Medicare Advantage and Prescription Drug Plans

May 30, 2014

Plan Communications User Guide

Main Guide

Version 8.1

CENTERS FOR MEDICARE & MEDICAID SERVICES

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Change Log
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1 Introduction

1.1 Document Overview

The *Plan Communication Users Guide* (*the Guide*) provides information to Medicare Managed Care Plans and Prescription Drug Sponsors (both hereafter referred to as Plans) regarding the use of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage and Prescription Drug Program (MARx) systems.

The Guide provides an overview of how Plans exchange data with CMS, describing the input received from the Plans and the report and data files that are sent from CMS in response. It includes information for Plans to reference in establishing connections with CMS.

Information about the enrollment, payment, and premium withhold processes, as well as the different reconciliations and policies, are available in *the Guide*. Web site links are included to assist the user in finding the various *Medicare Managed Care Manual (MMCM*) chapters associated with the functions in *the Guide*. In addition, a section is devoted entirely to the User Interface (UI), including screen shots and instructions. Plans may use the UI to obtain online Medicare eligibility for applicants and to submit certain types of transactions. Information is available online about member enrollment, payment, premium withhold status, and amounts.

Note: CMS provides future revision(s) of this document as information is updated.

1.2 Document Organization

The Guide includes the following information:

Section 1, Introduction, provides general information about the organization and content of this document.

Section 2, Establishing Communication with CMS, provides instructions for establishing user connectivity to MARx along with methods for exchanging data with CMS. Further information regarding Electronic File Transfer (EFT) capabilities and testing is available in the following Health Plan Management System (HPMS) guidance provided at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/HPMS-Guidance-History.html

Section 3, Accessing the CMS Systems for Eligibility Verification, provides information on the UI system batch component used for eligibility verification of Medicare beneficiary applications.

Section 4, Transaction Processing, provides information on the transaction processes for Plans. More information is available at the following link from Chapter 2 of the *MMCM*: http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp.

Section 5, Payment Process and Calculations, provides an overview of Part C and Part D payment calculations. More information is available at the following link from Chapter 4 and 8 of the *MMCM*: Chapter 4 http://www.cms.gov/manuals/downloads/mc86c04.pdf and Chapter 8 http://www.cms.gov/manuals/downloads/mc86c08.pdf.

Section 6, Premium Withhold Option for Beneficiaries, provides information on the premium withhold process for beneficiaries.

Section 7, Coordination of Benefits (COB) Attributes, provides an explanation of COB File Data element definitions and instructions for Part D Plans. More information is available at the following links from Chapter 2 and Chapter 14 of the *MMCM*: Chapter 2 http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp and Chapter 14 http://www.cms.gov/manuals/downloads/mc86c14.pdf.

Section 8, Reporting RxID/RxGROUP/RxPCN/RxBIN Data, provides detailed information for Plans to follow in submitting the 4Rx data elements to CMS.

Section 9, Establishing Low-Income Subsidy (LIS) Status, provides an explanation of LIS premiums and co-pay levels to ensure Part D Plans charge LIS beneficiaries the correct premium and cost-sharing amounts. More information is available at the following link from Chapter 17 of the *MMCM*: http://www.cms.gov/MedicareMangCareEligEnrol/Downloads/CostEnrollmentGuidanceUpdateFINAL2010.pdf.

Section 10, Using the Medicare Advantage and Part D Inquiry System Online Operations, provides information for Plans to access enrollment, eligibility, payment, premium withhold, and 4Rx information for beneficiaries.

1.2.1 Typographical Conventions

The typographical conventions used in *the Guide* are shown in **Table1-1**.

Table 1-1-1: Typographical Conventions:

Example	Description
<Alt-P>	**Keystroke**. Less than and greater than signs (<>) are placed around any keyboard entries mentioned in the text. For instance, by pressing the Enter key, the user sees <ENTER>.
[Find]	**Button Name.** Square brackets ([ ]) are placed around the references to all button names displayed on the screen. Button names use mixed-case alphanumeric characters.
|Beneficiaries|	**Menu or Submenu Name.** A menu is represented as a horizontal list of menu items, either on the UI main menu or at the top of a screen. Submenus list items below the menu; items vary based on the menu item selected. These names are shown as mixed-case text with bars on either side.
Beneficiaries: Find(M201)	**Screen Name**. All screen names are represented as mixed case, italic text, and contain the full screen description.
Label Names	**Label Name**. All field labels, for input and output, referenced in the text are shown as mixed-case alphanumeric characters.
Smith	**Input**. Input fields are spaces or locations that accept input on the screens. The input is in the form of mixed-case alphanumeric characters.
FEMALE	**Selection**. A dropdown list offers a choice of options from which to select. Selections from a dropdown option are generally presented on the screen in upper case.
The claim…	**Error Message.** If a problem occurs after the user clicks on an action button, such as [Find] or [Submit], an error message is provided in red on the upper left-hand corner of the screen. The message is displayed in mixed-case alphanumeric characters.
The request…	**Status Message**. Status messages are provided in green on the upper left corner of the screen. The message is displayed in mixed-case alphanumeric characters.
06/2002	**Link**. A hyperlink, or link, is a word or group of words that the user clicks to access additional information in another location. Links are displayed in underlined blue text.
Note	**Note**. Notes indicate important information. The accompanying text is enclosed in a box with Note as a header.
Tip	**Tip**. Tips alert the user to shortcuts and troubleshooting techniques. Accompanying text is enclosed in a box with Tip as a header.

Note: When screens are shown in this document, the browser title, menu, buttons, and other items are hidden to display the content as largely as possible.

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2 Establishing Communication with CMS

This section explains the steps necessary for communicating with CMS to submit transactions and receive monthly payments from CMS.

Note: Prior to this point, the organization must have established Health Plan Management System (HPMS) access, have an approved contract with CMS, and submitted all required information to allow for Part C and/or Part D transaction processing and payment. Please see the following link for instructions to obtain access to HPMS and to establish EFT capabilities: Plan Reference Guide for CMS Part C/D Systems.

2.1 Getting Started

To communicate with CMS, a Plan must:

- Establish an External Point of Contact (EPOC).
- Obtain a user ID and password.
- Establish connection to the User Interface (UI).
- Establish points of contact within CMS.
- Arrange payment.

2.1.1 Establish an External Point of Contact (EPOC)

1. New Plans must have a valid EPOC. The requirements and processes are available in the following CMS Memo located on the Medicare Advantage and Prescription Drug (MAPD) Help Desk Web site entitled, Designation of Individuals Authorized Access to CMS Computer Services (IACS) Plan User Approver/External Point of Contact (EPOC) –ACTION. Plans then send an EPOC designation letter by mail to Division of Payment Operations (DPO). **Note:** Registration can take up to two weeks to process. DPO approves all EPOCs who in turn approve the Plan users. EPOCs may not access the system, only approve and remove their users.
2. Once the EPOC is approved, submitters must register for their respective mailboxes. Registered submitters are approved by their Plan's EPOC.
3. The MAPD Help Desk sends connectivity information regarding the Plan's affected contract(s) to the CMS EFT Team to enable Plan access for exchanging data with CMS systems.

2.1.2 Obtain a user ID and password

Users of the MARx system must obtain a user ID and password. Users request an ID by registering in IACS. IACS is utilized for the registration and maintenance of Plan submitters and representatives. The Plan's EPOC is responsible for approving their personnel in accordance with established IACS policies. Plans may register new Plan users and/or modify Plan user roles by consulting the IACS system at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/IACS/index.html?redirect=/iacs or calling the MAPD Help Desk for assistance at 1-800-927-8069.

2.1.3 Establish connection to the User Interface (UI)

After obtaining a CMS user ID and password, a UI user profile is created. This profile defines the user's tasks and is based on the role(s) the user registered in IACS. Users are assigned one or more roles based on their job responsibilities. One of these roles is marked as the default. When logging on, users may accept the default role or choose one of the other roles to which they are assigned. The profile also defines which contracts users may access.

To access the UI, users must have the following software installed on their workstations:

- Windows 98 or higher.
- Microsoft Internet Explorer with Web browser, Version 5.5 or higher.
- Adobe Acrobat Reader, Version 4 or higher, for report viewing and display of online help. If the user does not have Adobe Acrobat Reader Version 4 or higher, the user can download a free version at (www.adobe.com).

Also, users must:

- Enable JavaScript in the browser.
- Allow pop-ups from the UI site.
- Disable script debugging, which is in the Internet Explorer's Internet Options under the Advanced tab.
- See section 10 for UI instructions and screen descriptions.

2.1.4 Establish points of contact within CMS

Contact Information

CMS provides a technical customer support mechanism for all of its external customers. The MAPD Help Desk provides quality support for all connectivity needs, as well as aid in resolving technical application issues. Contact the MAPD Help Desk at 1-800-927-8069 or by e-mail at mapdhelp@cms.hhs.gov.

Other helpful points of contact are listed below:

Table 2-1: COB Points of Contact:

Topic	Point Of Contact Information
COB Contractor	1-800-999-1118
COB Contractor Electronic Data Interchange Department	1-646-458-6740
COB Help Desk	1-212-615-4357
GHI Help Desk	1-212-615-4347

Table 2-2: Points of Contact:

Topic	Point Of Contact Information
Risk Adjustment Questions	riskadjustment@cms.hhs.gov
Technical Issues	MAPDHELP@CMS.HHS.gov or 1-800-927-8069
Prescription Drug Event (PDE) Submission Questions	www.csscoperations.com or 877-534-2772

2.1.5 Arranging payment with CMS

The Automated Plan Payment System (APPS) calculates the final monthly payment for all types of MAPD Plans and prepares the electronic transmittal that is sent to the U.S. Treasury for payment. CMS accomplishes this by collecting Plan banking information and other identifying data from the Plans on the Payment Information Form, when the contract/Plan Benefit Package (PBP) is activated. CMS enters the data in APPS to identify the financial institutions where the funds are deposited on the payment date. Additionally, CMS must have the Employee Identification Number/Tax Identification Number (EIN/TIN), and the associated name as registered with the IRS, for income reporting purposes to each Plan.

Plans are required to submit a completed Payment Information Form to the attention of the Payment Administrator in DPO either by fax 410-786-0322 or e-mail. Plans should submit the form prior to initial enrollment to ensure timely payment.

It is the Plan's responsibility to provide CMS with updates to the banking information by submitting changes on a new Payment Information Form. This ensures the timely deposit of monthly payments and accuracy of income reported for the organization. Figure B-1 in Appendix B includes the Payment Information Form.

3 Accessing the CMS Systems for Eligibility Verification

For completing an enrollment request, Plans must verify Medicare entitlement for all enrollment requests either using the Medicare Advantage Prescription Drug System User Interface (MARx UI) online query, described in Section 10 of *the Guide*, the Batch Eligibility Query (BEQ) process, or CMS contractors. This section of *the Guide* describes the BEQ and response process in detail.

3.1 BEQ Process

The BEQ Process provides a vehicle for all Plans to submit their batches of queries for individuals to obtain timely verification of Medicare eligibility, Prescription Drug Plan (PDP) eligibility, LIS information, and past drug coverage period information. This allows the Plans to determine the number of uncovered months relating to Late Enrollment Penalty (LEP). Detailed File/Record Formats are provided in Appendix F; Detailed Error Code Tables for the BEQ Response File in Appendix I.

3.2 BEQ Request Processing

Plans may submit multiple BEQ Request Files to CMS during any CMS business day, Monday through Friday, via Connect:Direct Network Data Mover (NDM); Sterling Electronic Mailbox, Gentran; or TIBCO MFT Internet Server. Plan transactions are processed as received and there is no minimum or maximum limit to the number of BEQ Request Transactions that Plans may submit in a day.

The BEQ Request Files should comply with the record formats and field definitions as described in Appendix F. Plans should send BEQ Request Files in flat file structure that conform to CMS naming conventions as described in Appendix K. Detailed BEQ Error Code Tables are included in Appendix I.

CMS recognizes BEQ Request Files by the information supplied in the Header and Trailer Records. Header Record information is considered critical as CMS uses it to track, control, formulate, and route files and transactions through the BEQ process and communicate responses to the Plans.

Each transaction on the BEQ Request File should identify a prospective or current Plan enrollee. Plans may submit BEQ transactions only for individuals who have requested enrollment. Plans may not submit BEQ transactions for individuals who have not requested enrollment.

CMS generates one BEQ Response File for a Plan every time a BEQ Request is processed during a regular business day. This BEQ Response File includes BEQ Request transactions processed by CMS for the Plan for each transaction request. If a Plan submits multiple BEQ Request Files during a regular business day, that Plan receives multiple BEQ Response files, corresponding to each BEQ Request File, during that same business day.

Note: BEQ Response Files are not time-stamped, so the Plan must process these files immediately upon receipt.

For Plans using a Connect:Direct data transmission protocol, if a second BEQ Response File is received by the Plan prior to the Plan's processing of a previous one, a Connect:Direct transmission error results and the Plan must manually retransmit the file. Plans may call the Medicare Advantage and Prescription Drug (MAPD) Help Desk for assistance.

Plans can use the Detail Record Sequence Number located in each Transaction, i.e., Detail Record, to track individual Transactions sent to and received from CMS.

3.3 BEQ Response File from CMS to Plans

3.3.1 BEQ Response Process

CMS analyzes a received BEQ Request File to determine the file's acceptance or rejection. CMS processes transactions of an accepted BEQ File, which creates a BEQ Response File. If a BEQ Request File is rejected, a BEQ Response File is not generated.

The system determines if a BEQ Request File is accepted or rejected based on the Request File Error Conditions, as documented in Appendix I. After determining whether a BEQ Request File is accepted or rejected, the BEQ process generates an e-mail acknowledgement of receipt indicating one of the following outcomes:

- If the BEQ Request File is accepted, an e-mail notification informs the Plan that the specific BEQ Request File is accepted and in process.
- If the BEQ Request File is rejected, the e-mail notification informs the Plan of the first File Error Condition that caused the rejection. A rejected file is not returned.

This e-mail acknowledgement/notification is issued to all submitters registered in the Individuals Authorized Access to the CMS Computer Services (IACS) for the Sending Entity contract.

CMS processes all transactions of an accepted BEQ Request File. Each Transaction is uniquely identified and tracked throughout the CMS processing service by the combination of the Contract ID of the Plan, i.e., Sending Entity, File Control Number, File Creation Date, and Detail Record Sequence Number, as provided by the Plan on the BEQ Request File.

When CMS processes a Transaction, CMS first verifies that all critical data is provided and valid on the record. CMS then attempts to perform a Beneficiary Match, in which the beneficiary identifying fields on the Transaction locate a single beneficiary and verify Medicare entitlement. Each Detail Record of the BEQ Response File maintains these four critical fields:

- If all critical data elements are not provided, subsequent processing is terminated for that transaction, including any attempt to locate, i.e., match the Beneficiary on the database and verify Medicare entitlement. The Processed Flag in the BEQ Response Detail Record is set to N and the Beneficiary Match Flag has a space. All Error Return Codes are assigned the appropriate values. See Appendix I.
- If all critical data elements are provided, CMS then attempts to perform a Beneficiary Match, in which the beneficiary identifying fields on the Transaction locate a single beneficiary on the database and verify Medicare entitlement.
- If a Beneficiary Match is found, the Beneficiary Match Flag in the BEQ Response, i.e., Detail Record is set to Y. All Error Return Codes are assigned the appropriate values. The Processing Flag is set to the value Y. See Appendix I.
- If the beneficiary is not matched, the Beneficiary Match Flag is set to N. All Error Return Codes are assigned the appropriate values. Processing Flag is set to the value N. See Appendix G.

If the beneficiary is successfully located on the database tables, CMS performs the following:

- Creates a detail record to return to the Plan in a BEQ Response File as specified in Appendix F;
- Assigns values to the Match Flag fields as defined in Appendix F; and
- Populates the additional Eligibility Query fields of the Response File Detail Record with data for the beneficiary.

Note: In this BEQ Response File, CMS provides the two most recent occurrences of LIS information. During an open enrollment period, CMS is unaware whether Plans are submitting queries for 2007 enrollments or 2008 enrollments. Therefore, the BEQ Response File provides the current and future LIS information, so that Plans have the correct information for the year in which they submit the enrollment transaction.

If CMS cannot locate the beneficiary on the database tables or the BEQ Request File Transaction contains critical errors, then CMS performs the following steps:

- Creates a Detail Record to return to the Sending Entity in a BEQ Response File as specified in Appendix F, BEQ Response File From CMS to Plans;
- Assigns values to the Match Flag fields as defined in Appendix F; and
- Does not populate the additional BEQ fields of the Response File Detail Record.

The BEQ Response File is issued to the Plan in the same transmission mechanism that the Plan uses to deliver the BEQ Request file to CMS. This mechanism is available through the Sterling Commerce Gentran Mailbox, TIBCO MFT Internet Server, or through Connect:Direct NDM.

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4 Transaction Processing

CMS systems process numerous transactions daily. Various Transactions are processed and received until the end of each calendar month. (Section 4.1.2.3 provides an explanation of Current Calendar Month (CCM)). Plan-submitted transactions, are processed as they enter the system, and payments are calculated separately. Transactions also enter the system throughout the processing month from other sources, including the 1-800 MEDICARE Service Center. For an overview of the methodologies that CMS employs for transaction processing, see the *Medicare Managed Care Manual (MMCM)* Chapter 2 link: http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp.

At the end of each Current Processing Month (the Plan Data Due Date), the Medicare Advantage and Prescription Drug (MARx) System also calculates the final beneficiary payments and adjustments, which ultimately result in payments to the Plans for the Current Payment Month (CPM). In addition, MARx assembles the monthly reports.

4.1 Transaction Processing

The following steps are taken to process transactions from a Plan:

- Plans submit transaction files using Connect: Direct NDM, TIBCO MFT Internet Server, or the Secure File Transfer Protocol (SFTP)/Hypertext Transfer Protocol over Secure Socket Layer (HTTPS). The transaction files are read and loaded into internal tables for processing, or posting.
- CMS processes the submitted transactions, resulting in actions that affect beneficiary enrollment, payment, and status.
- The Plan receives accepted transactions in the Daily Transaction Reply Report (DTRR). These are annotated with any resultant Transaction Reply Codes (TRCs).
- MARx calculates payments, and/or adjustments, and adds or subtracts the net dollar amount to the contract total for each month. These totals are dynamic and may change each time a transaction is processed for a contract, until the monthly payment operations are concluded and finalized.
- An unaccepted transaction results in either a failed or rejected status.
  - A ***failure*** results when incoming data is inconsistent with the database rules. A transaction fails during processing when it contains an error that is too severe to attempt to process and store the data in the system. For example, if the contract number is in an invalid format, the transaction is not saved in the database and therefore fails. The transaction is written to the Batch Completion Status Summary (BCSS) and transmitted to the Plan submitter, or Plan user, for review.
  - A ***rejection*** results when incoming data is of the correct type but is not successfully processed due to some inconsistency that violates an enrollment validation check or rule. For example, if the contract number does not identify a valid contract for the submitter, MARx rejects the transaction. Rejected transactions are reported on the DTRR and transmitted to the Plan submitter, or Plan user.

4.1.1 Plan File Processing Responsibilities

Election Periods

The term "election" includes both Plan enrollment and disenrollment. Enrollment is the addition of a beneficiary to a specific PBP within a Contract Number, such as an "H" number or an "S" number, and represents the organization's request for CMS payment. Disenrollment is the end of an individual's enrollment in a PBP and the termination of CMS Plan payment for the individual.

Note: For the very limited number of organization types that do not have PBPs, enrollment is only at the Contract Number.

A summary of the election periods and the MARx Transaction Codes (TC) that Plans must use for submitted enrollment and disenrollment transactions is provided in Table 4-2 below. Plans must identify the election period that applies to the action. Table 4-1 summarizes the relationship between the enrollment election periods and various Plan types.

Note: This summary shows the data values for use in MARx; Plans must refer to the appropriate CMS Enrollment policy guidance for definitive information regarding enrollment periods and how to determine if one applies to a beneficiary request for enrollment or disenrollment. Plans are responsible for correctly identifying and reporting the enrollment period applicable to the action submitted. The guidance documents are available at (http://www.cms.hhs.gov/home/medicare.asp).

Table 4-1: Valid Election Types for Plan Submitted Transactions

Election Types						
PLANS	**Annual Enrollment Period (AEP) (A)**	**Open Enrollment Period for Institutionalized Individuals (OEPI) (T)**	**Special Election Period (SEP)**	**Initial Enrollment Period (IEP) (E/F)**	**Medicare Advantage Disenrollment Period (MADP)**	**Initial Coverage Election Period (ICEP) (I)**
MA	Y	Y	Y	N	Y	Y
Medicare Advantage and Prescription Drug (MAPD)	Y	Y	Y	Y	Y	Y
Prescription Drug Plan (PDP)	Y	N (Use coordinating SEP where appropriate per CMS guidance)	Y	Y	N (Use coordinating SEP where appropriate per CMS guidance)	N
Social Health Maintenance Organization (SHMO) I	Y	Y	Y			Y
SHMO II	Y	Y	Y			Y
Cost with Part D	Y	N (Use coordinating SEP where appropriate per CMS guidance)	Y	Y	N (Use coordinating SEP where appropriate per CMS guidance)	
Cost without Part D	None required; however, if the beneficiary is currently enrolled in an MA Plan, a valid MA election period is required to leave that program and enroll in the cost Plan.					
Wisconsin Partnership Program (WPP)	Y	Y	Y	Y		Y
End Stage Renal Disease (ESRD) I			Y			
ESRD II			Y			
Program of All-Inclusive Care for the Elderly (PACE) National	None Required					
Chronic Care Improvement Program/Fee-for-Service (CCIP/FFS) Demos	None Required					

Election Types						
PLANS	**Annual Enrollment Period (AEP) (A)**	**Open Enrollment Period for Institutionalized Individuals (OEPI) (T)**	**Special Election Period (SEP)**	**Initial Enrollment Period (IEP) (E/F)**	**Medicare Advantage Disenrollment Period (MADP)**	**Initial Coverage Election Period (ICEP) (I)**
Minnesota Disability Health Options (MDHO) Demo	None Required					
Minnesota Senior Health Options (MSHO) Demo	None Required					
Medical Savings Account (MSA)	Y	N	Y	N	N	Y
MSA Demo	Y		Y		N	Y

Table 4-2 Transaction Codes (TCs)

Code	Description
01	MCO Correction
41	Update to Opt-Out Flag Submitted by CMS
42	Medicare and Medicaid Plan (MMP) Opt-Out Update (Submitted by 1-800-Medicare*)
51	Disenrollment (MCO or CMS)
54	Disenrollment (Submitted by 1-800-MEDICARE)
61	Enrollment
72	4Rx Record Update
73	NUNCMO Record Update
74	Employer Group Health Plan (EGHP) Record Update
75	Premium Payment Option (PPO) Update
76	Residence Address Record Update
77	Segment ID Record Update
78	Part C Premium Record Update
79	Part D Opt-Out Record Update
80	Cancellation of Enrollment
81	Cancellation of Disenrollment
82	MMP Enrollment Cancellation
83	MMP Opt-Out Update
90	POS Drug Edit

4.1.2 Enrollment/Disenrollment Requirements and Effective Dates

Enrollments

Plans accept enrollment requests from beneficiaries as provided in the CMS Enrollment and Disenrollment guidance applicable to their Plan type. After fulfilling the processes and requirements outlined in that guidance, the Plan must generate and submit the appropriate enrollment transaction to CMS, within the timeframes prescribed by the applicable guidance. Enrollment Transaction Records are either batch or online submitted records with TC 61 as shown in Table 4-2.

The enrollment effective date reported on the Enrollment Transaction Record is the first day of the month that the beneficiary is enrolled, i.e., that the beneficiary begins receiving benefits from the Plan, and represents the first month for which the Plan is requesting payment. The CCM affects the enrollment and disenrollment effective dates for Plans to submit to CMS using the different TCs available. The CCM is the calendar month for which MARx is currently processing transactions. The CCM begins on the first date of the calendar month and continues until the close of business on the end that same calendar month. Plans should refer to Table 4-3 to determine the appropriate effective enrollment date and Plan type for use with a TC 61.

Table 4-3: Enrollment TCs and Effective Dates

Code	Definition	Effective Date Options	Notes
61	Enrollment into Contract, PBP, EGHP, and Retroactive one Month	CCM – 3 (EGHP Only) CCM – 2 (EGHP Only) CCM – 1 CCM CCM + 1 CCM + 2 CCM + 3	Enrollment transaction

Disenrollments

Plans accept disenrollment requests from beneficiaries as allowed. Chapter 2 of the *Medicare Advantage Enrollment/Disenrollment Manual* provides more information on allowable disenrollment requests as applicable to different Plan types. Once the processes and requirements are fully satisfied, the Plan must generate and submit the appropriate disenrollment transaction to CMS. Additionally, Plans may, under limited circumstances, as provided in Chapter 2 of the *Medicare Advantage Enrollment/Disenrollment Manual*, report involuntary disenrollment actions. Plans should refer to the applicable guidance for more information.

The effective date of disenrollment is reported on the MARx disenrollment transaction as the first day of the month following the month enrollment ended. For example, if a beneficiary disenrolled as of March 31, TC 51 is submitted with April 1 as the effective date. CMS provides an annual calendar detailing the key dates for MARx processing. Appendix C provides this calendar.

The disenrollment transaction effective dates are limited according to the CCM described below.

Table 4-4: Disenrollment TCs and Effective Dates

Code	Use	Effective Date	Notes
51	Disenrollment submitted by Plan	CCM – 3 (Employer Group Health Plans [EGHP] Only/EGHP Cost Plans) CCM – 2 (EGHP Only/EGHP Cost Plans) CCM – 1 CCM CCM + 1 CCM + 2 CCM + 3	

Instructions for creating and submitting the transaction and the batch submission file are provided in Appendix F. Plans should note that disenrollment requests accepted by the Medicare Customer Service Center are entered into MARx using the TC 54, which only that entity can submit. Plans must include a valid disenrollment reason code on all TC 51 disenrollment transactions submitted. Table 4-5 includes the valid disenrollment reason code values:

Table 4-5: Disenrollment Reason Codes

Plan Action	When to Use	Code Value
Voluntary Disenrollment	Beneficiary requested disenrollment during a valid enrollment period	11
Auto Disenrollment	MMP Opt-Out After Enrolled	63
Auto Disenrollment	Loss of Demonstration Eligibility	64
Involuntary Disenrollment for Failure to Pay Plan Premiums	Beneficiary fails to pay Plan premiums and Plan completes all necessary steps in CMS disenrollment guidance to effectuate an involuntary disenrollment	91
Involuntary Disenrollment for a Move Out of Plan Service Area	It is determined that the Beneficiary is out of the Plan service area, according to the procedures in CMS disenrollment guidance, and the Plan meets all requirements necessary to effectuate an involuntary disenrollment	92
Involuntary Disenrollment for Loss of Special Needs Plan (SNP) Eligibility	It is determined that the Beneficiary no longer meets the eligibility requirements for enrollment in an exclusive SNP, and the Plan meets all requirements to effectuate an involuntary disenrollment, as defined in CMS disenrollment guidance, and including the deemed continuous eligibility provisions.	93

No other disenrollment reason code values are valid or acceptable on Plan-submitted disenrollment transactions. Failure to include a valid value does not result in a rejected transaction. Instead, MARx defaults the value to Disenrollment Reason Code (DRC) 99. CMS may use this information to track compliance or non-compliance with program requirements. CMS-generated disenrollment actions may contain other reason code values as applicable.

Plans normally receive their payment reports the last week of the month, with the actual payment occurring the first day of the following month. The Current Processing Month changes following the close of business on the Plan Data Due Date. For example:

January 10, 20xx is the Plan Data due date, therefore:

- On January 9, 20xx, the Current Processing Month is February.
- On January 10, 20xx, the Current Processing Month is February.
- On January 11, 20xx, the Current Processing Month is March.
- The Current Processing Month remains March until the day following the next Plan Data Due Date. When this occurs in early February, the Current Processing Month changes to the next payment month, which is April, as MARx is no longer processing transactions and calculating payments for the March 1 payment.

Examples of Effective Dates on MARx Transactions

To allow sufficient time for payment calculations, validation, and information sharing with the U.S. Treasury, MARx creates the payment data files and reports two to three weeks prior to the first day of the month for which the payment is made. This cycle is established via the MARx Plan Data Due Date each month. The timeframe from one Plan Data Due Date to the next Plan Data Due Date represents the Current Processing Month.

All transactions successfully processed for payments by MARx during the Current Processing Month are included in the monthly payment cycle and its associated reports. The Current Processing Month ends on the MARx Plan Data Due Date, i.e., the cut-off date, at 8:00 p.m. Eastern Time. The Plan Data Due Date is typically on or around the 10th of each month; however, CMS provides an annual calendar detailing the key dates for MARx processing including the Plan Data Due Date. This calendar is available in Appendix C.

Plans normally receive their payment reports the last week of the month with the actual payment on the first day of the following month. The Current Processing Month advances by one month following the close of business on the Plan Data Due Date.

Transaction processing for enrollment, disenrollment, and cancellations is decoupled from payment calculation, thereby allowing a separate schedule for transaction processing versus payment processing. MARx will accept enrollment, disenrollment and cancellation transaction effective dates based on the CCM in which a transaction is received by MARx for processing, as determined by the time and date stamp assigned by MARx upon acceptance of the transaction for processing. For example:

January 10, 20xx is the Plan Data Due Date, and January 20xx is the current calendar month therefore:

- On January 9, 20xx, the CPM is February.
- On January 10, 20xx (Plan Data Due Date), the CPM is February until 8:00 p.m.
- On January 11, 20xx, the CPM is now March.
- On January 1, 20xx the CCM is January until January 31, 20xx, 8:00 p.m.

February 8, 20xx is the next Plan Data Due Date, and February 20xx is the current calendar month therefore:

- On February 7, 20xx, the Current Processing Month is March.
- On February 8, 20xx, (Plan Data Due Date), the Current Processing Month is still March until 8:00 p.m.
- On February 9, 20xx, the Current Processing Month is now April.
- On February 1, 20xx, the CCM is February until February 28 (29 on a leap year), 20xx, 8:00 p.m.

Once the CPM advances to the next month, MARx is no longer processing transactions to include in the CPM payments and begins processing transactions reflected in the next CPM. The CCM always process transactions for enrollments, disenrollments, and cancellations for the month in which the transaction falls, until the end of that month. Transactions with retroactive effective dates received and successfully processed after the Plan Data Due Date generate payment adjustments as necessary for prior months' payment.

For each of the following examples, assume that today's date is May 5 and the next Plan Data Due Date is May 10; therefore the CPM is **June** and CCM is May:

- TC 61 submitted today may have an effective date of April 1, May 1, June 1, July 1, or August 1. Payment adjustments are made on the June payment MMR;
- TC 51 submitted today may have an effective date of April 1, May 1, June 1, July 1, or August 1. Payment adjustments are made on the June payment MMR.

For each of the following examples, assume today is now May 15, which is after the next Plan Data Due Date, i.e., May 10 in this example. Therefore the CPM changes to **July** and the CCM remains May:

- TC 61 submitted today may have an effective date of April 1, May 1, June 1, July 1, or August 1. Payment adjustments are made on the July payment MMR;
- TC 51 submitted today may have an effective date of April 1, May 1, June 1, July 1, or August 1. Payment adjustments are made on the July payment MMR.

Plans must comply with CMS enrollment and disenrollment guidance requirements for the timely submission of enrollment transactions following the receipt of a valid enrollment request. To meet these submission timeframes, Plans should submit a batch file at a minimum of every week and should strive for more frequent submissions.

Reinstatement of Enrollment/Disenrollment

Transaction Codes 80/81 removes a prior successfully processed enrollment or disenrollment action submitted by the current Plan and reinstates the beneficiary's enrollment to its prior state when MARx enrollment edits permit. Payments and premiums are also re-calculated and election period rules do not count against the beneficiary.

Reinstatement Criteria

Plans should consider the following criteria when MARx reinstates an enrollment period:

- Prior to beneficiary reinstatement, MARx evaluates the beneficiary and Plan status to ensure all values are within eligibility limits. The beneficiary is not reinstated for any month in which eligibility requirements are not met for the following subject areas:
    - Death of the beneficiary,
    - Medicare entitlement and Part D eligibility,
    - Beneficiary does not meet the health status requirements of the Plan, and
    - Plan is not open and active.
- A reinstated enrollment is not evaluated against the same rules as a new enrollment, such as timeliness of submission, Plan enrollment status, or election periods. The reinstatement qualifications are similar to the qualifications for remaining enrolled. For example, an enrollment is not reinstated when the beneficiary does not have sufficient entitlement or eligibility.
- MARx recalculates all beneficiary payments and premiums.

Reinstatement of Enrollment from Erroneous Auto Disenrollments

Notification of a beneficiary's date of death (DOD) triggers an automatic disenrollment in MARx. Sometimes these DODs are reversed or refined by subsequent updates, such that the original disenrollment is no longer appropriate.

A mechanism within the MARx system will attempt to automatically reinstate enrollments for beneficiaries who were auto-disenrolled by a report of DOD where there was a subsequent DOD correction or removal that impacts the Plan enrollment.

In conjunction with the reinstatement of enrollment, Plans receive appropriate TRCs that contain the information on the updated DOD and reinstated enrollment.

Reinstatement Resulting from Erroneous Auto Disenrollment Criteria

- Changes to the DOD effective date are applicable to auto reinstatement where Plan enrollment is impacted.
- All affected Plans receive a communication concerning reinstated enrollments.
- A reinstatement of enrollment does not exhaust or count against a beneficiary's usage of an election period.
- A corrected DOD that results in an earlier DOD also adjusts the Plan disenrollment.

Employer Group Health Plan (EGHP)

The Plan must set the EGHP Flag field to Y when submitting enrollment transactions for any beneficiary requesting enrollment into an employer or union group sponsored Plan. This includes Direct Contract, 800 series, and individual Plan enrollments. Plans should set this flag to Y for TC 61. Additionally, Plans may directly submit enrollment and disenrollment transactions for EGHP members up to three months retroactive to the CCM. Appendix F provides more details.

End-Stage Renal Disease (ESRD) Override Enrollment in MA and Cost Plans

The Prior Commercial Code field is used when an individual with ESRD is eligible to enroll in an MA or Cost Plan, as determined by the Plan, under any one of the exceptions to the ESRD eligibility rule, as provided in the CMS enrollment guidance applicable to the Plan type. It is critical that the Plan include this code in the enrollment transaction to ensure the enrollment is successful. If the Plan omits the code, MARx rejects the enrollment record if there is already an ESRD indicator in the MARx database or MARx receives a retroactive ESRD status.

The Prior Commercial Code is indicated in Position Number 80 on the Enrollment/ Disenrollment/Change Transaction record layout. The available code values are 0 through 9 and A through F, with which CMS previously recorded the number of months a beneficiary was enrolled in the commercial part of the Plan. Currently Plans should use code F in the Prior Commercial Months field for all cases.

MA/MAPD Plans

MA/MAPD eligible individuals may not enroll in more than one MA/MAPD Plan at any given time. Individuals enrolled in an MAPD Plan may not hold concurrent enrollment in a PDP, except for individuals enrolled in an MSA Plan, MA-Only Plan, or individuals enrolled in a PFFS Plan that does not offer Medicare prescription drug coverage.

Part D Plans

A Part D eligible individual cannot enroll in more than one PDP at the same time. A Part D eligible individual cannot simultaneously enroll in a PDP and an MA Plan except for an MA-PFFS Plan that does not offer the Part D benefit or an MSA or an MA-Only Plan. A beneficiary can enroll in a Part D Plan while enrolled in a Cost Plan but may not also enroll in the Cost Plan's optional supplemental Part D benefit.

4.2 Cost Plan Transaction Processing

Because beneficiaries can choose to enroll in separate or stand-alone PDPs and enroll in or remain enrolled in a Cost Plan, CMS uses PBP-level processing for Cost Plan organizations. CMS performs the following:

- The Health Plan Management System (HPMS) provides available drug and non-drug PBP numbers for Cost Plans to MARx. If the Cost Plan does not have an approved non-drug PBP, HPMS generates a dummy non-drug PBP number of 999 for this Plan. This is unnecessary for drug PBPs, as Cost Plans are required to create drug PBPs.

Beneficiaries who are members of a non-drug PBP of a Cost Plan may elect to obtain Part D coverage through the Cost Plan if it is offered as an optional, supplemental benefit by the Cost Plan or through a separate PDP.

If a current member elects to obtain Part D through the Cost Plan, the Plan submits a TC 61to move the member from the non-drug PBP to the drug PBP, including the valid election type and Part D premium-related information. If a current member elects to obtain Part D through a PDP while remaining in the Cost Plan, the Cost Plan submits no transactions. When the PDP submits a TC 61 to enroll the beneficiary, CMS does not disenroll the member from the Cost Plan.

If a current member enrolled in the Part D benefit of the Cost Plan requests to drop Part D, i.e. move from the drug PBP to the non-drug PBP, the Plan submits a TC 61 transaction to move the member and includes the valid election type that permits the disenrollment from Part D.

- If a new member elects to enroll in the non-drug portion of the Cost Plans, the Plan submits a TC 61 with a non-drug PBP number. The number 999 is used if the user does not have a non-drug PBP approved in HPMS.
- If a new member elects to enroll in the drug portion of the Cost Plans, the Plan submits a TC 61 with the drug PBP number, election type, and Part D premium-related information.

The following clarifications related to election periods also impact Cost Plans. In two of the three scenarios, the user must specify an election type:

- Enrollment into a Cost Plan's non-drug PBP from FFS or a non-MA Plan does not require the specification of an election type. The beneficiary does not utilize an election when enrolling in non-MA or non-Part D Plans.
- Enrollment into a Cost Plan's non-drug PBP requires that the member indicate if they are enrolled in an MA or MAPD. This occurs because the beneficiary must utilize an election to disenroll from the latter Plan types. At the time of enrollment, the Cost Plan may need to query the beneficiary if they are currently enrolled in an MA Plan.

Enrollment into, or disenrollment from, a Cost Plan's drug PBP always requires the specification of a Part D election type of AEP, IEP, or SEP. The beneficiary must request enrollment during a valid enrollment period.

4.3 Production Schedule

The following section describes the processing flows for submitting transactions to and receiving reports from CMS. In general, transaction processing occurs monthly for a CCM until the cutoff date, and ends at the end of each month. At the cut-off date, new transaction processing is suspended. The month-end process performs final summarization of beneficiary level payments to Plan level payments. While CMS reviews monthly payments for approval, Plan transaction processing resumes for the next month. Once CMS approves the monthly payments, reports are distributed to the Plans.

4.3.1 System Interfaces

Health Plan Management Systems (HPMS)

HPMS contains complete information about contracts between Plans and CMS. It provides information about contracts, PBPs, segment numbers, and service areas. Most importantly, HPMS identifies the type of contract and the Payment Bill Option (PBO) code, which is linked to rules for enrollment and payment. HPMS also provides MARx with information about terminations, rollovers (where some or all beneficiaries in one contract automatically move to another contract), payment rates, and rebate amounts. MARx receives reports regarding changes to contracts and Plan information. If changes affect payment, MARx calculates a new payment and any appropriate adjustments.

Risk Adjustment System (RAS)

- RAS provides MARx with beneficiary-specific, risk-adjusted factors for calculating Part C and Part D payments. Based on each beneficiary's medical history, the factors reflect claims and encounter data.
- Risk-adjusted factors are calculated annually. They are updated midyear and reconciled within nine months after the end of the year. When these changes occur, MARx automatically recalculates payments and appropriate adjustments.

Automated Plan Payment System (APPS)

- Upon successful enrollment, MARx calculates prospective Plan payment amounts for newly enrolled beneficiaries. At the end of the monthly payment cycle, payments and enrollments are summarized at segment, PBP, and contract levels in different monetary categories and transmitted in files to APPS.
- If CMS finds no problems during month-end payment validation, CMS certifies, or approves, the month's processing and allows APPS to generate a file of payment records. This file is passed to CMS' main accounting system, then to the U.S. Treasury, which initiates wire transfers to the Plans.
- If CMS finds a problem, built-in backup procedures allow reprocessing of all or part of the monthly production run.

Medicare Beneficiary Database (MBD) and Enrollment Database (EDB)

Many MARx operations require the MBD and EDB beneficiary information such as:

- Entitlement to Medicare Part A, Part B, and Part D.
- Health status, other than institutional and NHC coverage.
- Part C and Part D premium options.
- Mailing address.

MBD notifies MARx when the beneficiary information changes, so that MARx can determine validity of the beneficiary's enrollment and whether payments need adjustment.

Social Security Administration (SSA)

SSA maintains beneficiaries' benefit checks. SSA is responsible for withholding Part B, C, and D premiums and processing Part B Premium Reductions based on information received from CMS. MARx processes Plan-submitted requests for withholding and identifies any other changes that impact SSA processing of the benefit check. This includes changes in Plans, premium amounts, LIS status, and LEP. MARx transmits these changes to SSA for processing. SSA responds with the results of the processing and MARx notifies the Plans with specific TRCs.

Railroad Retirement Board (RRB)

Similarly, RRB maintains their retirees' benefit checks. RRB withholds Part B, C, and D premiums and processes Part B Premium Reductions based on information received from CMS. MARx processes Plan-submitted requests for withholding for RRB beneficiaries and identifies any other changes that impact RRB processing of the benefit check. This includes changes in Plans, premium amounts, LIS status, and LEP. MARx transmits these changes to RRB for processing. RRB responds with the results of the processing and MARx notifies the Plans with specific TRCs.

4.4 Transaction Reports

MARx communicates a transaction disposition through a variety of reports transmitted to the Plan. Upon receipt of a transaction file, the Plan representative-transmitter who submits the file receives the Batch Completion Status Summary (BCSS). Following the completion of a batch process, the DTRR is received by the user. The DTRR provides a disposition for the transactions submitted daily, along with results from various system notifications and CMS actions.

To allow Plans to automate processing, they receive many of the daily and monthly reports in a data file format. Appendices F and J provide reports and data file details. Plans may correct and resubmit failed and rejected transactions for processing. Plans validate payments at the beneficiary level based on information, i.e., enrollment, disenrollment, cancellation, applicable health statuses, effective at the time of processing. This information is available via the DTRR and several payment reports and data files. Payment reports include the Monthly Membership Detail Report (MMDR) and Monthly Membership Summary Report (MMSR).

4.4.1 General

CMS provides access to its reports to allow Plans to view their Medicare membership information. In general, these reports allow Plans to compare Medicare membership and payment information with their internal records to assist them in identifying and correcting any discrepancies. Each report is described in detail below. Appendices F and J provide record layouts and examples of the following reports.

4.4.2 Batch Completion Status Summary (BCSS)

The BCSS file is the daily communication created to ensure Plans confirm the status of their transactions submitted to CMS in a timely manner. Plans use this file as a receipt. When CMS receives the Plan-submitted transaction, the BCSS summarizes the Plan's submission. Appendix F.2 provides more information on this file.

4.4.3 Daily Transaction Reply Report (DTRR)

To assure Plans receive proper payment, the Plan's Medicare membership records must agree with those reported to and maintained by CMS. The DTRR identifies whether a beneficiary submission was accepted or rejected and provides additional information about Plan membership.

There are three types of records:

- **Reply Records** – indicate the types of CMS action taken on the transactions submitted by the Plans daily, if transactions were received and processed.
- **Maintenance Records** – indicates existing membership records were updated because CMS has initiated action to change or update.
- **Plan Submitted Transaction Records** – displays the transaction submitted by Plans; does not show results, but allows Plans to view a transaction paired with its generated replies.

Upon receipt of the DTRR, it is important that Plans continue to reconcile their beneficiary records with these reports. If Plans encounter potential system problems, they should report them to the MAPD Help Desk. Plans should submit corrected transactions to CMS promptly. Plans should not try to resolve a system issue by submitting falsified or incorrect data.

Each record is supplied to Plans for a specific purpose that is defined by the TRC. A three-digit reply code is supplied for each record. Reply code definitions are provided in Appendix I. Appendix F.14 provides more information on this file.

4.4.4 MAPD/Cost Plan Full Dual Auto Assignment Notification File

CMS has directed the following organizations to auto/facilitate enroll (AE-FE) LIS beneficiaries from their MA-only Plan into a MAPD Plan or Cost Plan Part D optional supplemental benefit:

- MA organizations that offer MA-only Plans;
- MA PFFS organizations that offer at least one Plan with a Part D benefit; and
- 1876 Cost Plans that offer at least one Plan with a Part D optional supplemental benefit.

Note: This file is driven by the Medicare Beneficiary Database (MBD) Application.
The organization must first identify LIS beneficiaries in its MA-only Plan or Cost Plan without Part D, e.g., those beneficiaries identified on the LIS bi-weekly report. The organization must then determine the full-dual eligible subsets, which is accomplished by reviewing the monthly MA Full Dual Auto Assignment Notification File. The MA Full Dual Auto Assignment Notification File identifies those who held full-benefit dual eligibility at any time during the calendar year. The organization must distinguish between the two populations because the effective date is calculated differently for full dual eligible for whom the organization auto-enrolls versus non-full dual eligible with LIS for whom the organization facilitates enrollment.

For information on the file layout, Plans should refer to Appendix F; for information on this file's naming standards, Plans should refer to Appendix K.

4.4.5 PDP Notification File for AE-FE (including Beneficiary Addresses)

CMS enrolls LIS beneficiaries into PDPs through AE-FE. The PDP Notification File provides LIS information and immediate access to full name and address data for these beneficiaries. Each October, it also provides information on individuals gained and lost due to reassignment. 1-800-MEDICARE Customer Service Representatives (CSRs) should have access to the data on this file so they can answer beneficiary queries prior to the PDP auto/facilitated enrollments. Also, this file assists Plans in expediting the submission of the 4Rx records for these beneficiaries.

Because CMS performs AE on a daily basis, PDPs may receive this file daily throughout the month. This file only contains assignments, not confirmation that MARx processed AE-FE transactions for beneficiaries. Plans must still check DTRRs to determine whether the assignments were accepted or rejected as actual enrollments into their PDP. These reports offer two ways for Plans to differentiate between the full and non-full dual eligible beneficiaries assigned to them. One option is the monthly PDP notification file and the DTRR, Enrollment Type = **A** for auto-enrollment or **C** for facilitated enrollment. A second option on the DTRR is TRC 117 = Auto-enrollment, and TRC118 = Facilitated enrollment.

For information on the file layout, Plans should refer to Appendix F; for information on this file's naming standards, Appendix K.

4.4.6 Monthly Full Enrollment File Data (FEFD)

FEFD provides Managed Care and Prescription Drug organizations with their official membership list on record with CMS. This invaluable tool helps Plans reconcile their membership records with CMS records. Plans receive FEFD with their other monthly reports. Appendix F.15 provides more information on this file.

4.5 Agent Broker Compensation Cycles

For Plan enrollments, MARx established a status of initial or renewal as well as a six-year compensation cycle. This status provides Plans with the information necessary to determine how to pay agents for specific beneficiary enrollments. Plans pay agents an initial amount or a renewal amount as provided in the CMS agent compensation guidance.

Based on the qualification rules, Year 1 is the initial year and Years 2 through 6 are the renewal years. Plans are responsible for using this information together with their internal payment and enrollment tracking systems to determine if an agent was used and the amount to pay the agent.

The Agent Broker Compensation Report Data File is generated and sent to Plans along with the first DTRR of each calendar month and reports the following:

- All new enrollments, whether retroactive, current, or prospective, with 6-year broker compensation cycles.
- All changes to existing and prior enrollments as a result of retroactive enrollments and disenrollments.
- Increments to cycle-year counts each January 1st.

Plans can re-order the Agent Broker Compensation Report Data File via the User Interface (UI). The detailed file layout for the Agent Broker Compensation Report Data File is located in Appendix F as report #29.

- The file naming convention for this data file is located in Appendix K.

4.5.1 Compensation Rate Adjustment for 2014

CMS regulations at 42 CFR §§422.2274(a)(1)(i)(A) and 423.2274(a)(1)(i)(A) stipulate that the compensation amount paid to an independent agent or broker for an enrollment is at or below the fair market value (FMV) cut-off amounts published yearly by CMS.

The chart below summarizes the CY 2014 FMV cut-off amounts for all organizations, Plan sponsors, and Cost Plans.

MA and Section 1876 Cost Plans				
Compensation Type	National	Connecticut, Pennsylvania, District of Columbia	California New Jersey	Puerto Rico, U.S. Virgin Islands
Initial Year	$425	$480	$532	$292
Renewal Years	$213	$240	$266	$146
PDPs				
Initial Year	$56			
Renewal Years	$28			

NOTE: The FMV amounts for CY 2014 are rounded to the nearest dollar. The Initial Year Amount is paid for enrollments during compensation cycle-year 1. The Renewal Amount is paid for enrollments during compensation cycle-years 2-6.

4.5.2 Compensation Rate Submission for 2014

As in past years, all Plans must inform CMS whether they are using employed, captive, or independent agents. Plans that use independent agents must provide the compensation amount or range of amounts paid for these agents. Additionally, if referral fees are paid, Plans must disclose the referral fee amount. The HPMS Marketing Module User Guide release on May 31, 2013 included data entry instructions.

Plans may submit their agent/broker information in the HPMS Marketing Module from May 31, 2013 through July 29, 2013. Please note that the submission process is not complete until the Plan's CEO, COO, or CFO has completed the attestation in HPMS. Plans failing to submit and attest to their agent/broker compensation data by July 29, 2013 are out of compliance.

CMS expect Plans to keep full records proving that compensation schedules are updated and agents/brokers are paid per CMS requirements.

CMS will make the CY 2014 compensation information submitted available for beneficiaries to view on www.cms.gov and www.medicare.gov, before the annual election period for CY 2014.

5 Payment Process and Calculations

The capitation payments provided to Medicare Advantage (MA) and Medicare Advantage and Prescription Drug (MAPD) sponsors are calculated and paid on a monthly basis. The estimated payments are based on system information at the time monthly payments are made. Part C payments are finalized annually with the final reconciliation of risk adjustment (RA) data. Part D payments are finalized annually with the final reconciliation of prescription drug event (PDE) data.

As changes to beneficiary or Plan data are received, adjustments are made to monthly payments. Changes will cause a recalculation of one or more payment components. The adjustments are processed retroactively to the change effective date and reported to the Plans on the monthly payment reports.

Note: Policy dictates that the actual payment adjustments are generally limited to the three-year period preceding the CPM. This limitation is known as the **36-Month Rule**.

The 36-Month Rule specifically limits retroactive corrective payment adjustments, both positive and negative, to a three-year period. This period precedes the month of receipt of data that indicates a change in the calculated Plan payment for a specific beneficiary or Plan payment component. The changes may include demographic adjustments such as age, sex, county of residence, or other indicators that reflect Medicare payment levels, such as End Stage Renal Disease (ESRD) or Medicare Secondary Payer (MSP) status. The three-year limitation ensures consistency with other Medicare payment limitations, and applies to payments for Managed Care Organizations (MCOs).

5.1 Part C Payment Calculation

This section provides an overview of Part C payment calculation. Part C payments are paid to an MCO in exchange for providing Medicare Part A and/or B coverage to Medicare beneficiaries enrolled in the MCO.

An overview of the methodologies that CMS employs to reimburse all types of Medicare Advantage (MA) Plans is available at the *Medicare Managed Care Manual (MMCM)* Chapter 8 link: http://www.cms.gov/manuals/downloads/mc86c08.pdf.

Before the payment process begins, the beneficiary submits the enrollment application, and the Plan checks the eligibility of the beneficiary and transmits an enrollment transaction to CMS. If the enrollment transaction is accepted, CMS calculates the Part C payment. If CMS rejects the enrollment, the Plan is notified. If possible, the Plan must correct the rejected information and resubmit the transaction.

The calculation of Part C payments varies and is separately described by the following:

- Beneficiaries electing Hospice Coverage.
- Beneficiaries with End Stage Renal Disease (ESRD).
- Aged or Disabled Beneficiaries enrolled in an MA Plan.
- Aged or Disabled Beneficiaries enrolled in a Program for All-Inclusive Care for the Elderly (PACE) Plan.
- When Medicare Secondary Payer (MSP) Status applies.

This section does not describe Part C payment for beneficiaries enrolled in Cost Plans, Healthcare Prepayment Plans, Chronic Care Demonstrations, and Medical Savings Account (MSA) Plans. Please refer to the following reference table for calculating Part C Payments.

Table 5-1: Part C Payment Reference

#	Monthly Membership Detail Data File Field Names for Part C Payment Calculations	Length	Position	Description
24	Risk Adjustment (RA) Factor A	7	72-78	Format NN.DDDD
25	RA Factor B	7	79-85	Format NN.DDDD
33	Risk Adjusted (RA) Payment Part A	9	126-134	Format -99999.99
34	RA Payment Part B	9	135-144	Format -99999.99
54	Part C Basic Premium Amount Part A	8	199-206	Format -9999.99
55	Part C Basic Premium Amount Part B	8	207-214	Format -9999.99
56	MA Rebate Part A Cost Sharing Reduction	8	215-222	Format -9999.99
57	MA Rebate Part B Cost Sharing Reduction	8	223-230	Format -9999.99
58	MA Rebate Part A Other Mandatory Supplemental Benefits	8	231-238	Format -9999.99
59	MA Rebate Part B Other Mandatory Supplemental Benefits	8	239-246	Format -9999.99
60	MA Rebate Part A – Part B Premium Reduction	8	247-254	Format -9999.99
61	MA Rebate Part B – Part B Premium Reduction	8	255-262	Format -9999.99
62	MA Rebate Part A - Part D Supplemental Benefits	8	263-270	Format -9999.99
63	MA Rebate Part B - Part D Supplemental Benefits	8	271-278	Format -9999.99
64	Total MA Payment – Part A	10	279-288	Format -999999.99
65	Total MA Payment – Part B	10	289-298	Format -999999.99
66	Total MA Payment	11	299-309	Format -9999999.99
81	Part C Frailty Score	7	412-418	Format NN.DDDD
82	MSP Factor	7	419-425	Format NN.DDDD
83	MSP Reduction Amount – Part A	10	426-435	Format -999999.99
84	MSP Reduction Amount – Part B	10	436-445	Format -999999.99
89	Part A Monthly Payment Rate	9	459-467	Format -99999.99
90	Part B Monthly Payment Rate	9	468-476	Format -99999.99

5.1.1 Part C Payments for Beneficiaries electing Hospice Coverage

Traditional Medicare Fee-for-Service (FFS) provides Medicare Part A and B benefits for a beneficiary electing Hospice Coverage. If the beneficiary is already enrolled in an MA Plan at the time of election, the Part C payment to the MA Plan is only for extra benefits provided by the Plan that are not provided by FFS.

The Part C payment is equal to the MA rebate, excluding any MA rebates for Part B premium reduction and Part D basic premium reduction. Otherwise, it equals zero.

- **Part C Payment**

  Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).

- Total MA Payment Part A (#64) = MA Rebate Part A Cost Sharing Reduction (#56) + MA Rebate Part A Other Mandatory Supplemental Benefits (#58) + MA Rebate Part A Part D Supplemental Benefits (#62).

- Total MA Payment Part B (#65) = MA Rebate Part B Cost Sharing Reduction (#57) + MA Rebate Part B Other Mandatory Supplemental Benefits (#59) + MA Rebate Part B Part D Supplemental Benefits (#63).

5.1.2 Part C Payments for Beneficiaries with ESRD

Medicare Part A and B benefits for beneficiaries with ESRD are provided by their Plans. The applicable monthly payment rates are set by CMS and remain outside the bidding process. Beneficiaries in Dialysis or Transplant statuses are paid State rates. Beneficiaries in Functioning Graft Status receive payment using CMS benchmark county rates.

Beneficiaries with ESRD who are enrolled in an MA Plan where an MA Rebate for Part B Premium Reduction or MA Rebate for Part D Basic Premium Reduction is applicable receive these rebate benefits through their enrollment in the Plan, despite the fact that the Part C risk-adjusted payment is not based upon the Plan's bid. The risk-adjusted portion of the Part C payment is therefore reduced by the MA Rebate premium reduction benefits to make room to provide the required rebate benefits.

For beneficiaries with ESRD who are enrolled in a PACE Plan, the Part C Payment calculations are exactly the same as if enrolled in an MA Plan, except MA Rebates are not applicable.

- Part C Payment = Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = RA Payment Part A (#33) - MA Rebate Part A for Part B Premium Reduction (#60) - MA Rebate Part D Basic Premium Reduction (Part A portion) (#72).
- RA Payment Part A (#33) = Part A Monthly Payment Rate (#89) * RA Factor A (#24).
- Total MA Payment Part B (#65) = RA Payment Part B (#34) - MA Rebate Part B for Part B Premium Reduction (#61) - MA Rebate Part D Basic Premium Reduction (Part B portion) (#72).
- RA Payment Part B (#34) = Part B Monthly Payment Rate (#90) * RA Factor B (#25).

