Sources.--

- HCFA may be notified outside of the monthly data exchange that a deletion action is required. Normally, notifications of this nature are submitted to HCFA by the SSO on the HCFA-1957 "SSO Report of State Buy-in Problem," or by the State on a memorandum.
- HCFA will take the appropriate action. If a deletion is processed, the State will be notified of the deletion in the monthly data exchange. Even though HCFA personnel complete the documents to delete the item, it is not technically a HCFA initiated deletion because HCFA is responding to an outside request.
- Deletion actions taken by HCFA for these situations will be identified in the State billing file with a transaction code 1759.

455. HCFA Initiated Accretions of SSI Recipients in Auto-Accrete States

HCFA is responsible for accreting SSI recipients to the buy-in rolls for accrete States. Individuals who are potentially eligible for buy-in are identified by internal processes developed by HCFA and SSA.

Each month the TPS receives from SSA a file of records that indicate potential buy-in.

The TPS examines the data fields and prepares an accretion action if:

- The individual is receiving SSI;
- The individual is a resident of an auto-accrete State; and
- Medicare entitlement is contained in the individual's MBR record.

The TPS determines the effective buy-in date based on the individual's SSI entitlement date, Medicare entitlement date, and date of residency in the State.

HCFA initiated SSI accretion records will be sent to the States in the regular monthly buy-in data exchange file. These accretion actions can be identified by a transaction code 1180. However, it is possible that the transaction code will contain an 1185. An 1185 is the same type of accretion action as an 1180 but indicates that an adjustment to the effective buy-in date was required due to prior buy-in coverage. Refer to Chapter V for an explanation of the transaction codes.

Accrete States will find a complete description of the SSI accretion record and explanation of all data fields in Chapter III.

The SSI status codes and the buy-in eligibility codes which are part of the SSI accretion record are described in Chapter V.

457. State Initiated Accretions of SSI Recipients in Auto-Accrete States

An auto-accrete State has the option to accrete an SSI recipient to the State's buy-in file through the automated State/HCFA data exchange. This procedure may be used whenever an eligible individual is on the State's SDX file but was not accreted through the automated SSA/HCFA data exchange.

A State initiated SSI accretion, code 64, is processed in the same manner as any other State initiated accretion. The TPS provides a response to each State initiated accretion record.

If the accretion is accepted, it will be maintained on the TPM as an ongoing code 41 item. It is the State's responsibility to monitor the record and to submit a deletion record, if appropriate.

If the TPS subsequently receives an SSI accretion through the SSA/HCFA automated data exchange, the TPS will delete the code 41 and simultaneously reaccrete the record with a code 1180. The code 1180 will become a code 91 the following month.

The optional SSI accretion and deletion procedures must not be used to adjust a master record or to correct a duplicate billing. Buy-in records which require corrective action of this type must be referred to HCFA through the established problem case resolution procedures.

The State may continue to request the assistance of the HCFA in correcting discrepant buy-in records involving HCFA initiated SSI accretions in accordance with §470.

460. HCFA Initiated Deletions in Auto-Accrete States

(Code 91 Records)

All code 91 records which appear on the buy-in files in accrete States are the result of an accretion action taken by HCFA for SSI recipients. HCFA will delete these individuals if they lose SSI payment status or move to another State (regardless of SSI eligibility). Additionally, HCFA will transfer buy-in responsibility to the State agency in situations where SSI payments have terminated but the individual's Medicaid eligibility is retained due to Medicaid regulations regarding redeterminations of Medicaid eligibility (§462).

A. Buy-In Processing When SSI Payments Are Terminated.--

- SSI termination events are conveyed to the TPS within the same framework as accretion actions.
- Each month the TPS receives SSI termination events and deletes the items from the accrete State's account. HCFA will generate a code 1787 deletion record to the State in the billing file. The deletion date will be the last month that the individual received an SSI payment. Usually, the code 1787 deletion record will be followed with a code 1190 reaccretion record.
- The SSI deletion record format is described in Chapter III.
- The SSI status codes and buy-in eligibility codes are described in Chapter V.

B. Deletions From Buy-In When Change of State Residency Occurs.--

- When an SSI recipient moves to another State, SSA will correct the SSI record to reflect the new State.
- When this change of State residency is entered in the SSI record, the SSI system will generate a change record to the TPS for appropriate action.
- The TPS, upon receipt of the State residency change record, will delete the individual from the accrete State's account with a code 1728 transaction. The deletion date will be the individual's last month of residency in that State.
- The new State of residency, which can be an alert State or accrete State, will receive either an SSI alert record (code 86) or an SSI accretion record (code 1180) if SSI entitlement continues.

462. Transfer of Buy-In Responsibility

(Code 1190 Procedure)

Medicaid regulations stipulate that a Medicaid recipient cannot be deleted from the buy-in rolls without a Medicaid eligibility redetermination. In order to conform to Medicaid regulations, buy-in responsibility for an individual currently on the rolls as code 91 (SSI record) is transferred from HCFA to the auto-accrete State when SSI payments are terminated unless the beneficiary has died or there is a change in the State of residency (see §460).

This transfer of responsibility is accomplished by a simultaneous deletion/reaccretion action initiated by HCFA. It is generally referred to as the code 1190 procedure. The procedure applies only to auto-accrete States and is as follows:

- The TPS will generate two records to the State agency. The first record is the SSI deletion event (transaction code 1787), the second record is the reaccretion event (transaction code 1190). The buy-in coverage is maintained for the individual in the TPS without interruption while buy-in accretion and deletion responsibility is transferred to the State. The code 1190 record becomes a code 41 in the next billing cycle.
- The code 1787 record contains the SSI status code and the deletion effective date, which is the last month of SSI coverage. States with buy-in coverage agreements covering noncash individuals should examine the living arrangement code field for a "D" which designates an individual living in a title XIX institution.
- The buy-in effective date in the code 1190 record is the first month of coverage under State responsibility. It is always the month immediately after the deletion date in the code 1787 record.

The State must maintain the beneficiary on the buy-in rolls until it has completed a Medicaid eligibility redetermination and establishes that the individual is no longer eligible for State buy-in under any of the State's buy-in coverage groups. If beneficiary is no longer eligible for State buy-in, the State must submit a deletion to HCFA in the monthly data exchange. According to Medicaid regulations, the beneficiary cannot be deleted until the Medicaid recipient's Medicaid eligibility has been redetermined.

If the beneficiary's eligibility for SSI benefits is reestablished, SSA will transmit an SSI reaccretion record to HCFA. HCFA will process another simultaneous deletion/reaccretion action. HCFA will delete the existing Part B master record with a code 14bb, effective with the last month of non SSI status, and reaccrete the Part B master record with a code 1180, effective with the first month of newly established SSI eligibility.

465. State Initiated Deletions in Auto-Accrete States

(Code 91 Records)

An auto-accrete State has the option to delete a code 91 record from its buy-in file through the automated State/HCFA data exchange. This procedure may be used to delete an individual who was terminated on the State's SDX file but was not deleted from buy-in through the automated SSA/HCFA data exchange.

A State initiated SSI deletion, code 81, is processed in the same manner as any other State initiated deletion. The TPS will provide a response to each State initiated deletion record.

Even though the State opts to use the code 81 deletion, the State must make a Medicaid eligibility redetermination to determine if the beneficiary is eligible for State buy-in under another of the State's buy-in coverage groups.

The optional SSI accretion and deletion procedures must not be used to adjust a TPM record or to correct a duplicate billing. Buy-in records which require corrective action of this type must be referred to HCFA for problem case resolution. (See §§245 and 470.)

The State may continue to request the assistance of HCFA in correcting discrepant buy-in records involving HCFA initiated SSI actions in accordance with §470.

470. State Request for Adjustment of SSI Actions Accreted By HCFA

A State, in which HCFA automatically accretes SSI recipients to the buy-in, may identify items on its buy-in account which do not agree with State records or the State Data Exchange Record (SDX).

Potential areas of disagreement between the TPM record and the State records or the SDX are:

- The individual is on the State buy-in as a code 91 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.
- The effective date of the HCFA initiated accretion and the effective date of SSI eligibility differ.
- The effective date of the HCFA initiated deletion and the effective date of the SSI eligibility differ.

NOTE: Medicaid regulations regarding re-determinations and appeals must be taken into consideration. Even if the code 1787 deletion date does not coincide with the termination date on the SDX, the beneficiary may be in a Medicaid eligibility re-determination period and an adjustment to the buy-in record is not necessary.

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

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

Submit each request to adjust a discrepant HCFA initiated SSI accretion or deletion action on a memorandum to HCFA at the P.O. Box in §200. Allow 90 days to elapse before submitting a follow up memorandum labeled "Second Request." Some situations may lend themselves to either the optional SSI accretion procedure or the optional SSI deletion procedure. (See §§457 and 465.)

Direct all other SSI buy-in related complaints to the HCFA RO.

475. HCFA Initiated Claim Number Changes

Chapter III, §§365-380 contain a complete explanation of Medicare claim numbers, railroad retirement board claim numbers and social security numbers.

HCFA notifies the State in the regular monthly billing file of any changes in the beneficiary's claim number and/or beneficiary identification code (BIC). A claim 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 HCFA.

A claim 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 claim number as an uninsured. She may then become entitled as a wife or widow on a spouse's claim number.

A BIC change will occur, for example, when an individual'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.

HCFA will generate a transaction code 23bb claim number/BIC or BIC only change record to the State when the TPS receives notification from internal systems of the BIC or claim number change. The code 23bb transaction also indicates that the change was for an existing open master record (code 41 or code 91) which will be contained in the billing file in proper sequence under the new claim number.

As a result of the code 23bb, a State could receive two open master records on the billing file under the new claim number. It is possible to receive two code 41 items or two code 91 items, or a code 41 and a code 91. The duplicate billing situation occurs because the individual was accreted under two different claim 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 HCFA 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 HCFA (see §200) describing the situation. There is no time limit to obtain an adjustment for duplicate billing.

States can receive claim 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 HCFA.
 - (a) 2361
 - (b) 2362
 - (c) 2363
 - (d) 2364
 - (e) 2384
 - (f) 2375
 - (g) 2376
 - (h) 2350
 - (i) 2351
 - (j) 2353
 - (k) 2381
- In addition to the transaction code 23XX record (XX represents State input code) HCFA will send a response record for the requested action to the State under the new claim number.

- The code 99 request (State change record) can also require a claim number change action by HCFA. Therefore, the State can receive a transaction response code 2399.

The record format for all transaction code 23 responses is contained in Chapter III.

