

DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES

BUY-IN PROGRAM

Operational Procedures

REVISION HISTORY

| Version | Date | Description | Author |
|---------|------------|---------------|------------|
| 1.0 | 6/6/2013 | Initial Draft | Tiaa Lewis |
| 1.0 | 9/30/2013 | Version 1.0 | Tiaa Lewis |
| 2.0 | 3/18/2014 | Version 2.0 | Tiaa Lewis |
| 3.0 | 6/1/14 | Version 3.0 | Tiaa Lewis |
| 4.0 | 10/15/2014 | Version 4.0 | Tiaa Lewis |
| 5.0 | 04/15/2016 | Version 5.0 | Tiaa Lewis |

TABLE OF CONTENTS

| | |
|--|-----------|
| 1.0 Introduction | 4 |
| 1.2 Purpose..... | 4 |
| 1.3 Buy-In Program Overview | 4 |
| 1.4 Buy-In Program – Statutory Authority..... | 4 |
| 1.5 Buy-In Program – Background Information of Medicare Eligibility..... | 5 |
| 1.6 Staffing Overview | 10 |
| 1.7 Job Descriptions..... | 11 |
| 1.7.1 Eligibility and Enrollment Unit Manager..... | 11 |
| 1.7.2 HIPP/Buy-In Unit Supervisor..... | 11 |
| 1.7.4 Buy- Analyst..... | 11 |
| 2.0 MMIS Access..... | 12 |
| 2.1 Purpose:..... | 12 |
| 2.2 Procedure: | 12 |
| 3.0 MONTHLY BUY-IN PROCESS..... | 16 |
| 3.1 MMIS BUY-IN PROGRAM PROCESSING | 19 |
| 4.0 Reports..... | 22 |
| 4.1 Purpose:..... | 22 |
| 4.2 Policy: | 22 |
| 4.3 REPORT PRIORITY LEVELS:..... | 22 |
| 4.3 Procedures - ECM | 77 |
| 4.4 Procedures – SOLQ | 81 |
| 5.0 Buy-In – ISR (Information Service Request) | 89 |
| 5.1 Purpose:..... | 89 |
| 6.0 Buy-In – Data Analytics..... | 89 |
| 6.1 Purpose:..... | 89 |
| 6.1 Description of Currnt Runs: | 89 |
| 7.0 Desk Review – Analyst..... | 90 |
| 7.1 Purpose:..... | 90 |
| 8.0 Contacts | 91 |
| 8.1 Contacts – Buy-In Staff | 91 |
| 8.2 Contacts – HIPP program..... | 91 |
| 8.3 Contacts – HIPP Staff..... | 91 |

| | | |
|-------------|---|-----------|
| 8.4 | Contacts – Enrollment Staff..... | 91 |
| 8.5 | Contacts – Information Management..... | 92 |
| 8.6 | Centers for Medicare and Medicaid Services..... | 92 |
| 10.0 | Equipment Repair..... | 94 |
| 11.0 | Glossary..... | 95 |
| 12.0 | Acronyms | 96 |
| 13.0 | Appendices..... | 97 |

1.0 Introduction

1.2 Purpose

The manual specifies the policies and procedures of the Commonwealth of Virginia's Department of Medical Assistance Services Buy-In Program. Each task is detailed to facilitate effective and efficient service delivery to all participants.

1.3 Buy-In Program Overview

Buy-In allows the State, as part of its total medical assistance plan, to provide for payment of supplemental medical insurance (SMI), also referred to as Medicare Part B, to certain groups of needy individuals. It also has the effect of transferring some medical costs for this population from the Title XIX Medicaid program, which is partially financed by the federal government, to the Title XVIII Medicare program, which is funded by the federal government. Some Medicare beneficiaries are charged by Social Security for their Medicare Part A (Hospital Insurance Premium). Usually Medicare Part A is free; however, there are circumstances where a person can be charged for the Part A premium. In some instances the state will pay for the cost of members' Medicare Part A if one is being charged.

Buy-In is the procedure by which a Medicaid eligible, who is also eligible for Medicare Part B, has the Part B premium paid for by the State.

Medicaid may also Buy-In the Medicare Part A (Hospital Insurance Premium) premium for those members who are charged a premium for their Medicare Part A coverage. Usually Part A is free; however some clients are charged a premium. A person may be charged a premium for their Part A coverage because they had insufficient work quarters during their working career to qualify for free Part A coverage. A person must have at least 40 quarters of qualified work in order to be eligible for free Part A. Some beneficiaries may have a reduced Part A premium cost; these are individuals who have 30 to 39 qualified work quarters. A person may also be charged a Part A fee when they failed to enroll in Part A when they were initially eligible to enroll (for example, a person may be eligible to enroll in Medicare at age 65 but they waited until age 68 to begin their Medicare coverage).

1.4 Buy-In Program – Statutory Authority

The statutory authority for the **Buy-In** program is section 1843 of the Social Security Act. Under the buy-in program, States may enroll certain groups of needy members under the supplementary medical insurance program (also referred to as SMI or Medicare Part B) and pay their premiums.

1.5 Buy-In Program – Background Information of Medicare Eligibility

The Medicare Program (Title XVIII of the Social Security Act) provides hospital insurance, also known as Part A coverage, and supplementary medical insurance, also known as Part B coverage. Coverage for Part A is automatic for people age 65 or older (and for certain disabled persons) who have insured status under Social Security or Railroad Retirement. Most people don't pay a monthly premium for Part A. Coverage for Part A may be purchased by individuals who do not have insured status through the payment of monthly Part A premiums. Coverage for Part B also requires payment of monthly premiums.

- 1) Medicare Part B coverage groups include:
 - a. persons 65 years old or older;
 - b. persons who have been receiving monthly social security benefits based on the disability for at least 24 consecutive months;
 - c. persons with a chronic end stage renal disease.
- 2) The Social Security Administration (SSA) maintains the Master Beneficiary Record (MBR). They determine whether an individual is eligible for Medicare, although the Medicare program is managed by the Centers for Medicare and Medicaid Services (CMS). SSA sends information to CMS regarding Medicare eligibility. CMS maintains a master file of all individuals eligible for Medicare Part A and Part B.
 - a. Exception: Aliens who have not been in the country for 5 years. They do not qualify for Medicare until they have been in the country 5 years.
 - b. Some members have refused Medicare Part B because of the cost of the premiums. If they are Medicaid eligible, they do not have to wait for the open enrollment period to sign up for Medicare Part B. Their Part B premium will be set at the prevailing rate for all other members and the state will pick up the cost either immediately or within 2 months.

Cost of Medicare Part A & B Premiums:

Regular Part A – Hospital Insurance (HI)

Base Rate \$411.00

10% surcharge \$452.10

Reduced Part A

(Individuals with 30-39 quarters of Social Security coverage)

Base Rate \$226.00

10% surcharge \$248.60

Part B – Supplementary Medical Insurance (SMI)

Base Rate \$121.80

- c. Medicaid eligible's age 65 or over who do not have Medicare Part A must wait for the next enrollment period (January-March each year) to sign up for Part A. Although the person can sign up during the enrollment period, it is not effective until the following July. These Medicare beneficiaries may be "conditional" Medicare Part A, which means they will only accept the Medicare Part A if the state is willing to pay the cost of their Medicare Part A premium. A person must meet Medicaid "QMB" Qualified Medicaid Beneficiary eligibility criteria in order to be eligible for payment of Part A premiums.

Claim Numbers

The Social security account number is the number assigned to an individual and is used throughout a wage earners lifetime to identify his or her earnings under the social security program..

The Social Security claim number is the account number of the individual on whose earnings benefits are being paid followed by a letter suffix (sometime as many as three letters) designating the type of beneficiary, e.g. wife, widow, child, etc.

There are two types of claim numbers:

- 1) Social Security Account (SSA) number - always begins with nine numbers and followed by either alpha or alpha numeric characters, e.g. 123-45-6789A. The most common symbols are T, M, A, B, J1, K1, D, W, E.
- 2) Railroad Retirement Board Annuity (RR) claim number- contains an alpha prefix and a six digit number, e.g. A123456. The most common RR prefixes are A, MA, MH, WCD, WCH, WCA, CA, WD, and PD.

BUY-IN ELIGIBILITY

- 1) SSA establishes Medicare eligibility as stated above.
- 2) The local Department of Social Services (DSS) determines Medicaid eligibility. In the process of determining eligibility, the member will be assigned an Aid Category (AC). The AC assigned will determine if the person is eligible for Part B Buy-In.
- 3) The combination of the person's Medicare eligibility and Medicaid AC determine their eligibility for Buy-In.
- 4) ACs 018, 020, 038, 040, 058, and 060 are Medicaid Needy non-QMB AC's and have a 2-month waiting period from the date that Medicaid eligibility begins before Buy-In can occur.

- 5) If Social Security records (SOLQ) confirm Medicare Part A coverage with no Medicare Part B coverage, the caseworker should enter the Medicare Part A coverage in TPL.
 - a. Send an email to the DMAS Buy-In Unit requesting Medicare Part B coverage be added to the member record. The subject line of the email should read "Add Medicare Part B" and the body of the email should contain the member's Medicaid ID # and their Social Security number (SSN). Buy-In Unit inbox: MedicareBuyIn@dmass.virginia.gov . The Buy-In Unit will determine the correct effective date of Part B coverage and will send an accretion request. Once CMS shows successful accretion, the Buy-In Unit will add the Part B coverage to MMIS.

- b. Note: If a worker adds Medicare Policy and Part A coverage information but fails to send a request to DMAS to add Part B, the MMIS will automatically send an accretion (i.e. Buy-In) request to CMS to enroll the member in Part B. If CMS's response file shows successful accretion, the MMIS then automatically add Part B coverage to the member's Medicare policy information in the MMIS. When this occurs the begin date of Part B will not cover any retroactive eligibility period for which buy-in was appropriate; thereby, causing a gap in member's coverage.
- c. If an emergency arises, such as an individual being unable to receive services, workers may call the Buy- Unit staff member.

THE FOLLOWING AC's ARE NOT ELIGIBLE FOR BUY-IN:

- ACs 001-004, State and Local Hospitalization (SLH)
- AC 066, Breast or Cervical Cancer Group
- AC 080, Family Planning Waiver Individual
- AC 055, QDWI are not eligible for Part B Buy-In
- AC 108-109 DOC Incarceration
- AC 87 – GOVERNOR'S ACCESS PLAN (GAP)

Release to Authorized Representatives:

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives. The designation must be in writing, with the applicant or participant specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

This guide is for internal use only. Any information shared is strictly for training and developmental purposes for internal Department of Medical Assistance Services employees.

Notification of Incarceration from Department of Corrections:

The Department of Correction's Health Care Reimbursement Specialist will attempt to contact the local agency three times to have open Medicaid coverage closed. If unsuccessful after a third attempt a spreadsheet will be submitted weekly by email to the Senior Enrollment Specialist as notification of members who are incarcerated with open enrollment in the MMIS. The spreadsheet is to

contain the member's name, Social Security number, MMIS member ID number, the member's FIPS code, and the date of incarceration.

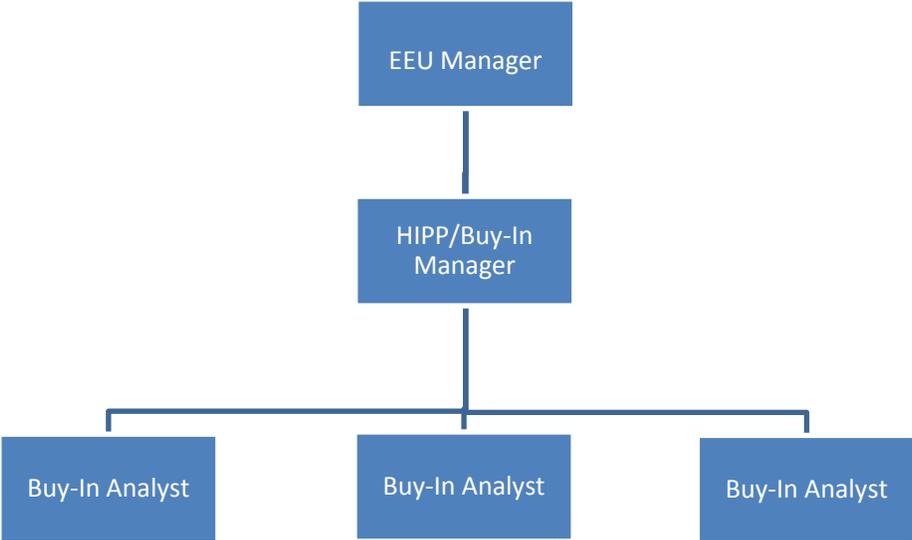
Upon receipt of the report the Senior Enrollment Specialist will close out the eligibility for these members using cancel reason code 008 on the date of notification per Medicaid Manual chapter M1510.102 B.2. A Notice of Action will be sent to the Department of Correction's Health Care Reimbursement Specialist, the local agency, and the Medicaid consultant for that agency. The name of the Health Care Reimbursement Specialist at the Department of Corrections will be placed on the Comment screen at the authorized representative and the Member Demographic address will be updated with the representative's mailing address as follows:

c/o Myra Smith - DOC
6900 Atmore Drive
Richmond, VA 23225

The local agency will be responsible for reevaluating any other members on the case to determine ongoing eligibility. The local agency will also need to submit a referral to the DMAS Recipient Audit Unit for any months' coverage was received in error. The Senior Enrollment Specialist will email the report, after updating the eligibility, to the Recipient Audit Unit Program Manager as notification of referrals that should be expected from the local agency.

If the member also has open Medicare coverage in the TPL screens the Senior Enrollment Specialist will forward the request to the Buy-In Unit with a copy to the Buy-In Manager for Medicare coverage to be updated per Social Security records.

1.6 Staffing Overview



1.7 Job Descriptions

1.7.1 Eligibility and Enrollment Unit Manager

Eligibility & Enrollment Manager-Oversees the day to day operation of the Eligibility and Enrollments Unit, which consists of the HIPP, Buy-In and Enrollment Units. The manager is involved in the research, development and implementation of regulations and policy; holds authority for approval of unit policy and procedures, business decisions and personnel issues. The manager reports directly to the Division Director on matters that require approval of administration and unit activities.

1.7.2 HIPP/Buy-In Unit Supervisor

The Buy-In Unit Supervisor oversees the daily operations for the HIPP/BUY-IN Units; researches regulation and policy, handles personnel issues and insures proper staffing, including filling in when needed. The supervisor reports directly to the Eligibility and Enrollment Manager.

1.7.4 Buy- Analyst

The Buy-In Analyst determines eligibility for and initiates enrollment in Medicare Parts A and B premium payments in the Buy-In Unit in accordance with established guidelines. The analysts report directly to the Buy-In Unit Supervisor.

2.0 MMIS Access

2.1 Purpose:

To demonstrate the procedure followed for Login and Logout to the Virginia Medicaid Management Information System.

2.2 Procedure:

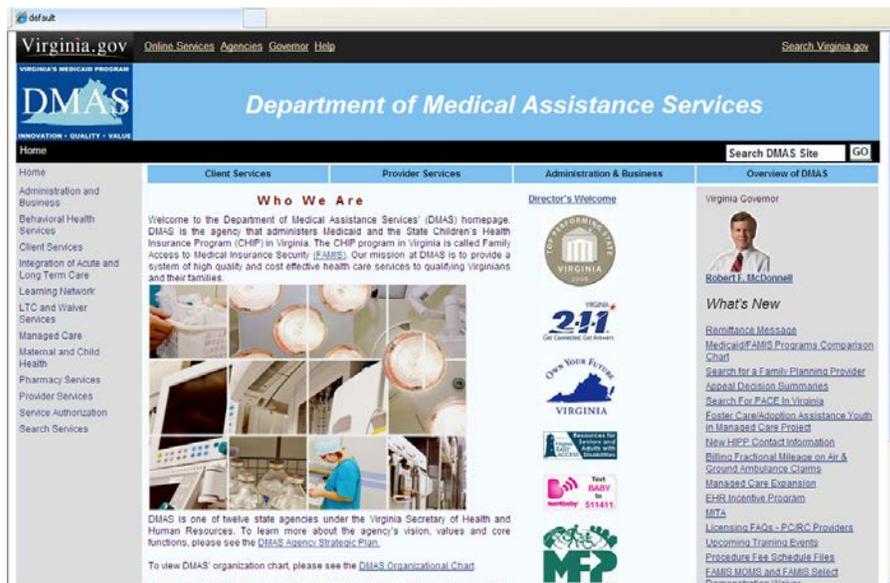
- 1) To access MMIS (Medicaid Management Information System) the Internet Explorer Browser, which is located on the Start Menu Bar at the bottom of the screen as displayed below must be launched.



- 2) Next, move the cursor over the icon and the description of the icon will appear as displayed below.

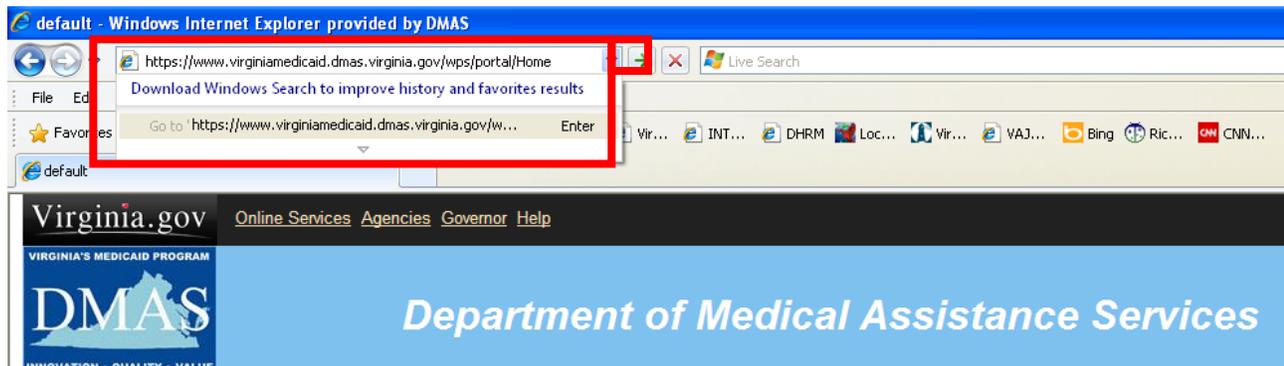


- 3) Next, click on the icon and the internet explorer browser be displayed as shown below.

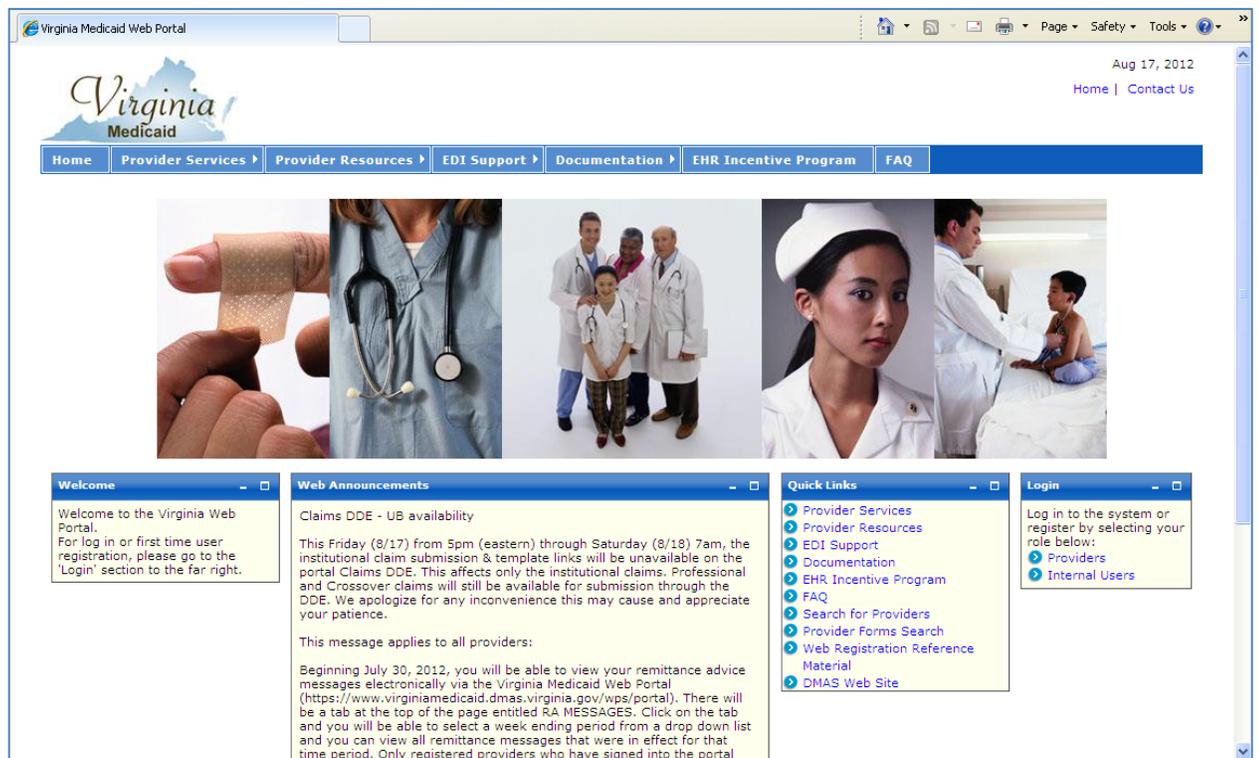


a.