5.1.3 Part C Payments for Aged or Disabled Beneficiaries enrolled in an MA Plan

Calculation of Part C Payments for Aged/Disabled Beneficiaries in an MA Plan depends upon the relationship of the Plan's A/B Bid to the applicable CMS Benchmark.

Plan's A/B Bid Equal to CMS Benchmark

- Part C Payment = Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = RA Payment Part A (#33)
- RA Payment Part A (#33) = Part A Monthly Payment Rate (#89) * RA Factor A (#24).
- Total MA Payment Part B (#65) = RA Payment Part B (#34)
- RA Payment Part B (#34) = Part B Monthly Payment Rate (#90) * RA Factor B (#25).

Plan's A/B Bid Less than CMS Benchmark (MA Rebate Applies)

- Part C Payment = Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = RA Payment Part A (#33) + MA Rebate Part A Cost Sharing Reduction (#56) + MA Rebate Part A Other Mandatory Supplemental Benefits (#58) + MA Rebate Part A Part D Supplemental Benefits (#62).
- RA Payment Part A (#33) = Part A Monthly Payment Rate (#89) * RA Factor A (#24).
- Total MA Payment Part B (#65) = RA Payment Part B (#34) + MA Rebate Part B Cost Sharing Reduction (#57) + MA Rebate Part B Other Mandatory Supplemental Benefits (#59) + MA Rebate Part B Part D Supplemental Benefits (#63).
- RA Payment Part B (#34) = Part B Monthly Payment Rate (#90) * RA Factor B (#25).

Plan's A/B Bid Greater than CMS Benchmark (Part C Basic Premium Applies)

- Part C Payment = Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = RA Payment Part A (#33) - Part C Basic Premium Amount Part A (#54).
- RA Payment Part A (#33) = Part A Monthly Payment Rate (#89) * RA Factor A (#24).
- Total MA Payment Part B (#65) = RA Payment Part B (#34) - Part C Basic Premium Amount Part B (#55).
- RA Payment Part B (#34) = Part B Monthly Payment Rate (#90) * RA Factor B (#25).

5.1.4 Part C Payments for Aged or Disabled Beneficiaries enrolled in a PACE Plan

Part C Payment calculations for Aged/Disabled Beneficiaries in a PACE Plan are based upon monthly payment rates set by CMS which, like ESRD, remain outside the bidding process. MA Rebates and Part C Basic premiums are components of bid-based payments and do not apply. Aged/Disabled Beneficiaries enrolled in a PACE Plan who reside in a community setting also receive a Frailty Factor Adjustment in addition to the normal Risk Adjustment.

- Part C Payment = Total MA Payment[1] (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = RA Payment Part A (#33).
- RA Payment Part A (#33) = Part A Monthly Payment Rate (#89) * (RA Factor A (#24) + Part C Frailty Score (#81)).
- Total MA Payment Part B (#65) = RA Payment Part B (#34).
- RA Payment Part B (#34) = Part B Monthly Payment Rate (#90) * (RA Factor B (#25) + Part C Frailty Score (#81)).

[1] MA payment fields are still used on the MMR to describe these PACE payments even though the term MA is a misnomer.

5.1.5 Part C Payments When Medicare Secondary Payer (MSP) Status Applies

Medicare is a secondary payer for Aged or Disabled beneficiaries with employer-provided health insurance, or for beneficiaries with ESRD, during the coordination of benefits period. When MSP Status applies, the risk-adjusted portion of the Part C Payment is reduced to account for the coverage that the employer provides for Working Aged or Working Disabled beneficiaries, or that the health Plan provides for beneficiaries with ESRD.

The MSP Reduction Amount is an additional Part C payment adjustment that is applied after all other calculations described in the previous sections are completed.

For Part C Payments involving an MA Rebate, the Rebate is ignored in computing the MSP Reduction Amounts:

- Part C Payment = Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = Total MA Payment Part A (#64) - MSP Reduction Amount Part A (#83).
- MSP Reduction Amount Part A (#83) = RA Payment Part A (#33) * (1 - MSP Factor (#82)).
- Total MA Payment Part B (#65) = Total MA Payment Part B (#65) - MSP Reduction Amount Part B (#84).
- MSP Reduction Amount Part B (#84) = RA Payment Part B (#34) * (1 - MSP Factor (#82)).

For Part C Payments involving a Part C Basic Premium, the Premium is subtracted from the RA Payment before computing the MSP Reduction Amounts:

- Part C Payment = Total MA Payment (#66) = Total MA Payment Part A (#64) + Total MA Payment Part B (#65).
- Total MA Payment Part A (#64) = MA Part A Payment/Adjustment (#33) - MSP Reduction Amount Part A (#83).
- MSP Reduction Amount Part A (#83) = (RA Payment Part A (#33) - Part C Basic Premium Amount Part A (#54)) * (1 - MSP Factor (#82)).
- Total MA Payment Part B (#65) = MA Part B Payment/Adjustment (#34) - MSP Reduction Amount Part B (#84).
- MSP Reduction Amount Part B (#84) = (RA Payment Part B (#34) - Part C Basic Premium Amount Part B (#55)) * (1 - MSP Factor (#82)).

5.2 Part D Payment Calculation

5.2.1 General

This section provides an overview of Part D payment calculation. MCOs receive Part D payments in exchange for providing Medicare Part D coverage to Medicare beneficiaries. Before the payment process begins, the beneficiary submits the enrollment application, and the Plan checks the beneficiary's eligibility and transmits an enrollment transaction to CMS. If the enrollment transaction is accepted, CMS finalizes the accepted enrollment and notifies the Plan, which then notifies the beneficiary. If CMS rejects the enrollment, the Plan is notified and must correct the rejection reason. With an accepted enrollment transaction, CMS calculates the Part D payment.

Several Part D Payment components are estimated amounts subject to a cost-based annual Part D payment reconciliation; these results are reflected on the Plan Payment Report (PPR) and not on the Monthly Membership Report (MMR). The estimated payments are:

- Part D Low-Income Cost-Sharing (LICS) Subsidy.
- Part D Reinsurance Subsidy.
- Part D Coverage Gap Discount Amount[2]

Please refer to the following reference table for calculating Part D Payments:

Table 5-2: Part D Payment Reference

#	Monthly Membership Detail Data File Field Names for Part D Payment Calculations	Length	Position	Description
35	Part D Low-Income Premium Subsidy (LIPS) Amount	8	144-151	Format -9999.99
67	Part D RA Factor	7	310-316	Format NN.DDDD
72	MA Rebate Part D Basic Premium Reduction	8	333-340	Format -9999.99
73	Part D Basic Premium Amount	8	341-348	Format -9999.99
74	Part D Direct Subsidy Amount	10	349-358	Format -999999.99
75	Part D Reinsurance Subsidy Amount	10	359-368	Format -999999.99
76	Part D LICS Subsidy	10	369-378	Format -999999.99
77	Total Part D Payment	11	379-389	Format -9999999.99
79	PACE Part D Premium Add-on	10	392-401	Format -999999.99
80	PACE Part D Cost Sharing Add-on	10	402-411	Format -999999.99
86	Part D Coverage Gap Discount Amount	8	448-455	Format -9999.99
91	Part D Monthly Payment Rate	9	477-485	Format -99999.99

[2] The Coverage Gap Discount is not a subsidy, but an advance to provide cash flow. Offsets against the Plan's total payment are periodically taken when the discount payments are made by drug manufacturers, and again during the Annual Part D Reconciliation.

5.2.2 Calculation of the Total Part D Payment

The Total Part D Payment (#77) for a beneficiary is the sum of the following amounts; no individual payment includes all components:

- Part D LIPS (#35).
- MA Rebate Part D Basic Premium Reduction (#72).
- Part D Direct Subsidy Amount (#74).
- Part D Reinsurance Subsidy (#75).
- Part D LICS Subsidy (#76).
- PACE Part D Premium Add-on (#79).
- PACE Part D Cost Sharing Add-on (#80).
- Part D Coverage Gap Discount Amount (#86).

5.2.3 Calculation of the Part D Direct Subsidy

The Plan's Part D bid is reported on the MMR and shown below as the Part D Monthly Payment Rate. The Part D Basic Premium Amount reported on the MMR, and included in the formula below, is not necessarily the same as the premium paid by the beneficiary but an amount specifically calculated for use in this payment formula.

Note: It is possible for the Part D Direct Subsidy calculation to result in a negative amount for an individual beneficiary.

- Part D Direct Subsidy Amount (#74) = (Part D Monthly Payment Rate (#91) * Part D RA Factor (#67)) - Part D Basic Premium Amount (#73).

5.3 Part D Creditable Coverage and Late Enrollment Penalty (LEP)

Medicare-eligible beneficiaries are legally required to have prescription drug coverage, either from a Medicare Prescription Drug Plan (PDP) or a non-Medicare equivalent insurer that provides drug coverage. If a Medicare-eligible beneficiary does not have prescription drug coverage after Part D eligibility is established, an LEP is assessed against the beneficiary. The penalty is added to the Part D premium once the beneficiary is enrolled in a Medicare PDP.

To establish whether or not a beneficiary is assessed an LEP, Plans must determine the number of months in which a Medicare-eligible beneficiary did not have creditable drug coverage for a continuous period of 63 days or more, and report this as the Number of Uncovered Months (NUNCMO) to CMS. CMS calculates the LEP by multiplying a percentage, currently 1 percent, of the national base beneficiary Part D premium for the current coverage year by the total NUNCMO, regardless of the year(s) in which those months occurred. This calculation occurs annually because the percentage and the base beneficiary Part D premium changes each year.

Plans report the NUNCMO to CMS by including it on an enrollment, Transaction Code (TC) 61 or separately on a TC 73 if the determination is made after the enrollment transaction is submitted. If there are no uncovered months to report, Plans must place a Y in the creditable coverage field and 000 in the NUNCMO field. If there are uncovered months to report, Plans place an N in the creditable coverage field and the applicable number in the NUNCMO field.

An R value in the creditable coverage field resets a NUNCMO value to zero as of the transaction effective date. This could occur, for example, if the beneficiary has a new Part D Initial Enrollment Period (IEP) or if the beneficiary becomes LIS eligible. The Plans cannot use the R value to correct existing NUNCMO data. The outcome of the Reset action is two distinct periods of NUNCMO; the original period with an end date, followed by the new Reset period where the NUNCMO value was reset to zero going forward. A U value in the creditable coverage field reverses a previously submitted R, or Reset, only. Each of the above values is associated with the effective date of a Part D enrollment period. Only the R value is associated with a date within a Part D enrollment period.

The table below summarizes the actions Plans should take to submit NUNCMO data:

Table 5-3: Summary of Medicare Advantage and Prescription Drug System (MARx) Transactions to Add, Change, or Remove the NUNCMO for Enrolled Beneficiary

Action	Creditable Coverage Flag Value	NUNCMO Field Value	Effective Date on Transaction Code 73
Submit a new NUNCMO	N	Number greater than 0	Equal to existing enrollment effective date **Note:** An enrollment TC 61 may also provide this information.
Change/correct an existing NUNCMO due to Plan error or reconsideration decision	N	Revised existing number to a number greater than 0 – new number of months (>0)	Equal to existing enrollment effective date
	Y	0 to remove the existing number completely.	Equal to existing enrollment effective date

5.4 Coverage Gap Discount Program Payments

The Coverage Gap Discount Program (CGDP) provides manufacturer discounts to eligible Medicare beneficiaries receiving covered Part D drugs while in the coverage gap (aka the "donut hole"). Eligible Medicare beneficiaries in the program consist of non-low income subsidy eligible (non-LIS) beneficiaries who are not enrolled in an Employer Group Waiver Plan (EGWP) or a Program of the All Inclusive Care for the Elderly (PACE) organization. Part D sponsors must provide the discounts for applicable drugs in the coverage gap at point-of-sale (POS). CMS coordinates the collection of discount payments from manufacturers and payment to Part D sponsors that provided the discount.

5.4.1 Prospective Payments

CMS provides a monthly prospective CGDP payment that is calculated on the projection in each Part D Plan's bid and their current enrollment. These prospective payments provide cash flow to Part D sponsors for advancing the gap discounts at the POS.

Prospective CGDP payments for a contract year begin with the January monthly payment for the contract year and end with the December monthly payment. Adjustments for a contract year continue until January of the following year. For example, the first prospective payment for benefit year 2013 are in the January 2013 monthly payment and the last payment containing adjustments are in the January 2014 monthly payment. The prospective CGDP payment amounts will be found on the Monthly Membership Report (MMR).

5.4.2 Manufacturers Offset

On a quarterly basis, CMS will invoice manufacturers for discounts provided by Part D sponsors. Manufacturers will remit payments for invoiced amounts directly to Part D sponsors. The prospective payments made to Part D sponsors will be reduced by the discount amounts invoiced to manufacturers. These offsets will ensure that Part D sponsors do not receive duplicate payments for discounts made available to their enrollees.

On a quarterly basis following the invoicing cycle, CMS offsets monthly prospective CGDP payments for discount amounts invoiced to manufacturers. The offset amount will appear as a negative adjustment to the next monthly prospective payment processed through Automated Plan Payment System (APPS). When the APPS offset exceed the prospective CGDP payment for that month, CMS will apply the offset to the Part D sponsor's total payment.

5.4.3 CGDP Reconciliation

After the end of the contract year, CMS will conduct a cost-based reconciliation for the CGDP. Prospective payments are an estimate and Part D sponsors may experience actual CGDP costs greater than or less than the prospective payments. The actual manufacturer discount amounts will be determined based on the manufacturer discount amounts reported by Part D sponsors on the prescription drug event (PDE) records. Active plans during the reconciliation benefit year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing the inputs and results of the CGDP reconciliation process for the contract year. Questions regarding Coverage Gap Discount Reconciliation should be directed to StrategicHealthSolutions, LLC (Strategic) at PartDPaymentReview@strategichs.com

5.5 Payment Reports

CMS reports contain Plan Medicare membership and payment information as indicated in CMS systems for that CPM. In general, these reports allow Plans to compare Medicare membership and payment information with the Plan's internal records to assist Plans in identifying and correcting any discrepancies. Each report is described in detail below. Appendices F and J provide record layouts and examples of the following reports.

5.5.1 Monthly Membership Report (MMR)

The MMR is available in both print image and the data file format. Created monthly, the MMR provides information to Plans for reconciling the Plan Medicare membership and payment records to CMS records. This report does not reflect the deduction of the Balanced Budget Act of 1997 (BBA) user fee or any bonus payments. The Plan Payment Report (PPR) indicates that amount.

The print image report is actually three reports: two detailed and one summary.

- The print image report provides beneficiary-level detail for Part C payments. A second print image report, containing beneficiary-level Part D payment detail, is available for MAPDs and PDPs. Finally, a detail data file for both Part C and Part D payments and a summary data file are also available.

- The print image summary report presents a summary of the payments and adjustments applicable to the Plan's Medicare membership. For example, this format indicates the total number of beneficiaries that received a hospice, ESRD, or institutionalized payment.
- The MMR total amount should match the PPR total payment. The MMR reflects RA information. Since all Plans are 100 percent risk-adjusted, the RA payment method is reflected on the MMR. The report continues to display beneficiary-level status and also includes RA factor and payment rate information. Both the print image and the downloadable data file contain this data. Appendices F.9, F.10, J.4, J.5, and J.6 contain more information on this file.

5.5.2 Plan Payment Report (PPR)

The PPR is also referred to as the Payment Letter, and displays the payment amount wired by the U.S. Treasury to the Plan's bank account each month, including the Part A/Part B and Part D payment amounts. The PPR contains the total number of members and the amount paid for those members for the upcoming month, prospectively. The report also shows Plan-level adjustments for that payment amount.

This report itemizes the final monthly payments to the Plans. Produced by the Automated Plan Payment System (APPS) when final payment is calculated, CMS makes the PPR available to Plans as part of the month-end processing.

The PPR includes Part D payments and adjustments, the National Medicare Education Campaign (NMEC), and Coordination of Benefits (COB) User Fees and premium settlement information. Appendices F.25 and J.11 provide more information on this file.

5.5.3 Low-Income Subsidy (LIS)/Late Enrollment Penalty (LEP) Report

LIS/LEP Report contains members that:

- Are eligible for the Low Income Premium Subsidy (LIPS);
- Must pay an LEP and elect to directly pay Plans the premiums, i.e., Direct Bill.

Note: The premium amounts withheld from SSA benefits for LIS members are provided on the separate Monthly Premium Withhold Extract. CMS retains the LEP obtained from these members electing premium withhold prior to passing these premiums to the Plans. CMS offsets the LEP for directly billed members from the Plans' monthly payments.

The LIS/LEP Report is beneficiary-level and contains payments for the upcoming month as well as any applicable adjustments. Appendix F.16 provides more information on this file. The MMR reports the LEP subsidy amounts to Plans.

5.6 Reconciliation of Plan Data with CMS Data

Plans are responsible for providing CMS with timely and accurate information regarding the beneficiaries' enrollment, disenrollments, special membership status, and State and County Code (SCC) changes. CMS is responsible for providing Plans with timely and accurate reports to verify membership and payment information.

During their monthly reconciliation process, Plans should verify their membership and payment information. To ensure a complete and accurate reconciliation, Plans must understand and review all CMS-provided reports. The Appendices contain all provided reports and their data. It is required that all Plans are familiar with all of these reports and their impact on the accuracy of beneficiaries' information.

CMS also provides reports to Plans for information verification. Some reports have very specialized data, such as the Bonus Payment Report, with limited use in the overall reconciliation effort. However, the reports listed in this section are the most useful in the reconciliation process; they allow Plans to compare Medicare membership and payment information. Plans should use the Daily Transaction Reply Report (DTRR) to reconcile their beneficiary records with the Monthly Membership Detail Report (MMDR), which is beneficiary specific.

The PPR includes contract/PBP payment information and contract/PBP payment adjustment information. Therefore, when reconciling report data, Plans must compare the beneficiary level payment on the MMR with the contract level payment information on the PPR.

To complete the final month-end reconciliation, Plans should reconcile the DTRRs with the MMR, PPR, Monthly Premium Withholding Report (MPWR) Data File, and LIS/LEP Report. Plans must submit certification of enrollment monthly, to attest to the completion of reconciliation of membership and payment reports. The MARx Monthly Schedule lists certification due dates. Plans with specific reconciliation questions should contact the Division of Payment Operations (DPO) Central Office (CO) contact person. The DPO contact list is in Appendix B.

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6 Premium Withhold Process

Beneficiaries may elect to withhold their Part C and Part D premiums from their monthly Social Security and Railroad Retirement Board (RRB) benefits if the benefits amount equals or exceeds their premiums.

The premium withhold process relies on data reported by the Plans and on an interface between the Social Security Administration (SSA), RRB, and CMS. Processing begins when Plans submit premium information for new members on the enrollment transaction and for current members on the Premium Payment Option (PPO) Change Transaction Code (TC) 75.

Appendix F, Table F.6.4.4 provides the PPO Change (TC 75) Detailed Record Layout.

Plans report their Part C premiums as applicable and the premium withhold option selected by the member. Current options are SSA Withholding, RRB Withholding, or Direct Bill (self-pay).

Appendix F, Section F.10, details the Monthly Premium Withholding Report Data File (MPWR) layouts.

The Part C premium amount reported by the Plan to CMS includes additional premium amounts for any optional supplemental benefits selected by the member. TC 78 is used to submit Part C premium amounts.

Appendix F, Table F.6.4.7, provides the Part C Premium Change (TC 78) Detailed Record Layout.

For Part C premiums, the presence of optional supplemental benefit premiums precludes MARx from identifying the exact amount. Therefore, MARx edits the Part C premium using a range defined by the lowest Part C premium amount, which starts at zero for the PBP, and the highest Part C premium amount, which is the sum of all available optional supplemental premiums for the PBP that the member could elect. As long as the submitted Part C premium falls within this range, it is accepted unchanged. If it is not within this range, MARx changes it to the lowest possible Part C premium for the PBP and notifies the Plan with a TRC 182.

If the beneficiary elects the direct bill, i.e., self-pay option, the Plan receives payment directly from the member. If the beneficiary elects SSA premium withhold, CMS transmits this information to SSA. Monthly, SSA withholds premiums and sends them to CMS, which verifies the premiums and passes payment to the Plans. If SSA is unable to deduct a member's premium from their benefit check due to insufficient funds or some type of data issue, CMS notifies the Plan with a TRC 144, which instructs the Plan to bill the member for the premiums. Appendix I Table I-2 lists current TRCs.

Note: SSA may reject withholding requests due to insufficient funds even if the premiums are relatively low due to the difference in the timing of the payment cycles between SSA and CMS. This difference often requires SSA to process a withholding request with premiums due for two or three months. Additionally, SSA limits premium withholding to $300 a month per beneficiary, which can also impact SSA's ability to accept and process premium withholding for a member.

6.1 Low-Income Premium Subsidy (LIPS)

If a member is determined eligible for LIPS and elects the withholding option, SSA withholds the non-subsidized amount, if any, and CMS pays the subsidy to the Plan. If the member elects the direct billing option, the Plan bills the non-subsidized amount, if any, to the member and CMS pays the Plan the subsidy. The Monthly Membership Report (MMR) reports the LIPS payments to the Plans. Appendix F contains MMR detail and summary file layouts.

6.2 Late Enrollment Penalty (LEP)

For members assessed an LEP, their premium includes a penalty. If the member elects the withholding option, SSA withholds the penalty amount and CMS retains it. Plans can view the amounts on the Monthly Premium Withhold Report Data File (MPWR). If the member elects the direct billing option, the Plan bills the premium amount that includes the LEP and CMS deducts the LEP from the Plan payment. Plans can view the amounts on the LIS/LEP Report. Appendix F contains this file layout.

6.3 All or Nothing Rule

The all or nothing rule means that the beneficiary may deduct their entire premium amount due, i.e., the sum of Part C and Part D premiums for one Plan, from their monthly SSA benefit. Partial deductions are not allowed. When the benefit amount is insufficient to cover the entire premium amount, SSA rejects the withhold request and notifies CMS. CMS notifies the Plan of the insufficient benefit amount and rejection of the withhold option, and instructs the Plan to change the member to direct bill, i.e., self-pay, for the full amount of premiums due and for subsequent monthly premiums. MARx notifies the Plan with a modified TRC 213, Exceed Safety Net Amount, for transactions rejected due to the $300 safety net.

6.4 Single Payment Option Rule

The single payment option rule requires that both the Part C and Part D premiums are either direct bill or withhold as a member may only elect one payment option. This rule applies to a single Plan enrollment. For beneficiaries legally enrolled in two different Plans, they may elect two payment options. Examples:

- Beneficiary enrolls in a Medicare Advantage Prescription Drug (MAPD) Plan for Part C and Part D coverage, which results in a single premium; the member must elect one payment option, either withholding or direct bill.
- Beneficiary enrolls in a Private Fee-for-Service (FFS) Plan for Part C coverage and a Prescription Drug Plan (PDP) for Part D coverage, which results in enrollment in two different types of Plans and two different premiums. The member may elect to pay the Part C premium option as direct bill (self-pay), and the Part D premium option as withhold from the SSA benefit.

6.5 Reporting

6.5.1 Premium Withholding Report

The Premium Withholding Report contains information regarding Part C and Part D premium amounts that are withheld by the SSA, RRB, or Office of Personnel Management (OPM). This report includes such information as:

- Benefit package ID.
- Premium payment options.
- Premium start and end dates.
- Part C and Part D premiums withheld.
- Beneficiary identification total amount of premiums collected.

This report is provided to Plans on a monthly basis and in data format. Appendix F.10 contains more information on this file.

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7 Coordination of Benefits Attributes

7.1 Reporting Coordination of Benefits (COB) Data

CMS provides COB information for the Plan's enrollees. The COB file contains only members for whom there is COB information available. Each member on the file may have multiple records associated with primary and supplemental insurers. This section defines the order of the records in the file. Appendix F contains COB file layouts and Appendix K provides file naming information.

7.1.1 COB File Data Element Definitions and Instructions for Part D Plans

This section defines and provides instructions on the use of data elements found in the COB File Formats. The COB File contains the Other Health Insurance (OHI) information of enrollees in that Part D Plan. The OHI information contained in the COB file is collected by the COB Contractor (COBC) through its Data Sharing Agreements (DSAs), COB Agreements (COBAs), and other data exchanges with non-Part D payers, e.g. Pharmacy Benefit Manager (PBMs), Employer Group Health Plan (EGHP) sponsors, Section 111 Responsible Reporting Entity (RREs), State programs; questionnaires filled out by beneficiaries, employers, and providers; and from leads submitted from Part D Plans and other Medicare contractors. The information collected by the COBC and provided to the Part D Plan assists the Part D Plan in fulfilling its requirement to coordinate with OHI.

The COB File consists of a Detail (DTL) record identifying the Part D Plan's Contract Number, the Plan Benefit Package (PBP) number, and identifying information for the enrollee whose OHI is contained in the records attached to the DTL record. The DTL record may have two types of subordinate records attached to it: the Primary (PRM) record and the Supplemental (SUP) record. PRM records contain OHI that is primary to Part D. Primary does not necessarily refer to a single primary insurance, but to all occurrences of insurance that are statutorily required to pay prior to, i.e., primary to, Part D. It is possible to have multiple occurrences of primary insurance. Each occurrence of primary insurance is contained in PRM records subordinate to the DTL record. SUP records contain all supplemental insurance that pays after, i.e., supplemental to, Part D. Each occurrence of supplemental insurance is contained in SUP records subordinate to the DTL record.

The COB File contains full-record replacements for enrollees with newly discovered or changed OHI. The addition, change or deletion of an enrollee's OHI record triggers a full replacement of that enrollee's DTL and subordinate PRM and SUP records. The Part D Plan replaces its entire existing OHI profile for an enrollee with the most recent DTL and subordinate PRM and SUP records for that enrollee.

The Medicare Beneficiary Database (MBD) sends the COB File to Part D Plans via Medicare Advantage and Prescription Drug System (MARx). The COB File is automatically sent to Part D Plans when, at enrollment, the MBD already contains OHI information on that enrollee. For instance, if an individual has OHI, disenrolls from Part D Plan A, and then enrolls in Part D Plan B, all of the OHI that the MBD held and previously sent to Plan A is automatically sent to Plan B in the COB File.

Note: When the beneficiary disenrolls from Plan A, Plan A no longer receive updates for the beneficiary, unless the change is effective for a period that overlaps the Plan A enrollment.

The COB File is sent out to Part D Plans as the COBC collects OHI and applies records to the MBD. This can occur as often as daily. The Part D Plan may or may not receive the COB File daily; if it does receive a file, it only includes records for new or current enrollees with changed or newly discovered OHI. Most data exchanges administered by the COBC for CMS are monthly. Each data exchange partner has a unique submission schedule, however. The COBC can receive file submissions from data exchange partners on any given day. The COBC conducts development, i.e., phone calls, mailed questionnaires, on a continual basis. The COBC may apply records originating from development or data exchanges to the MBD any day. As soon as the records are applied to the MBD, the COB File is sent to the Part D Plan of the OHI enrollee.
.
The Part D Plan uses the elements contained in the PRM and SUP records to make payment determinations, recover mistaken payments, identify whether or not payments made by OHI count towards True Out-of-Pocket (TrOOP), and to populate the claim's response to the pharmacy.

Under provisions found in § 1860D-2(a) (4) of the Medicare Modernization Act (MMA), the Medicare Secondary Payer (MSP) rules were incorporated in the MMA and apply to Part D Plans as payers of Medicare benefits and to non-Part D GHP and non-GHP prescription drug payers that meet the MSP rules. The MSP rules are found at 42 U.S.C. § 1395y(b).

In some cases, the Part D Plan makes mistaken primary payments, i.e., if the COBC, CMS, and the Part D Plan are all unaware of any primary coverage. Under other circumstances, the Part D Plan makes conditional payments. These circumstances include:

- When the Part D Plan is aware that the enrollee has Workers' Compensation (WC)/no-fault/liability coverage but is unaware whether the drugs for which a bill is sent are related to the WC/no-fault/liability incident.
- When the Part D Plan learns of potential primary coverage and sends information to the COBC for development and it chooses to wait for validation before considering itself a secondary payer. This option is entirely up to the Plan; it may act as a secondary payer immediately or wait for validation, depending on its confidence of the information's validity.
- When the Part D Plan is aware that the primary WC/no-fault/liability coverage applies but the primary payer does not make prompt payment.

When these mistaken or conditional primary payments are made, the Part D Plan is required to recover the primary payment from the relevant employer, insurer, WC/no-fault/liability carrier, or enrollee. The Part D Plan is also subject to audit or reporting requirements. CMS is writing and will shortly publish further guidance on these and other MSP procedures.

Electronic Correspondence Referral System (ECRS) Contact Information

Table 7-1: ECRS Contact Information

Topic	Point Of Contact Information
ECRS Web site link	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c05_att1.pdf
ECRS Computer Based Training (CBT)	http://nhassociates.na5.acrobat.com/ecrs-hp/
COB Contractor EDI Department	1-646-458-6740

7.1.2 PRM Record Layout Elements

OHI contained in the PRM record is primary to, i.e., pays before, Part D. The following are definitions and instructions on the use of elements contained in the PRM record layout. Some of the PRM record layout elements are the same as elements contained in the SUP record layout. Note that * indicates that the element is found in both, but may have slightly different definitions and instructions. Not all element fields populate, depending on the information that the COBC possesses when it applies the record to the MBD.

*RxID Number**

The National Council of Prescription Drug Programs (NCPDP) standard Rx Identification Number (ID) is used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and the RxID number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

*RxGroup Number**

The NCPDP standard Rx Group Number is used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxGroup number to identify an individual in the recovery of mistaken payments, as well.

*Benefit Identification Number Rx (BIN)**

The NCPDP standard International BIN is used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxBIN number to identify an individual in the recovery of mistaken payments, as well.

*Processor Control Number Rx (PCN)**

The NCPDP standard PCN used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxPCN number to identify an individual in the recovery of mistaken payments, as well.

*Rx Plan Toll-Free Number**

The help desk number for the pharmacy benefit is the primary insurance. The Part D Plan displays this in the reply to the pharmacy.

Sequence Number*

The unique identifier for the PRM occurrence, the Sequence Number may identify the PRM occurrence when inquiring about a record to the COBC.

COB Source Code*

The code for the COBC, Common Working File, and MBD is used to identify the origin from which the COBC received primary insurance information. Customer Service may use the COB Source Code when inquiring about a record to the COBC.

Note: For any instances where an unknown COB Source Code is provided, Plans should contact COBC for clarification.

MSP Reason*

Medicare is the Secondary Payer, i.e., the other insurance is primary to Medicare, for EGHPs, MSP Reason codes A, B, G, and the Part D Plan rejects Primary payment. The EGHP is statutorily required to make primary payment in those cases, i.e. A, B, and G. The Part D Plan makes conditional primary payment, as it is possible these MSP types are incident related. Without a diagnosis code, the Part D Plan cannot determine whether or not the non-EGHP insurance is primary for that particular claim, unless the Part D Plan is certain that the claim is related to the incident. If the Part D Plan is certain that the claim is incident related, and that primary insurance for this incident exists, it should reject primary payment in the same way it rejects GHP MSP primary insurance. If the Part D Plan makes a conditional primary payment, it must reconcile with the non-GHP insurance post Point-of-Sale (POS).

Coverage Code*

This code identifies whether the coverage offered by the primary insurance is a network drug or non-network drug benefit. When the primary insurance is a network drug benefit coverage type (U), the record includes routing information, i.e., BIN and PCN, when available. The Group and Individual Policy Number Fields may populate when the primary insurance is a non-network drug benefit coverage type (V & Z).

Insurer's Name*

The name of the primary insurance carrier can assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Insurer's Address-1*
Insurer's Address-2*
Insurer's City*
Insurer's State*
Insurer's Zip Code*

The Address, City, State, and Zip Code of the primary insurance carrier can assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Insurer Tax Identification Number (TIN)

The TIN of primary insurance carrier may assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Individual Policy Number*

The Individual Policy Number used for non-network drug benefit primary insurance. Part D Plan uses this to identify non-network drug benefit primary insurance and may use the Individual Policy Number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Group Policy Number*

The Group Policy Number used for non-network drug benefit primary insurance. The Part D Plan uses this to identify non-network drug benefit primary insurance and may use the Group Policy Number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Effective Date*

The MSP start date. For MSP types D, E, and L, it identifies the date of the accident, illness, or injury, or the Medicare entitlement date, whichever is earlier.

Termination Date*

MSP end date, which identifies whether or not the primary insurance is terminated. If the insurance is open, the field is populated with all zeros.

Relationship Code*

Relationship to primary insurance policyholder used for MSP determinations.
01=Self
02=Spouse
03=Child
04=Other

Payer ID*

Future

Person Code*

NCPDP standard Person Code used by the Plan to identify specific individuals on the primary insurance policy. Used for routing of network drug benefit, the Part D Plan displays the Person Code in the reply to the pharmacy and may use the Person Code in the recovery of mistaken payments.

Payer Order*

The order of payment for primary insurance, the Part D Plan displays this in reply to the pharmacy in order of Payment Order Indicator. The lowest number in ascending order, i.e., 001 to 400, is the first primary insurance displayed in the reply to the pharmacy. OHI with a payment order less than 401 is displayed prior, i.e., primary to, the Part D Plan. The rules that COBCs use to assign the Payer Order are attached for reference.

Policy Holder's First Name

The first name of the primary GHP (MSP Types: A, B, G) insurance policy holder. Part D Plans may use the Policy Holder's first name in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Policy Holder's Last Name

The last name of the primary GHP (MSP Types: A, B, G) insurance policy holder. Part D Plans may use the Policy Holder's last name to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Policy Holder's Social Security Number (SSN)

The Social Security Number of the primary GHP (MSP Types: A, B, G) insurance policy holder. Part D Plans may use the Policy Holder's SSN to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Employee Information Code

Not used.

Employer's Name

The name of Employer sponsor of primary GHP (MSP Reason codes: A, B, G) insurance. Part D Plans may use the Employer's Name in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Employer's Address 1
Employer's Address 2
Employer's City
Employer's State
Employer's Zip Code

The address, city, state, and zip code of the Employer sponsoring the primary GHP (MSP Reason codes: A, B, G) insurance. Part D Plans may use the Employer's Address in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Claim Diagnosis Code 1
Claim Diagnosis Code 2
Claim Diagnosis Code 3
Claim Diagnosis Code 4
Claim Diagnosis Code 5

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) Diagnosis code – Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the U.S. National Center for Health Statistics and CMS are the U.S. governmental agencies responsible for overseeing all changes to the ICD-9-CM. No instructions at this time.

Attorney's Name

The name of the attorney handling the incident related case (MSP Types D: Automobile Insurance, No Fault, E: WC, L: Liability) for the enrollee. Part D Plans may use the Attorney's Name in the recovery of mistaken payments, as well. CMS provides guidance for recoveries to Part D Plans.

Attorney's Address 1
Attorney's Address 2
Attorney's City
Attorney's State
Attorney's Zip

The address of the attorney Part D Plans may use in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Lead Contractor

The assigned lead Medicare claims payment contractor responsible for developing, tracking, and recovering Medicare payments made where the enrollee received payments from a liability insurer. Part D Plans may use the Lead Contractor in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Class Action Type

This is assigned where a liability case is a class action lawsuit involving more than one Medicare beneficiary.

Administrator Name

The administrator of WC Set-Aside (WCSA) Settlement that CMS will bill for payment of future claims related to the incident that allowed the enrollee to receive WC benefits. CMS is developing payment and recovery rules for WCSAs.

Administrator Address 1
Administrator Address 2
Administrator City
Administrator State
Administrator Zip

The Address, City, State, and Zip Code of the WCSA settlement; CMS is developing payment and recovery rules for WCSAs.

WCSA Amount

WCSA Amount; CMS is developing payment and recovery rules for WCSAs.

WCSA Indicator

WCSA Indicator; CMS is developing payment and recovery rules for WCSAs.

A= Approved
D= Denied
P = Pending
Z = Zero set aside amount

7.1.3 SUP Record Layout Elements

OHI contained in the SUP record is supplemental to, i.e., pays after, Part D. The following are definitions and instructions on the use of elements contained in the SUP record layout. Some of the SUP record layout elements are the same as elements contained in the PRM record layout, but may have slightly different definitions and instructions. Not all element fields populate, depending on the information that the COBC possesses when it applies the record to the MBD.

RxID Number*

NCPDP standard Rx Identification Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxGroup Number*

NCPDP standard Rx Group Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxBIN Number*

NCPDP standard International BIN used for the network drug benefit routing of supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

Rx Plan Toll-Free Number*

The Part D Plan displays this help desk number of the pharmacy benefit in the Plan's reply to the pharmacy. For Supplemental Insurance Type Code P, this field instead populates with contact information for the patient assistance program.

Sequence Number*

The unique identifier for the supplemental SUP occurrence, Part D Plans may use the number to identify the SUP occurrence when inquiring about a record to the COBC.

COB Source Code*

The code the COBC, Common Working File, and MBD use to identify the process from which the COBC received supplemental insurance information. Customer service may use the COB Source Code when inquiring about a record to the COBC.

Supplemental Type Code

The type of supplemental insurance contained in the record. The Part D Plan uses this to determine if the payments made by this supplemental insurance count towards TrOOP. Supplemental Insurance Type Codes Q (SPAP) and R (Charity) count towards TrOOP. All other codes do not count toward TrOOP.

Coverage Code*

This code identifies whether the supplemental insurance drug benefit is a network drug or non-network drug benefit. When the supplemental insurance is a network drug benefit coverage type (U), the record includes routing information (BIN and PCN, when available). When the supplemental insurance is a non-network drug benefit coverage type (V & Z) the Group and Individual Policy Number Fields populate.

Insurer's Name*

The name of the supplemental insurance carrier, the Part D Plan uses this to identify supplemental insurance carrier.

Insurer's Address-1*
Insurer's Address-2*
Insurer's City*
Insurer's State*
Insurer's Zip Code*

The Address, City, State, and Zip Code of the supplemental insurance carrier, which customer service may use.

Individual Policy Number*

The Individual Policy Number is used for non-network drug benefit supplemental insurance. The Part D Plan uses the Individual Policy Number to identify non-network drug benefit supplemental insurance.

Group Policy Number*

The Group Policy number is used for non-network drug benefit supplemental insurance. The Part D Plan uses the Group Policy number to identify non-network drug benefit supplemental insurance.

Effective Date*

The supplemental insurance start date.

Termination Date*

The supplemental insurance end date, which identifies whether or not the supplemental insurance terminated. If the insurance is open, the field populates with all zeros.

*Relationship Code**

Relationship to supplemental insurance policyholder. No instructions at this time.

*Payer ID**

Future

*Person Code**

The NCPDP standard Person Code the supplemental insurance uses to identify specific individuals on the supplemental insurance policy. Used for routing of network drug benefit, the Part D Plan displays the Person Code in the reply to the pharmacy.

*Payer Order**

The order of payment for supplemental insurance, the Part D Plan displays this in reply to the pharmacy in order of the Payment Order Indicator. The lowest number in ascending order, i.e., 401 to 999, is the first supplemental insurance displayed in the reply to the pharmacy. OHI with a payment order greater than or equal to 401 is displayed after, i.e., secondary or supplemental to, the Part D Plan. The rules that the COBC uses to assign the Payer Order are in Table 7-2.

Table 7-2: Payment Order Rules

Payment Order	Payment Type	MSP Reason	Supplemental Insurance Type	Coverage (to
001 – 100	GHP w/ Patient Relationship= 1	A, B, G		Primary
101 – 200	GHP w/ Patient Relationship >= 2	A, B, G		Primary
201 – 300	Non-GHP	D, E, H,		Primary
301 – 400	For Future Use			N/A
401 – 500	Secondary Insurer w/ Person Code = 1		L, M, O,	Secondary
501 – 600	Secondary Insurer w/ Person Code>= 2		L, M, O	Secondary
601 – 700	Federal Government Programs		T, 2	Secondary
701 – 800	AIDS Drug Assistance Program (ADAP),, Patient Association Programs (PAPs), Charities		N, P, R, S	Secondary
801 – 900	SPAPs		Q	Secondary
901 – 999	Medicaid		1	Secondary

1. 'Payment Order Indicator' indicates payment ordering; the lowest number in ascending order, 001 to 999, is the first coverage billed at the pharmacy.
2. All drug coverage with a payment order less than 401 is billed using the COB to MBD – Other Insurance PRM format prior, or primary to, the Part D Plan; all drug coverage with a payment order greater than or equal to 401 is billed using the COB to MBD – Other Insurance SUP format after, or secondary to, the Part D Plan.
3. EGHPs include MSP Types A (Working Aged), B (End Stage Renal Disease [ESRD]) and G (Disabled). These are applied payment orders in the 001 to 200 range.
4. Non-EGHPs include MSP Types D (Automobile Insurance, No Fault), E (WC), L (Liability) and H (Black Lung); these applied payment orders are in the 201 to 300 range.
5. For two GHPs with a Patient Relationship Code of 1, the GHP with the earlier effective date is before the GHP with the later effective date.
6. For two GHPs with Patient Relationship Code of 1, with the same effective date, the GHP with the first accretion date is before the later accretion date.
7. For two GHPs with Patient Relationship Code of 2 or more, the GHP with the earlier effective date is before the GHP with the later effective date.
8. For two GHPs with Patient Relationship Code of 2 or more, and with the same effective date, the GHP with the first accretion date is before the later accretion date.
9. For two insurers with Person Code of 1, the insurer with the first accretion date is before the later accretion date.
10. For two insurers with Person Code of 2 or more, the insurer with the first accretion date is before the later accretion date.
11. If the record represents a supplemental insurer, the Insurance Type code determines the order. Within the Supplemental Types, those for Federal Government Programs take precedence over the ADAP, PAPs and Charities, which take precedence over the State Pharmaceutical Assistance Programs, which take precedence over Medicaid.
12. ESRD. A beneficiary receives the ESRD status when a physician prescribes a regular course of dialysis because the member reaches that stage of renal impairment that a kidney transplant or a regular course of dialysis is necessary to maintain life. Medicare pays the Plan at the higher ESRD rate for that beneficiary, unless the beneficiary elects hospice care.

7.2 Additional ESRD Information

Prospective payments are made based on the ESRD health status. The process of passing the information through the various databases may take as long as four months from the time the beneficiary is identified by the physician as having ESRD. Therefore, the Plan may not begin receiving the ESRD capitation rate of pay for the beneficiary for at least four months. When the health status is included in the capitation/risk adjustment (RA) rate for the beneficiary already in Medicare, the MARx automatically calculates retroactively to include the first month of ESRD health status within 36 months. However, if the beneficiary is entitled to Medicare as a result of ESRD, there is a three-month waiting period before Medicare entitlement begins.

The Renal Management Information System (REMIS) automatically adjusts for the three-month waiting period and updates the Enrollment Database (EDB) system and MARx, resulting in Plans receiving payment at the ESRD capitation/RA rate of pay. The health

status is based on the first date of dialysis as indicated on the ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration, Form CMS-2728-U3. In addition, the physician's clearly legible signature and signature date are necessary before the Renal Network can enter any information in the Standard Information Management System (SIMS).

The managed care staff at the Retro-Processing Contractor, the regional office, or central office cannot enter ESRD status changes and corrections into MARx. The managed care staff can synchronize MBD to the Enrollment Database if these systems' data do not match. This process may result in a change in the ESRD status and the associated positive or negative payment. The ESRD facilities enter the data from the CMS-2728-U3, which is transmitted to the CMS CROWN Web system through an automated process. The CMS-2728-U3 is the key source of documentation to ensure that a beneficiary is identified with ESRD health status indicator. The ESRD facility must complete the CMS-2728-U3 within 45-days of beginning a regular course of dialysis or receiving a kidney transplant, which was prescribed by a physician.

- The ESRD facility forwards a copy of the CMS 2728-U3 to its local SSA Field Office
- For individuals diagnosed with ESRD, the SSA determines eligibility for the Medicare ESRD entitlement based on CMS-2728-U3 under the ESRD provisions of the law.
- The ESRD facility inputs the information into the CMS CROWNWeb data system.
- CMS updates the information in REMIS, the CMS central repository for beneficiaries with ESRD.
- Daily, REMIS updates the EDB with ESRD health status start and/or end dates for the Plan member. MARx is the source of information used in computing the monthly capitation rates that the Plan receives.

Plans may contact the appropriate Renal Network contact, found in Table 7-3, to verify specific discrepancy data. The Renal Network will only supply the following information:

- The first date of dialysis or date of transplant.
- Date the beneficiary's CMS-2728-U3 was submitted to DMS by the Renal Network.
- Current Renal Status.

Note: This information is not required for a retroactive adjustment.

Table 7-3: ESRD Network Contact Information

NETWORK 1 (CT, ME, MA, NH, RI, VT) **DANIELLE DALEY, MBA** IPRO ESRD Network of New England 30 Hazel Terrace, Woodbridge, CT 06525 Phone: (203) 387-9332 • Fax: (203) 389-9902 E-mail: ddaley@nw1.esrd.net	**NETWORK 10 (IL)** **SUSAN A. STARK** The Renal Network, Inc. 911 East 86th Street, Suite 202, Indianapolis, IN 46240 Phone: (317) 257-8265 • Fax: (317) 257-8291/2120 E-mail: sstark@nw10.esrd.net
NETWORK 2 (NY) **SUSAN CAPONI, BSN, RN** IPRO ESRD Network of New York 1979 Marcus Avenue, Lake Success, NY 11042 Phone: (516) 209-5619 • Fax: (516) 326-8929 E-mail: scaponi@nw2.esrd.net	**NETWORK 11 (MI, MN, ND, SD, WI)** **DIANE CARLSON** Renal Network of the Upper Midwest, Inc. 1360 Energy Park Drive, Suite 200, St. Paul, MN 55108 Phone: (651) 644-9877 • Fax: (651) 644-9853 E-mail: dcarlson@nw11.esrd.net
NETWORK 3 (NJ, PR, VI) **CHRISTOPHER BROWN** Quality Insights Renal Network 3 Cranbury Gates Office Park 109 South Main Street, Suite 21, Cranbury, NJ 08512 Phone: (609) 490-0310 • Fax: (609) 490-0835 E-mail: chrisbrown@nw3.esrd.net	**NETWORK 12 (IA, KS, MO, NE)** **KATRINA M. DINKEL, MA** Heartland Kidney Network 7306 NW Tiffany Springs Parkway, Suite 230 Kansas City, MO 64153 Phone: (816) 880-9990 • Fax: (816) 880-9088 E-mail: kdinkel@nw12.esrd.net
NETWORK 4 (DE, PA) **CHRISTOPHER BROWN** Quality Insights Renal Network 4 Cranbury Gates Office Park 109 South Main Street, Suite 21, Cranbury, NJ 08512 Phone: (609) 490-0310 • Fax: (609) 490-0835 E-mail: chrisbrown@nw4.esrd.net	**NETWORK 13 (AR, LA, OK)** **SANDRA WOODRUFF, MSPH** FMQAI: ESRD Network 13 4200 Perimeter Center Drive, Suite 102 Oklahoma City, OK 73112 Phone: (405) 942-6000 • Fax: (405) 942-6884 E-mail: swoodruff@nw13.esrd.net
NETWORK 5 (DC, MD, VA, WV) **NANCY C. ARMISTEAD, MPA** Mid-Atlantic Renal Coalition 300 Arboretum Place, Suite 310, Richmond, VA 23236 Phone: (804) 320-0004 • Fax: (804) 320-5918 E-mail: narmistead@nw5.esrd.net	**NETWORK 14 (TX)** **GLENDA HARBERT, RN, CNN, CPHQ** ESRD Network of Texas, Inc. 4040 McEwen Road, Suite 350, Dallas, TX 75244 Phone: (972) 503-3215 • Fax: (972) 503-3219 E-mail: gharbert@nw14.esrd.net

NETWORK 6 (GA, NC, SC) **JENNA KRISHER** Southeastern Kidney Council, Inc. 1000 St. Albans Drive, Suite 270, Raleigh, NC 27609 Phone: (919) 855-0882 • Fax: (919) 855-0753 E-mail: jkrisher@nw6.esrd.net	**NETWORK 15 (AZ, CO, NV, NM, UT, WY)** **DARLENE RODGERS, BSN, RN, CNN, CPHQ** Intermountain ESRD Network, Inc. 165 South Union Boulevard, Suite 466, Lakewood, CO 80228 Phone: (303) 831-8818 • Fax: (303) 860-8392 E-mail: drodgers@nw15.esrd.net
NETWORK 7 (FL) **MARTHA HANTHORN, MSW, LCSW** FMQAI: The Florida ESRD Network 5201 West Kennedy Boulevard, Suite 900, Tampa, FL 33609 Phone: (813) 383-1530 • Fax: (813) 354-1514 E-mail: mhanthorn@nw7.esrd.net	**NETWORK 16 (AK, ID, MT, OR, WA)** **WILLIAM C. (CHAD) LENNOX, MPH** Northwest Renal Network 4702 42nd Avenue SW, Seattle, WA 98116 Phone: (206) 923-0714 • Fax: (206) 923-0716 E-mail: wlennox@nw16.esrd.net
NETWORK 8 (AL, MS, TN) **JERRY W. FULLER, MSW, LCSW** Network 8, Inc. 1755 Lelia Drive, Jackson, MS 39216 Phone: (601) 936-9260 • Fax: (601) 932-4446 E-mail: jfuller@nw8.esrd.net	**NETWORK 17 (AS, GU, HI, MP, N. CA)** **DARLENE RODGERS, BSN, RN, CNN, CPHQ** Western Pacific Renal Network, LLC 505 San Marin Drive, Building A, Suite 300, Novato, CA 94945 Phone: (415) 897-2400 • Fax: (415) 897-2422 E-mail: drodgers@nw15.esrd.net
NETWORK 9 (IN, KY, OH) **SUSAN A. STARK** The Renal Network, Inc. 911 East 86th Street, Suite 202, Indianapolis, IN 46240 Phone: (317) 257-8265 • Fax: (317) 257-8291/2120 E-mail: sstark@nw10.esrd.net	**NETWORK 18 (S. CA)** **HARRIET L. EDWARDS, MSW/MSG** FMQAI: ESRD Network 18 6255 Sunset Boulevard, Suite 2211, Los Angeles, CA 90028 Phone: (323) 962-2020 • Fax: (323) 962-2891 E-mail: hedwards@nw18.esrd.net

8 Reporting RxID/RxGroup/RxPCN/RxBIN Data

The 4Rx Notification process is a data exchange between the Plans and CMS. Plans provide CMS with Plan enrollment and claims processing information to support Point of Service (POS) and other pharmacy-related information needs. This exchange makes 4Rx data available to the True Out-of-Pocket (TrOOP) Facilitator and through the Facilitator to the pharmacy.

Pharmacies operate in a real-time processing environment and require accurate information at POS to properly adjudicate the claim with all payers that cover the beneficiary. In addition, many pharmacies' automated billing is based on eligibility data. The sooner Plans submit their 4Rx data to CMS, the faster complete data is available from the E1 eligibility query, which the transaction pharmacies submit to the TrOOP Facilitator to obtain 4Rx data. As a result, CMS requires prompt submission of 4Rx data. Plans must include 4Rx data on Plan-submitted enrollment transactions. However, for CMS-generated enrollments, for example facilitated and auto-enrollments, Plans are required to submit their 4Rx data within 72 hours of the Plan's receipt of the Daily Transaction Reply Report (DTRR) reporting these enrollments. One of the most difficult issues for CMS and the TrOOP Facilitator is collecting the 4Rx data from the Plans and ensuring a steady flow of the information to the TrOOP Facilitator.

This enables pharmacies to assist beneficiaries who are unable to identify the Plan in which they are enrolled. Pharmacists rely on the E1 eligibility query to obtain beneficiary billing information, particularly the Cardholder Identification Number (ID), which is a National Council of Prescription Drug Programs (NCPDP) mandatory field in the pharmacy billing transaction. When pharmacists are unable to obtain the 4Rx information from an E1 transaction, they must rely on dedicated phone lines at Plans and their processors to provide the required beneficiary billing information.

8.1 Plan Submission of 4Rx Notification Files/Record Formats

The four Rx data elements are:

- RxBIN – Benefit Identification Number.
- RxPCN – Processor Control Number.
- RxID – Identification Number.
- RxGRP – Group Number.

Plans must submit 4Rx data using Plan Transaction Code (TC) 61 for enrollment and Plan Benefit Package (PBP) changes. Plan transactions for enrollment TC 61, and disenrollment TCs 51/54 include the 4Rx fields of Primary Rx Benefit Identification Number (BIN), Primary Rx ID, Primary Rx Processor Control Number **(**PCN), Primary Rx Group, Secondary Rx BIN, and Secondary Rx PCN.

Note: The layout for disenrollment TCs 51/54 transactions includes the 4Rx fields. However, Plans are not required to submit 4Rx data as part of a disenrollment transaction. Appendix F provides detail of the layout.

The Primary Rx BIN and Primary Rx ID fields are mandatory and must accompany enrollment TC 61. Other noted fields, i.e., Primary Rx PCN, Primary Rx Group, Secondary Rx BIN and Secondary Rx PCN, are optional. Transaction files must formulate to the record formats and field definitions in Appendix F. Plans should send the files in flat file structure and conform to CMS naming conventions. Section 3 and Appendix K contain more information on naming standards.

Note: Detailed File/Record Formats are located in Appendix F; detailed Transactions Reply Codes (TRCs) for 4Rx Notification are located in Appendix I.

8.1.1 *Making Changes to 4Rx Data*

Plans must use Plan Change TC 72 to submit 4Rx data changes in the following circumstances:

- Auto-assigned enrollment.
- CMS facilitated enrollment.
- Any other CMS-generated enrollments not initiated by the Plan where 4Rx data is not included in the enrollment transaction, i.e., Regional Office/Central Office (RO/CO) actions, retro processing contractor actions, reassignment, and annual rollover activity.

If any of the above three scenarios apply, the Plan must submit 4Rx Data to CMS within 72 hours of the Plan's receipt of the DTRR reflecting the enrollment. The Plan change TC 72 file layout includes the 4Rx fields of Primary Rx BIN, Primary Rx ID, Primary Rx PCN, Primary Rx Group, Secondary Rx BIN and Secondary Rx PCN. The Primary Rx BIN and Primary Rx ID fields are mandatory and Plans must submit them; the other noted fields, i.e., Primary Rx PCN, Primary Rx Group, Secondary Rx BIN and Secondary Rx PCN, are optional. When submitting 4Rx changes, Plans should only populate the following fields, required for 4Rx processing:

- Beneficiary Identification Fields, i.e., Health Insurance Claim Number (HICN), Name, Date of Birth (DOB)
- Surname
- First Name
- Sex
- DOB
- PBP # (when applicable)
- Contract Number
- Transaction Code
- Effective Date
- Rx BIN
- Rx ID
- Rx GRP (optional)
- Rx PCN (optional)
- Secondary Drug Insurance Flag (optional)
- Secondary Rx BIN (optional)
- Secondary Rx ID (optional)
- Secondary Rx GRP (optional)
- Secondary Rx PCN (optional)

Plans may submit multiple change transactions for the same beneficiary in the same transmission file. The current requirement for effective dates submitted with Plan change TC 72s are within a date range of the Current Calendar Month (CCM) minus one month (CCM-1) through CCM plus three months (CCM+3). This is referred to as the allowable range.

However, editing for allowable date range is not performed on Plan change TC 72s submitted with 4Rx data, since auto-enrollments can have a retroactive effective date of several months and facilitated enrollments can have a prospective effective date of several months. Any Plan change TC 72 submitted with 4Rx data is accepted as long as the effective date in the transaction falls within the Plan's enrollment period.

The Allowable Date Range Tables 4-3 and 4-4 provide more information regarding the allowable date range.

8.1.2 CMS Editing of 4Rx Data

CMS edits against all 4Rx data fields. Any fields on an enrollment TC 61 or Plan change TC 72 transactions containing invalid information reject with an appropriate TRC.

Note: If 4Rx data is submitted as part of a disenrollment TC 51/54, that data is not edited for validity. CMS does not edit against any 4Rx data fields for MA-only Plans, along with other Plans that do not provide Part D benefits; these Plans submit blanks in the 4Rx data fields.