480. Public Welfare Accretion Procedure

(Code 1167)

The Public Welfare (PW) accretion procedure is initiated by the SSO when an individual files an application for Medicare and appears to be eligible for Medicaid. The purpose of the PW procedure is to establish Part B of Medicare for the individual via 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.

In an alert State, the SSO verifies the individual's Medicaid eligibility at either the local welfare office or at the State welfare office in accordance with procedures agreed upon by the State, HCFA RO and the SSA. If the individual is entitled to title XIX MAO, and the State Buy-In Agreement covers this group, the mandatory 2-month waiting period must be reflected in the buy-in effective date.

NOTE: In order to minimize the number of erroneous PW accretions, each State should coordinate with its HCFA and SSA RO to establish a PW verification procedure which will be used by all the SSOs in the State.

In an accrete State, if the individual is SSI eligible, SSI eligibility is equivalent to Medicaid eligibility. If the individual is not SSI eligible, the procedure is the same as in an alert State.

After SSA has established a MBR for the individual, it transmits a PW accretion action to the TPS. HCFA accretes the item and sends an accretion record containing an 1167 disposition code to the State. If, however, the individual is SSI eligible and resides in an accrete State, the accretion record will contain a disposition code 1180. The effective date of a PW accretion for a cash recipient is the first month for which the individual is eligible for both Medicare and Medicaid. The effective date of PW accretion for a MAO (noncash) recipient is 2 months after the month in which Medicaid eligibility is determined.

Chapter III, describes the record format and provides an explanation of the data fields for the code 1167 accretion.

482. Erroneous PW Accretion - All States

If the State determines that a PW accretion (code 1167) action is erroneous, the State may protest the action. It must react to the PW accretion before the end of the fourth month following the month in which it received notification of the PW accretion on its billing file. If the State does not react timely, the State becomes responsible for the premium liability until it submits a deletion action to the TPS. In that situation, the Commissioner's Decision, which limits the retroactivity of deletions to processing month minus two, is applicable and the State is liable for all premiums from the month of accretion through the month of deletion.

State Action:

1. Document Required.--If the State determines that a PW accretion is erroneous it must furnish the following information to HCFA in accordance with the instructions in subsequent paragraphs of this section:
 - a. Health insurance claim number;
 - b. Enrollee's name;
 - c. Enrollee's date of birth and sex;
 - d. Accretion date; and
 - e. Billing month in which the code 1167 was received.
2. Closed Period of Medicaid Coverage.--If the State determines that the effective date of the PW accretion is correct, but the individual is no longer eligible for Medicaid, it should notify HCFA in writing of the last date of Medicaid eligibility so that HCFA may establish a closed period of buy-in coverage. In order to terminate erroneous buy-in as quickly as possible, delete the individual with a code 51. If the individual's entitlement to Medicaid ended earlier than the date reflected in the code 51, ask HCFA to adjust the deletion date and cite this paragraph in the request.
3. Incorrect Effective Date or No Medicaid Eligibility.--If the State determines that the PW accretion date is incorrect (earlier than date of Medicaid eligibility) or that the individual has not been Medicaid eligible since the effective date of the PW accretion, the State's complaint must be directed to the HCFA RO. If the individual is not currently Medicaid eligible, delete the individual with a code 51 and notify the RO citing this paragraph. The RO will contact the Program Service Center and request a review of the claims folder in order to determine whether the documentation in the folder supports the PW accretion. The RO notifies the State of the results of the folder review.

If the RO determines that the SSO followed the correct procedures and obtained verification of Medicaid coverage from the correct public welfare office, the accretion will stand.

If the RO determines that the evidence in the claims folder does not support buy-in coverage or that the SSO was in error, the RO will adjust the deletion date if necessary.

If the RO determines that the individual does have Medicaid coverage but the buy-in accretion date is erroneous, it will adjust the accretion date. The State will receive a disposition code 4267 credit after HCFA has adjusted the record. The beneficiary's premium liability will not be affected.

484. PW Accretion - Auto-Accrete States

When a code 1167 is received by an accrete State, the accretion should be for a non-cash recipient; i.e., generally, a member of the State's MAO coverage group. It is possible, however, that the code 1167 can be for a cash assistance (SSI) recipient whom HCFA should have accreted to the buy-in as a code 1180 action.

Accrete States should compare all code 1167 actions to the appropriate SDX file to identify those which should have been code 1180 actions. The chart below should be followed by all accrete States to determine the proper notification procedure for resolution of PW complaints. When using this chart, 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 the State buy-in agreement covers only cash-assistance individuals and Part A of Title IV, the PW effective date could be related to the AFDC eligibility period. If SSI is involved, the State can examine the SDX record for evidence of AFDC eligibility and verify receipt by review of the AFDC file.
- If the State buy-in agreement includes non-cash assistance (MAO), the PW effective date could be related to State medical assistance eligibility prior to receipt of SSI benefits. The State should examine its medical assistance file to verify initial date of medical assistance eligibility.

486. Resolution of PW Records Received by Auto-Accrete States

Related SDX	Current Pay Status	CN in Unearned Income Field	PW Buy-in Date Acceptable
No	---	---	---

Disposition:

SSI not involved. Handle in accordance with procedures outlined in the preceding paragraphs.

Related SDX	Current Pay Status	CN in Unearned Income Field	PW Buy-in Date Acceptable
Yes	No	---	---

Disposition:

SSI not involved. Handle in accordance with procedures outlined in the preceding paragraphs.

Related SDX	Current Pay Status	CN in Unearned Income Field	PW Buy-in Date Acceptable
Yes	Yes	Yes	Yes

Disposition:

Notify HCFA that the case should be accreted to buy-in with an SSI accretion. If a code 1180 is not received within 90 days after notification to HCFA, submit a second request.

Related SDX	Current Pay Status	CN in Unearned Income Field	PW Buy-in Date Acceptable
Yes	Yes	Yes	No

Disposition:

If the PW effective date is later than the SSI entitlement date, notify the TP unit of the correct date and that the item should be accreted to the buy-in with an SSI accretion. If a code 1180 is not received within 90 days after notification to HCFA, submit a second request.

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 is questionable, but the individual should be on the buy-in as an SSI accretion. The RO will advise the State of the results of its investigation of prior buy-in eligibility (non-SSI period) and will initiate corrective action for both the prior period and current period if necessary.

Related SDX	Current Pay Status	CN in Unearned Income Field	PW Buy-in Date Acceptable
Yes	Yes	No	Yes

Disposition:

Notify the SSO (parallel or servicing as specified by local agreement with HCFA RO and SSA) 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 SSO input of the claim number. If the unearned income field does not contain this number, submit a second request to the responsible SSO. Notify the TP unit that the case should be accreted to the buy-in with an SSI accretion. If a code 1180 is not received within 90 days submit a second request.

Related SDX	Current Pay Status	CN in Unearned Income Field	PW Buy-in Date Acceptable
Yes	Yes	No	No

Disposition:

If the PW date is later than the SSI entitlement date, notify the SSO (parallel or servicing as specified by local agreement with HCFA RO and SSA) 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 SSO input of the claim number. If the unearned income field does not contain this number, submit a second request to the responsible SSO. Notify the TP unit that the case should be accreted to the buy-in with an SSI accretion. If a code 1180 is not received within 90 days submit a second request.

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 is questionable, but the individual should be accreted to the buy-in with an SSI accretion. The RO will advise the State of the results of its investigation of prior buy-in eligibility (non-SSI period) and will initiate corrective action for both the prior period and the current period if necessary. In addition, the HCFA RO will notify the appropriate SSO of the omission of the individual's claim number in the SSI record.

488. HCFA-L 1614-TR Notice of Part B State Buy-In Accretion

This section intentionally omitted.

490. HCFA-L 1636-TR Notice of Part B State Buy-In Deletion

This section intentionally omitted.

492. HCFA-L 1907-TR Notice of Part B State Buy-In for Closed Period

This section intentionally omitted.

Chapter 5 Part B Transaction Codes

500 General Information

(Rev. 1, 10-01-03)

The buy-in transaction codes provide a concise, definitive means of communication between CMS and the States. The States are restricted to the use of the following two position numeric codes that should always appear in positions 76 and 77 of the State input record.

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

The transaction codes used by CMS consist of not less than two, nor more than four numerics 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.

The transaction codes used in communication between CMS and the States are defined below. 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 and are self-explanatory. For ease of understanding, codes are illustrated as follows:

11XX - The XX is shown here to indicate that the code 11 is a prefix code. The XX represents the last two numeric positions.

41bb - The bb indicates that the State can receive this transaction code followed by two blanks. Any code displayed in this section followed by the bb is a valid transaction code.

It is important that the State program its system to accommodate all transaction codes and sub-codes.

510 Part B Buy In Transaction Codes

(Rev. 1, 10-01-03)

TRANSACTION CODE	DEFINITION
11XX	The code 11 informs the State that the individual was accreted 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 Third Party Master (TPM). The accretion results in a debit action to the State. Next month, the item will appear on the State's bill as a code 41 (ongoing item). The State is liable for the individual's Part B premium and will be billed monthly until the individual is deleted from the State's buy-in 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 TPM 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. Next month the item will appear on the State's bill as a code 41 (ongoing item) unless the item is deleted.
1161	The code 1161 or 1163 informs the State that an accretion it submitted has been added to the TPM. The accretion date is the same as reported on the State input record except when a code 30 action is present. (The code 30 notifies the State that the accretion will be adjusted to conform to the individual's Medicare entitlement date.) Next month the item will appear on the State's bill as a code 41 (ongoing item) unless the item is deleted.
1163	
1165	The code 1165 informs the State that an accretion was processed to the TPM by CMS. The accretion occurred because the State submitted a written request to CMS requesting an accretion action or because an SSO submitted a form CMS-1957 reporting a problem case. It could also occur because of a computer exception that occurred while processing an accretion submitted by the State in a prior month's data exchange (these occurrences will be rare). Next 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 to annul the accretion or establish a closed period of buy-in coverage. If the code 50 is submitted beyond the two-month rule, the code 1165 will be deleted in accordance with limitation imposed by the Commissioner's Decision.
	If the accretion date is incorrect, annul the transaction within the 2 month time limitation and reaccrete the record with the correct effective date.
1167	The code 1167 informs the State that a Public Welfare (PW) accretion was accreted to the TPM.
	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 to annul the accretion or establish a closed period of buy-in coverage. If the code 50 is submitted beyond the 2-month rule, the code 1167 will be deleted in accordance with the limitation imposed by the