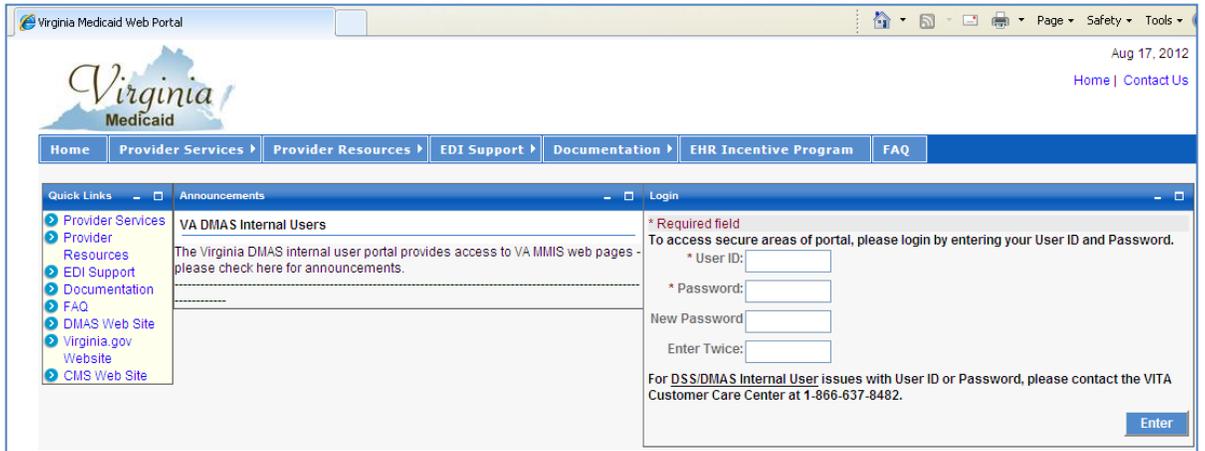
- 4) Next, copy and paste this link:
<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home> into the url field and press the enter key or the  green arrow as displayed below.



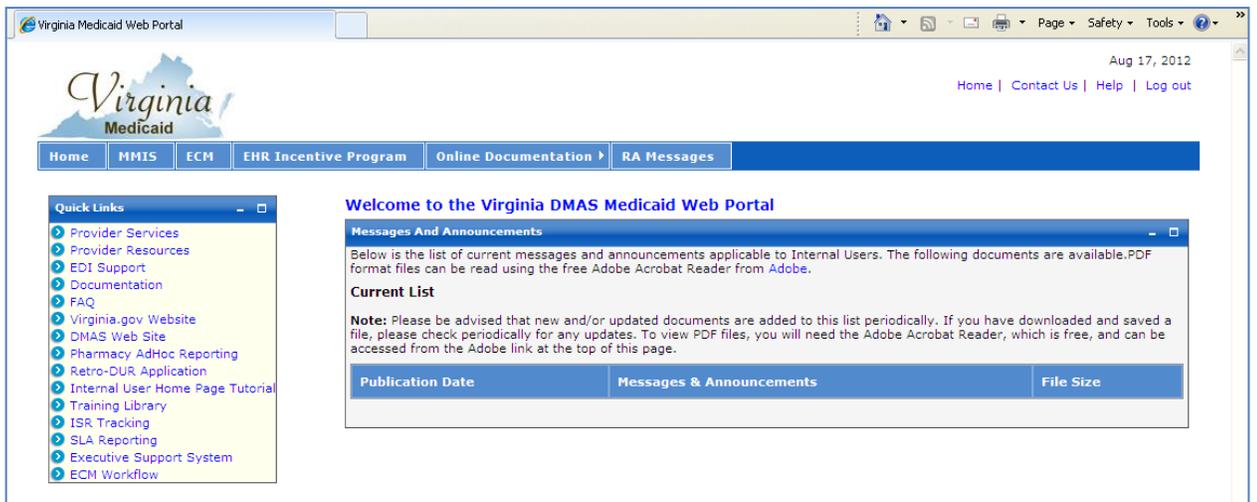
- 5) Next, the MMIS welcome page will display as shown below.



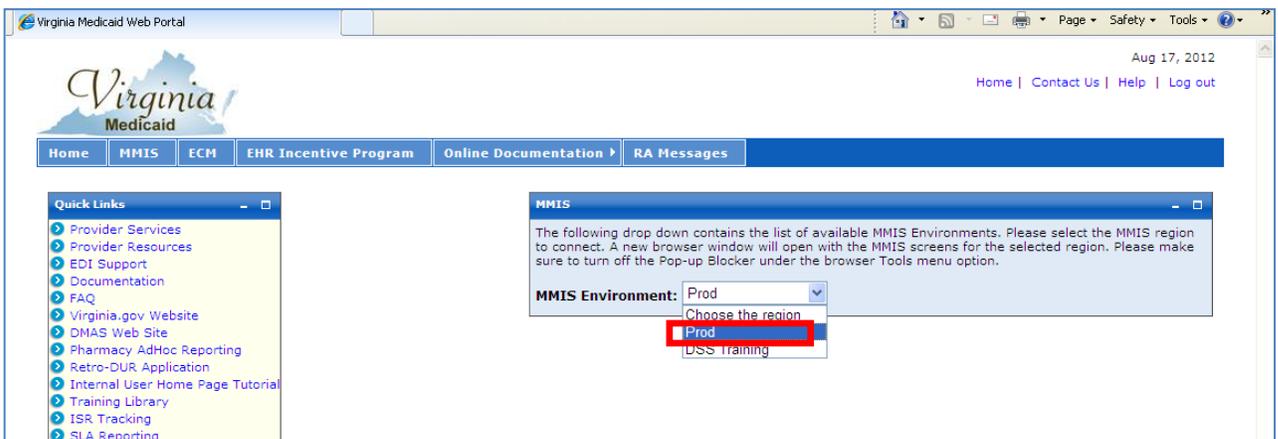
- 6) Enter your User ID and password and Web Portal page is displayed as shown below.



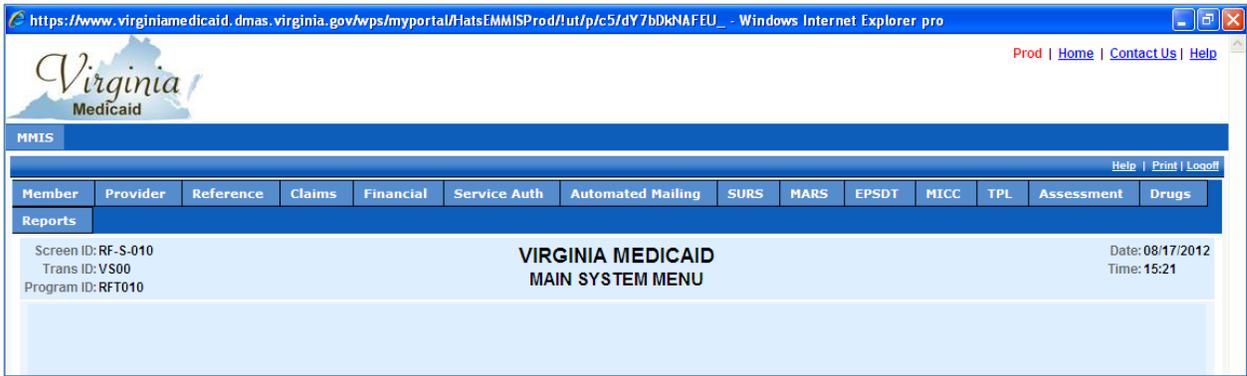
7) Next click on MMIS



8) Using drop down button, highlight 'Prod' as shown in sample displayed below.



9) Next, the MMIS main system menu will be displayed sample shown below.



10) Next, click Member tab button subsystem displayed below



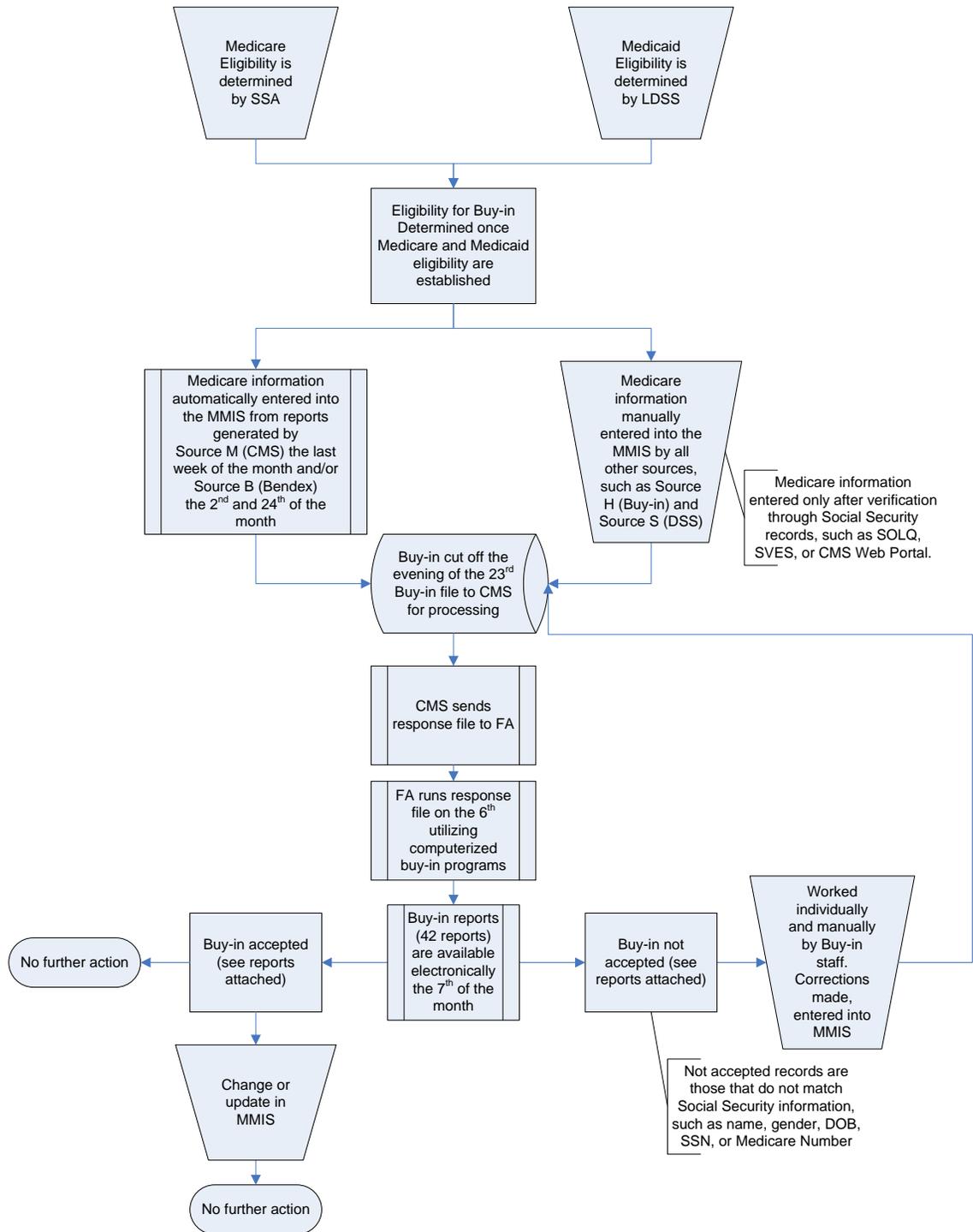
3.0 MONTHLY BUY-IN PROCESS

- 1) On the 23rd of each month, programs are run in the Medicaid Management Information System (MMIS) in order to obtain the files for the Part A and Part B Buy-In process.
- 2) The electronic files produced by MMIS are sent by the agency's fiscal agent to the Virginia Information Technologies Agency (VITA) which are then transmitted to CMS.
- 3) The transmission of our Buy-In files must be received by CMS by the 25th of the month in order to be processed.
- 4) CMS processes the electronic files, matching records in their system to the information extracted from the MMIS transmitted to them.
- 5) CMS prepares a response file, which is transmitted back through VITA to the agency's fiscal agent for processing.
- 6) CMS updates the Buy-In master file with:
 - a. accretion - adding new members
 - b. deletion - taking off those who no longer qualify
 - c. change records which had accumulated since the last update.
- 7) Before an accretion can be in effect, CMS must run the list against their Medicare eligibility list for a match in name spelling (including titles of Jr and Sr). If there is no match, it is rejected. Each individual must have established his eligibility for Medicare with SSA who sends the Medicare information to CMS in order for the state to "Buy-In" that individual.
- 8) The fiscal agent runs the response file through a variety of pre-defined computer programs which identify transactions that processed correctly, any potential errors in Buy-In transmission, as well as notifications received from CMS of Medicare beneficiaries who may be eligible from Buy-In from the state of Virginia.
- 9) The fiscal agent electronically sorts the output of these programs into a variety of reports.
- 10) The reports produced can include such items as new TPL information, records which were dropped or added during the CMS processing of our files as well as errors that may have occurred during processing.
- 11) The total process results in over 50 reports being produced.
- 12) An12 reports relate to information we are sending to CMS as part of the Buy-In process. This includes manual accretions, deletions, changes and requests for

retroactive Buy-In prepared by Buy-In staff. These reports are available the next business day after the 23rd of the month.

- 13) The other 30+ reports are created from the response file received from CMS. The response file is processed into various reference and error reports. These reports are available on the 6th of the month.

Work Process for *Establishing* Buy-In
 (This is distinct from the work process
 for ongoing Buy-in.)



3.1 MMIS BUY-IN PROGRAM PROCESSING

Part A Extract Processing: VMPBM350

RSM350 Medicare Part A Premium Extract Processing

Program RSM350 creates the Medicare Premium Processing file containing those members currently eligible for Medical Assistance, who are also eligible for participation in the Medicare Premium Processing program and those who are no longer eligible. The extract file created accretion and deletion requests based on transaction codes, Medicaid eligibility, medical assistance status, and Medicare coverage. Accretions are requests for those where the state is seeking to establish Buy-In for a member for a period of time. Deletion requests are sent for member whose premiums are currently covered but have been determined by the state to no longer be eligible for participation in the Buy-In program. Change requests are also included in the extract. These records indicate the state believes CMS demographic data to be missing/incorrect and need to be updated.

RSM360 Medicare Premium Online Transaction Processing

RSM360 reads the RSF810 (Online Transaction File) and writes these transactions to RSF520 to be merged with the system identified transactions from RSM350. These transactions are manually entered by DMAS staff and contain those members currently eligible for Medical Assistance, who the State determines should be accreted, deleted, or changed that would not otherwise be processed by the monthly batch Medicare Premium Extract Processing Program. RSM360 is designed to be executed twice per month, once for Part A extract and once for Part B extract processing.

RSM355 Medicare Part A Premium Merge

This program will take the sorted RS-F-520 Part A Medicare premium file which includes both batch and on-line transactions, and determine the final transactions to be sent to CMS. This program will compare and edit the records to determine which (if any) should be sent to CMS. Conditions isolated include, multiple add, multiple delete, interrupted coverage, continuous coverage, and non-processable pairs. Only successfully processed and unduplicated transactions will be sent to CMS as well as added to the RS_MEDICARE_BUYIN table as valid history.

PART B EXTRACT PROCESSING: VMPBM360

RSM027 Letters and Reports for Aid Category 056

The program will determine if there are enough funds to approve an member for the Q11 program and update the parameter table with the new amounts. It also produces two reports and writes requests for notifications to members eligible for Medicare premium payment under aid category 056 (Q11) to the RSF250 (Correspondence Request File).

RSM351 Select Buy-In Medicare Part B for CMS

This program is the Part B equivalent of Part A RSM350. The extract file created accretion and deletion requests based on transaction codes, Medicaid eligibility, medical assistance status, and Medicare coverage. Accretions are requests for those where the state is seeking to establish Buy-In for a member for a period of time. Deletion requests are sent for members whose premiums are currently covered but have been determined by the state to no longer be eligible for participation in the Buy-In program. Change requests are also included in the

extract. These records indicate the state believes CMS demographic data to be missing/incorrect and need to be updated.

RSM352 Extract Medicare Part B Members

This program will take the sorted RS-F-520 Part A Medicare premium file which includes both batch and on-line transactions, and determine the final transactions to be sent to CMS. This program will compare and edit the records to determine which (if any) should be sent to CMS. Conditions isolated include, multiple add, multiple delete, interrupted coverage, continuous coverage, and pairs that are unable to be processed. Only successfully processed and unduplicated transactions will be sent to CMS as well as added to the RS_MEDICARE_BUYIN table as valid history. Similar to RSM355 of Part A processing but without inclusion of the online merge functionality.

RSM353 Process Medicare Part B for CMS

Program RSM353 formats the RS-F-520 State Buy-In Transaction record according to CMS requirements and prints itemized reports showing transactions sent to CMS, mismatches, and CMS investigation items outstanding more than three months.

RSM360 Medicare Premium Online Transactions Processing

Previously described in Part A extract processing section. This program writes manual Buy-In transactions to RSF520, a work file, to be merged later with the system created Buy-In transactions

RSM370 Medicare Premium Retroactive Processing

Program RSM370 is executed monthly to create an extract file of retroactive eligibility that should result in retroactive Buy-In to the Medicare premium payment program for the member. A report is also generated that details all records selected.

PART A BUY-IN RECEIVE PROGRESS: VMPBM385

RSM373 Part A and B Personal Characteristics Change Report

This program reads the RS-F-512, the CMS billing file, for record type E only and creates the Medicare Personal Characteristics Change Reports (RS0339 Part A and RS0341 Part B). This reports differences between what was sent to CMS (in the first half of Record Type E) and what CMS has on file for the member (in the second half of Record Type E).

RSM385 Medicare Part A Preliminary Reporting Program

Reads the CMS billing file (RSF512) except for personal characteristic records (record type E) and accumulates debits and credits by transaction code in order to arrive at the payment due from the state.

RSM386 Medicare Part A Premium Processing Apply

Edits the CMS Part A transactions from the billing file with invalid records being written to an error report while valid records are reported, written to the Buy-In history table, and written to the RSF511 (State Agency Billing Extract Record) which contains all valid records to continue on in processing.

RSM387 Medicare Premium History Merge/Update

Program uses the RSF511 (State Agency Billing Extract Record) containing the accepted part A transactions and uses this to update the Buy-In history file (RSF905), purges records over 2 years old from the file, and writes any AC 080 records to RSF370 (Members in AC 080 with Part A Transactions). This program runs once for each Part A and Part B.

PART B BUY-IN RECEIVE PROCESS: VMPBM390**RSM389 Medicare Part B Preliminary Reporting**

This program is to Part B processing what RSM385 is to Part A. It reads the CMS billing file (RSF512) and accumulates debits and credits by transaction code in order to arrive at the payment due form the state.

RSM373 Part A and B Personal Characteristics Change Report

This program reads the RS-F-512, the CMS billing file, for record type E only and creates the Medicare Personal Characteristics Change Reports (RS0339 Part A and RS0341 Part B). This reports differences between what was sent to CMS (in the first half of Record Type E) and what CMS has on file for the member (in the second half of Record Type E).

RSM390 Medicare Part B Premium Receive

Edits the CMS Part B transactions from the billing file with invalid records being written to an error report while valid records are reported, written to the Buy-In history table, and written to the RSF390 (Medicare Part B SSA Extract Data) which contains all valid records to continue on in processing.

RSM391 Medicare Part B Premium Processing

Program reads RSF390 and handles the final validation of Part B response records, updating of the Buy-In history tables based on the CMS file, and Part B processing reporting.

RSM387 Medicare Premium History Merge/Update

Program uses the RSF511 (State Agency Billing Extract Record) containing the accepted part B transactions and uses this to update the Buy-In history file (RSF905), purges records over 2 years old from the file. This program runs once for each Part A and Part B.

RSM395 Medicare Premium Reporting

Reads the output from RSM391, the RSF390 file, the Part B post processing reports. Which records are written to which of the output reports is determined by a flag set in the RSM391 run.

4.0 Reports

4.1 Purpose:

To provide access to view, open and download program reports.

4.2 Policy:

Each report has been assigned a priority level to ensure the most crucial reports are worked first.