When 4Rx data is rejected, the entire enrollment is rejected. Plans should correct and resubmit the enrollment transaction using the same transaction type as originally submitted. All Plan TCs 61 submitted for Part D Plan enrollments, i.e., any contract and PBP combination with Part D coverage that must include 4Rx data elements for enrollments are edited for 4Rx data elements. CMS requires Plans to submit the Rx BIN and the Rx ID in the 4Rx data fields. This data is required to meet the specific following criteria for acceptance:

- Rx BIN for primary drug coverage of 6 characters in length and numeric.
- Rx ID for primary drug coverage no longer than 20 characters, alphanumeric, left justified, and contain spaces in the empty positions when the value in the field is less than 20 characters in length.

Submission of data in the following 4Rx fields is optional. If not submitted, the Plan should leave the fields blank. However, if submitted, the data is required to meet the following specific criteria for acceptance:

- Rx GRP for primary drug coverage of no longer than 15 characters, alphanumeric, left justified, and containing spaces in the empty positions when the value in the field is less than 15 characters in length.
- Rx PCN for primary drug coverage of no longer than 10 characters, alphanumeric, left justified, and containing spaces in the empty positions when the value in the field is less than 10 characters in length.

Editing of the 4Rx data elements does not occur in the following situations:

- Enrollment TC 61 submitted by Plans that do not include Part D coverage.
- Plan enrollment change TC 72, unless at least one field is submitted; then all edits apply.
- 4Rx information stored in CMS files. These files are sent towards the end of the month.

8.1.3 CMS to Plans/4Rx Response

CMS responses to Plan submission of 4Rx data are provided in the DTRR. Appendix F provides file/record layouts.

8.1.4 CMS to Plan/Monthly NoRx File

CMS creates and sends monthly NoRx files to Plans identifying all enrollees that do not currently have 4Rx information stored in CMS files. Typically, these files are sent the third week of the month. CMS uses the standard 4Rx Response File Format to inform the Plans of the incomplete 4Rx information. To distinguish between this file and a standard 4Rx Response File, a Detail Record Type containing a value of NRX in positions 1-3 of the file layout indicates that the record is a request for the Plan to send CMS 4Rx information for the beneficiary. The file containing this information is transmitted to the Plans using the same methodology that transmits the normal 4Rx Response File.

Appendix F contains information on the file layout; Appendix K provides information on this file's naming standards.

9 Establishing Low-Income Subsidy (LIS) Status

To establish the correct premium, cost sharing, and deductible levels with the correct effective dates for current, prior, and prospective enrollees, Part D sponsors should refer to the Daily Transaction Reply Report (DTRR). The Health Plan Management System (HPMS) memorandum entitled *"Announcement of Spring 2009 Software Release"* dated January 9, 2009 outlined the technical changes to the DTRR related to LIS status that went into effect July 2009.

As discussed in Section 1 of the memorandum, the DTRRs provide full replacement LIS profiles to Plans in response to Part D enrollments and Plan Benefit Package (PBP) changes as well as any LIS change that impacts a Part D enrollment period. Therefore, the DTRR is the definitive source of LIS eligibility information. It is important to note that these changes represent a shift in reporting methodology. Unlike much of the data provided in the DTRR, LIS eligibility information is not based on Current Calendar Month (CCM) reporting.

9.1 Key Changes in LIS Data Reporting

- LIS data is no longer returned in association with the Transaction Reply Codes (TRCs) generated in response to enrollment and PBP change transactions. Specifically, LIS data no longer accompanies enrollment and PBP change TRCs 011, 100, 117, 118, 210, and 212. Instead, LIS TRCs independently accompany enrollment and PBP change transaction responses.
- Specific LIS changes are no longer identified. Instead, Plans receive full replacement LIS profiles in response to low-income changes that accumulate over the weekly and monthly reporting cycles. Replacement profiles are established using data known to CMS at the end of each reporting cycle. Reported data spans a PBP enrollment.
- To more clearly communicate these changes, CMS eliminated TRCs 167 and 168. Existing TRCs 121 and 194 were retained but with modified definitions.
- The addition of new TRC 223 now identifies LIS periods that were removed from and are no longer affecting an enrollment. Appendix I provides more detailed information and a complete list of changes regarding these TRCs.
- An ensemble composed of one or more of the TRCs 121, 194, and 223 represents full replacement LIS profiles. Each profile returns LIS period start and end dates, premium subsidy percentage, co-payment level, enrollee type flag, and LIS source code. Low-Income Premium Subsidy (LIPS) percentage and co-payment level values retain their current definitions. The enrollee type flag identifies a beneficiary as a prior, current, or prospective enrollee. The source code identifies whether the LIS period is the result of CMS deeming or Social Security Administration (SSA) approval.

9.2 Other Sources of LIS Data

Although the DTRR is the primary source of LIS eligibility information, Plans continue to receive a number of reports and/or data sources containing LIS information. While each of these files may contain some LIS information about sponsors' enrollees, none of these contain the comprehensive LIS profile that is provided on the DTRR.

1. **Batch Completion Status Summary (BCSS)**: This report is in response to Plan-submitted transactions. Because it is not provided for CMS-generated transactions, i.e., auto/facilitated enrollments, it is not intended as a source of LIS data.
2. **LIS/ Late Enrollment Penalty** (**LEP) Data File**: This data file contains beneficiary level LIS and the LEP payment and adjustment details. LEP details are provided for direct bill beneficiaries only.
3. **LIS/Part D Premium Data File**: This data file displays beneficiaries from the premium profile table with a low-income designation. It is provided on a bi-weekly basis and is the reference file used to determine the LIS Match Rate.
4. **LIS History Data File (LIS HIST)**: This report provides a comprehensive list of a sponsor's current LIS membership. The data on each beneficiary spans through the most recent 36 consecutive months of contract enrollment. This report also informs Plans whether a beneficiary is LIS in the next calendar year.

In addition to the regularly issued reports listed above, Part D sponsors should consult the Loss of Subsidy Files sent in December for those beneficiaries losing LIS status at the end of the current year. TRC 996 is used for this special file type. Appendix F provides a copy of this file record layout.

10 Using the Medicare Advantage and Part D Inquiry System Online Operations

The Medicare Advantage and Part D Inquiry System User Interface (UI) enables access to enrollment, eligibility, payment, premium withhold, and 4Rx information for beneficiaries.

The UI accommodates online and batch processing. Online capabilities enable viewing of beneficiary or contract information. Batch capabilities allow submission of data, such as enrollment and disenrollment transactions.

UI online operations support the following capabilities:

- Log on and view messages.
- View beneficiary information.
- View payment information.
- View premiums charged by Plans.
- Request historical reports.

Information is available for enrollments from the start of the program.

The following sections describe online processing.

The user may read this section in its entirety, but it is also designed as a reference. Each topic provides content specific to that particular topic. The majority of the general information, such as common buttons, navigation processes, and messages, is provided either in **Section 10.1.6** or in *the Guide* Appendices, and is not duplicated in the remainder of this section.

All of the beneficiary, contract, and user information in the screen snapshots in this document are fictional. The names and Social Security Numbers do not identify any person living or dead. The claim numbers start with ‘997,’ ‘998,’ or ‘999’ because those numbers are never assigned.

On certain screens, if no end date displays for the subsidy period, this does not mean the beneficiary’s status terminated; rather a blank Subsidy End date means that the status rolled over to the current year.

10.1 Getting Started

This section provides some basic information necessary to conduct online operations:

- Accessing the UI and Logging onto the System.
- Changing Password.
- Logging out of the System.
- Understanding Roles and Privileges.
- Using the Screens.
- Navigating the System.

10.1.1 Accessing the UI and Logging onto the System

How Do I Get Started Using the UI?

After obtaining a CMS user ID and password, a UI user profile is created for the user. This profile defines the user's tasks. Users are assigned one or more roles based on their job responsibilities. One of these roles is marked as the default. When a user logs on, the user may accept the default role or choose one of the other roles assigned to the user. The profile also defines which contracts the user may access.

To access the UI, users must have the following software installed on their workstation:

- Windows 98 or higher.
- Microsoft Internet Explorer with Web browser, Version 5.5 or higher.
- Adobe Acrobat Reader, Version 4 or higher, for report viewing and display of online help. If the user does not have Adobe Acrobat Reader Version 4 or higher, the user can download a free version at (www.adobe.com).

Also, the user must:

- Enable JavaScript in the browser.
- Allow pop-ups from the UI site.
- Disable script debugging, which is in the Internet Explorer's Internet Options under the Advanced tab.

How Do I Log On?

The UI is accessed via the CMS Applications Portal (https://applications.cms.hhs.gov). A user logs on to the CMS Applications Portal and then selects the Medicare Advantage and Prescription Drug (MAPD) Inquiry System link.

10.1.2 Changing Password

CMS Individuals Authorized Access to the CMS Computer Services (IACS) controls password management. For more information on IACS, users may refer to the *IACS User Guide* on the MAPD Help Desk Web site: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/IACS/index.html?redirect=/iacs

10.1.3 Logging out of the System

When the user exits the UI, logging out closes the browser windows. Section 10.2.4 provides the steps for logging out. Closing the browser also logs the user out of the system.

10.1.4 Understanding Roles and Privileges

What Are the Different Roles and Privileges?

The MAPD Inquiry System is role-based, which provides a secure environment for data. A role describes a user's job by the tasks that the user performs. To fulfill the security goals, the system provides functionality and data filtering based on the needs of users and security considerations.

The roles currently defined for Plan users are as follows:

- Managed Care Organization (MCO) Representative - An individual who works for a Plan managing beneficiaries in the Medicare program via Medicare Advantage Prescription Drug System (MARx). MCO Representatives access detailed enrollment data only for their own membership and minimal current enrollment data for other beneficiaries. The representative cannot transmit batch files containing membership changes and health status corrections.
- MCO Representative UI Update - An individual who works for a Plan managing beneficiaries in the Medicare program via MARx. MCO Representatives access detailed enrollment data only for their own membership and minimal current enrollment data for other beneficiaries. The representative cannot transmit batch files containing membership changes and health status corrections. The representative can update member records in MARx.

Note: External Point of Contacts (EPOCs) must approve a maximum of two MCO Representative UI Update users per parent organization. CMS continues to evaluate this limit as experience is gained with the new UI Update functionality. MCO Representative UI Update users must work for the parent organization. Designated MCO Representative UI Update users that already have an IACS account must access the IACS system to modify and change their current role to the new role.

- MCO Representative Transmitter - An individual with the same capabilities as the MCO Representative role, with the additional ability to transmit batch files containing membership changes and health status corrections.

Note: UI screens display the term *MCO* rather than *Plan*. *MCO* represents all types of Managed Care Plans, e.g., Cost Plans, Medicare Advantage (MA) Plans, MAPD Plans, and Prescription Drug Plans (PDPs).

The *IACS User Guide* provides further information regarding user registration and role modification (http://www.cms.gov/MAPDHelpDesk/07_IACS.asp#TopOfPage).

Can I Change My Role?

When the user logs on to the UI, the first screen displayed is the User Security Role Selection (M002) screen. It appears only at logon; the user cannot access this screen using the menu system. However, at logon the user is presented with the list of profile specific roles. **Figure 10-1** lists roles for the user XXXX, who is eligible to choose either of the MCO roles.

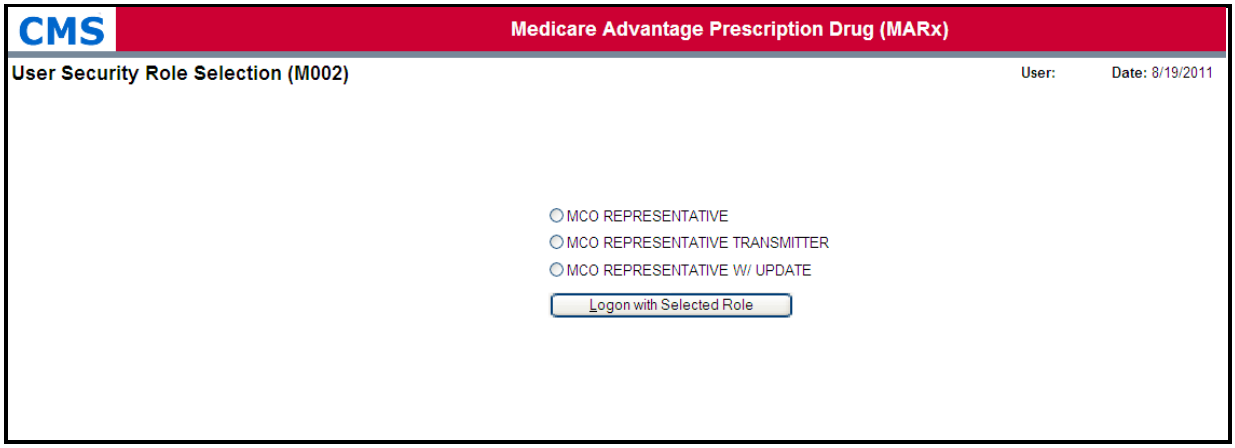


Figure 10-1 : User Security Role Selection (M002) Screen

10.1.5 Using the Screens

General Properties of Screens

UI screens share many properties. Once users understand the screens' organization, they can access information quickly and easily.

There are two main types of general screen layouts: primary and secondary. The principal differences between a primary window and a secondary window are the design and content of the headers and the manner in which the screens are navigated.

There is also a third special type of screen, the log-out window, which remains in the background for the duration of the session.

Layout – Primary Screens

The main window contains a primary screen with a menu and submenu. Only one primary screen opens at a time. When the user navigates from one primary screen to another, the new screen replaces the previous primary screen in the main window.

The heading of each primary screen contains the UI main menu. See **Figure 10-2**. In most cases, there is a submenu below the main menu, which provides options based on the menu item chosen. The selected menu and submenu items are highlighted in yellow on the system.

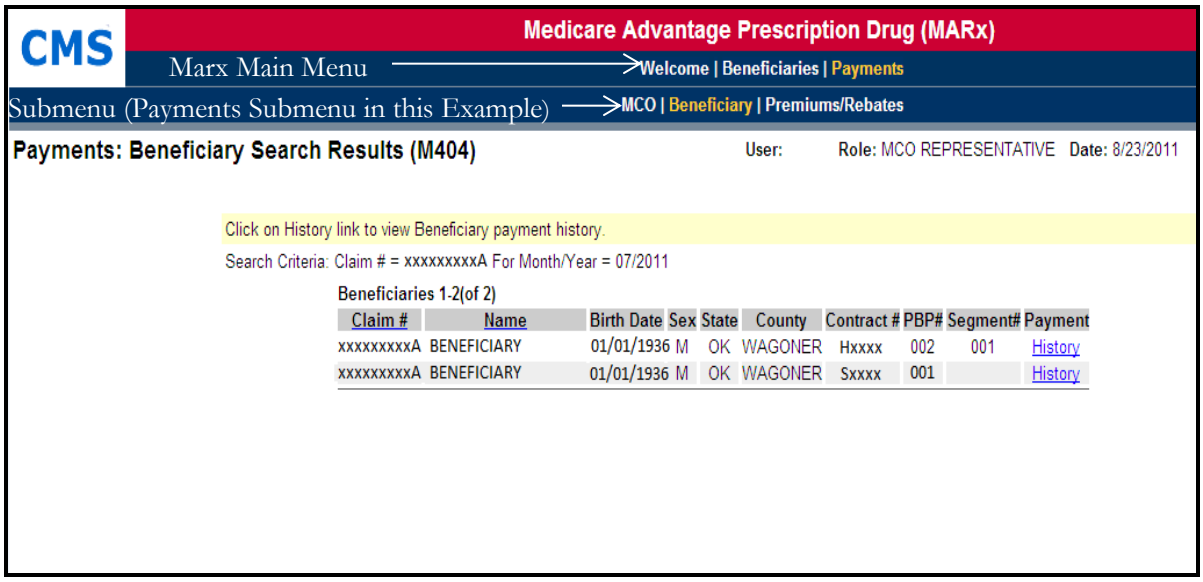


Figure 10-2: MCO Representative (View Only) Example of a Primary Window

Screen Layout – Secondary Screens

A secondary screen is opened from a primary screen to drill down for more information. It is displayed in a new, pop-up window. The user may open multiple pop-up windows simultaneously. When the user switches primary screens, any open secondary screens associated with that primary screen automatically close.

Secondary screens do not have the menu/submenu headers shown on primary screens. Instead, their headers vary based on the screen. Many secondary screens have headers that provide information specific to the contents of the screen. In the example shown in **Figure 10-3**, the header information, which is indicated with a brace, is specific to the selected beneficiary and includes such information as the beneficiary's name, claim number, date of birth (DOB), date of death (DOD) when applicable, street address, age, sex, state, and county.

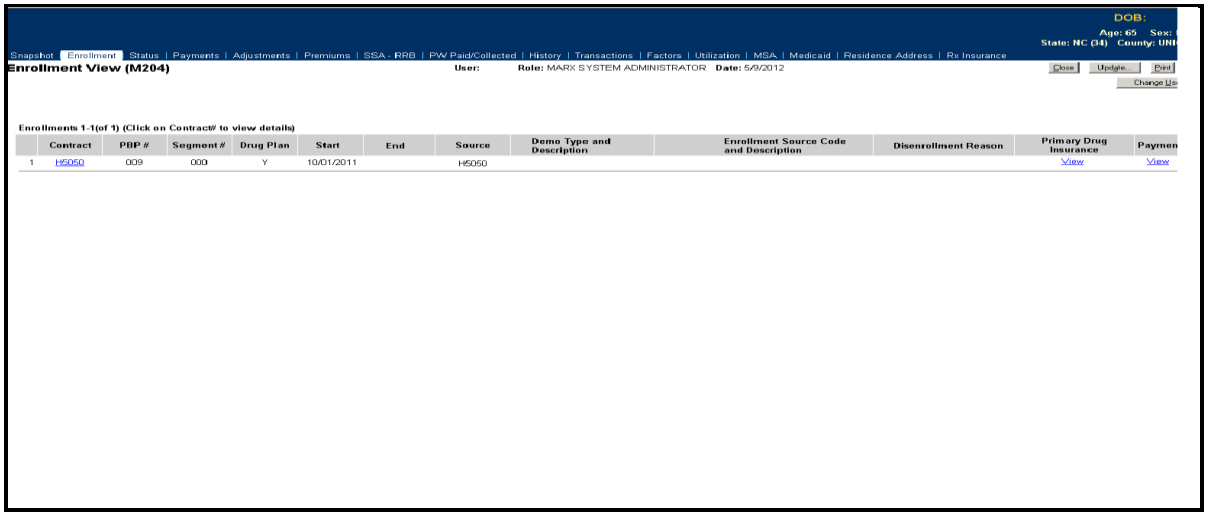


Figure 10-3 : MCO Representative (View Only) Example of a Secondary Window (Pop-Up)

In addition, some secondary screens have their own navigation; a lower-level menu system. In the example, the secondary-level menu consists of the following items: |Snapshot|, |Enrollment|, |Status|, |Payments|, |Adjustments|, |Premiums|, and |Factors|. The user moves among these screens by clicking the appropriate menu item. One feature unique to the secondary window navigation is a [Close] or [Cancel] button. Clicking one of these buttons closes that window.

Some Common Features of the Screens

Below the headings, most of the screens are in the same format. The top of the screen contains a title line with the following information, as shown in **Figure 10-4.**

Claim #:

DOB:

State: Age: Sex: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Payments View (M206) User: Role: MCO REPRESENTATIVE Date: 8/22/2011 Close Print Help...

Enter required field information below and click "Find."

** Indicates required field

* Payment Date 08/2011

Find Reset

Payments 1-20(0f 154) (Click on payment date to view details) Go to Page: 1 Go

				Payments				Adjustments						
Payment Date	Contract	PBP#	Seg#	Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj	Total	Part B Premium Reduction	Regional MA BSF
08/2011	Hxxxx	000	000	$842.19	$744.74	$143.38	$1,730.31	$0.00	$0.00	$0.00	$0.00	$1,730.31	-	$0.00
07/2011	Hxxxx	000	000	$842.19	$744.74	$143.38	$1,730.31	$1,567.26	$1,385.94	$133.20	$3,086.40	$4,816.71	-	$0.00
06/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
05/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
04/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
03/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
02/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
01/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
12/2010	Hxxxx	000	000	$582.39	$514.99	$199.44	$1,296.82	$0.00	$0.00	($117.32)	($117.32)	$1,179.50	-	$0.00
11/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
10/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
09/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
08/2010	Hxxxx	000	000	$0.00	$0.00	$0.00	$0.00	($1,101.48)	($965.04)	$0.00	($2,066.52)	($2,066.52)	-	$0.00
08/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
07/2010	Hxxxx	000	000	$0.00	$0.00	$0.00	$0.00	($70.34)	($62.20)	$4.54	($128.00)	($128.00)	-	$0.00
07/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	($313.00)	($276.80)	$28.90	($560.90)	$853.24	-	$0.00
06/2010	Hxxxx	000	000	$644.99	$570.35	$310.98	$1,526.32	$0.00	$0.00	$0.00	$0.00	$1,526.32	-	$0.00
05/2010	Hxxxx	000	000	$644.99	$570.35	$310.98	$1,526.32	$0.00	$0.00	$0.00	$0.00	$1,526.32	-	$0.00
04/2010	Hxxxx	000	000	$644.99	$570.35	$310.98	$1,526.32	$0.00	$0.00	$0.00	$0.00	$1,526.32	-	$0.00
03/2010	Hxxxx	000	000	$0.00	$0.00	$0.00	$0.00	($694.31)	($613.98)	($325.09)	($1,633.38)	($1,633.38)	-	$0.00

Figure 10-4 : MCO Representative (View Only) Common Features of a Screen

- Screen name, which describes the screen's purpose.
- Primary screen's name reflects the navigation to the screen using menu and submenu.
- Screen identifier, which starts with an *M*. This identifier is useful when asking for help, reporting a problem to the help desk, or using *the Guide*.
- User ID.
- User's current role.
- Current date.
- [Print] and [Help] buttons (and the [Close] and other buttons for secondary windows).

The message line appears below the title line. Error messages display in red and messages indicating success display in green. If there is no message, this area of the screen is blank.

Many screens include instructions at the top, which are displayed on the screen with a yellow background to provide information on using the screen. Additional information is available by clicking on the [Help] button.

A screen may contain input (data entry fields), output (information fields), and links to other screens and tables, etc. See **Figure 10-5** for an example of a screen with links that display:

- Additional information on same screen; Action column link Payment in the first table.

- Other screens; the Contract column links H6666 and H9999 in the first table and the dates – 07/2006 through 03/2006 – in the Payment Date column link of the second table.

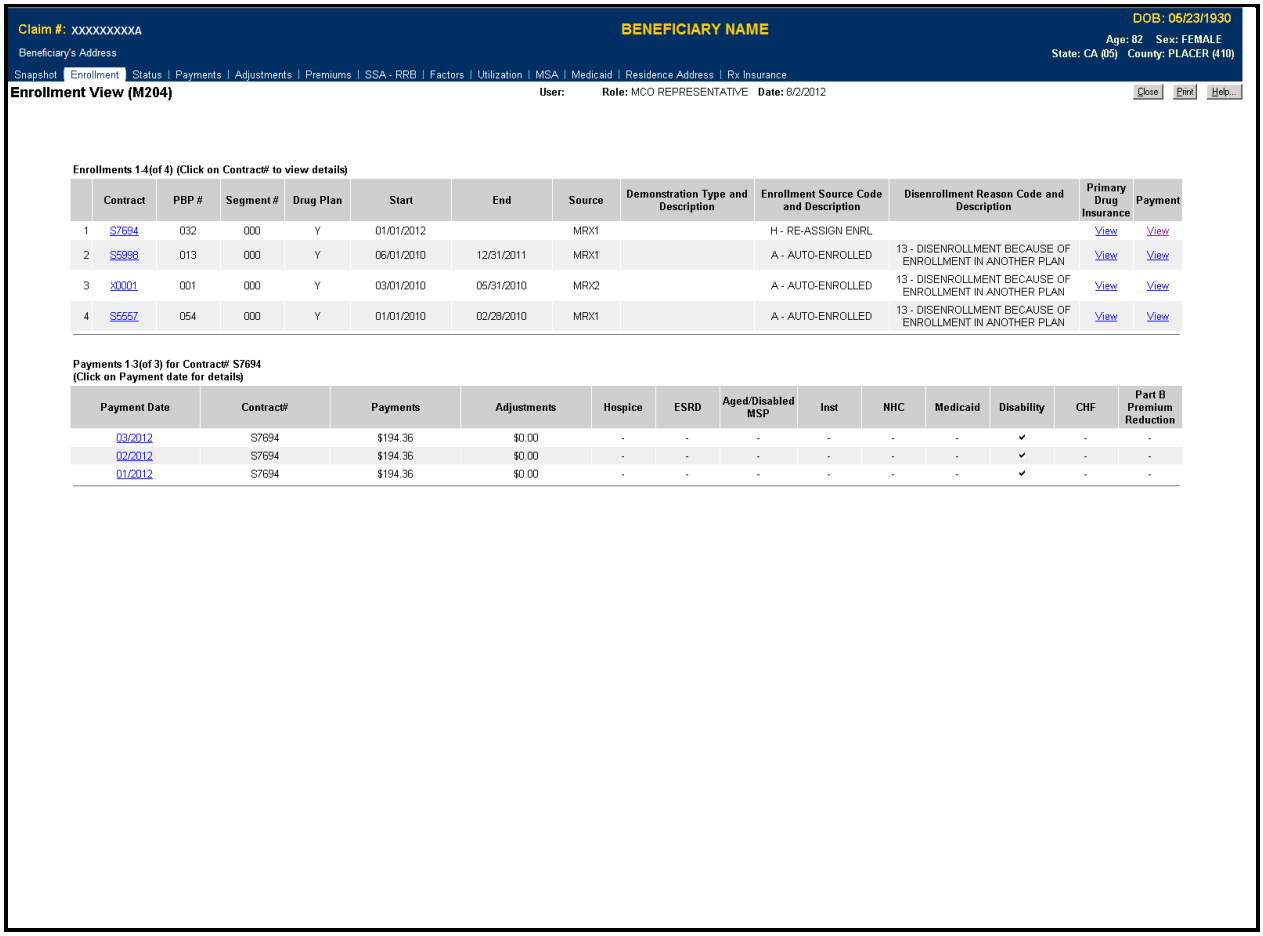


Figure 10-5: MCO Representative (View Only) Example of a Screen with Links

Some screens show information using a numerical code. When there is room on the screen, a code description also displays. When there is no room, the user places the mouse pointer over the code, which causes a description to pop up. See **Figure 10-6**.

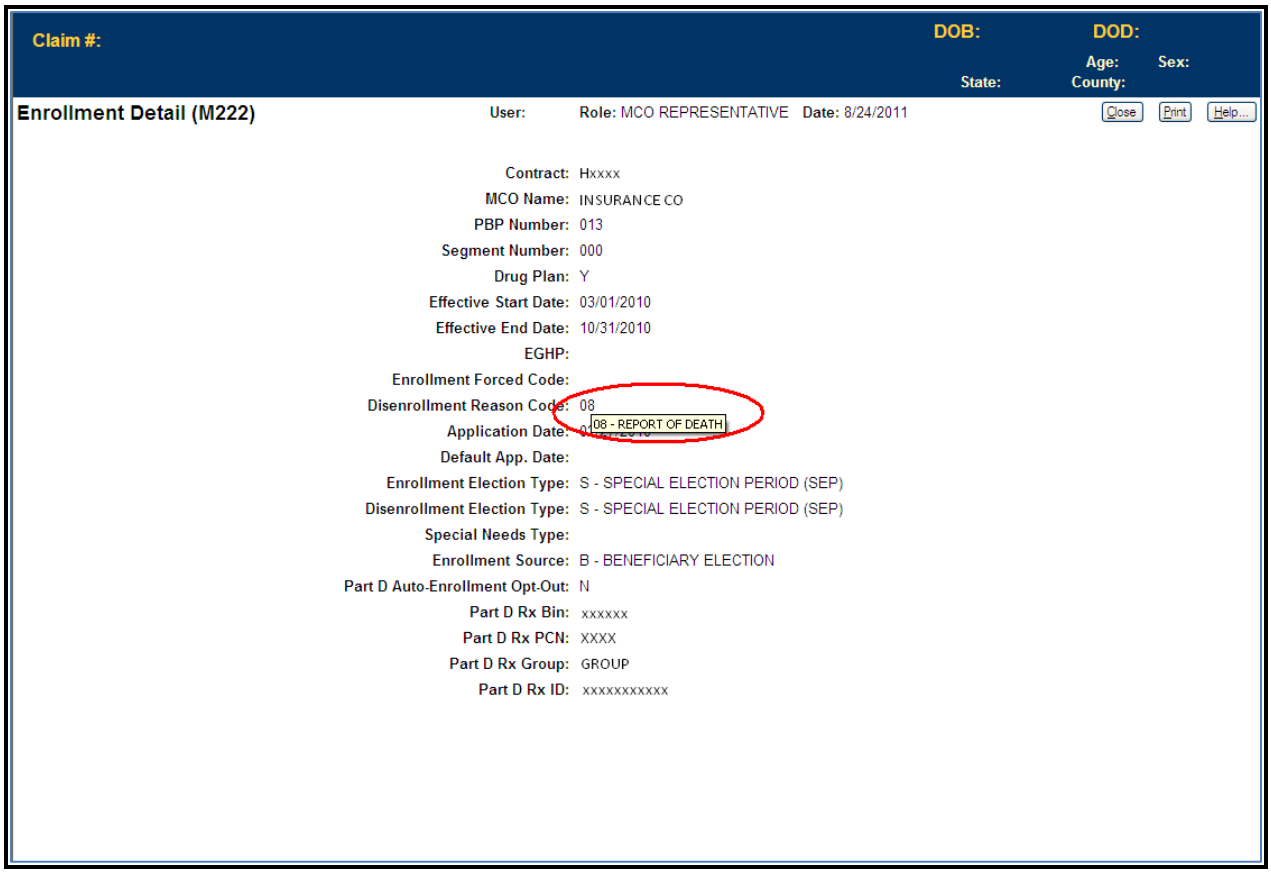


Figure 10-6: MCO Representative (View Only) Example of a Code with a Pop-Up Description

Some Common Characteristics of the Screens

Screens are customized by role in several ways:

- Not all screens are available to each role. The menu and submenus include links only to the available screens. For example, the screen that orders historical reports is not available to each role.
- The fields and buttons on some screens vary by role.

Screens may carry out one or more of the following functions:

- Find specific information.
- Display information.
- Provide links/buttons to additional functions.

Many screens contain forms that the user must populate and buttons that the user must click on to carry out an action. Some fields are required and others are optional. A red asterisk (*****) appears next to a field label to indicate that it is required. A red plus sign (+) appears next to field labels to indicate that one or more of those fields are required.

Sometimes there are additional rules regarding the combination of fields that are acceptable; those rules are often indicated in instructions on the form.

There are different options for entering information into a field:

- Text entry. Most fields, such as claim number or contract, allow the user to type in the information.
- Dropdown list. Some fields, such as file type, provide a list of values from which to select. The user clicks on the down arrow next to the field to display the list, and then clicks on a value to select it.
- Radio buttons. The user chooses one of the items in a group by clicking on the circle next to that item.
- Check boxes. The user selects any number of the items in a group by clicking on the box next to each item.

Some fields are initialized with default values. For example, date fields are often initialized with the current date.

The information that the user enters on a form is validated to ensure that the request is valid, and an error message is displayed to inform the user of an error.

Information entered into a field is validated when the user exits that field, such as when the user hits tab or clicks elsewhere on the screen. The field is color coded; *yellow* for a valid field and *pink* for an invalid field.

Some validation is not performed after the user exits the field. Generally this happens when the validation involves the relationship between fields, such as checking that a start date is not after an end date. When an error is detected upon clicking a button, an error message is displayed and the requested change/action does not occur.

After validation is complete, the user's action is submitted. The buttons on the screen, except the [Print], [Help], [Close], and [Cancel] buttons, are disabled, i.e., grayed out, until the action completes, to prevent a user from clicking a button more than once, which may lead to multiple actions. Also, a message asks the user to wait until the requested action is completed. If the processing succeeds, a message indicating that the action was successfully completed displays in green. If an error occurs during processing, a message explaining the problem displays in red and the user's inputs display on the screen again.

Screen Components

A screen may contain links to other screens, in addition to the links on the menu and submenu. These links are indicated by underlined words.

When a screen displays a list of information, such as multiple beneficiaries or transactions, the information displays in a table format. When there are too many rows in the table to fit on one screen, only a portion of the table displays at one time. The screen navigation arrows at the top and bottom of the table allow the user to scroll through the list. When the first page is displayed, the back arrow is disabled. When the last page is displayed, the forward arrow is disabled. There are additional arrows for jumping directly to the first or last page. Users can access a particular page directly by selecting a page number from the list displayed at the top of the table, next to the arrows, and clicking the [Go] button. If all of the information fits on one page, there are no arrows or page numbers listed.

If a column heading in a table is underlined, the user may sort the table by the information in that column. The user clicks on the column heading to sort by that column in ascending order. Note that the column heading does not act as a toggle, i.e., clicking on the heading a second time does not return the screen to the previous sort order nor does it sort the column in descending order. Sorting is conducted for all rows in the list, not just for the rows on the current page, so the user may see different rows display on the screen after sorting.

Accessibility

Instead of using a mouse to move through screens, it is also possible to navigate, select items, and click on actions using only the keyboard. The tab keys allow users to move from one screen element to the next, including links, fields, and buttons. To move backward from one screen element to the previous one, the user holds down the <SHIFT> key when tabbing. To select a particular radio button, the user utilizes the tab keys to move to the radio button that is selected within a group of buttons, and then use the arrow keys to change which button is selected in the group. To select or deselect a check box, the user hits the tab keys to move to the check box, and then uses the space bar to toggle between selected and deselected.

In addition, buttons and fields have keyboard shortcuts that allow the user to go directly to a screen element. The underlined letter on the field or button label indicates the shortcut. Pressing the <Alt> key with that letter provides a way of accessing that button or field. For a button, using its shortcut is the same as clicking on that button. For example, <Alt F> is equivalent to clicking on the [Find] button. For a field, using its shortcut is the same as tabbing to the field; the focus is on that field, and the value in it is selected. For a check box field, the shortcut also toggles the check box on and off.

The UI meets U.S. regulations, Section 508 of the Rehabilitation Act Amendments of 1998, requiring all U.S. Federal agencies to make their Information Technology (IT) accessible to their employees and customers with disabilities. The System meets the following criteria for a user employing assisting technologies, such as screen readers:

- Text equivalents are provided for non-text elements such as graphics.
- All information conveyed with color is also available without color.
- Web-based reporting tools and Hypertext Markup Language (HTML)-generated data support the use of row and column headings.
- HTML 4 tagging format is used.
- The System is designed to allow users to skip repetitive navigation links. A link, which is only visible with a screen reader, is placed at the start of the page. When clicked, the link skips over the menu and submenu.

Commonly Referenced Buttons and Links

Table 10-1 describes buttons and links on many of the screens.

Table 10-1: Common Buttons and Links

Example	Description
[Print]	**Print**. Every screen contains a [Print] button. The [Print] button supports printing the entire contents of the active Web page. It displays the 'Printer Options' pop-up screen.
[Help]	**Help**. Every screen contains a [Help] button, which invokes a menu of topics. At the top of the menu is a link to information specific to the current screen. Below that link are topic links that display for each screen. When the user clicks on a link, the help displays in a separate window using Adobe Acrobat Reader. The help comes directly from this user's guide, providing the user an easy way to obtain online access to this guide.
[Close]	**Close**. Closes the pop-up window without submitting the data. This button does not appear on any screens accessed directly from an item on the UI main menu.
[Cancel]	**Cancel**. Closes the pop-up window without submitting the data.
	Screen navigation arrows. When not all list items fit on a screen, navigation arrows scroll through the list. These arrows are shown at the top and the bottom of the list items on the screen. The arrows function as follows: – go to the first page of items in the list – go to the previous page of items in the list – go to the next page of items in the list – go to the last page of items in the list
	Go to Page Number. In addition to the screen navigation arrows, [Go to Page Number] is displayed at the top of the list items. It allows the user to jump directly to a particular page. Select the page number to display, and click on the [Go] button. The page numbers in the dropdown list reflect the actual number of pages in the list.
[Reset]	**Reset**. Resets the entered data to their previous values. If a button was clicked on the screen, the previous values are those displayed when the button was clicked. Otherwise, they are the initial values on the screen. It does not clear the screen, unless the screen was previously clear.

Common Fields

Table 10-2 describes the formats of input fields used on many of the screens. The field labels vary among screens. For example, contract field labels include *Contract #* or *Contract*, or *Birth Date* or *Effective Date*.

Table 10-2: Common Fields

Field	Format
Claim #	One of three formats is permitted. This field consists of a Claim Account Number (CAN) and a Beneficiary Identification Code (BIC). Whether a BIC is or is not optional depends on the screen and format: Social Security Administration (SSA) – 9-digit Social Security Number is the CAN followed by a 1- or 2-character BIC, where the first character is a letter and the second is a letter or number. Railroad Retirement Board (RRB) – RRB identifier, with a 1-to-3-character BIC, which has one of these values: CA, A, JA, MA, PA, WA, WCA, WCD, PD, WD, H, I, MH, PH, WH, WCH, followed by a 6- or 9-digit number, i.e., CAN. The BIC is not optional. CMS internal number – The internal format of an SSA claim number is the same as the SSA format. For an RRB claim number, the RRB format is translated to nine characters, i.e., CAN, followed by a two-digit BIC, which has one of these values: 10, 11, 13 through 17, 43, 45, 46, 80, 83 through 86.
Contract #	Starts with an 'H', '9', 'R,' 'S,' 'E,' or 'F' and is followed by four characters: H = local Medicare Advantage (MA), local MAPD, or non-MA Plan 9 = non-MA Plan (no longer assigned) R = regional MA or MAPD Plan S = regular standalone PDP Plan E = employer direct PDP Plan F = fallback Plan
Plan Benefit Package (PBP) #	Three alphanumeric characters.
Segment #	Three digits. A value of 000 indicates that there is no segment.
Date	Month, day, and four-digit year. A zero in front of a single-digit month or day is optional: (M)M/(D)D/YYYY.
Month	Month and four-digit year. A zero in front of a single-digit month is optional: (M)M/YYYY.
Last Name	May contain letters, upper and lower case; apostrophe; hyphen; and blank; with a maximum length of 40 characters.

Error Message Screens

This section covers screens that report possible system errors. Appendix B provides contact information to report the error.

If a screen is unavailable for display, the Page Not Found screen is displayed to notify the user of the problem. See **Figure 10-7.**

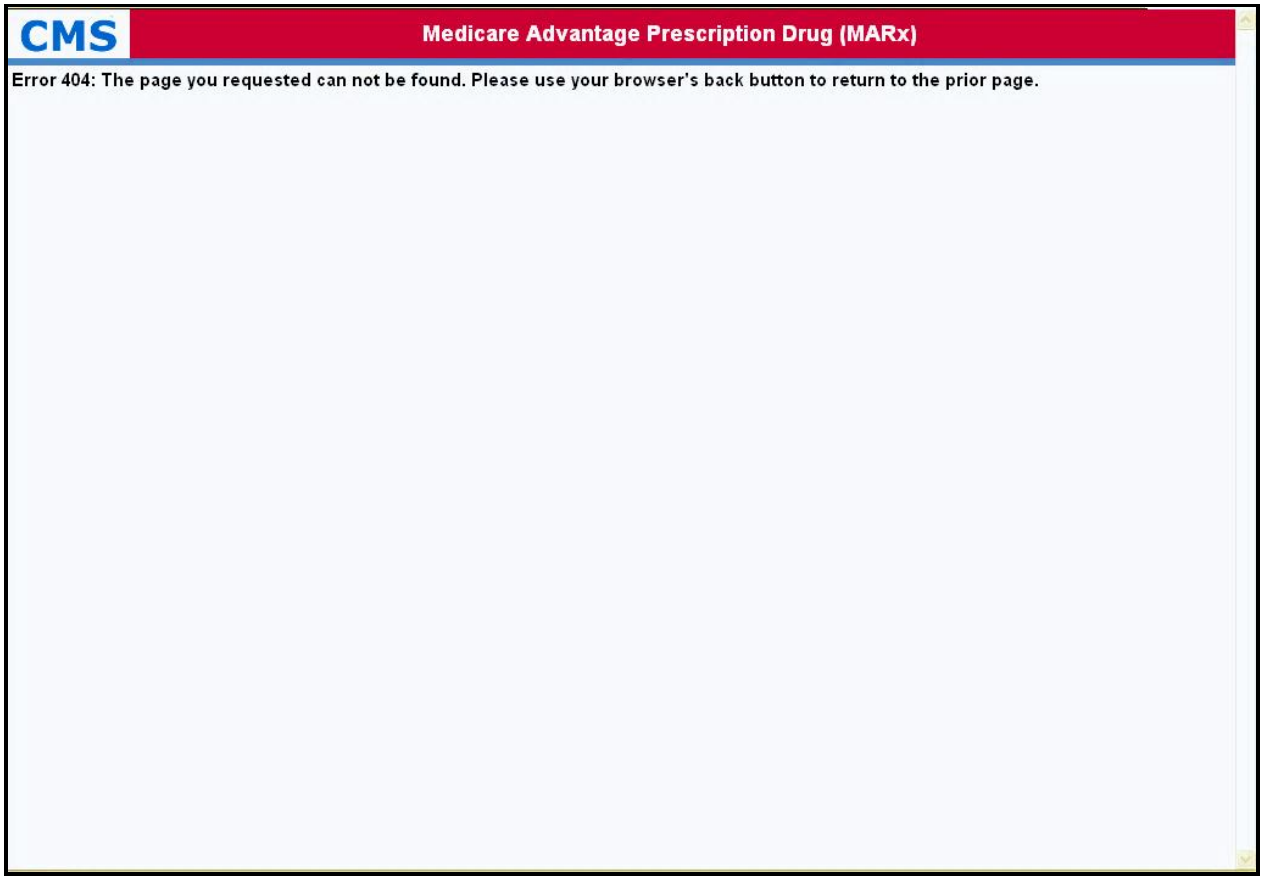


Figure 10-7: Page Not Found Screen

If a time-out occurs during an attempt to display a screen, the Page Time-Out screen appears, notifying the user of the problem. See **Figure 10-8.**

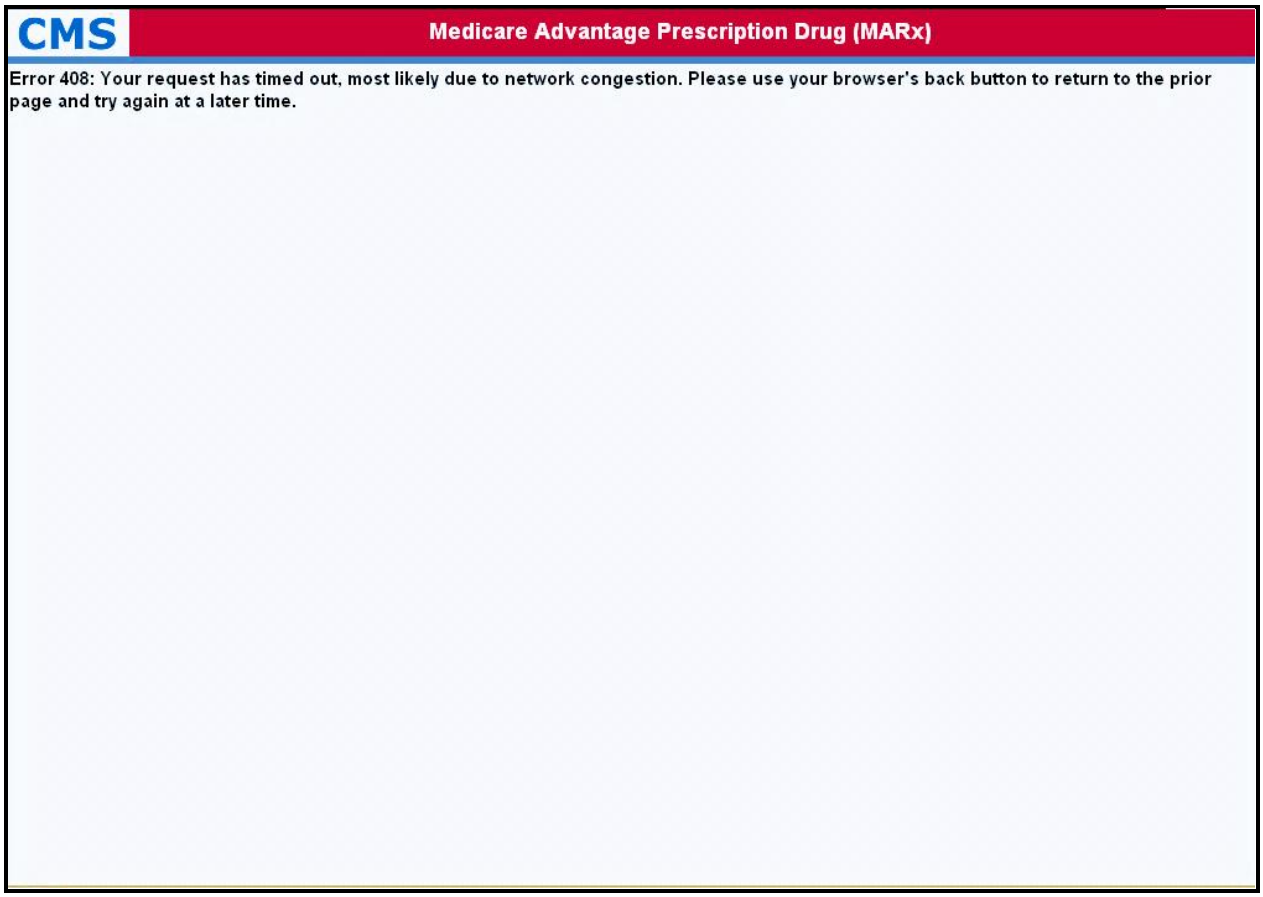


Figure 10-8: Page Time-Out Screen

10.1.6 Navigating the System

How Do I Get Where I Want To Go?

The user functions to which users have access depend upon their role. Only those functions available to the user's role appear in the menu and submenus. The tasks within each function may also vary based on the user's role. See **Table 10-3** for the names of the main menu items and a general description of the functions under each item.

Table 10-3: Main Menu Items

Menu Item	Description
|Welcome|	Messages, CPM, and calendar.
|Beneficiaries|	Search for beneficiaries and view beneficiary information.
|Payments|	Retrieve payment and adjustment information for MCOs and beneficiaries.
|Reports|	Request historical reports.
|Transactions|	View status of batch transmittals.

How Do I Find Specific Information?

The UI uses the drill-down system. This means that the user starts at a very high level, and drills down to more specific detailed information.

Navigating Menus and Submenus

The menus and submenus all work in the same way, as follows: the first view of the UI main menu appears with the |Welcome| menu item highlighted on the screen. See **Figure 10-9.**

Figure 10-9: MARx Main Menu with Welcome Selected

When the user selects an item from the UI main menu by clicking on the general area, e.g., the |Beneficiaries| menu item, the screen changes. See **Figure 10-10.**

- The selected menu item; in this case, the |Beneficiaries| menu item, is highlighted in yellow on the screen.
- The associated submenu is displayed just below the main menu, the first item in the submenu is selected and highlighted in yellow on the screen as well, by default, and the associated screen; in this case, the *Beneficiaries: MCO (M201)*, is displayed in the form area.
- To view any of the other selections, click the menu or submenu item, e.g. the |Payment| menu item, to see the associated screen.

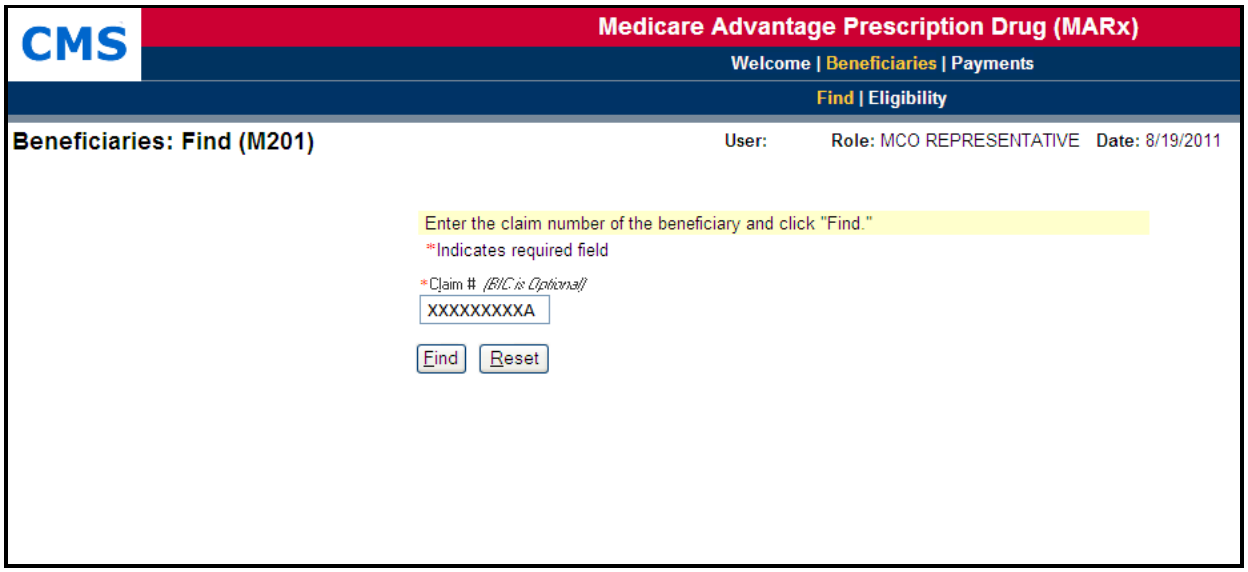


Figure 10-10: MCO Representative (View Only) Beneficiaries: Find (M201) Screen

Note: The first level screen names are comprised of the names of the Menu: Submenu selection. This assists with navigating to a particular screen.

Navigating Using the Screens

After accessing a screen, the user may conduct a search to find information about a particular beneficiary or month. After narrowing the search to this more specific level, the user may find even more detail by clicking on links and/or buttons that lead to additional screens.

An Example

The following example is provided to demonstrate the drill-down navigation method used by the Medicare Advantage and Prescription Drug System (MARx) in its online processing. Note that the screens only indicate the flow. Specific information about screen content is not provided here. See Section 10.3 for this particular function detail.

This example demonstrates how to view the details of an adjustment for a selected beneficiary during a selected month:

Consider a scenario where the user wants to determine the reason a specific beneficiary has a particular adjustment. Starting at the top level on the MARx main menu, the user selects their general area of interest. The user looks at the screens that pertain to beneficiaries, and clicks on the |Beneficiaries| menu item, as in **Figure 10-9**. *The Beneficiaries: Find (M201)* screen is displayed, as in **Figure 10-10**. Because the user wants to find a specific beneficiary, they should enter the Health Insurance Claim Number (HICN), as shown in **Figure 10-11**, and click on the [Find] button.

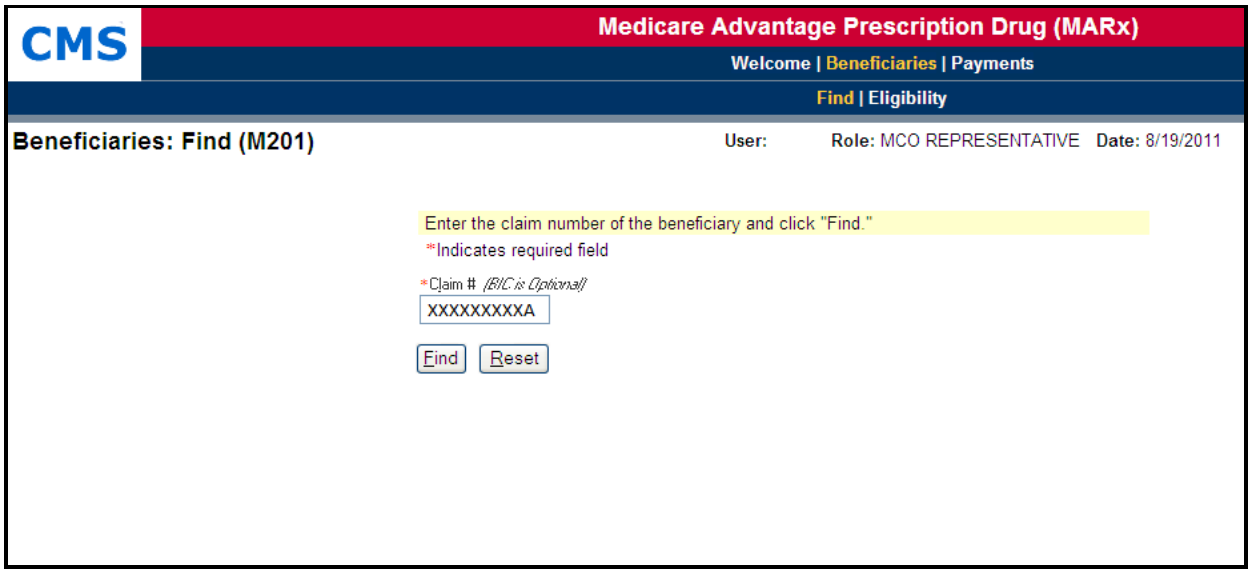


Figure 10-11: MCO Representative (View Only) Beneficiaries: Find (M201) Screen with Claim Number Entered

This displays the *Beneficiaries: Search Results (M202)* screen, as in **Figure 10-12**. In this example, there is only one beneficiary who meets the selection criteria. However, if, for example, the BIC is not entered on the search, it is possible to have more than one beneficiary who meets the selection criteria.

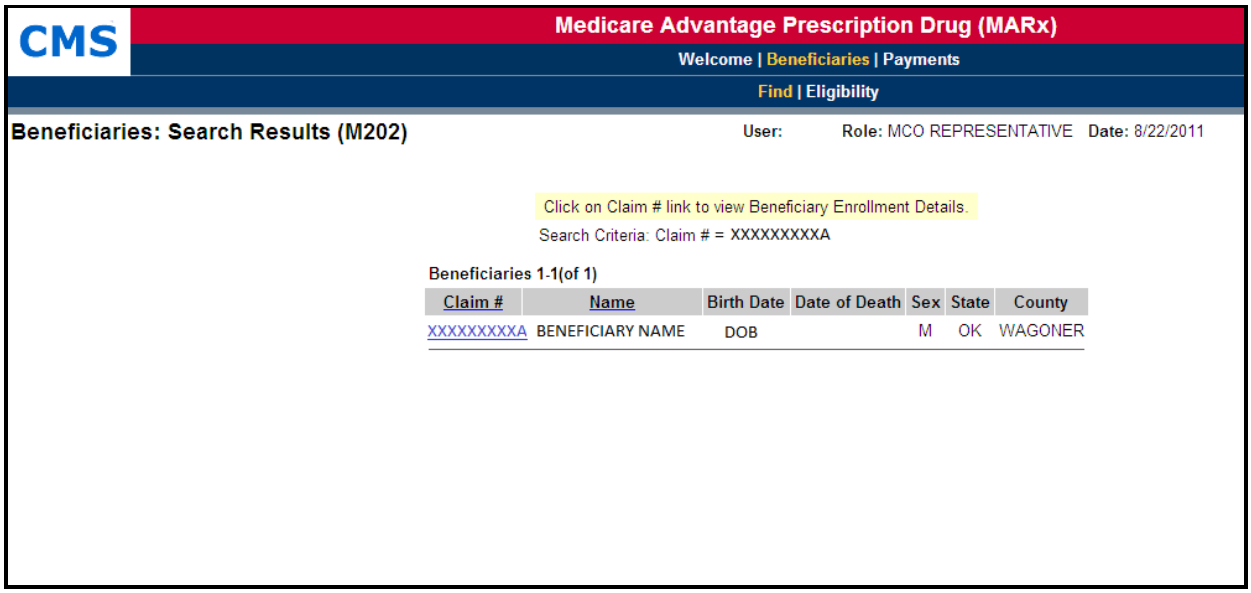


Figure 10-12: MCO Representative (View Only) Beneficiaries: Search Results (M202) for the Claim Number Specified

From here, the user can view beneficiary summary information returned from the search based on the input criteria, or the user can drill down to find more detailed information about a specific beneficiary. In this example, the user wishes to view adjustment information for a beneficiary. The first step to viewing this information is to click on the linked Claim# associated with the beneficiary, **XXXXXXXXXA**. This displays the *Beneficiary Detail: Snapshot (M203)* screen, as shown in **Figure 10-13**. This is a secondary, i.e., pop-up window, which has a different header with the Beneficiary's name, claim number, DOB, street address, age, sex, state, and county. Because this is a pop-up window, there is a [Close] button in the upper right-hand corner of the body of the window.

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Beneficiary Snapshot (M203) User: Role: Date: Close Print Help...

Change date to re-display Beneficiary Details and click "Find."