	Commissioner's Decision.
	If the accretion date is incorrect, annul the record within the 2-month limitation and reaccrete the record with the correct effective date.
1180	The code 1180 informs the State which has a 1634 Agreement (autoaccrete State) that CMS has established a buy-in record for an SSI recipient. The effective date of the accretion will be the first month of buy-in eligibility based upon SSI or a Federally administered State supplement but in no case will the retroactivity be greater than 4 years. Next month the item will appear on the State's bill as a code 41 (ongoing item) unless the item is deleted.
	Subcode A - 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 subcode A to alert the State that it will also receive a RIC A record with the complete SSI data. The State will review the SSI record, and if it determines that the beneficiary is eligible for additional buy-in coverage, the State will submit a simultaneous accretion/deletion record (code 75) to expand the buyin coverage.
	State Action - Review the SDX file to ensure that the individual is recorded on the SDX and that the accretion date is correct. If a RIC A was received, examine the data and expand the buy-in coverage as appropriate
1184	The code 1184 informs the State that an accretion, which may be submitted by an alert State in response to a code 86 accretion alert record or may be submitted by an auto-accrete State based on an examination of the SDX file, has been added to the TPM. The effective date is the same as reported on the State input record except when a code 30 action is present. (The code 30 informs the State that the effective date was adjusted to a later date to conform to the individual's Medicare entitlement date.) Next 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 a record as the result of an internal systems adjustment. These occurrences are rare.
15bb	This code informs the State that the individual was deleted from the State's buy-in account because SSA's records indicate that the individual currently does not 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 individual does meet the requirements for Medicare, refer the individual to the SSO to re-establish Medicare entitlement. If Medicare entitlement is re-established, reaccrete 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 buy-in.
	State Action - If the State believes that the individual is alive, obtain corroboration from the SSO. The State may then re-accrete the individual to State buy-in through the automated data exchange. If SSA's records have not been corrected, the State's reaccretion 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 SSO before sending a memorandum to CMS requesting an adjustment to the deletion date.
17XX \	The code 17 informs the State that the individual was deleted 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 Part B premium ends with the month in which the buyin 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 SSI records show 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 receives the code 1728 believes it should retain jurisdiction of the case, it must contact the State that submitted the new accretion in order to resolve jurisdictional issues.
1750	This code informs the State that CMS has processed a code 50 to annul or establish a closed period of buy-in coverage for a code 1165 or 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 reflect the deletion date in the code 50 submitted by the State. If the code 50 was not submitted timely, the code 1750 will reflect a deletion date in accordance with the limitation imposed by the Commissioner's Decision.
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 by the Commissioner's Decision.
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 in CMS. The clerical action was prompted by a written request from the State (which should be extremely rare) or by a form CMS 1957 submitted by an SSO (which should be extremely rare.) Occasionally, the code 1759 may reflect a deletion date that exceeds that allowed by the Commissioner's Decision.
20XX	The Code 20 informs the State that a deletion action it submitted was rejected because there is no record of ongoing buy-in coverage for that State under the claim number submitted.
2050	
2051	
2053	
	State Action - Examine the claim number in the deletion record to ensure that there was not a keying error at input. The claim number in the deletion record must match a corresponding record on the TPM 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 the history file to determine if a code 1728 was received transferring jurisdiction to another State.
21XX	The code 21 informs the State that the accretion or simultaneous accretion/deletion record it submitted cannot be matched to a record 2163 on the EDB. 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. Subcode A - There is no record of the claim number on the EDB. The claim number may be absent
2161	
2175	

2184	from the EDB or the claim number in the accretion may contain blanks, alpha characters or special nonnumeric characters in positions that should be numeric.
	Subcode B - The claim number on the accretion matches a claim number on the EDB record. The personal characteristics differ, however.
	Subcode C - 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 QI1 (buy-in eligibility code "U") and the EDB does not reflect Medicare Part A entitlement.
	Subcode D - The claim 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.
	Subcode 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, there is no Medicare entitlement for the period of time that the State is attempting to buy-in.
	State Action - Subcodes 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 fields 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 can access and correct the input record.
	State Action - Subcode C - If the beneficiary is eligible for State buy-in, resubmit the transaction without the SLMB, QMB, or QI1 buy-in eligibility code in position(s) 71-72.
	State Action - Subcode D - Drop the item. If the beneficiary meets the QDWI eligibility requirements, accrete the beneficiary through the Part A system.
	State Action - Subcode E - 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 EDB. If the State believes that the beneficiary should be entitled to Medicare, refer the beneficiary to the SSO to resolve the Medicare entitlement issue.
23XX	The code 23 informs 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	These codes inform the State that a claim number change was processed to a deletion record.
2351	

2353	
2361	These codes inform the State that a claim number change was processed to an accretion record.
2363	
2375	
2384	
2399	This code informs the State that a claim number change was processed to a change record.
24XX	The code 24 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 later than the billing month. It will be orbited for one month if the effective date is equal to the billing month (see transaction code 32).
	A deletion action, other than a death deletion, will be rejected if the effective date is equal to or greater than the billing month.
	A death deletion (code 53) will be rejected if the effective date (i.e. date of death) is later than the update month.
2450	These codes inform the State that the deletion record it submitted was rejected. Refer to code 24XX for a detailed explanation.
2451	
2453	
2461	These codes inform the State that the accretion record it submitted was rejected. Refer to code 24XX for a detailed explanation.
2463	
2475	
2484	
25XX	This code 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	These codes inform the State that the accretion or simultaneous accretion/deletion record it submitted duplicates an existing accretion.
2563	
2575	
2584	
27XX	This code 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 numerics 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	These codes inform the State that the accretion or simultaneous accretion/deletion action it submitted was rejected because there is a death deletion on the EDB which is at least one month earlier than the accretion effective date. The code 29 may apply to a new accretion or to a reaccretion. The month and year of death will appear in positions 97 through 102 of the reject record.
2961	
2963	
2975	
2984	
	State Action: If investigation establishes that the beneficiary died later than the date of death on SSA/CMS records or that the beneficiary is alive, contact the SSO to correct the date of death on the MBR. When the date is corrected on the MBR or is removed from the MBR, the updated information will be reflected on the EDB. When the MBR has been corrected, resubmit the buy-in accretion through the automated data exchange.
30XX	These codes inform 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. 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. The second record contains the adjusted effective date that corresponds to the individual's Medicare entitlement date. The transaction code in this record can be any one of the possible response codes for a State submitted accretion.
3061	
3063	
3075	
3084	
32XX	This code informs the State that the effective date in the accretion transaction it submitted is equal to the billing month. An accretion that is equal to the billing month is orbited for one month before it is processed to completion.
41bb	This code informs the State that the beneficiary is on the State's buyin rolls as an ongoing billing item. The State is responsible for paying the beneficiary's Part 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	All code 42XX records represent 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 third party master record. The adjustment may be applied to an open or a closed record. Adjustments are made for a variety of reasons such as a notification from SSA of a correction to Medicare entitlement or termination dates, a correction in the date of death, or the identification of duplicate billing records on the TPM for the beneficiary.
42bb	This code informs the State of a credit adjustment due to the presence of duplicate billing records on the TPM. The duplicate billing occurred for one or more months of buy-in coverage. The duplicate premiums are refunded to the State as a credit adjustment. The transaction date field will be blank if the adjustment action does not involve the current period of buy-in coverage.
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 date on the TPM 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 the accretion date on a TP master record was adjusted to a later date resulting in a credit to the State. The adjustment is the result of a CMS clerical action.
4269	This code informs the State that the deletion date on a TP master record was adjusted to an earlier date resulting in a credit to the State. The adjustment is the result of a CMS clerical action.
43XX	All code 43XX records represent a debit to the State. Debit actions result from the establishment of a closed period of buy-in coverage caused by a retroactive accretion or a simultaneous accretion/ deletion action. Debit actions also result from the adjustment of either the accretion effective date or the deletion effective date on a third party master record. The adjusted master record may be an open or closed record. Adjustments occur for several reasons. Most occur as a result of a State request to expand coverage. Others are SSI related or occur from a TPS recovery action to correct a program error.
4361	These codes inform the State that an earlier period of buy-in coverage, brought about by 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 receive a code 1161, 1163, or 1184.
4363	
4384	
4368	This code informs the State that the accretion date on a TP master 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 TP master 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 TPM.
4380	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	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	This code informs the State of an increase in the monthly Part B premium rate resulting in a debit to the State. The beneficiary is or was a member of a Group Health Plan that

	offered a reduction in the Part B premium in accordance with the provisions of BIPA 606. 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 master record was rejected because the claim number or State agency code in the code 99 did not match a master record on the TPM. This reject code is also used if the State submits a code 99 record with a buy-in eligibility code of "L", "P", or "U" (all of which require Medicare Part A entitlement) and the EDB does not reflect Medicare Part A.
50	This deletion code is used by the State to delete or annul a code 1165 or code 1167 accretion posted to the State's buy-in account by CMS either as the result of a clerical action (1165) or a PW accretion (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 deletion in accordance with the limitation imposed by the Commissioner's Decision. The code 50 will be rejected only if the State attempts to apply the code 50 against any codes other than the 1165 and 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.
51	This deletion code is used by the State 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 to the processing month minus 2 months due to the limitation imposed by the Commissioner's Decision. For example, a code 51 deletion processed in the December 2003 update may terminate an individual's coverage retroactive to October 2003. If the State submits a deletion date that exceeds the limitation of the Commissioner's Decision, the TPS adjusts the deletion date so that it conforms.
53	This deletion code is used by the State to delete an individual from the State's buy-in account because the individual is deceased. The effective date of the deletion must be the month and year of death.
61	This code is used by the State to accrete a beneficiary to the State's buy-in account. There is no limitation on the retroactivity of an accretion provided all factors of entitlement are met. 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 in error.
63	This code is used by the State 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	This code is used by the State to designate a request for a simultaneous

	<p>accretion/deletion action to establish a closed period of buy-in coverage for a beneficiary. The State is responsible for the accuracy of the dates in the simultaneous accretion/deletion record. When the simultaneous accretion/deletion is accepted by 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.</p>
84	<p>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 is used 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.</p>
86bb	<p>This code informs 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 the beneficiary has been accreted to the buy-in rolls the individual subsequently becomes eligible for SSI benefits. The TPS will not delete and reaccrete the buy-in record if a beneficiary who was accreted to buy-in by an auto-accrete State subsequently becomes eligible for SSI.</p>
	<p>The beneficiary's SSI and Medicare entitlement dates are contained in the record.</p>
	<p>An auto-accrete State may receive a code 86 record in conjunction with a code 1180 record if the beneficiary has been eligible for SSI in the same State for more than 4 years.</p>
	<p>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.</p>
87bb	<p>This code informs both the SSI alert State and the SSI auto-accrete State that SSI entitlement has terminated for the beneficiary.</p>
	<p>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.</p>
	<p>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 TPM.</p>

Chapter 6 Part A Buy-In/Group Payer System

600. General Systems Description

- A. Part A Third Party System.--The Part A Third Party System was developed to collect the Part A premiums from the State Agencies for individuals on the States' Medicaid rolls, who are eligible for either the QMB or the QDWI program and are not entitled to free Medicare Part A. The State is responsible for all Part A accretions.