4.3 REPORT PRIORITY LEVELS:

Level 1

Reports in which issues need to be resolved in order for the Buy-In process to occur correctly. These are the most important reports to resolve and must be completed by the next Buy-In cycle (the 23rd of the month). Issues on these identified cases have occurred which impacted the Buy-In process. The reports also include notifications of Medicare beneficiaries that CMS has identified as belonging in the state of Virginia and they have begun the Buy-In process. In accordance with the State Buy-In Manual issued by CMS, the state has a limited amount of time in which to respond to the request for the state to Buy-In a person. Failure to send a deletion transaction to CMS for members that we are not responsible for the Buy-In could result in the state paying for people inappropriately. Staff researches various sources (SOLQ, SVES, MMIS) to resolve issues identified. They may update information in the MMIS, such as Medicare claim number, TPL information, Buy-In transaction codes, etc. as a result of their research.

Level 2

Reports identify members who potentially have Medicare coverage and potentially reside in the state of Virginia. These reports are second in priority to ensure TPL coverage is properly identified for cost avoidance for Title XIX (Medicaid), shifting cost to Title XVIII (Medicare) when appropriate. The staff works these reports to determine if in fact the member has Medicare coverage, what coverage dates they may have as well. In addition, they verify Medicaid eligibility and determine if initiation of Buy-In is appropriate. Staff may update the MMIS, such as Medicare claim number or TPL information or initiate the Buy-In process as a result of these reports. In addition to level 2 Buy-In reports, reports from other sources, such as the medical claims processing area are reviewed by Buy-In staff. This includes medical claims that have pended for review as the billing provider has indicated Medicare coverage but there is not Medicare coverage listed in MMIS. These reports also include medical claims that have been pended for further review as result of an edit in the system

Level 3

Reports identify other areas in which the Medicare information in the MMIS may differ from the information CMS has in their files. These are ranked 3rd because most often Buy-In process is working appropriately for these members. However, we need to ensure our TPL information and personal characteristic information is

accurate. In addition, some of these reports contain information that is duplicative of other reports. (for example the RS-O-349, Members by City/County code who CMS has indicated has died, these members are also reported on RS-O-363, Multiple Records by Transaction Codes). Often these reports contain information about Medicare Part D policy dates. Although the Part D information does not impact the Buy-In process, this information needs to be accurate in the MMIS. Also, reports are generated in which the personal characteristics (i.e., date of birth) in our MMIS does not match to CMS data, however, sufficient criteria has been matched between the two files to permit the Buy-In process to occur.

RS-O-330 (RSM390)

MEMBER WITH 1165 OR 1167 TRANSACTION CODES

Priority Level 1

Report is processed on the 7th of each month and must be completed by the 23rd of each month

Description of Report

This report contains a listing of members Social Security Administration has sent to CMS and CMS is billing us for the Part B premium. On occasion the state is billed for non Medicaid members, billed for members that were not Medicare or Medicaid eligible or members being billed under an incorrect Medicare number. These issues are addressed with letters to CMS.

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number, provided in MMIS.
- 3) Once SOLQ provides a match for the member in question, we verify and update any demographic information in MMIS which requires updating, such as first name, middle initial, last name, date of birth, sex and social security number.
- 4) We verify, update or add Medicare information (Medicare number and Medicare dates of coverage) in MMIS
- 5) A manual transaction code 99 is submitted on all transaction codes 1167s on this report because CMS needs to match the Medicaid number to the Medicare number that we are being billed for.
- 6) A manual transaction code 99 is submitted on 1165, only if any demographic changes are made.

| CLAIM NO | LAST NAME | FIRST NAME | M I | SEX | BIRTH DTE | AGC | TPC | PREMIUM | BILL DATE | TR CD | TRAN DATE | ENROLLEE ID | SEQ. NO. |
|----------|-----------|------------|-----|-----|-----------|-----|-----|---------|-----------|-------|-----------|-------------|----------|
| | | | | K | M | 490 | | 461.60 | 201112 | 1167 | 092011 | | 1,579 |
| | | | | R | M | 490 | | 461.60 | 201112 | 1167 | 092011 | | 3,478 |
| | | | | J | F | 490 | | 346.20 | 201112 | 1167 | 102011 | | 7,623 |
| | | | | M | F | 490 | | 346.20 | 201112 | 1167 | 102011 | | 8,982 |
| | | | | P | M | 490 | | 346.20 | 201112 | 1167 | 102011 | | 11,042 |
| | | | | H | M | 490 | | 461.60 | 201112 | 1167 | 092011 | | 11,305 |
| | | | | F | | 490 | | 461.60 | 201112 | 1167 | 092011 | | 14,069 |
| | | | | M | | 490 | | 807.80 | 201112 | 1167 | 062011 | | 15,341 |
| | | | | F | | 490 | | 6411.90 | 201112 | 1167 | 102006 | | 18,320 |
| | | | | A | F | 490 | | 1154.00 | 201112 | 1167 | 032011 | | 26,604 |

RS-O-344(RSM395)

Member Records with No 41 Buy-In update

Priority Level 1

Report Available

Report is available on the 7th of each month and must be completed by the 23rd of each month in order for the Buy-In to occur.

Description of Report

This report contains a listing of members that have had closed periods of Buy-In but do not have ongoing Buy-In, members that have ongoing Buy-In but the Medicare number has changed, members that have died and Buy-In may be ongoing and cases we are paying the premiums but social security records do not reflect that the state of Virginia is doing Buy-In for the member.

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number, provided in MMIS.
- 3) Once SOLQ provides a match for the member in question, we verify and update any demographic information needing updating in MMIS,(first name, middle initial, last name, date of birth, sex and social security number)
- 4) We verify, update or add Medicare information (Medicare number and Medicare dates of coverage) in MMIS
- 5) Review the SMIB (Supplementary Medical Insurance Benefits) Premium Payment Notice (RS-O-322), also referred to as “the bill” to make sure Buy-In is under the correct Medicare number, if Buy-In is under a different Medicare number on the SMIB Premium Payment Notice report, research, utilizing SOLQ, the Medicare number on the SMIB Premium Payment Notice.
- 6) MMIS is updated by changing the incorrect Medicare number in MMIS with the correct Medicare number.
- 7) Railroad members cannot be verified through SOLQ, the SMIB Premium Payment Notice is the easiest way to verify railroad members’ Buy-In. If the SMIB Premium Payment Notice shows no Buy-In, the Rail Road Retirement Board will need to be contacted by phone to verify all demographic information and Medicare information.

- 8) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).
- 9) If SOLQ shows the member has died and the Medicaid case is still open, notify the Medicaid Enrollment Unit at DMAS to follow-up on the case for potential closure due to death of the member.

If SOLQ does not show that the state of Virginia is paying the Part B premiums but our records (the MMIS) and the SMIB Premium Payment Notice indicate the state of Virginia is paying the Part B premium, we need to notify Social Security Administration in writing about the discrepancy. A social security administration form (1610) is completed by the Buy-In staff member and sent to the member's local social security office. Additional information about completing the SSA form 1610 is provided further in this manual (See pg 64).

RS-O-345 (RSM395)

Non-Premium List

Priority Level 1

Report is available on the 7th of each month must be completed by the 23rd of each month in order for the Buy-In to occur

Description of Report

This report contains a listing of members with transaction code 2461 (2461-informs the state that the accretion or deletion action it submitted was rejected because of incorrect or incomplete date)

Procedures

- 1) Utilizing the Medicaid number on the report, obtain the social security number in MMIS.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS.
- 3) Once SOLQ provides a match for the member in question, we verify and update any demographic information in MMIS which needs to be updated (first name, middle initial, last name, date of birth, sex and social security number).
- 4) We verify or update Medicare information (Medicare number and Medicare dates of coverage) in MMIS

- 5) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

RS-O-348 (RSM395)

Medicare Premium Processing Non-Premium List, Code 2161 Alphabetic

Priority Level 1

Report is processed on the 6th of each month and must be completed by the 23rd of each month in order for the Buy-In to occur.

Description of Report

This report contains a listing of members who had an accretion attempted in the prior month but the member cannot be matched to the information that CMS has on file for this member. The errors can be: an incorrect Medicare number, incorrect spelling of the name, incorrect date of birth, incorrect Social Security number, incorrect sex or the member no longer has Medicare coverage.

Procedures

- 1) MMIS is reviewed to obtain the Social Security number
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number to obtain the correct Medicare number, correct spelling of the name (including special characters such as hyphens, apostrophes and numbers with the exception of letters with accents), correct date of birth, correct sex, and correct Social Security number.
- 3) MMIS will be updated as needed to ensure the correct information is in MMIS
- 4) If MMIS matches the data from Social Security, reference report RS-O-470(RSM460) Demographic Data Mismatch, to see if the member is listed on the report. This report is received each month from CMS and it will show the correct information for this member.
- 5) If the member is on the RS-O-470 report, obtain the correct information from this report in order to update MMIS.
- 6) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in MMIS. (Directions for entering a manual accretion are provided further in this manual).
- 7) If SOLQ(SPIDER) indicates this member does not have Medicare coverage, delete the Medicare information in MMIS, and set the Premium Indicator on the BENDEX screen to "0"(indicates the member has no Medicare coverage)
- 8) If SOLQ(SPIDER) indicates that the Medicare coverage has ended, look at the Premium History for response code 15 (client no longer meets the Medicare requirements).
- 9) Update MMIS to show the Medicare end dates, set the Premium Indicator on the BENDEX screen to "0"(indicates the member no longer has Medicare coverage)

- 10) If the date of birth in MMIS needs to be corrected Buy-In staff will update the date of birth. However, in some instances MMIS will not permit the date of birth to be updated. This can occur when the assigned Aid Category will not permit the age of the person when the birth date information is updated.
- 11) If Buy-In staff is not able to update the date of birth as result of a mis-match between the AC and the person's age, a letter to the member's DSS caseworker is sent requesting the caseworker to review the Aid Category and the date of birth for the caseworker to determine the updates needed to the Medicaid eligibility.

1

| VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES | | | | | | | | | | REPORT NO.: | RS-0-348 | |
|--|-----------|--------------|-------|----------|---------|------------------|------|--------------------|--------------|---------------------|----------|------------|
| MEDICARE PREMIUM PROCESSING | | | | | | | | | | PAGE NUMBER: | 1 | |
| NON-PREMIUM LIST | | | | | | | | | | | | |
| CODE 2161 ALPHABETIC | | | | | | | | | | | | |
| CLAIM NUMBER | LAST NAME | FIRST M NAME | I SEX | BIRTH DA | MO YEAR | TRANSACTION CODE | DATE | ENROLLEE ID NUMBER | CUR C/C RACE | MESSAGE /ADDRESS | | |
| | | | | 03 01 | 1943 | 2161 | 122 | | | | | |
| | | | | 07 01 | 1972 | 2161 | 122 | | | FAIRFAX | VA | 22031-1024 |
| | | | | 11 21 | 1916 | 2161 | 122 | | | FALLS CHURCH | VA | 22042-6613 |
| | | | | 11 13 | 1946 | 2161 | 122 | | | BUY-IN INFO UPDATED | | |
| | | | | 03 12 | 1945 | 2161 | 122 | | | POWhatan | VA | 23139-4902 |
| | | | | 10 20 | 1943 | 2161 | 122 | | | LEESBURG | VA | 20176-4854 |
| | | | | 10 27 | 1986 | 2161 | 122 | | | BURKE | VA | 22015- |
| | | | | 02 17 | 1946 | 2161 | 122 | | | BURKE | VA | 22015- |
| | | | | 05 01 | 1932 | 2161 | 122 | | | RICHMOND | VA | 23224- |
| | | | | 12 21 | 1955 | 2161 | 122 | | | HIGHLAND SPRINGS | VA | 23075- |
| | | | | 11 11 | 1929 | 2161 | 122 | | | CANCELLED ENROLLEE | | |
| | | | | | | | | | | CHAB CHASE CITY | VA | 23924-3727 |
| | | | | | | | | | | BUY-IN INFO UPDATED | | |
| | | | | | | | | | | AXTON | VA | 24054-1896 |

RS-O-230A (RSM145)

DUAL ELIGIBLE ENROLLMENT ERRORS: DSS

Priority Level 1

Report is available weekly.

Description of Report

This report contains a listing of member's whose Medicare number in MMIS does not match the Medicare number that CMS has on their files. This report is sorted by the City/County code as well as the individual DSS caseworker ID at the local DSS.

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number, provided in MMIS, in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 3) If SOLQ (SPIDER) cannot retrieve the Medicare information, the DSS caseworker identified on the member's demographics in MMIS is contacted by phone to obtain the social security number they have on file for the member.
- 4) Once the caseworker verbally provides the social security number she has on file, the SOLQ is researched again utilizing the number provided by the caseworker.
- 5) Once SOLQ provides the match for the member in question, the correct Medicare information is provided. This information will include the correct Medicare number and the dates for the Medicare coverage.
- 6) MMIS is updated by deleting the incorrect Medicare number in the MMIS.
- 7) The MMIS is updated with the correct social security number.
- 8) The MMIS is updated with the correct Medicare information to include the correct Medicare number and the correct dates for Medicare Part A, Part B and Part D.
- 9) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter the manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

RS-0-377 (RSM140)

MMA TPL NON-UPATE REPORT M- BIC RECORDS

Priority Level 1

Report Available on a weekly basis, but must be completed by the 23rd of each month.

Description of Report

This report contains a listing from CMS of members whose Medicare Part A, Part B and/or Part D eligibility information does not match the information the state of Virginia has for these members. In some instances CMS may report Part A eligibility when the member is not eligible for Part A Buy-In.

Procedures

- 1) Utilizing the Medicaid number on the report, obtain the social security number in MMIS.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS.
- 3) Once SOLQ provides a match for the member in question, we verify and update any demographic information in MMIS which needs to be updated(first name, middle initial, last name, date of birth, sex and social security number).
- 4) If Social Security records show member is eligible for Part A and the person is Medicaid eligible, information in MMIS regarding Medicare Part A is updated.
- 5) The state of Virginia does not pay Part A premiums on non-QMB individuals (AC 18, 20, 38, 40, 58, and 60). If the member is currently in a non-QMB AC and is eligible for Part A, SOLQ is researched to determine if the person is receiving SSI payments (Title XVI payments), we contact the member's DSS caseworker and request re-evaluation of the member's Medicaid eligibility AC assignment as it is possible the AC assigned is incorrect.
- 6) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

RS-O-324 (RSM391)

Medicare Policy Error Report

Priority Level 1

Report available on the 7th of each month and must be completed by the 23rd of each month

Description of Report

The report lists members that have been added to the Buy-In process, but MMIS indicates an end date for Medicare Part B coverage.

Procedures

- 1) MMIS is reviewed to obtain the social security number
- 2) SOLQ (SPIDER) is researched utilizing the social security number to retrieve the Medicare number and Medicare dates.
- 3) The MMIS is research to review the member's Medicaid eligibility and Medicare premium history
- 4) Determine appropriate segments for Medicare coverage to enter into MMIS TPL

RS-O-328 (RSM391)

C101 Report Error Messages

Priority Level 1

Report is available on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members who have an error in Buy-In which could be based upon their Aid Category. Also currently reports errors based upon the member ID/case relationship. The members with Aid Category issues may not be eligible for State Buy-In

Procedures

- 1) Utilizing the Medicaid number on the report, obtain the social security number in MMIS.
- 2) SOLQ (SPIDER) is researched utilizing the social security number provided in MMIS.
- 3) If SOLQ is showing Virginia State Buy-In, verify aid category in MMIS, if it is an aid category (AC 55, AC 003) that is not eligible for State Buy-In, deletion code 51 is sent to CMS to end the Buy-In

RS-O-325 (RSM390)

SSA Claim Number Change Activity

Priority Level 1

Report is processed on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members who claim number CMS has changed in MMIS. The claim numbers have to be changed because either, the incorrect Medicare number was in MMIS or the member's Medicare number has changed.

Procedures

- 1) The members worked on this report are those who have an "M" BIC Medicare number.
- 2) The MMIS is reviewed to obtain the SSA number.
- 3) SOLQ (SPIDER) is researched utilizing the social security number
- 4) MMIS is updated with the correct Medicare number and the correct Medicare dates.
- 5) Under Comments on the Report, if there is a comment of "Duplicate Policy", review MMIS to obtain the SSA number,
- 6) SOLQ(SPIDER) is researched utilizing the social security number to obtain the correct Medicare number and the correct Medicare dates
- 7) Compare the Medicare number from SOLQ to the SMIB (Supplementary Medical Insurance Beneficiary Premium Payment Notice- RS-O-322, RSM389) to see what claim number Buy-In is occurring under.
- 8) If necessary, MMIS is updated with the correct Medicare number and the correct Medicare eligibility dates.

RSM390 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
AS OF: 09/07/2011 MEDICARE PREMIUM PROCESSING
RUN DATE: 09/07/2011 01:10 SSA CLAIM NUMBER CHANGE ACTIVITY

REQUIRE NO: [REDACTED]
PAGE NUMBER: 1

| SSA OLD CLAIM NUMBER | SSA NEW CLAIM NUMBER | ELIG OLD CLAIM NUMBER | SSA FIBOLLET | SSA SIBOLLET | SSA FIRST | H S | SSA TRANS | ELIG BIRTH | COMMENTS |
|----------------------|----------------------|-----------------------|--------------|--------------|------------|------------|------------|------------|-------------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CHANGE NOT NEEDED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CLAIM # CHANGED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | CHANGE NOT NEEDED |

RS-O-310 (RSM386)

Medicare Premium Processing Invalid Data – Part A records dropped

Priority Level 1

Report is available on the 7th of each month and must be completed by the 23rd of each month

Description of Report

This report contains a listing of members who have no valid Medicaid number of the Part A bill.

Procedures

- 1) The MMIS is reviewed to obtain the SSA number.
- 2) SOLQ(SPIDER) is researched utilizing the social security number to obtain the correct Medicare number and the correct Medicare dates
- 3) MMIS is updated with the correct Medicare number and the correct Medicare dates.
- 4) Compare the Medicare number from SOLQ to the HI (Premium Payment Notice (Hospital Insurance Premium Payment Notice (RS-O-314) to see what claim number Buy-In is occurring under.
- 5) If necessary, MMIS is updated with the correct Medicare number and the correct Medicare eligibility dates.

RS-O-355 (RSM395)**Claim Number Mismatch, SSA Active-Eligibility Cancelled****RS-O-357 (RSM395)****Claim Number Mismatch, SSA active – Eligibility Active****RS-O-359 (RSM395)****Claim Number Mismatch, SSA Active – Remaining Eligibility Active****RS-O-361 (RSM395)****Claim Number Mismatch, Remaining Eligibility Cancelled****Priority Level 2**

Report is available on the 7th of each month and must be completed monthly.

Description of Report

These reports contain a listing of members that have different Medicare numbers in MMIS as compared to the Medicare number on the SMIB (Supplementary Medical Insurance Beneficiary Premium Payment Notice, RS-O-322). The reports lists two lines for each client, the first line shows the information on the SMIB, the second line shows the information in MMIS, (TPL).

Procedures

- 1) Utilizing the Medicare numbers from the report, SOLQ is researched on each number to determine the correct Medicare number and Medicare dates.
- 2) Compare the Medicare numbers on SOLQ to the SMIB (Premium Payment Notice, RS-O-322) to ensure Buy-In is occurring under the correct Medicare number.
- 3) If Buy-In billing is occurring on an incorrect number or under both numbers, a letter is sent to CMS for resolve the issue.
- 4) If the incorrect Medicare number is in MMIS, and the correct number is on the SMIB, update MMIS to show correct Medicare information.
- 5) These four different reports have the same resolution, but the clients on the RS-O-355 report indicate that a member's Medicaid eligibility is currently cancelled, and has a transaction code of "11" or "41", which indicates the state is doing Buy-In on the person.
- 6) The members listed on the RS-O-359 are the members who are Medicaid eligible, but the transaction codes are not an "11" or "41".
- 7) The members listed on RS-O-361 are the members who are not currently Medicaid eligible, and have transaction codes that are not an "11" or "41".