As Of: 08/10/2011 Find

Contract: Hxxxx
MCO Name: INSURANCE COMPANY A
PBP Number: 002
Segment Number: 001
Demo Type and Description:
Enrollment Source Code and Description:
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Contract: Sxxxx
MCO Name: INSURANCE COMPANY C
PBP Number: 001
Segment Number: 000
Demo Type and Description:
Enrollment Source Code and Description:
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Residence for Payments: State: OK (37) County: WAGONER (720)

Status Flags: ☐ Hospice ☐ ESRD ☐ ESRD MSP ☐ Aged/Disabled MSP ☐ Inst ☐ NHC ☐ HCBS

Payment Flags: ☐ Disabled ☐ CHF ☐ Long Term Institutional ☐ Part B Premium Reduction

Low Income Subsidy: Subsidy Start: Subsidy End: LI Premium Subsidy Level: LI Co-payment Level:

Original Reason for Entitlement: 0
Aged/Disabled MSP Factor: 0.00
ESRD MSP Factor: 0.00

Payments For Payment Date 08/01/2011

Rate Used		Part A	Part B	Part D	Total	Paid Flag
*	BLEND	$305.63	$270.27	$0.00	$575.90	Y
	RISK ADJUSTMENT	$305.63	$270.27	$0.00	$575.90	-
*	PART A/B COST SHARING REDUCTION	$38.95	$34.45	$0.00	$73.40	Y
*	TOTAL	$344.58	$304.72	$0.00	$649.30	Y
*	PART D COVERAGE GAP DISCOUNT	$0.00	$0.00	$4.85	$4.85	Y
	PART D BASIC PREMIUM	$0.00	$0.00	$14.79	$14.79	-
*	PART D DIRECT SUBSIDY	$0.00	$0.00	$47.07	$47.07	Y
*	PART D REINSURANCE	$0.00	$0.00	$14.85	$14.85	Y
*	TOTAL PDP	$0.00	$0.00	$66.77	$66.77	Y

Adjustments Applied to 08/01/2011

Rate Used		Part A	Part B	Part D	Total	Paid Flag

No Adjustments applied to 08/01/2011 for Hxxxx/002/001
No Adjustments applied to 08/01/2011 for Sxxxx/001/000

Entitlement Information

	Start Date	End Date	Option
Part A:	07/01/2001		E
Part B:	07/01/2001		Y

Enrollment Information

Contract	Start Date	End Date
Hxxxx	01/01/2011	
Sxxxx	01/01/2011	

Eligibility Information

	Start Date	End Date
Part D:	01/01/2006	

Premiums

Premium Payment Option:	DEDUCT FROM SSA BENEFITS/DEDUCT FROM SSA BENEFITS
Premium Payment Option Pending:	
Part C Premium (from enrollment):	$19.00
Part D Premium (from HPMS):	$0.00
De minimis:	$0.00
Part D Net of De minimis:	$14.80
Low Income Subsidy:	$0.00
Late Enrollment Penalty:	$0.00
Late Enrollment Penalty Waived Amount:	$0.00
Late Enrollment Penalty Subsidy:	$0.00
Beneficiary's Total Part D Premium:	$14.80
Total C+D Premium (paid by beneficiary):	$33.80

Figure 10-13: MCO Representative (View Only) Beneficiary Detail: Snapshot (M203) for Selected Beneficiary

To view adjustment information specific to a beneficiary, the user selects the |Adjustments| menu item, located just below the header. See **Figure 10-14** for screen display.

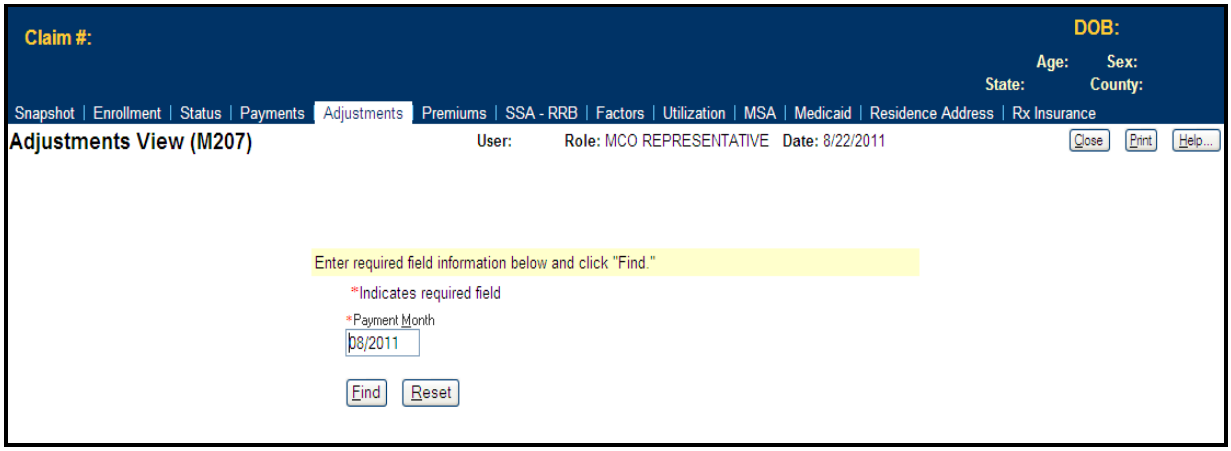


Figure 10-14: MCO Representative (View Only) Beneficiary Detail: Adjustments (M207) Screen for the Selected Beneficiary

Next, to obtain the adjustments for a particular payment date, the user enters the Payment Month, in this case, 08/2011, and clicks on the [Find] button. This displays adjustment information for that beneficiary for months up through and including the payment month, as shown in **Figure 10-15.**

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Adjustments View (M207) User: Role: MCO REPRESENTATIVE Date: 8/22/2011 Close Print Help...

Enter required field information below and click "Find."

*Indicates required field

*Payment Month 07/2011

Find Reset

Adjustments 1-20(0f 142) (Click on adjustment date to view details) Go to Page: 1 Go

						Adjustments					
Adjustment Date	Contract	PBP	Segment	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	06/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	06/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	05/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	05/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	04/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	04/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	03/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	03/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	02/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	02/2011	Y

Figure 10-15: MCO Representative (View Only) Beneficiary Detail: Adjustments (M207) Screen for Selected Beneficiary Expanded for Specified Payment Month

Finally, the user selects a particular adjustment by clicking on the month/year link in the Adjustment Date column, in this case, 07/2011, to display **Figure 10-16**.

At this point, a display-only screen appears. There are no other links or options for drilling down, but the user has access to all the information regarding this beneficiary's adjustments.

Again, the drill-down method enables the user to navigate from very general information to very specific information just by following a path of menu and submenu items, links, and searches. Appendix G provides more information and a complete description of the system navigational hierarchy.

Claim #: **DOB:**
State: **Age:** **Sex:** **County:**

Payment/Adjustment Detail (M215) **User:** **Role:** MCO REPRESENTATIVE **Date:** 8/22/2011 Close Print Help...

Payments/Adjustment Table - Contract# Hxxxx

Rebate for Part D Premium reduction is in the A and B columns. It is reflected correctly in the total Part D payments.

				Payment/Adjustments						
Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
07/2011	PAYMENT COMPONENT	RISK ADJUSTMENT	-	$790.39	$698.93	$0.00	$1,489.32	07/2011	Y	
07/2011	PAYMENT	PART D COVERAGE GAP DISCOUNT	-	$0.00	$0.00	$9.36	$9.36	07/2011	Y	
07/2011	PAYMENT	PART C PREMIUM	-	$0.00	$0.00	$0.00	$0.00	07/2011	Y	
07/2011	PAYMENT	PART A/B COST SHARING REDUCTION	-	$36.33	$32.12	$0.00	$68.45	07/2011	Y	
07/2011	PAYMENT	PART A/B MANDATORY SUPP BENEFITS	-	$4.17	$3.69	$0.00	$7.86	07/2011	Y	
07/2011	PAYMENT	PART D SUPP BENEFITS	-	$11.30	$10.00	$0.00	$21.30	07/2011	Y	
07/2011	PAYMENT COMPONENT	PART D BASIC PREMIUM	-	$0.00	$0.00	$24.59	$24.59	07/2011	-	
07/2011	PAYMENT	PART D DIRECT SUBSIDY	-	$0.00	$0.00	$97.37	$97.37	07/2011	Y	
07/2011	PAYMENT	PART D REINSURANCE	-	$0.00	$0.00	$12.05	$12.05	07/2011	Y	
07/2011	PAYMENT	PART D BASIC PREMIUM REDUCTION REBATE	-	$13.06	$11.54	$0.00	$24.60	07/2011	Y	
07/2011	PAYMENT	TOTAL	-	$842.19	$744.74	$143.38	$1,730.31	07/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	06/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	06/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	06/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	06/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	05/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	05/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	05/2011	Y	

Figure 10-16: MCO Representative (View Only) Payment/Adjustment Detail (M215) Screen for the Selected Adjustment

Payment adjustments due to system clean-ups are uniquely identified on the Payment/Adjustment Detail (M215) Screen by a Clean-Up Identifier, which also appears on the MMR data file. The identifiers provide a convenient reference and linkage to documentation provided via Plan communications from CMS to enhance the Plan's understanding of a particular payment adjustment.

10.2 Logging On and Viewing Messages

To use the UI online, the user must log on. A screen containing messages and the calendar appears.

10.2.1 Logging On

STEP 1: Accessing the Logon screen

Section 10.2.1 includes instructions on logging onto the CMS applications portal and navigating to the UI. If successful, the *User Security Role Selection (M002)* screen displays, from which the user selects their role. If the system is down when the user tries to log on, the browser displays a message that the *page is unavailable* or the *page cannot be found*. The content of this message is dependent on the browser, not on the system.

If the system is up and logon is unsuccessful, the *Logon Error (M009)* screen displays an error message describing why logon failed. See **Figure 10-17.**

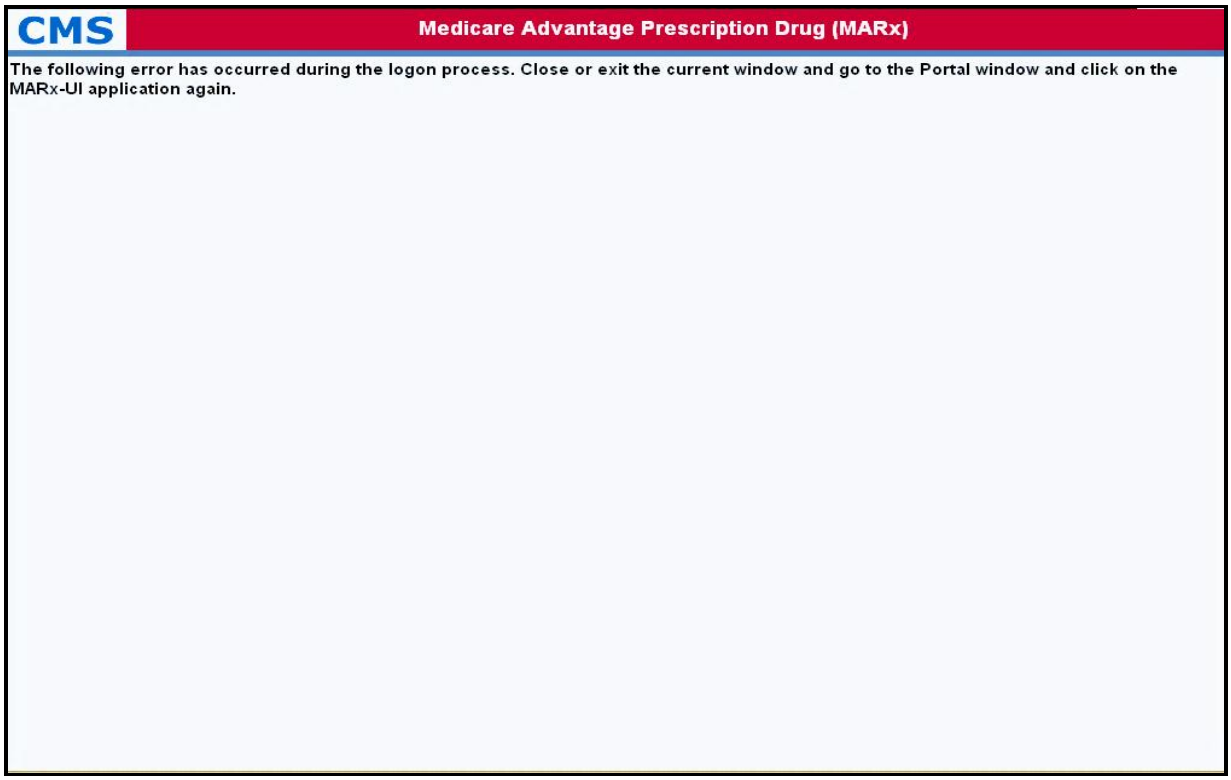


Figure 10-17: Logon Error (M009) Screen

STEP 2: Selecting a Role

The *User Security Role Selection (M002)* screen displays the roles available to the user. Typically, a user has only one role available, and that role is selected. This screen is shown in **Figure 10-18** and described in **Table 10-4**, with error and validation messages provided in **Table 10-5.**

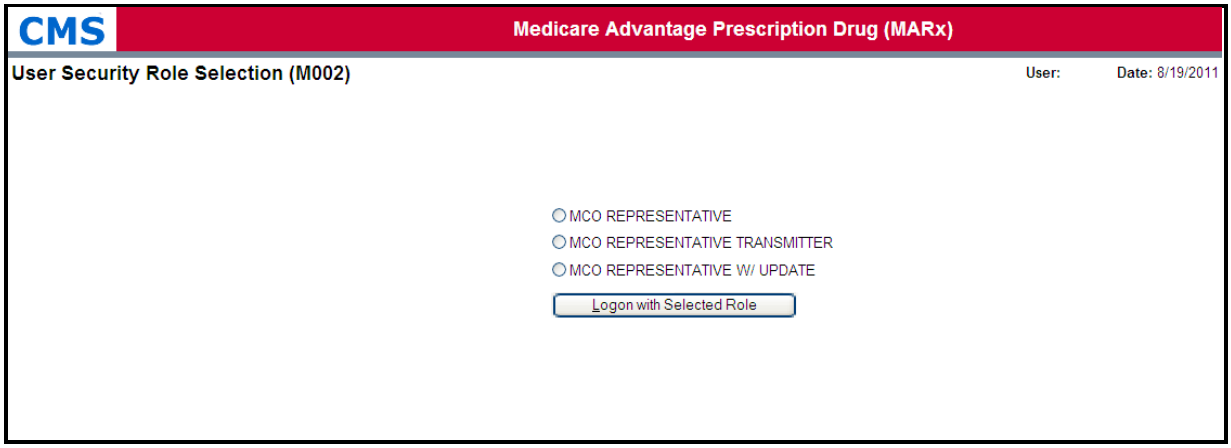


Figure 10-18: User Security Role Selection (M002) Screen

Table 10-4: M002 Screen Field Descriptions and Actions

Item	Input/Output	Description
Role selection	Required radio button	Click on one of the buttons to indicate under which role the user will log on.
[Log on with Selected Role]	Button	Click on this button to complete the logon with the selected role.

Table 10-5: M002 Screen Messages

Message Type	Message Text	Suggested Action
Workstation setup	Click on the message 'Pop-up blocked. To view this pop-up or additional options click 'here…,' then click 'Always Allow Pop-ups from This Site…'	Follow the directions given in the message to enable pop-ups from the UI. When a message is displayed asking if the user wants to allow pop-ups from the site, click [Yes]. Next, a message displays asking if the user wants to close the window. Click [No]. The *Welcome (M101)* screen then displays.
Missing data	No contracts are defined for this role	The user must update their profile. Appendix B includes contact information to report the error.
Software or Database Error	No security roles are defined for your user ID	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error retrieving your security roles from the database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Your user ID does not exist	The user should access Appendix B for contact information to report the error.
Software or Database Error	Your user ID was not supplied	The user should access Appendix B for contact information to report the error.
Software or Database Error	Your user ID profile is inactive	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database while retrieving your security roles	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error retrieving the expected number of security setting results. Retrieved <# of results sets retrieved> out of <# of results sets expected>	The user should access Appendix B for contact information to report the error.
Software or Database Error	No screen items defined for this role	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error retrieving your security settings	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database while retrieving your security settings	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error retrieving the expected number of dropdown list results. Retrieved <# of results sets retrieved> out of <# of results sets expected>	The user should access Appendix B for contact information to report the error.
Software or Database Error	The dropdown lists results set is empty	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error retrieving dropdown lists from the database	The user should access Appendix B for contact information to report the error.
Software or Database Error	No CPM has been set	The user should access Appendix B for contact information to report the error.

Message Type	Message Text	Suggested Action
Software or Database Error	Unexpected error code from database while retrieving the dropdown lists	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

The default role is selected on the screen. If the user has more than one role available, the user may change from the default to another role. The selected role shows on the title line of subsequent screens. Once a role is selected, the user clicks on the [Logon with Selected Role] button.

After a role is selected, the *Welcome (M101)* screen appears, as shown in **Figure 10-19** and described in **Table 10-6**, with error and validation messages provided in **Table 10-7**.

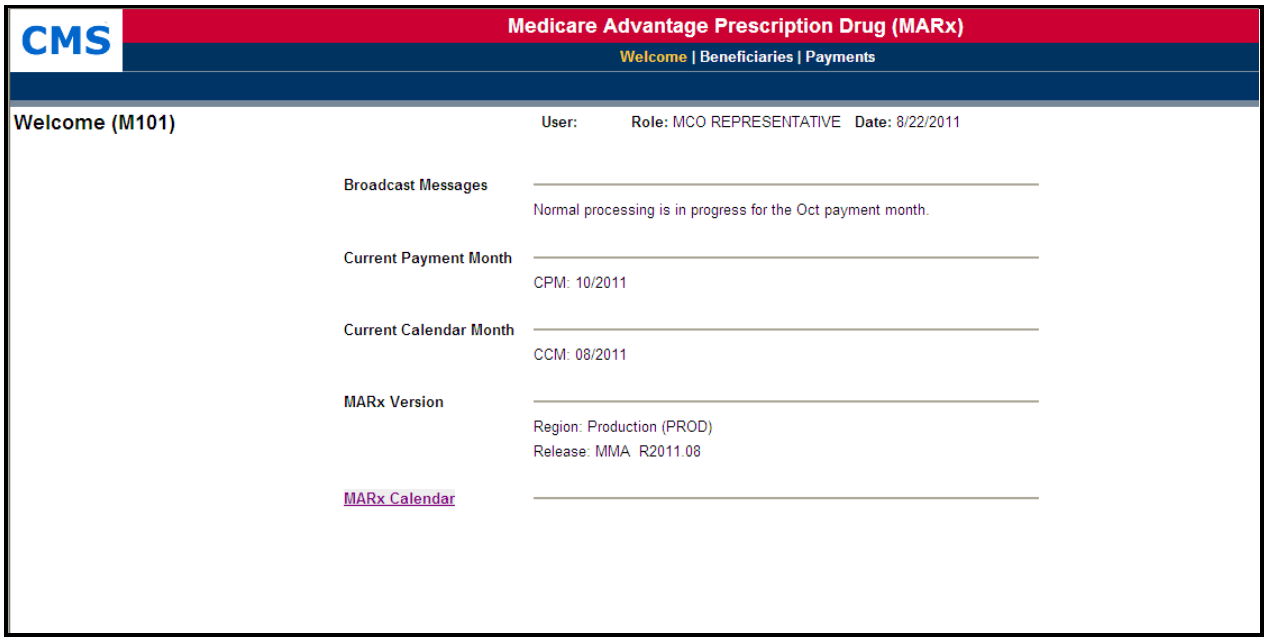


Figure 10-19: MCO Representative (View Only) Welcome (M101) Screen

Table 10-6: MCO Representative (View Only) (M101) Field Descriptions and Actions

Item	Input/Output	Description
Broadcast Messages	Output	Provides general information about the system's actions, e.g. month-end processing started. The list of messages refreshes every time the user returns to the screen.
Current Payment Month (CPM)	Output	The month/year currently in process by the system.
MARx Version	Output	The region and release information of the MARx UI display.
MARx Calendar	Link	Provides general information about what is happening in the system, e.g. month-end processing started. The list of messages refreshes every time the user returns to the screen.

Table 10-7: MCO Representative (View Only) (M101) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	The result set that contains the system message is empty!	The user should access Appendix B for contact information to report the error.
Software or Database Error	Database errors occur in retrieving the system messages!	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

The following sections provide information on the *Welcome (M101)* Screen:

- Broadcast message. See the next section, Viewing System Broadcast Messages
- Calendar. See **Section 10.2.3**

10.2.2 Viewing System Broadcast Messages

Broadcast messages display for all users and provide information about system-wide events, such as the start or completion of month-end processing. These messages expire without any user action.

STEP 1: Accessing the Welcome (M101) Screen

From the system main menu, the user clicks on the |Welcome| menu item. This displays the *Welcome (M101)* screen.

STEP 2: Viewing the Broadcast Messages

The broadcast messages show on the *Welcome (M101)* screen under the Broadcast Messages heading. The list of messages refreshes every time the user returns to the screen.

10.2.3 Viewing the Calendar

From the calendar, there is a list of operational events scheduled for any month.

STEP 1: Accessing the Calendar (M105) Screen

From the system main menu, the user clicks on the |Welcome| menu item. This automatically selects the *Welcome (M101)* screen. The user clicks on the MARx Calendar link to display the *Calendar (M105)* screen, as shown in **Figure 10-20** and described in **Table 10-8**, with error and validation messages provided in **Table 10-9**.

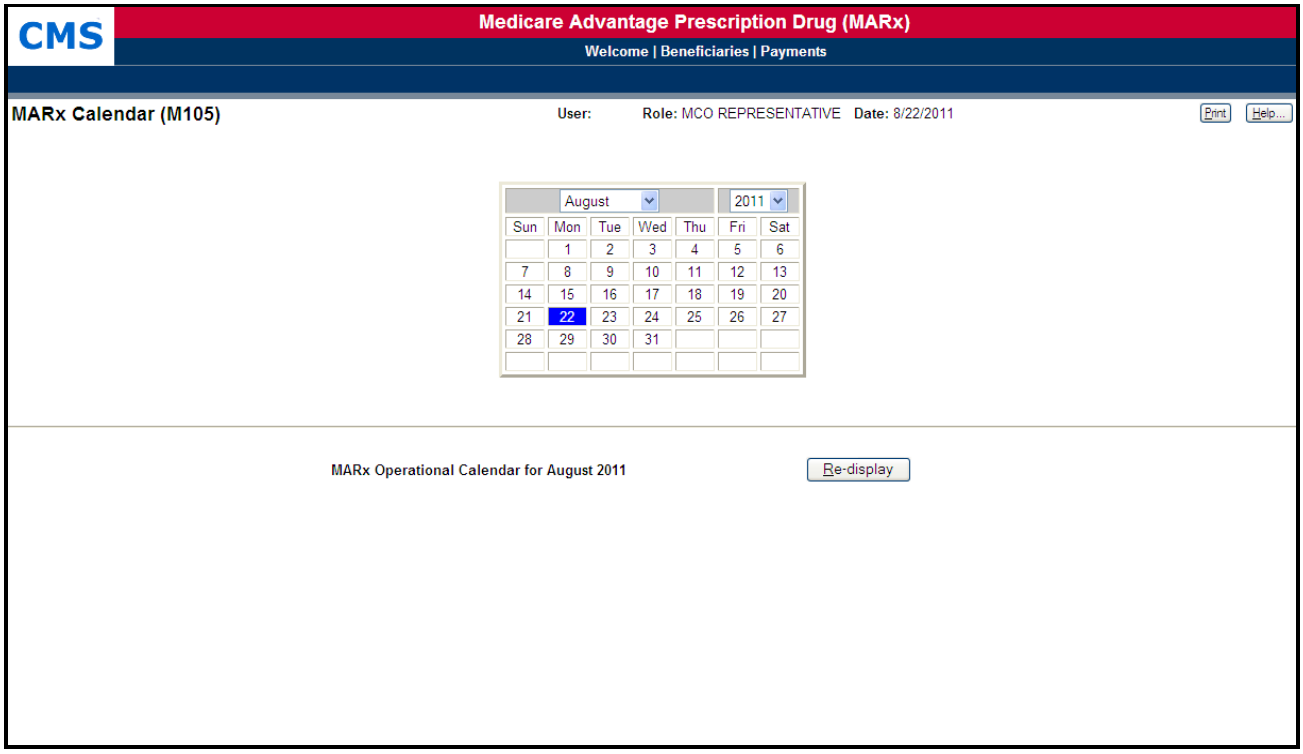


Figure 10-20: MCO Representative (View Only) Calendar (M105) Screen

Table 10-8: MCO Representative (View Only) (M105) Field Descriptions and Actions

Item	Input/Output	Description
Above Line		
Month	Required dropdown list	Defaults to current calendar month. When this changes, the pictorial calendar automatically updates to the selected month and year.
Year	Required dropdown list	Defaults to current calendar year. When this changes, the pictorial calendar automatically updates to the selected month and year.
Calendar	Output	Pictorial calendar for selected month and year. When in the current month, the current day is highlighted in blue.
Below Line		
MARx Operational Calendar	Output	List of events scheduled for the selected month and year.
[Re-display]	Button	After changing the month or year, the user clicks on this button to display the operational calendar for the newly selected month.

Table 10-9: MCO Representative (View Only) (M105) Screen Messages

Message Type	Message Text	Suggested Action
No data	No schedule events found for <month/year>	The user should pick a different month.
Software or Database Error	Error occurred while retrieving schedule results for <month/year>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving schedule events for <month/year>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

STEP 2: Viewing the Calendar Events

The top part of the screen shows a pictorial calendar for one month. When the screen first displays, the current month shows with the current day highlighted in blue. The bottom part of the screen, i.e., the operational calendar, shows the calendar events scheduled for that month, with the date and description of each event.

STEP 3: Changing the Month

To view a different month, select a different month and/or year in the pictorial calendar. The calendar for the new month is then displayed. To view the operational calendar for the newly selected month, click on the [Re-display] button in the bottom part of the screen.

10.2.4 Logging Out of the Medicare Advantage and Part D Inquiry System

When the user is finished with all activities, the user should log out. If the user does not log completely out, the session eventually times out. However, logging out as soon as the user is finished with the system is a more secure process to follow and is therefore recommended.

If the browser window is closed, the user is logged out automatically. To simplify logging out, the user may use the logout screen to close all of windows in one step.

When the user logs on to the system, the logon screen is replaced with a logout screen as shown in **Figure 10-21** and described in **Table 10-10**, with error and validation messages provided in **Table 10-11**. This logout screen is behind the UI primary window and the user may access it at any time by selecting the window.

The user clicks on the [Logout] button. The browser then asks the user if they want to close the window.

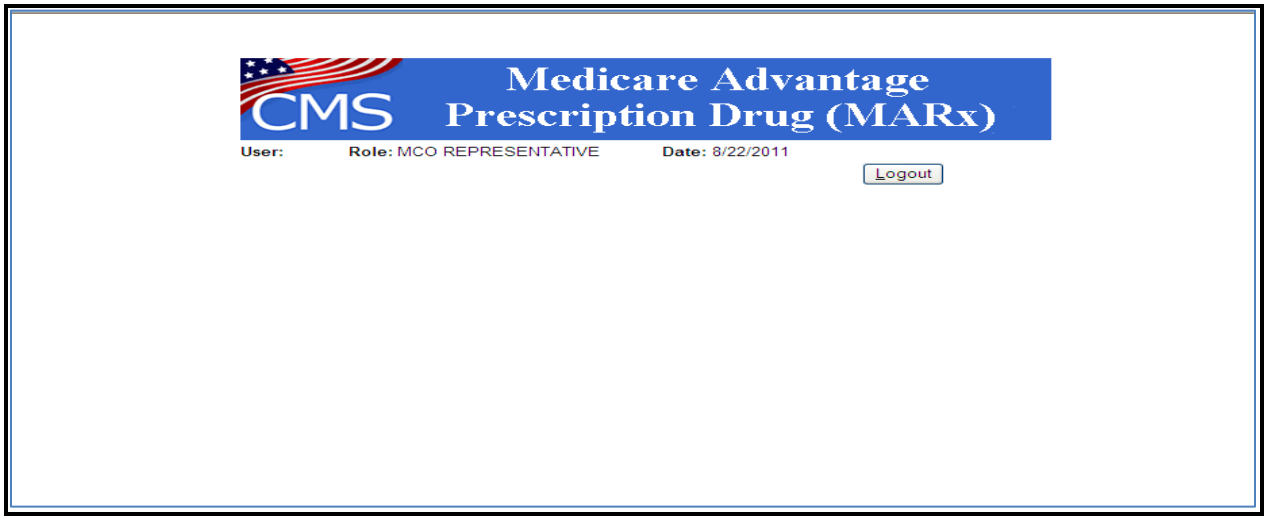


Figure 10-21: MCO Representative (View Only) Logout Screen

Table 10-10: MCO Representative (View Only) Field Descriptions and Actions

Item	Input/Output	Description
[Logout]	Button	The user clicks on this button to log out of the system, closing all windows.

Table 10-11: MCO Representative (View Only) Logout Screen Messages

Message Type	Message Text	Suggested Action
Process	The Web page you are viewing is trying to close the window. Do you want to close this window? [Yes] or [No]	The user clicks on the [Yes] button to close the window. The user clicks on the [No] button to keep the window open.

10.3 Viewing/Updating Beneficiary Information

Each user role identified below can search for a particular beneficiary by specifying one or more selection criteria. After finding the beneficiary of interest, the user may view detailed information specific to their role. This section describes the following steps for viewing beneficiary information by user role:

- *STEP 1: Accessing the Beneficiaries: Find (M201) Screen*
- *STEP 2: Using the Beneficiaries: Find (M201) Screen*
- *STEP 3: Using the Beneficiaries: Search Results (M202) Screen*
- *STEP 4: Viewing Detailed Enrollment Information for a Beneficiary*
  - *STEP 4a: Viewing the Beneficiary Detail: Snapshot (M203) Screen*
  - *STEP 4b: Updating the Beneficiary Detail: Snapshot (M203) Screen*
  - *STEP 4c: Viewing the Beneficiary Detail: Enrollment (M204) Screen*
  - *STEP 4d: Updating the Beneficiary Detail: Enrollment (M204) Screen*
  - *STEP 4e: Viewing the Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance*
  - *STEP 4f: Updating the Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance*
  - *STEP 4g: Viewing the Beneficiary Detail: Enrollment (M204) Screen Payment*
  - *STEP 4h: Updating the Beneficiary Detail: Enrollment (M204) Screen Payment*
  - *STEP 4i: Updating the Beneficiaries: New Enrollment (M221) Screen*
  - *STEP 4j: Updating the Beneficiaries: Update Enrollment (M212) Screen*
  - *STEP 4k: Updating the Beneficiaries: Additional Update Enrollment (M230) Screen*
  - *STEP 4l: Viewing the Beneficiary Detail: Status (M205) Screen*
  - *STEP 4m: Viewing the Beneficiary Detail: Payments (M206) Screen*
  - *STEP 4n: Viewing the Beneficiary Detail: Adjustments (M207) Screen*
  - *STEP 4o: Viewing the Beneficiary Detail: Premiums (M231) Screen*
  - *STEP 4p: Updating the Beneficiary Detail: Premiums (M231) Screen*
  - *STEP 4q: Updating the Beneficiary Detail: Update Premiums (M226) Screen NUNCMO*
  - *STEP 4r: Viewing the Beneficiary Detail: SSA/RRB Transaction Status (M237) Screen*
  - *STEP 4s: Viewing the Beneficiary Detail: Factors (M220) Screen*
  - *STEP 4t: Viewing the Beneficiary Detail: Utilization (M233) Screen*

- *STEP 4u: Viewing the Beneficiary Detail: Medicaid (M236) Screen*
- *STEP 4v: Viewing the Beneficiary Detail: MSA Lump Sum (M235) Screen*
- *STEP 4w: Viewing the Residence Address View (M243) Screen*
- *STEP 4x: Updating the Residence Address View (M243) Screen*
- *STEP 4y: Updating the Update Residence Address View (M242) Screen*
- *STEP4z: Viewing the Enrollment Detail (M222) Screen*

- *STEP 5: View Beneficiary Eligibility – Beneficiary Eligibility Query via the UI*
  - *STEP 5a: Viewing the Beneficiary: Eligibility (M232) Screen*
- *STEP 6: Viewing the Rx Information for a Beneficiary*
  - *STEP 6a: Viewing the Rx Insurance View (M244) Screen*
  - *STEP 6b: Updating the Rx Insurance View (M244) Screen*
  - *STEP 6c: Updating the Rx Insurance View (M228) Screen*
  - *STEP 6d: Updating the Beneficiary Opt-Out (M234) Screen*
- *STEP 7: Viewing the Payment/Adjustment for a Beneficiary*
  - *STEP 7a: Viewing the Payment/Adjustment Detail (M215) Screen*

10.3.1 Finding a Beneficiary

To find information about a beneficiary who is enrolled in a contract; either currently, in the past, or in the future, the user accesses the *Beneficiaries: Find (M201)* screen to search for the beneficiary. Once the person is located, the user can view information on that beneficiary.

Validation Messages

Table 11-12 lists validation messages that appear directly on the screen during data entry/processing in the status line (the line just below the title line, as in **Figure 10-22**.

Figure 10-22: Validation Message Placement on Screen

These are common validation messages, not specific to a single screen but related to the fields that appear on many screens. Note that screen/function-specific messages appear in the section related to the specific function and are associated with the specific screen.

Table 10-12: Validation Messages

Error Messages	Suggested Action
User must enter a contract number	Enter the field specified by the message.
A contract number must start with an ‘E’, ‘H’, ‘R’, ‘S’, ‘X,’ or ‘9’, followed by four characters	Re-enter the field and follow the format indicated in the message.
User must enter a sex	Enter the field specified by the message.
User must select a state	Enter the field specified by the message.
Invalid Contract/PBP combination	Check the combination and re-enter.
Invalid Contract/PBP/segment combination	Check the combination and re-enter.
<kind-of-date> is invalid. Must have format (M)M/(D)D/YYYY	Re-enter the field and follow the format indicated in the message.
User must enter <kind of date>	Enter the field specified by the message.
PBP number must have three alphanumeric characters	Re-enter the field and follow the format indicated in the message.
Please enter at least one of the required fields	Make sure to enter all the required fields.
Please enter user ID or password	Make sure to enter one of the fields specified by the message.
Segment number must have three digits	Re-enter the field and follow the format indicated in the message.
The claim number is not a valid SSA or RRB number, or CMS Internal number	Re-enter the field in SSA, RRB, or CMS Internal format.
The last name contains invalid characters	Re-enter the field using only letters, apostrophes, hyphens, or blanks.
The user ID contains invalid characters	Re-enter the field and follow the format indicated in the message.
You do not have access rights to this contract	First, make sure that the Contract # is entered correctly. If not, re-enter it. If the user did, he/she should have rights to this contract; see the Security Administrator who can update the user profile for these rights.

STEP 1: Accessing the Beneficiaries: Find (M201) Screen

From the main menu, the user clicks on the |Beneficiaries| menu item. The |Find| submenu item is already selected and displays the *Beneficiaries: Find (M201)* screen as shown in **Figure 10-23** and described in **Table 10-13**, with error and validation messages provided in **Table 10-14**.

STEP 2: Using the Beneficiaries: Find (M201) Screen

The user enters search criteria and clicks on the [Find] button.

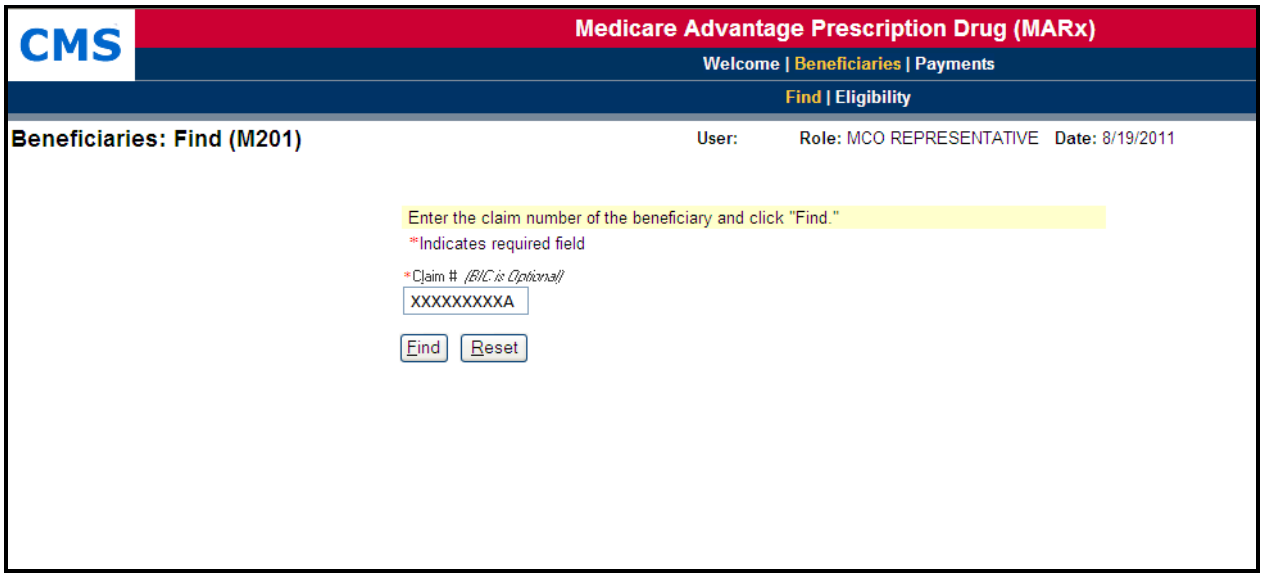


Figure 10-23: MCO Representative (View Only) Beneficiaries: Find (M201) Screen

Table 10-13: MCO Representative (View Only) (M201) Field Descriptions and Actions

Item	Input/Output	Description
Claim #	Required data entry field	The user finds beneficiaries with this claim number. **Note:** The BIC is optional except when an RRB number is entered.
[Find]	Button	After entering a claim number, the user clicks on this button to initiate the search for beneficiaries.

Table 10-14: MCO Representative (View Only) (M201) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Enter a claim number.	The user must make sure to enter a valid claim number.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	The user re-enters the claim number.
No data	No beneficiary records found for the search criteria.	The user should verify the accuracy of information entered. The user should perform a more general search, in case the constraints are too restricting.
Software or Database Error	Error occurred while retrieving beneficiary search results.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary records.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error.	The user should access Appendix B for contact information to report the error.

10.3.2 Viewing Summary Information about a Beneficiary

Beneficiaries meeting search criteria display on the *Beneficiaries: Search Results (M202)* screen.

STEP 3: Using the Beneficiaries: Search Results (M202) Screen

If the search is successful, the *Beneficiaries: Search Results (M202)* screen displays as in **Figure 10-24** and described by **Table 10-15**. Because any error associated with the search would display on the *Beneficiaries: Find (M201)* screen, no error messages display. If a user enters an inactive Claim Number for the Beneficiary, a message displays to that effect as shown in **Table 10-16**.

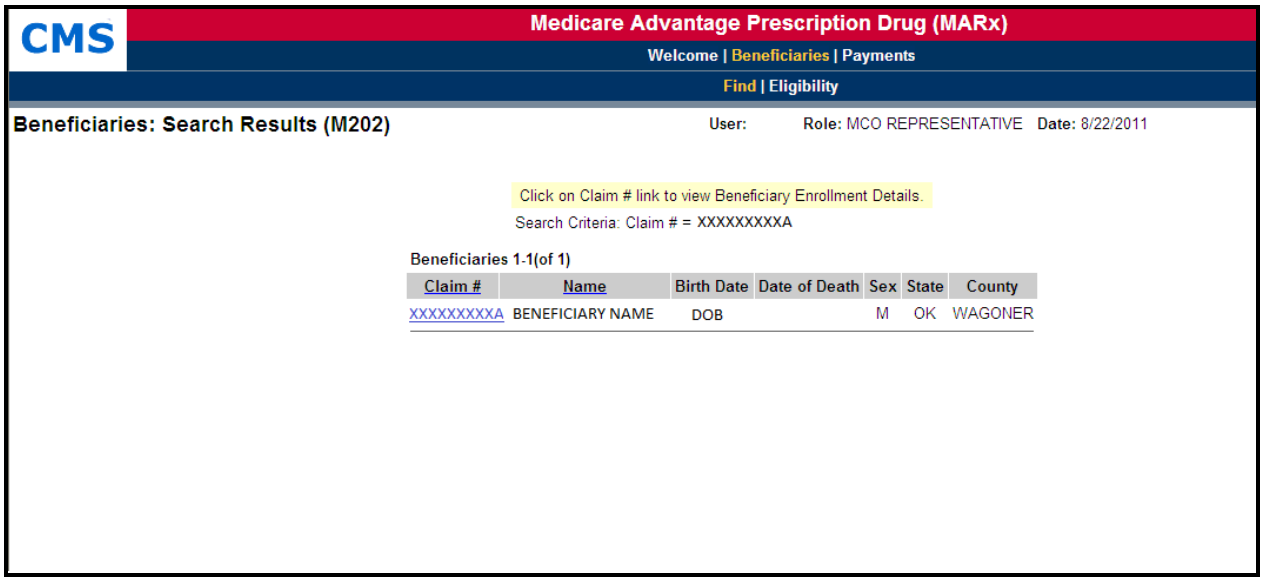


Figure 10-24: MCO Representative (View Only) Beneficiaries: Search Results (M202) Screen

Table 10-15: MCO Representative (View Only) (M202) Field Descriptions and Actions

Item	Input/Output	Description
Claim # column heading	Sorter	Sorts the results by claim numbers.
Claim # in the Claim # column	Link	The user clicks on a Claim # link to display the *Beneficiary Detail: Snapshot (M203)* screen.
Name column heading	Sorter	Sorts the results by beneficiary name.
Birth Date column	Output	DOB of each beneficiary.
Date of Death column	Output	DOD, if applicable, of each beneficiary.
Sex column	Output	Sex of each beneficiary.
State column	Output	State of residence of each beneficiary.
County column	Output	County of residence of each beneficiary.

Table 10-16: MCO Representative (View Only) (M202) Screen Messages

Message Type	Message Text	Suggested Action
Informational	The beneficiary's active claim number is displayed for the claim number entered	None Needed.

Tip: Returning to the previous screen to add other selection criteria may narrow search results.

From this screen, the user sees summary information about each beneficiary that meets the search criteria. The user can sort the list by claim number or by name by clicking on the Claim # column heading or the Name column heading, respectively. To see more details about any particular beneficiary in this list, the user clicks on a Claim # link in the Claim # column. This displays the *Beneficiary Detail: Snapshot (M203)* screen in a pop-up window with a menu to get to various screens. Each screen provides specific details about the beneficiary's enrollment or payment history. These screens are described in more detail later in this section.

10.3.3 Viewing Detailed Information for a Beneficiary

The user finds the beneficiary on the *Beneficiaries: Search Results (M202)* screen and drills down for more information.

STEP 4: Viewing Detailed Information for a Beneficiary

To see detailed information about any of the beneficiaries listed in the *Beneficiaries: Search Results (M202)* screen, the user clicks on the associated Claim #.

Note: Instead of seeing a screen in the same area as previously displayed, a new window with a new screen and new header appears. This is a pop-up window, with its own header information specific to the selected beneficiary. The beneficiary's latest mailing address is displayed, along with the current State and County Code (SCC). The header, by itself, is shown in **Figure 10-25.**

Figure 10-25: Sample Header for the Beneficiary Detail Screens

To improve system performance, CMS begins archiving inactive beneficiaries as of the February 2013 release. By reducing the volume of data in the operational databases, the overall performance of the systems is enhanced.

Beneficiaries that meet both of the following criteria are selected for archiving:

- Were deceased for at least 15 years or, are at least 120 years old with a BIC of M or T
- Have had no activity for at least two years

However, the business owners may decide to exclude moving a population of beneficiaries to the archived database.

All beneficiaries, whether in the active or the archived database, are available for view using the MARx User Interface (UI).

To identify whether a beneficiary is archived, the UI displays either an "Active" or "Archived" status on the UI Banner appearing at the top of the screen. Update capability is only available for beneficiary records in the active database.

Archiving of data for the selected beneficiaries crosses all MAPD systems. CMS has the capability to recall beneficiaries from the archived database into the active database. If a Plan wishes to recall an archived beneficiary, the Plan should discuss it with CMS.

In addition, just below the header is a set of menu items, described in **Table 10-17**. The user can switch back and forth among the seven different screens by clicking the menu items. Each screen pertains to the beneficiary selected from the *Beneficiaries: Search Results (M202)* screen. **Figure 10-24** provides an example of the menu items.

Table 10-17: Menu Items for Viewing Beneficiary Detail Information

Menu Item	Screen Name	Description
|Snapshot|	*Beneficiary Detail: Snapshot (M203)*	Displays an overall summary of payment information for the beneficiary as of the date specified. If the beneficiary is not currently enrolled, the summary of last available payments and adjustments information displays. When the screen first displays, the date defaults to the current date.
|Enrollment|	*Beneficiary Detail: Enrollment (M204)*	Displays a summary list of enrollment information, by contract, for the enrollments to which the user has access. It also provides links to drill down to more detailed payment, adjustment, and enrollment information for the beneficiary on a selected contract.
|Status|	*Beneficiary Detail: Status (M205)*	Displays a summary list of enrollment and health status, by contract, for the enrollments to which the user has access.
|Payments|	*Beneficiary Detail: Payments (M206)*	Displays a list, ordered by month as of the specified payment date, of payment and adjustment information, broken down by Part A, Part B, and Part D. The payment date defaults to the current month. It also provides links to drill down to more detailed payment and adjustment information for the beneficiary on a selected contract.
|Adjustments|	*Beneficiary Detail: Adjustments (M207)*	Displays a list, ordered by adjustment month as of the specified payment month, of adjustment information, broken down by Part A, Part B, and Part D, for months up through a specified date. The payment month defaults to the current month. It also provides links to drill down to more detailed payment and adjustment information for the beneficiary on a selected contract.
|Premiums|	*Beneficiary Detail: Premiums (M231)*	Displays a list of premium information for the specified month. The payment month defaults to the current month.
|Premium Withhold|	*Beneficiary Detail: Premium Withhold Transactions (M237)*	Displays a list of premium withhold transaction information for the beneficiary. The initial display defaults to the information for Current Processing Month
|Factors|	*Beneficiary Detail: Factors (M220)*	Displays the factors, beneficiary-specific or default, used in payment calculation.
[Utilization]	*Beneficiary Detail: Utilization (M233)*	Displays information on the beneficiary's use of Medicare services.
[MSA]	*Beneficiary Detail: MSA Lump Sum (M235)*	Displays Medical Savings Account Lump Sum information for a beneficiary for which the user has access.
[Medicaid]	*Beneficiary Detail: Medicaid (M236)*	Displays a summary list of Medicaid information for a beneficiary for which the user has access.

To view information for other beneficiaries, the user can either select another beneficiary from the *Beneficiaries: Search Results (M202)* screen or perform a new search on the *Beneficiaries: Find (M201)* screen.

10.3.4 Viewing a Snapshot of Beneficiary Information

A snapshot shows a summary of membership, health status, and payment/adjustment information for the beneficiary as of a specified month. If payments are unavailable for the specified month, the last available payments and adjustments information is shown.

STEP 4a: Viewing the Beneficiary Detail: Snapshot (M203) Screen

The *Beneficiary Detail: Snapshot (M203)* screen, as shown in **Figure 10-26** and **Figure 10-27** and described in **Table 10-18**, with error and validation messages provided in **Table 10-19,** provides payment, status, adjustment, entitlement, eligibility, enrollment, and premium information for the beneficiary as of the date the user specifics. When the beneficiary enrolls in two contracts, one for Part A and/or Part B and the other for Part D, information is displayed on both the contracts. On the initial display, the current date is used. To view the details as of a different date, the user updates the date in the *As Of* data entry area and clicks on the [Find] button. If the beneficiary is enrolled with an effective date in the future, no status information is available. The user changes the *As Of* date to the future date to view the snapshot information. If the beneficiary is not currently enrolled, a status message states that "the latest available snapshot information is for a payment month in the past and last available payments are adjustments".

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Beneficiary Snapshot (M203) User: Role: Date: Close Print Help...

Change date to re-display Beneficiary Details and click "Find."

As Of: 08/10/2011 Find

Contract: Hxxxx
MCO Name: INSURANCE COMPANY A
PBP Number: 002
Segment Number: 001
Demo Type and Description:
Enrollment Source Code and Description:
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Contract: Sxxxx
MCO Name: INSURANCE COMPANY C
PBP Number: 001
Segment Number: 000
Demo Type and Description:
Enrollment Source Code and Description:
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Residence for Payments: State: OK (37) County: WAGONER (720)

Status Flags: ☐ Hospice ☐ ESRD ☐ ESRD MSP ☐ Aged/Disabled MSP ☐ Inst ☐ NHC ☐ HCBS

Payment Flags: ☐ Disabled ☐ CHF ☐ Long Term Institutional ☐ Part B Premium Reduction

Low Income Subsidy: Subsidy Start: Subsidy End: LI Premium Subsidy Level: LI Co-payment Level:

Original Reason for Entitlement: 0
Aged/Disabled MSP Factor: 0.00
ESRD MSP Factor: 0.00

Payments For Payment Date 08/01/2011

Rate Used		Part A	Part B	Part D	Total	Paid Flag
*	BLEND	$305.63	$270.27	$0.00	$575.90	Y
	RISK ADJUSTMENT	$305.63	$270.27	$0.00	$575.90	-
*	PART A/B COST SHARING REDUCTION	$38.95	$34.45	$0.00	$73.40	Y
*	TOTAL	$344.58	$304.72	$0.00	$649.30	Y
*	PART D COVERAGE GAP DISCOUNT	$0.00	$0.00	$4.85	$4.85	Y
	PART D BASIC PREMIUM	$0.00	$0.00	$14.79	$14.79	-
*	PART D DIRECT SUBSIDY	$0.00	$0.00	$47.07	$47.07	Y
*	PART D REINSURANCE	$0.00	$0.00	$14.85	$14.85	Y
*	TOTAL PDP	$0.00	$0.00	$66.77	$66.77	Y

Adjustments Applied to 08/01/2011

Rate Used		Part A	Part B	Part D	Total	Paid Flag

No Adjustments applied to 08/01/2011 for Hxxxx/002/001
No Adjustments applied to 08/01/2011 for Sxxxx/001/000

Entitlement Information

	Start Date	End Date	Option
Part A:	07/01/2001		E
Part B:	07/01/2001		Y

Eligibility Information

	Start Date	End Date
Part D:	01/01/2006	

Enrollment Information

Contract	Start Date	End Date
Hxxxx	01/01/2011	
Sxxxx	01/01/2011	

Premiums

Premium Payment Option:	DEDUCT FROM SSA BENEFITS/DEDUCT FROM SSA BENEFITS	
Premium Payment Option Pending:		
Part C Premium (from enrollment):		$19.00
Part D Premium (from HPMS):	$0.00	
De minimis:	$0.00	
Part D Net of De minimis:	$14.80	
Low Income Subsidy:	$0.00	
Late Enrollment Penalty:	$0.00	
Late Enrollment Penalty Waived Amount:	$0.00	
Late Enrollment Penalty Subsidy:	$0.00	
Beneficiary's Total Part D Premium:		$14.80
Total C+D Premium (paid by beneficiary):		$33.80

Figure 10-26: MCO Representative (View Only) Beneficiary Detail: Snapshot (M203) Screen

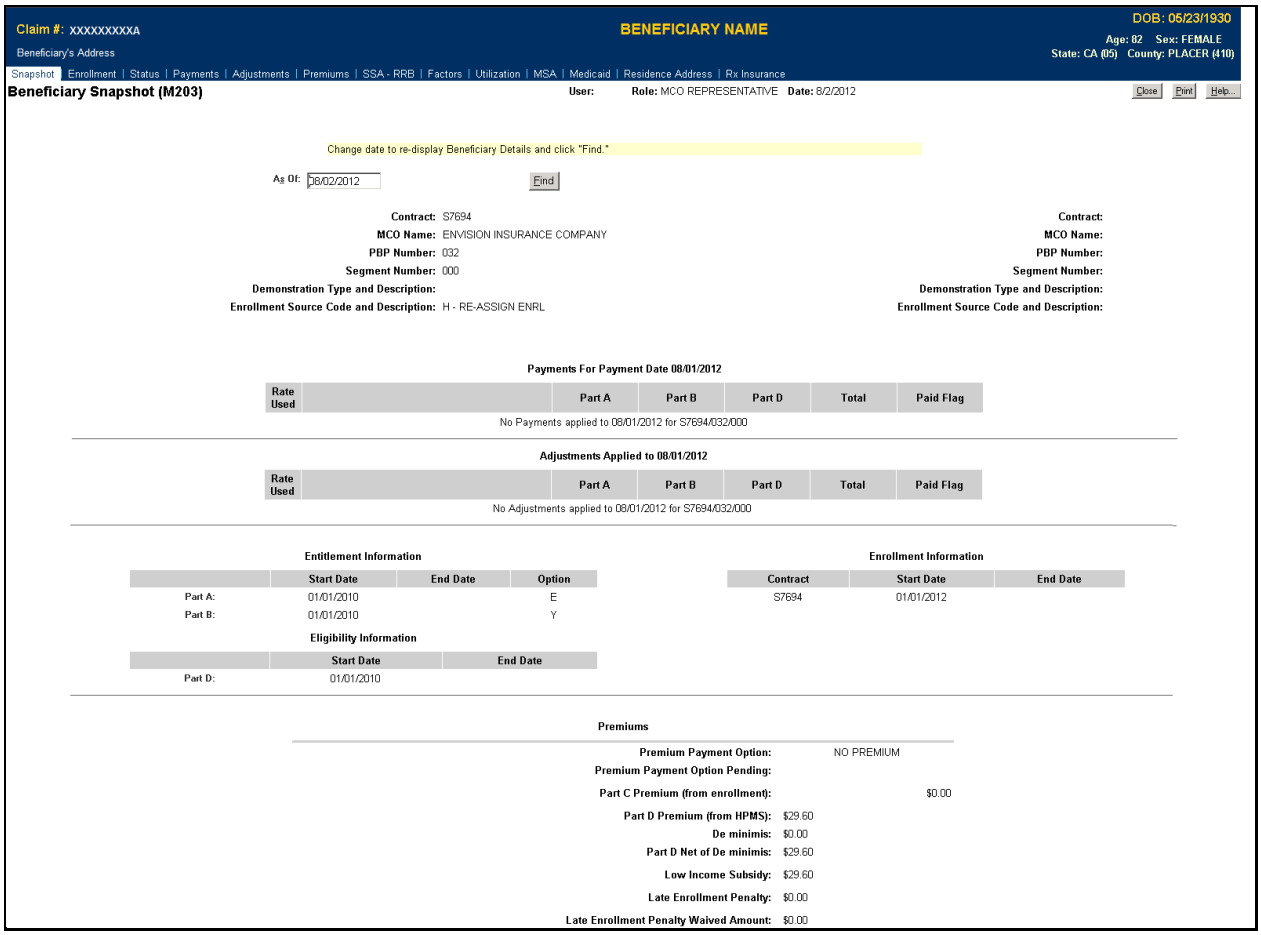


Figure 10-27: MCO Representative (View Only) Beneficiary Detail: Snapshot (M203) Screen with Payments and Adjustments for Past Payment Month

Table 10-18: MCO Representative (View Only) (M203) Field Descriptions and Actions

Item	Input/Output	Description
As Of	Optional data entry field	Enter a valid date in the form (M)M/(D)D/YYYY. The user may change the As Of date. After changing the date, the user clicks on the [Find] button to bring up the information for that date.
[Find]	Button	Displays the information for the specified As Of date.
The following fields are repeated for each contract, up to two, in which the beneficiary is enrolled		
Contract	Output	Contract number for this beneficiary on the As Of date.
MCO Name	Output	Contract name for this beneficiary on the As Of date.
PBP Number	Output	PBP number on the contract for this beneficiary on the As Of date.
Segment Number	Output	Segment number on the contract and PBP for this beneficiary on the As Of date.
Special Needs Type	Output	Indicates the special needs population that the contract serves, if applicable.
Bonus Payment Portion Percent	Output	The percentage applied to the payment to determine the bonus amount to pay the MCO. This is not applicable to a PDP.
Residency Status	Output	The residency status for this beneficiary on the As Of date.