The State may accrete eligible individuals to the Part A Third Party System through either the Part A State Buy-in System or the Part A Group Payer System. The State must specify which system it will use. When the QMB program began in January 1989, all States paid the Part A premiums under the Group Payer System. Following a legislative change, Part A State Buy-in became an option effective January 1990. All States were deemed to have elected Part A State Buy-in unless they formally declined to participate and chose instead to remain Part A Group Payer States.

The Part A premiums for individuals eligible as QDWIs must be paid under the Part A Group Payer System. However, in a Part A Buy-in State, the State may submit the accretions for those eligible for the QDWI program on the same file on which it submits the accretions for its QMBs. The TPS can distinguish between the two types of accretions.

- B. Part A State Buy-in.--The Part A State Buy-in System will create Medicare Part A entitlement for an individual who does not have free Part A provided the individual is entitled to Medicare Part B. If the individual is not entitled to Medicare Part B, the individual must file an application for Medicare Part B with SSA. SSA must determine that the individual is entitled to Medicare.
- C. Part A Group Payer.--The Part A Group Payer System does not create Part A entitlement. In order for an accretion to be processed by the Part A Group Payer System, the individual must file an application for actual or conditional Medicare Part A with SSA. A beneficiary may file an application for actual or conditional Part A enrollment only during the initial enrollment period (IEP) or the general enrollment period (GEP). SSA must determine that the individual is entitled to Medicare Part A. If the enrollment is for conditional Part A, SSA must determine that the individual meets all of the requirements for Part A entitlement even though Part A entitlement will not occur until the State submits and the TPS accepts a Part A accretion.
- D. Conditional Part A Enrollment and the Group Payer Process.--Conditional Part A enrollment does not convey Medicare Part A entitlement. Rather, it is the means by which a beneficiary may express his/her desire to be entitled to Medicare Part A only if the State will pay the Part A premium. An application for conditional enrollment cannot later be used to establish actual or non-conditional enrollment.

Conditional Part A enrollment is not reflected on the EDB because conditional Part A enrollment does not convey Medicare entitlement. It is, however, reflected on SSA's MBR record in the following manner: the Part A entitlement field contains the earliest date for which the beneficiary can be entitled to Medicare Part A and the Third Party Line contains the pseudo agency code Z99. Medicare Part A entitlement will be established only if the State submits an accretion to the Part A TPS and the accretion is accepted. The Part A entitlement date established through the group payer process for a beneficiary who enrolled conditionally in Medicare Part A can be no earlier than the effective date of the conditional Part A enrollment but it may be later. The date is dependent upon the effective date of the State's Part A accretion. In addition, when the State's accretion is accepted by TPS, the State Part A Agency Code will overlay the Z99 Agency Code on the MBR.

605. State Initiated Accretions

Each State is responsible for accreting those individuals whom the State has determined are eligible. HCFA does not accrete individuals to the Part A rolls except when requested to do so by the State in conjunction with problem case resolution. The record format for the Part A accretion is contained in Chapter III. The accretion code 61 is the only code which the States may use for a routine accretion to the Part A TPS.

NOTE: Buy-in Eligibility Codes are not used on the Part A billing records.

607. State Accretions for Closed Periods of Coverage

There are situations where States fail to accrete eligible individuals on a timely basis. That is, the individual 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 on the Part A rolls. This situation should occur infrequently.

A Part A State buy-in State may use the codes 75-76 to establish Part A buy-in coverage for a closed or limited period of coverage. The Part A group payer States may not establish closed periods of Part A coverage.

In order for a Part A buy-in State to establish a closed period of Part A coverage, the State must submit both the accretion and the deletion record in the same update. Failure to submit both the accretion and the deletion will result in a reject. The codes 75 and 76 are never processed independently of each other. Only one pair of code 75-76 records may be submitted per beneficiary per month. If the State submits multiple code 75-76 records for a beneficiary during an update month, the TPS will reject all the input records. The code 75 record will be rejected with a code 2175 and the code 76 record will be rejected with a code 2076. The record format for the simultaneous accretion/deletion is the same as the format for any regular accretion or deletion. (See Chapter III.)

- Code 75 - the accretion action to establish the start date.
- Code 76 - the deletion action to establish the stop date.

610. Matching Accretion Records to the Enrollment Data Base

HCFA maintains the Enrollment Data Base (EDB) file which contains the current status of all individuals who are or were entitled to Medicare. The EDB does not maintain a record of conditional Part A enrollment. Conditional Part A enrollments are maintained internally by HCFA as informational records on the TPM.

When the State submits a Part A accretion record, the accretion is matched against the EDB to ensure that the accretion was submitted under the correct 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:

- Medicare Claim Number - Nine position social security claim number (or pseudo social security claim number if the beneficiary is entitled under a Railroad Retirement Board number) followed by a one or two position alpha-numeric Beneficiary Identification Code (BIC). An accretion record for a RRB QDWI may be submitted with an unconverted RRB claim number. A detailed description of the RRB claim number is contained in §375.

NOTE: Only beneficiaries for whom the RRB has made a Disabled Working Individual (DWI) determination and whom the State has determined is eligible under the QDWI program can be accreted to the Part A Third Party System with a RRB claim number. Any beneficiary who is a QMB and who has an RRB Medicare claim number has free Part A and should not be accreted to the Part A Third Party System.

- 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. Do not use any special characters such as a period, comma, or hyphen.

EXAMPLE: Fox Jr

NOTE: There may be records on the Part B buy-in file in which there are special characters in the surname. Generally these are records which were accreted directly from the MBR interface for SSI recipients in auto-accrete States. Those records are not edited against the EDB. If the State encounters a record of this type, do not include any special characters in the Part A accretion record.

- First Name - First three positions.
- Sex Code - One position.
- Date of Birth - All six positions. Although only month and year are used for matching, the day must be included so that the correct Medicare entitlement date can be computed.

615. State Initiated Deletions

States have deletion responsibility for all code 41 records which appear on the State's Part A file. However, there are situations under which HCFA will delete code 41 records. (See §655)

The deletion codes listed below are for use by the State and each should be used for the proper reason. (Chapter VII provides a full explanation of these codes.) The format of the State initiated deletion record is contained in Chapter III.

- Code 51 - normal deletion for an individual who is no longer a member of the State's coverage group.

NOTE: The deletion date, whether submitted by a Part A State Buy-in or Part A group payer State, is subject to the same limitations. The deletion date is limited to the update month or to the month following the update month.

- Code 53 - death deletion may be retroactive to the month of death.
- Code 76 - deletion action which must be submitted in conjunction with the code 75 accretion record to establish a closed period of buy-in coverage.

As with deletions for Part B buy-in records, the State submitted deletion record must be received by HCFA by the 25th of the month in order for it to be considered timely.

620. State Initiated Change Records

The State may change the following fields on the Part A master record:

- Sex code; and
- State welfare identification number.

The record format is the same as the format for the State accretion or deletion record described in Chapter III.

The transaction code for the change record is 99. A code 99 can be applied to an open or to a closed master record.

625. HCFA Response to State Initiated Accretions and Deletions

HCFA TPS will provide a response record for each State initiated accretion or deletion record. The record format for these response actions is contained in Chapter III. HCFA response records for State accretions and deletions will be one of the following types:

- An acknowledgment response that the Part A TPS has accepted the accretion or deletion action.
- A reject response with a definitive code describing the reason for the rejected accretion or deletion action.
- An interim response record for an accretion or deletion action that requires additional electronic or clerical investigation before the transaction can be completed. Generally, an electronic response will be made in the next monthly update and will indicate the final disposition of the original request. In rare instances, the State may receive a paper document from HCFA explaining why the original request could not be completed.

The HCFA response is contained in a four position transaction code field (positions 60-63) of the billing record.

- Chapter VII lists all Part A transaction codes in numerical order and provides a detailed definition for each code. A brief synopsis of the codes is given in the following paragraphs for reference purposes only.
- The first two positions of the transaction code field contain the type of response the TPS generated for the accretion or deletion request.
- The last two positions of the transaction code field contain the State input code.
- In the majority of situations there will be only one response record for each action submitted by the State. However, there are instances where intervening transactions generate multiple responses to the State.
- The transaction code field always contains four numeric characters when HCFA responds to a valid accretion or deletion action submitted by the State.
- When HCFA transmits an ongoing Part A record or certain HCFA initiated actions, the last two positions will be blank. Chapter VII lists all transaction codes in numeric order and identifies those codes which are blank in the last two positions by displaying the blank indicator (bb) immediately after the two position numeric code.
- In subsequent paragraphs of this section, the explanation of HCFA response codes will, for ease of expression, list the State input code as "XX". If "XX" is not shown as part of the HCFA response code but numerics appear, the response record will carry the numerics shown and not the State input code. This change to the State code results from an adjustment of the accretion date requested by the State.

630. Acknowledgment Codes for State Initiated Accretions

The acknowledgment codes for the State initiated accretion (code 61) are listed below. They inform the State that the accretion action has been completed.

11XX - beneficiary has been accreted to State buy-in (code 11 is always followed by a two digit explanatory code).

1125 - accretion adjusted to a later date (a closed period of coverage, which overlaps the accretion date, is on record for the State submitting the accretion)

1128 - accretion adjusted to a later date (a closed period of coverage, which overlaps the accretion date, is on record for a different State).

4368 - accretion adjusted to an earlier date resulting in a debit to the State.

The reject codes for the State initiated accretion (code 61) are listed below. Accretion actions can reject for a number of reasons. Examine the reason for the reject action and ensure that all other data contained in the record is valid. The following HCFA reject codes notify the States that the accretion could not be processed. Some of the reject codes have an additional explanation which is identified by the presence of data in the subcode field of the response. The subcode is in position 51 of the billing record. (See Chapter III.)

21XX - (subcode) - failure to match EDB.

24XX - effective date invalid.

25XX - duplicates an existing master record.

27XX - invalid transaction code.

29XX - (subcode) - death deletion on master record.

The interim codes for the State initiated accretion (code 61) are listed below. The interim response informs the State that the action which the State requested cannot be completed in the month in which it was submitted. In most instances a definitive response will be generated the following month. In rare instances the State may receive a paper document explaining why the action originally requested cannot be taken.