RSM395 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: RS-0-357
AS OF:11/05/2011 MEDICARE PREMIUM PROCESSING PAGE NUMBER: 1
RUN DATE: 11/05/2011 07:01 CLAIM NUMBER MISMATCH SSA ACTIVE - ELIGIBILITY ACTIVE

| CLAIM NUMBER | NAME SURNAME FIRST | S I X | BIRTH DATE | AGY E C | PREM AMT | PREM PERIOD | TRANS CODE | ENROLLEE ID NUMBER | APPL DATE | CUR AID C/C | PT B CAT | CAN ELIG | CANCEL RSH DATE |
|--------------|--------------------|-------|------------|---------|----------|-------------|------------|--------------------|-----------|-------------|----------|----------|-----------------|
| SSA ELIG | [REDACTED] | F | 90 L | | 115.40 | | 41 12201 | [REDACTED] | 1112008 | 015 053 | 042008 | 00 | |
| SSA ELIG | [REDACTED] | F | 490 V | | 115.40 | | 41 122011 | [REDACTED] | 10012010 | 075 029 | 092006 | 00 | |
| SSA ELIG | [REDACTED] | F | 490 V | | 115.40 | | 41 122011 | [REDACTED] | 05232011 | 153 029 | 062011 | 07 | |

RSM395 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: RS-0-355
AS OF:11/05/2011 MEDICARE PREMIUM PROCESSING PAGE NUMBER: 1
RUN DATE: 11/05/2011 07:01 CLAIM NUMBER MISMATCH SSA ACTIVE - ELIGIBILITY CANCELLED

| CLAIM NUMBER | NAME SURNAME FIRST | S I X | BIRTH DATE | AGY E C | PREM AMT | PREM PERIOD | TRANS CODE | ENROLLEE ID NUMBER | APPL DATE | CUR AID C/C | PT B CAT | CAN ELIG | CANCEL RSH DATE |
|-----------------------|--------------------|-------|------------|---------|----------|-------------|------------|--------------------|-----------|-------------|----------|----------|-----------------|
| TOTAL ITEMS REPORTED | | | | | | | | | | | | | |
| *** END OF REPORT *** | | | | | | | | | | | | | |

RSM395 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: RS-0-359
AS OF:11/05/2011 MEDICARE PREMIUM PROCESSING PAGE NUMBER: 1
RUN DATE: 11/05/2011 07:01 CLAIM NUMBER MISMATCH SSA ACTIVE REMAINING ELIGIBILITY ACTIVE

| CLAIM NUMBER | NAME SURNAME FIRST | S I X | BIRTH DATE | AGY E C | PREM AMT | PREM PERIOD | TRANS CODE | ENROLLEE ID NUMBER | APPL DATE | CUR AID C/C | PT B CAT | CAN ELIG | CANCEL RSH DATE |
|------------------------|--------------------|-------|------------|---------|----------|-------------|-------------|--------------------|-----------|-------------|----------|----------|-----------------|
| SSA ELIG | [REDACTED] | M F | 190 M | | | | 4999 112009 | [REDACTED] | 07221996 | 097 058 | | 00 | |
| SSA ELIG | [REDACTED] | F | [REDACTED] | | | | 2050 112009 | [REDACTED] | 07221996 | 097 058 | | 00 | |
| SSA ELIG | [REDACTED] | | | | 230.80 | | 4361 082011 | [REDACTED] | 08152011 | 520 051 | 052006 | 00 | |
| TOTAL ITEMS REPORTED 3 | | | | | | | | | | | | | |

RSM395 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: RS-0-361
AS OF:11/05/2011 MEDICARE PREMIUM PROCESSING PAGE NUMBER: 1
RUN DATE: 11/05/2011 07:01 CLAIM NUMBER MISMATCH REMAINING ELIGIBILITY CANCELLED

| CLAIM NUMBER | NAME SURNAME FIRST | S I X | BIRTH DATE | AGY E C | PREM AMT | PREM PERIOD | TRANS CODE | ENROLLEE ID NUMBER | APPL DATE | CUR AID C/C | PT B CAT | CAN ELIG | CANCEL RSH DATE |
|------------------------|--------------------|-------|------------|---------|----------|-------------|-------------|--------------------|-----------|-------------|----------|-------------|-----------------|
| SSA ELIG | [REDACTED] | | 490 A | | | | 2051 092011 | [REDACTED] | 09041986 | 590 011 | 121992 | 03 09302011 | |
| TOTAL ITEMS REPORTED 1 | | | | | | | | | | | | | |

RS-O-425 (RSM420)

BENDEX TPL UPDATE REPORT

Priority Level 2

Report is available on the 6th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members whose Medicare information has been put in the system by BENDEX (from SSA)

Procedures

- 1) Utilizing the Medicaid number on the report, obtain the social security number in MMIS
- 2) SOLQ (SPIDER) is researched utilizing the social security number provided in MMIS in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 3) Once SOLQ provides a match for the member in question the correct Medicare information will be obtained.
- 4) We verify or update Medicare information (Medicare number and Medicare dates of coverage) in MMIS
- 5) On the cases that the Medicare eligibility is not future dates and there has been a match of all Medicare information, determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter the manual accretion in MMIS. (Directions for entering a manual accretion are provided further in his manual).

| ENROLLEE ID | ENROLLEE NAME | CLAIM NUMBER | TPL | MI BGN DATE | MI END DATE | SHI BGN DATE | SHI END DATE |
|-------------|---------------|--------------|-----|-------------|-------------|--------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] | A | 04/2011 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 04/2011 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 08/2010 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 11/2011 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 11/2011 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 11/2011 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 03/2012 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 03/2012 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 02/2009 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 09/2011 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 06/2010 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 07/2011 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 03/2012 | 00/0000 | / | / |
| [REDACTED] | [REDACTED] | [REDACTED] | B | / | / | 03/2012 | 00/0000 |
| [REDACTED] | [REDACTED] | [REDACTED] | A | 10/2009 | 00/0000 | / | / |

CP-O-053 (CPR305R1)

Weekly Aged Pend List by ICN

Priority Level 2

Report available weekly and must be completed by the 23rd of each month.

Description of Report

This report lists members who have medical claims currently pending for edit 282, which means pend for review of Medicare coverage. The medical provider who provided the service to the member has billed the Virginia Medicaid program for the coinsurance and/or deductible amount remaining after they have billed the service to Medicare. However, the MMIS has no record of the Medicare coverage for the time period billed on the medical claim. It is received from the staff at DMAS that resolve pended claims. They put the information in an excel spreadsheet for Buy-In staff to review.

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS to determine the Medicare number and Medicare dates.
- 3) MMIS will be updated as needed with the correct Medicare number and Medicare dates.
- 4) If SOLQ indicates the member does not have Medicare, the copy of the medical claim submitted by the provider is reviewed to analyze any attachments included with the billing invoice.
- 5) Determine if the provider billed the Virginia Medicaid Program utilizing the incorrect billing form.(client has other insurance but no Medicare) or
- 6) Determine if the provider is billing for another client using the incorrect Medicaid ID number
- 7) Determine if medical claim has been keyed correctly in the MMIS, to include the date of service. In some instances, a member may be eligible for the actual date of service but the bill submitted was incorrect.
- 8) Findings from the review conducted by the Buy-In staff is entered in the Excel spreadsheet provided by the pended claims staff, with the resolution for each member added to the spreadsheet.
- 9) Upon completion of the report, the excel spreadsheet is forwarded to the staff in the pended claims section at DMAS.

CPR305 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REP: [REDACTED]

AS OF: 12/09/2011 RUN DATE: 12/03/2011 06:02 WEEKLY AGED PEND LIST BY ICH PAGE NUMBER: 65

CLAIM TYPE: TITLE-18 UNIT: 219 - CONTRACT MONITOR

| ICH NUMBER | ENROLLEE ID | ENROLLEE NAME | PROVIDER NUMBER | PROVIDER NAME | FROM DATE | CHARGES | CLM MOD | ERROR CHT | ERR ST | STATUS DATE |
|------------|-------------|---------------|-----------------|---------------|------------|---------|---------|-----------|--------|-------------|
| [REDACTED] | [REDACTED] | [REDACTED] | 1952320061 | INOVA HEAL | 11/05/2010 | 141.85 | 1 | 0001 | 202 4 | 12/01/2011 |
| [REDACTED] | [REDACTED] | [REDACTED] | 1497935365 | COMMONWEAL | 08/20/2011 | 13.61 | 1 | 0001 | 202 4 | 12/01/2011 |
| [REDACTED] | [REDACTED] | [REDACTED] | 1497935365 | COMMONWEAL | 08/21/2011 | 13.61 | 1 | 0001 | 202 4 | 12/01/2011 |
| [REDACTED] | [REDACTED] | [REDACTED] | 1497935365 | COMMONWEAL | 08/22/2011 | 7.53 | 1 | 0001 | 202 4 | 12/01/2011 |
| [REDACTED] | [REDACTED] | [REDACTED] | 1497935365 | COMMONWEAL | 08/23/2011 | 13.55 | 1 | 0001 | 202 4 | 12/01/2011 |

CLAIM TYPE: TITLE-18 TOTAL CLAIMS PENDING: 5 TOTAL CHARGES: 190.15

RS-O-332 (RSM140)

MMA PRO RECORD RESPONSE FILE, MEDICARE PART A/B DISCREPENCY DATES

Priority Level 2

Report available on a weekly basis and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members with Medicare Part A/B dates on file with CMS

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 3) Once SOLQ provides a match for the member in question, the correct Medicare information will be obtained.
- 4) MMIS will be updated as needed with the correct Medicare Part A/B eligibility dates.
- 5) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

| ENROLLEE ID | LAST NAME | FIRST NAME | M | BIRTH | SEX | POLICY/SSN | MA PART A/ MCIS PART A | MA PART B/ MCIS PART B | DISCREPANCY TYPE |
|-------------|------------|------------|------------|------------|------------|------------|---------------------------|---------------------------|---------------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 12/01/2006 | 05/01/2011 | MULTIPLE CMS |
| | | | | | | | 08/31/2011 | 08/31/2011 | |
| | | | | | | | | 12/01/2006 | |
| | | | | | | | | 08/31/2010 | |
| | | | | | | | 12/01/2006 | 12/01/2006 | |
| | | | | | | | 08/31/2011 | 08/31/2010 | |
| | | | | | | | | 05/01/2011 | |
| | | | | | | | | 08/31/2011 | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 01/01/2005 | 02/01/2008 | MULTIPLE CMS |
| | | | | | | | 07/31/2010 | 07/31/2010 | |
| | | | | | | | | 10/01/2007 | |
| | | | | | | | | 12/31/2007 | |

RS-O-424(RSM140)

MMA TPL Update Report

Priority Level 2

Report is available on the 6th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a list of Medicaid members in which Medicare coverage has been entered in MMIS. The data on this report indicates the Medicare coverage is received from CMS.

Procedures

- 1) View each member's Medicaid record in MMIS to be sure the information in MMIS is correct. MMIS is update as needed with the correct information.
- 2) Rail Road Medicare pseudo claim number that was entered into the system has to be changed to the correct Rail Road Medicare number
- 3) If member's Medicaid case has been cancelled with reason 23(Automatic system generated cancellation for QMB, SLMB, QDWI, & QI1s, the Medicaid eligibility may need to be re-opened.
- 4) Buy-In staff contact the DSS caseworker as needed in order for the caseworker to update the Medicaid eligibility information.
- 5) Determine if a manual transaction to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

RSO140 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: RS-O-424
AS OF: 11/29/2011 MMA TPL UPDATE REPORT PAGE NUMBER: 1
RUN DATE: 11/29/2011 20:48

| ENROLLEE ID | ENROLLEE NAME | CLAIM NUMBER | SSN | DOB | TPL | BEGIN DATE | END DATE |
|-------------|---------------|--------------|------------|------------|-----|------------|----------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | A | 01/2012 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | B | 01/2012 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | RD | 01/2012 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | A | 12/2005 | 08/2009 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | RD | 01/2006 | 08/2009 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | A | 10/2006 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | B | 01/2007 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | RD | 10/2006 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | A | 05/2006 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | B | 05/2006 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | RD | 05/2006 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | A | 10/2011 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | B | 10/2011 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | RD | 10/2011 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | A | 10/1992 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | B | 10/1992 | 12/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | RD | 01/2006 | 12/9999 |

RS-O-318 (RSM386)

Member record with no 41 Group Payer Update

Priority Level 2

Report is available on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members that have had closed periods of Buy-In but do not have ongoing Buy-In, members that have ongoing Buy-In but the Medicare number has changed, members that have died and Buy-In may be ongoing and cases we are paying the premiums but social security records do not reflect that the state of Virginia is doing Buy-In for the member.

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number, provided in MMIS.
- 3) Once SOLQ provides a match for the member in question, we verify and update any demographic information needing updating in MMIS,(first name, middle initial, last name, date of birth, sex and social security number)
- 4) We verify, update or add Medicare information (Medicare number and Medicare dates of coverage) in MMIS
- 5) Review the HI Premium Payment Notice (RS-O-314), also referred to as “the bill” to make sure Buy-In is under the correct Medicare number, if Buy-In is under a different Medicare number on the HI Premium Payment Notice report, research, utilizing SOLQ, the Medicare number on the HI Premium Payment Notice.
- 6) MMIS is updated by changing the incorrect Medicare number in MMIS with the correct Medicare number.
- 7) Railroad members cannot be verified through SOLQ, the HI Premium Payment Notice is the easiest way to verify railroad members' Buy-In. If the HI Premium Payment Notice shows no Buy-In, the Rail Road Retirement Board will need to be contacted by phone to verify all demographic information and Medicare information.
- 8) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).
- 9) If SOLQ shows the member has died and the Medicaid case is still open, notify the Medicaid Enrollment Unit at DMAS to follow-up on the case for potential closure due to death of the member.

- 10) If SOLQ does not show that the state of Virginia is paying the Part B premiums but our records (the MMIS) and the SMIB Premium Payment Notice indicate the state of Virginia is paying the Part B premium, we need to notify Social Security Administration in writing about the discrepancy. A social security administration form (1610) is completed by the Buy-In staff member and sent to the member's local social security office. Additional information about completing the SSA form 1610 is provided further in this manual.

| VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES | | | | | | | | | |
|--|------------|------------|------------|------------|-----|----------------|--------------------|--|--|
| MEDICARE PREMIUM PROCESSING | | | | | | | | | |
| ENROLLEE RECORDS WITH NO 41 GROUP PAYER UPDATE | | | | | | | | | |
| PAGE NUMBER: 1 | | | | | | | | | |
| CLAIM NUMBER | SURNAME | NAME FIRST | SEX | BIRTH DATE | AGE | EFFECTIVE DATE | ENROLLEE ID NUMBER | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 549 | 10/2011 | [REDACTED] | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 549 | 10/2011 | [REDACTED] | | |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 549 | 10/2011 | [REDACTED] | | |

RS-O-363 (RSM395)

Multiple Records for member by HIC number

Priority Level 2

Report is available on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members with transaction codes 16 (death), 1728 (out of state) and 15 (Medicare has ended)

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS.
- 3) Transaction Code 16 – Verify death and date of death from SOLQ.
- 4) If MMIS is not showing the Medicaid case closed due to death, the member's DSS caseworker is contacted by phone to provide the information regarding a reported death of the member. The DSS case worker will perform the follow-up to verify the date of death and determine if the Medicaid eligibility case should be closed, and if so, the date of closure.
- 5) If the caseworker verifies the client is alive, we send an erroneous death deletion letter to CMS and determine if a manual transaction to begin the Buy-In process needs to occur. If yes, enter the manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).
- 6) Transaction Code 1728 - if the social security records in SOLQ have an out of state address for the member, the DSS case worker is contacted by phone for them to verify residency. If the DSS case worker verifies the member has moved to another state, the DSS caseworker is responsible for ending the Medicaid eligibility. If the member still is residing in the state of Virginia, the DSS caseworker notifies the member that they need to contact SSA in order for the SSA record to reflect Virginia residency. Buy-In staff will follow-up with another state if contact as needed to ensure both states' issues on the member have been resolved.
- 7) Transaction Code 15 – if the social security records in SOLQ have documented that Medicare has ended, the MMIS TPL information for Medicare is updated.

BSM395
 AS OF: 11/05/2011
 RUN DATE: 11/05/2011 07:01

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 MEDICARE PREMIUM PROCESSING
 MULTIPLE RECORDS FOR ENROLLEE BY HIC NUMBER
 RECORDS LISTED IN ASCENDING ORDER OF PRIORITY WITHIN ENROLLEE NUMBER

HEADQUARTERS NO. DC 6-262
 PAGE NUMBER: 1

| CLAIM NUMBER | SURNAME | NAME FIRST | S I X | BIRTH DATE | AGY E C | PREM AMT | PREM PERIOD | TRANS CODE | TRANS DATE | ENROLLEE ID NUMBER |
|--------------|---------|------------|-------|------------|---------|----------|-------------|------------|------------|--------------------|
| | | | | | 490 P | 1495.30 | | 1161 | 122010 | |
| | | | | | 490 V | 110.50 | | 4375 | 112010 | |
| | | | | | 490 L | 461.60 | | 1161 | 092011 | |
| | | | | | 490 L | | | 2575 | 092011 | |

RS-O-365 (RSM395)

Records listed "M" BIC ascending order of priority within HIC number

Priority Level 2

Report is available on the 6th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members with transaction codes 16 (death), 1728 (out of state) and 15 (Medicare has ended) for "M" BIC beneficiaries

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS.
- 3) Transaction Code 16 – Verify death and date of death from SOLQ.
- 4) If MMIS is not showing the Medicaid case closed due to death, the member's DSS caseworker is contacted by phone to provide the information regarding a reported death of the member. The DSS case worker will perform the follow-up to verify the date of death and determine if the Medicaid eligibility case should be closed, and if so, the date of closure.

If the caseworker verifies the client is alive, we send an erroneous death deletion letter to CMS and determine if a manual transaction to begin the Buy-In process needs to occur. If yes, enter the manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

- 5) 4. Transaction Code 1728 - if the social security records in SOLQ have an out of state address for the member, the DSS case worker is contacted by phone for them to verify residency. If the DSS case worker verifies the member has moved to another state, the DSS caseworker is responsible for ending the Medicaid eligibility. If the member still is residing in the state of Virginia, the DSS caseworker notifies the member that they need to contact SSA in order for the SSA record to reflect Virginia residency. Buy-In staff will follow-up with another state if contact as needed to ensure both states' issues on the member have been resolved.
- 6) 5. Transaction Code 15 – if the social security records in SOLQ have documented that Medicare has ended, the MMIS TPL information for Medicare is updated.

RSM395
 AS OF: 11/05/2011
 RUN DATE: 11/05/2011 07:01

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 MEDICARE PREMIUM PROCESSING
 MULTIPLE RECORDS FOR ENROLLEE WITH 'M' BIC
 RECORDS LISTED 'M' BIC ASCENDING ORDER OF PRIORITY WITH IN HIC NUMBER

REPORT NO: [REDACTED]
 RS-0-365
 PAGE NUMBER: 1

| CLAIM NUMBER | NAME SURNAME | NAME FIRST | S I X | BIRTH DATE | AGY E C | PREM AMT | PREM PERIOD | TRANS CODE | TRANS DATE | ENROLLEE ID NUMBER |
|--------------|--------------|------------|------------|------------|---------|----------|-------------|------------|------------|--------------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | 346.20 | | 1125 | 102011 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | 42.70 | | 4361 | 121907 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | 115.40 | | 41 | 122011 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | | | 2561 | 062011 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | 3096.40 | | 1161 | 092009 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | 402.00 | | 4361 | 042009 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | 115.40 | | 41 | 122011 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 A | | | 2561 | 082011 | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 490 V | 115.40 | | 41 | 122011 | [REDACTED] |

Managed Care Organization TPL/COB Reports

Priority Level 2

Report is available monthly around the 15th and must be completed by the 16th of the following month so Managed care assignment will end if TPL does actually exist.

Description of Report

This is a file found on the K drive/TPL/COB folder. Within this folder is a file for each MCO that has a contract with Medicaid to provide coverage for the Medicaid members. The MCOs will report information regarding TPL coverage they may discover on our Medicaid members, including potential Medicare coverage.

Procedure

- 1) The K drive on the computer is reviewed, searching for folder "TPL/COB".
- 2) Within this folder are individual folders from each MCO that participates in the Medicaid Managed Care Program.
- 3) There is a folder for each MCO, which is further delineated by a folder for each month/ year.
- 4) Buy-In staff reviews each MCO/month/year folder for current month. The folders each contain an excel spreadsheet.
- 5) Staff opens the excel spreadsheet to determine if the Sheet titled "Medicare COB" list any members with potential Medicare coverage.
- 6) If any Medicaid members are listed, the MMIS is reviewed to obtain the Social Security Number.
- 7) The SOLQ(SPIDER) is researched utilizing the Social Security number, provided in MMIS.
- 8) Once SOLQ provides a match for the member in question, we verify and update any demographic information needing updating in MMIS,(first name, middle initial, last name, date of birth, sex and social security number). Medicare information is updated in MMIS as appropriate.
- 9) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes,, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

RS-O-338 (RSM395)

Medicare Premium Processing – Part B Processing Error Report for Aid Category 080

Priority Level 2

Report is available on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

This report lists clients in AC 80 (Family Planning Waiver). These members are not eligible for Medicare Buy-In and they should not have a Buy-In transaction. This report would list any of these clients who did have a Buy-In transaction on file.

Procedure

- 1) The MMIS is reviewed to obtain the Medicaid eligibility information to determine if the member is in Aid Category 80.
- 2) The MMIS is reviewed to determine if Medicare information is on file and to review the Premium History information to determine if Buy-In requests were sent for the member in error.
- 3) The Premium Payment Reports (“the bill) (reports RS-O-314 and RS-O-323) may also be researched to determine if the member is on the Buy-In.
- 4) If Buy-In has occurred on the member and the member is in AC 80, a deletion to end the Buy-In needs to be submitted.
- 5) Staff will determine if any funds have been spent incorrectly for Buy-In and seek recovery as needed.

| ENROLLEE ID NUMBER | LAST | FIRST | M AID CAT | RACE | SEX | BIRTHDATE | CLAIM NUMBER |
|--------------------|------------|------------|-----------|------|------------|------------|--------------|
| [REDACTED] | [REDACTED] | [REDACTED] | 000 | 1 | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | 000 | 1 | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | 000 | 1 | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | 000 | 1 | [REDACTED] | [REDACTED] | [REDACTED] |

RS-O-331 (RMS140)

MMA PRO RECORD RESPONSE FILE, MEDICARE PART D DISCREPANCY DATES

Priority Level 3

Report available on a weekly basis and must be completed by the 23rd of the month.