Item	Input/Output	Description
Part B Premium Reduction Benefit	Output	The Part B Premium Reduction Benefit amount is shown only for a non-drug contractor. For the Pre-2006 Part B Premium Reduction Benefit, multiply the Benefits Improvement & Protection Act of 2000 (BIPA) amount by 0.80.
Residence for Payments: State	Output	State used for payment calculation, which may differ from the state in the mailing address in the screen header.
Residence for Payments: County	Output	County used for payment calculation, which may differ from the county in the mailing address in the screen header.
Status Flags	Output	The flags set for the beneficiary on the As Of date.
Payment Flags	Output	The flags set for the beneficiary on the As Of date.
Low-Income Subsidy	Output	Date range; subsidy start date and end date, co-payment level, and amount of the LIS on the As Of date.
Original Reason for Entitlement	Output	The reason for the beneficiary's original entitlement to Medicare; disabled or aged.
Aged/Disabled Medicare Secondary Payer (MSP) Factor	Output	Beneficiary's aged/disabled reduction factor.
End State Renal Disease (ESRD) MSP Factor	Output	Beneficiary's ESRD Medicare Secondary Payer reduction factor.
The lines in the Payments section define each component used in the calculation of the Plan's payment for this beneficiary for the payment month associated with the As Of date. These may include Demographic, Risk Adjustment, Blended, ESRD, Part D Basic Premium, Part D Direct Subsidy, Part D Reinsurance, etc. Each line is broken into the columns below. ***When there are no payments to display, "No Payments for MM/DD/YYYY for CONTRACT/PBP/SEG" displays.***		
Rate Used	Output	Payments have asterisks, but components used in the payment calculation do not have an asterisk.
Part A	Output	The amount of the payment line that is categorized as Medicare Part A.
Part B	Output	The amount of the payment line that is categorized as Medicare Part B.
Part D	Output	The amount of the payment line that is categorized as Medicare Part D.
Total	Output	The Net Payments amount includes additions and subtractions based on rebates, subsidies, and bonuses. Payments are made in the As Of month.
Paid Flag	***Output***	***The Paid Flag indicates whether the Plan received this payment or adjustment. Following the 36-month rule, some payments or adjustments are calculated but not included in an actual payment.***
The lines in the Adjustments section define each component used in the calculation of any Plan payment adjustments for this beneficiary for the payment month associated with the As Of date. These may include Demographic, Risk Adjustment, Blended, ESRD, Part D Basic Premium, Part D Direct Subsidy, Part D Reinsurance, etc. Each line is broken into the columns below. ***When there are no adjustments to display, "No Adjustments for MM/DD/YYYY for CONTRACT/PBP/SEG" displays.***		
Rate Used	Output	Adjustments have asterisks, but components used in the adjustment calculation do not, have an asterisk, but the demographic and risk-adjusted components used in the blend do not have an asterisk.
Part A	Output	The amount of the adjustment line that is categorized as Medicare Part A.

Item	Input/Output	Description
Part B	Output	The amount of the adjustment line that is categorized as Medicare Part B.
Part D	Output	The amount of the adjustment line that is categorized as Medicare Part D.
Total	Output	The Net Adjustment amount includes additions and subtractions based on rebates, subsidies, and bonuses. Adjustments are made in the As Of month.
Paid Flag	***Output***	***The Paid Flag indicates whether the Plan received this payment or adjustment. Following the 36-month rule, some payments or adjustments are calculated but not included in an actual payment.***
Entitlement, Eligibility, and Enrollment Information		
Entitlement Information	Output	Entitlement Start Date and End Date, as well as Option for Part A and Part B for this beneficiary on the As Of date.
Eligibility Information	Output	Eligibility Start Date and End Date for Part D for this beneficiary on the As Of date.
Enrollment Information	Output	Provides the Start Date and the End Date for this beneficiary's enrollment under the user's contract on the As Of date.
Premium Information – This section provides information on the beneficiary's premiums on the As Of date. ***When there are no premiums to display, "No Premiums found for MM/DD/YYYY for CONTRACT/PBP" displays.***		
Premium Withholding Option	Output	The Premium Withholding Option on the As Of date.
Premium Withholding Option Pending	Output	When a withholding request is submitted but not yet accepted by the withholding agency, the request is "Pending". This indicates whether this withholding request is "Pending".
Part C Premium (from enrollment)	Output	The amount of the beneficiary's premium that represents their Part C premium. This is provided by the Plan on the enrollment transaction.
Part D Premium from the Health Plan Management System (HPMS)	Output	The amount of the beneficiary's premium that represents their Part D premium. This amount is contracted with the Plan and maintained by HPMS.
De Minimis	Output	The De Minimis adjustment included in the beneficiary's premium.
Part D Net of De Minimis	Output	The Part D premium with any De Minimis adjustment.
LIS	Output	The amount of the beneficiary's premium that is subsidized due to low-income status.
Late Enrollment Penalty (LEP)	Output	The penalty amount that is added to the beneficiary's premium due to uncovered months.
LEP Waived Amount	Output	The amount of the LEP that is waived for the beneficiary.
LEP Subsidy	Output	The amount of the LEP that is subsidized.
Beneficiary's Total Part D Premium	Output	The total Part D premium for the month associated with the As Of date. This incorporates all of the Part D components that are detailed in this section.
Total C+D Premium (paid by beneficiary)	Output	The total premium paid by the beneficiary for Part C and Part D coverage.

Table 10-19: MCO Representative (View Only) (M203) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	As Of Date must be entered.	Enter the date.
Invalid format	As Of Date is invalid. Must have format (M)M/(D)D/YYYY.	Re-enter the date in one of the required formats.
Informational	The latest available Snapshot information is for payment month of <actual payment month>.	None.
No data	No payment profile information for claim number <claim number> and coverage date as of <date>.	There is no payment data available for that claim number on the As Of date entered on the screen. If the user expects to see payment data, the user verifies the date and month and re-enters the corrected information. If the date and month are correct, the user contacts the MAPD Help Desk for assistance.
No data	Invalid input for claim number <claim number> and coverage date as of <date>.	There is no payment data available for that claim number on the As Of date entered on the screen. If the user expects to see payment data, the user verifies the date and month and re-enters the corrected information. If the date and month are correct, the user contacts the MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary snapshot data for claim number <claim number> and coverage date as of <date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4b: Updating the Beneficiary Detail: Snapshot (M203) Screen

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Beneficiary Snapshot (M203) User: Role: Date: Close Print Help...

Change date to re-display Beneficiary Details and click "Find."

As Of: 08/10/2011 Find

Contract: Hxxxx
MCO Name: INSURANCE COMPANY A
PBP Number: 002
Segment Number: 001
Demo Type and Description:
Enrollment Source Code and Description:
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Contract: Sxxxx
MCO Name: INSURANCE COMPANY C
PBP Number: 001
Segment Number: 000
Demo Type and Description:
Enrollment Source Code and Description:
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Residence for Payments: State: OK (37) County: WAGONER (720)

Status Flags: ☐ Hospice ☐ ESRD ☐ ESRD MSP ☐ Aged/Disabled MSP ☐ Inst ☐ NHC ☐ HCBS

Payment Flags: ☐ Disabled ☐ CHF ☐ Long Term Institutional ☐ Part B Premium Reduction

Low Income Subsidy: Subsidy Start: Subsidy End: LI Premium Subsidy Level: LI Co-payment Level:

Original Reason for Entitlement: 0
Aged/Disabled MSP Factor: 0.00
ESRD MSP Factor: 0.00

Payments For Payment Date 08/01/2011

Rate Used		Part A	Part B	Part D	Total	Paid Flag
*	BLEND	$305.63	$270.27	$0.00	$575.90	Y
	RISK ADJUSTMENT	$305.63	$270.27	$0.00	$575.90	-
*	PART A/B COST SHARING REDUCTION	$38.95	$34.45	$0.00	$73.40	Y
*	TOTAL	$344.58	$304.72	$0.00	$649.30	Y
*	PART D COVERAGE GAP DISCOUNT	$0.00	$0.00	$4.85	$4.85	Y
	PART D BASIC PREMIUM	$0.00	$0.00	$14.79	$14.79	-
*	PART D DIRECT SUBSIDY	$0.00	$0.00	$47.07	$47.07	Y
*	PART D REINSURANCE	$0.00	$0.00	$14.85	$14.85	Y
*	TOTAL PDP	$0.00	$0.00	$66.77	$66.77	Y

Adjustments Applied to 08/01/2011

Rate Used		Part A	Part B	Part D	Total	Paid Flag

No Adjustments applied to 08/01/2011 for Hxxxx/002/001
No Adjustments applied to 08/01/2011 for Sxxxx/001/000

Entitlement Information

	Start Date	End Date	Option
Part A:	07/01/2001		E
Part B:	07/01/2001		Y

Eligibility Information

	Start Date	End Date
Part D:	01/01/2006	

Enrollment Information

Contract	Start Date	End Date
Hxxxx	01/01/2011	
Sxxxx	01/01/2011	

Premiums

Premium Payment Option:	DEDUCT FROM SSA BENEFITS/DEDUCT FROM SSA BENEFITS	
Premium Payment Option Pending:		
Part C Premium (from enrollment):		$19.00
Part D Premium (from HPMS):	$0.00	
De minimis:	$0.00	
Part D Net of De minimis:	$14.80	
Low Income Subsidy:	$0.00	
Late Enrollment Penalty:	$0.00	
Late Enrollment Penalty Waived Amount:	$0.00	
Late Enrollment Penalty Subsidy:	$0.00	
Beneficiary's Total Part D Premium:		$14.80
Total C+D Premium (paid by beneficiary):		$33.80

Figure 10-28: MCO Representative (UI Update) Beneficiary Detail: Snapshot (M203) Screen

Table 10-20: MCO Representative (UI Update) (M203) Field Descriptions and Actions

Item	Input/Output	Description
As Of	Input (optional)	This field initially defaults to the current date. The user may change it by entering a valid date in the form (M)M/(D)D/YYYY. Selecting the "Find" button displays the information as of that date.
[Find]	Button	Displays the information for the specified As Of date.
[Update]	Button	Selecting this button takes the user to the Enrollment Update screen.
The following fields are repeated for each contract (up to two) in which the beneficiary is enrolled		
Contract	Output	Contract number for the beneficiary's enrollment on the As Of date.
MCO Name	Output	Contract name for the beneficiary's enrollment on the As Of date.
PBP Number	Output	PBP number for the beneficiary's enrollment on the As Of date.
Segment Number	Output	Segment number for the beneficiary's enrollment on the As Of date.
SN Type	Output	Indicates the special needs population that the contract serves.
Bonus Payment Portion Percent	Output	Percentage applied to the payment to determine the bonus amount to pay to MCO, not applicable to PDP.
Residency Status	Output	Residency status for beneficiary on the As Of date.
Part B Premium Reduction Benefit	Output	The Part B Premium Reduction Benefit amount is shown only for a non-drug contractor. For the Pre 2006 Part B Premium Reduction Benefit, the BIPA amount is multiplied by 0.80
Residence for Payments: State	Output	State used for payment calculation. **Note:** The state may differ from the state in the mailing address that displays in the screen header.
Residence for Payments: County	Output	County used for payment calculation. **Note:** The county may differ from the state in the mailing address that displays in the screen header.
Status Flags	Output	Status flags set for the beneficiary on the As Of date. The user may check any of the applicable flags, including: Hospice ESRD ESRD MSP Aged/Disabled MSP Institutional Nursing Home Certifiable (NHC)
Payment Flags	Output	The payment flags set for the beneficiary on the As Of date. The user may check any of the applicable flags, including: Disabled Congestive Heart Failure (CHF) Long Term Institutional Part B Premium Reduction
Low-Income Subsidy	Output	Date range (subsidy start date and end date), co-payment level, and Low-Income Premium Subsidy (LIPS) level on the As Of date.
Original Reason for Entitlement	Output	Why the beneficiary was initially entitled to Medicare; disabled or aged.
Aged/Disabled MSP Factor	Output	Beneficiary's aged/disabled reduction factor.
ESRD MSP Factor	Output	Beneficiary's ESRD Medicare Secondary Payer reduction factor.
The Payments section lines define each component that calculates this beneficiary's Plan payment for the payment month of the As Of date. These may include Demographic, Risk Adjustment, Blended, ESRD, Part D Basic Premium, Part D Direct Subsidy, Part D Reinsurance, etc. Each line is broken into the columns below. When no payments display, "No Payments for MM/DD/YYYY for CONTRACT/PBP/SEG" displays.		
Rate Used	Output	Payments have asterisks, but components used in the payment calculation do not have an asterisk, but the demographic and risk-adjusted components in the blend do not have an asterisk.
Part A	Output	The amount of the payment line that is categorized as Medicare Part A.

Item	Input/Output	Description
Part B	Output	The amount of the payment line that is categorized as Medicare Part B.
Part D	Output	The amount of the payment line that is categorized as Medicare Part D.
Total	Output	The Net Payments amount includes additions and subtractions based on rebates, subsidies, and bonuses. Payments were made in the As Of month.
Paid Flag	Output	The Paid Flag indicates whether the Plan received this payment or adjustment. Following the 36- month rule, some payments or adjustments are calculated but not included in an actual payment.
The lines in the Adjustments section define each component that calculate any Plan payment adjustments for this beneficiary for the payment month of the As Of date. These may include Demographic, Risk Adjustment, Blended, ESRD, Part D Basic Premium, Part D Direct Subsidy, Part D Reinsurance, etc. When no adjustments display, "No Adjustments for MM/DD/YYYY for CONTRACT/PBP/SEG" displays.		
Rate Used	Output	Adjustments have asterisks, but components used in the adjustment calculation do not.
Part A	Output	The amount of the adjustment line that is categorized as Medicare Part A.
Part B	Output	The amount of the adjustment line that is categorized as Medicare Part B.
Part D	Output	The amount of the adjustment line that is categorized as Medicare Part D.
Total	Output	The Net Adjustment amount includes additions and subtractions based on rebates, subsidies, and bonuses. Adjustments are made in the As Of month.
Paid Flag	Output	The Paid Flag indicates whether the Plan received this payment or adjustment. Following the 36-month rule, some payments or adjustments are calculated but not included in an actual payment.
Entitlement, Eligibility, and Enrollment Information		
Entitlement Information	Output	Entitlement Start Date and End Date, as well as Option for Part A and Part B for this beneficiary on the As Of date.
Eligibility Information	Output	Eligibility Start Date and End Date for Part D for this beneficiary on the As Of date.
Enrollment Information	Output	Provides the Start Date and the End Date for each of this beneficiary's enrollment under the user's contract on the As Of date.
Premium Information – This section provides information on the beneficiary's premiums on the As Of date. When no premiums display, "No Premiums found for MM/DD/YYYY for CONTRACT/PBP" displays.		
Premium Withholding Option	Output	The Premium Withholding Option on the As Of date.
Premium Withholding Option Pending	Output	When a withholding request is submitted but not yet accepted by the withholding agency, the request is pending.
Part C Premium from enrollment	Output	The amount of the beneficiary's premium that represents their Part C premium. This is provided by the Plan on the enrollment transaction.
Part D Premium from HPMS	Output	Portion of beneficiary's premium that represents their Part D premium. This amount is contracted with the Plan and maintained by HPMS.
De Minimis	Output	The De Minimis adjustment included in the beneficiary's premium.
Part D Net of De Minimis	Output	The amount of the Part D premium with any De Minimis adjustment.
LIS	Output	The amount of the beneficiary's premium subsidized due to low-income status.
LEP	Output	Penalty amount added to beneficiary's premium for uncovered months.
LEP Waived Amount	Output	The amount of the LEP waived for the beneficiary.
LEP Subsidy	Output	The amount of the LEP subsidized.
Beneficiary's Total Part D Premium	Output	Total Part D premium for the month associated with the As Of date. This incorporates all Part D components detailed in this section.
Total C+D	Output	Total premium paid by the beneficiary for Part C and Part D coverage.

Item	Input/Output	Description
Premium		

Table 10-21: MCO Representative (UI Update) (M203) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	As Of Date must be entered.	Enter the date.
Invalid format	As Of Date is invalid. Must have format (M)M/(D)D/YYYY.	Re-enter the date in one of the required formats.
Informational	The latest available Snapshot information is for payment month of <actual payment month>.	None.
No data	No payment profile information for claim number <claim number> and coverage date as of <date>.	There is no payment data available for that claim number on the As Of date entered on the screen. If the user expects to see payment data, the user verifies the date and month and re-enters the corrected information. If the date and month are correct, then the user contacts the MAPD Help Desk for assistance.
No data	Invalid input for claim number <claim number> and coverage date as of <date>.	There is no payment data available for that claim number on the As Of date entered on the screen. If the user expects to see payment data, the user verifies the date and month and re-enters the corrected information. If the date and month are correct, then the user contacts the MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary snapshot data for claim number <claim number> and coverage date as of <date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

10.3.5 Viewing Enrollment Information

An enrollment history displays all of the times that the beneficiary is, was, or will have enrollment in any of the user's contracts.

STEP 4c: Viewing the Beneficiary Detail: Enrollment (M204) Screen

To access the *Beneficiary Detail: Enrollment (M204)* screen, the user clicks on the |Enrollment| menu item. This displays a screen, as shown in **Figure 10-29**, with a summary list of enrollment information by contract, and PBP and segment numbers, as applicable. When the beneficiary enrolls in Part A and/or Part B and the other for Part D, two rows covering the same time period display. The screen is described in **Table 10-22;** note that the Payments section is not yet displayed, with error and validation messages provided in **Table 10-23**.
Note: The user can only see contracts to which the user has access. Therefore, gaps may exist in the user's list where the user cannot see the enrollment information.

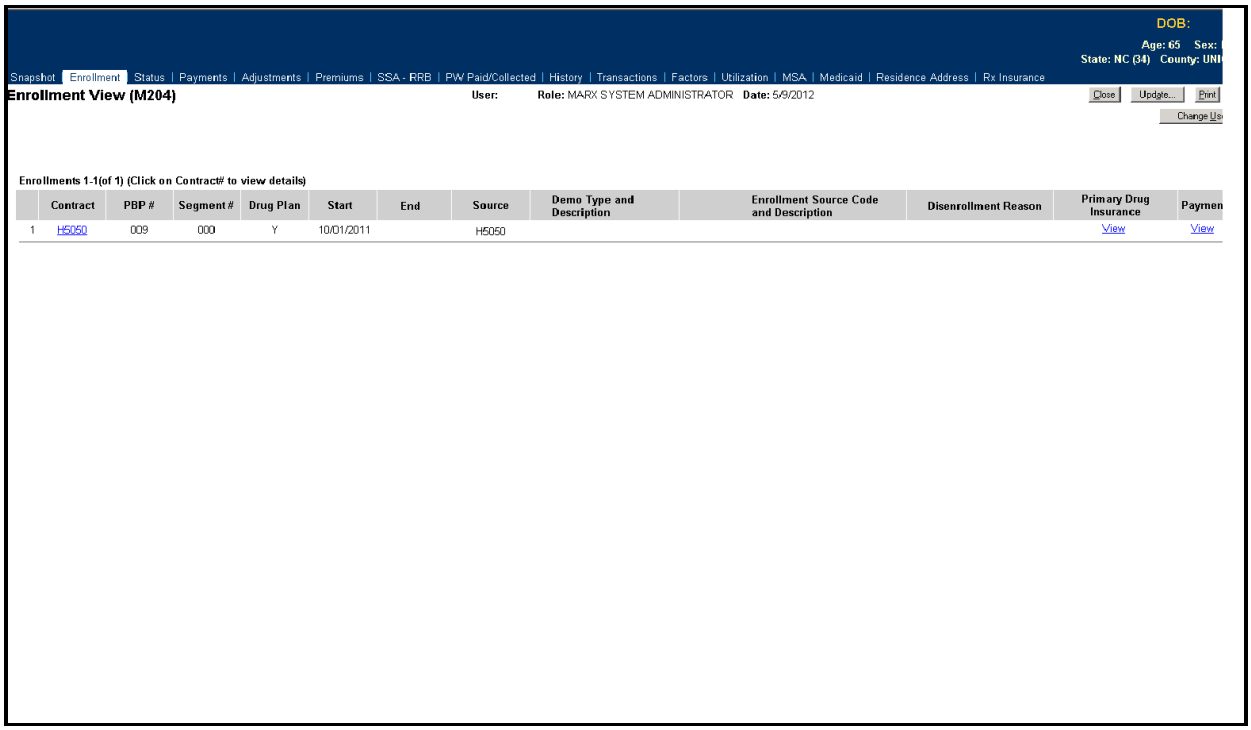


Figure 10-29: MCO Representative (View Only) Beneficiary Detail: Enrollment (M204) Screen (Initial Display)

Table 10-22: MCO Representative (View Only) (M204) Field Descriptions and Actions

Item	Input/Output	Description
Contract	Output	Contract in which the beneficiary is enrolled. The values displayed in this column link to display the *Enrollment Details (M222)* screen for the enrollment on this line.
PBP #	Output	PBP number for the enrollment on this line.
Segment #	Output	Segment number for the enrollment on this line.
Drug Plan	Output	Indicates whether the contract/PBP on this line provides drug insurance coverage. (Y or N).
Start	Output	Start date for the beneficiary's enrollment in this Contract/PBP/Segment.
End	Output	End date for the beneficiary's enrollment in this Contract/PBP/Segment.
Source	Output	The person or system that submitted the enrollment; contract number when entered by an MCO; user ID when entered at CMS, SSA, or Medicare Customer Service Center (MCSC).
Disenrollment Reason	Output	If the enrollment on this line includes an end date, this is the reason for the beneficiary's disenrollment.
Primary Drug Insurance	Link	Click the View link in the Primary Insurance Information column to display all occurrences of primary insurance information associated with the beneficiary's enrollment. This information displays in the bottom portion of the screen.
Payment	Link	Select the *View* link in the Payment column to display all payment information associated with the enrollment for the contract/PBP/segment.

Table 10-23: MCO Representative (View Only) (M204) Screen Messages

Message Type	Message Text	Suggested Action
No data	No enrollment information found for claim number <claim number> and coverage date <coverage date>.	No corresponding data is available for that claim number on that date. If the user expects to see enrollment data, the user verifies the date and month and re-enters the corrected information.
No data	No payments found for claim number <claim number> and contract number <contract #>.	No corresponding payment data is available for that claim number on that date.
Software or Database Error	Error occurred while retrieving enrollment results for claim number <claim number> and coverage date <coverage date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving enrollment history for claim number <claim number> and coverage date <coverage date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input on retrieval of beneficiary enrollment history.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid screen ID.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving payment results for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving payment information for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Prospective payment information missing for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Payment profile information missing for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

To view details of the beneficiary enrollment transaction in a contract, the user clicks on a Contract link, which displays the *Enrollment Detail (M222)* screen for that contract and the beneficiary. To view a summary of payment and adjustment information for a particular contract, the user clicks on the Payment link associated with that contract; PBP; and segment; as applicable, and start date. This expands the information on the *Beneficiary Detail: Enrollment (M204)* screen to include the Payments section. The information is listed by month, as shown in **Figure 10-30** and previously described in **Table 10-24**, with error and validation messages previously provided in **Table 10-25**.

STEP 4d: Updating the Beneficiary Detail: Enrollment (M204) Screen

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

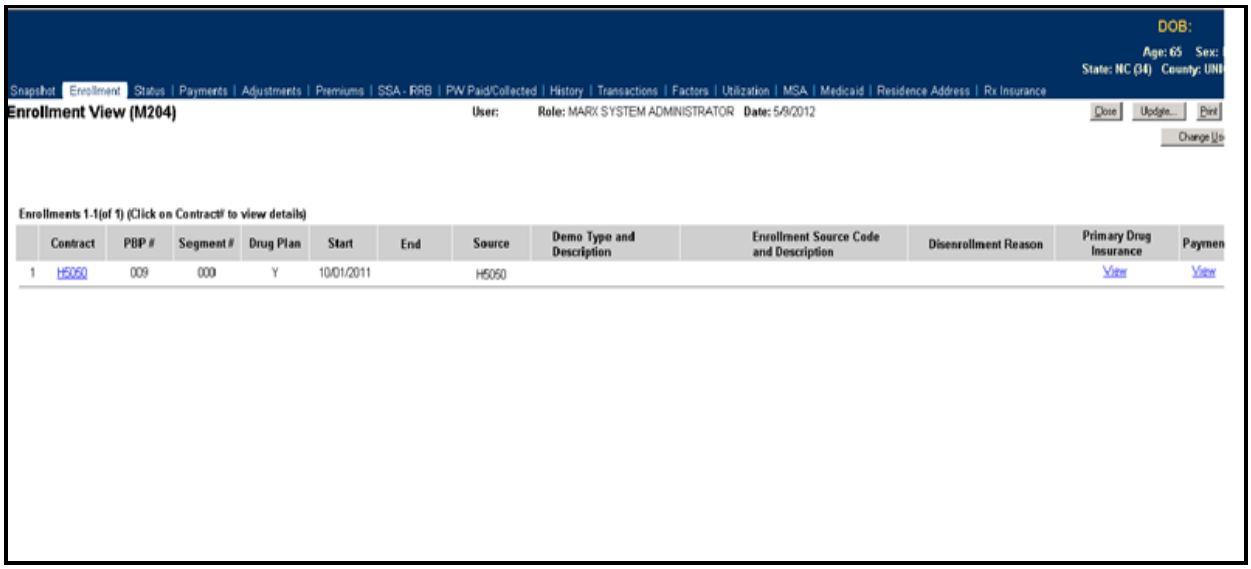


Figure 10-30: MCO Representative (UI Update) Beneficiary Detail: Enrollment (M204) Screen (Initial Display)

Table 10-24: MCO Representative (UI Update) (M204) Field Descriptions and Actions

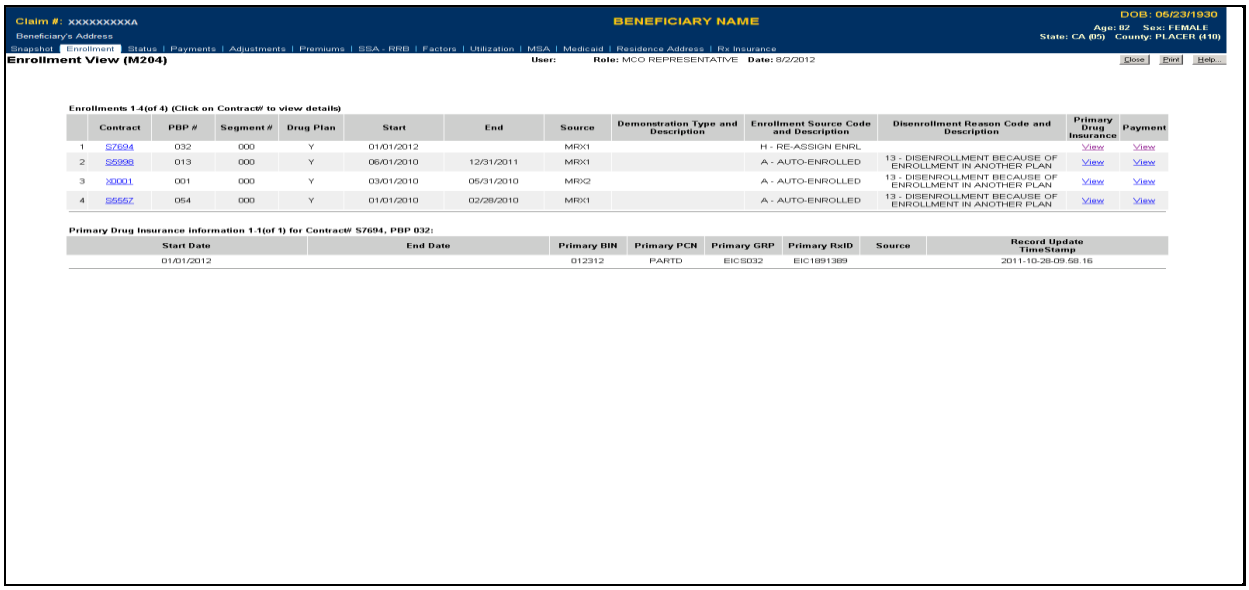
Item	Input/Output	Description
This section contains one row for each of a beneficiary's enrollment. Only enrollment in Plans to which the user has access is shown.		
[Update]	Button	Selecting this button takes the user to the Update Enrollment (M212) screen.
Contract	Output	Contract in which the beneficiary is enrolled. The values displayed in this column link to display the *Enrollment Details (M222)* screen for the enrollment on this line.
PBP #	Output	PBP number for the enrollment on this line.
Segment #	Output	Segment number for the enrollment on this line.
Drug Plan	Output	Indicates whether the contract/PBP on this line provides drug insurance coverage. (Y or N).
Start	Output	Start date for the beneficiary's enrollment in this Contract/PBP/Segment.
End	Output	End date for the beneficiary's enrollment in this Contract/PBP/Segment.
Source	Output	The person or system that submitted the enrollment; contract number when entered by an MCO; user ID when entered at CMS, SSA, or MCSC.
Disenrollment Reason	Output	If the enrollment on this line has an end date, this is the reason for the beneficiary's disenrollment.
Primary Drug Insurance	Link	Select the View link in the Primary Drug Insurance Information column to display all occurrences of primary insurance information associated with the beneficiary's enrollment. This information displays in the bottom portion of the screen.
Payment	Link	Select the *View* link in the Payment column to display all payment information associated with the enrollment for the contract/PBP/segment.

Table 10-25: MCO Representative (UI Update) (M204) Screen Messages

Message Type	Message Text	Suggested Action
No data	No enrollment information found for claim number <claim number> and coverage date <coverage date>.	No corresponding data is available for that claim number on that date. If the user expects to view enrollment data, the user verifies the date and month and re-enters the corrected information.
No data	No payments found for claim number <claim number> and contract number <contract #>.	No corresponding payment data is available for that claim number on that date.
Software or Database Error	Error occurred while retrieving enrollment results for claim number <claim number> and coverage date <coverage date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving enrollment history for claim number <claim number> and coverage date <coverage date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input on retrieval of beneficiary enrollment history.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid screen ID.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving payment results for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving payment information for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Prospective payment information missing for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Payment profile information missing for claim number <claim number> and contract number <contract #>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4e: Viewing the Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance

To view the Primary Drug Insurance information in the bottom portion of the screen, the user clicks the View link that is in the Primary Drug Insurance column. This displays an additional section on the screen, showing the beneficiary's primary 4Rx values. The information is listed by start and end date, as shown in **Figure 10-31**.



Claim #: XXXXXXXXXA
Beneficiary's Address

BENEFICIARY NAME

DOB: 06/23/1930
Age: 82 Sex: FEMALE
State: CA (05) County: PLACER (410)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Enrollment View (M204) User: Role: MCO REPRESENTATIVE Date: 8/2/2012 Close Print Help...

Enrollments 1-4(of 4) (Click on Contract# to view details)

	Contract	PBP #	Segment #	Drug Plan	Start	End	Source	Demonstration Type and Description	Enrollment Source Code and Description	Disenrollment Reason Code and Description	Primary Drug Insurance	Payment
1	S7694	032	000	Y	01/01/2012		MRX1		H - RE-ASSIGN ENRL		View	View
2	S5998	013	000	Y	06/01/2010	12/31/2011	MRX1		A - AUTO-ENROLLED	13 - DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	View	View
3	X0001	001	000	Y	03/01/2010	05/31/2010	MRX2		A - AUTO-ENROLLED	13 - DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	View	View
4	S5557	054	000	Y	01/01/2010	02/28/2010	MRX1		A - AUTO-ENROLLED	13 - DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	View	View

Primary Drug Insurance information 1-1(of 1) for Contract# S7694, PBP 032:

Start Date	End Date	Primary BIN	Primary PCN	Primary GRP	Primary RxID	Source	Record Update TimeStamp
01/01/2012		012312	PARTD	EICS032	EIC1891389		2011-10-28-09.58.16

Figure 10-31: MCO Representative (View Only) Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance

Table 10-26: MCO Representative (View Only) (M204) Field Descriptions and Actions

Item	Input/Output	Description
Primary Drug Insurance Information This section contains one line per period during which the beneficiary has a unique combination of Contract, PBP, and Primary 4Rx information.		
Start Date	Output	Start date per period when the beneficiary has a unique combination of Primary Drug Insurance information (4Rx).
End Date	Output	End date per period when the beneficiary has a unique combination of Primary Drug Insurance information. This is blank for open-ended periods.
Primary Benefit Identification Number (BIN)	Output	Primary BIN for the Primary Drug Insurance period on this line.
Primary Processor Control Number (PCN)	Output	Primary PCN for the Primary Drug Insurance period on this line.
Primary Group Number (GRP)	Output	Primary GRP for the Primary Drug Insurance period on this line.
Primary Rx Identification Number (ID)	Output	Primary RxID for the Primary Drug Insurance period on this line.
Source	Output	The source of the Primary Insurance information.
Record Update Timestamp	Output	The date and time the Primary Insurance information is received.

Table 10-27: MCO Representative (View Only) (M204) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurs while retrieving beneficiary transaction results for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurs while retrieving beneficiary transaction information for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input data to retrieve transaction.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4f: Updating the Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

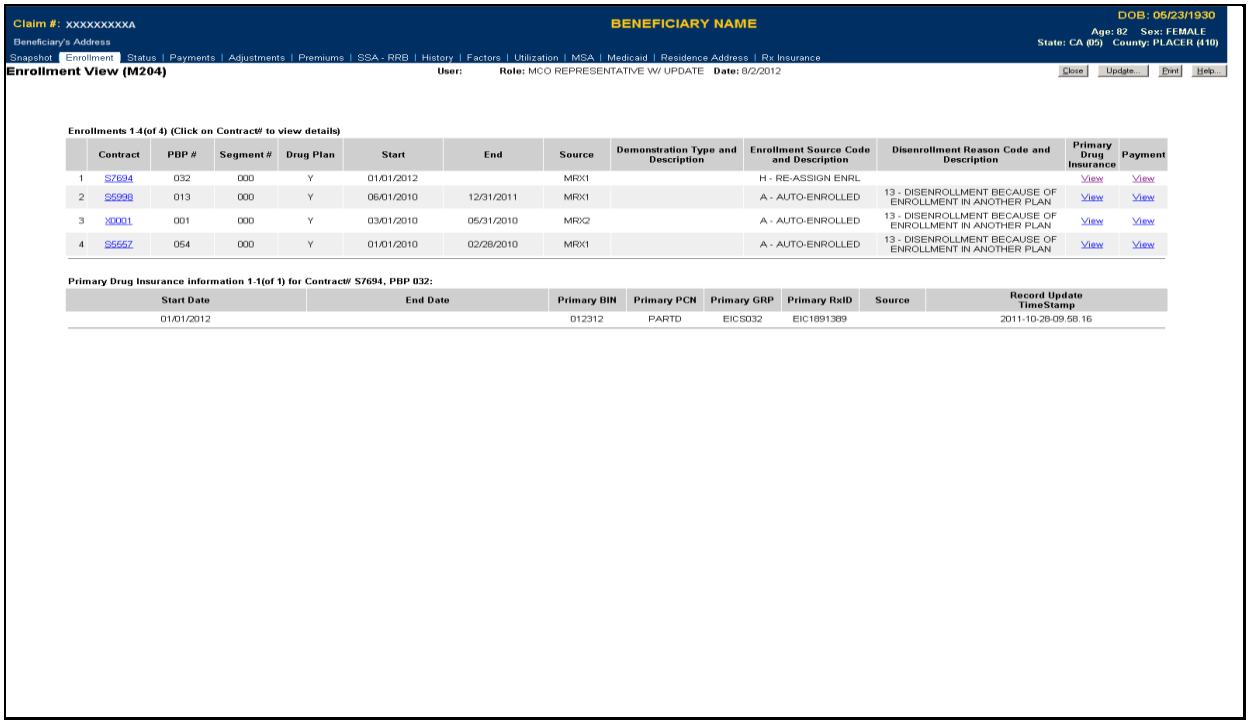


Figure 10-32: MCO Representative (UI Update) Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance

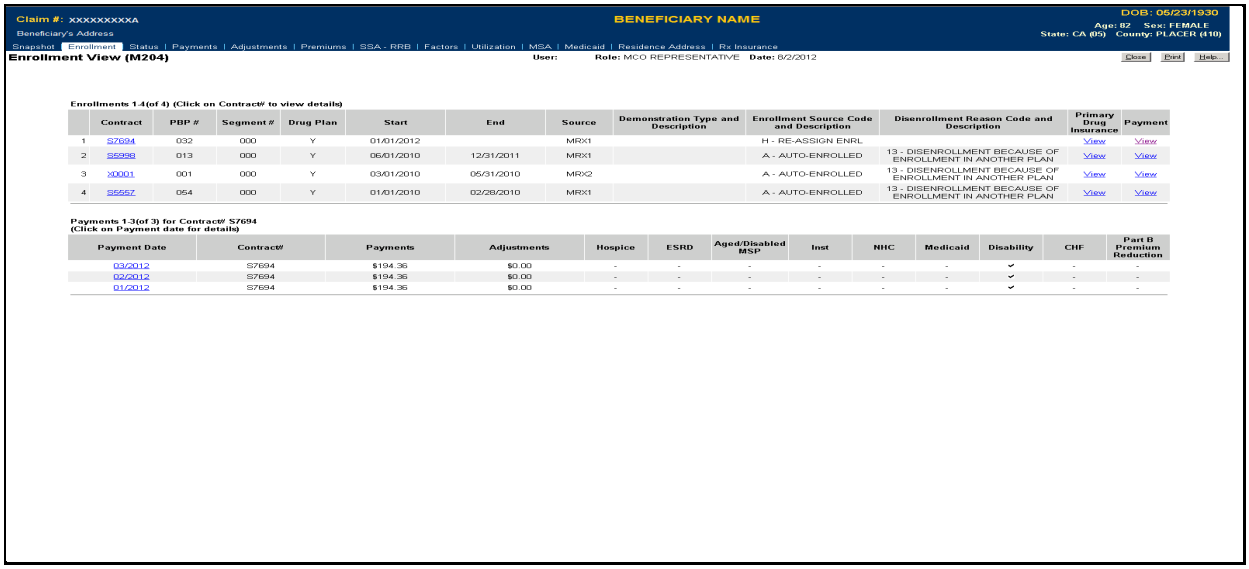
Table 10-28: MCO Representative (UI Update) (M204) Field Descriptions and Actions

Item	Input/Output	Description
Primary Drug Insurance Information This section contains one line for each period that the beneficiary has a unique combination of Contract, PBP, and Primary 4Rx information.		
Start Date	Output	Start date for each period that the beneficiary has a unique combination of Primary Drug Insurance information (4Rx).
End Date	Output	End date for each period that the beneficiary has a unique combination of Primary Drug Insurance information. This is blank for open-ended periods.
Primary BIN	Output	Primary BIN for the Primary Drug Insurance period on this line.
Primary PCN	Output	Primary PCN for the Primary Drug Insurance period on this line.
Primary GRP	Output	Primary GRP for the Primary Drug Insurance period on this line.
Primary RxID	Output	Primary RxID for the Primary Drug Insurance period on this line.
Source	Output	The source of the primary insurance information.
Record Update Timestamp	Output	The date and time the primary insurance information is received.

Table 10-29: MCO Representative (UI Update) (M204) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving beneficiary transaction results for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary transaction information for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input data to retrieve transaction.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4g: Viewing the Beneficiary Detail: Enrollment (M204) Screen Payment



Claim #: XXXXXXXXXA
Beneficiary's Address

BENEFICIARY NAME

DOB: 05/23/1930
Age: 82 Sex: FEMALE
State: CA (05) County: PLACER (410)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Enrollment View (M204) User: Role: MCO REPRESENTATIVE Date: 8/2/2012 Close Print Help...

Enrollments 1-4(of 4) (Click on Contract# to view details)

	Contract	PBP #	Segment #	Drug Plan	Start	End	Source	Demonstration Type and Description	Enrollment Source Code and Description	Disenrollment Reason Code and Description	Primary Drug Insurance	Payment
1	S7694	032	000	Y	01/01/2012		MRX1		H - RE-ASSIGN ENRL		View	View
2	S5998	013	000	Y	06/01/2010	12/31/2011	MRX1		A - AUTO-ENROLLED	13 - DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	View	View
3	X0001	001	000	Y	03/01/2010	05/31/2010	MRX2		A - AUTO-ENROLLED	13 - DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	View	View
4	S5557	054	000	Y	01/01/2010	02/28/2010	MRX1		A - AUTO-ENROLLED	13 - DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	View	View

Payments 1-3(of 3) for Contract# S7694
(Click on Payment date for details)

Payment Date	Contract#	Payments	Adjustments	Hospice	ESRD	Aged/Disabled MSP	Inst	NHC	Medicaid	Disability	CHF	Part B Premium Reduction
03/2012	S7694	$194.36	$0.00	-	-	-	-	-	-	✓	-	-
02/2012	S7694	$194.36	$0.00	-	-	-	-	-	-	✓	-	-
01/2012	S7694	$194.36	$0.00	-	-	-	-	-	-	✓	-	-

Figure 10-33: MCO Representative (View Only) Beneficiary Detail: Enrollment (M204) Screen Payment

Table 10-30: MCO Representative (View Only) (M204) Field Descriptions and Actions

Item	Input/Output	Description
Payments This section shows payment information for the selected enrollment line. One line displays for each month that the Plan received a payment.		
Payment Date	Output/Link	Month/year payments/adjustments made. User selects month/year on pop-up screen, which shows payment and adjustment details on payment row.
Contract #	Output	Contract associated with payment selected.
Payments	Output	Payment amounts, broken down by month, for the selected enrollment in the contract, PBP, and segment, as applicable.
Adjustments	Output	Adjustments by month for selected enrollment in contract, PBP, and segment, as applicable.
Hospice	Output	Check if beneficiary has Hospice status for month on payment row.
End Stage Renal Disease (ESRD)	Output	Check if beneficiary has ESRD status for month on payment row.
Aged/Disabled MSP	Output	Check if beneficiary has Working Aged or Disabled status for month on payment row.
Institutional (Inst)	Output	Check if beneficiary has Institutional status for month on payment row.
Nursing Home Certifiable (NHC)	Output	Check if beneficiary has NHC status for month on payment row.
Medicaid	Output	Checked if beneficiary has Medicaid status for month on payment row.
Disability	Output	Checked if beneficiary has Disability status for month on payment row.
Congestive Heart Failure (CHF)	Output	Check if beneficiary has CHF status for month on payment row.
Part B Premium Reduction	Output	Check if Part B premium reduction is applied to payment and/or adjustments for beneficiary for month on payment row.

Table 10-31: MCO Representative (View Only) (M204) Screen Messages

Message Type	Message Text	Suggested Action
No data	No transactions found for claim number <claim number>.	No action needed.
Software or Database Error	Error occurs while retrieving beneficiary transaction results for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurs while retrieving beneficiary transaction information for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input data to retrieve transaction.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

To view the payment and adjustment information in further detail, the user clicks on one of the month/year links in the Payment Date column to display the *Payment/Adjustment Detail (M215)* screen, as described in Section 10.3.18.

STEP 4h: Updating the Beneficiary Detail: Enrollment (M204) Screen Payment

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

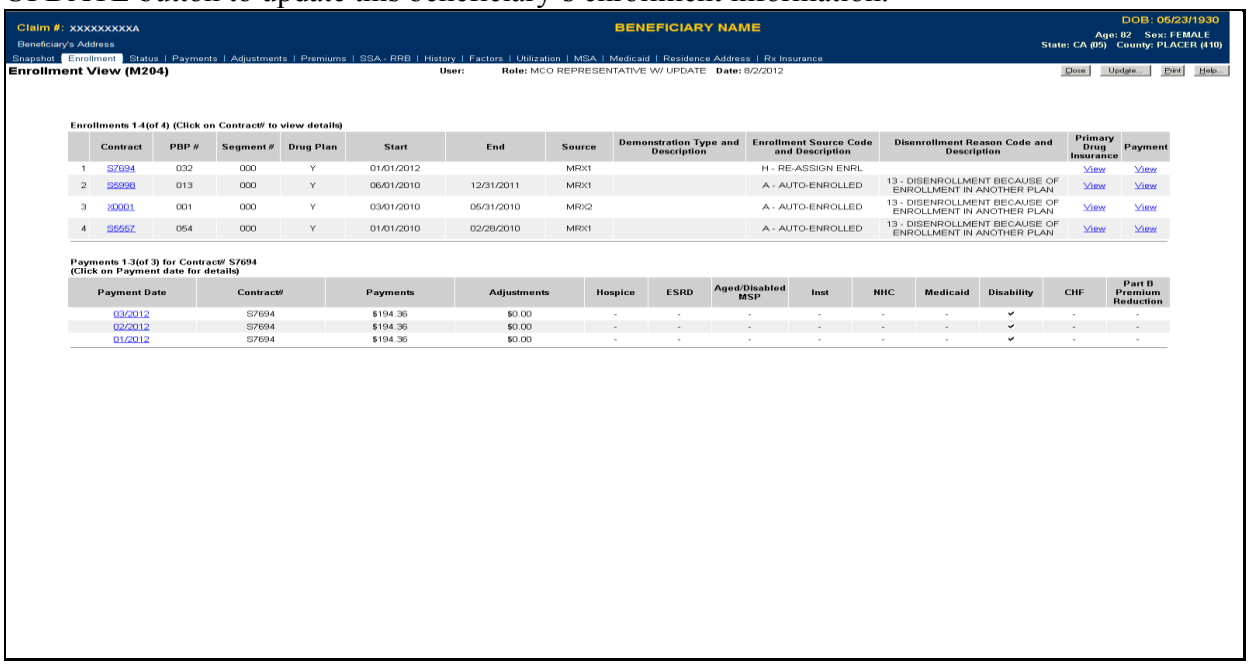


Figure 10-34: MCO Representative (UI Update) Beneficiary Detail: Enrollment (M204) Screen Payment

Table 10-32: MCO Representative (UI Update) (M204) Field Descriptions and Actions

Item	Input/Output	Description
Payments This section shows payment information for the selected enrollment line. One line is displayed for each month for which the Plan receives a payment.		
Payment Date	Output	Month/year in which the payments and/or adjustments are made.
Month/Year in the Payment Date column	Link	Select a month/year to display the pop-up screen *Payment/Adjustment Detail (M215)*. This shows payment and adjustment details for the selected payment line.
Contract #	Output	The contract associated with the payment selected.
Payments	Output	Payment amount, broken down by month, for the selected enrollment in the contract, PBP, and segment, as applicable.
Adjustments	Output	Adjustments, broken down by month, for the selected enrollment in the contract, PBP, and segment, as applicable.
Hospice	Output	Checked if the beneficiary has Hospice status for the month represented by the payment row.
ESRD	Output	Checked if the beneficiary has ESRD status for the month represented by the payment row.
Aged/Disabled MSP	Output	Checked if the beneficiary has Working Aged or Disabled status for the month represented by the payment row.
Inst	Output	Checked if the beneficiary has Institutional status for the month represented by the payment row.
NHC	Output	Checked if the beneficiary has NHC status for the month represented by the payment row.
Medicaid	Output	Checked if the beneficiary has Medicaid status for the month represented by the payment row.
Disability	Output	Checked if the beneficiary has Disability status for the month represented by the payment row.
CHF	Output	Checked if the beneficiary has CHF status for the month represented by the payment row.
Part B Premium Reduction	Output	Checked if a Part B premium, formerly BIPA, reduction is applied to the payment and/or adjustments for the beneficiary for the month represented by the payment row.

Table 10-33: MCO Representative (UI Update) (M204) Screen Messages

Message Type	Message Text	Suggested Action
No data	No transactions found for claim number <claim number>.	No action needed.
Software or Database Error	Error occurred while retrieving beneficiary transaction results for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary transaction information for claim number <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input data to retrieve transaction.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4i: Updating the Beneficiaries: New Enrollment (M221) Screen

The (M221) screen is new and is accessible only by users with update authorization. MARx users with a role of *MCO Representative with Update* may enter new enrollment for a beneficiary using the New Enrollment screen (M221). The beneficiary may enroll only into one of the contracts to which the user has access. Once an enrollment is submitted by selecting the *Enter* button, it is processed by MARx and the Plan sees the resultant Transaction Reply Codes (TRCs) on its Daily Transaction Reply Report (DTRR).

To navigate to the New Enrollment (M221) screen from the main menu, the user selects the |Beneficiaries| tab to display the three tabs Find, New Enrollment, and Eligibility. Selecting the |New Enrollment| tab displays the Beneficiary: New Enrollment (M221) screen. This screen allows the user to enter all values needed to enroll the beneficiary in a Plan. Required fields are marked with a red asterisk. Selecting the New Enrollment button from the Update Enrollment (M212) screen also takes the user to the New Enrollment (M221) screen.

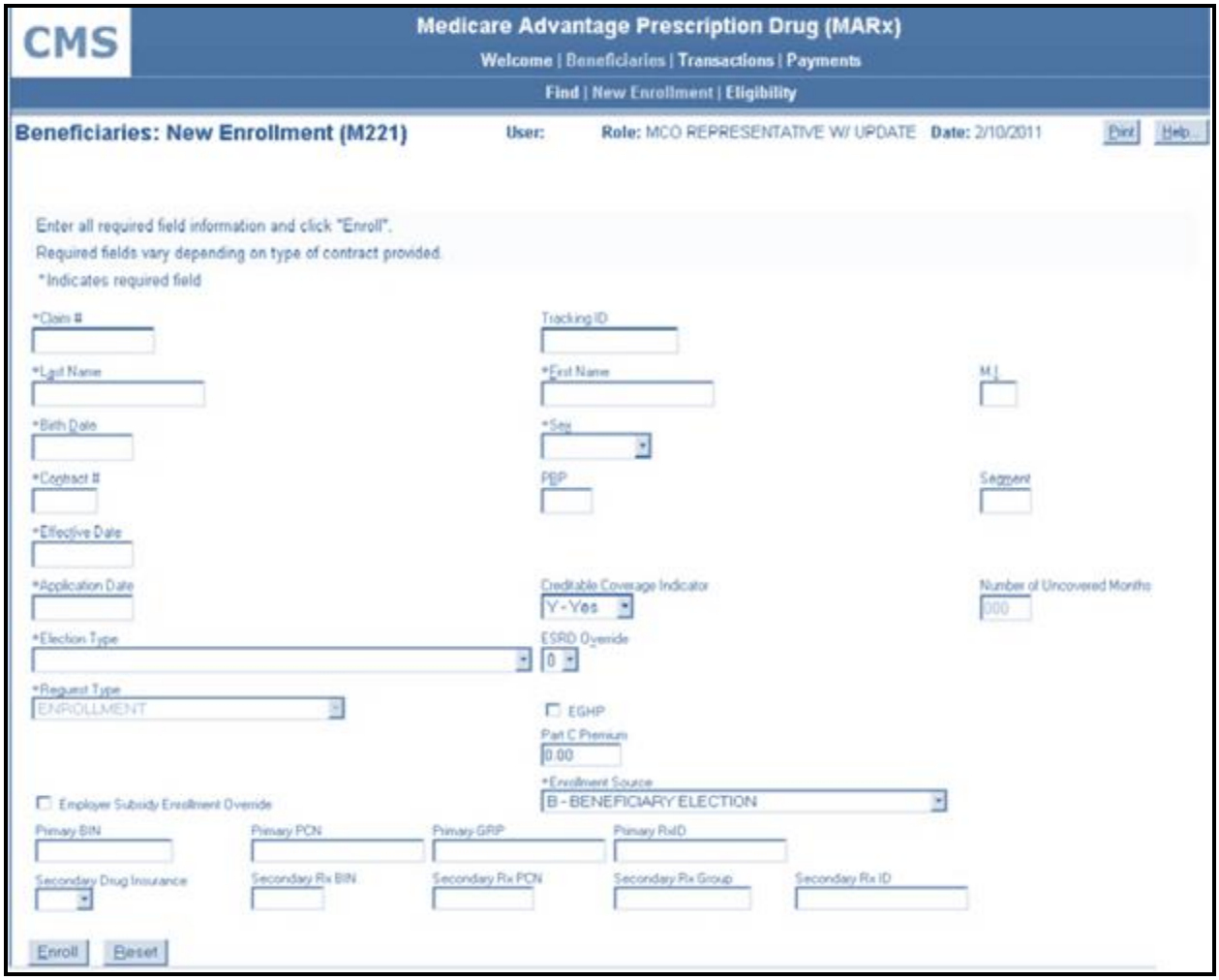


Figure 10-35: MCO Representative (UI Update) Beneficiaries: New Enrollment (M221) Screen

Table 10-34: MCO Representative (UI Update) (M221) Field Descriptions and Actions

Item	Input/Output	Description
Beneficiary identification fields		
Claim #	Required input	Claim number associated with the enrolled beneficiary**.** This input field accepts an RRB number, which then converts to a corresponding claim number. The user must include the BIC.
Tracking ID	Input	The Tracking ID is an optional unique identifier provided by the Plan for its use in transaction tracking. This tracking ID is stored in the MARx system, associated with the transaction submitted, and returned to the Plan with the TRCs. Data format is alpha-numeric with a maximum of 15 characters.
Last Name	Required input	Last name of enrolled beneficiary.
First Name	Required input	First name of enrolled beneficiary.
M.I.	Input	Middle initial of enrolled beneficiary enrolled.
Birth Date	Required input	The date of birth of the enrolled beneficiary. Required format is (M)M/(D)D/YYYY.
Sex	Required input (dropdown list)	The gender of the enrolled beneficiary. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field.
Enrollment fields		
Contract #	Required input	Contract number associated with the Plan into which the beneficiary is enrolled.
PBP	Input	PBP number for this enrollment. It is required for MA contracts and applies to some non-MA contracts.
Segment	Input	Segment number for this enrollment. This is applicable only when a contract number and PBP number are entered. It applies to MA and MAPD contracts.
Effective Date	Required input	Date that coverage in this Plan begins. Required format is (M)M/(D)D/YYYY.
Application Date	Input	Application Date associated with this enrollment. This is the date when the beneficiary signed the enrollment request (if available) or the date when the enrollment request was received by the Plan. Required format is (M)M/(D)D/YYYY.
Creditable Coverage	Required input (dropdown list)	Indicator of whether the beneficiary had creditable coverage between the end of their previous enrollment and the beginning of this enrollment. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. All values except “No” render the Number of Uncovered months to zero and disable that field.
NUNCMO	Input	Number of months between the end of their previous enrollment and the beginning of this enrollment when the beneficiary did not have Creditable Coverage as defined by CMS policy. This field is available for entry only if the Creditable Coverage field is set to No, indicating that they did not have Creditable Coverage prior to this enrollment.
Election Type	Input (dropdown list)	Type of election period used for this enrollment. The input value is selected from a dropdown list which is accessed by selecting the arrow at the right end of the field. Refer to Table M-1 in *the Guide* Appendices for valid election types.

Item	Input/Output	Description
ESRD Override	Input (dropdown list)	This field is only used when a beneficiary with ESRD status meets any of the exception criteria for enrollment into an MA or 1876 Cost based Plan as defined in the CMS Enrollment Guidance applicable to the Plan type. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. Valid values are A through F; select any value.
Request Type	Input (dropdown list)	The type of request for this enrollment. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. Select one of the types of enrollment from the list: • Enrollment (EMPLOYER GROUP) • Enrollment • Enrollment (2 MTHS RETRO) • Enrollment (WITH GAP END DATE)
EGHP	Input (Checkbox)	Indicates whether the enrollment is an EGHP. Automatically checked when Request Type is Enrollment (EGHP).
Enrollment Premium Part C	Input	The amount of the beneficiary's premium for Part C coverage that is part of this enrollment.
Employer Subsidy Enrollment Override	Input (Checkbox)	Indicates whether the beneficiary chose to enroll in a Part D Plan despite having employer coverage. Only if a user receives a TRC 127 can they select this override feature.
Enrollment Source	Input (dropdown list)	The initiating event that triggered this enrollment. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. • Automatically enrolled by CMS • Beneficiary election • Facilitated enrollment by CMS
Primary BIN	Input	The BIN number for the Part D insurance Plan associated with this enrollment.
Primary PCN	Input	The PCN number for the Part D insurance Plan associated with this enrollment.
Primary Group	Input	Group ID for the Part D insurance Plan associated with this enrollment.
Primary RxID	Input	Identifier assigned to the beneficiary by the Part D insurance Plan for drug coverage.
Secondary Drug Insurance	Input (dropdown list)	Indicates whether the beneficiary has drug insurance coverage other than through Part D. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field.
Secondary Rx Group	Input	Identifier for the group providing secondary drug insurance coverage. Not applicable unless the Secondary Drug Insurance indicator is Yes.
Secondary RxID	Input	Identifier assigned to beneficiary by the secondary insurance company for drug coverage. Not applicable unless the Secondary Drug Insurance indicator is Yes.
Buttons		
[Enroll]	Button	Submits the request to enroll the beneficiary.
[Reset]	Button	Resets all screen fields to original values prior to data entry.