31XX -the accretion encountered a cross-reference action on the TPM and must be swung to the new location or the TPS is encountered an inactive master record which must be retrieved before the current transaction can be processed.

32XX - the coverage requested in the accretion is prior to existing coverage in the current history field on the TPM.

635. Acknowledgment Codes for State Initiated Deletions

The acknowledgment code for State initiated deletions (input codes 51 and 53) is a code 17XX. The response code tells the State that the deletion action the State requested has been taken.

The reject codes for State initiated deletions (input codes 51 and 53) are listed below. A deletion request can be rejected for several reasons. Examine the reason for the reject action and ensure that all other data fields are correct before resubmitting the deletion.

20XX - there is no record of ongoing buy-in coverage or there is ongoing coverage for another State.

24XX - the effective date is invalid.

25XX - (subcode) - duplicates existing master record.

The interim code from HCFA for State initiated deletions (input codes 51 and 53) is a code 31XX. The number of interim responses from HCFA for a State deletion is minimal as most deletions are either accepted or rejected.

640. Adjustment of State Accretion Effective Date

All Part A accretion records, whether submitted by a Part A buy-in State or a Part A group payer State, are screened to determine the correct Part A Medicare entitlement date. The screening determines the correct Part A Medicare date, not the beneficiary's QMB status. The Part A accretion date for a beneficiary in a Part A buy-in State may not be earlier than the latest of the following dates:

- The Part B entitlement date on the EDB;
- January 1990 (the earliest effective date for Part A State buy-in permitted by law); or
- The date the State became a Part A buy-in State if later than January 1990.

The Part A accretion date for a beneficiary who has enrolled conditionally for Medicare Part A in a Part A group payer State may not be earlier than the conditional Part A entitlement date which is reflected in the Z99 record. If the beneficiary enrolled for premium Part A, the accretion date may not be earlier than the effective date of premium Part A. In no case, may the effective date be earlier than January 1989.

If the Part A accretion date submitted by the State is earlier than the earliest possible entitlement date, the TPS will automatically adjust the accretion date to agree with the individual's Medicare entitlement date. The method used by HCFA is the creation of an additional response record in addition to the normal response for a State accretion. One of the HCFA response records will always be a code 30XX. The other record will be any valid HCFA response code for an accretion request.

EXAMPLE: The State initiated accretion record contains a buy-in effective date of 03/94 and the date of birth in the accretion record is 3/15/29. When the accretion is screened, HCFA will examine the date of birth and Medicare entitlement date in both records. In this example, the EDB date of birth is 04/29/29; therefore the Medicare entitlement date is 04/94.

The State will receive two response records for this situation. The first record will be a code 30XX. This record will contain the date of birth and buy-in effective date submitted by the State. The second record (if accreted) will be a code 1161. The buy-in effective date contained in this record will be 04/94. The date of birth field will contain the EDB date of birth which in this example is 04/29/29. The corrected date of birth will convey a "zoned plus" in the last position of the year for ease of identification by the State. In this case the date of birth will appear as 04/29/21. The TPM record will maintain the corrected date of birth as all numerics (04/29/29).

645. HCFA Response to a State Initiated Simultaneous Accretion/Deletion Action

(CODE 76-76)

The simultaneous accretion/deletion action (codes 75 and 76) may be used by a Part A buy-in State to establish a closed period of part A coverage. These codes should be used infrequently. State input code 75 must always be accompanied by a code 76. Only one pair of codes 75/76 for an individual can be processed by HCFA in a given month. Code 75 (accretion portion) must contain the proper Medicare identification to allow the item to be processed in the month it was submitted. If the code 75 record does not match on Medicare data, it is automatically rejected. Code 76 will also be rejected.

The following HCFA response codes inform the State of the action taken on a code 75/76 request.

- The acknowledgment codes for a completed action are 1175 and 1776.
- The reject codes, if HCFA is unable to take the requested action are:
 - 2175 - 2076
 - 2475 - 2476
 - 2775 - 2776
 - 2875 - 2876
 - 2975 - 2976
- The interim response codes are:
 - 3175 - 3176
 - 3275 - 3276

650. HCFA Response To A State Initiated Change Record

(CODE 99)

State change records (code 99) are applied to existing Part A TPM records if the change record matches the existing master on claim number and State agency code. If the master record is an ongoing item (Code 41), the change record will be applied to the master record. The State will not receive a special acknowledgment record but will see the change in either the sex code or the State welfare identification number reflected in the next code 41 record it receives for the beneficiary.

If the master record is closed, the change record will be applied but the State will not receive any communication. If the change record does not match an existing master record on claim number and State agency code, HCFA will reject the change record with the transaction code 4999.

655. HCFA Initiated Deletions

- A. Death Deletion - Code 16.--SSA receives reports of death from a number of sources in the daily operation of its various programs. If a report of death is received for an individual for whom the State is paying the Part A premium, SSA sends a death deletion record to the TPS in the regular monthly data exchange.
- TPS deletes the individual from the Part A system effective with the month of death. HCFA sends code 16bb, notification of death, to the State on the next billing file. The month and year of death reported by SSA are shown in the transaction effective date field.
- B. Loss of Medicare Entitlement or Entitled to Free Part A - Code 15.--SSA, in the course of reviewing its files, may determine that an individual currently does not meet all of the requirements for Medicare. Among the reasons are a determination that the individual has not attained age 65, that the requirements for citizenship or alien residency have not been met or in the case of a QDWI that entitlement to disability has ceased. SSA may also determine that the beneficiary is entitled to free Part A. SSA will send a deletion record to the TPS in the regular monthly data exchange.
- TPS deletes the individual from the Part A system effective with the month and year that the individual's entitlement to Medicare terminated or the individual became entitled to free Part A. HCFA sends a code 15bb, to the State on the next billing file. The month and year of Medicare termination, reported by SSA, are shown in the transaction effective date field.
- C. Deletion as the Result of Another State's Accretion Action - Code 1728.--If a beneficiary is on the Part A rolls for one State and another State submits an accretion action for the same individual, the first State will receive a code 1728 deletion and the beneficiary will be accreted to the Part A rolls for the State which submitted the latest accretion. TPS assumes that the State which submits the latest accretion action is the State which has jurisdiction. The effective date of code 1728 will be the month prior to the month that the new State assumed jurisdiction.
- The State should examine the Medicaid record for any individual for whom it receives a code 1728 record to ensure that the State's Medicaid eligibility record has been closed. This will prevent a cycle of reaccretion and deletion actions between States. If the State which received the code 1728 believes it is responsible for the beneficiary's Medicaid eligibility, 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.
- D. Deletions from Other Sources.--Occasionally HCFA may receive a request, outside of the monthly data exchange, to process a deletion. Requests of this nature should be rare. Normally the request is submitted to HCFA on a memorandum from the State or on Form HCFA-1957, "SSO Report of State Buy-in Problem".
- HCFA will take the appropriate action. If a deletion is processed, the State will be notified of the deletion in the monthly data exchange. Even though HCFA personnel enter the deletion into the system, the transaction is not technically a HCFA initiated deletion because HCFA is responding to an outside request. Normally a deletion action processed as a result of a written request for assistance will appear on the States's billing file with a code 1759 deletion.

660. HCFA Initiated Deletion and Reaccretion to Remove a Part A Premium Surcharge Indicator on a Part A Master Record in a Group Payer State

TPS has established a penalty conversion date (PCD), which is maintained internally by HCFA, for each Part A master record in a group payer State on which a 10% Part A premium surcharge has been assessed. The PCD is the month in which the Part A premium reverts to the base rate. When the PCD is reached, TPS will delete the Part A master record with the code 17bb effective with the last month for which the surcharge is applicable. TPS will reaccrete the Part A master record, minus the Part A premium surcharge indicator (position 50), with a code 1161 effective with the PCD. The beneficiary's Part A third party coverage will be uninterrupted by this action.

EXAMPLE: If the PCD is December, TPS will delete the Part A master record (code 17bb) during the October third party update (December billing month) effective November (the last month during which the surcharge is applicable), and will immediately reaccrete the record (code 1161) with an effective date of December.

665. HCFA Initiated Deletion and Reaccretion to Accommodate Part A Premium Overflow Condition

The TPM record cannot accommodate more than \$9999.99 in accrued Part A premium liability on an individual Part A master record. Many of the Part A master records have been in existence since 1989 and the total premium liability is nearing or exceeds \$9999.99.

Whenever TPS encounters a Part A premium overflow condition, HCFA will delete the existing Part A TPM record with a code 17bb. The deletion date will be two months prior to the current billing month. HCFA will reaccrete the record with a code 1161 which is effective one month prior to the current billing month. The deletion/reaccretion action will establish a new history period and begin a new accrual of Part A premiums.

EXAMPLE: If the overflow condition is encountered during the July third party update (September billing month), TPS will delete the Part A master record (code 17bb) effective May (which is two months prior to the current billing month), and will immediately reaccrete the record (code 1161) effective June (which is one month prior to the current billing month).

670. Part A Accretions With More Than 24 Months Retroactivity

The same limitation which precludes TPM from accommodating a Part A master record in which the accrued premium liability exceeds \$9999.99 also precludes HCFA from accommodating, as a single billing record, a Part A accretion in which retroactivity of the accretion exceeds 24 months.

Whenever the State submits a Part A accretion in which the effective date of the accretion is retroactive for more than 24 months from the billing month, TPS will process the accretion as a series of transactions, none of which will include more than 24 months of Part A coverage and \$9999.99 in Part A premiums.

TPS will send code 3061 to inform the State that HCFA has adjusted the accretion date to a date which is equal to the billing month minus 24 months. In addition, the State will receive a code 1161 for the adjusted segment. In order to accommodate the remainder of the billing period requested by the State, TPS will create a code 4372, debit adjustment record, for each remaining segment of not more than 24 months until billing records have been created for the entire period. The debit adjustment record is a self contained record which contains all of the data for the segment including the beginning and ending dates for the billing period and the corresponding Part A premium liability.

675. Conversion of Part A Premium From Standard Rate to Reduced Rate

HCFA is notified through the data exchange with SSA whenever the Part A premium qualifies for conversion from standard rate to reduced rate. Whenever a reduced Part A premium is applicable, the third party system will delete the current Part A master record with code 14bb with an effective date which is one month prior to the month that the reduced Part A premium is effective. The system will reaccrete the Part A master record with a code 1165 which is equal to the month that the reduced Part A premium is effective, but in no case will the accretion date be earlier than January 1994 billing month.

When a reduced Part A premium is applicable, TPS will code a "1" in position 46 of the Part A master record.