Description of Report

This report contains a listing of members with Part D eligible dates that CMS has on file

Procedures

- 6) The MMIS is reviewed to obtain the Social Security number.
- 7) SOLQ (SPIDER) is researched utilizing the Social Security number, provided in MMIS, in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 8) Once SOLQ provides a match for the member in question, the correct Medicare information will be obtained.
- 9) MMIS will be updated to show correct Part D eligibility dates, based on the Medicare eligibility dates.

| ENROLLEE ID | LAST NAME | FIRST NAME | M | BIRTH | SEX | POLICY/SSN | MMA PART D/ MMIS PART D |
|-------------|------------|------------|------------|------------|------------|------------|--|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 01/01/2006 12/31/9999 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 01/01/2006 07/31/2011 01/01/2006 07/31/2011 |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 02/01/2007 12/31/9999 |

RS-O-333 (RSM333)

Active Part D eligibility – invalid data

Priority Level 3

Report available on a weekly basis and must be completed by the 23rd of the month.

Description of Report

This report contains a listing of members with invalid Part D dates

Procedures

- 6) The MMIS is reviewed to obtain the Social Security number.
- 7) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 8) Once SOLQ provides a match for the member in question, the correct Medicare information will be obtained.
- 9) MMIS will be updated with the correct Part D eligibility dates, based on the Medicare eligibility dates.

| EMPLOYEE ID | LAST NAME | FIRST NAME | M | BIRTH | SEX | POLICY/SSN | PART A REG DT/END DT | PART B REG DT/END DT | PART D REG DT/END DT |
|-------------|-----------|------------|---|-------|-----|------------|-------------------------|-------------------------|-------------------------|
| | | | | | | | 11/01/2000 | | |
| | | | | | | | 04/30/2006 | | |
| | | | | | | | 12/01/2011 | | |
| | | | | | | | 12/31/9999 | | |

RS-O-385 (RSM355)

Medicare Premium Processing Listing of Add/Cancel Members

Priority Level 3

Report is available on the 24th of each month and must be completed by the 23rd of the following month.

Description of Report

Lists of Part A add/cancel transactions sent and dropped on the file to CMS, including record counts.

Procedures

- 1) The MMIS is reviewed to obtain the Social Security number.
- 2) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 3) Once SOLQ provides a match for the member in question, the correct Medicare information will be obtained.
- 4) MMIS will be updated as needed with the correct Medicare Part A/B eligibility dates.
- 5) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

| CLAIM NUMBER | NAME | BIRTH DATE | NON PAY | TRANS CODE | SMID DATE | SEX | ENROLLEE ID | COMMENTS |
|--------------|------------|------------|------------|------------|-----------|--------|-------------|--|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 99 | 201111 | M | [REDACTED] DUPLICATE CLAIM & RECIP - DROPPED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 61 | 201109 | M | [REDACTED] DUPLICATE CLAIM & RECIP - DROPPED |

RS-O-376 (RSM140)

MEDICARE PART D DISCREPANCY DATES ON M-BIC RECORDS

Priority Level 3

Report available on a weekly basis and must be completed by the 23rd of the month.

Description of Report

This report contains a listing of members with Medicare numbers with M-BIC that Part D eligibility needs to be verified.

Procedures

- 6) Utilizing the Medicaid number on the report, obtain the social security number in MMIS.
- 7) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS in order to determine the Medicare number, Medicare eligibility and Medicare dates.
- 8) Once SOLQ provides a match for the member in question, the correct Medicare information will be obtained.
- 9) MMIS will be updated to with the correct Part D eligibility dates, based on the Medicare eligibility dates.

| ENROLLEE ID | LAST NAME | FIRST NAME | M | BIRTH | SEX | POLICY/SSN | MBA PART D/ | MMIS PART D |
|-------------|-----------|------------|---|-------|-----|------------|-------------|-------------|
| | | | | | | | 01/01/2006 | 12/31/9999 |
| | | | | | | | 01/01/2006 | 02/28/2011 |
| | | | | | | | 01/01/2006 | 02/28/2011 |
| | | | | | | | 12/01/2011 | 12/31/9999 |

RS-O-320 (RSM390)

Medicare Premium Processing Invalid Data Encountered

Priority Level 3

Report is available on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

Reports occurrence of invalid data encountered in editing the SSA tape, indicates whether the SSA record is allowed continued processing or permanently dropped. Includes total record counts and amounts by transaction codes.

Procedures

- 1) Report is reviewed based upon the list of transaction codes.
- 2) The MMIS is reviewed to obtain the Social Security number.
- 3) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 4) Once SOLQ provides a match for the member in question, the correct Medicare information will be obtained.
- 5) MMIS will be updated as needed with the correct Medicare Part A/B eligibility dates.
- 6) Determine if a manual accretion to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

| CLAIM NO | LAST NAME | FIRST NAME | M | SEX | BIRTH DT | NEW CLM NO | AGY | EC | BILL DT | TRAN CODE | TRAN DATE | ENRL ID | RID | SEQ |
|----------|-----------|------------|---|-----|----------|------------|-----|----|---------|-----------|--|---------|-----|-------|
| 490 D | | | | | 102011 | | | | 4214 | 05012011 | | | | 823 |
| | | | | | | | | | | FLD: 13 | ERROR ENCOUNTERED: DUP CLAIM/DIFF RECIP ID | | | |
| 490 D | | | | | 102011 | | | | 41 | 10012011 | | | | 890 |
| | | | | | | | | | | FLD: 13 | ERROR ENCOUNTERED: DUP CLAIM/DIFF RECIP ID | | | |
| 490 E | | | | | 102011 | | | | 1161 | 07012011 | | | | 988 |
| | | | | | | | | | | FLD: 13 | ERROR ENCOUNTERED: DUP CLAIM/DIFF RECIP ID | | | |
| 490 D | | | | | 000000 | | | | 86 | 03012011 | | | | 1,109 |
| | | | | | | | | | | FLD: | ERROR ENCOUNTERED: EXACT DUPLICATE OF PREV | | | |

RS-O-465 (RSM460)

EDB FILE

Priority Level 3

Report is available on the 7th of each month and must be processed on the 23rd of the month.

Description of Report

This report contains a listing of Medicaid members that have been given an incorrect Medicare number or have been assigned Medicare erroneously.

Procedures

- 1) Utilizing the Medicaid number on the report, obtain the social security number in MMIS
- 2) SOLQ (SPIDER) is researched utilizing the social security number provided in MMIS in order to determine Medicare number, Medicare eligibility and Medicare dates.
- 3) Once SOLQ provides a match for the member in question the correct Medicare information will be obtained.
- 4) If the SOLQ social security number for the member does not match to the social security number in MMIS, the member's DSS caseworker is contacted by phone to obtain the social security number they have on file.
- 5) Once the DSS caseworker verbally provides the social security number she has on file, the SOLQ is searched again utilizing the social security number provided by the case worker in order to obtain accurate Medicare information for the member.
- 6) We verify, delete, or update Medicare information (Medicare number and Medicare dates of coverage) in MMIS.
- 7) Determine if a manual transaction to begin the Buy-In process needs to occur. If yes, enter a manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

| MEDICAID ID | HIC # | PART-A BEGIN/END DATE | PART-B BEGIN/END DATE | LAST NAME | FIRST | MI | SSN |
|-------------|------------|-----------------------|-----------------------|------------|------------|------------|------------|
| [REDACTED] | [REDACTED] | 10/01/2003 01/31/2010 | 10/01/2003 01/31/2010 | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | 06/01/1994 12/31/2004 | 06/01/1994 02/29/2004 | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | 06/01/2008 06/30/2011 | 06/01/2008 06/30/2011 | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

RS-O-341 (RSM373)

Part B-Personal Characteristics Change Report

Priority Level 3

Report Available

Report is processed on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

This report contains a listing of members the state is being billed for Part B premiums but demographics (first name, middle initial, last name, DOB, social security number and/or sex) in the MMIS do not match CMS records. Although some demographic information is a mis-match between MMIS and CMS there is currently sufficient information that matched between the two systems to permit the Buy-In process to occur. This report is analyzed to determine if information in MMIS needs to be updated.

Procedures

- 8) The MMIS is reviewed to obtain the Social Security number.
- 9) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS.
- 10) Once SOLQ provides a match for the member in question, the correct demographic information will be obtained.
- 11) MMIS is updated as needed based upon information in SOLQ.

| MEDICAID ID | SSN | LAST NAME | FIRST | MI | SEX | DOB | DISCREPANCY | CHS DATA |
|-------------|------------|------------|------------|------------|------------|------------|-------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |

RS-O-339 (RSM373)

PART A – PERSONAL CHARACTERISTICS CHANGE REPORT

Priority Level 3

Report is available on the 7th of each month and must be processed on the 23rd of the month.

Description of Report

This report contains a listing of members the state is being billed for Part A premiums but demographics (first name, middle initial, last name, DOB, social security number and/or sex) in the MMIS do not match CMS records. Although some demographic information is a mis-match between MMIS and CMS there is currently sufficient information that matched between the two systems to permit the Buy-In process to occur. This report is analyzed to determine if information in MMIS needs to be updated.

Procedures

- 12) The MMIS is reviewed to obtain the Social Security number.
- 13) SOLQ (SPIDER) is researched utilizing the Social Security number, provided in MMIS.
- 14) Once SOLQ provides a match for the member in question, the correct demographic information will be obtained.
- 15) MMIS will be updated as needed to ensure the correct demographic information is in MMIS.

| MEDICAID ID | SSH | LAST NAME | FIRST | MI | SEX | DOB | DISCREPANCY |
|-------------|-----|-----------|-------|----|-----|-----|-------------|
| | | | | | | | |

RS-O-312 (RSM386)

Medicare Premium Processing Part A Group Payer Not Found

Priority Level 3

Report is available on the 7th of each month and must be completed by the 23rd of each month.

Description of Report

Report shows members who have Buy-In for Part A but not showing in Premium History.

Procedures

- 16) Report is reviewed to determine the members that outstanding from the previous month.
- 17) Staff will obtain the transaction code indicated on the report to determine the potential source of the error.
- 18) The MMIS is reviewed to obtain the Social Security number.
- 19) SOLQ (SPIDER) is researched utilizing the Social Security number provided in MMIS.
- 20) Once SOLQ provides a match for the member in question, the correct demographic information will be obtained.
- 21) MMIS is updated as needed based upon information in SOLQ.

| ENROLLEE ID | LAST NAME | FIRST NAME | MI | SSA CLAIM NO |
|--|------------|------------|------------|--------------|
| ██████████ | ██████████ | ██████████ | ██████████ | ██████████ |
| \$ ENROLS NOT FOUND : 450.00 # ENROLS NOT FOUND: 1 | | | | |
| *** END OF REPORT *** | | | | |

Report No. RS-O-312
PAGE NUMBER: 1

RS-O-349 (RSM395)

Medicare Premium Processing Non-Premium List Code 29 current City/County Code 001

Priority Level 3

Report is available on the 7th of each month and must be processed on the 23rd of the month.

Description of Report

This report contains a listing of members who have died. This report is sorted by the City-County code.

Procedures

- 1) Utilizing the Medicaid number on the report, obtain the social security number in MMIS.
- 2) SOLQ (SPIDER) is researched utilizing the social security number provided in MMIS.
- 3) Verify death and date of death from SOLQ.
- 4) If MMIS is not showing the Medicaid case closed due to death, the member's DSS caseworker is contacted by phone to provide the information regarding a reported death of the member. The DSS case worker will perform the follow-up to verify the date of death and determine if the Medicaid eligibility case should be closed, and if so, the date of closure.
- 5) If the caseworker verifies the client is alive, we send an erroneous death deletion letter to CMS and determine if a manual transaction to begin the Buy-In process needs to occur. If yes, enter the manual accretion in the MMIS. (Directions for entering a manual accretion are provided further in this manual).

The screenshot shows a report header with the following text: "RSM395", "AS OF: 11/05/2011", "RUN DATE: 11/05/2011 07:01", "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES", "MEDICARE PREMIUM PROCESSING", "NON-PREMIUM LIST", "CODE 29 CURRENT CITY/COUNTY CODE 035", "REPORT NO. RS-O-349", and "PAGE NUMBER: 1". Below the header is a table with columns: CLAIM NUMBER, LAST NAME, FIRST NAME, SEX, DA, MO, YEAR, TRANSACTION CODE, DATE, ENROLLEE ID NUMBER, CUR C/C RACE, and MESSAGE /ADDRESS. Two rows of data are visible, with some fields redacted by blue bars. The first row shows a transaction code of 2961, date 102011, and a message "ACTIVE ENROLLEE BUY-IN INFO UPDATED". The second row shows a transaction code of 2961, date 112011, and a message "TRINITY MISSION HEALTH AND REHAB".

| CLAIM NUMBER | LAST NAME | FIRST NAME | SEX | DA | MO | YEAR | TRANSACTION CODE | DATE | ENROLLEE ID NUMBER | CUR C/C RACE | MESSAGE /ADDRESS |
|--------------|------------|------------|------------|------------|------------|------------|------------------|--------|--------------------|--------------|--|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 2961 | 102011 | [REDACTED] | 035 1 | ACTIVE ENROLLEE BUY-IN INFO UPDATED |
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] | 2961 | 112011 | [REDACTED] | 035 1 | GALAX VA 24333-2592 TRINITY MISSION HEALTH AND REHAB HILLSVILLE VA 24343-1633 |

CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY ACCOUNTING STATEMENT- BILLING NOTICE

Priority Level 1

Notice is available on a monthly basis and must be processed by the 23rd of the month.

Description of Notice

The State Part A and B Medicare premium liability is calculated by CMS once a month at the conclusion of the Buy-In processing. CMS prepares a separate Summary Accounting Statement for each State's Part A and Part B premium liability. The Buy-In unit's responsibility is to ascertain that the premium liabilities for the billing month on the Part A and Part B billing notices are correct.

Procedures

The Fiscal and Accounting Division at the Department of Medical Assistance Services receives the Parts A & B Medicare Summary Accounting Statements from CMS (around the 15th day of the month). This division provides a copy of the billing summary to the Buy-In unit staff to review.

Part A Summary Accounting Statement:

- 6) Upon receipt of the CMS billing statement, Buy-In staff retrieve the following Buy-In reports:
 - a. RS-O-311 (RSM386)- Invalid Data-Part A Records Dropped Summary. This report shows a summary of the transaction codes and the number of invalid data for each transaction code.
 - b. RS-O-314 (RSM385) - HI Premium Payment Notice Summary. This is the billing notice summary, which shows the debit, credit, the money associated with the transaction codes and the totals for the billing month. This data is calculated from the information received from CMS.
 - c. RS-O-316 (RSM386)- Accepted Part A Group Payer Summary – Shows all the transaction codes with valid data, the counts and the amounts associated with each code.

- 7) Staff compares the RS-O-314 report with the Lab listing for agency code S49 (Virginia) that is attached to the billing notice from CMS. The LAB listing originates from CMS. The data on both the RS-O-314 and the Lab listing should be identical.

8) If there is a discrepancy, Buy-In staff ascertains whether it is the DMAS' data or the CMS' data that is not correct. If the CMS' data is not correct, Buy-In staff contacts CMS to discuss the potential error. Currently our contact at CMS regarding the bill is Lucia Diaz-Robinson at 410-786-0598. If the issue is a DMAS' error, the supervisor of the Buy-In unit would need to research the matter further.

9) To verify the data on the Lab Listing (or RS-O-314) to determine whether there is a discrepancy or not, perform the following:

Compare total count to code specific # items under DEBIT utilizing the RS-O-311 report. For example:

On the RS-O-311 review the total count for transaction code 41.

On the RS-O-316 review the count for transaction code 41.

Add the amounts from these two reports for this transaction code.

The total should equal the total count listed on the Lab report issued by CMS for transaction code 41

10) This procedure is repeated for each transaction code under the DEBIT amounts.

11) Compare total dollar amounts by codes to total dollar amount under DEBIT information on the Lab report. For example:

On the RS-O-311 review the total dollar amount for transaction code 41.

On the RS-00316 review the total dollar amount for transaction code 41.

Add the amounts from these two reports for this transaction code.

The total should equal the total dollar amount for this transaction code on the Lab report issued by CMS.

12) This procedure is repeated for each transaction code under the DEBIT dollar amounts.

13) To verify the data on the Lab Listing (or RS-O-314) to determine whether there is a discrepancy or not, perform the following:

Compare total count to code specific # items under CREDIT utilizing the RS-O-311 report. For example:

On the RS-O-311 review the total count for transaction code 41.

On the RS-O-316 review the count for transaction code 41.

Add the amounts from these two reports for this transaction code.

The total should equal the total count listed on the Lab report issued by CMS for transaction code 41

- 14) To verify the data on the Lab Listing (or RS-O-314) to determine whether there is a discrepancy or not, perform the following:

Compare total dollar amount to code specific # items under CREDIT utilizing the RS-O-311 report. For example:

On the RS-O-311 review the total dollar amount for transaction code 41.

On the RS-O-316 review the total dollar amount for transaction code 41.

Add the amounts from these two reports for this transaction code.

The total should equal the total amount as CREDIT listed on the Lab report issued by CMS for transaction code 41.

- 15) On the Lab Listing, now deduct the credit dollar amount from the debit dollar amount money total. This final calculation should equal the dollar amount listed as item #3, Current Month's Liability on the Summary Account Statement from CMS.

- 16) After determining that the current month's liability is correct, an Accounts Payable Invoice Payment Request form needs to be completed.

- 17) The top portion of the form remains the same each month and has already been completed on the form. Buy-In staff signs the form, which certifies that they agree with that month's liability.

- 18) A cover memo is prepared by Buy-In staff to the Budget Division. The memo indicates also indicates the Buy-In staff has certified the current month's liability amount. Included with the memo the Budget Division is the original CMS Summary Account Statement Billing Notice, the original Lab Listing (showing the deduction of the credit amount from the debit amount) and the original Accounts Payable Invoice Payment Request form.

Part B Summary Accounting Statement:

- 19) Upon receipt of the CMS billing statement, Buy-In staff retrieve the following Buy-In reports:
- a. **RS-O-321** (RSM390) – Invalid Data Encountered Summary – This report shows all of the transaction codes, counts and amounts associated with the data received from CMS.
 - b. **RS-O-323**(RSM389) – SMIB Premium Payment Notice Summary. This is the billing notice summary, which shows the debit, credit, the money associated with the transaction codes and the totals for the billing month.
- 20) Staff compares the RS-O-323 report with the Lab listing for agency code 490 (Virginia) that is attached to the billing notice from CMS. The Lab listing originates from CMS. The data on both the RS-O-323 and the Lab listing should be identical.
- 21) If there is a discrepancy, the same procedures followed under the Part A Summary Accounting Statement are followed, however, RS-O-323 and RS-O-321 reports are used to compare to the Lab report submitted by CMS.
- 22) To verify the data on the Lab listing(or RS-O-323) perform the following:
- Compare total count to code specific # under DEBIT
- Example: on RS-O-321, get total count of transaction code 41
- Compare this count to the transaction code 41 listed under the DEBIT portion of the Lab Listing.
- They should be identical.
- Do the same procedure for each transaction code under the DEBIT.
- 23) Compare total dollar amounts by codes to total dollar amounts under DEBIT.
- Example: on RS-O-321, get total dollar amount for
- Code 41.
- Compare to the money amount under the DEBIT portion of the Lab Listing
- They should be identical.
- Do the same procedure for each code under the DEBIT.
- 24) Compare the total count to specific # of items under CREDIT.
- Compare the total amount by codes to money under CREDIT.

Follow the same procedures as stated above.

- 25) On the Lab Listing, now deduct the total credit dollar amount from the total debit dollar amount. This final calculation should equal the dollar amount listed as item #3, Current Month's Liability on the Summary Account Statement from CMS.

After determining that the current month's liability is correct, an Accounts Payable Invoice Payment Request form needs to be completed.

- 26) The top portion of the form remains the same each month and has already been completed on the form. Buy-In staff signs the form, which certifies that they agree with that month's liability.

- 27) 9. A cover memo is prepared by Buy-In staff to the Budget Division. The memo indicates also indicates the Buy-In staff has certified the current month's liability amount. Included with the memo the Budget Division is the original CMS Summary Account Statement Billing Notice, the original Lab Listing (showing the deduction of the credit amount from the debit amount) and the original Accounts Payable Invoice Payment Request form.