Table 10-35: MCO Representative (UI Update) (M221) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Please enter a required field.	Ensure that all the required fields are populated.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	Re-enter the claim number.
Invalid format	The claim number is missing the required BIC	Change the claim number to include both CAN and BIC.
Invalid format	The last name contains invalid characters	Re-enter the name using only letters, apostrophes, hyphens, or blanks.
Invalid format	The first name contains invalid characters	Re-enter the name using only letters, apostrophes, hyphens, or blanks.
Invalid format	The middle initial contains invalid characters	Re-enter the initial using only a letter.
Invalid format	Date of Birth is invalid. Required format is (M)M/(D)D/YYYY	Re-enter the date in the required format.
Invalid format	A contract number must start with an 'H', '9', 'R', 'S', 'F', or 'E' and be followed by 4 characters	Re-enter the contract number.
Invalid format	PBP number must be 3 alpha-numeric characters	Re-enter the PBP.
Invalid format	Segment number must be a 3-digit number	Re-enter the segment number.
Invalid format	Effective Date is invalid. Required format is (M)M/(D)D/YYYY	Re-enter the date in the required format.
Invalid format	Application Date is invalid. Required format is (M)M/(D)D/YYYY	Re-enter the date in the required format.
Invalid format	Number of months must be a number.	Re-enter the number of months.
Invalid format	Enter dollars and cents for Part C Premium	Re-enter the premium in dollars and cents format.
Invalid entry	Birth date cannot be in the future	Re-enter the birth date.
Invalid entry	Secondary Rx Group must be provided when secondary insurance is "Yes"	Do one of the following, as applicable: Change secondary insurance indicator to No Enter secondary Rx group.
Invalid entry	Secondary RxID must be provided when secondary insurance is "Yes"	Do one of the following, as applicable: Change Secondary insurance indicator to No Enter Secondary RxID.
Invalid entry	Secondary Rx insurance must be "Yes" if secondary RxID or group provided	Do one of the following, as applicable: Delete secondary RxID and group Change secondary insurance indicator to Yes.
Invalid entry	Invalid contract/PBP combination	Enter a valid Contract/PBP combination.
Invalid entry	Invalid contract/PBP/segment combination	Enter a valid Contract/PBP/Segment combination.
Invalid entry	You do not have access rights to this contract	The user determines if contract number entered correctly. If it was entered correctly and user should have rights to this contract, the user should see the Security Administrator, who can update the user profile to give user these rights.

Message Type	Message Text	Suggested Action
Invalid entry	Number of Uncovered Months cannot be 0 when the Creditable Coverage is "No"	Enter an uncovered months value or change the Creditable Coverage Indicator to a value other than No.
Software or Database Error	The enrollment request is not submitted due to database errors	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input error	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred validating contract/PBP/segment combination	Contact MAPD Help Desk for assistance.
Software or Database Error	Error queuing up the enrollment transaction	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.
Success	Enrollment accepted as submitted	No action required.
Success	Enrollment accepted as submitted, out of area	No action required.

STEP 4j: Updating the Beneficiaries: Update Enrollment (M212) Screen

The following screen is new and is accessible only by users with update authorization. The M212 screen allows the user with an update role to add an end date to an existing enrollment or change the end date to an earlier date. This screen also cancels enrollment or disenrollment. To update enrollment information, such as the EGHP Flag, select the more button, which takes the user to the Additional Update Enrollment Information (M230) screen. To navigate to the Update Enrollment (M212) screen, select the Update button from the Enrollment (M204) screen or select the Update Enrollment button from the Search Results (M202) screen after finding a beneficiary.

Figure 10-36: MCO Representative (UI Update) Update Enrollment (M212) Screen

Table 10-36: MCO Representative (UI Update) (M212) Field Descriptions and Actions

Item	Input/Output	Description
Updating Enrollment Information This section contains one line for each period during which the beneficiary was enrolled in the contracts to which the user has access. The user can work with each line to update the enrollment end date, to cancel an enrollment, or to cancel a disenrollment.		
Select	Input (checkbox)	Check this box to select a row to either cancel an existing enrollment or to cancel an existing disenrollment.
Contract	Output	The contract for the applicable period. *The user cannot update this field.*
PBP#	Output	The PBP for the applicable period. *The user cannot update this field.*
Seg#	Output	The segment for the applicable period. *The user cannot update this field.*
Start Date	Output	Start date for the enrollment on this line. *The user cannot update this field.*
End Date	Update	User can add or update an earlier date for the enrollment on this line.
Application Date	Output	Application date for the enrollment period on this line. *The user cannot update this field.*
More Info	Button	This takes the user to the M230 screen, where they may view or update additional information about the enrollment on this line.
Disenroll Reason	Input (dropdown)	The user must select a disenrollment reason code from the drop down box when entering or updating a disenrollment date.
Action Buttons These buttons operate on any lines that are selected by checking the Select checkbox.		
Submit	Button	Any enrollment changes are submitted for processing. After processing, the new enrollment information is displayed for the beneficiary.
Cancel Enroll	Button	Selecting Cancel Enroll cancels a selected enrollment. Users must cancel enroll within the timeframe defined by CMS policy and follow normal Enrollment Cancellation rules.
Cancel Disenroll	Button	Selecting Cancel Disenroll cancels a selected disenrollment. Users must cancel disenroll within the timeframe defined by CMS policy and follow normal Disenrollment Cancellation rules.
Reset	Button	Selecting the reset button resets any entered values that were not submitted to their original values.

Table 10-37: MCO Representative (UI Update) (M212) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	A disenrollment reason must be selected	If the user enters or updates an end date for an existing enrollment, they must also supply a disenrollment reason.
Invalid entry	The end date must be the last day of the month	Check that the date entered is actually the last day of that month, e.g., if the user enters 5/30/2003, they get this error message because May has 31 days. The user would then re-enter 5/31/2003.
Invalid entry	The end date is earlier than the start date	Make sure that the end date is later than the start date.
Invalid entry	The new end date already exists at enrollment period <period #>	Adjust the enrollment end date for the specified period.
Processing error–monthly summarization in progress	Unable to perform update during the monthly summarization. Please try again later.	Updates are not allowed during the monthly summarization. Try again after the summarization is complete.
Processing error—enrollment edits failed	Update error occurred. See details at the bottom of the screen.	Scroll down to the bottom of the screen to view the detailed edit error messages. Modify the changes to address the problems raised in the messages.
Software or Database Error	No enrollment information found for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving enrollment information results for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving enrollment information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving enrollment information from MBD for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Update error occurred	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input error	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.
Success	Enrollment has been updated.	No action required.
Success	UI enrollment cancelled	No action required.
Success	UI assigns end date	No action required.
Success	UI moved end date earlier	No action required.
Success	UI removed enrollment end date	No action required.

STEP 4k: Updating the Beneficiaries: Additional Update Enrollment (M230) Screen

The following screen is new and is accessible only by users with update authorization.

The M230 screen allows the user with an update role to update the Disenrollment Election Period Type, the EGHP indicator, and/or the Part D Auto Enrollment-Facilitated Enrollment (AE-FE) Opt-Out indicator. The user cannot update any of the other fields displayed.

After completing the appropriate updates via the M230 screen, the user must click the Save and Return to Update Enrollment button. These changes are submitted when the user clicks the Submit on the M212 screen. This will then return the user to the M212 screen.

To navigate to the Additional Update Enrollment Information (M230) screen, the user selects the More button from one of the enrollment lines on the Enrollment Update (M212) screen.

Figure 10-37: MCO Representative (UI Update) Additional Update Enrollment Information (M230) Screen

Table 10-38: MCO Representative (UI Update) (M230) Field Descriptions and Actions

Item	Input/Output	Description
Enrollment Election Period Type	Output	The Election Type used for the enrollment selected. *The user cannot update this field.*
Disenrollment Election Period Type	Update (dropdown list)	Select an election period from the dropdown list provided. This is the election period associated with the disenrollment.
EGHP	Update (checkbox)	Indicator of whether the enrollment is an EGHP.
ESRD Override	Output	The prior number of months of ESRD enrollment in a commercial contract is displayed. This one-digit field is populated with 0-9 and the values A through F represent 10 through 15 months. *The user cannot update this field.*
Employer Subsidy Enrollment Override	Output	Indicates whether the beneficiary chose to enroll in a Part D Plan despite having employer coverage. *The user cannot update this field.*
Enrollment Source	Output	The initiating event that triggered this enrollment. • Automatically enrolled by CMS • Beneficiary election • Facilitated enrollment by CMS *The user cannot update this field.*
Part D AE-FE Opt-Out	Update (checkbox)	Indicates whether the beneficiary chose to opt out of CMS' automatic Part D enrollment process. Select this checkbox to update the indicator if needed.

Table 10-39: MCO Representative (UI Update) (M230) Screen Messages

Message Type	Message Text	Suggested Action
Invalid format	Enter dollars and cents for Part C Premium	Re-enter the premium in dollars and cents format.
Invalid format	Enter dollars and cents for Part D Premium	Re-enter the premium in dollars and cents format.
Invalid format	Number of months must be a number	Re-enter the number of months.
Invalid format	Enrollment Source code cannot change to 'E', 'F' or 'H' when beneficiary Part D AE-FE Opt-Out was checked initially. To change Enrollment source to 'E', 'F' or 'H', is a two-step submission process to uncheck Part D AE-FE Opt-Out and change Enrollment source to 'E', 'F' or 'H'.	Re-select any option other than E, F, or H from the dropdown or uncheck the Part D AE-FE and submit. Then return to the screen and select any option.

10.3.6 Viewing the Status of a Beneficiary

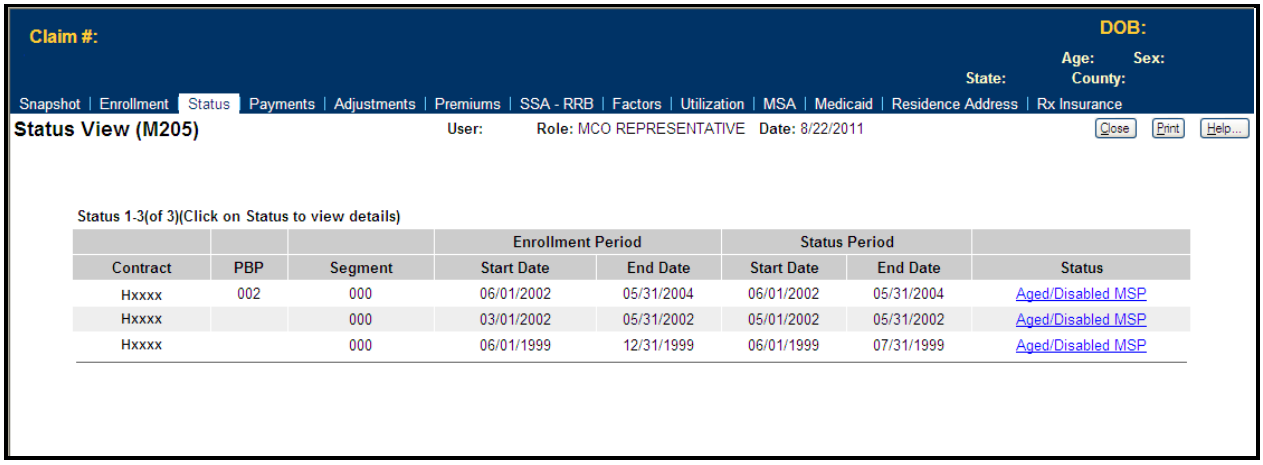
A status history shows the beneficiary's statuses while enrolled in the Plan.

STEP 4l: Viewing the Beneficiary Detail: Status (M205) Screen

To access the *Beneficiary Detail: Status (M205)* screen, the user clicks on the |Status| menu item. This displays a screen, as shown in **Figure 10-38**, with a list of enrollment and health status periods by enrollment period, contract/PBP/segment, for this beneficiary. The information displays as follows:

- When more than one status applies to the beneficiary during an enrollment, such as if the beneficiary is in a hospice and has ESRD, each status appears on a separate row.
- If there are non-contiguous periods for a status, such as a break in Medicaid coverage, then each period appears on a separate row.
- If the details for a status change, such as a change in hospice provider, the contiguous status periods combine and display as one period. When requesting the period details, this combined period expands to show changes in those details. If there is no status information for an enrollment period, that enrollment period is not displayed.
- When the beneficiary is enrolled in two contracts, one for Part A and/or Part B and the other for Part D, and there is an applicable status for each contract, rows for each contract display.

This is how the screen appears when it initially displays. This screen is described in **Table 10-40;** note that the details section is not yet displayed, with error and validation messages provided in **Table 10-41.**



			Enrollment Period		Status Period		
Contract	PBP	Segment	Start Date	End Date	Start Date	End Date	Status
Hxxxx	002	000	06/01/2002	05/31/2004	06/01/2002	05/31/2004	Aged/Disabled MSP
Hxxxx		000	03/01/2002	05/31/2002	05/01/2002	05/31/2002	Aged/Disabled MSP
Hxxxx		000	06/01/1999	12/31/1999	06/01/1999	07/31/1999	Aged/Disabled MSP

Figure 10-38: MCO Representative (View Only) Beneficiary Detail: Status (M205) Screen (Initial Display)

Table 10-40: MCO Representative (View Only) (M205) Field Descriptions and Actions

Item	Input/Output	Description
Statuses		
Contract column	Output	Contract for an enrollment period for which there is an applicable status. A contract/PBP/segment may list more than once if there was a change in status. The contract/PBP/segment does not list if there is no status information during that enrollment period.
PBP column	Output	PBP number for each enrollment period.
Segment column	Output	Segment number for each enrollment period.
Enrollment Period Start Date column	Output	Start date for each enrollment period.
Enrollment Period End Date column	Output	End date for each enrollment period.
Status Period Start Date column	Output	Start date for each status period.
Status Period End Date column	Output	End date for each status period.
Status column	Output	Type of status, i.e. hospice, ESRD, ESRD Dialysis, ESRD Transplant, Plan Medicaid, Third Party Medicaid, Institutional, NHC, Working Aged, or MSP, for each status period.
Status in the Status column	Link	The user clicks on this link to display details about the status period. For some status types, there are no additional details to display, so the status displays without a link.
Hospice Details		
Start Date column	Output	When the selected hospice period started.
End Date column	Output	When the selected hospice period ended; may have no information.
Provider Number column	Output	The unique identifier for the hospice from which the beneficiary received care.
Revocation Code column	Output	Code that identifies if the beneficiary elected to terminate the use of hospice.
Record Add Timestamp column	Output	The date and time that the information was added.
ESRD Details		
Start Date column	Output	When the selected ESRD period started.
End Date column	Output	When the selected ESRD period ended; may have no information.
Start Source column	Output	Determines whether contract or system provided notification that the ESRD period started.
Termination Reason column	Output	The reason ESRD coverage terminated.
ESRD Self-Care Training Date column	Output	Date of first instance of training for ESRD self-care.
Third Party Medicaid Details		
Start Date column	Output	When the selected third party Medicaid period started.

Item	Input/Output	Description
End Date column	Output	When the selected third party Medicaid period ended; may have no information.
Premiums Payer Code column	Output	Identifying code for a third party agency.
Institutional Details		
Start Date column	Output	When the selected institutional period started.
End Date column	Output	When the selected institutional period ended; may have no information.
Start Source column	Output	Determines whether contract or system provided notification that the institutional period started.
End Source column	Output	Determines whether contract or system provided notification that the institutional period ended.
NHC Details		
Start Date column	Output	When the selected NHC period started.
End Date column	Output	When the selected NHC period ended; may have no information.
Start Source column	Output	Determines whether contract or system provided notification that the NHC period started.
End Source column	Output	Determines whether contract or system provided notification that the NHC period ended.
ESRD MSP Details		
Medical Coverage Type column	Output	Insurance type of the MSP.
Start Date column	Output	Start date for the selected MSP period.
End Date column	Output	End date for the selected MSP period; may have no information.
Primary Insurance Type column	Output	Code of primary insurance coverage provided by the enrollment.
Policy# column	Output	Policy Number for the insurance coverage.
COB Contractor column	Output	Contract Number that identifies the insurer.
Insurance Name column	Output	Name of group coverage Plan in which the beneficiary is enrolled.
Insurance Address column	Output	Insurer's mailing address.
Aged/Disabled MSP Details		
Medical Coverage Type column	Output	Insurance type of the MSP.
Start Date column	Output	Start date for the selected MSP period.
End Date column	Output	End date for the selected MSP period; may have no information.
Primary Insurance Type column	Output	Code of primary insurance coverage provided by the enrollment.
Policy# column	Output	Policy Number for the insurance coverage.
COB Contractor column	Output	Contract Number that identifies the insurer.
Insurance Name column	Output	Name of group coverage Plan in which the beneficiary is enrolled.
Insurance Address column	Output	Insurer's mailing address.

Table 10-41: MCO Representative (View Only) (M205) Screen Messages

Message Type	Message Text	Suggested Action
No data	No status information found for contract number <contract>	No corresponding data is available for that contract number.
Software or Database Error	Error occurred while retrieving beneficiary results for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary status history for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary status history	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

Note: The user may only view contracts to which they have access. Therefore, the user may have gaps in their list where the user cannot see the enrollment information.

To view the details of a particular status period, the user clicks on the status link in the Status column for the corresponding enrollment period. This expands the information on the *Beneficiary Detail: Status (M205)* screen to include the status details. If contiguous periods were combined into a single period on the initial display, that period is now expanded to show when each status detail was applicable. The contents of the details sections vary according to the type of status. For some status types, there are no additional details to display. The information is shown in **Figure 10-39** and was previously described in **Table 10-40,** with error and validation messages previously provided in **Table 10-41**.

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Status View (M205) User: Role: MCO REPRESENTATIVE Date: 8/22/2011 Close Print Help...

Status 1-3(of 3)(Click on Status to view details)

			Enrollment Period		Status Period		
Contract	PBP	Segment	Start Date	End Date	Start Date	End Date	Status
Hxxxx	002	000	06/01/2002	05/31/2004	06/01/2002	05/31/2004	Aged/Disabled MSP
Hxxxx		000	03/01/2002	05/31/2002	05/01/2002	05/31/2002	Aged/Disabled MSP
Hxxxx		000	06/01/1999	12/31/1999	06/01/1999	07/31/1999	Aged/Disabled MSP

Aged/Disabled MSP Details

Medical Coverage Type	Start Date	End Date	Primary Insurance Type	Policy#	COB Contractor	Insurance Name	Insurance Address
PRIMARY	06/01/2002	05/31/2004	12		Hxxxx	INSURANCE PLAN	

Figure 10-39: MCO Representative (View Only) Beneficiary Detail: Status (M205) Screen (Expanded)

10.3.7 Viewing the Payment Information for a Beneficiary

Payment history shows the payments made for beneficiary enrolled in a particular contract.

STEP 4m: Viewing the Beneficiary Detail: Payments (M206) Screen

To access the *Beneficiary Detail: Payments (M206)* screen, the user clicks on the |Payments| menu item. This displays a screen, as shown in **Figure 10-40,** that provides a field for entering a payment month and year. When the beneficiary enrolls in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month display. In initial display, the current month appears in that field. This screen is described in **Table 10-42;** note that Payments section is not yet displayed, with error and validation messages provided in **Table 10-43.**

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Payments View (M206) User: Role: MCO REPRESENTATIVE Date: 8/22/2011 Close Print Help...

Enter required field information below and click "Find."

* Indicates required field

* Payment Date

08/2011

Find Reset

Figure 10-40: MCO Representative (View Only) Beneficiary Detail: Payments (M206) Screen (Initial Display)

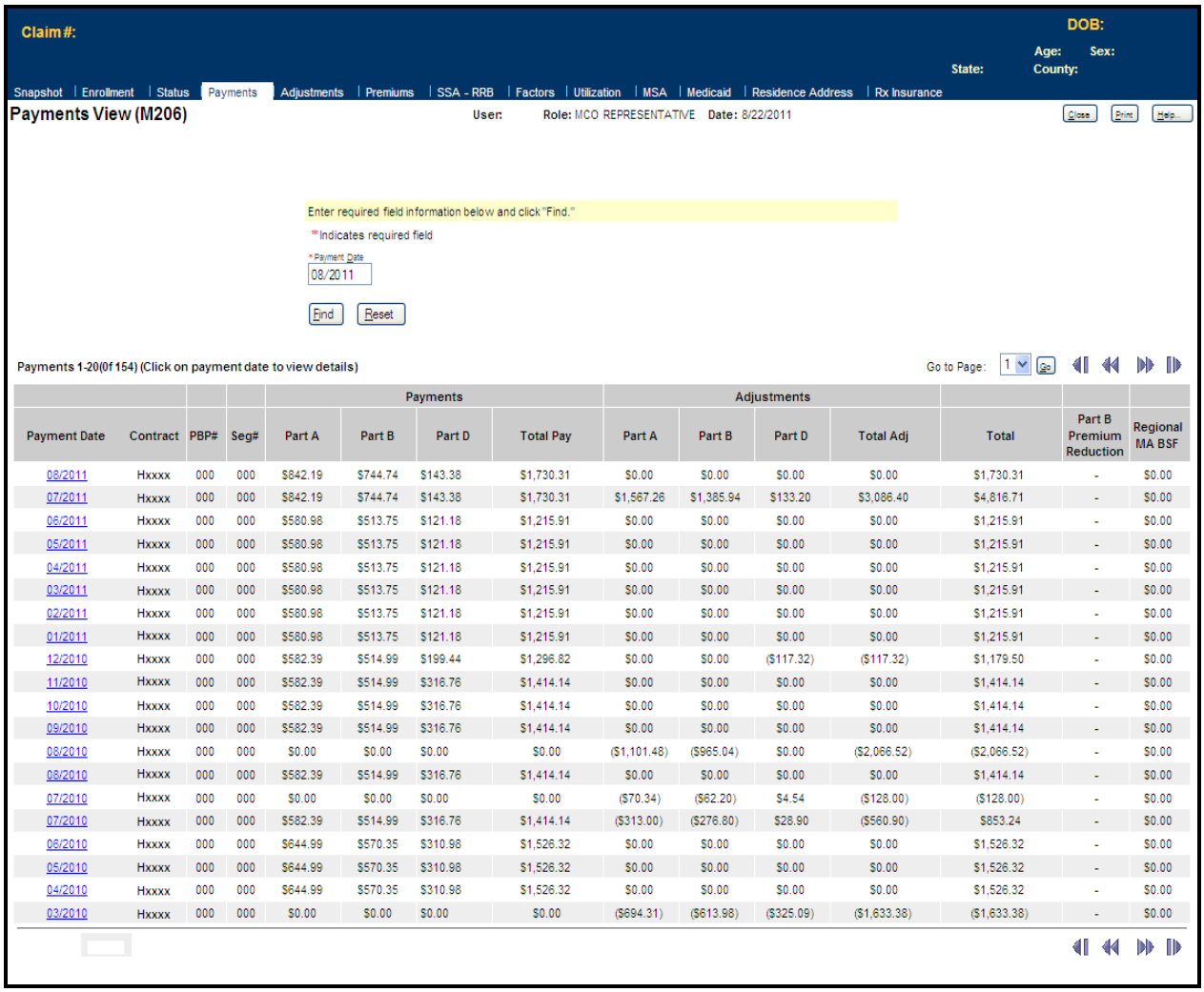
Table 10-42: MCO Representative (View Only) (M206) Field Descriptions and Actions

Item	Input/Output	Description
Search Criteria		
Payment Date	Required data entry field	The user enters a month and year in the form (M)M/YYYY.
[Find]	Button	The user clicks on this button to display payment information in the lower portion of the screen.
Payments		
Payment Date column	Output	When payment/adjustments were paid.
Month/Year in the Payment Date column	Link	The user clicks on a month/year link to display the pop-up screen *Payment/Adjustment Detail (M215)* screen discussed in Section 5.3.3.7.
Contract column	Output	Contracts for which payments/adjustments were made.
PBP # column	Output	PBPs for which payments/adjustments were made.
Seg # column	Output	Segments for which payments/adjustments were made.
Part A Payments column	Output	Part A payments for the beneficiary by month.
Part B Payments column	Output	Part B payments for the beneficiary by month.
Part D Payments column	Output	Part D payments for the beneficiary by month.
Total Pay column	Output	Part A, Part B, and Part D total monthly payments for beneficiary.
Part A Adjustments column	Output	Part A adjustments for the beneficiary by month.
Part B Adjustments column	Output	Part B adjustments for the beneficiary by month.
Part D Adjustments column	Output	Part D adjustments for the beneficiary by month.
Total Adj column	Output	Totals of Part A, Part B, and Part D adjustments for the beneficiary by month.
Total Pay+Adj column	Output	Payments plus adjustments for the beneficiary by month.
Part B Premium Reduction column	Output	Indicates whether the payments/adjustments were adjusted for Part B premium reduction. Formerly known as a BIPA reduction.
Regional Medicare Advantage Benefit Stabilization Fund (MA BSF) column	Output	Lists the bonus paid from the regional MA BSF.

Table 10-43: MCO Representative (View Only) (M206) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Payment Date must be entered.	The user enters the date.
Invalid format	Payment Date is invalid. Must have format (M)M/YYYY.	The user re-enters the date in one of the required formats.
No data	No composite payments found for claim number <claim number> and coverage date <date>.	No payment data is available for that claim number on that date. If the user expects to see payment data, the user must verify the date and month and re-enter the corrected information.
Software or Database Error	Error occurred while retrieving composite payment results for claim number <claim number> and coverage date <coverage date>.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving composite payment information for claim number <claim number and coverage date <coverage date>.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error.	The user should access Appendix B for contact information to report the error.

To expand the *Beneficiary Detail: Payments (M206)* screen and display a list, ordered by payment month, of payment and adjustment information; the user enters the month and year of the payment date and clicks on the [Find] button. The information displays by Part A, Part B, and Part D for months up through the payment date, as shown in **Figure 10-41** and described in **Table 10-42**, with error and validation messages provided in **Table 10-43.**



Claim #:

DOB:

Age: Sex:

State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Payments View (M206)

User: Role: MCO REPRESENTATIVE Date: 8/22/2011

Close Print Help...

Enter required field information below and click "Find."

* Indicates required field

* Payment Date

08/2011

Find Reset

Payments 1-20(0f 154) (Click on payment date to view details)

Go to Page: 1 Go

				Payments				Adjustments						
Payment Date	Contract	PBP#	Seg#	Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj	Total	Part B Premium Reduction	Regional MA BSF
08/2011	Hxxxx	000	000	$842.19	$744.74	$143.38	$1,730.31	$0.00	$0.00	$0.00	$0.00	$1,730.31	-	$0.00
07/2011	Hxxxx	000	000	$842.19	$744.74	$143.38	$1,730.31	$1,567.26	$1,385.94	$133.20	$3,086.40	$4,816.71	-	$0.00
06/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
05/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
04/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
03/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
02/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
01/2011	Hxxxx	000	000	$580.98	$513.75	$121.18	$1,215.91	$0.00	$0.00	$0.00	$0.00	$1,215.91	-	$0.00
12/2010	Hxxxx	000	000	$582.39	$514.99	$199.44	$1,296.82	$0.00	$0.00	($117.32)	($117.32)	$1,179.50	-	$0.00
11/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
10/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
09/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
08/2010	Hxxxx	000	000	$0.00	$0.00	$0.00	$0.00	($1,101.48)	($965.04)	$0.00	($2,066.52)	($2,066.52)	-	$0.00
08/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	$0.00	$0.00	$0.00	$0.00	$1,414.14	-	$0.00
07/2010	Hxxxx	000	000	$0.00	$0.00	$0.00	$0.00	($70.34)	($62.20)	$4.54	($128.00)	($128.00)	-	$0.00
07/2010	Hxxxx	000	000	$582.39	$514.99	$316.76	$1,414.14	($313.00)	($276.80)	$28.90	($560.90)	$853.24	-	$0.00
06/2010	Hxxxx	000	000	$644.99	$570.35	$310.98	$1,526.32	$0.00	$0.00	$0.00	$0.00	$1,526.32	-	$0.00
05/2010	Hxxxx	000	000	$644.99	$570.35	$310.98	$1,526.32	$0.00	$0.00	$0.00	$0.00	$1,526.32	-	$0.00
04/2010	Hxxxx	000	000	$644.99	$570.35	$310.98	$1,526.32	$0.00	$0.00	$0.00	$0.00	$1,526.32	-	$0.00
03/2010	Hxxxx	000	000	$0.00	$0.00	$0.00	$0.00	($694.31)	($613.98)	($325.09)	($1,633.38)	($1,633.38)	-	$0.00

Figure 10-41: MCO Representative (View Only) Beneficiary Detail: Payments (M206) Screen (Expanded)

To see the payment and adjustment information in more detail, the user clicks on one of the month/year links in the Payment Date column to display the *Payment/Adjustment Detail (M215)* screen, as described in **Section 10.3.18**.

10.3.8 Viewing the Adjustment Information for a Beneficiary

An adjustment history shows the adjustments made for the beneficiary while enrolled in any of the user's contracts.

STEP 4n: Viewing the Beneficiary Detail: Adjustments (M207) Screen

To access the *Beneficiary Detail: Adjustments (M207)* screen, the user clicks on the |Adjustments| menu item. This displays a screen, as shown in **Figure 10-42**, that provides a field for entering a payment month and year. When the beneficiary enrolls in two contracts, one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed. Upon initial display, the current date appears in that field. This screen is described in **Table 10-44;** note that the Adjustments section is not yet displayed, with error and validation messages provided in **Table 10-45.**

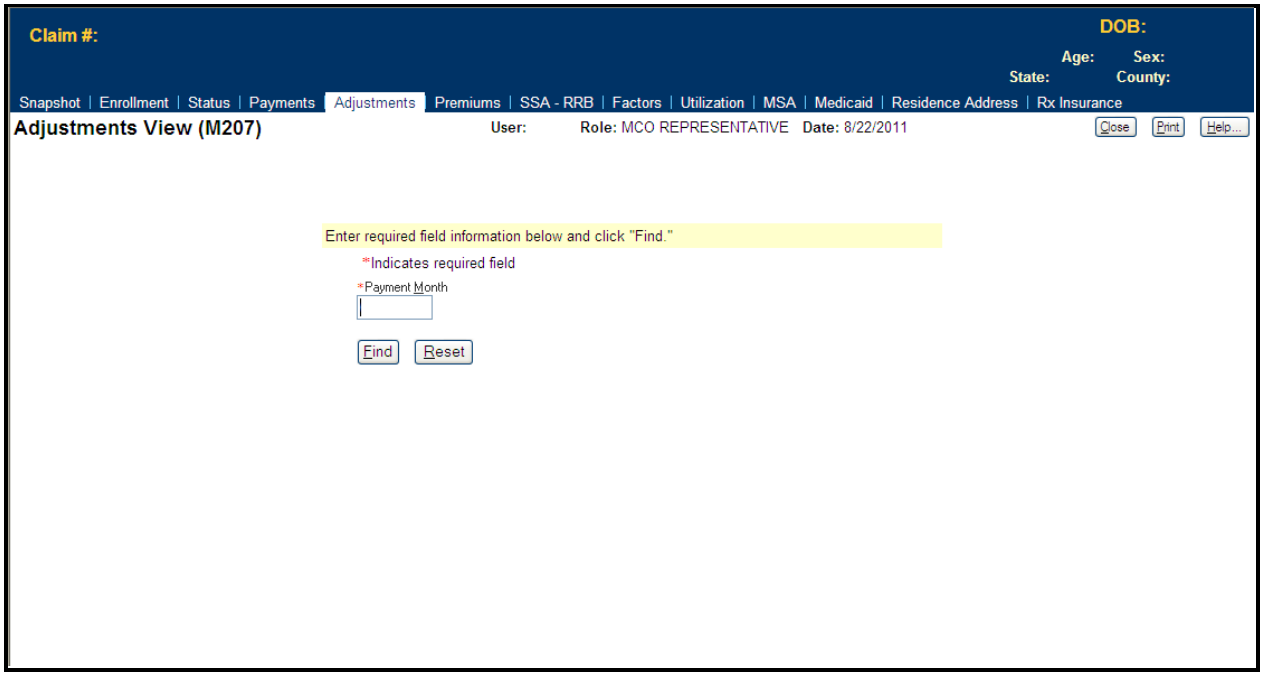


Figure 10-42: MCO Representative (View Only) Beneficiary Detail: Adjustments (M207) Screen (Initial Display)

Table 10-44: MCO Representative (View Only) (M207) Field Descriptions and Actions

Item	Input/Output	Description
Search Criteria		
Payment Month	Required data entry field	The user enters a month and year in the form (M)M/YYYY.
[Find]	Button	The user clicks on this button to display adjustment information in the lower portion of the screen.
Adjustments		
Adjustment Date column	Output	Indicates when adjustments were paid.
Month/Year in the Adjustment Date column	Link	User clicks on month/year link to display pop-up screen *Payment/Adjustment Detail (M215)* in Section 5.3.3.9.
Contract column	Output	Contracts for which adjustments were made.
PBP column	Output	PBPs for which adjustments were made.
Segment column	Output	Segments for which adjustments were made.
Description column	Output	Description of the adjustment reason for each adjustment.
Adjustment Code column	Output	Code for the adjustment reason for each adjustment.
Part A Adjustments column	Output	Part A adjustments by Paid for Month and adjustment reason.
Part B Adjustments column	Output	Part B adjustments by Paid for Month and adjustment reason.
Part D Adjustments column	Output	Part D adjustments by Paid for Month and adjustment reason.
Total Adjustments column	Output	Total adjustments by month and adjustment reason.
Paid for Month column	Output	Indicates the month to which the adjustment applies.

Table 10-45: MCO Representative (View Only) (M207) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Payment Month must be entered	User enters the date.
Invalid format	Payment Month is invalid. Must have format (M)M/YYYY.	User re-enters the date in one of the required formats.
No data	No adjustments found for claim number <claim number> and payment month <month>.	No adjustment data is available for that claim number through that month. If users expect to see payment data, they should verify the month and re-enter the corrected information.
Software or Database Error	Error occurred while retrieving adjustment results for claim number <claim number> and payment month <payment month>.	User accesses Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving adjustment history for claim number <claim number> and payment month <payment month>.	User accesses Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary adjustment history	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database = <error code>.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

To expand the screen to display a list, ordered by adjustment month, of adjustment information that occurred up through the payment month that the user entered, the user enters the month and year of the payment date and clicks on the [Find] button. The Part A, Part B, and Part D adjustments are listed in adjustment code as shown in **Figure 10-43**, as previously described by **Table 10-44**, with error and validation messages previously provided in **Table 10-45.**

Claim #: DOB:
Age: Sex:
State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

Adjustments View (M207) User: Role: MCO REPRESENTATIVE Date: 8/22/2011 Close Print Help...

Enter required field information below and click "Find."

*Indicates required field

*Payment Month
07/2011

Find Reset

Adjustments 1-20(0f 142) (Click on adjustment date to view details) Go to Page: 1 Go

						Adjustments					
Adjustment Date	Contract	PBP	Segment	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	06/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	06/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	05/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	05/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	04/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	04/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	03/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	03/2011	Y
07/2011	Hxxxx	000	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$22.20	$22.20	02/2011	Y
07/2011	Hxxxx	000	000	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	26	$261.21	$230.99	$0.00	$492.20	02/2011	Y

Figure 10-43: MCO Representative (View Only) Beneficiary Detail: Adjustments (M207) Screen (Expanded)

To view the payment and adjustment information in more detail, the user clicks on one of the month/year links in the Adjustment Date column to display the *Payment/Adjustment Detail (M215)* screen, as described in **Section 10.3.18**.

10.3.9 Viewing the Premium Information for a Beneficiary

The premium information includes the history of basic premiums paid by the beneficiary, the penalty for late enrollment added to the premiums, and the subsidies paid by the Government that reduce the premiums.

STEP 4o: Viewing the Beneficiary Detail: Premiums (M231) Screen

To access the *Beneficiary Detail: Premiums (M231)* screen, the user clicks on the |Premiums| menu item. This displays a screen, as shown in **Figure 10-44**, that provides a field for entering a payment month and year. When the beneficiary enrolls in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed. Upon initial display, the current month appears in that field. This screen and its premium details sub view dropdown are described in **Table 10-46;** note that the premiums section is not yet displayed, with error and validation messages provided in **Table 10-47**.

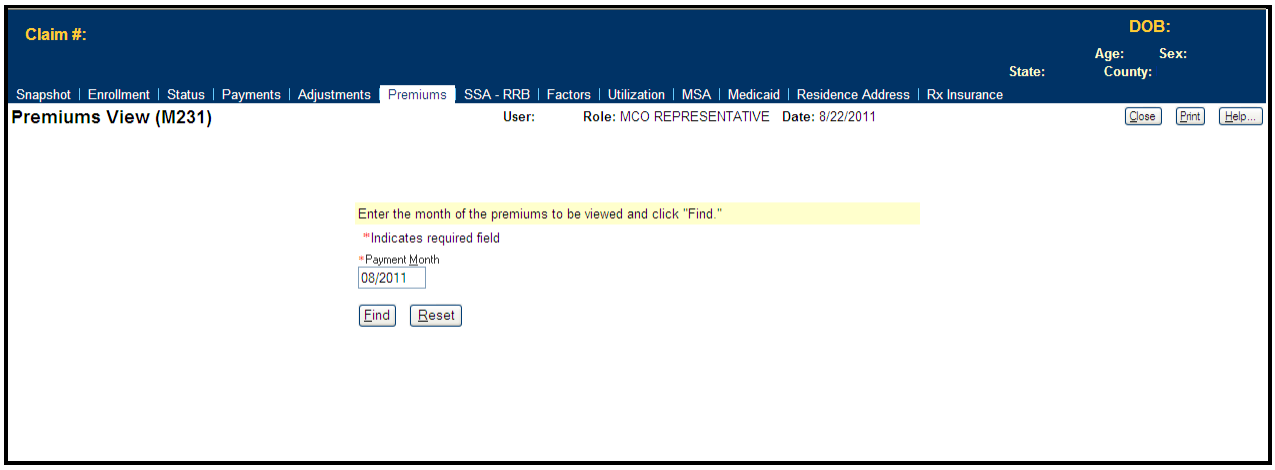


Figure 10-44: MCO Representative (View Only) Beneficiary Detail: Premiums (M231) Screen (Initial Display)

Table 10-46: MCO Representative (View Only) (M231) Field Descriptions and Actions

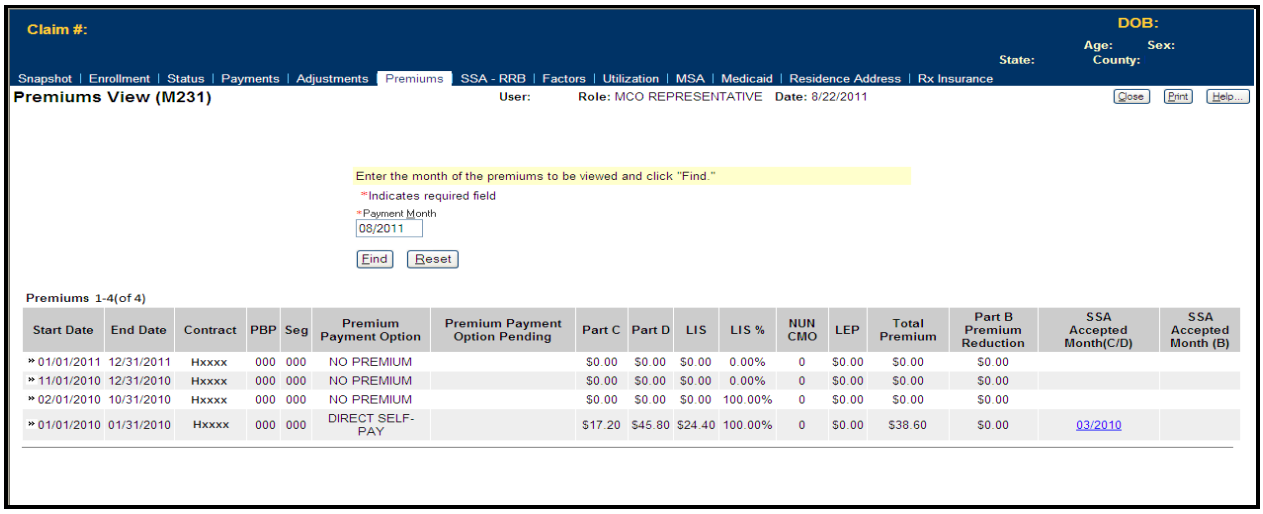
Item	Input/Output	Description
Search Criteria		
CPM	Input (Required)	Enter a month and year in the format (M)M/YYYY. This date defaults to the CPM when the screen is initially opened.
Find	Button	Displays premium information associated with the Payment Month entered.
Reset	Button	Resets the entered date to the CPM.
Premiums		
[>>]	Button	Displays additional details about the premium in a dropdown below the premium line.
[▼] [▼]	Button	Selecting this closes the already opened dropdown premium detail information view.
Start Date	Output	When the period for this row's premium began.
End Date	Output	When the period for this row's premium ended.
Contract	Output	Contract for which premiums were charged.
PBP	Output	PBP for which premiums were charged.
Seg	Output	Segment for which premiums were charged.
Premium Payment Option (PPO)	Output	The PPOPPO that the beneficiary chose for paying the premiums; Direct Self Pay or Withholding from one of the withholding agencies (SSA or RRB).
PPO Pending	Output	'Y' – Request for PPO change was not yet accepted by the withholding agency. 'Blank' – no PPO change is pending.
Part C	Output	Part C premium for the beneficiary for this period.
Part D	Output	Part D premium for the beneficiary for this period.
LIS	Output	Low-Income Subsidy - Amount of Part D premiums that were subsidized due to the beneficiary's low-income status.
LIS %	Output	Percentage level for the Part D premium subsidy due to the beneficiary's low-income status.
NUNCMO	Output	Number of months during which the beneficiary did not have creditable drug insurance coverage associated with this premium period.
Late Enrollment Penalty (LEP)	Output	LEP - Penalty charged for late enrollment in Part D coverage. This is determined by the number of uncovered months.
Total Premium	Output	Total premium charged for Parts C and/or D, as applicable, taking into account subsidies and penalties.
Part B Premium Reduction	Output	Total Part B premium reduction, as applicable.
SSA Accepted Month (C/D)	Link	Date Parts C and/or D premium withholding request accepted by SSA. If the beneficiary did not request withholding from SSA or if the request was rejected, field is blank. Selecting this link displays the *Beneficiary Detail: Premium Withhold Transactions (M237)* screen, which shows the Parts C and/or D Premium Withhold Transactions accepted by SSA for specific premium period.
SSA Accepted Month (B)	Link	Date Part B premium reduction transaction accepted by SSA. If Part B premium reduction does not apply to beneficiary or if transaction rejected by SSA, field is blank. Selecting this link displays the *Beneficiary Detail: Premium Withhold Transactions (M237)* screen, which shows the Part B Reduction Premium Withhold Transactions accepted by SSA for specific premium period.
Premium Details This section displays when the premium line dropdown arrow is selected. It shows additional details for the line.		
Creation Date	Output	Date on which the transaction is sent to SSA.
De Minimis	Output	De Minimis amount that was applied to this premium.

Item	Input/Output	Description
Part D Net of De Minimis	Output	The Part D premium amount adjusted for De Minimis.
LEP Subsidy	Output	Amount of the LEP that was subsidized.

Table 10-47: MCO Representative (View Only) (M231) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Payment Month must be entered	Enter the date.
Invalid format	Payment Month is invalid. Must have format (M)M/YYYY	Re-enter the date in one of the required formats.
No data	No premiums found for claim number <claim number>	No payment data is available for the beneficiary for the entered date. If the user expects to see payment data, verify the date and month and re-enter the corrected information.
Software or Database Error	Error occurred while retrieving beneficiary premium information for claim number <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input data to retrieve premiums	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database = <error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.

To expand the *Beneficiary Detail: Premiums (M231)* screen and display a list of premium information; the user enters the month and year of the payment date and clicks on the [Find] button. Information for the contracts in which the beneficiary was enrolled that month is displayed, as shown in **Figure 10-45** and previously described in **Table 10-46**, with error and validation messages previously provided in **Table 10-47**.



Start Date	End Date	Contract	PBP	Seg	Premium Payment Option	Premium Payment Option Pending	Part C	Part D	LIS	LIS %	NUN CMO	LEP	Total Premium	Part B Premium Reduction	SSA Accepted Month(C/D)	SSA Accepted Month (B)
» 01/01/2011	12/31/2011	Hxxxx	000	000	NO PREMIUM		$0.00	$0.00	$0.00	0.00%	0	$0.00	$0.00	$0.00		
» 11/01/2010	12/31/2010	Hxxxx	000	000	NO PREMIUM		$0.00	$0.00	$0.00	0.00%	0	$0.00	$0.00	$0.00		
» 02/01/2010	10/31/2010	Hxxxx	000	000	NO PREMIUM		$0.00	$0.00	$0.00	100.00%	0	$0.00	$0.00	$0.00		
» 01/01/2010	01/31/2010	Hxxxx	000	000	DIRECT SELF-PAY		$17.20	$45.80	$24.40	100.00%	0	$0.00	$38.60	$0.00	03/2010	

Figure 10-45: MCO Representative (View Only) Beneficiary Detail: Premiums (M231) Screen (Expanded)

STEP 4p: Updating the Beneficiary Detail: Premiums (M231) Screen

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

The top portion of this screen provides a field for entering a payment month and year. The bottom portion of the screen shows the beneficiary's premium data associated with the month and year for the specified month. When the screen is initially opened, the date defaults to the current payment month, the user can change the month by entering a new date and selecting the Find button. When the beneficiary is enrolled in two contracts; one for Parts A and/or B and the other for Part D, two rows for the same month display. This screen also allows the user to view additional details by using the dropdown arrows on the premium period line.

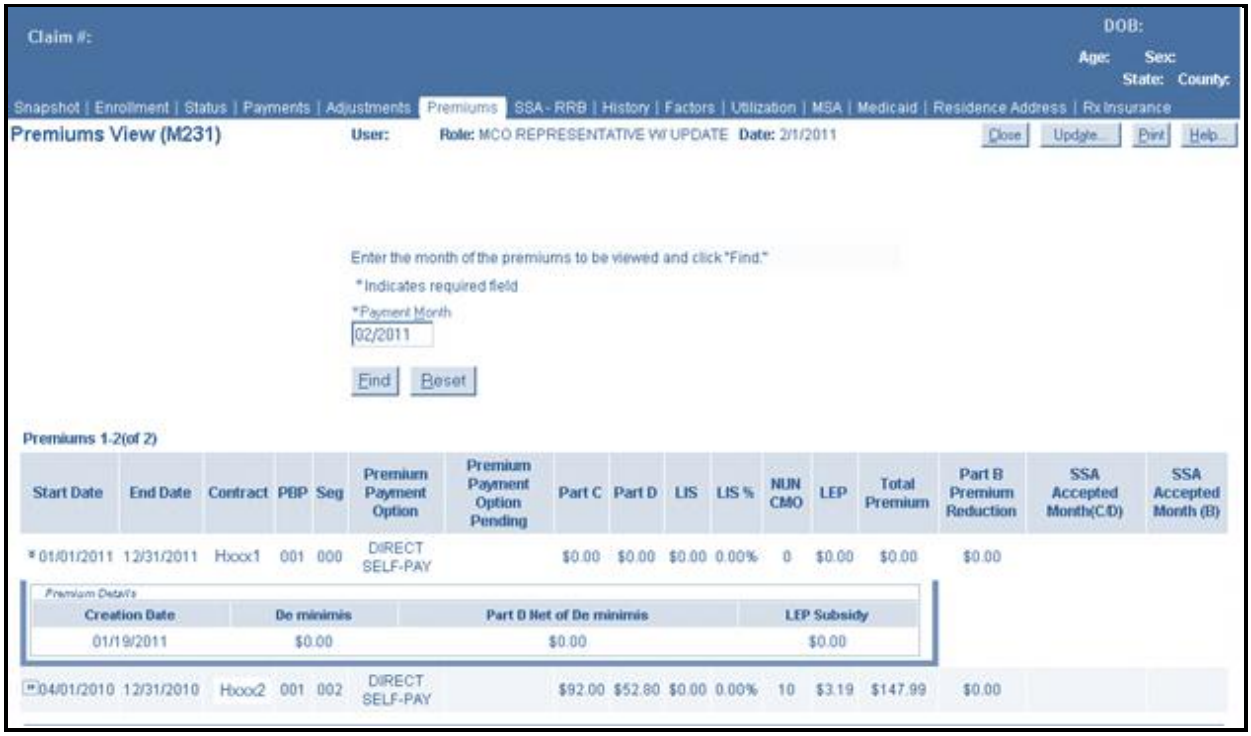


Figure 10-46: MCO Representative (UI Update) Premiums View (M231) Screen

Table 10-48: MCO Representative (UI Update) (M231) Field Descriptions and Actions

Item	Input/Output	Description
Search Criteria		
[Update]	Button	Selecting this button will take the user to the Update Enrollment (M212) screen.
Payment Month	Input (Required)	Enter a month and year in the format (M)M/YYYY. This date defaults to the current payment month when the screen is initially opened.
Find	Button	Selecting this button displays premium information associated with the Payment Month entered.
Reset	Button	Resets the entered date to the current payment month.
Premiums		
[>>]	Button	Selecting this button on a transaction status row displays additional details about the premium transaction in a dropdown view.
[^] [^]	Button	Selecting this closes the already opened dropdown premium detail transaction information view.
Start Date	Output	The date that this row's premium began.
End Date	Output	The date that this row's premium ended.
Contract	Output	Contract for which premiums were charged.
PBP	Output	PBP for which premiums were charged.
Seg	Output	Segment for which premiums were charged.
PPOPPO	Output	The PPOPPO that the beneficiary chose for paying the premiums. The options are Direct Self Pay or Withholding from one of the withholding agencies (SSA or RRB).
PPOPPO Pending	Output	'Y' – Request for PPO change was not yet accepted by the withholding agency. 'blank' – no PPO change is pending.
Part C	Output	Part C premium for the beneficiary for this period.
Part D	Output	Part D premium for the beneficiary for this period.
LIS	Output	LIS - Amount of Part D premiums that were subsidized due to the beneficiary's low-income status.
LIS %	Output	Percentage level for the Part D premium subsidy due to the beneficiary's low-income status
NUNCMO	Output	Number of months during which the beneficiary did not have creditable drug insurance coverage associated with this premium period.
LEP	Output	LEP - Penalty charged for late enrollment in Part D coverage. This is determined by the NUNCMO.
Total Premium	Output	Total premium charged for Parts C and/or D, as applicable, taking into account subsidies and penalties.
Part B Premium Reduction	Output	Total Part B premium reduction, as applicable.
SSA Accepted Month (C/D)	Link	Date on which Parts C and/or D premium withholding request was accepted by SSA. If the beneficiary did not request withholding from SSA or if the request was rejected, this field is blank. Selecting this link displays the *Premium Withhold Transactions (M237)* screen, which shows the Parts C and/or D Premium Withhold Transactions accepted by SSA for that specific premium period.

Item	Input/Output	Description
SSA Accepted Month (B)	Link	Date on which Part B premium reduction transaction was accepted by SSA. If Part B Premium Reduction does not apply to this beneficiary or if the transaction was rejected by SSA, this field is blank. Selecting this link displays the *Beneficiary Detail: Premium Withhold Transactions (M237)* screen, which shows the Part B Reduction Premium Withhold Transactions accepted by SSA for that specific premium period.
Premium Details This section is displayed when the dropdown arrow for a premium line is selected. It shows additional details for the line.		
Creation Date	Output	Date when the transaction is sent to SSA.
De Minimis	Output	De Minimis amount applied to this premium.
Part D Net of De Minimis	Output	The Part D premium amount adjusted for De Minimis.
LEP Subsidy	Output	Amount of the late enrollment penalty that was subsidized.

Table 10-49: MCO Representative (UI Update) (M231) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Payment Month must be entered	Enter the date.
Invalid format	Payment Month is invalid. Must have format (M)M/YYYY	Re-enter the date in one of the required formats.
No data	No premiums found for claim number <claim number>	No payment data is available for the beneficiary for the entered date. If the user expects to see payment data, verify the date and month and re-enter the corrected information.
Software or Database Error	Error occurred while retrieving beneficiary premium information for claim number <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input data to retrieve premiums	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database = <error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.

10.3.10 View the Update Premiums for the Number of Uncovered Months (NUNCMO)

The Plan user who has MCO Representative with Update role can change the beneficiary's incremental uncovered months from the M226 screen. Plan users cannot update the Part C premium amount(s) and the premium payment options via the UI.

STEP 4q: Updating the Beneficiary Detail: Update Premiums (M226) Screen NUNCMO

To navigate to the *Update Premiums (M226)* screen, select the *Update* button from the *Premiums (M231) screen and then select* the |Update Premiums| tab.

Figure 10-47: MCO Representative (UI Update) Update Premiums (M226) Screen NUNCMO

Table 10-50: MCO Representative (UI Update) (M226) Field Descriptions and Actions

Item	Input/Output	Description
Part C/D Premium Information This section contains one line for each premium period during which the beneficiary was enrolled in the contracts to which the user has access. *The user cannot update this information.*		
Contract	Output	Contract number of the enrollment for the premium period.
PBP	Output	PBP number associated with this enrollment.
Segment	Output	Segment number associated with this enrollment.
Premium Start Date	Output	The effective date for the Part C and/or D premiums on this line.
Premium End Date	Output	The last effective date for Part C and/or D premiums on this line. If no value is displayed, the premium period is open-ended.
PPOPPO	Output	PPO for this beneficiary for this premium period.
PPOPPO Pending	Output	A value of 'Y' means that a request for withholding was transmitted to the withholding agency but the agency has not yet returned an approval. Otherwise, this field is blank.
Part C Premium	Output	The cost charged by the Plan to the beneficiary for Part C coverage.
Part D Premium	Output	The cost charged by the Plan to the beneficiary for Part D coverage.

Item	Input/Output	Description
Late Enrollment Penalty	Output	The penalty amount that is added to the premium when the beneficiary has an uncovered period without creditable coverage. This amount is calculated based on the uncovered months.
Updating NUNCMO Information Uncovered months are associated with the first day of each enrollment. This section contains one line for each of the beneficiary's enrollment periods along with the associated NUNCMO. It also displays any NUNCMO resets that may have occurred. NUNCMO values for all enrollment are shown but the associated contract number is displayed only for contracts to which the user has access. The user can update the NUNCMO associated with any contract to which they have access. A user with access to the contract in which the beneficiary is currently enrolled can update that NUNCMO value or the value for any preceding enrollment.		
Current Cumulative NUNCMO	Output	The total NUNCMO used when calculating the LEP for a current enrollment period. This total includes uncovered months associated with all previous enrollments as well as any NUNCMO Resets.
Contract	Output	Contract number of the enrollment associated with this uncovered month period.
PBP #	Output	PBP number of the enrollment associated with this uncovered month period.
Start Date	Output	The start date of the enrollment associated with this uncovered month value or the date of the reset.
Incremental Uncovered Months	Update	Number of months that the beneficiary did not have creditable coverage in the period immediately prior to the enrollment on this line. The field is either left blank or set to zero when there are no uncovered months.
Cumulative Uncovered Months	Output	The running total of uncovered months. Uncovered months accumulate over time unless a NUNCMO reset is in place. Accumulation begins again at zero after a NUNCMO reset.
Indicator	Output	This indicates the type of uncovered months – • Reset (R) – This line represents a NUNCMO reset. It is a point in time where the accumulation of uncovered months is set back to zero. • L- LIS Reset: This beneficiary's NUNCMO were reset because of an LIS status as of the effective date shown on the table. • A- IEP Reset: This beneficiary's NUNCMO were reset because their 2nd Initial Enrollment Period (IEP) for Part D started as of the effective date shown on the table

Table 10-51: MCO Representative (UI Update) (M226) Screen Messages

Message Type	Message Text	Suggested Action
Invalid format	Number of uncovered months must be a number.	Re-enter the number of uncovered months in number format.
Processing error–monthly summarization in progress	Unable to perform update during the monthly summarization. Please try again later.	Updates are not allowed during the monthly summarization. Try again after the summarization is complete.
Processing error–enrollment edits failed	Update error occurred. See details at the bottom of the screen. Contact your CMS representative.	Scroll down to the bottom of the screen to view the detailed edit error messages. Modify the changes to address the problems raised in the messages. If needed, contact MAPD Help Desk for assistance.
Processing error–enrollment edits failed	Update error occurred. See details at the bottom of the screen.	Contact MAPD Help Desk for assistance.
No data	No premium information found for <claim number>	No action required. The user may start a new premium period.
No data	No creditable coverage information found for <claim number>	No action required.
No data	No premium or creditable coverage information found for <claim number>	No action required.
Software or Database Error	Invalid premium results for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid creditable coverage results for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving premium and creditable coverage information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.
Software or Database Error	The number of uncovered months has been updated but redisplay has failed.	Contact MAPD Help Desk for assistance.
Success	The number of uncovered months has been updated.	No action required.