EXAMPLE: If the reduced Part A premium record is received in the February Third Party Update (April billing month) but was effective in January, TPS will delete the record (code 14bb) effective the preceding December (the last month for which the standard rate was applicable), and reaccrete the Part A master record (code 1165) effective January.

680. Conversion of Records From Part A Group Payer to Part A Buy-In Status

A State which elected to pay the Part A Medicare premiums on behalf of its QMB population in accordance with the Part A Group Payer arrangement may, upon formal written notification to the HCFA RO, elect to become a Part A buy-in State. The effective date of the change in status can be no earlier than the first day of the second month following the month in which the formal notification is signed by the State and accepted by HCFA.

TPS will convert the Part A master records from Part A group payer status to Part A buy-in status effective with the billing month in which the State's Part A status changes. The system will delete the Part A group payer records with code 14bb effective with the last month for which the State is a group payer State. The system will reaccrue the Part A records with a code 1165 effective with the first month for which the State is a Part A buy-in State. The Part A premium surcharge indicator, position 50, will be changed from "1" to blank. The beneficiary's Part A third party coverage will be unaffected by this action.

EXAMPLE: If the conversion from Part A group payer to Part A buy-in State is effective with July, TPS will delete the Part A master record (code 14bb) during the May Third Party Update (July billing month) with a June effective date (which is the last month for which the State has group payer status) and will reaccrue the record (code 1165) with an effective date of July.

685. HCFA-L 1601-TR Notice of Part A State Buy-In/Group Payer Accretion

This section intentionally omitted.

(This space is reserved for HCFA-L 1601-TR)

687. HCFA-L 1617-TR Notice of Part A State Buy-In/Group Payer Deletion

This section intentionally omitted.

(This space is reserved for HCFA-L 1617-TR)

689. HCFA-L 1900-TR Notice of Part A State Buy-In Closed Period

This section intentionally omitted.

(This space is reserved for HCFA-L 1900-TR)

Chapter 7 Part A Buy-In/Group Payer Transaction Codes

Table of Contents (Rev. 1, 10-01-03)

700 General Information (Rev. 1, 10-01-03)

The buy-in transaction codes provide a concise, definitive means of communication between CMS and the States. The States are restricted to the use of the following two position numeric codes that should always appear in positions 76 and 77 of the State input record.

Accretion action - codes 61 and 63. Deletion action - codes 50, 51, and 53.

Simultaneous accretion/deletion action (closed period) - code 75. The use of this code is restricted to Part A buy-in States.

State change record - code 99

The transaction codes used by CMS consist of not less than two, nor more than four numerics 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.

The transaction codes used in communication between CMS and the States are defined below. 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 and are self-explanatory. For ease of understanding, codes are illustrated as follows:

11XX - The XX is shown here to indicate that the code 11 is a prefix code. The XX represents the last two numeric positions.

41bb - The bb indicates that the State can receive this transaction code followed by two blanks. Any code displayed in this section followed by the bb is a valid transaction code.

It is important that the State program its system to accommodate all transaction codes and sub-codes.

710 Part A Transaction Codes

(Rev. 1, 10-01-03)

TRANSACTION CODE	DEFINITION
11XX	The code 11 informs the State that the individual was accreted to the State's Part A 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 Third Party Master (TPM). The accretion results in a debit action to the State. Next month, the item will appear on the State's bill as a code 41 (ongoing item). The State is liable for the individual's Part A premium and will be billed monthly until the individual is deleted from the State's Part A 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 TPM 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. Next month the item will appear on the State's bill as a code 41 (ongoing item) unless the item is deleted.
1161	The code 1161 or 1163 informs the State that an accretion submitted by the State has been added to the TPM. The accretion date is the same as reported on the State input record except when a code 30 action is present. (The code 30 notifies the State that the accretion will be adjusted to conform to the individual's Medicare entitlement date.) Next month the item will appear on the State's bill as a code 41 (ongoing item) unless the item is deleted.
1163	
1165	The code 1165 informs the State that an accretion was processed to the TPM by CMS. The accretion occurred because the State submitted a written request to CMS requesting an accretion action or because an SSO submitted a form CMS-1957 reporting a problem case. If the SSO submits a form CMS-1957 requesting a Part A accretion action, it must be accompanied by a letter from the State confirming that the beneficiary qualifies as a QMB or QDWI. Next 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 notification of the code 1165 to submit a code 50 deletion to annul the accretion or establish a closed period of buy-in coverage. If the code 50 is submitted beyond the two-month rule, the code 1165 will be deleted with a current month deletion.
14bb	This code informs the State that CMS has deleted the Part A record because the beneficiary is entitled to free Part A. CMS may also delete a record as the result of an internal systems adjustment. These occurrences are rare.
15bb	This code informs the State that the individual was deleted from the State's Part A account because SSA's records indicate that the individual currently does not meet all the requirements for Medicare (such as age, citizenship or residency).
	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, reaccrete 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 Part A account.
	State Action - If the State believes that the individual is alive, obtain corroboration from the SSO. The State may then re-accrete the individual through the automated data exchange. If SSA's records have not been corrected, the State's reaccretion 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 SSO before sending a memorandum to CMS requesting an adjustment to the deletion date.
17XX	The code 17 informs the State that the individual was deleted from the State's Part A 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 Part A premium ends with the month in which the 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 Part A account because another State submitted an accretion that was accepted by the TPS.
	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 receives the code 1728 believes it should retain jurisdiction of the case, it must contact the State that submitted the new accretion in order to resolve jurisdictional issues.
1750	This code informs the State that CMS has processed a code 50 to annul or establish a closed period of buy-in coverage for a code 1165 transaction that was accreted clerically. If the code 50 was submitted within 2 months of the month in which the State received the code 1165, the code 1750 will reflect the deletion date in the code 50 submitted by the State. If the code 50 was not submitted timely, the code 1750 will reflect a current month deletion date.
1751	This code informs the State that the beneficiary was deleted from the State's Part A account based on a deletion record submitted by the State. The code 1751 is limited to the current month or the following month.
1753	This code informs the State that the beneficiary was deleted from the State's Part A 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 Part A account by a clerical action in CMS. The clerical action was prompted by a written request from the State (which should be extremely rare) 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 retroactivity for a Part A deletion.
20XX	This code informs the State that a deletion action it submitted was rejected because there is no record of ongoing buy-in/group payer coverage for that State under the claim number submitted.
2050	
2051	
2053	

	<p>State Action - Examine the claim number in the deletion record to ensure that there was not a keying error at input. The claim number in the deletion record must match a corresponding record on the TPM 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 the history file to determine if a code 1728 was received transferring jurisdiction to another State.</p>
21XX	<p>This code informs the state that the accretion or simultaneous accretion/deletion record it submitted cannot be matched to a record 2163 on the EDB. 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.</p>
2161	
2175	
	<p>Subcode 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 nonnumeric characters in positions that should be numeric.</p>
	<p>Subcode B - The claim number in the accretion matches the claim number on the EDB record but the personal characteristics differ.</p>
	<p>Subcode C - The beneficiary is entitled to free Part A or, in a group payer State, the beneficiary does not have premium Part A entitlement or has not enrolled conditionally for Medicare Part A.</p>
	<p>Subcode D - There is no record of 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.</p>
	<p>Subcode 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, there is no Medicare entitlement for the period of time that the State is attempting to buy-in.</p>
	<p>State Action - Subcodes 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 eligibility files that the State receives or can access and correct the input record.</p>
	<p>State Action - Subcode C - If the beneficiary has free Part A, no further action is necessary. If the beneficiary resides in a group payer State and does not have premium Part A and has not enrolled conditionally for Medicare Part A, advise the beneficiary of the need to contact the SSO during the next general enrollment period (GEP) to enroll.</p>
	<p>State Action - Subcode D - If the beneficiary is eligible for Part B buy-in, accrete the beneficiary to the Part B system. After the Part B accretion is accepted by the TPS, submit the Part A accretion.</p>
	<p>State Action - Subcode E - This condition can occur when there was an invalid Medicare enrollment (option codes F or X). It can also occur if there is no Medicare entitlement on the EDB. If the State believes that the beneficiary should be entitled to Medicare, refer the beneficiary to the SSO to resolve the Medicare entitlement issue.</p>

23XX	This code informs 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.
	State Action - Change the claim number in the State's record 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
	These codes inform the state that a claim number change was 2351 processed to a deletion record.
2361	These codes inform the State that a claim number change was processed to an accretion or to a simultaneous accretion/deletion record.
2363	
2375	
2399	This code informs the State that a claim number change was processed to a State submitted change record.
24XX	The code 24 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 later than the billing month. It will be orbited for one month if the effective date is equal to the billing month (see transaction code 32).
	A deletion action, other than a death deletion, will be rejected if the effective date is equal to or later than the billing month.
	A death deletion (code 53) will be rejected if the effective date (i.e. date of death) is later than the update month.
2450	These codes inform the State that the deletion record it submitted was rejected. Refer to code 24XX for a detailed explanation.
2451	
2453	
2461	These codes inform the State that the accretion or simultaneous accretion/deletion record it submitted was rejected. Refer to code 24XX for a detailed explanation.
2463	
2475	
25XX	This code 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	These codes inform the State that the accretion or simultaneous accretion/deletion record it submitted duplicates an existing accretion.
2563	
2575	

27XX	This code 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 numerics 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, the transaction will reject as a code 2750. The reject displays the erroneous input code immediately following the code 27.
29XX	These codes inform the State that the accretion or simultaneous accretion/deletion action it submitted was rejected because there is a 2963 death deletion on the EDB which is at least one month earlier than the effective date of the accretion. 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.
2961	
2975	
	State Action: If investigation establishes that the beneficiary died later than the date of death on SSA/ CMS records or that the beneficiary is alive, contact the SSO to correct the date of death on the MBR. When the date is corrected on the MBR or is removed from the MBR, the updated information will be reflected on the EDB. When the MBR has been corrected, resubmit the accretion through the automated data exchange.
30XX	These codes inform 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. 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. The second record contains the adjusted effective date that corresponds to the individual's Medicare entitlement date. The transaction code in this record can be any one of the possible response codes for a State submitted accretion.
3061	
3063	
3075	
32XX	This code informs the State that the effective date in the accretion transaction it submitted is equal to the billing month. An accretion that is equal to the billing month is orbited for one month before it is processed to completion.
41bb	This code informs the State that the beneficiary is on the State's Part A account as an ongoing billing item. The State is responsible for paying the beneficiary's Part A premium and has deletion responsibility if the beneficiary is no longer eligible. The code 41 also means that there has not been a change in the beneficiary's status since the last billing record.
42XX	All code 42XX records represent 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 TPM. The adjustment may be applied to an open or a closed record. Adjustments are made for a variety of reasons such as a notification from SSA of a correction to Medicare entitlement or termination dates, a correction in the date of death, or the identification of duplicate billing records on the TPM for the beneficiary.
42bb	This code informs the State of a credit adjustment due to the presence of duplicate billing records on the TPM. The duplicate billing occurred for one or more months of Part A coverage. The duplicate premiums are refunded to the State as a credit adjustment. The transaction date field will be blank if the adjustment action does not involve the current period of buy-in coverage.
4211	This code informs the State that the 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 effective date on the TPM was earlier than the corrected Medicare entitlement date.