MANUAL TRANSACTIONS

A manual transaction may be required when the Medicare information has been added or changed. The following are the directions for doing a manual transaction in the MMIS.

Directions for entering a manual transaction:

- 1) Enter Main System Menu
- 2) Go to Member Sub-system Menu
- 3) select Medicare
- 4) enter member ID # or Medicare #
- 5) Selection, arrow down to Medicare Buy-In Transactions
- 6) Use Function, add

Manual transaction codes which the state can use:

61 Accretion

75 Closed period of Buy-In coverage

99 Change of state data on SSA files

50/51 Deletion – ineligible

53 Deletion – death

Use appropriate **Transaction code**

Agency Code: 490 for Part B

S49 for Part A

Enter **Effective Date** of Buy-In eligibility

Verify all information on the screen, **Enter** and **Update**

For closed periods of coverage, 75 Transaction code, you enter the **Effective Date** of Buy-In eligibility and you will enter the end date of Buy-In eligibility in the **Code 75 End Date**

Omni Track

The Call Center at the Department of Medical Assistance Services utilizes an electronic call tracking system. The tracking system is referred to as “Omni Track ” and permits the agency to document information about the calls received. When callers contact the call center they may have issues related to Medicare. The staff in the call center can assign the call to the Buy-In unit to handle. These are usually calls into the call center from physicians, hospitals or members. The physician or hospital calls are usually verifying Medicare information; calls from the member are Buy-In or Part D issues. A user guide is available and is located at J:\PROGOPS\EEU\Omni Track-CS.

Procedures for Omnitrack Tickets Received

- 7) Review the Omnitrack ticket to determine what the issue is that the caller needed to have resolved.
- 8) Retrieve information from social security through SVES or SPIDER
- 9) Retrieve eligibility information from the MMIS as needed to match social security records with information in the MMIS (Medicare demographics, and Buy-In)
- 10) Determine the member’s issue.
- 11) Contact the member as needed to resolve the issue
- 12) Buy-In staff does not contact the medical providers directly. Buy-In staff will update the MMIS TPL information as appropriate and notify the call center when the update has occurred so the call center can call the provider about potential re-billing or if Medicare eligibility was not found.
- 13) If the issue is a Part D issue, verify Medicaid and Medicare information, advise them to call the 1-800-Medicare number to let them know that because they are Medicaid eligible they do qualify for “extra help” and they are eligible for a free Part D plan.
- 14) On occasion, the Buy-In staff is not able to resolve the Part D issue; the issue may need to be sent to the Policy Division at DMAS who has a policy analyst who can assist further with Part D issues, or they may need to call their Part D plan.
- 15) The final step in resolving the Omnitrack ticket is for staff to document in the electronic ticket how ticket resolved and to close the ticket out. In some instances

the Omnitrack ticket has been incorrectly assigned by the call center to the Buy-In staff and needs to be re-assigned back to call center to re-assigned elsewhere.

- 16) If needed, information in MMIS is updated, to include resetting the BENDEX accordingly.

REFUND OF MEDICARE PREMIUMS TO BENEFICIARIES (1610'S)

These are cases that the state is paying the Medicare premiums and social security administration has no record of the state paying the premium. Usually the state Buy-In unit is informed of the situations from DSS caseworkers or members when they contact the Buy-In unit directly. The member is still having the Medicare premium being withheld from their social security check so they have contacted either their DSS caseworker or the Buy-In unit directly.

Procedures:

- 17) Retrieve social security information through SVES or SPIDER.
- 18) Retrieve MMIS information regarding the premium history which will show the Buy-In transaction for the member.
- 19) Match all information with social security records (Medicare and demographics).
- 20) If SVES or SPIDER is showing we are not paying the Medicare premiums but the VAMMS and the bill from CMS bill demonstrates that we are paying the Medicare premium, social security administration needs to be notified.
- 21) Refund of Medicare Premiums to Beneficiaries Request form (Form "1610") must be completed by the Buy-In staff
- 22) The "1610" form is sent to the member's local social security office. Included with the "1610" we attach a copy of the Medicare premium bill received from CMS which demonstrates we are paying the premium.
- 23) Social Security Administration has to contact their payment center to get their records corrected and refund member if applicable. (remember "M" and "T" BICs are not reimbursed, they receive bills).
- 24) This process can take up to 90 days to resolve so Buy-In staff monitors SOLQ to determine when the SSA records have been updated with the information that the state is paying the person's Medicare premium.

Appeals

The Buy-In unit is responsible for representing DMAS when an appeal is requested by the member concerning the loss of his/her Medicare premium payment. When a member in aid categories 053 or 056 is cancelled by the local Department of Social Services, a letter is mailed to the member from DMAS. This letter informs the member that he/she no longer meets the requirement for Medicaid coverage of his/her premium payment. The letter shows the date that Buy-In will stop and informs that member that he/she can appeal this decision.

- 1) The Buy-In unit is notified by the Appeals Section when a member has appealed.
- 2) If the member appeals within 30 days of the date on the DMAS letter, the member's Medicaid coverage can be reinstated. Buy-In will continue for this member until the hearing officer makes a decision on the case or the member's Medicaid coverage is reinstated because he/she meets the Medicaid requirements for coverage.
- 3) Contact the member's worker at the local Department of Social Services.
- 4) Ask the worker why the member was cancelled and what the member has to do to be reinstated as an eligible Medicaid member.
- 5) If the member's case has been reinstated, ask the worker if the case was reopened due to the appeal or was the member reinstated because he/she is now Medicaid eligible.
- 6) With the information gathered from the worker, write a letter to the member. The letter can contain information as to how the member's coverage can be reinstated, or informing the member that he/she is Medicaid eligible because he/she meets the Medicaid requirements.
- 7) Mail the letter to the member and send an original copy to the administrative assistant handling the case.
- 8) If the case is not resolved, a Buy-In appeal hearing will be scheduled and an appeal summary has to be written and mailed to the member ten days before the date of the hearing.
- 9) Attend the appeal hearing and explain to the member why the Buy-In stopped and what can be done by the member to become Medicaid eligible.
- 10) The hearing officer will mail the member, within a certain time frame, his/her decision concerning the outcome of the hearing.

Appeal Regulation

Emergency Regulation effective January 1, 2014:

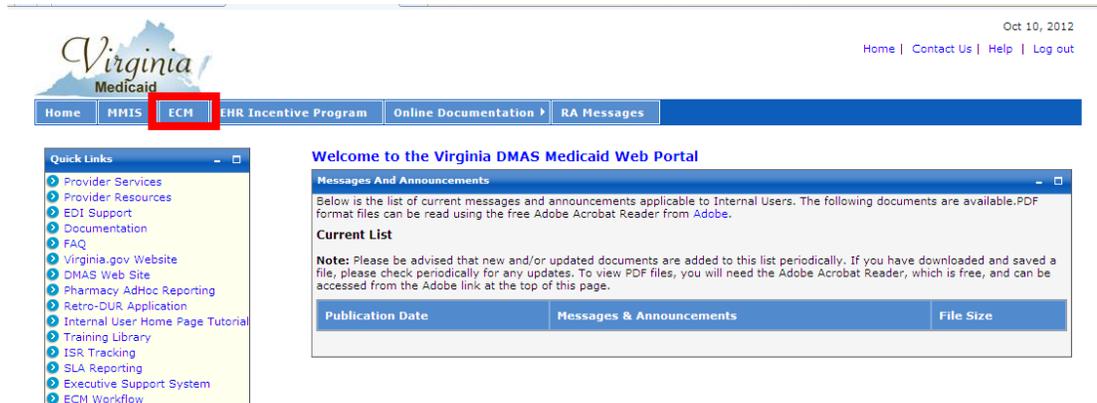
12VAC30-20-520(I) Documents that are filed with the DMAS Appeals Division or the hearing officer after 5:00 pm eastern standard time on the due date shall be untimely.

Those responsible for filing a case summary or filing other documentation with the Appeals Division for a current provider appeal must have those documents to the Appeals Division and date stamped no later than 5:00 PM on the date they are due. Any documents received after 5:00 PM will be date stamped as received on the next business day.

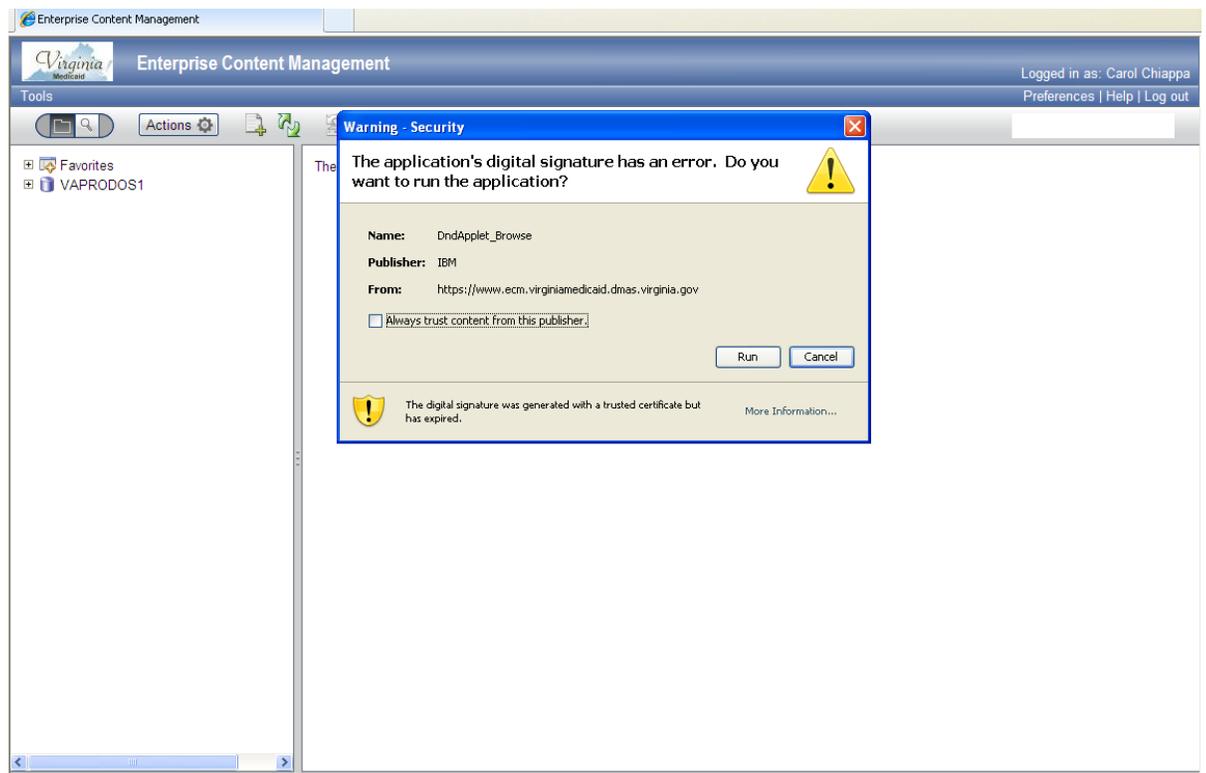
4.3 Procedures - ECM

To view/print reports copy and paste the same ink used to access MMIS and follow steps 1-4 as displayed below.

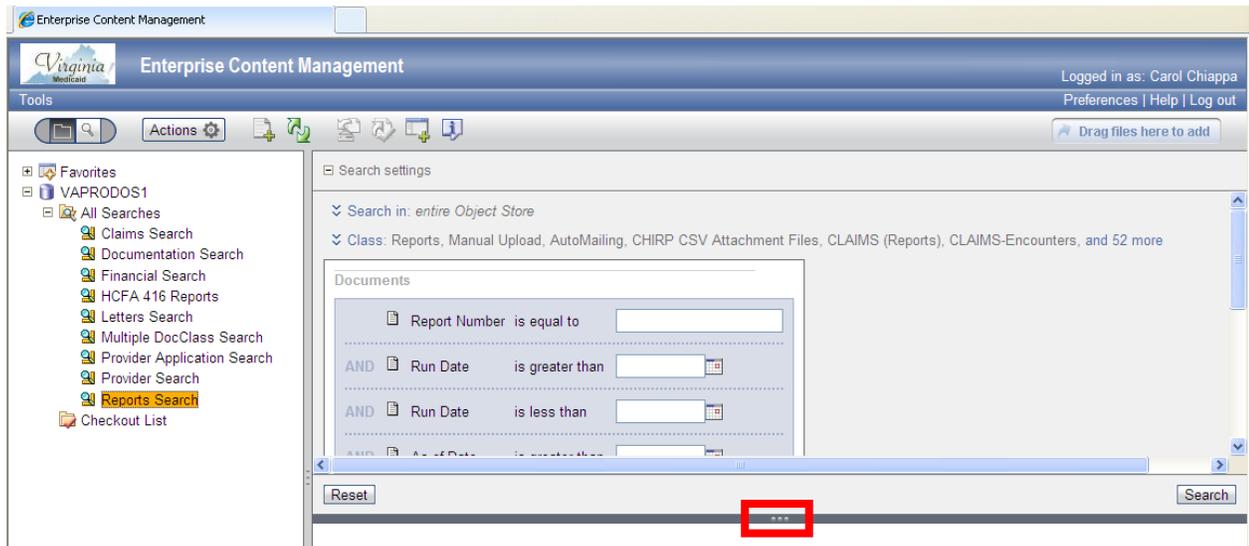
- 1) When the MMIS welcome screen displays click on ECM button.



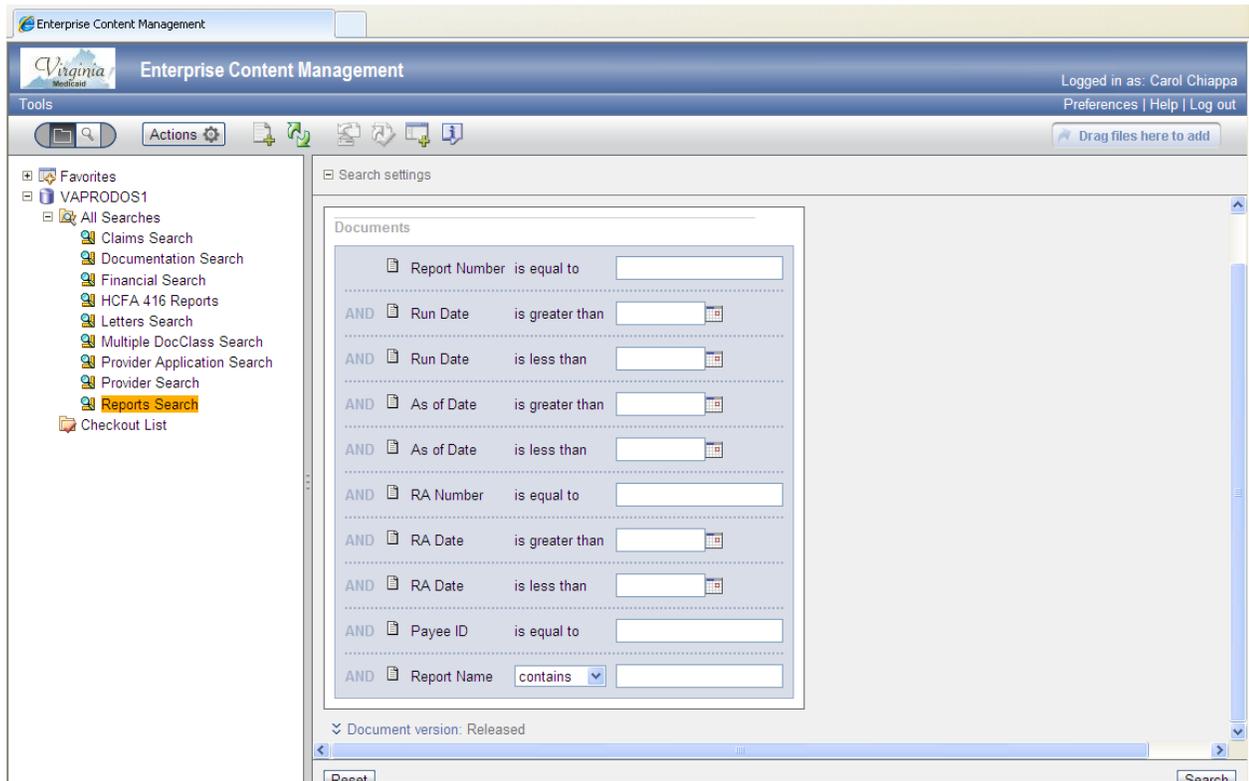
- 2) When the ECM screen displays there will also be a 'Warning-Security' pop-up window that asks a questions that must be answered before access is given to view ECM screens. Click on 'Run' button



- Next, when ECM screen appears click on 'VAPRODOS1' and then click on 'All Searches' then click on 'Reports Search' and the following screen will display.

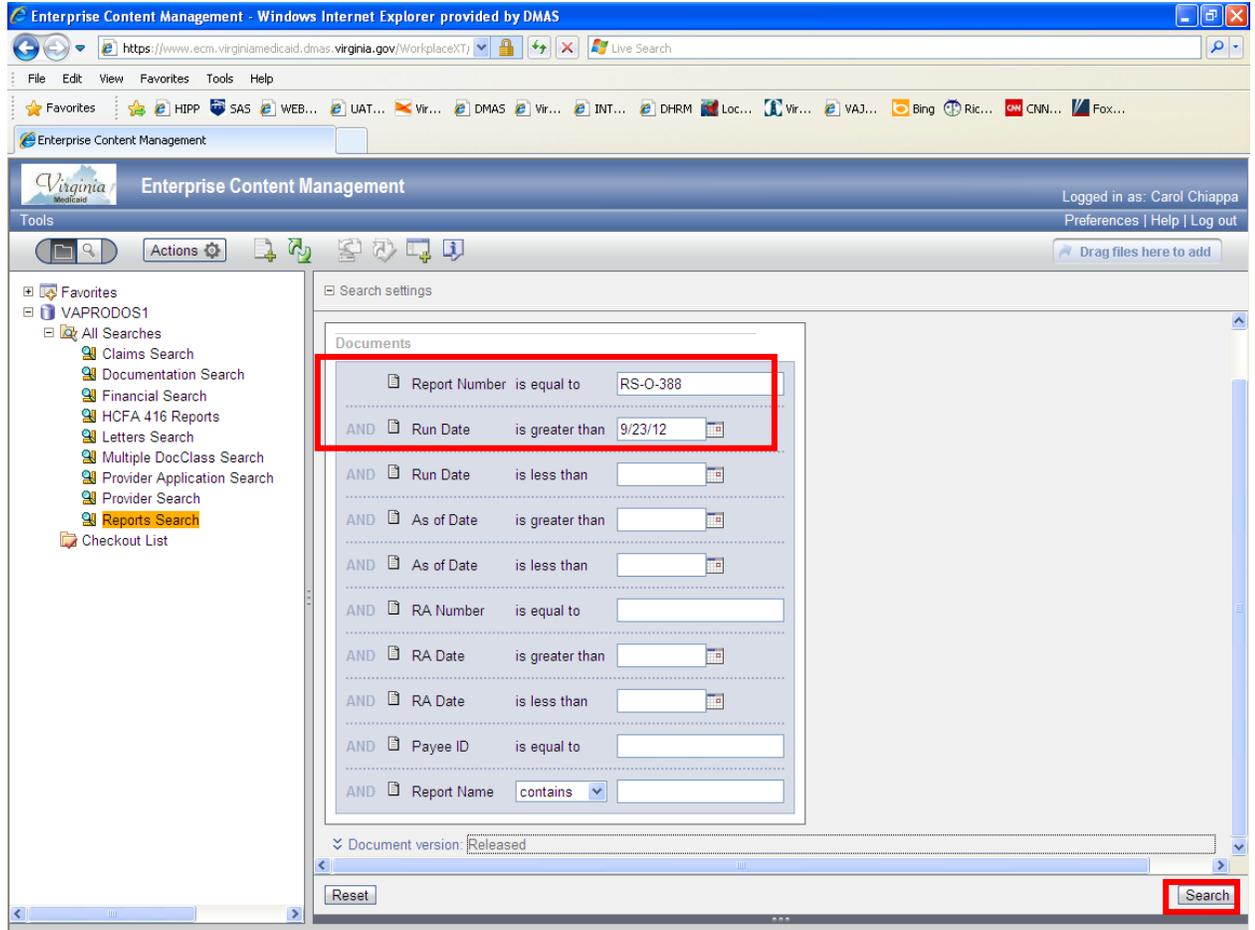


- The upper right hand corner indicates that you are now logged into ECM Next, move cursor over the 3 dots at the bottom of the page and drag downward till the full screen is viewable as displayed below.