10.3.11 View the Premium Withhold Transactions for a Beneficiary

Beneficiary Premium Withhold Status (M237) screen displays the SSA/RRB processing status for the Part C/Part D premium withhold and Part B Premium Reduction transactions sent by CMS to SSA and RRB for a specific beneficiary with premium year range. Four separate views display SSA and RRB transactions:

- SSA Part C/Part D Premium Withhold.
- RRB Part C/Part D Premium Withhold.
- SSA/RRB Part B Premium Reduction.
- All SSA-RRB.

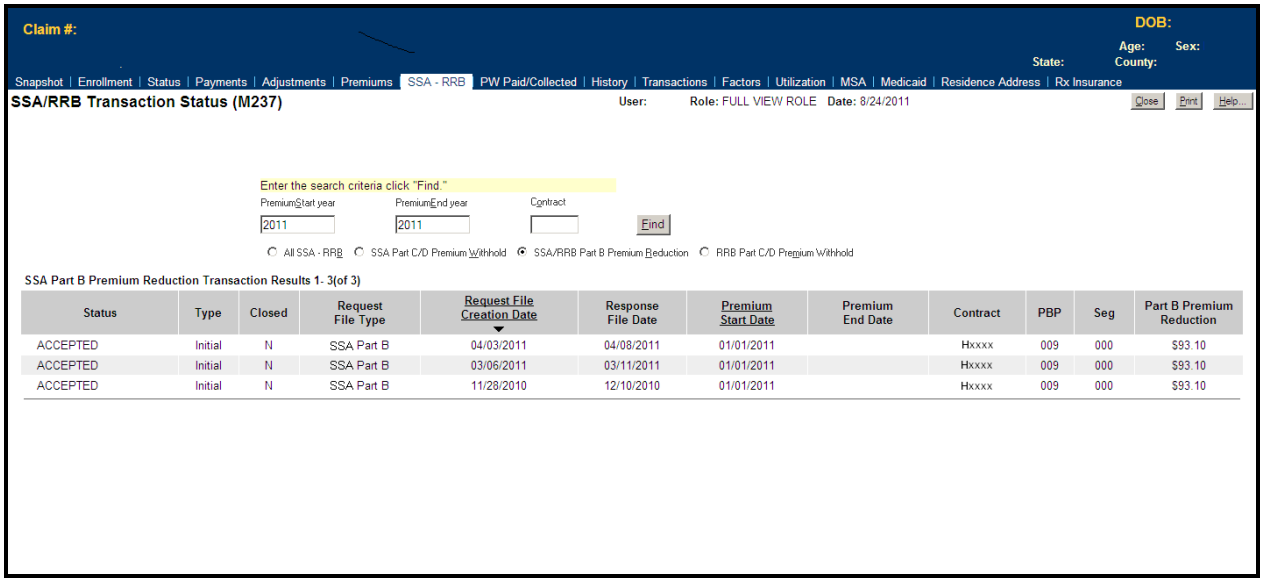
These views display whether or not SSA or RRB accepts or rejects the transaction.

STEP 4r: Viewing the Beneficiary Detail: SSA/RRB Transaction Status (M237) Screen

To access the *Beneficiary Detail: Premium Withhold Transactions (M237) SSA/RRB Transactions* screen, click on the |SSA - RRB| menu item. This displays 'All SSA-RRB' view, as shown in **Figure 10-48**, which provides the following Request File Type of premium withhold transactions:

- SSA Part C/Part D.
- RRB Part C/Part D.
- Historical SSA C/D/B.

By clicking the right arrow before the start of arrow, more detail transactions display, as described in **Table 10-52**. This screen is described in **Table 10-53** with error and validation messages provided in **Table 10-54.**



Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Part B Premium Reduction
ACCEPTED	Initial	N	SSA Part B	04/03/2011	04/08/2011	01/01/2011		Hxxxx	009	000	$93.10
ACCEPTED	Initial	N	SSA Part B	03/06/2011	03/11/2011	01/01/2011		Hxxxx	009	000	$93.10
ACCEPTED	Initial	N	SSA Part B	11/28/2010	12/10/2010	01/01/2011		Hxxxx	009	000	$93.10

Figure 10-48: MCO Representative (View Only) Beneficiary Detail: Premium Withhold Transactions (M237) Screen

Table 10-52: MCO Representative (View Only) (M237) Field Descriptions and Actions

Item	Input/Output	Description
Premium Start Year	Optional data entry field	The user enters year in the form YYYY.
Premium End Year	Optional data entry field	The user enters year in the form YYYY.
Contract	Optional data entry field	The user enters a valid contract number
[Find]	Button	The user clicks on this button to display premium transaction information for the search criteria.
Status column	Output	SSA/RRB Transaction Status is shown as Accepted for an accepted transaction and Rejected for a rejected transaction.
Type column	Output	Transaction Type (Initial, Retry or FDB): **Initial** – (for both SSA and RRB) – indicates a first submission of a Premium Withhold transaction from CMS to SSA or RRB. The transaction is accepted or rejected. The rejection is because of a mismatch in demographic information between CMS and SSA or because of a new enrollment for which SSA does not yet have information. **Retry** – (for SSA only) – Indicates a transaction transmitted to SSA after the first submission was rejected by SSA. The transaction is accepted or rejected by SSA. Transactions that are rejected by SSA in 'retry' are resubmitted to SSA as a Facilitated Direct Bill (FDB) transaction. Prior Year Transaction rejects are not submitted for FDB. **FDB** – (for SSA only) – indicates a transaction was transmitted to SSA after the second attempt was rejected by SSA. The FDB transaction is accepted or rejected by SSA.
Closed	Output	Transaction Closed indicator. Shown as 'Y' for closed transactions.
Request File Creation Date column heading	Sorter	For SSA: sorts the results by SSA sent date. For RRB: sorts the results in order by Response File Creation Date, Response File Date, and Premium Start Date. Rows are sorted in ascending order by default and the order is switched between ascending and descending by clicking on column heading.
Request File Creation Date column	Output	Date transaction is sent to SSA or RRB.
Response File Date column	Output	Date on which response is received from SSA or RRB Header date on SSA Response File, date that RRB Reply File is processed.
Premium Start Date column heading	Sorter	Sorts the results by Premium Start Date Rows are sorted in ascending order by default and the order is switched between ascending and descending by clicking on column heading.
Premium Start Date column	Output	When the premium charge began.

Item	Input/Output	Description
Premium End Date column	Output	When the premium charge ended.
Contract column	Output	Contract for which premiums were charged.
PBP column	Output	PBP for which premiums were charged.
Segment Column	Output	Segment for which premiums were charged.
Drug Plan	Output	Only SSA or RRB Part C, Part D Premium Withhold. Indicates whether each contract/PBP provides drug insurance coverage. Set to Y or N.
Premium Withholding Option column	Output	Option that the beneficiary chose for paying the premiums.
Part B Premium Reduction column	Output	This displays the Part B premium reduction amount for SSA C/D/B types; this view only.

Note: For FDB transactions only SSA Status, Transaction Type, SSA Sent date, SSA Response File Date, and Premium Withhold Option are displayed.

Table 10-53: MCO Representative (View Only) (M237) Screen Transaction Details Dropdown Inputs, Outputs, and Actions

Item	Type	Description
[>>]	Button	The user clicks on this button on a particular transaction status row to display dropdown premium detail transaction information view.
[^] [^]	Button	The user clicks on this button on a particular transaction status row to close the already opened dropdown premium detail transaction information view.
Reason For Reject column	Output	Reason for SSA or RRB reject of the transaction. Shown only for rejected transaction.
Part C Premium column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold; cost charged by Plan to beneficiary for Part C coverage.
Part D Premium column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold; cost to beneficiary for Basic Part D coverage.
Part D Enhanced Premium column	Output	This displays for SSA/RRB Part C and Part D Premium Withhold Cost to beneficiary for additional Part D coverage not included in the Basic coverage.
LEP column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold – Penalty charged to beneficiary for late enrollment in Part D coverage.
LEP Subsidy column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold; amount of the LEP that was subsidized.
LIS Column	Output	This displays for SSA/RRB Part C, Part D Premium Withhold; amount of Part D premiums that were subsidized by the government LIS.

Table 10-54: MCO Representative (View Only) (M237) Screen Messages

Message Type	Message Text	Suggested Action
Invalid format	Year must be a 4-digit number	The user enters a valid year
Invalid format	A contract number must start with an 'H', '9', 'R', 'S', 'F', or 'E' and be followed by 4 characters	The user re-enters the contract number.
Invalid Entry	You do not have access rights to this Contract.	The user should determine if the contract number was entered correctly. If it was entered correctly and if the user should have rights to this contract, the user should see the Security Administrator, who can update the user profile to give the user these rights.
No Data	No Premium Withhold Transactions found.	No Premium Withhold Transaction data is available for that claim number for the search criteria provided.
Informational	Transactions are currently being held for this beneficiary for the year <blocked >. This may be due to a mismatch between CMS and SSA/RRB data.	None needed.
Software or Database Error	Error occurred while retrieving beneficiary premium withhold transaction information	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

Additional search criteria are provided by clicking on the [Find] button. The list of Premium Withhold Transactions for the search criteria entered are displayed, as shown in **Figure 10-49, Figure 10-50, Figure 10-51, Figure 10-52, and Figure 10-53** and as previously provided in **Table 10-52** and **Table 10-53** with error and validation messages previously described in **Table 10-54.**

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

SSA/RRB Transaction Status (M237) User: Role: MCO REPRESENTATIVE Date: 8/26/2011 Close Print Help...

Enter the search criteria click "Find."

PremiumStart year 2011 PremiumEnd year 2011 Contract Find

All SSA - RRB | SSA Part C/D Premium Withhold | SSA/RRB Part B Premium Reduction | RRB Part C/D Premium Withhold

RRB Part C/D Premium Withhold Transaction Results 1- 1(of 1)

Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Drug Plan	Premium Payment Option
» ACCEPTED	Initial		RRB Part C/D		07/01/2011	07/01/2011	09/30/2011	Hxxxx	032	000	Y	R - DEDUCT FROM RRB BENEFITS

Figure 10-49: MCO Representative (View Only) Beneficiary Detail: Premium Withhold Transactions (M237) Screen for RRB Transaction Options

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

SSA/RRB Transaction Status (M237) User: Role: MCO REPRESENTATIVE Date: 8/26/2011 Close Print Help...

Enter the search criteria click "Find."

PremiumStart year 2011 PremiumEnd year 2011 Contract Find

All SSA - RRB | SSA Part C/D Premium Withhold | SSA/RRB Part B Premium Reduction | RRB Part C/D Premium Withhold

RRB Part C/D Premium Withhold Transaction Results 1- 1(of 1)

Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Drug Plan	Premium Payment Option
˅ ACCEPTED	Initial		RRB Part C/D		07/01/2011	07/01/2011	09/30/2011	Hxxxx	032	000	Y	R - DEDUCT FROM RRB BENEFITS

Transaction Details

Part C Premium	Part D Premium	Part D Enhanced Premium	LEP	LEP Subsidy	LIS
$81.00	$0.00	$0.00	$0.00	$0.00	$0.00

Figure 10-50: MCO Representative (View Only) Beneficiary Detail: Premium Withhold Transactions (M237) Screen for All RRB Transaction Options Expanded

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

SSA/RRB Transaction Status (M237) User: Role: MCO REPRESENTATIVE Date: 8/26/2011 Close Print Help...

Enter the search criteria click "Find."

PremiumStart year: 2011 PremiumEnd year: 2011 Contract: Find

All SSA - RRB | SSA Part C/D Premium Withhold | SSA/RRB Part B Premium Reduction | RRB Part C/D Premium Withhold

SSA Part C/D Premium Withhold Transaction Results 1- 3(of 3)

Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Drug Plan	Premium Payment Option
» ACCEPTED	Initial	N	SSA Part C/D	05/08/2011	05/13/2011	05/01/2011	04/30/2011	Hxxxx	806	000	Y	-
» ACCEPTED	Initial	N	SSA Part C/D	05/08/2011	05/13/2011	03/01/2011	04/30/2011	Hxxxx	806	000	Y	D - DIRECT SELF-PAY
» ACCEPTED	Initial	N	SSA Part C/D	05/08/2011	05/13/2011	05/01/2011	06/30/2011	Hxxxx	032	000	Y	D - DIRECT SELF-PAY

Figure 10-51: MCO Representative (View Only) Beneficiary Detail: Premium Withhold Transactions (M237) Screen for All SSA Transaction Options

Claim #: DOB: Age: Sex: State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

SSA/RRB Transaction Status (M237) User: Role: MCO REPRESENTATIVE Date: 8/26/2011 Close Print Help...

Enter the search criteria click "Find."

PremiumStart year: 2011 PremiumEnd year: 2011 Contract: Find

All SSA - RRB | SSA Part C/D Premium Withhold | SSA/RRB Part B Premium Reduction | RRB Part C/D Premium Withhold

SSA Part C/D Premium Withhold Transaction Results 1- 3(of 3)

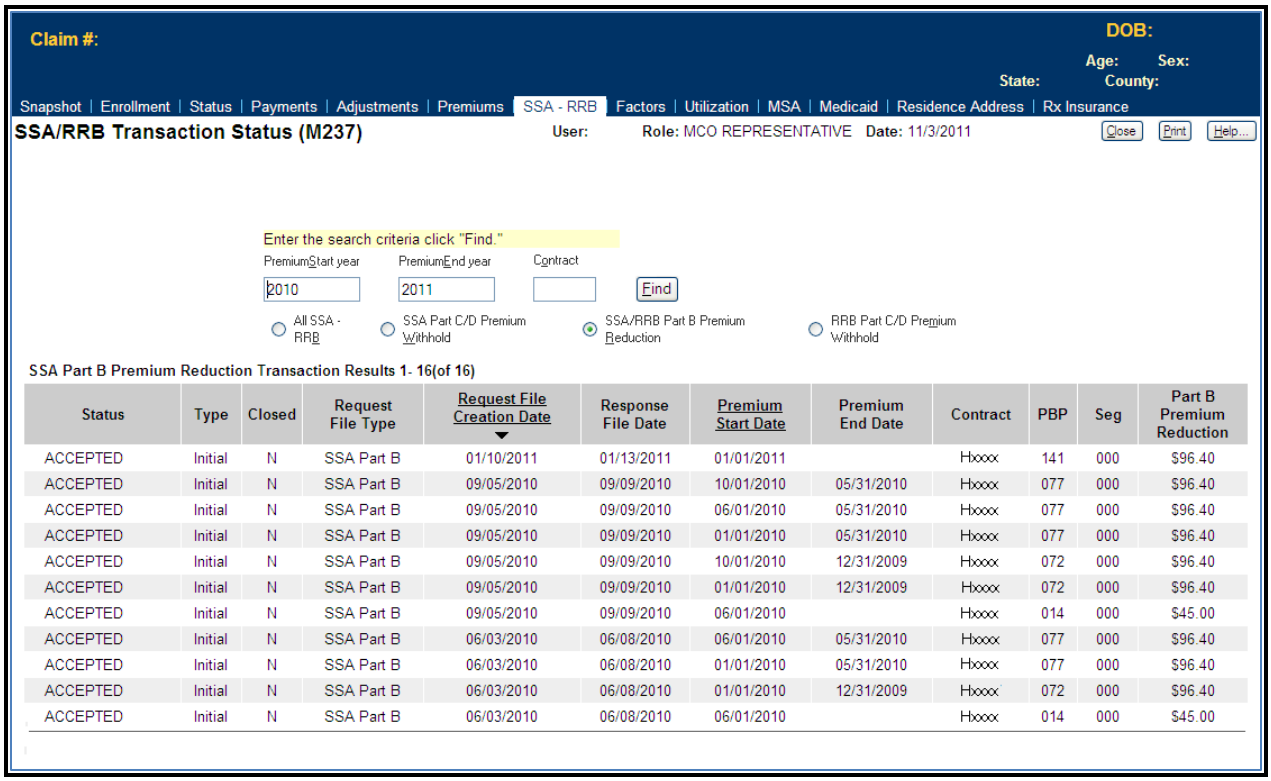
Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Drug Plan	Premium Payment Option
˅ ACCEPTED	Initial	N	SSA Part C/D	05/08/2011	05/13/2011	05/01/2011	04/30/2011	Hxxxx	806	000	Y	-

Transaction Details

Part C Premium	Part D Premium	Part D Enhanced Premium	LEP	LEP Subsidy	LIS
$101.40	$32.30	$0.00	$0.00	$0.00	$0.00

Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Drug Plan	Premium Payment Option
» ACCEPTED	Initial	N	SSA Part C/D	05/08/2011	05/13/2011	03/01/2011	04/30/2011	Hxxxx	806	000	Y	D - DIRECT SELF-PAY
» ACCEPTED	Initial	N	SSA Part C/D	05/08/2011	05/13/2011	05/01/2011	06/30/2011	Hxxxx	032	000	Y	D - DIRECT SELF-PAY

Figure 10-52: MCO Representative (View Only) Beneficiary Detail: Premium Withhold Transactions (M237) Screen for all SSA Transaction Options expanded



Claim #:

DOB:

Age: Sex:

State: County:

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid | Residence Address | Rx Insurance

SSA/RRB Transaction Status (M237) User: Role: MCO REPRESENTATIVE Date: 11/3/2011 Close Print Help...

Enter the search criteria click "Find."

PremiumStart year: 2010 PremiumEnd year: 2011 Contract: Find

All SSA - RRB | SSA Part C/D Premium Withhold | SSA/RRB Part B Premium Reduction | RRB Part C/D Premium Withhold

SSA Part B Premium Reduction Transaction Results 1- 16(of 16)

Status	Type	Closed	Request File Type	Request File Creation Date	Response File Date	Premium Start Date	Premium End Date	Contract	PBP	Seg	Part B Premium Reduction
ACCEPTED	Initial	N	SSA Part B	01/10/2011	01/13/2011	01/01/2011		Hxxxx	141	000	$96.40
ACCEPTED	Initial	N	SSA Part B	09/05/2010	09/09/2010	10/01/2010	05/31/2010	Hxxxx	077	000	$96.40
ACCEPTED	Initial	N	SSA Part B	09/05/2010	09/09/2010	06/01/2010	05/31/2010	Hxxxx	077	000	$96.40
ACCEPTED	Initial	N	SSA Part B	09/05/2010	09/09/2010	01/01/2010	05/31/2010	Hxxxx	077	000	$96.40
ACCEPTED	Initial	N	SSA Part B	09/05/2010	09/09/2010	10/01/2010	12/31/2009	Hxxxx	072	000	$96.40
ACCEPTED	Initial	N	SSA Part B	09/05/2010	09/09/2010	01/01/2010	12/31/2009	Hxxxx	072	000	$96.40
ACCEPTED	Initial	N	SSA Part B	09/05/2010	09/09/2010	06/01/2010		Hxxxx	014	000	$45.00
ACCEPTED	Initial	N	SSA Part B	06/03/2010	06/08/2010	06/01/2010	05/31/2010	Hxxxx	077	000	$96.40
ACCEPTED	Initial	N	SSA Part B	06/03/2010	06/08/2010	01/01/2010	05/31/2010	Hxxxx	077	000	$96.40
ACCEPTED	Initial	N	SSA Part B	06/03/2010	06/08/2010	01/01/2010	12/31/2009	Hxxxx	072	000	$96.40
ACCEPTED	Initial	N	SSA Part B	06/03/2010	06/08/2010	06/01/2010		Hxxxx	014	000	$45.00

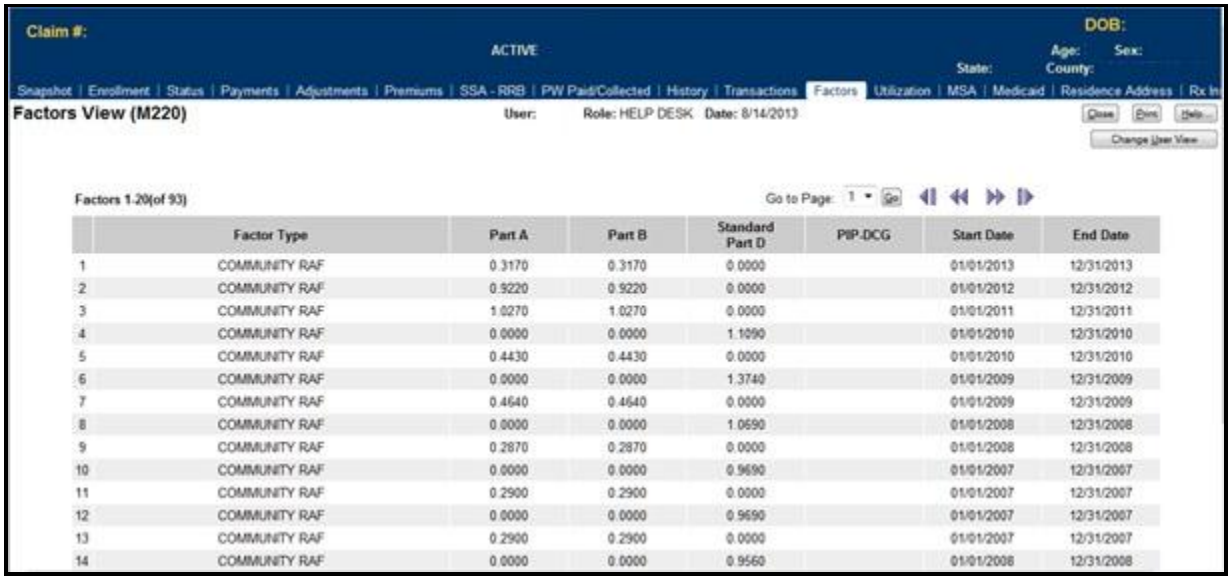
Figure 10-53: MCO Representative (View Only) Beneficiary Detail: Premium Withhold Transactions (M237) Screen for SSA Part B Premium Reduction Transaction Option

10.3.12 Viewing Beneficiary Factors

STEP 4s: Viewing the Beneficiary Detail: Factors (M220) screen

Indicates the factors used to calculate payments made for the beneficiary while enrolled in any of the user's contracts.

To access the *Beneficiary Detail: Factors (M220)* screen, the user clicks on the |Factors| menu item. This displays a screen, as shown in **Figure 10-54**, that provides the factors used to calculate payments. This screen is described in **Table 10-55**, with error and validation messages provided in **Table 10-56**.



	Factor Type	Part A	Part B	Standard Part D	PIP-DCG	Start Date	End Date
1	COMMUNITY RAF	0.3170	0.3170	0.0000		01/01/2013	12/31/2013
2	COMMUNITY RAF	0.9220	0.9220	0.0000		01/01/2012	12/31/2012
3	COMMUNITY RAF	1.0270	1.0270	0.0000		01/01/2011	12/31/2011
4	COMMUNITY RAF	0.0000	0.0000	1.1090		01/01/2010	12/31/2010
5	COMMUNITY RAF	0.4430	0.4430	0.0000		01/01/2010	12/31/2010
6	COMMUNITY RAF	0.0000	0.0000	1.3740		01/01/2009	12/31/2009
7	COMMUNITY RAF	0.4640	0.4640	0.0000		01/01/2009	12/31/2009
8	COMMUNITY RAF	0.0000	0.0000	1.0690		01/01/2008	12/31/2008
9	COMMUNITY RAF	0.2870	0.2870	0.0000		01/01/2008	12/31/2008
10	COMMUNITY RAF	0.0000	0.0000	0.9690		01/01/2007	12/31/2007
11	COMMUNITY RAF	0.2900	0.2900	0.0000		01/01/2007	12/31/2007
12	COMMUNITY RAF	0.0000	0.0000	0.9690		01/01/2007	12/31/2007
13	COMMUNITY RAF	0.2900	0.2900	0.0000		01/01/2007	12/31/2007
14	COMMUNITY RAF	0.0000	0.0000	0.9560		01/01/2008	12/31/2008

Figure 10-54: MCO Representative (View Only) Beneficiary Detail: Factors (M220) Screen

Table 10-55: MCO Representative (View Only) (M220) Field Descriptions and Actions

Item	Input/Output	Description
Factor Type column	Output	Type of factor calculated for the beneficiary, such as CHF.
Part A column	Output	Part A factor calculated for the beneficiary for the factor type shown.
Part B column	Output	Part B factor calculated for the beneficiary for the factor type shown.
Standard Part D	Output	Part D factor calculated for the beneficiary for the factor type shown.
PIP-DCG column	Output	Principal Inpatient Diagnosis Cost Group (PIP-DCG) score calculated for the beneficiary.
Start Date column	Output	First day the factors were effective.
End Date column	Output	Last day the factors were effective.

Table 10-56: MCO Representative (View Only) (M220) Screen Messages

Message Type	Message Text	Suggested Action
No data	No factors found for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary-specific factors results for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary-specific factors information for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.3.13 Viewing Beneficiary Utilization

The beneficiary's utilization information indicates the beneficiary's use of Medicare, including home health care, billings, deductibles, remaining days of coverage, and additional coverage by Medicaid. When a beneficiary's Medicare coverage is under different claim numbers, these numbers are listed.

STEP 4t: Viewing the Beneficiary Detail: Utilization (M233) Screen

To access the *Beneficiary Detail: Utilization (M233)* screen, the user clicks on the |Utilization| menu item. This displays a screen, as shown in **Figure 10-55** and described in **Table 10-57**, with error and validation messages provided in **Table 10-58.**

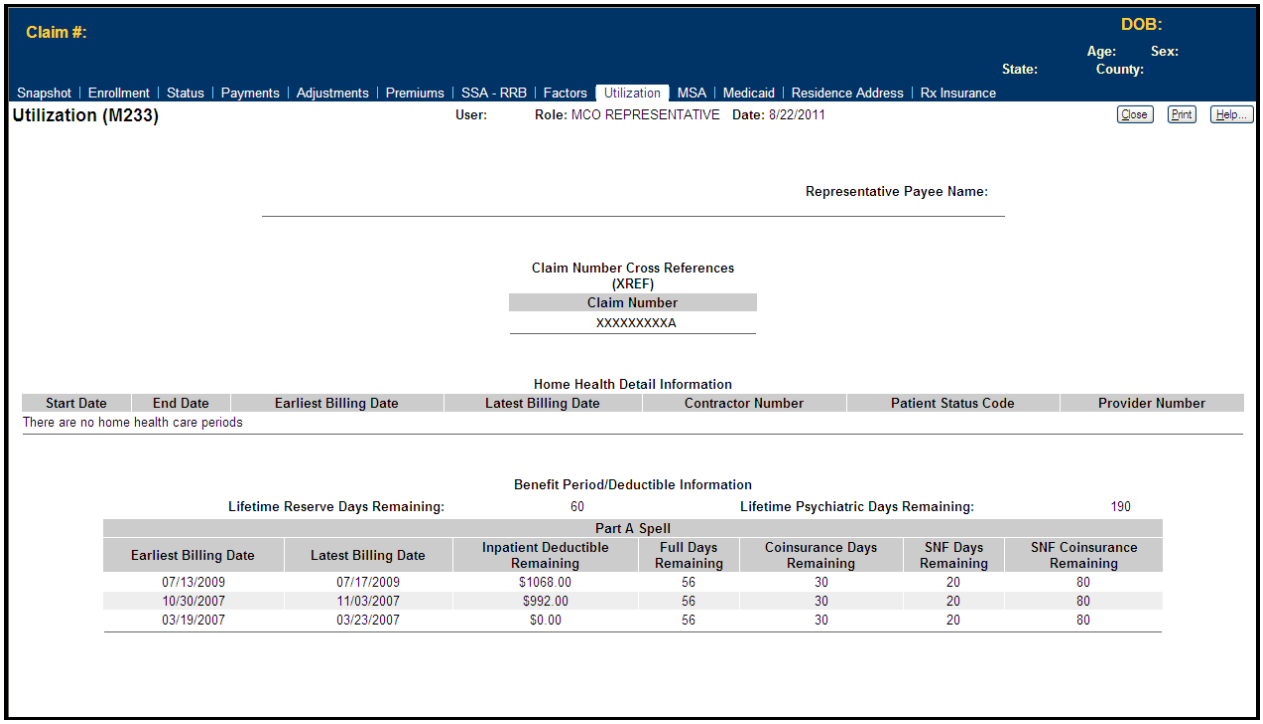


Figure 10-55: MCO Representative (View Only) Beneficiary Detail: Utilization (M233) Screen

Table 10-57: MCO Representative (View Only) (M233) Field Descriptions and Actions

Item	Input/Output	Description
Representative Payee Name	Output	Name of most recent representative for payment.
History of Claim Number Cross References (XREF)		
Claim Number column	Output	Claim number previously used by the beneficiary.
History of Home Health Care Information		
Start Date column	Output	Start of home health care period.
End Date column	Output	End of home health care period.
Earliest Billing Date column	Output	When billing began for this home health care period.
Latest Billing Date column	Output	When last bill was sent for this home health care period.
Contractor Number column	Output	Identifier of contractor for this home health care period.
Patient Status Code column	Output	Status of home health care for this home health care period.
Provider Number column	Output	Identifier of home health care provider for this home health care period.
History of Benefit Period/Deductible Information		
Lifetime Reserve Days Remaining	Output	Remaining reserve days left which Medicare will pay over beneficiary's lifetime.
Lifetime Psychiatric Days Remaining	Output	Remaining days of psychiatric care coverage.
Earliest Billing Date column	Output	When billing began for this benefit period.
Latest Billing Date column	Output	When last bill was sent for this benefit period.
Patient Deductible Remaining column	Output	Deductible balance for inpatient, e.g., hospital care that is remaining in the benefit period.
Full Days Remaining column	Output	Number of full days of inpatient care that are remaining in the benefit period.
Coinsurance Days Remaining column	Output	Number of coinsurance covered days of inpatient that are remaining in the benefit period.
Skilled Nursing Facilities (SNF) Days Remaining	Output	Number of days of SNF remaining in the benefit period.
SNF Coinsurance Remaining	Output	Number of coinsurance covered days of SNF remaining in the benefit period.

Table 10-58: M233 Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving beneficiary utilization for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid cross reference results	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid home health period results	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid benefit/deductible period results	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid Medicaid eligibility results	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input data to retrieve utilization	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.3.14 Viewing the Medicaid of a Beneficiary

Plans can access a Medicaid history for the enrollees; the history shows each beneficiary's Medicaid periods, by reporting source.

STEP 4u: Viewing the Beneficiary Detail: Medicaid (M236) Screen

To access the *Beneficiary Detail: Medicaid (M236)* screen, the user clicks on the |Medicaid| menu item. This displays a screen, as shown in **Figure 10-56,** with a list of Medicaid periods for this beneficiary. The information displays as follows:

- When a beneficiary has Medicaid periods reported by multiple entities, e.g., a State Medicaid program, a Plan, each reported Medicaid period is shown on a separate row.
- If there are non-contiguous Medicaid periods, e.g., when there is a break in Medicaid coverage, then each period is displayed on a separate row.
- If there is no Medicaid reported for a beneficiary, the Medicaid screen is empty.
- The screen does not provide Medicaid periods for dates that are not used in calculation Part C risk scores. CMS does not use Third Party Medicaid periods in calculating risk scores after Medicaid dates in 2007.

This is how the screen appears when it initially displays. This screen is described in **Table 10-59;** note that the details section is not yet displayed, with error and validation messages provided in **Table 10-60.**

Figure 10-56: MCO Representative (View Only) Beneficiary Detail: Medicaid (M236) Screen (Initial Display)

Table 10-59: MCO Representative (View Only) (M236) Field Descriptions and Actions

Item	Input/Output	Description
Medicaid sources		
Medicaid Period Start Date column	Output	Start date for each Medicaid period.
Medicaid Period End Date column	Output	End date for each Medicaid period.
Medicaid source column	Output	Type of Medicaid, e.g., Plan Medicaid, Third Party Medicaid through 2007, CMS User Medicaid, Point of Sale, Low-Income Territory, or State, for each Medicaid period.
Medicaid in the Medicaid source column	Link	The user clicks on this link to display details about the Medicaid period. For some Medicaid types, there are no additional details to display, so the Medicaid is displayed without a link.
Plan Reported		
Start Date column	Start Date column	Start Date column
End Date column	End Date column	End Date column
Start Source column	Start Source column	Start Source column
End Source column	End Source column	End Source column
Third Party Medicaid Details		
Start Date column	Start Date column	Start Date column
End Date column	End Date column	End Date column
Premiums Payer Code column	Premiums Payer Code column	Premiums Payer Code column

Item	Input/Output	Description
State Medicaid Details		
Start Date column	Start Date column	Start Date column
End Date column	End Date column	End Date column
Medicaid Eligibility column	Output	When the selected State Medicaid period started.
Dual Eligibility Status column	Output	Identifying description and code for a Dual Eligibility Status.
State column	Output	Identifying description and code for State
Point of Sale		
Start Date column	Output	Start Date column
End Date column	Output	End Date column
Low-Income Territory		
Start Date column	Output	Start Date column
End Date column	Output	End Date column

Table 10-60: MCO Representative (View Only) (M236) Screen Messages

Message Type	Message Text	Suggested Action
No data	No Medicaid information found for claim number	No corresponding data is available for that claim number.
Software or Database Error	Error occurred while retrieving beneficiary results for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary Medicaid history for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary Medicaid history	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

Note: The user can see only contracts to which the user has access. Therefore, the user may have gaps where they cannot see the Medicaid information.

To see the details of a particular status period, the user clicks on the Medicaid link in the Medicaid Source column for the corresponding Medicaid period. This expands the information on the *Beneficiary Detail: Medicaid (M236)* screen to include the Medicaid details. If contiguous periods combine into a single period on the initial display, that period now expands to show when each Medicaid detail was applicable. The contents of the details sections vary according to the type of Medicaid. For some Medicaid types, there are no additional details to display. The information is shown in **Figure 10-57** and was previously described in **Table 10-59**, with error and validation messages previously provided in **Table 10-60**.

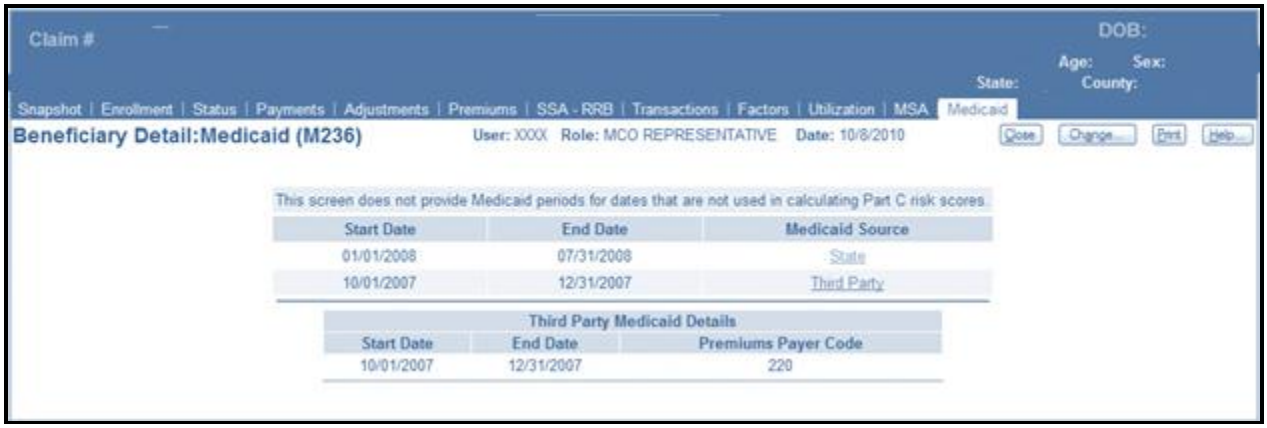


Figure 10-57: MCO Representative (View Only) Beneficiary Detail: Medicaid (M236) Screen (Expanded)

10.3.15 View Beneficiary MSA Lump Sum

The beneficiary's MSA Lump Sum screen indicates the MSA enrollment and payment information effective January 1, 2008.

STEP 4v: Viewing the Beneficiary Detail: MSA Lump Sum (M235) Screen

To access the *Beneficiary Detail: MSA Lump Sum (M235)* screen, the user clicks on the |MSA Lump Sum| menu item. This displays a screen, as shown in **Figure 10-58** and described in **Table 10-61**, with error and validation messages provided in **Table 10-62.**

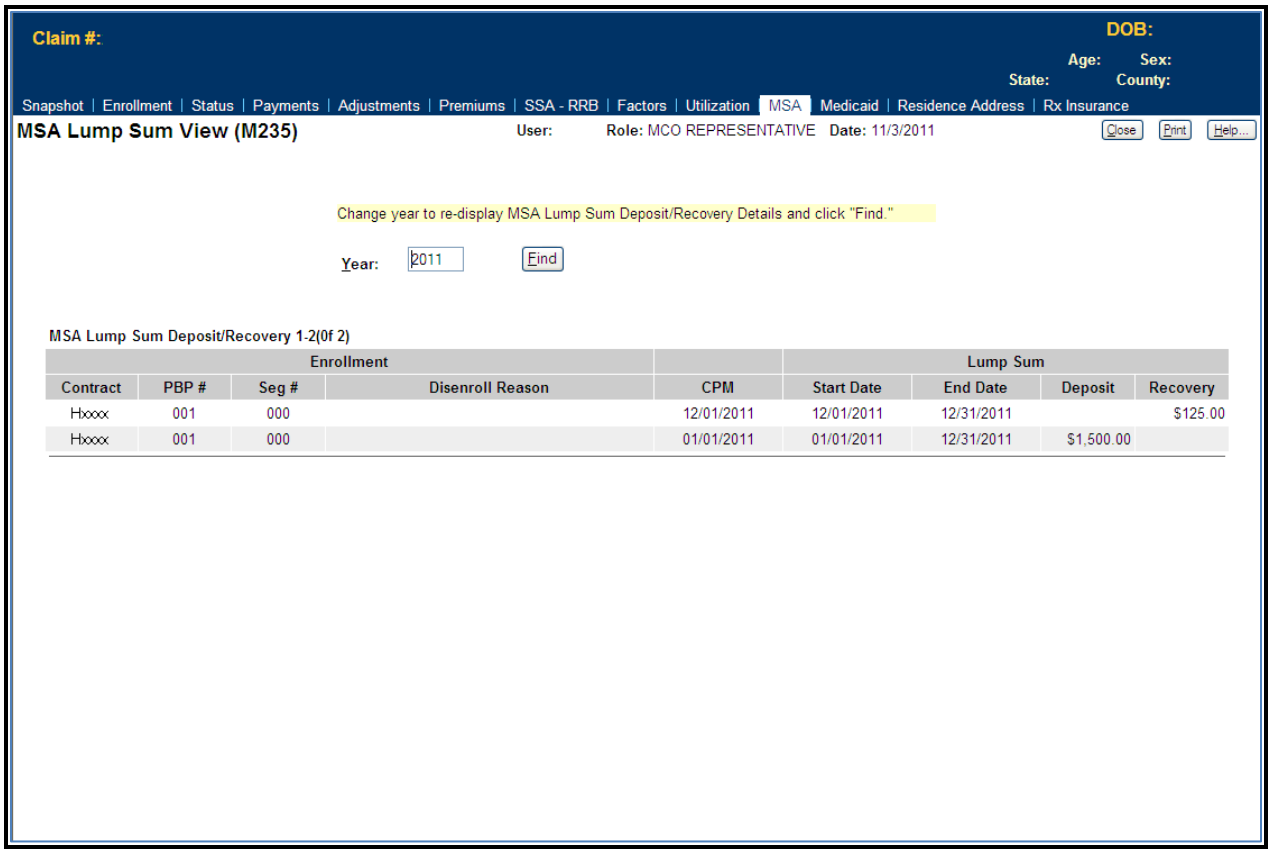


Figure 10-58: MCO Representative (View Only) Beneficiary Detail: MSA Lump Sum (M235) Screen

Table 10-61: MCO Representative (View Only) (M235) Field Descriptions and Actions

Item	Input/Output	Description
Search Criteria		
Year	Required data entry field	The user enters a year in the form YYYY.
[Find]	Button	The user clicks on this button to display MSA Lump Sum information in the lower portion of the screen.
MSA Lump Sum Deposit/Recovery		
Contract column	Output	Contracts for MSA Lump Sum record
PBP column	Output	PBPs for MSA Lump Sum record
Segment column	Output	Segments for MSA Lump Sum record
Disenroll Reason	Output	Description of the disenroll reason for MSA
Current Processing Month	Output	Current Processing Month for MSA Lump Sum record
Start Date	Output	Start date for Lump Sum.
End Date	Output	End date for Lump Sum.
Deposit	Output	Lump Sum deposit dollar amount
Recovery	Output	Lump Sum recovery dollar amount.

Table 10-62: MCO Representative (View Only) (M235) Screen Messages

Message Type	Message Text	Suggested Action
No data	No MSA Lump Sum information found for claim number <claim number> as of <year>	User enters a year greater than the one previously entered and searches again.
Software or Database Error	Error occurred while retrieving MSA Lump Sum results for claim number <claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.3.16 View Beneficiary Residence Address

SSA provides CMS with a beneficiary address. This is not always the address through which the Plan interfaces with the beneficiary. A Plan user with update authority may enter an address. These addresses are associated with the period of time during which each is effective. The M243 screen gives the Plan user an historical view of a beneficiary's residence addresses during the time they were enrolled in one of the Plans to which the user has access. The screen displays the beneficiary's historical residence address information, with the most recent address periods shown first. The Plan will only see residence address information for periods during which the beneficiary is enrolled in any of their Plans.

STEP 4w: Viewing the Residence Address View (M243) Screen

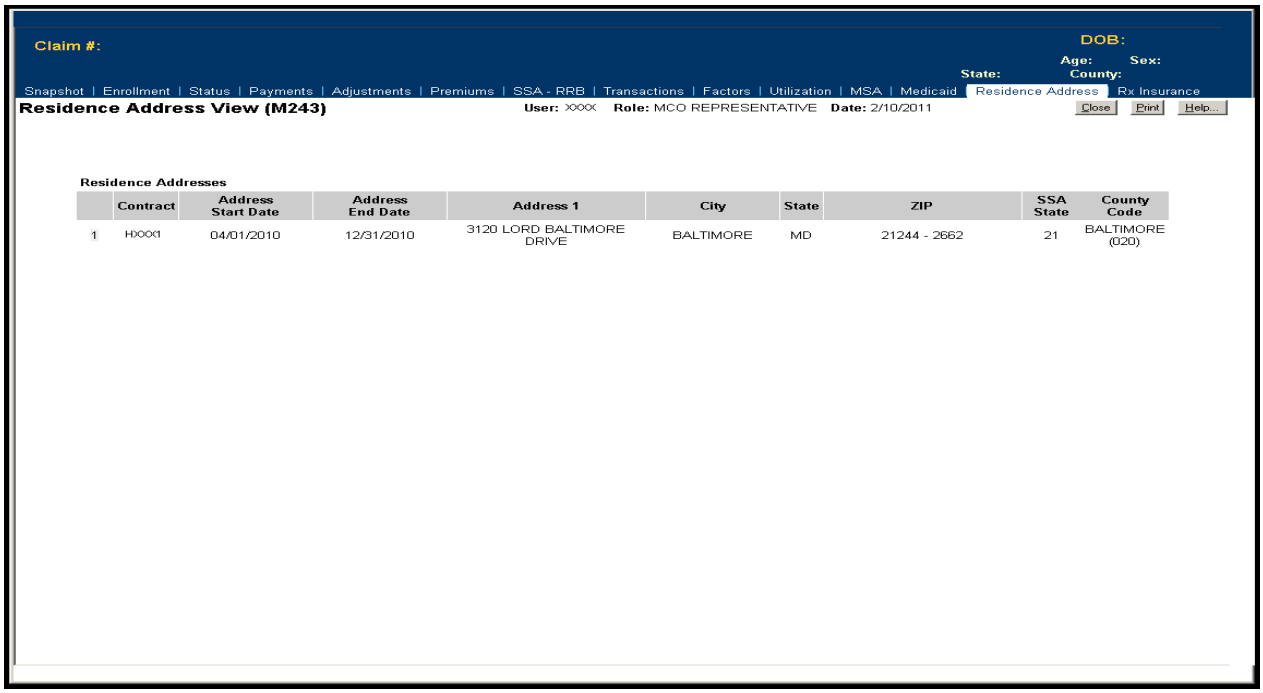


Figure 10-59: MCO Representative (View Only) Residence Address View (M243) Screen

Table 10-63: MCO Representative (View Only) (M243) Field Descriptions and Actions

Item	Input/Output	Description
Beneficiary's Residence Address Information This section contains one line for each period during which the beneficiary had a unique residence address, i.e., address where the beneficiary resided.		
Contract	Output	The contract for the applicable period.
Address Start Date	Output	Start date for the residence address listed on this line.
Address End Date	Output	End date for the residence address listed on this line.
Address 1	Output	Residence Street Address (Line 1) for the period on this line
Address 2	Output	Residence Street Address (Line 2, if applicable) for the period on this line.
City	Output	Residence City for the period on this line
State	Output	Residence State for the period on this line
Zip	Output	Residence Zip for the period on this line
SSA State Code	Output	The State Code assigned by SSA for the state on this line
SSA County Code	Output	The county where this residence is located, along with the County Code assigned by SSA for the county.

Table 10-64: MCO Representative (View Only) (M243) Screen Messages

Message Type	Message Text	Suggested Action
No data	No Residence Address information found for <claim number>.	No corresponding data is available for that claim number. If the user expects to see data, they should verify the claim number and try again. If the claim number is correct, the user should contact the MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary residence address results for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary residence address history for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid screen ID	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input on retrieval of beneficiary residence address history.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4x: Updating the Residence Address View (M243) Screen

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

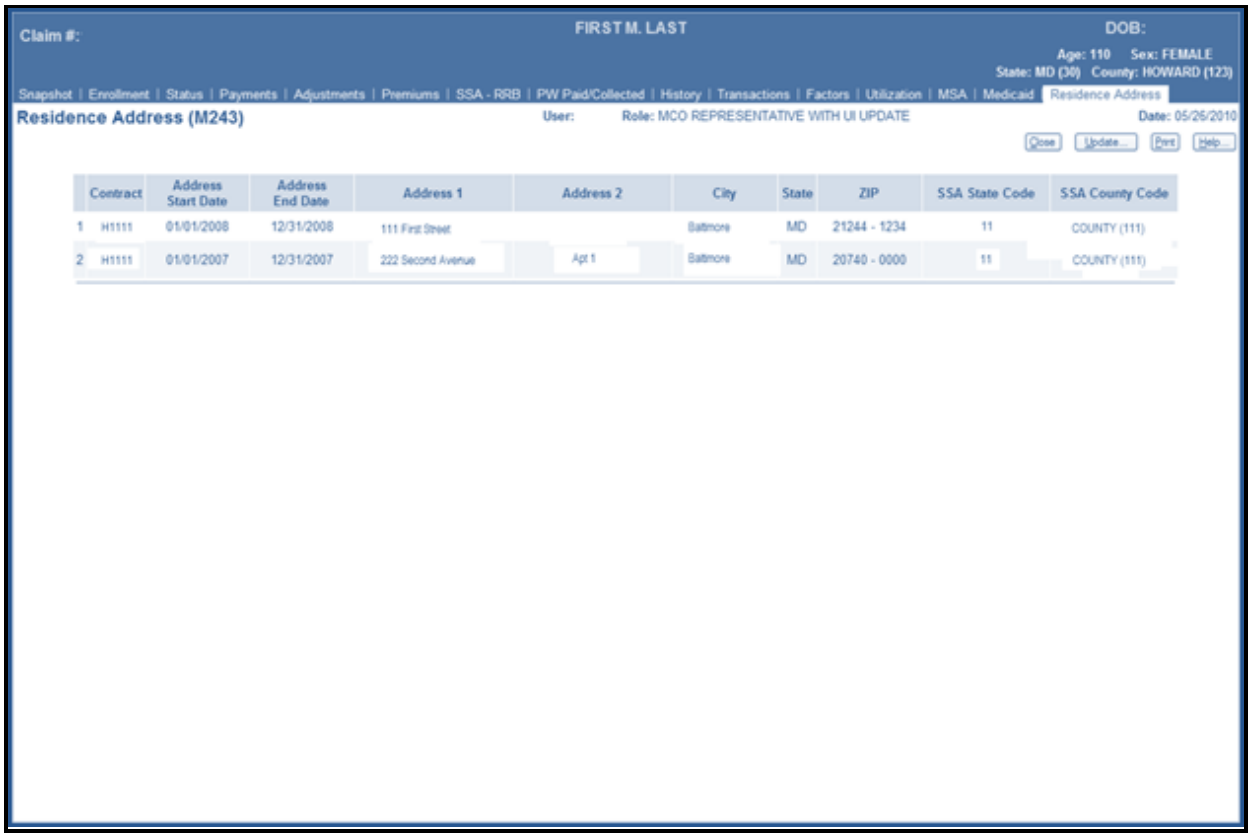


Figure 10-60: MCO Representative (UI Update) Residence Address View (M243) Screen

Table 10-65: MCO Representative (UI Update) (M243) Field Descriptions and Actions

Item	Input/Output	Description
Beneficiary's Residence Address Information This section contains one line for each period during which the beneficiary had a unique residence address, i.e., address where the beneficiary resides.		
[Update]	Button	This button takes the user to the Residence Address Update screen.
Contract	Output	The contract for the applicable period.
Address Start Date	Output	Start date for the residence address listed on this line.
Address End Date	Output	End date for the residence address listed on this line.
Address 1	Output	Residence Street Address (Line 1) for the period on this line.
Address 2	Output	Residence Street Address (Line 2) for the period on this line.
City	Output	Residence City for the period on this line.
State	Output	Residence State for the period on this line.
Zip	Output	Residence Zip for the period on this line.
SSA State Code	Output	The State Code assigned by SSA for the state on this line.
SSA County Code	Output	The county where this residence is located, along with the County Code assigned by SSA for the county.

STEP 4y: Updating the Update Residence Address View (M242) Screen

The following screen is new and is accessible only by users with update authorization.

The M242 screen allows the user with an update role to change or delete any address that is in the current list of residence address information and for periods where the user has access to those Plans. The screen also includes a blank line, labeled *New*, which allows the user to enter a new address for the beneficiary.

To open the Update Residence Address (M242) screen, click the Update button from the Residence Address (M243) screen.

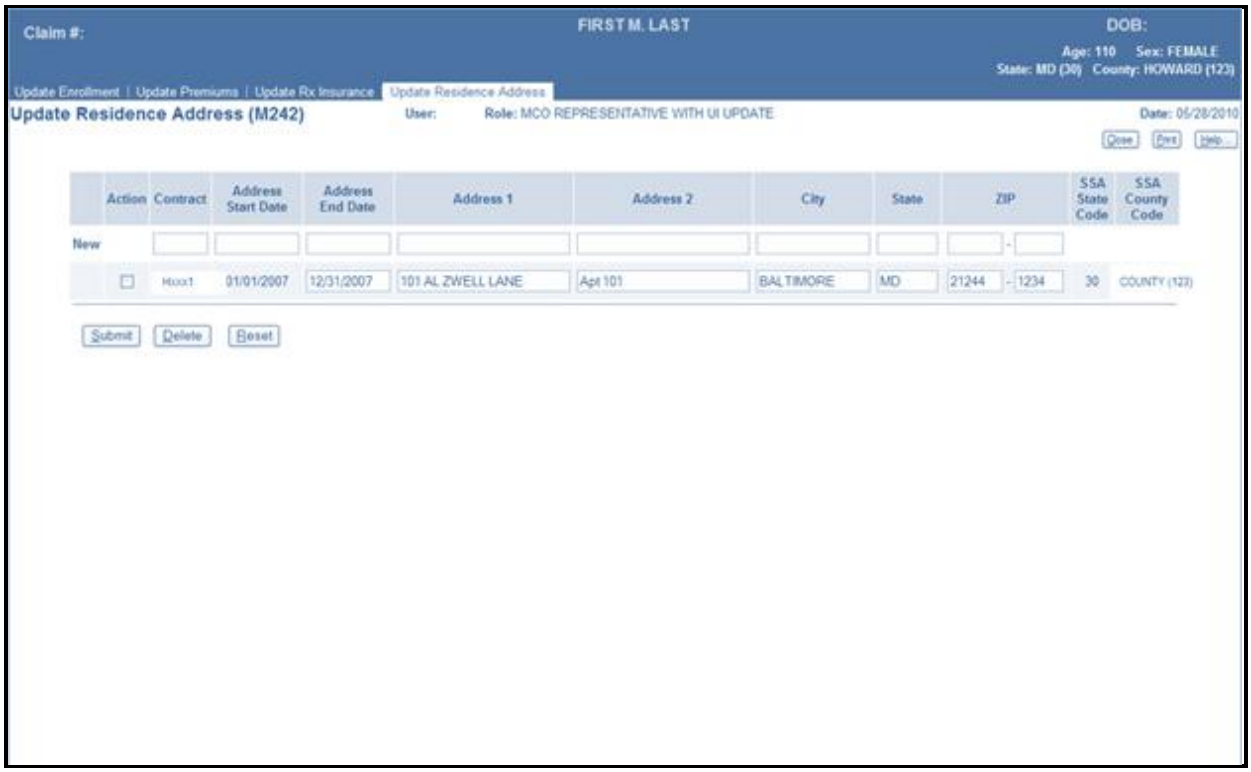


Figure 10-61: MCO Representative (UI Update) Update Residence Address View (M242) Screen

Table 10-66: MCO Representative (UI Update) (M242) Field Descriptions and Actions

Item	Input/Output	Description
The *New* Line This line is used to enter a new residence address, along with the effective time period. Users can only add addresses for periods during the beneficiary's enrollment in a contract to which the user has access.		
Contract	Input	The contract for the applicable period.
Address Start Date	Input	Start date for the residence address listed on this line. This date must occur during an enrollment that the user can view on the Enrollment (M203) screen.
Address End Date	Input	End date for the residence address listed on this line.
Address 1	Input	Residence Street Address (Line 1) for the period on this line.
Address 2	Input	Residence Street Address (Line 2, if applicable) for the period on this line.
City	Input	Residence City for the period on this line
State	Input	Residence State for the period on this line
Zip	Input	Residence Zip for the period on this line
Updating or Deleting Residence Address Information This section contains one line for each period that the beneficiary has a unique residence address (address where the beneficiary resides). The user can edit each line to mark it for delete or update the available fields.		
Action	Input	Check this box, then select the desired action (i.e. Submit, Delete, or Reset) when updating, deleting, or resetting information for an existing residence address period.
Contract	Output	The contract for the applicable period. *The user cannot update this field.*
Address Start Date	Output	Start date for the residence address listed on this line. *The user cannot update this field.*
Address End Date	Update	The user can add or update an End date for the residence address on this line.
Address 1	Update	Residence Street Address (Line 1) for the period on this line.
Address 2	Update	The user can add or update the Residence Street Address (Line 2) for the period on this line.
City	Update	Residence City for the address on this line.
State	Update	Residence State for the address on this line.
Zip	Update	Residence Zip for the address on this line.
SSA State Code	Output	The State Code assigned by SSA for the state on this line. The user cannot update this field as it automatically updates when the address is processed.
SSA County Code	Output	The county where this residence is located, along with the County Code assigned by SSA for the county. The user cannot update this field as it automatically updates when the address is processed.
Action Buttons These buttons operate on any selected lines by checking the Action checkbox.		
Submit	Button	Any address entered on the New line or address changes in a selected line is submitted for processing. After processing, the new addresses are viewable in the list of addresses for the beneficiary.
Reset	Button	On a selected line, any non-submitted values are reset to their original values.
Delete	Button	The address on the selected line is deleted from the beneficiary's addresses.

Table 10-67: MCO Representative (UI Update) (M242) Screen Messages

Message Type	Message Text	Suggested Action
No data	No Residence Address information found for <claim number>.	No corresponding data is available for that claim number. If the user expects to view data, they should verify the claim number and try again. If the claim number is correct, the user contacts the MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary residence address results for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary residence address history for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid screen ID	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input on retrieval of beneficiary residence address history.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4z: Viewing the Enrollment Detail (M222) Screen

The enrollment details show the information on the enrollment, disenrollment (as applicable), and Part D insurance information for a beneficiary in a Plan.

The *Enrollment Detail (M222)* screen is accessible by selecting a Contract # link from the *Beneficiary Detail: Enrollment (M204)* screen.