4214	This code informs the State that the deletion date in an established record was adjusted to an earlier date.
4215	This code informs the State that the deletion date in 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 the accretion date on a TP master record was adjusted to a later date resulting in a credit to the State. The adjustment is the result of a CMS clerical action.
4269	This code informs the State that the deletion date on a TP master record was adjusted to an earlier date resulting in a credit to the State. The adjustment is the result of a CMS clerical action.
43XX	All code 43XX records represent a debit to the State. Debit actions result from the establishment of a closed period of buy-in coverage caused by a retroactive accretion or a simultaneous accretion/deletion action. Debit actions also result from the adjustment of either the accretion effective date or the deletion effective date on a third party master record. The adjusted master record may be an open or closed record. Adjustments occur for several reasons. Most occur as a result of a State request to expand coverage. An adjustment may result from a TPS recovery action to correct a program error.
4361	This code informs 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 or 4363 records from a single input record. These codes always refer to earlier coverage. If ongoing coverage is established, the State will receive a code 1161 or 1163.
4363	
4368	This code informs the State that the accretion date on a TP master 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 TP master 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) has been added to the TPM. The closed period may be the result of a single State input record or may be the result of one or more adjustments to a State input record.
44	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 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.
45	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.
4999	This code informs the State that a request to correct the welfare identification number on a master record was rejected because the claim number or State agency code in the code 99 did not match a master record on the TPM.
50	This deletion code is used by the State to delete or annul a code 1165 accretion posted to the State's buy-in account by CMS as the result of a clerical accretion. 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 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 current month deletion. The code 50 will be rejected only if the State attempts to apply the code 50 against any code other than the 1165.
	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. 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.
51	This deletion code is used by the State to delete a beneficiary from the State's Part A 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 to the update month or the update month plus one month. For example, a code 51 deletion processed in the December 2002 update may terminate an individual's coverage December 2002 or January 2003. If the State submits a retroactive deletion date, the TPS adjusts the deletion date so that it conforms to the update month.
53	This deletion code is used by the State to delete an individual from the State's Part A account because the individual is deceased. The effective date of the deletion must be the month and year of death.
61	This code is used by the State to accrete a beneficiary to the State's Part A account. There is no limitation on the retroactivity of an accretion provided all factors of entitlement are met including a timely Medicaid eligibility determination.
	NOTE: The QMB program was effective January 1989 and the QDWI program was effective July 1990. 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 in error.
63	This code is used by the State 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	This code is used by the State to designate a request for a simultaneous accretion/deletion action to establish a closed period of buy-in coverage for a beneficiary. The State is responsible for the accuracy of the dates in the simultaneous accretion/deletion record. When the simultaneous accretion/deletion is accepted by 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.

99

This code is used by the State to correct the welfare identification number on an existing Part A record on the TPM.

Chapter 8 Premium Payments By States

800. Background

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

805. Premium Billing

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

The SAS is mailed to the States around the 15th of each month. Since HCFA bills the States prospectively, the SAS represents premiums due the following month. For example, the SAS created in the May 25th third party update, and mailed on June 15th, contains the State's premium liability for July.

The current month's premium liability, shown on line 3 of the SAS, is due the 1st day of the month specified on line 3. However, HCFA has established an unofficial grace period which gives the States until the 25th day of the month to pay the premiums. If the 25th day of the month is not a business day, the premiums are due no later than close of business on the last business day prior to the 25th. Premiums are considered paid when they are received by HCFA.

State premiums unpaid at the end of the grace period for the month in which they are due are considered late payments and will be subject to assessment of interest and offset against the State's Medicaid Grant Award Authority.

If a State disagrees with the amount of the premium bill or offset adjustments, the State must submit evidence to support its position to:

HCFA, BPO, OCC

Entitlement and Premium Billing

Mailstop N2-05-03

7500 Security Blvd.

Baltimore, MD. 21244-1850

HCFA will evaluate the evidence submitted. If it determines that a credit is due the State, the credit will be reflected as an adjustment on line 2 of a subsequent SAS.

If a State disagrees with the amount of the premium bill based upon an individual case(s), the State should pay the amount billed in order to avoid an interest assessment and offset against the Medicaid Grant Award Authority. Disagreements over individual problem cases, should be handled in accordance with problem case procedures in Chapter II.

810. Summary Accounting Statement - Billing Notice

A separate SAS, also known as the bill, is prepared for each State's monthly Part A and Part B Medicare premium liability.

The SAS contains the following information:

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
Line 1	Previous balance. This entry reflects either the premium amount due HCFA (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.
Line 2	<p>Adjustments. This entry reflects a debit or credit adjustment to the total balance, line 6, on the prior month's bill. Normally it is based on items reported on the Supplemental Billing Form HCFA 2344 which was attached to 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.</p> <p>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.</p>
Line 3	<p>Current Month's Liability - Payable By (MM/DD/YY). "Payable by" date is the first day of the month of the billing period.</p> <p>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 and 91), accretions, deletions, and adjustments processed in the current billing period but does not include the debit or credit adjustments shown on line 2.</p> <p>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 appear 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 HCFA 64.9 or 64.9P.</p>
Line 4	Payments received. This reflects the receipt date and payment amount for each payment received from the State which was not previously posted to the State's

	account.
Line 5	Premiums collected through offset. This line reflects the amount of overdue premiums which were offset against the State's Medicaid Grant Award Authority.
Line 6	Total balance. This reflects the premium amount due to HCFA (debit) or amount due the State (credit).

812. Summary Accounting Statement - Exhibit

THIS PAGE IS PROVIDED FOR THE SUMMARY ACCOUNTING STATEMENT BILLING NOTICE

814. Supplemental Billing List

THIS PAGE IS PROVIDED FOR THE SUPPLEMENTAL BILLING FORM

816. Agency Total Sheet

THIS PAGE IS PROVIDED FOR THE AGENCY TOTAL SHEET

820. Crediting of State Payments

State remittances are credited in the following manner:

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

When a State payment is received late and the premium amount which was due is collected by offset, HCFA will credit the late payment to the premium liability for the following month. For example, if the payment due was June 25th but was received July 1st, the State's late payment will be credited toward the July premium liability and will be reflected on the September bill. This is due to HCFA's policy of prospective billing. The SAS prepared during the July third party update is for the billing month of September and will reflect all premium payments (including late payments and offsets) credited by July 25th.

825. Interest Assessment

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

- State payments which are less than the amount billed on the SAS; or
- State payments received after the unofficial grace period in the month in which the premiums were due.

- A. Interest is Assessed in 30 Day Increments.--On overdue premiums, the assessment begins with the first day of the billing month and ends with the month HCFA receives the State's payment or initiates offset to the State's Medicaid Grant Award Authority.
- B. Percentage Rate for Interest.--The interest rate for overdue Part A and Part B premiums is the SMI trust fund rate as computed for new investments in accordance with §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. Treasury as of the last day of the month.
- C. State Notification.--The amount of overdue 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 premiums and the accrued interest which is being offset. (See §830.)

830. Offset Against State Medicaid Grant Award

Offset will be made immediately against the State's Medicaid Award Authority for premiums which are overdue beyond the grace period, together with any accrued interest beginning with the first day of the month for which the premiums are due to the date offset is initiated. The offset of premiums and interest against monies due the State on its grant award is not a disallowance of Federal financial participation but is an accounting adjustment which reduces the amount of money paid to a State.

835. Methods States May Use to Pay Medicare Premiums

States must use one of the following methods of electronic funds transfer to pay the Medicare premiums for beneficiaries on the buy-in/group payer rolls:

- The U.S. Treasury Department's electronic transfer of monies system, known as the Treasury Financial Communications System (TFCS) (FEDWIRE); or
- The HCFA Customer Initiated Payments (CIP) program.

HCFA will continue to compute the premium amounts due for each State and to mail the billing form, Summary Accounting Statement - Billing Notice, to the States.

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

840. U.S. Treasury Financial Communications System (TFCS) Procedures

States electing to use TFCS must adhere exactly to the procedures to ensure timely and accurate payment of Medicare premiums.

The U.S. Department of Treasury has established a computer interface system known as TFCS with the Federal Reserve Bank of New York. The system provides the Treasury with on-line access to the Federal Reserve Bank of New York and utilizes the Federal Reserve Communication System (FRCS or 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. 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 transfers, checks and the accompanying collection time are completely eliminated, providing the recipient 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.

842. Description of Treasury Financial Communications System (TFCS)

The State notifies its commercial bank to wire funds to the U.S. Department of the Treasury. Regardless of the State's bank status with the Federal Reserve System (an on-line member, off-line member or not a member), the State must furnish its bank with the specific information listed in §845.

If the State's commercial bank is an on-line member of the Federal Reserve System, the bank prepares the standard funds transfer wire message and enters it into the Fedwire system. If the State's commercial bank is a member of the Federal Reserve System but off-line, the bank initiates the funds transfer by contacting its servicing Federal Reserve Bank. If the commercial bank is not a member of the Federal Reserve System, it can effect the transfer through a correspondent member bank.

The fund transfers flow through the commercial bank's servicing Federal Reserve Bank to the U.S. Treasury Department account at the Federal Reserve Bank of New York. Through a computer-to-computer link, information on all fund transfers is transmitted to the U.S. Treasury's accounts from the New York Federal Reserve Bank to the Treasury Department in Washington, D.C. and to selected government agencies including HCFA. As deposit data are received by the Treasury computer, they are categorized and maintained according to the receiving Federal agency location code as indicated on the wire message. Upon receipt of the deposit information, HCFA makes entries to accounts receivable records maintained for each buy-in State. Separate accounts receivable records are maintained for Part A (Hospital Insurance) and Part B (Medical Insurance) premiums. HCFA will not send an acknowledgement of receipt of the wire deposit message to the State since the next month's Summary Accounting Statement - Billing Notice form will reflect wire deposit payments. (See below regarding deposit receipts the State should obtain from its bank.)