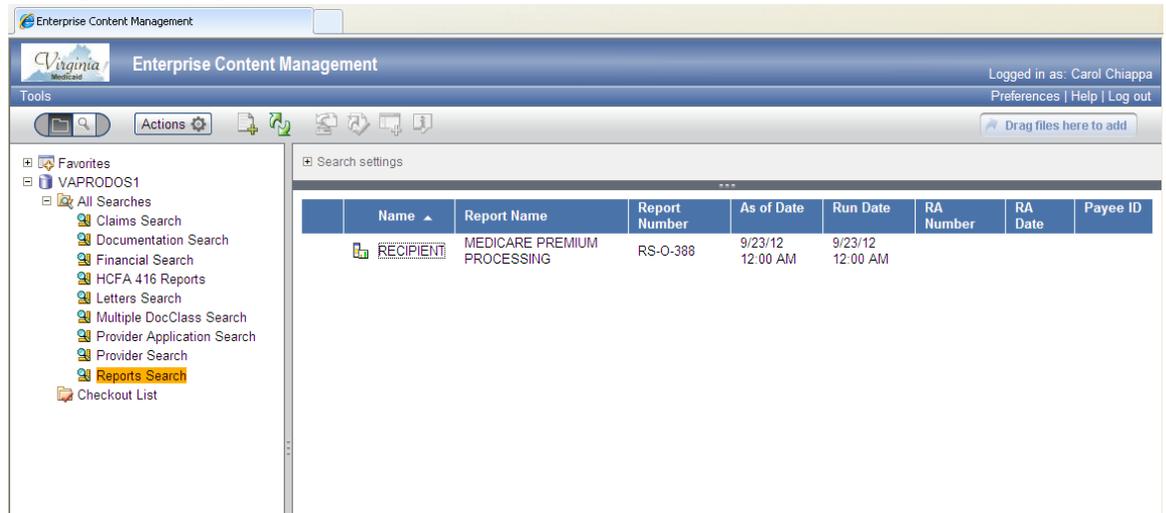


To search for a report:

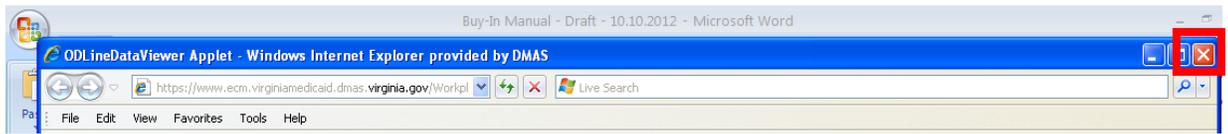
- 1) Enter the report number into the first field labeled 'Report Number' and then enter the day prior to the desired report runs in the field labeled 'Run Date is greater than' as displayed below click on the 'Search' button.



- 2) The report will display on the next screen. .



To Close the report: Click on the red 'X' located at the top of the screen on the far right as displayed below.



To Logout of ECM:

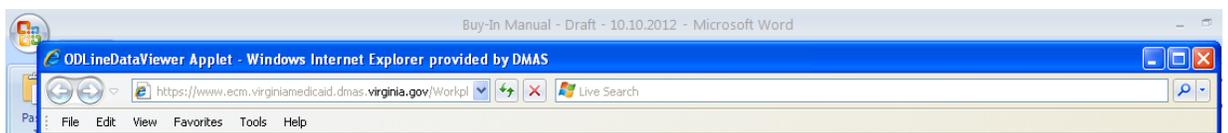
1) Click on the words 'Log Out' located at the top far right of the screen as displayed below.



2) The next screen will display to log-in to go back into ECM.



3) To clear the Log In screen, click on the red 'X' located at the top of the screen on the far right as displayed below.

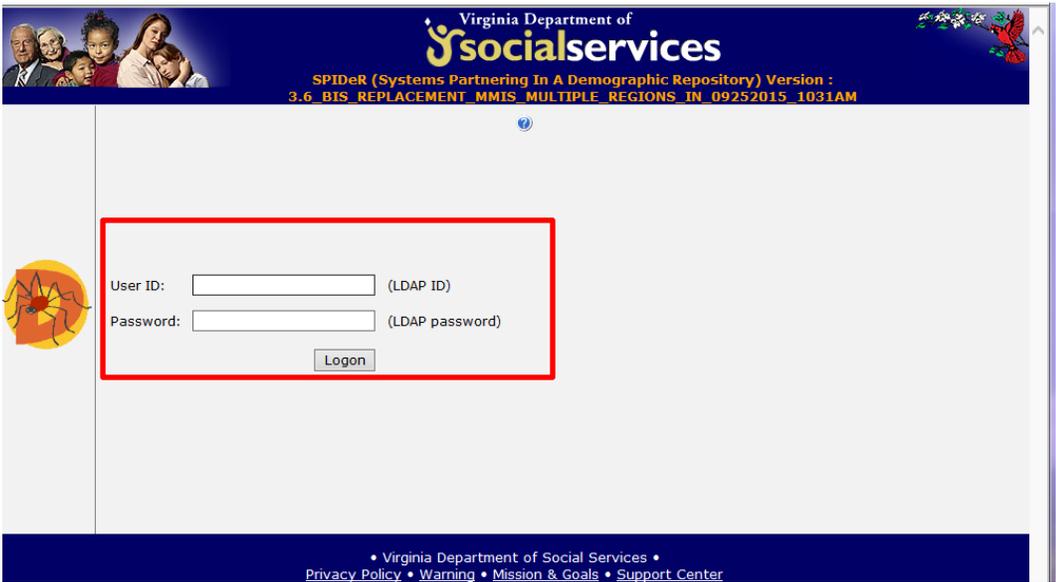


4.4 Procedures – SOLQ

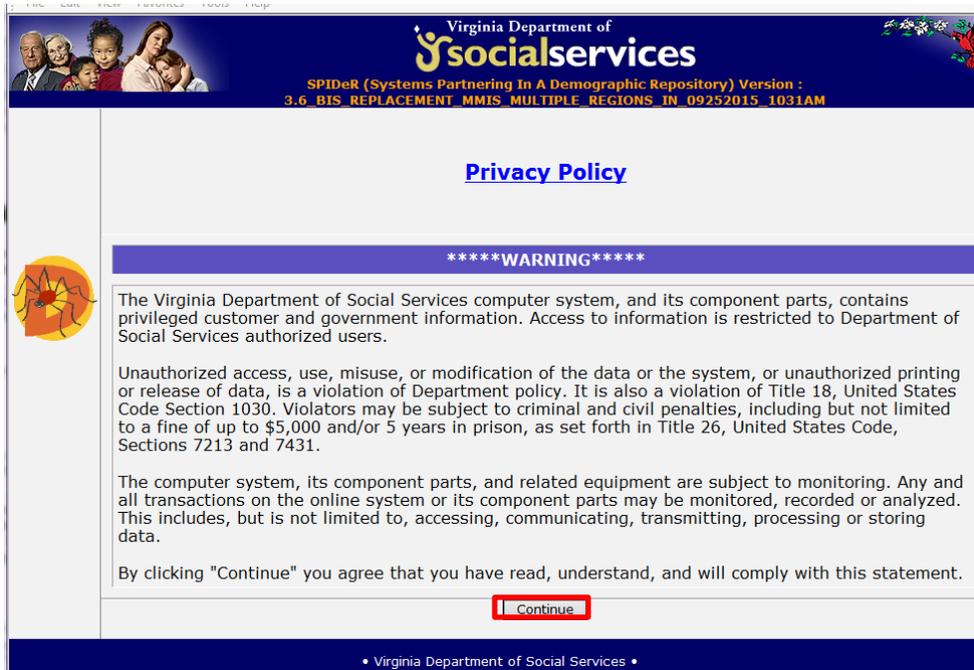
DMAS uses DSS's system (SPIDeR) to view SOLQ

To Log-on:

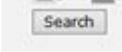
- 1) Enter User ID and Password and click on 'Logon' button as displayed below.

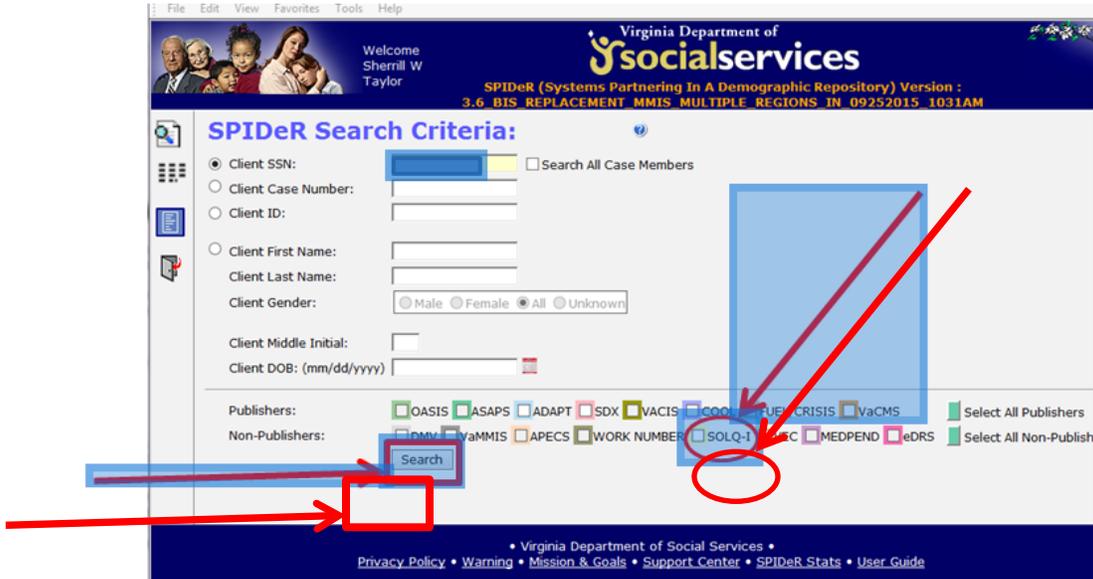


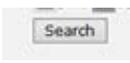
- 2) Click on the continue button



- 3)

- 4) Next, select option Client SSN to enter the member's social security number and check the  box and then click on the  button as displayed below.



- 5) Next, click on the  button again and the 'Search Selection:' screen will be displayed as below.



- 6) Next click on the  button again and the SPIDeR Search Results screen will be displayed.

- 7) Next, click on the first blue cell labeled 'Client ID/ Customer ID' to display the SPIDeR Detailed Results as displayed below.
- 8) Next, to access Title II Information click the highlighted 'Yes' as displayed above.

9) Next, the SOLQ-I Title II Detail Results will be displayed as shown below:

The results displayed from first section of the screen : full name, date of birth, gender, social security number, Medicare claim number, Medicare effective dates Buy-In enrollment, current payment status, date of initial entitlement, social security check amount, refunds that Social Security sends to the member.

To view the remaining section of the page scroll down for social security payments.

SPIDeR - Windows Internet Explorer provided by DMAS

SPIDeR Detailed Results

SOLQ-I Title II Detail Results

Worker Input Information

| State Code | SSN | CAN | BIC | First Name | Middle Initial | Last Name | Date of Birth |
|------------|-----|-----|-----|------------|----------------|-----------|---------------|
| 049 | | | | | | | |

SSA Information

| First Name | Middle Initial | Last Name | Date of Birth | Gender | Proof of Age | Person's Own SSN |
|------------|----------------|-----------|---------------|------------|---------------------|------------------|
| | | | | (F) Female | (B) Birth/Baptismal | |

| CAN / BIC | State/County Code | Address | Date of Death | Disability Onset Date |
|-----------|-------------------|---------|---------------|-----------------------|
| | 49 / 320 | | | 10/21/2012 |

| LAF (Ledger Account File) Code | Date of Initial Entitlement | Date of Current Entitlement | Date of Suspension or Termination | Net Monthly Benefit Payable (MBP) |
|--|-----------------------------|-----------------------------|-----------------------------------|-----------------------------------|
| (C) Current payment status (except railroad payment) | 04/2013 | 04/2013 | | \$ 1,532.00 |

| Direct Deposit Indicator | Deferred Payment Date | Schedule Payment Indicator | Schedule Payment Date | Schedule Current Payment | Schedule Prior Payment | Schedule Combined Check Indicator |
|--------------------------|-----------------------|---|-----------------------|--------------------------|------------------------|-----------------------------------|
| (C) Checking | | (R) Current month accrual paid by monthly merge | 11/2015 | \$ 1,532.00 | \$ 104.90 | (N) Combined check not issued. |

| | Part B (SMI - Supplemental Medical Insurance) | Part A (HI - Health Insurance) |
|-------------------|---|---|
| Indicator | (Y) YES | (Y) YES |
| Option Code | (Y) Yes (has Part B coverage) | (E) Yes (automatic; no premium necessary) |
| Start Date | 04/2015 | 04/2015 |
| Stop Date | | |
| Premium | \$ 104.90 | \$ 0.00 |
| Buy-In Indicator | Y | (N) NO |
| Buy-In Code | (490) Virginia | |
| Buy-In Start Date | 11/2015 | |

| Welfare Agency Code | Category of Assistance Code |
|---------------------|-----------------------------|
| 490 | (D) Disabled |

| Black Lung Entitlement Code | Black Lung Payment Amount | Railroad Retirement Indicator |
|-----------------------------|---------------------------|-------------------------------|
| | \$ 0.00 | |

| Dual Entitlement Number | Dual Entitlement BIC | Dual Entitlement Type | Dual Entitlement Status Code | Other Date of Entitlement |
|-------------------------|----------------------|-----------------------|------------------------------|---------------------------|
| | | | (I) Default value | |

| Cross Reference Code | Cross Reference Entitlement Number | Cross Reference BIC |
|----------------------|------------------------------------|---------------------|
| | | |

| MBC Type | MBC Date | MBC Amount |
|-------------------|----------|-------------|
| (C) Benefits paid | 12/2015 | \$ 1,532.00 |
| (C) Benefits paid | 10/2015 | \$ 1,532.00 |
| (C) Benefits paid | 03/2015 | \$ 1,531.90 |
| (C) Benefits paid | 12/2014 | \$ 1,532.00 |
| (C) Benefits paid | 01/2014 | \$ 1,506.00 |
| (C) Benefits paid | 12/2013 | \$ 1,505.00 |
| (C) Benefits paid | 04/2013 | \$ 1,483.00 |

close

Title II information is not available for this member as displayed below.


 Welcome
 Sherrill W
 Taylor

SPIDeR (Systems Partnering In A Demographic Repository) Version :
3.6 BIS REPLACEMENT MMIS MULTIPLE REGIONS IN 09252015 1031AM

SPIDeR Detailed Results

SOLQ-I Detail Results

Worker Input Information

| State Code | SSN | CAN | BIC | First Name | Middle Initial | Last Name | Date of Birth |
|------------|-----|-----|-----|------------|----------------|-----------|---------------|
| 049 | | | | | | | |

SSA Information

| Error Condition Code | Identity Discrepancy Code (Title II) | Identity Discrepancy Code (Title XVI) | SSN Verification Code | SSN Verification Data |
|----------------------|--------------------------------------|---------------------------------------|-----------------------|-----------------------|
| Input data is valid | () Match | () Match | (V) SSN is verified | |

| | |
|-----------------------|-----|
| Title II Information | NO |
| Title XVI Information | YES |

• Virginia Department of Social Services •
[Privacy Policy](#) • [Warning](#) • [Mission & Goals](#) • [Support Center](#) • [SPIDeR Stats](#) • [User Guide](#)

To view the Title XVI Information click on the 'yes' as displayed above and the SOLQ-I Title XVI Detail Results will display as shown below. There are 3 sections to this screen so scrolling down will provide the full results of the members information.

Section #1 of 3 screens:

| SOLQ-I Title XVI Detail Results | | | | | | | |
|---|---------------------------|--------------------------|--|-----------------------------------|---|-----------|---------------|
| Worker Input Information | | | | | | | |
| State Code | SSN | CAN | BIC | First Name | Middle Initial | Last Name | Date of Birth |
| 049 | | | | | | | |
| Supplemental Security Income Information | | | | | | | |
| First Name | Middle Initial | Last Name | Date of Birth | Gender | Race Code | | |
| | | | | (M) Male | (B) Black | | |
| Other Name | Person's Own SSN | SSN Correction Indicator | Date Of Death | Date of Death Source Code | | | |
| | | | | | | | |
| Payee Name and Address | | | | State / County Code | | | |
| | | | | 49 / 641 | | | |
| Residence Address | | | | Phone Number | | | |
| | | | | | | | |
| SSI Application Date | Record Establishment Date | Date of Eligibility | Onset Date of Disability Blindness (alleged) | Disability Payment Code | Medicaid Test Indicator | | |
| 02/05/2009 | 03/05/2009 | 02/2009 | 02/05/2009 | (F) Final determination allowance | (I) Tests for status for title XIX not applicable | | |
| Denial Code | Denial Date | Appeal Code | Date of Appeal | Appeal Decision Code | Appeal Decision Date | | |
| | | | | | | | |

Section #2 of 3 screens:

| | | | | | | |
|-------------------------------------|--------------------------------------|---|--|-----------------------------------|---------------------------|--------------------------------|
| Denial Code | Denial Date | Appeal Code | Date of Appeal | Appeal Decision Code | Appeal Decision Date | |
| | | | | | | |
| Type of Recipient | Head of Household Indicator | | Marital Status | Student | | |
| (DI) Disabled individual | (N) Not head of household | | | (N) Not a student | | |
| SSN's Used by Individual | Alien Indicator Code | Alien Date of Residency | Country of Origin | | | |
| | | | | | | |
| Representative Payee Indicator | Type of Payee Code | Representative Payee Selection Date | Federal Eligibility Code | Optional State Eligibility Code | | |
| (Y) There is a representative payee | (MTH) Natural or adoptive mother | 11/20/2009 | (E) Eligible | (N) Not eligible | | |
| Current Payment Date | Current SSI Gross Payable Amount | Current State Gross Payable Amount | Current Payment Status Code | Current Pay Status Effective Date | | |
| 12/01/2015 | \$ 733.00 | \$ 0.00 | (C01) Current Pay | 01/2009 | | |
| Earned Income Net Countable Amount | Unearned Income Net Countable Amount | Deemed Income Amount | Budget Month Flag | Payment Status Code | | |
| \$ 0.00 | \$ 0.00 | \$ 0.00 | (2) Payment based on factors 2 months before computation month | (C01) Current Pay | | |
| Advance Payment Indicator | Advance Payment Date | Advance Payment Amount | Over Payment/Under Payment Indicator | | | |
| | | \$ 0.00 | | | | |
| Unearned Income Type Code | Unearned Income Verification Code | Unearned Income Start Date | Unearned Income Stop Date | Unearned Income Amount | Unearned Income Frequency | Claim or Identification Number |
| | | | | | | |
| Earned Income Wage Amount | Earned Income Net Self Employment | Earned Income Exclusion Plan for Self Support | Blind Work Expense Exclusion (BWE) | Direct Deposit Indicator | | |
| \$ 0.00 | \$ 0.00 | \$ 0.00 | \$ 0.00 | (C) Checking | | |

Section 3 of 3 Screens:

| Earned Income Wage Amount | Earned Income Net Self Employment | Earned Income Exclusion Plan for Self Support | Blind Work Expense Exclusion (BWE) | Direct Deposit Indicator |
|---------------------------|-----------------------------------|---|------------------------------------|--------------------------|
| \$ 0.00 | \$ 0.00 | \$ 0.00 | \$ 0.00 | (C) Checking |

| Payment History Payment Date | Payment History SSI Monthly Assistance Amount | Payment History State Supplement Amount | Payment History Payment Pay Flag 1 | Payment History Payment Pay Flag 2 |
|------------------------------|---|---|---|---|
| 01/01/2015 | \$ 733.00 | | (1) Recurring payment dated the first of the month | (N) Force payment not involved or total of type 4 OTP check |
| 01/01/2014 | \$ 721.00 | | (1) Recurring payment dated the first of the month | (N) Force payment not involved or total of type 4 OTP check |
| 02/01/2013 | \$ 710.00 | | (1) Recurring payment dated the first of the month | (N) Force payment not involved or total of type 4 OTP check |
| 01/01/2013 | | | (0) No payment made | (N) Force payment not involved or total of type 4 OTP check |
| 01/01/2013 | \$ 710.00 | | (3) Supplemental payment dated the first of the month | (N) Force payment not involved or total of type 4 OTP check |
| 01/01/2012 | \$ 698.00 | | (1) Recurring payment dated the first of the month | (N) Force payment not involved or total of type 4 OTP check |
| 06/01/2010 | \$ 674.00 | | (1) Recurring payment dated the first of the month | (N) Force payment not involved or total of type 4 OTP check |
| 05/02/2010 | \$ 2,022.06 | | (2) Regular daily payment (underpayment) | (E) Total of type 2 underpayment check |

| Resource -- House | Resource -- Vehicle | Resource -- Insurance | Resource -- Property | Resource -- Other |
|-------------------|---------------------|-----------------------|----------------------|-------------------|
| (Z) None | (Z) None | (Z) None | (Z) None | (Z) None |

| Federal Living Arrangement Code for Current Month | Federal Living Arrangement Code for Budget Month |
|---|--|
| (A) Own household | (A) Own household |

| Interim Assistance Reimbursement (IAR) Status Code | State and County Code of Reimbursement | Mandatory Eligibility Code |
|--|--|----------------------------|
| | | (N) Not eligible |

close

5.0 Buy-In – ISR (Information Service Request)

5.1 Purpose:

To save the State money by not erroneously paying Medicare premiums. To enhance the system ability, enhance audit capability and more accurately report data.