844. General Information On TFCS

The date the Federal Reserve Bank of New York receives the wire deposit message is considered the date of receipt by HCFA.

Most banks sending wire deposits for a State will provide the State, on request, a record of each deposit. The State should make arrangements with the bank to receive such a record so that it will have an audit trail.

Operating hours of the Fedwire System are 9:00 a.m. to 4:30 p.m. Eastern Standard Time (EST). Send wire deposits by 10:00 a.m., if possible, so that the deposit will be received by the Federal Reserve Bank of New York the same day. The date the Federal Reserve Bank of New York receives the wire deposit message is the date the premium payment is considered paid.

845. Instructions for Payment of Medicare Premiums Via TFCS

The following instructions for funds transfer to a U. S. Treasury Account at the Federal Reserve Bank of New York should be given to the commercial bank which will handle the funds transfer for the State. Care must be exercised in making the transfers. All of the information must be sent in the prescribed format. Failure to do so may delay crediting of the wire transfer.

The items described below refer to the corresponding item on the Funds Transfer Message Format:

Line #	Format Item Number	Description of Item Number		
1	1	Priority Code - The priority code is provided by the sending bank. (NOTE: Some Federal Reserve district banks do not require this item.)		
2	2	Treasury Department - The nine-digit identifier "021030004" is the routing symbol of the U.S. Treasury. This item is constant and required for all funds transfer messages sent to the Treasury.		
2	3	Type Code - The type code is provided by the sending bank.		
3	4	Sending Bank Code - This nine-digit identifier is provided by the sending bank.		
3	5	Class Code - The class code may be provided by the sending bank at its option (if permitted by the Federal Reserve district bank).		
3	6	Reference Number - The reference number may be inserted by the sending bank to identify the transaction.		
3	7	Amount - The amount includes the dollar sign and the appropriate punctuation including cents digits. The State will provide this amount.		
4	8	Ordering Bank and Related Data - The telegraphic abbreviation which corresponds to item 4 is provided by the sending bank.		
	9	U.S. Treasury Department Name And HCFA Agency Location Code - This item is critical. It must appear on the funds transfer message in the precise manner as stated or the deposit will not be accepted. The item consists of a rigid format, non-variable sequence of 20 characters defined as follows:		
		Position	Entry	Definition
		1-5	TREAS	First part of U.S. Treasury Department telegraphic abbreviation
		6	SPACE	(leave blank)
		7-9	NYC	Second part of U.S. Treasury Department abbreviation
		10	/	Slash
		11	(Left parenthesis
		12-19	75050080	HCFA's agency location code

		20)	Right parenthesis
		<p>Left justify these 20 characters on line 5 of the funds transfer message. They must appear exactly as follows:</p> <p>TREAS NYC/(75050080)</p> <p>There must be no additional spaces, dashes, or extra characters.</p> <p>NOTE: All information must be shown on a single line of the deposit message.</p>		
5(or)6	10	U.S. Agency Name - Use "DHHS, HCFA," an abbreviation for the U.S. Department of Health and Human Services, Health Care Financing Administration.		

NOTE: Item 10 may be included on line 5 with item 9. However, if there is not enough space on a single line of the message format used by the bank to enter the information in items 9 and 10, the information in item 10 may be shown on the next line. The information in item 9, however, must never be broken between two lines.

6(or)7	11	<p>State Agency Name and State Code - One of the following entries must be included in order to receive credit for the payment:</p> <p>"Buy-in Part A Medicare Premium Payment, (State). (Part A Agency Code)"; or</p> <p>"Buy-in Part B Medicare Premium Payment, (State). (Part B Agency Code)".</p>		
8	12	For State Use - This space is for optional State use. Note items 11 and 12 combined cannot exceed 230 characters of information.		

Items listed above that must be provided by the State:

Constant Items - 2, 9, 10, and 11

Variable Items - 7 and 12

Items listed above that must or may be provided by the State's Commercial Bank:

1, 3, 4, 5, 6, and 8

847. TFCS Funds Transfer Message Format

EXHIBIT (not provided in e-document)

850. HCFA Policy On Premium Payments Made By TFCS

A. Receipt Date.--State buy-in Medicare premium payments are considered paid as of the date the wire is received in the Federal Reserve Bank of New York.

B. Delayed Receipt Date.--If a problem occurs with a wire deposit, the deposit may be delayed. This could cause the receipt date to be later than the date the deposit was sent. In such a case, submit evidence to HCFA at the address shown in §805. Include the date and time the wire deposit message was sent and a copy of the text of the message sent by the bank.

HCFA will apply the following criteria in evaluating the evidence:

- Critical Errors.--Item 2 (9 digit U.S. Treasury Department Code) and item 9 (U.S. Treasury Department name and HCFA Agency Code) must have been completed correctly per §845. The wire must have been sent by 10:00 a.m. EST to be considered received on the same day.
- Non-critical Errors.--The other items in the wire deposit message must be correct to a reasonable extent as determined by HCFA.

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

855. Customer Initiated Payments - Background

States electing to use the Customer Initiated Payments (CIP) program must adhere exactly to the procedures to ensure timely and accurate payment of Medicare premiums.

The HCFA CIP was developed in conjunction with Mellon Bank. The State must complete an authorization agreement for automatic payments prior to participation in the CIP program. A sample of the authorization form appears in §870. Additional copies of the authorization form together with a brochure developed in conjunction with Mellon Bank can be obtained from Entitlement and Premium Billing at the address shown in §805.

The CIP program can be used with the State's current checking account. All transactions will appear on the State's bank statement. Mellon Bank will produce Depository Transfer Checks in lieu of electronic transactions for those banks that cannot process electronic entries.

The HCFA CIP enables the State to call Mellon Bank's toll free number or to input the Medicare premium payment via a computer terminal on the day before the payment is due. The State will be debited, and HCFA will be credited, on the next business day provided the State completes the payment transaction by 8:15 P.M. EST the day before payment is due. If the payment is due on Monday, the information must be received by 8:15 P.M. EST the preceding Friday.

In order for the bank to debit the State's account, the State must have sufficient funds on deposit to cover the entire transaction by the next business day following the telephone call or terminal entry. The bank will not make a partial transfer to HCFA. Mellon Bank will notify HCFA immediately if the State's account does not have sufficient funds to cover the premium payment.

857. Customer Initiated Payments - General Information

The State must make separate payments for the Part A and Part B premiums.

Mellon Bank's operator-assisted toll free number is 1-800-944-1400. A sample dialogue for the operator assisted telephone call is described in §865.

The State will report the following information to the Mellon Bank CIP operator:

- HCFA company number, assigned by Mellon (Company #82);
- State buy-in agency code;
- Personal identification number (PIN) assigned by Mellon (the PIN is not disclosed to HCFA); and
- Total payment amount (dollars and cents).

Regardless of whether the transaction is conducted via telephone call or terminal entry, the payment information is entered into the system while the State is on line. The Mellon Bank operator or computer terminal will give the State a verification code. Record the verification number since it is the State's proof of payment.

The verification code is systems generated. The code is calculated using an arithmetic formula developed from the deposit amount. By using the formula, the State can calculate the first two positions of the verification code. By comparing the first two positions of the verification code developed by the State with the first two positions of the verification code developed by the bank, the State can insure that it entered the deposit amount correctly. An example of the formula is described below.

EXAMPLE:

Deposit Amount - \$4,131.00:

The sum of the digits: $4 + 1 + 3 + 1 + 0 + 0 = \underline{9}$

The number of digits $413100 = \underline{6}$

To develop the first two positions of the verification code, add the sum of the digits and the number of digits; i.e., $9 + 6 = 15$. In this example, the first two positions of the verification code are 15.

The State can change or correct the payment information until 8:15 p.m. EST on the day that the payment was reported to the HCFA CIP system.

860. HCFA Policy On Premium Payments Made By CIP

State buy-in Medicare premium payments are considered paid as of the date the funds are deposited in HCFA's account. The State's bank account is debited, and HCFA is credited on the next business day after the State inputs the payment information to a Mellon CIP operator or inputs the payment via a computer terminal provided the payment is reported by 8:15 p.m. eastern standard time the day before the payment is due. If the payment is due on Monday, the payment must be input by 8:15 p.m. eastern standard time the preceding Friday. If the payment due date occurs on the weekend or on a holiday, the funds must be deposited in HCFA's account no later than the last business day before the weekend or the holiday.

All operator-assisted telephone calls are made on a recorded line and are kept on file by Mellon Bank for 90 days so that they may be reviewed if any questions arise.

In the event a question arises, submit evidence to HCFA at the address shown in §805. Include the verification code issued by the Mellon Bank operator or computer terminal when the initial transaction was concluded.

865. Operator Assisted Telephone Dialogue for a CIP Payment

The following is an example of a typical operator-assisted telephone call for a HCFA CIP payment, (telephone: 1-800-944-1400).

The following is an example of a typical operator-assisted telephone call for a HCFA CIP payment, (telephone: 1-800-944-1400).

1.	Mellon Operator	"Mellon Bank"
2.	State Buy-in Agency	This is company number 82 reporting a deposit with a supplemental field. (Mellon Bank has assigned company #82 to HCFA.)
3.	State Buy-in Agency	My unit number is _____. (This is the State buy-in Part A or Part B agency code.)
4.	State Buy-in Agency	The payment amount is _____. (This is the total dollar payment the State is making, the net of all debits and credits. State each digit without a decimal. For example, report \$1,523.05 as one, five, two, three, zero, five.) Report all zeros.
5.	State Buy-in Agency	My PIN number is _____. (Provide the four-digit PIN assigned to State by Mellon Bank. Provide each digit. For example, PIN 1234 is reported as one, two, three, four.)
5a.	Mellon Operator	"PIN number is _____." (Operator reads back PIN number.)
6.	State Buy-in Agency	My supplemental field is _____. (Medicare Part A if payment for Part A premiums or Medicare Part B if payment is for Part B premiums.)
6a.	Mellon Operator	The operator will read back all the information at this time. "Company # is 82. Unit # is _____. Deposit amount is _____. Is this correct?" Y/N
7.	State Buy-in Agency	Yes. (If State agrees with the information.) No. (If State does not agree). Provide the correct information, the operator will verify.
7a.	Mellon Operator	"Your verification code is ____." (Enter the verification code on the work sheet as a record that the call was made.)

If the transaction is input via touch-tone telephone or computer terminal, the Mellon Bank computer will provide the prompt. The information which is required is the same as is required for the operator-assisted dialogue.

870. Authorization Agreement for Automatic Payments Via CIP

[Click here to view the Authorization Agreement for Automatic Payments.](#)