6.0 Buy-In – Data Analytics

6.1 Purpose:

6.1 Description of Current Runs:

- 1) Run on QMB's (AC 23,43,63) SLMB's (AC 53) and QI1's (AC 56) , for Part A enrollment, these AC's require Part A for Medicaid enrollment
- 2) Run on QI1's (AC 56) for erroneous Part A premium payment.
- 3) AC 109 not eligible for State Buy-In
- 4) AC 55 eligible for Part A premium payment only, if free Part A they are not eligible for Medicaid.

7.0 Desk Review – Analyst

7.1 Purpose:

To assure that each staff member is in compliance with applicable regulations and policy, a desk review will be performed based on each staff member’s performance each month

| Buy-in Program Desk Review | | | |
|---|------------------|-----------------------------------|----------------------------|
| Review Details | | Performance Scale | |
| Analyst Name | | 100% & Above - Outstanding | |
| | | 95% - 99.9% - Exceeds Expectation | |
| Review Date: | | 90% - 94.9% Meets Expectation | |
| | | 80% - 89.9% Below Expectation | |
| Reviewer: | | 79.9% & Below Unsatisfactory | |
| Performance Percentage= | | 0 | |
| Action | Points Available | Points Earned | Coaching Comments |
| Reports (50 Points) | | | |
| Were all corrections and updates made prior to cut off? | 10 | | |
| Were all assigned reports worked within set times frames? | 10 | | |
| Was proper request given for all manual reports? | 10 | | |
| Were there any inconsistencies in reports recd given to the Manger/Supervisor? | 10 | | |
| Were system/technical issues clearly and concisely communicated? | 10 | | |
| Oracle/Phone/Email/Fax Documentation (20 Points) | | | |
| Were all important actions notated clearly with details on actions taken? | 5 | | |
| Were any valid complaint calls made to the supervisor or Manger regarding cases?(Research will be done to determine if the complaint was justifiable) | 5 | | |
| If emails were received, were high priority issues shared with the supervisor and or manager? | 5 | | |
| Were all phone calls returned within 48 business hours? | 5 | | |
| Omnitrack (20 Points) | | | |
| Were all ticket requests responded to in the allotted turn around time? | 10 | | |
| Were resolutions clear and tickets closed and or transferred appropriately? | 10 | | |
| APPEALS (10 Points) | | | |
| Were all appeal actions recorded in Oracle? | 5 | | |
| Were summaries completed accurately and in a timely manner? | 5 | | |
| Total Points Available: | 100 | 0 | Total Points Earned |
| Recommendation/Comments: | | | |

8.0 Contacts

8.1 Contacts – Buy-In Staff

| | |
|---------------------------|--------------|
| Analyst (Rhonda Bowers) | 804-371-8888 |
| Analyst (Sherrill Taylor) | 804-786-7414 |
| Analyst (Monica Wells) | 804-371-2375 |

8.2 Contacts – HIPP program

| | |
|-----------------------------------|--------------|
| APPEALS | 804-612-0036 |
| DMAS – Customer Service Help Line | 804-786-6145 |
| FAMIS SELECT (Melissa Goggin) | 866-873-2647 |
| FAMIS – CPU | 866-873-2647 |
| FRAUD RECOVERY (Abbie Cook) | 804-786-1101 |
| HIPP Fax # | 804-612-0020 |
| HIPP Local Number | 804-225-4393 |
| HIPP Toll Free Number | 800-432-5924 |
| Uninsured/Catastrophe | 804-786-3528 |
| VITA – Computer/Printer Issues | 866-637-8482 |
| Xerox Checks (Ida Beverly) | 804-267-7286 |
| Xerox Checks (Phyllis Washington) | 804-267-7287 |

8.3 Contacts – HIPP Staff

| | |
|----------------------------------|--------------|
| Manager (Vacant) | 804-786-1373 |
| Manager (Tiaa Lewis) | 804-786-0690 |
| Supervisor (Carol Chiappa) | 804-786-1459 |
| Supervisor (Robin Lee) | 804-371-2120 |
| Analyst (Letitia Bracey) | 804-786-9491 |
| Analyst (Charice Finn) | 804-371-0880 |
| Analyst (Nyeta Goodall) | 804-786-8050 |
| Analyst (Theresa Smith) | 804-786-0684 |
| Analyst (Lisha Jackson) | 804-786-5409 |
| Program Tech Support (Ola Smith) | 804-225-4238 |

8.4 Contacts – Enrollment Staff

| | |
|--|--------------|
| Supervisor (Vacant) | 804-786-4537 |
| Enrollment Specialist (Helen Roberts) | 804-786-7701 |
| Enrollment Specialist (Pricilla Giles) | 804-786-0328 |

8.5 *Contacts – Information Management*

| | |
|--|--------------|
| System Analyst (Mike Jones) | 804-225-4513 |
| Information Technology Mgr. (Jim Rogers) | 804-225-4291 |

8.6 *Centers for Medicare and Medicaid Services*

| | |
|--|--|
| Shared Mailbox Users: Tiaa Lewis, Jim Rogers, Sanja Mulay, Brenda Edwards Theresa Fleming, Kelly Jenkins | A602-DMAS-MB-Buy-In Data Exchange (DMAS) |
| Email Address | buyindataexchange@dmass.virginia.gov |
| | |
| | |

supplies

NOTE: See both Program Tech Support before placing an order or calling any of these contacts.

| | |
|---|---------------------|
| HP Printers Repair VITA | 866-637-8482 |
| HP Printer Cartridges <i>Troy Hart, DMAS</i> | 804-371-7986 |
| HP Printer Paper <i>Troy Hart, DMAS</i> | 804-371-7986 |
| OSC COPIER/SCANNER – Toner HIPP Program Tech Support | 804-786-5409 |

10.0 Equipment Repair

NOTE: See both Program Tech Support before placing an order or calling any of these contacts.

| | |
|------------------------------|---|
| HP Printers VITA | 866-637-8482 |
| DMAS BLDG MAINTENANCE | <i>email to:</i> BuildingMaintenance@DMAS.virginia.gov |
| Pharmacy Printer | <i>Notify Dental Manager</i> |

11.0 Glossary

| | |
|------------------|---|
| Accretion | The federally defined process for the actions states are to take to pay Medicare premiums |
| Buy-In | Is the State process for paying the Medicare premiums for Medicaid members. |
| Deletion | action to stop payment of Medicare premium |
| CMS | Centers for Medicare and Medicaid Services is the federal governing body for both the Medicaid and Medicare Programs. |
| Medicare | The Medicare Program (Title XVIII of the Social Security Act) provides hospital insurance, also known as Part A coverage, and supplementary medical insurance, also known as Part B coverage. |
| Medicaid | A U.S. Government Program, financed by Federal, State, and Local Funds, of hospitalization and <u>medical</u> insurance for persons of all ages within certain income limits. |
| Premium | Cost of Medicare Part B coverage and uninsured Medicare Part A coverage. |
| SPIDeR | (Systems Partnering in a Demographic Repository) is a multisystem search engine run by the VDSS and allows real time access to Social Security Records. |
| SVES | State Verification Exchange System, is the system that provides access to Social Security Records |
| MMIS | Medicaid Management Information System is the claims payment processing system for the Medicaid and FAMIS programs. All pertinent member data is stored in this system. |

12.0 Acronyms

| | |
|---------------|---|
| 490 | Agency Code for State of Virginia Medicare Part B |
| AC | Aid Category |
| BENDEX | Beneficiary and Earnings Data Exchange |
| BIC | Beneficiary Identification Code |
| CMS | Center for Medicaid and Medicare Services |
| DMAS | Department of Medical Assistance Services |
| DOB | Date of Birth |
| DOD | Date of Death |
| DSS | Department of Social Services |
| ECM | Enterprise Content Management |
| ESRD | End Stage Renal Disease |
| EW | Eligibility Worker |
| GEP | General Enrollment Period |
| HI | Health Insurance (Medicare Part A) |
| ID | Identification Number |
| IEP | Initial Enrollment Period |
| MAO | Medical Assistance Only |
| MBR | Master Beneficiary Record |
| MMIS | Medicaid Management Information System |
| QDWI | Qualified Disabled Working Individual |
| QMB | Qualified Medicare Beneficiary |
| RRB | Railroad Retirement Board |
| S49 | Agency Code for State of Virginia Medicare Part A |
| SLMB | Specified Low Income Medicare Beneficiary |
| SMI | Supplemental Medical Insurance (Medicare Part B) |
| SPIDeR | Systems Partnering In A Demographic Repository |
| SOLQ-I | SSA State Online Query |
| SSA | Social Security Administration |
| SSI | Supplemental Security Income |
| SSN | Social Security Number |
| SVES | State Verification and Exchange System |
| TPL | Third Party Liability |
| Z99 | Conditional (Part A) |

13.0 Appendices

- Appendix A** Buy-In Report Chart
- Appendix B** MEMBER BUY-IN SMI ELIGIBILITY CODES
- Appendix C** Transaction Codes

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|-----------------------|--------------------------------|---|-------------------------|---|--------------------------|--|
| Buy-In | RS-O-324 | 1 | 6 | Medicare Policy Error Report | ST | List clients added to the Buy-In process but the MMIS list an end date for Part B coverage. TPL is updated in MMIS according to research conducted to verify Medicare segments | 1 | 4 to 5 |
| Buy-In | RS-O-328 | 1 | 6 | Medicare Premium Processing C101 Report Error Messages | RB | List of clients with an error in information. Currently reports members not -01 or -02 on the Medicaid case, also reports errors in Aid Categories on Buy-In potentially should not be on Buy-In | 197 | focus on AC issues only. FHS updating report |
| Buy-In | RS-O-330 | 1 | 1 | Medicare Premium Processing Members with 1165 or 1167 Transaction Codes | RB | Report lists individuals with Medicare and analyst researches individuals to determine if Medicaid member in VA. If so, sends transaction code of 99 to CMS to link client with VA Medicaid ID #. | 2 | 80 |
| Buy-In | RS-O-344 | 1 | 3 | Medicare Premium Processing Member Records with No 41 Buy-In Update | RB | Report lists eligibility file records with Buy-In information for which CMS Buy-In update is not received. | 2 | 58 |

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|-----------------------|--------------------------------|--|-------------------------|---|--------------------------|-----------------------------|
| Buy-In | RS-O-345 | 1 | 2 | Medicare Premium Processing Non Premium List (by claim #) (2461 Report) | RB | Submits a manual accretion to CMS for each client with a transaction code of 2461 (rejected by CMS because effective date is later than the billing month). | 37 | 1540 entries |
| Buy-In | RS-O-348 | 1 | 1 | Medicare Premium Processing Non-Premium List Code 2161 Alphabetic | ST | Report lists CMS transactions with no match for current billing month due to demographic mis-match or incorrect Medicare #. | 6 to 7 | 120 |
| Buy-In | RS-O-355 | 1 | 2 | Medicare Premium Processing Claim Number Mismatch SSA Active - Elig Cancel | ST | Report lists cancelled clients whose claim number on the CMS bill does not match claim number in MMIS and whose transaction codes are 41 or 11. | last few months blank | |
| Buy-In | RS-O-357 | 1 | 3 | Medicare Premium Processing Claim Number Mismatch SSA Active - Elig Active | ST | Report lists active clients with a 41 or 11 transaction code whose claim number on the CMS bill does not match claim number in MMIS. | 1 | 8 to 9 |
| Buy-In | RS-O-359 | 1 | 4 | Medicare Premium Processing Claim Number Mismatch SSA Active -Active Remaining Elig Active | ST | Report lists active clients with a non 41 or 11 transaction code whose claim number on the CMS bill does not match claim number in MMIS. | 3 | 45 |

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|-----------------------|--------------------------------|--|-------------------------|---|--------------------------|-----------------------------|
| Buy-In | RS-O-361 | 1 | 5 | Medicare Premium Processing Claim Number Mismatch Remaining Elig Cancelled | ST | Report lists cancelled clients with a non 41 or 11 transaction code whose claim number on the CMS bill does not match claim number in MMIS. | 1 | 1 |
| MMA | RS-O-230A | 1 | 4 | Dual Eligibility Enrollment Errors – DSS | RB | SSN not correct in MMIS, verify SSN and update MMIS with correct information. | 1 to 2 | no total |
| MMA | RS-O-377 | 1 | 5 | MMA PRO TPL Non-update Report M-BIC Records | RB | New report as of 3/2009 lists M-BIC recipients with no TPL information in MMIS. Staff Assigned Analyst report to determine if TPL should be added. | 1 | 5 |
| Buy-In | RS-O-325 | 1 | 7 | Medicare Premium Processing SSA Claim number change activity | ST | This report is an Audit Trail of Medicare claim number changes. Monitor specific claim number changes to ensure correct information was entered into MMIS | | |
| Buy-In | RS-O-310 | 1 | 8 | Medicare Premium Processing Invalid Data-Part A records dropped | ST | Lists members that have no valid Medicaid number on Part A bill | | |
| Buy-In | RS-O-318 | 2 | 3 | Medicare Premium Processing Part A Group Payer Not Found | ST | Report lists Part A clients in which a CMS 41 transaction code was not received. | 3 to 4 | 100 |

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|---------------------------|--|--|-----------------------------|--|---------------------------------|-------------------------------------|
| Buy-In | RS-0-338 | 2 | 5 | Medicare Premium Processing – Part B Processing Error Report For Aid Category 80 | ST | Report lists clients in AC 80 (Family Planning Waiver and not eligible for Medicare Buy-In)) and there's a Buy-In transaction. Monitors to ensure that a deletion for Buy-In has been submitted to CMS by MMIS. If not, a manual deletion is sent. | usually blank, 1 page 2/2010 | 1 reported 2/2010 |
| Buy-In | RS-0-363 | 2 | 3 | Medicare Premium Processing Multiple Records for Member by HIC Number | RB | Report lists clients with multiple transaction codes, can include transaction 16 (deceased), 15 (Medicare ended), 1728 (out of state). | 62 | no total, usually 15/pg |
| Buy-In | RS-0-365 | 2 | 4 | Medicare Premium Processing Multiple Records for Member with "M" Bic | RB | Report lists clients by HIC number when the BIC number is "M" for whom more than one record has been received with multiple transaction codes, can include transaction 16 (deceased), 15 (Medicare ended), 1728 (out of state). | 3 to 4 | no total, usually 21/pg |

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|---------------------------|--|--|-----------------------------|---|---|-------------------------------------|
| Bendex | RS-O-425 | 2 | 1 | BENDEX TPL Update Report | RB | Report lists clients whose Medicare data has been updated by BENDEX. | 2x/month end of month report larger 13 to 14 pages | 180 |
| MMA | RS-O-332 | 2 | 2 | Medicare Part A and B discrepancy report (MMA Pro record response file) | RB | Review and update Medicare TPL in MMIS as appropriate | runs weekly 6 pgs | 34 |
| MMA | RS-O-424 | 2 | 2 | MMA (PRO) Report | ST | List clients whose TPL has been automatically updated in the MMIS based on the MMA response file. Staff verifies that the TPL information updated correctly and make changes to the TPL file in MMIS if errors are identified | | |
| Claims | CP-O-053 | 2 | 1 | Pended claims report for edit 282, potential Medicare coverage | ST | Report lists claims pended for edit 282, sources are reviewed to determine if Medicare exist, if so, ensures MMIS has properly been updated with TPL information. Findings are sent to Cindy Bosley. | | |
| MCO Report | K Drive | 2 | 4 | TPL/COB Reports (in K drive; varies by MCO – only a few entries per MCO) | ST | Report lists clients sent by HMOs to DMAS indicating other insurance. If Medicare TPL is indicated, research and update TPL in MMIS. | varies by MCO, most have none reported | |

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|---------------------------|--|--|-----------------------------|--|------------------------------|-------------------------------------|
| Buy-In | RS-O-320 | 3 | 3 | Medicare Premium Processing Invalid Data Encountered | ST | Report occurrence of invalid data encountered in editing the SSA tape, indicates whether the SSA record is allowed continued processing or permanently dropped. Includes total record counts and amounts by transaction codes. | 80 | no totals listed, 17/pg |
| Buy-In | RS-O-339 | 3 | 6 | Personal Characteristics Change Report for Part A | RB | New report as of 3/2009 lists discrepancies in personal characteristics between DMAS and CMS. Buy-In is occurring for these clients but data reviewed for discrepancy resolution | 0-1 | 1 to 5 |
| Buy-In | RS-O-341 | 3 | 5 | Personal Characteristics Change Report for Part B | DA | New report as of 3/2009 lists discrepancies in personal characteristics between DMAS and CMS. Buy-In is occurring for these clients but data reviewed for discrepancy resolution | 15 to 20 | no total, 16/pg |
| EDB | RS-O-465 | 3 | 4 | EDB File Missing/Mismatch HIC# | RB/DA | This is a return file from CMS. It lists those VA Medicaid clients who have Medicare coverage but HIC number doesn't match. Researches to verify Medicare coverage. | 3 to 4 pgs | no total, 22/pg |
| MMA | RS-O-331 | 3 | 1 | MMA PRO record response file Medicare Discrepancy Part D dates | RB | Reviewed to ensure Part D is correctly reported and in MMIS. | weekly, 0 to 4 pages | 0 to 30 |
| MMA | RS-O-333 | 3 | 2 | Part D Invalid Data | RB/DA | Report lists client's Part D enrollment date. Analyst corrects Part D effective date, if different. | weekly, 4 pages | about 50 |
| MMA | RS-O-376 | 3 | 3 | Medicare Part D Discrepancy dates M-BIC records | RB | Ensure Part D dates for M-BICs are correct in MMIS, updates done as appropriate. | every 2 weeks, last 2 blank | |

Appendix A

Buy-In Report Chart

| <i>Source/Type</i> | <i>Report #</i> | <i>Priority 1,2,3</i> | <i>Order of reports Worked</i> | <i>NAME OF REPORT</i> | <i>Assigned Analyst</i> | <i>Purpose</i> | <i>Report Page Total</i> | <i>Average # of Members</i> |
|--------------------|-----------------|---------------------------|--|--|-----------------------------|--|------------------------------|-------------------------------------|
| Buy-In | RS-O-385 | 3 | 2 | Medicare Premium Processing Listing of Error Transactions | ST | Lists of Part A Add/Cancel transactions sent and dropped on file to CMS, including record counts. | 1 | 12 |
| Buy-In | RS-O-388 | 3 | 1 | Medicare Premium Processing Listing of Add/Cancel Members | ST | Lists of Part B Add/Cancel transactions sent and dropped on file to CMS, including record counts. The Medicare Premium processing includes Q11 and Q12 members | 1 | 18 |
| Buy-In | RS-O-312 | 3 | 8 | Medicare Premium Processing Part A Group Payer Not Found | ST | Report shows members who have Buy-In for Part A but no showing in Premium History | | |
| Buy-In | RS-O-349 | 3 | 8 | Medicare Premium Processing non-premium list code 29 current city/county | RB | Report lists members who have died and Medicaid case is still open. | | |

APPENDIX B

MEMBER BUY-IN SMI ELIGIBILITY CODES

| <u>Code</u> | | <u>Aid Category</u> |
|-------------|---|---|
| A | Federal SSI Payments Aged | 11 |
| B | Federal SSI Payments Blind | 31 |
| C | Entitled Under Part A of Title IV (TANF) | None |
| D | Federal SSI Payments Disabled | 51 |
| E | SSA Supplemental Payment Aged | 12 |
| F | SSA Supplemental Payment Blind | 32 |
| G | SSA Supplemental Payment Disabled Member | 52 |
| H | One Time Payment of Aged, Blind, or Disabled Member | None |
| L | Specified Low Income Medicare Beneficiary (SLMB) | 53 |
| | Specified Low Income Medicare Beneficiary (SLMB PLUS) | 24, 44, 25, 45 |
| M | Entitled to Medical Assistance Only | 18, 38, 58, 20, 40, 60 |
| P | Qualified Medicare Beneficiary (QMB) | 23, 43, 63 |
| U | Qualified Individual (QI1) | 56 |
| V | Categorically Needy (Aged, Blind, Disabled, TANF) | 22, 42, 62, 29, 39, 49, 28, 48, 68, 72, 74, 75, 81, 83, 90, 91, 92, 93, 85, 86, 88, 97, 98, 99, 54, 76, 82, 59 |
| Z | Deemed Categorically Needy | 21, 41, 61 |

Any Aid Category that is not listed would be in the Category of “V”

APPENDIX C

Transaction Codes (Records sent to CMS)

| | |
|------------------------------------|-------------------|
| Accretions: | 61 |
| Closed Periods of Coverage: | 75/76 |
| Changes: | 99 |
| Deletions: | 50, 51, 53 |