The screen, as shown in **Figure 10-62**, provides details of the selected enrollment or enrollment period. The screen is described in **Table 10-68**, with error and validation messages provided in **Table 10-69**.

Claim #:

DOB:

Age: Sex:

State: County:

Enrollment Detail (M222)

User: Role: Date:

Close Print Help...

Viewing Plan User: Plan Role:

Contract:	
MCO Name:	MEDICA HEALTHCARE PLANS, INC.
PBP Number:	001
Segment Number:	000
Drug Plan:	Y
Effective Start Date:	01/01/2012
Effective End Date:	03/31/2012
EGHP:	
Enrollment Forced Code:	
Disenrollment Reason Code and Description:	07 - FOR CAUSE
Application Date:	12/30/2011
Default App. Date:	
Enrollment Election Type:	S - SPECIAL ELECTION PERIOD (SEP)
Disenrollment Election Type:	S - SPECIAL ELECTION PERIOD (SEP)
Special Needs Type:	
Enrollment Source:	B - BENEFICIARY ELECTION
Part D Auto-Enrollment Opt-Out:	
Part D Rx Bin:	
Part D Rx PCN:	
Part D Rx Group:	
Part D Rx ID:	

Figure 10-62: MCO Representative (View Only) Enrollment Detail (M222) Screen

Table 10-68: MCO Representative (View Only) (M222) Field Descriptions and Actions

Item	Input/Output	Description
Contract	Output	Contract number in which the beneficiary is enrolled.
MCO Name	Output	Name of the contract.
PBP Number	Output	PBP in which the beneficiary is enrolled, when applicable.
Segment Number	Output	Segment in which the beneficiary is enrolled, when applicable.
Drug Plan	Output	Indicates whether the contract provides drug insurance coverage. The user sets to Y or N.
Effective Start Date	Output	Start of enrollment.
Effective End Date	Output	End of enrollment, when applicable.
EGHP	Output	Indicates whether the enrollment is an EGHP. The user sets to Y or N.
Enrollment Forced Code	Output	Reason for overriding certain membership validation rules, when applicable.
Disenrollment Reason Code	Output	Reason for disenrollment, when applicable.
Application Date	Output	The date the Plan received the beneficiary's completed enrollment application.
Enrollment Election Type	Output	Type of election period when enrollment took place.
Disenrollment Election Type	Output	Type of election period when disenrollment took place.
Special Needs Type	Output	Type of special needs population for which the Plan provides coverage, e.g., Institutional, Dual Eligible, or Chronic or Disabling Condition.
Enrollment Source	Output	The action that triggered the enrollment: automatically enrolled by CMS, beneficiary election, or facilitated enrollment by CMS.
Part D Auto-Enrollment Opt-Out	Output	Indicates whether the beneficiary opted out of Part D coverage. Applies only to automatic enrollments by CMS. Set to Y or N.
Part D Rx Bin	Output	Card issuer identifier or a bank identifying number used for network routing.
Part D Rx PCN	Output	Identifier assigned by the processor.
Part D Rx Group	Output	Identifying number assigned to the cardholder group or employer group.
Part D Rx ID	Output	Member ID assigned to the beneficiary.

Table 10-69: MCO Representative (View Only) (M222) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving beneficiary enrollment information	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input retrieving beneficiary enrollment information	The user should access Appendix B for contact information to report the error.
Software or Database Error	Beneficiary enrollment information is missing	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database = <error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

STEP 5: View Beneficiary Eligibility – Beneficiary Eligibility Query via the UI

Beneficiary eligibility provides information regarding a beneficiary's entitlement for Part A, Plan B, and eligibility for Part D, as applicable and relevant to the Plan. If the beneficiary is eligible for the Part D LIS, then the number of uncovered months is indicated, as are then the details of that subsidy. Periods when a beneficiary is covered in a Plan that qualifies for the Retiree Drug Subsidy (RDS) are shown. Periods when a beneficiary was covered in a Part D Plan are also shown. Depending upon the user's access rights, either the current information or the complete history is shown. Plans may also submit Batch Eligibility Queries as described in Section 6 of this guide.

STEP 5a: Viewing the Beneficiary: Eligibility (M232) Screen

From the main menu, the user clicks on the |Beneficiaries| menu item, and then clicks on the |Eligibility| submenu item to view the *Beneficiary: Eligibility (M232)* screen.

The next step is to identify the beneficiary by claim number on the *Beneficiary: Eligibility (M232)* screen, which is shown in **Figure 10-63;** note that beneficiary identification, entitlement, eligibility, number of uncovered months, employer subsidy, Part D enrollment, and low-income status are not yet shown but appear later on this screen and described in **Table 10-70**, with error and validation messages provided in **Table 10-71**.

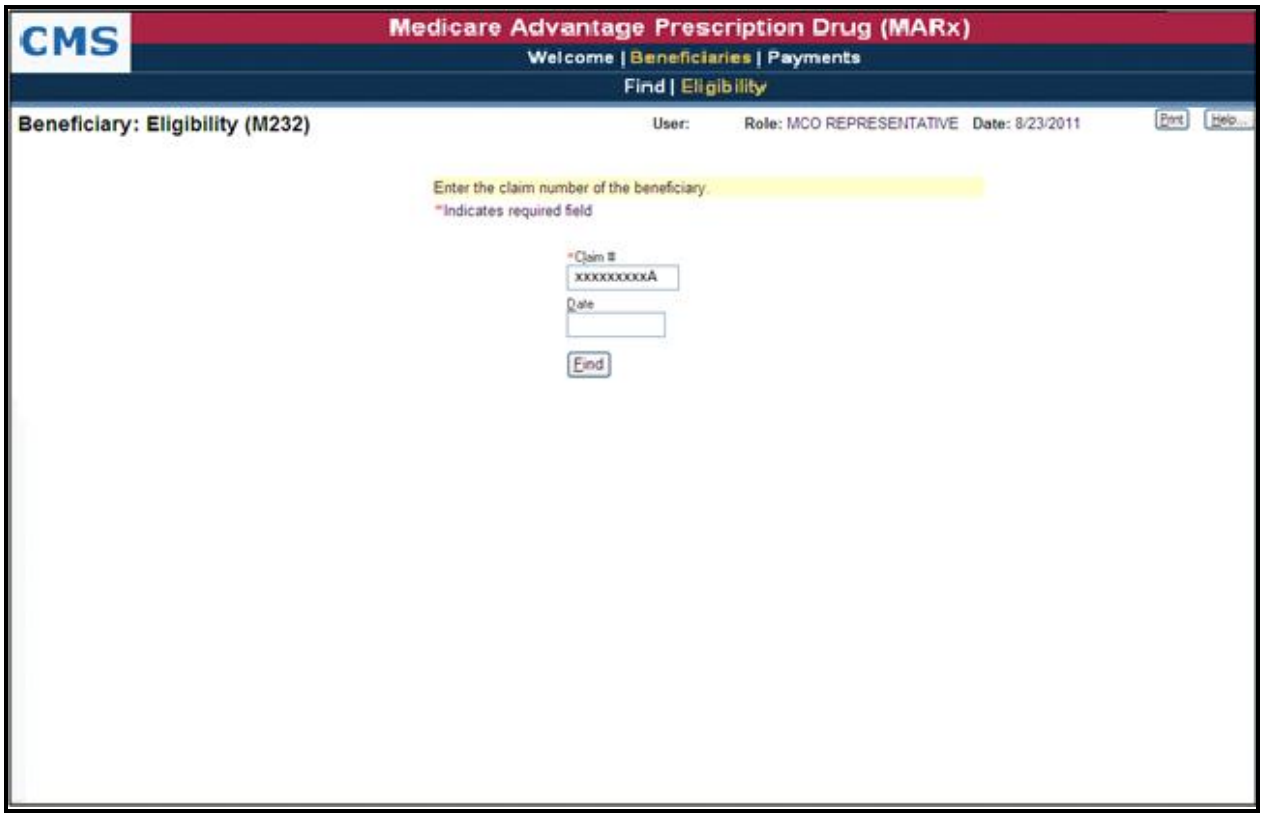


Figure 10-63: MCO Representative (View Only) Beneficiary: Eligibility (M232) Screen (Initial)

Table 10-70: MCO Representative (View Only) (M232) Field Descriptions and Actions

Item	Inputs/Outputs	Description
Search Criteria		
Claim #	Required data entry field	Identifies the beneficiary whose eligibility information displays.
Date	Date field	Provide eligibility information as of this date.
[Find]	Button	The user clicks on this button after entering the claim number of the beneficiary. If the beneficiary is found, eligibility information for the beneficiary is displayed.
Beneficiary Identification		
Claim Number	Output	Claim number of beneficiary.
Claim Number Cross Reference	Output	Most recent cross-referenced claim number of the beneficiary.
Name	Output	Name of beneficiary.
Birth Date	Output	Date of birth of beneficiary.
Date of Death	Output	Date of death of beneficiary.
Sex	Output	Sex of beneficiary.
Address	Output	Street address, city, state, and zip code of beneficiary.
Most recent State	Output	The most recent state on record for the beneficiary.

Item	Inputs/Outputs	Description
Most recent County	Output	The most recent county on record for the beneficiary.
Enrollment Information		
Contract	Output	Contract number for the beneficiary's enrollment(s).
Start	Output	Start date of the beneficiary's enrollment(s).
Drug Plan	Output	Drug Plan indicator for the beneficiary's enrollment(s).
Entitlement Information		
Part column	Output	Entitlement information that applies to the Part A and Part B of Medicare.
Start column	Output	When the entitlement period began.
End column	Output	When the entitlement period ended, as applicable.
Option column	Output	Option selected for this part.
Eligibility Information		
Part column	Output	Eligibility information that applies to this Part D of Medicare.
Start column	Output	When the eligibility period began.
End column	Output	When the eligibility period ended, as applicable.
NUNCMO		
Start Date	Output	Start Date for uncovered months period.
Indicator	Output	Indicator showing record type.
NUNCMO	Output	NUNCMO.
Total NUNCMO	Output	Total NUNCMO based on the Indicator.
Record Add-Timestamp	Output	Timestamp for when the record was added.
Employer Subsidy		
Start Date column	Output	When a Retiree Drub Subsidy coverage period began.
End Date column	Output	When a RDSRDS coverage period ended.
Part D Enrollment		
Start Date column	Output	When a Part D enrollment began for the beneficiary.
End Date column	Output	When a Part D enrollment ended for the beneficiary.
Low-Income Status		
Subsidy Start Date column	Output	When the subsidy of Part D premiums began.
Subsidy End Date column	Output	When the subsidy of Part D premiums ended, as applicable.
Premium Subsidy Level column	Output	Level at which the premiums are subsidized.
Co-Payment Level column	Output	Level of co-payment that the beneficiary must pay.
Subsidy Source Column	Output	The source of LIS subsidy.

Table 10-71: MCO Representative (View Only) (M232) Screen Messages

Message Type	Message Text	Suggested Action
No claim number	A claim number must be entered.	The user enters the claim number.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	The user re-enters the claim number.
Invalid format	The claim number is missing the required BIC.	The user changes the claim number to include both CAN and BIC.
Invalid date	Date is invalid. Must have format (M)M/(D)D/YYYY	The user re-enters the date.
Informational	The beneficiary is not enrolled in any Plan for "MM/DD/YYYY."	None.
Informational	There is no eligibility information for the beneficiary.	None.
Informational	There are no employer subsidies for the beneficiary	None.
Informational	There is no Part D enrollment information for the beneficiary	None.
Informational	There are no low-income subsidies for the beneficiary	None.
Informational	There are no number of uncovered months for the beneficiary	None.
Informational	Pre-enrollment information for the beneficiary is displayed	None.
No data	Beneficiary not found	The user checks the claim number. If it is incorrect, the user re-enters it.
Software or Database Error	Error occurred while retrieving beneficiary entitlement information	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving Part D Enrollment information for claim number<claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving number of uncovered months information for claim number<claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary low-income status information for claim number<claim number>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

After the claim number is entered, the user clicks the [Find] button to show the beneficiary's identification to verify that the correct claim number was entered, followed by the beneficiary's entitlement and eligibility information past periods of RDSRDS and/or Part D enrollment, and low-income status. The information is displayed on the same screen, below the search criteria, as shown in **Figure 10-64**.

xxxxxxxxxA

CMS

Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Payments

Find | Eligibility

Beneficiary: Eligibility (M232) User: Role: MCO REPRESENTATIVE Date: 8/23/2011 Print Help...

Enter the claim number of the beneficiary
*Indicates required field

*Claim #
xxxxxxxxxA
Date

Find

Claim Number: xxxxxxxxxA
Claim Number Cross Reference: xxxxxxxxxA
Name: BENEFICIARY NAME
Birth Date: 07/03/1936
Date of Death:
Sex: M
Address: ADDRESS

Most recent State: OK (37)
Most recent County: WAGONER (720)

Enrollment Information for 08/23/2011		
Contract	Start	Drug Plan
Hxxxx	01/01/2011	N
Sxxxx	01/01/2011	Y

Entitlement Information			
Part	Start	End	Option
A	07/01/2001		E
B	07/01/2001		Y

Eligibility Information		
Part	Start	End
D	01/01/2006	

Number of Uncovered Months				
Start Date	Indicator	Number of Uncovered Months	Total Number of Uncovered Months	Record Add-Time Stamp
02/01/2006		0	0	01/28/2006 0:0:0
01/01/2007		0	0	12/19/2006 0:0:0
01/01/2009		0	0	12/05/2008 0:0:0
01/01/2010		0	0	12/16/2009 0:0:0
01/01/2011		0	0	12/03/2010 0:0:0

Employer Subsidy	
Start	End
There are no employer subsidies for the beneficiary	

Part D Enrollment	
Start	End
04/01/2005	07/31/2005
02/01/2006	

Low Income Status				
Subsidy Start Date	Subsidy End Date	Premium Subsidy Level	Co-Payment Level	Subsidy Source
There are no low income subsidies for the beneficiary				

Figure 10-64: MCO Representative (View Only) Beneficiary: Eligibility (M232) Screen (with Eligibility Information)

Entitlement, Eligibility, employer subsidy, and LIS display as follows:

- If a date is entered, then only the information for that date is shown.
- If a date is not entered and the beneficiary is enrolled in one of the user's Plans, then current, historical, and future information is shown.
- If the beneficiary is not enrolled in one of the user's Plans, then only the current information is shown.
- When the beneficiary was not covered by a Plan that received the RDSRDS, a message is displayed in the Employer Subsidy section.
- When the beneficiary does not receive a Part D LIS, message displays in the LIS section.

NUNCMO section displays as follows:

Tool tips display when hovering over the Indicator and Record Type columns Part D enrollments display as follows:

- The 10 most recent periods of Part D enrollment are shown, including Plans with employer subsidies.
- If there are several Part D enrollments back to back, the screen displays the start date of the first enrollment and the end date of the last enrollment.
- When the beneficiary does not have Part D Enrollment information, a message displays in the Part D Enrollment section.

Enrollment Information displays as follows:

- The Contract number, Effective date, and Drug Plan indicator of the beneficiary's current enrollment in the PBP is displayed.
- If the beneficiary is dual enrolled, the system displays the drug and non-drug Contract information for both of the beneficiary's current enrollments in PBPs.
- If the beneficiary is enrolled in a Plan that does not have PBPs, the Contract, Drug Plan indicator and the Effective date of the beneficiary's current enrollment is displayed.
- If the user enters a date in the "Date" field, the system considers the entered date as the current date when displaying the beneficiary's current enrollment information.

The inputs, outputs, and actions, as well as the error and validation messages, are described previously in **Tables 10-70** and **10-71**, respectively.

10.3.17 View Beneficiary Rx Insurance

STEP 6: Viewing the Rx Information for a Beneficiary

A Plan can use the M244 screen to view the Rx Insurance history, both primary and secondary, for beneficiaries enrolled in their Plans. The screen displays the beneficiary's 4Rx information as it has changed over time. The Plan only sees 4Rx information for periods during which the beneficiary is enrolled in any of their Part D Plans.

STEP 6a: Viewing the Rx Insurance View (M244) Screen

To access the Rx Insurance (M244) screen, select the Rx Insurance tab.

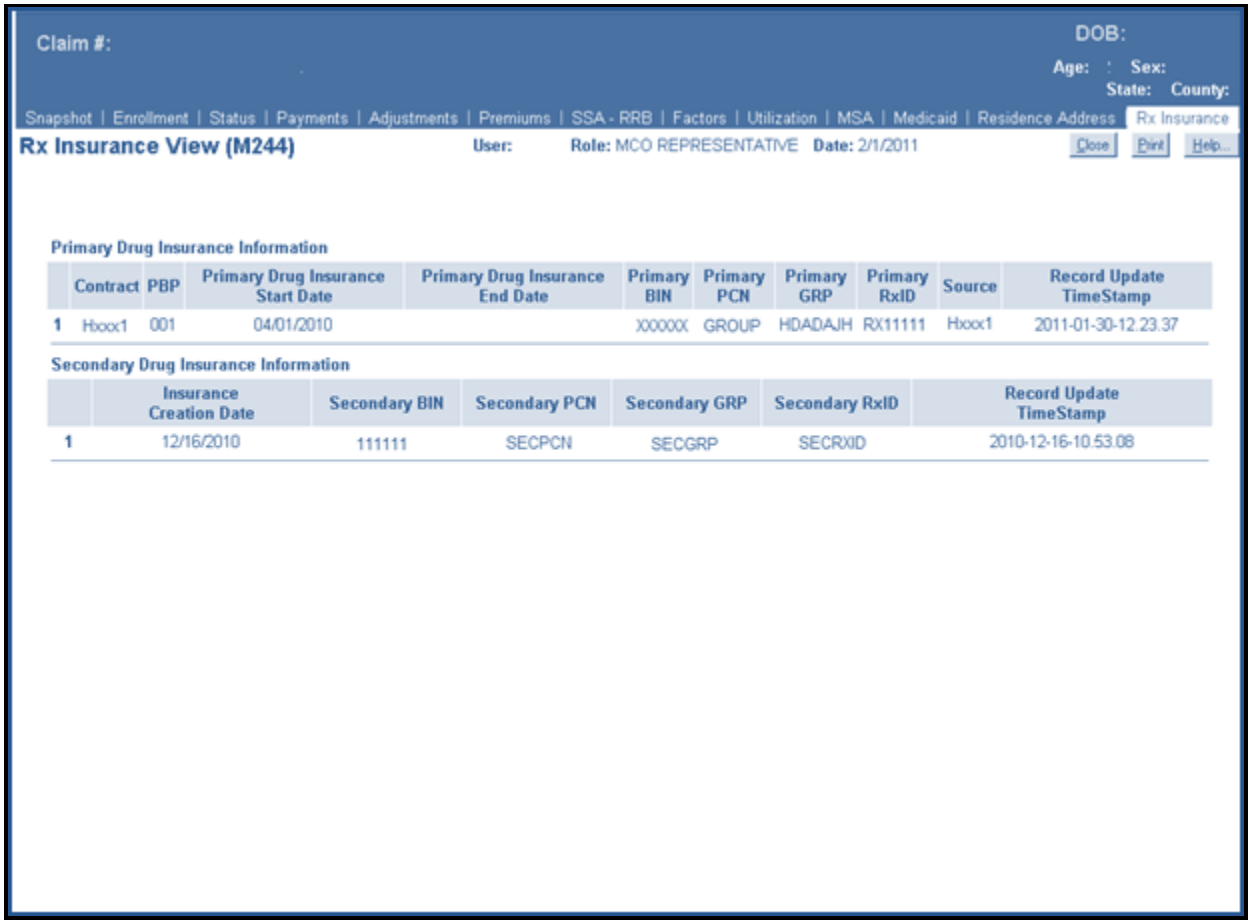


Figure 10-65: MCO Representative (View Only) Rx Insurance View (M244) Screen

Table 10-72: MCO Representative (View Only) (M244) Field Descriptions and Actions

Item	Input/Output	Description
Primary Drug Insurance Information This section contains one line for each period during which the beneficiary had a unique combination of Contract, PBP and Primary 4Rx information.		
Contract	Output	The contract for the applicable period.
PBP #	Output	The PBP for the applicable period.
Primary Drug Insurance Start Date	Output	Start date for Primary 4Rx information on this line.
Primary Drug Insurance End Date	Output	End date for the Primary 4Rx information on this line.
Primary BIN	Output	Part D insurance Plan's BIN for the primary contract, PBP, and period specified.
Primary PCN	Output	Part D insurance Plan's PCN for the primary contract, PBP, and period specified.
Primary GRP	Output	Part D insurance Plan's group number for the primary contract, PBP, and period specified.
Primary RxID	Output	Identifier assigned to the beneficiary by the primary Part D insurance Plan for drug coverage.
Source	Output	Source of the enrollment into the contract and PBP for the period specified.
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated.
Secondary Drug Insurance Information This section contains one line for each period during which the beneficiary had a unique combination of Contract, PBP and Secondary 4Rx information.		
Insurance Creation Date	Output	Date that was reported for the initiation of this secondary insurance period.
Secondary BIN	Output	Secondary drug insurance Plan's BIN number.
Secondary PCN	Output	Secondary drug insurance Plan's PCN number.
Secondary GRP	Output	Identifier for the group providing secondary drug insurance coverage.
Secondary RxID	Output	Identifier assigned to the beneficiary by the secondary drug insurance.
Record Update Timestamp	Output	Date this row was added or updated.

Table 10-73: MCO Representative (View Only) (M244) Screen Messages

Message Type	Message Text	Suggested Action
No data	No primary drug insurance information found for <claim number>.	No corresponding data available for claim number. If user expects to see data, verify the claim number and try again. If claim number is correct, user contacts MAPD Help Desk for assistance.
No data	No secondary drug insurance information found for <claim number>.	No corresponding data available for claim number. If user expects to see data, verify the claim number and try again. If claim number is correct, user contacts MAPD Help Desk for assistance.
Software or Database Error	Invalid primary drug insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid secondary drug insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving drug insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input retrieving drug insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 6b: Updating the Rx Insurance View (M244) Screen

From this screen, the user with the MCO Representative with UI Update role may select the UPDATE button to update this beneficiary's enrollment information.

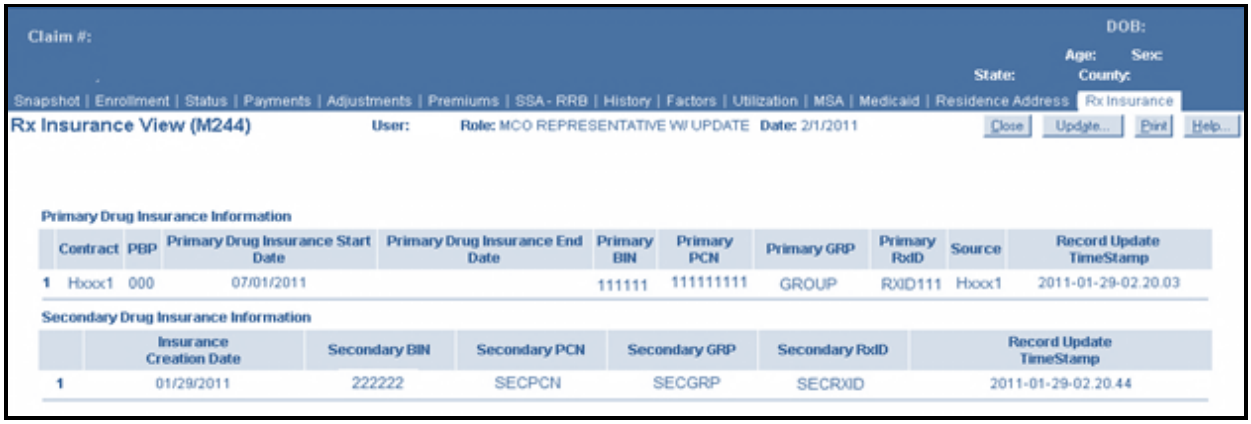


Figure 10-66: MCO Representative (UI Update) Rx Insurance View (M244) Screen

Table 10-74: MCO Representative (UI Update) (M244) Field Descriptions and Actions

Item	Input/Output	Description
[Update]	Button	Takes the user to the Update Rx Insurance Screen (M228).
Primary Drug Insurance Information This section contains one line for each period during which the beneficiary had a unique combination of Contract, PBP, and Primary 4Rx information.		
Contract	Output	Contract in which the beneficiary was enrolled during the period on this line.
PBP #	Output	The PBP in which the beneficiary was enrolled during the period on this line.
Primary Drug Insurance Start Date	Output	Start date for the Primary Rx Insurance listed on this line.
Primary Drug Insurance End Date	Output	End date for the Primary Rx Insurance listed on this line.
Primary BIN	Output	Part D insurance Plan's BIN for the primary contract, PBP, and period specified.
Primary PCN	Output	Part D insurance Plan's PCN for the primary contract, PBP, and period specified.
Primary GRP	Output	Part D insurance Plan's group number for the primary contract, PBP, and period specified.
Primary RxID	Output	Identifier assigned to the beneficiary by the primary Part D insurance Plan for drug coverage.
Source	Output	Source of the enrollment into the contract and PBP for the period specified.
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated.
Secondary Drug Insurance Information This section contains one line for each period during which the beneficiary had a unique combination of Contract, PBP, and Secondary 4Rx information.		
Insurance Creation Date	Output	Date reported for the initiation of this secondary insurance period.
Secondary BIN	Output	Secondary drug insurance Plan's BIN number.
Secondary PCN	Output	Secondary drug insurance Plan's PCN number.
Secondary GRP	Output	Identifier for the group providing secondary drug insurance coverage.
Secondary RxID	Output	Identifier assigned to the beneficiary by the secondary drug insurance.
Record Update Timestamp	Output	Date Rx insurance information was added or updated.

Table 10-75: MCO Representative (UI Update) (M244) Screen Messages

Message Type	Message Text	Suggested Action
No data	No primary drug insurance information found for <claim number>.	No corresponding data is available for that claim number. If the user expects to view data, they should verify the claim number and try again. If the claim number is correct, the user should contact the MAPD Help Desk for assistance.
No data	No secondary drug insurance information found for <claim number>.	No corresponding data is available for that claim number. If the user expects to view data, they should verify the claim number and try again. If the claim number is correct, the user should contact the MAPD Help Desk for assistance.
Software or Database Error	Invalid primary drug insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid secondary drug insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving drug insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input retrieving drug insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 6c: Updating the Rx Insurance View (M228) Screen

The following screen is new and is accessible only by users with update authorization.

Plans can use the M228 screen to view, update, and add new Rx Insurance information, both primary and secondary, for beneficiaries enrolled in its Plan. The screen displays the beneficiary's 4Rx history. The Plan only views 4Rx information for periods during which the beneficiary is enrolled in any of its Part D Plans.

To access the *Update Rx Insurance (M228)* screen, select the Update button from the *Rx Insurance (M244)* screen.

Claim #:

DOB:

Age: Sex:

State: County:

Update Enrollment | Update Premiums | Update Rx Insurance | Update Residence Address

Update Rx Insurance (M228) User: Role: MCO REPRESENTATIVE W/ UPDATE Date: 2/15/2011 Close Print Help...

Primary Drug Insurance Information

	Action	Contract	PBP	Primary Drug Insurance Start Date	Primary Drug Insurance End Date	Primary BIN	Primary PCN	Primary GRP	Primary RxID	Source	Record Update TimeStamp
New											
1	☐	Hxxx1	017	03/01/2008	10/31/2009	610649	03200000	P5390	H52902688		2009-10-29-10.49.43
2	☐	Hxxx1	002	01/01/2008	01/31/2008	004336	ADV	Rx8503	073620093		2008-01-11-05.20.10
3	☐	Hxxx1	002	02/01/2006	12/31/2007	610468	MDARBCBS	5600490	100542148	R3444	2007-12-29-06.44.59

Secondary Drug Insurance Information

	Action	Insurance Creation Date	Secondary BIN	Secondary PCN	Secondary GRP	Secondary RxID	Record Update TimeStamp
New							
1	☐	01/09/2006	004336	MDARBCBS	5600490	100542148	2006-01-09-01.49.14

Delete Submit Reset

Figure 10-67: MCO Representative (UI Update) Update Rx Insurance View (M228) Screen

Table 10-76: MCO Representative (UI Update) (M228) Field Descriptions and Actions

Item	Input/Output	Description
The *New* Line for Primary Rx Insurance This line is used to enter new Primary Rx Insurance information, along with the effective time period, and the contract and PBP that the beneficiary is enrolled in during the applicable time period. The user may only add Primary Rx Insurance for periods during which the beneficiary's enrollment is in a contract to which the user has access.		
Contract	Input	Contract in which the beneficiary was enrolled during the period on this line.
PBP	Input	The PBP in which the beneficiary was enrolled during the period on this line.
Primary Rx Insurance Start Date	Input	Start date for the Primary Rx Insurance listed on this line. This date must fall during an enrollment that the user can view on the Enrollment (M203) screen.
Primary Rx Insurance End Date	Input	End date for the Primary Rx Insurance listed on this line.
Primary BIN	Input	BIN for the Primary Rx Insurance period on this line.
Primary PCN	Input	PCN for the Primary Rx Insurance period on this line.
Primary GRP	Input	GRP for the Primary Rx Insurance period on this line.
Primary RxID	Input	RxID for the Primary Rx Insurance period on this line.
The *New* Line for Secondary Rx Insurance This line is used to enter new Secondary Rx Insurance information.		
Secondary Rx Insurance	Input (dropdown)	Select "Yes" from the dropdown list to indicate that this is a Secondary Rx Insurance entry.
Secondary BIN	Input	BIN for the Secondary Rx Insurance period on this line.
Secondary PCN	Input	PCN for the Secondary Rx Insurance period on this line.
Secondary GRP	Input	GRP for the Secondary Rx Insurance period on this line.
Secondary RxID	Input	RxID for the Secondary Rx Insurance period on this line.
Item	Type	Description
Update or Delete Primary Rx Insurance Information This section contains one line for each period that the beneficiary had a unique Primary Rx Insurance period. The user can mark each line to delete or to update the available fields.		
Action	Input (Checkbox)	Check this box, and then use the buttons at the bottom of the screen to select the desired action (i.e. Submit, Delete, or Reset) for this line.
Contract	Output	Contract in which the beneficiary was enrolled during the period on this line. *The user cannot update this field.*
PBP	Output	The PBP in which the beneficiary was enrolled during the period on this line. *The user cannot update this field.*
Primary Rx Insurance Start Date	Output	Start date for the Primary Rx Insurance listed on this line. *The user cannot update this field.*
Primary Rx Insurance End Date	Update	The user can add or update an end date for the Primary Rx Insurance on this line.
Primary BIN	Update	The user can update the BIN for the Primary Rx Insurance on this line.
Primary PCN	Update	The user can update the PCN for the Primary Rx Insurance on this line.
Primary GRP	Update	The user can update the GRP for the Primary Rx Insurance on this line.
Primary RxID	Update	The user can update the RxID for the Primary Rx Insurance on this line.
Source	Output	Source of the Rx insurance information for the period specified. The Rx Information is submitted on an enrollment transaction code (TC 61), a Plan change transaction (TC 72), or through a UI update. If the update is completed through the UI, the source is the user's ID. *The user cannot update this field as it will automatically update when the Primary Rx Change is processed.*

Item	Input/Output	Description
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated. *The user cannot update this field as it will automatically update when the Primary Rx Change is processed.*
Update or Delete Secondary Rx Insurance Information This section contains one line for each period that the beneficiary had a unique Secondary Rx Insurance period. The user can mark each line to delete or to update the available fields.		
Action	Input (Checkbox)	Check this box, then select the *delete* button to delete this line of existing Secondary Insurance information.
Secondary Rx Insurance	Output	Yes indicates that the line represents Secondary Insurance Information.
Insurance Creation Date	Output	Date that was reported for the initiation of this secondary insurance period. *The user cannot update this field.*
Secondary BIN	Update	The user can update the BIN for the Secondary Rx Insurance period on this line.
Secondary PCN	Update	The user can update the PCN for the Secondary Rx Insurance period on this line.
Secondary GRP	Update	The user can update the GRP for the Secondary Rx Insurance period on this line.
Secondary RxID	Update	The user can update the RxID for the Secondary Rx Insurance period on this line.
Source	Output	Source of the Rx insurance information for the period specified. The Rx Information is submitted on an enrollment transaction (TC 61), a Plan change transaction (TC 72), or through a UI update. If the update is conducted through the UI, the source is the user's ID. *The user cannot update this field as it will automatically update when the Primary Rx Change is processed.*
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated.
Action Buttons These buttons operate on any lines that are selected by checking the Action checkbox.		
Submit	Button	Any Rx Insurance Information entered on the New line or Rx Information changes in a selected line are submitted for processing. After processing, a new line of Rx Insurance Information is displayed for the beneficiary.
Reset	Button	Any updated, or changed, values that are not submitted are reset to their original values.
Delete	Button	The Rx Insurance Information on the selected line is deleted from the beneficiary's record.

Table 10-77: MCO Representative (UI Update) (M228) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	A Primary RxID must be entered	Provide the RxID for the primary Rx insurance.
Missing entry	A Primary Rx Group must be entered	Provide the Rx group for the primary Rx insurance.
Missing entry	A Secondary RxID must be entered	Either provide an RxID for the secondary Rx insurance or change the secondary drug insurance to No.
Missing entry	A Secondary Rx Group must be entered	Either provide an Rx group for the secondary Rx insurance or change the secondary drug insurance to No.
Missing entry	Please update a period or start a new one	The user selected the [Submit] button but did not make a change to an existing period, or enter a new period.
Missing entry	Please start a new period	The user selected the [Submit] button when there are no existing periods and a new period is not entered.
Invalid entry	For new period, a Primary RxID is not provided unless the Primary Drug Insurance is Yes	Since the beneficiary does not have primary drug insurance, the user cannot enter a Primary RxID.
Invalid entry	For new period, a Primary Rx group is not provided unless the Primary Drug Insurance is Yes	Since the beneficiary does not have primary drug insurance, the user cannot enter a Primary Rx group.
Invalid entry	A Primary RxBIN is not provided unless the Primary Drug Insurance is Yes	Since the beneficiary does not have primary drug insurance, the user cannot enter a Primary RxBIN.
Invalid entry	A Primary RxPCN is not provided unless the Primary Drug Insurance is Yes	Since the beneficiary does not have primary drug insurance, the user cannot enter a Primary RxPCN.
Invalid entry	For new period, a Secondary RxID may not be provided unless the Secondary Drug Insurance is Yes	Either clear the secondary RxID or change the Secondary Drug Insurance value to Yes.
Invalid entry	For new period, a Secondary Rx group may not be provided unless the Secondary Drug Insurance is Yes	Either clear the secondary Rx group or change the Secondary Drug Insurance value to Yes.
Invalid entry	A Secondary RxBIN may not be provided unless the Secondary Drug Insurance is Yes	Either clear the secondary RxBIN or change the secondary drug insurance to Yes.
Invalid entry	A Secondary RxPCN may not be provided unless the Secondary Drug Insurance is Yes	Either clear the secondary RxPCN or change the secondary drug insurance to Yes.
Processing error–monthly summarization in progress	Unable to perform update during the monthly summarization. Please try again later.	Updates are not allowed during the monthly summarization. Try again after the summarization is complete.
No data	No Primary drug insurance information found for <claim number>	No action required. The user may enter primary drug insurance information.
Software or Database Error	Invalid Primary drug insurance results retrieved for <claim number>	Contact MAPD Help Desk for assistance.

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving Primary drug insurance information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input retrieving Primary drug insurance information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred updating Primary drug insurance information for <claim number>	Contact MAPD Help Desk for assistance.
No data	No secondary drug insurance information found for <claim number>	No action required. The user may enter secondary drug insurance information.
Software or Database Error	Invalid secondary drug insurance results retrieved for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving secondary drug insurance information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input retrieving secondary drug insurance information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred updating secondary drug insurance information for <claim number>	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input error	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.
Software or Database Error	The primary drug insurance has been updated but redisplay has failed	Contact MAPD Help Desk for assistance.
Success	The primary drug insurance information has been updated	None
Software or Database Error	The secondary drug insurance has been updated but redisplay has failed	Contact MAPD Help Desk for assistance.
Success	The secondary drug insurance information has been updated	None

10.3.18 Beneficiary Opt-Out Screen (M234)

STEP 6d: Updating the Beneficiary Opt-Out (M234) Screen

The following screen is new and is accessible only by users with update authorization.

The M234 screen displays beneficiary's Part D AE-FE/MMP Opt-Out information. The Plan uses this screen to view, verify, and update beneficiary's Part D AE-FE/MMP Opt-Out election. To navigate to the Part D AE-FE/MMP Opt-Out (M234) screen, select the |Part D AE-FE Opt-Out| and/or |MMP Opt-Out| tab from the Search Results (M202) screen.

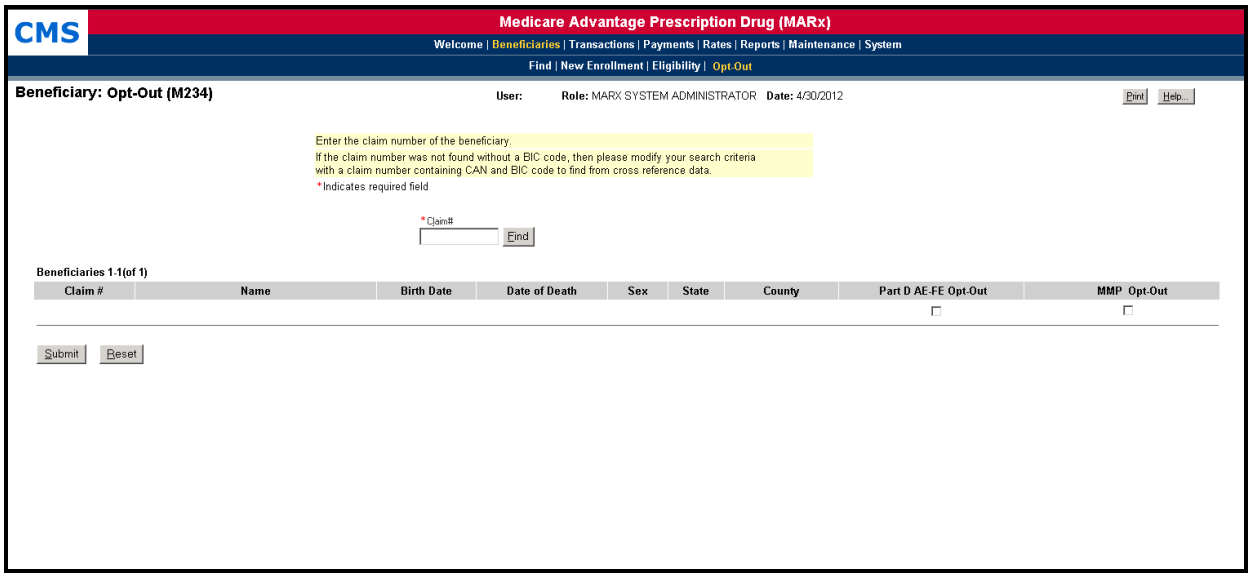


Figure 10-68: MCO Representative (UI Update) Beneficiary Opt-Out (M234) Screen

Table 10-78: MCO Representative (UI Update) (M234) Field Descriptions and Actions

Item	Input/Output	Description
Claim #	Required Input	Identifies the beneficiary whose eligibility information displays. The user may enter the Claim number with or without a BIC.
[Find]	Button	Select after entering the beneficiary claim number. If beneficiary is found, Part D AE-FE Opt-Out displays and user may update it.
Claim Number	Output	Claim number of beneficiary.
Name	Output	Name of beneficiary.
Birth Date	Output	Date of birth of beneficiary.
Date of Death	Output	Date of death of beneficiary.
Sex	Output	Sex of beneficiary.
State	Output	State of beneficiary's address.
County	Output	County of beneficiary's address.
Part D AE-FE Opt-Out	Input	Indicates if beneficiary opted-out of AE-FE.
MMP Opt-Out	Input	Indicates if beneficiary opted-out of MMP.
Action Buttons		
Submit	Button	Changes to Part D AE-FE/MMP Opt-Out indicator submitted for processing.
Reset	Button	Updated (or changed) values not submitted are reset to original values.

Table 10-79: MCO Representative (UI Update) (M234) Screen Messages

Message Type	Message Text	Suggested Action
No claim number	A claim number must be entered	Enter the claim number.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	Re-enter the claim number.
No data	Beneficiary not found	Check the claim number. If it is incorrect, re-enter it, or add a BIC if it is missing.
Different claim number retrieved.	The beneficiary's active claim number displays for the claim number entered	An initial search of the entered beneficiary did not succeed and another search for the cross reference claim numbers was successful and returned to the screen.
Software or Database Error	Error occurred while retrieving beneficiary Opt-Out information	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid Input	Contact MAPD Help Desk for assistance.
Software or Database Error	Error queuing up the updated transaction	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Unable to perform update during the monthly summarization. Please try again later.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.

10.3.19 Viewing Payment and Adjustment Details

The payment and adjustment details show the components that comprise the payments, adjustments, premiums, rebates, subsidies, and bonuses that apply to a beneficiary in a month.

STEP 7: Viewing the Payment/Adjustment for a Beneficiary

The *Payment/Adjustment Detail (M215)* screen is accessible by clicking on a Payment Date or Adjustment Date link from the following screens:

- Beneficiary Detail: Enrollment (M204).
- Beneficiary Detail: Payments (M206).
- Beneficiary Detail: Adjustments (M207).
- Beneficiary Payment History *(M406).*

The screen, as shown in **Figure 10-69**, provides payment and adjustment details for the selected month and contract. Adjustments are listed by adjustment reason code and are shown for the month in which they are paid, not the month to which they apply. When a blended rate displays, the demographic and risk-adjusted components used in the blending calculation also displays. Any additions and subtractions for bonuses, rebates, and/or subsidies are on separate lines. The screen is described in **Table 10-80**, with error and validation messages in **Table 10-81**.

STEP 7a: Viewing the Payment/Adjustment Detail (M215) Screen

Claim #: **DOB:**

State: **Age:** **Sex:** **County:**

Payment/Adjustment Detail (M215) **User:** **Role:** MCO REPRESENTATIVE **Date:** 8/22/2011 Close Print Help...

Payments/Adjustment Table - **Contract#** Hxxxx

Rebate for Part D Premium reduction is in the A and B columns. It is reflected correctly in the total Part D payments.

				Payment/Adjustments						
Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
07/2011	PAYMENT COMPONENT	RISK ADJUSTMENT	-	$790.39	$698.93	$0.00	$1,489.32	07/2011	Y	
07/2011	PAYMENT	PART D COVERAGE GAP DISCOUNT	-	$0.00	$0.00	$9.36	$9.36	07/2011	Y	
07/2011	PAYMENT	PART C PREMIUM	-	$0.00	$0.00	$0.00	$0.00	07/2011	Y	
07/2011	PAYMENT	PART A/B COST SHARING REDUCTION	-	$36.33	$32.12	$0.00	$68.45	07/2011	Y	
07/2011	PAYMENT	PART A/B MANDATORY SUPP BENEFITS	-	$4.17	$3.69	$0.00	$7.86	07/2011	Y	
07/2011	PAYMENT	PART D SUPP BENEFITS	-	$11.30	$10.00	$0.00	$21.30	07/2011	Y	
07/2011	PAYMENT COMPONENT	PART D BASIC PREMIUM	-	$0.00	$0.00	$24.59	$24.59	07/2011	-	
07/2011	PAYMENT	PART D DIRECT SUBSIDY	-	$0.00	$0.00	$97.37	$97.37	07/2011	Y	
07/2011	PAYMENT	PART D REINSURANCE	-	$0.00	$0.00	$12.05	$12.05	07/2011	Y	
07/2011	PAYMENT	PART D BASIC PREMIUM REDUCTION REBATE	-	$13.06	$11.54	$0.00	$24.60	07/2011	Y	
07/2011	PAYMENT	TOTAL	-	$842.19	$744.74	$143.38	$1,730.31	07/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	06/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	06/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	06/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	06/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	05/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	05/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	05/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	05/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	04/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	04/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	04/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	04/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	03/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	03/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	03/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	03/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	02/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	02/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	02/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	02/2011	Y	
07/2011	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	01/2011	Y	
07/2011	ADJUSTMENT	PART D DIRECT SUBSIDY	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	01/2011	Y	
07/2011	ADJUSTMENT	TOTAL	41-PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	$0.00	$0.00	$22.20	$22.20	01/2011	Y	
07/2011	ADJUSTMENT	TOTAL	26-PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	$261.21	$230.99	$0.00	$492.20	01/2011	Y	

Figure 10-69: MCO Representative (View Only) Payment/Adjustment Detail (M215) Screen

Table 10-80: MCO Representative (View Only) (M215) Field Descriptions and Actions

Item	Input/Output	Description
Payment Date column	Output	Date on which the payments were made.
Type column	Output	Specifies the type. These include payment, payment component, equivalent, and adjustment component.
Description column	Output	For payments or equivalent, provides description, such as demographic, risk adjusted, blended, one of the premium types, one of the rebate types, or one of the subsidy types. For adjustments, describes reason for the adjustment.
Adjustment Code column	Output	Code of adjustment reason for each adjustment. Dashes are used when it is not an adjustment.
Payment/Adjustments Part A column	Output	Part A amount of payment or adjustment, as applicable.
Payment/Adjustments Part B column	Output	Part B amount of payment or adjustment, as applicable.
Payment/Adjustments Part D column	Output	Part D amount of payment or adjustment, as applicable.
Payment/Adjustments Total column	Output	Total amount of payment or adjustment, as applicable.
Paid for Month column	Output	Month/year to which the payment applies. For adjustments, this month is being adjusted, not the month in which the adjustment is paid.

Table 10-81: MCO Representative (View Only) (M215) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving payments/adjustments from database.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving payments/adjustments detail results.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input for retrieval of payments/adjustments.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.3.19.1 Viewing the Payment/Adjustment for Displaying Risk Adjustment Factors (RAFs) for a Beneficiary

The Payment/Adjustment Detail screen displays the risk adjustment factor used in determining the beneficiary's payment. This information is displayed and hidden at the user's discretion. CMS added the RAF and RAF types to existing payment history lines on the MARx Payment/Adjustment Detail screen.

Navigating to the RAF:
A chevron (>>) will appear next to each row of data on the Payment/Adjustment Detail screen where a risk adjustment factor is used to calculate a payment or an adjustment amount. When a user selects the chevron, a drop down display of the risk adjustment factor appears. The RAF data values populated to the Payment/Adjustment Detail Screen are:

- RAF Type
- RAF Class
- RAF used for Part A payment calculation
- RAF used for Part B payment calculation
- RAF used for Part D payment calculation
- Part C Frailty Factor used in the payment calculation
- RAF Start and End date

STEP 8a: Viewing the Payment/Adjustment for Displaying RAFs for a Beneficiary (Screen M215)

Claim #: ACTIVE DOB: Age: 86 Sex: FEMALE State: IA (16) County: WINNESHIEK (950)

Payment/Adjustment Detail (M215) User: S59K Role: MARX SYSTEM ADMINISTRATOR Date: 2/15/2014 Viewing Plan User: Plan Role: Close Print Help...

Payments/Adjustment Table - Contract# H1234

Payment Date	Type	Description	Adjustment Code	Payment/Adjustments Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
* 03/2013	PAYMENT COMPONENT	PART D RISK ADJUSTED RATE (DIRECT SUBSIDY)	-	$0.00	$0.00	$79.11	$79.11	03/2013	-	
03/2013	PAYMENT	PART D COVERAGE GAP DISCOUNT	-	$0.00	$0.00	$10.54	$10.54	03/2013	Y	
03/2013	PAYMENT COMPONENT	PART D BASIC PREMIUM	-	$0.00	$0.00	$30.64	$30.64	03/2013	-	
03/2013	PAYMENT	PART D DIRECT SUBSIDY	-	$0.00	$0.00	$64.21	$64.21	03/2013	Y	
03/2013	PAYMENT	PART D REINSURANCE	-	$0.00	$0.00	$40.68	$40.68	03/2013	Y	
03/2013	PAYMENT	TOTAL	-	$0.00	$0.00	$115.43	$115.43	03/2013	Y	

Figure 10-70: Payment/Adjustment Detail (M215) Screen

STEP 8b: Viewing the Payment/Adjustment Detail Screen with Display of RAF

Claim #: ACTIVE DOB: Age: 86 Sex: FEMALE State: IA (16) County: WINNESHIEK (950)

Payment/Adjustment Detail (M215) User: Role: MARX SYSTEM ADMINISTRATOR Date: 2/15/2014 Viewing Plan User: Plan Role: Close Print Help...

Payments/Adjustment Table - Contract# H1234

Payment Date	Type	Description	Adjustment Code	Payment/Adjustments Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
* 03/2013	PAYMENT COMPONENT	PART D RISK ADJUSTED RATE (DIRECT SUBSIDY)	-	$0.00	$0.00	$79.11	$79.11	03/2013	-	

Risk Adjustment Factor

Factor Type	Factor Class	Part A	Part B	Part D	Part C Frailty Switch	Start Date	End Date
22 - ESRD GRAFT	4 - DEFAULT RAF	-	-	1.4390	N	01/01/2013	12/31/2013

03/2013	PAYMENT	PART D COVERAGE GAP DISCOUNT	-	$0.00	$0.00	$10.54	$10.54	03/2013	Y	
03/2013	PAYMENT COMPONENT	PART D BASIC PREMIUM	-	$0.00	$0.00	$30.64	$30.64	03/2013	-	
03/2013	PAYMENT	PART D DIRECT SUBSIDY	-	$0.00	$0.00	$64.21	$64.21	03/2013	Y	
03/2013	PAYMENT	PART D REINSURANCE	-	$0.00	$0.00	$40.68	$40.68	03/2013	Y	

Figure 10-71: Payment/Adjustment Detail (M215) Screen Display of RAF

10.3.20 Status Activity (M256)

The Status Activity screen displays a beneficiary's current health status information, as well as current values for eligibility, uncovered months, low income subsidy, and state and county codes.

The following special status categories display on the screen:

- SSA State and County Codes
- Low Income Subsidy
- Number of Uncovered Months
- Health Status Flags (ESRD, MSP, etc…)
- Eligibility Status Flags (Part A, Part B, and Part D)

STEP 9: Viewing the Status Activity Screen

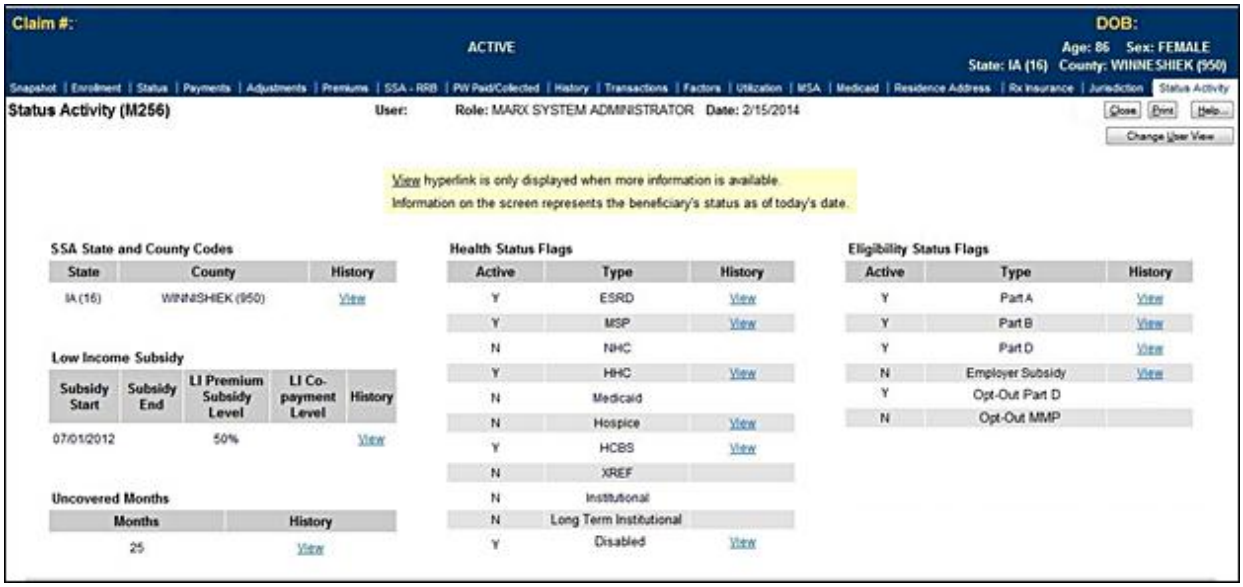


Figure 10-72: Status Activity (M256) Screen

Table 10-82: Status Activity (M256) Field Descriptions and Actions

Item	Type	Description
[Close]	Button	Click this button to exit the active window.
[Update]	Button	Displays the *Update Enrollment (M212)* pop-up window, which also provides access to the *Update Institutional/NHC (M213)* screen, the *Update Medicaid (M214)* screen, the *Update Premiums (M226)* screen, and the *Update Rx Insurance (M228)* screen, discussed in Sections 5.5.2.1 Update Beneficiary Enrollment Information, 5.5.2.2 Updating Institutional/NHC Information for a Beneficiary, 5.5.2.3 Updating Medicaid Information for a Beneficiary, 5.5.2.4 Updating Premium Information for a Beneficiary, 5.5.2.5 Updating Rx Insurance Information for a Beneficiary and 5.4.16.1 Updating the Premium Withhold Collection Detail Records for a Beneficiary, respectively.
[Print]	Button	Click this button to produce a paper-based copy of the screen content.

Item	Type	Description
[Help]	Button	Click this button to open the MARx Help system.
[Change User View]	Button	Displays the *Change User View (M002)* screen where users can mirror the view of another role.
SSA State and County Codes-State	Output	Current state of residence abbreviation and number as provided by SSA.
SSA State and County Codes-County	Output	Current county of residence abbreviation and number as provided by SSA.
SSA State and County Codes-History	Link	**View** link appears for user to access the *Status Detail: [status category] (M257) screen*, when detailed information exists for a specific beneficiary's status. Otherwise, this field is blank.
Health Status Flags-Active	Output	A yes or no indicator to show that the status is either active or audit information for the beneficiary as of today. 'Y' = status active. 'N' = status is not active.
Health Status Flags-Type	Output	Current health status information for these special status subcategories: • ESRD (End Stage Renal Disease) • MSP (Medicare Secondary Payer) • NHC (Nursing Home Certifiable) • HHC (Home Health Care) • Medicaid • Hospice • HCBS (Home and Community Based Services) • XREF (Cross Reference) • Institutional • Long Term Institutional • Disabled
Health Status Flags-History	Output	**View** link appears for user to access the *Status Detail: [status category] (M257) screen*, when detailed information exists for a specific beneficiary's status. Otherwise, this field is blank.
Eligibility Status Flags-Active	Output	A yes or no indicator to show that the status is either active or audit information for the beneficiary as of today. 'Y' = status active. 'N' = status is not active.

Item	Type	Description
Eligibility Status Flags-Type	Output	Current active or audit eligibility status listed for each of these eligibility subcategories: • Part A • Part B • Part D • Employer Subsidy • Opt-Out Part D • Opt-Out MMP
Eligibility Status Flags-History	Output	**View** link appears for user to access the *Status Detail: [status category] (M257) screen*, when detailed information exists for an eligibility type. Otherwise, this field is blank.
Low Income Subsidy-LI Subsidy Start	Output	The effective date (MM/DD/YYYY) when this LIS event began.
Low Income Subsidy-LI Subsidy End	Output	The effective date (MM/DD/YYYY) when this LIS event stopped.
Low Income Subsidy-LI Premium Subsidy Level	Output	Percentage of LI subsidy for this LIS event, expressed as ###%.
Low Income Subsidy-Co-payment Level	Output	The number to indicate the co-payment level assigned to the beneficiary.
Low Income Subsidy-History	Link	**View** link appears for user to access the *Status Detail: [status category] (M257) screen*, when detailed information exists for an eligibility type. Otherwise, this field is blank.
Uncovered Months-Months	Output	The current and cumulative total number of months that a beneficiary was without creditable coverage.
Uncovered Months-History	Link	**View** link appears for user to access the *Status Detail: [status category] (M257) screen*, when detailed information exists for an eligibility type. Otherwise, this field is blank.

10.3.21 Status Activity Detail (M257)

If a beneficiary has a history of a special status, a “View” hyperlink is displayed in the history column for that special status. When the user selects the hyperlink, the user can view the special status history on the Status Detail screen.

The Status Detail screen displays data specific to each of the special statuses (e.g., ESRD, MSP, etc.) and, if applicable, the data records/periods that are valid and audited. The most common data values populated on the Status Detail screen are:

- Status Start and End Date

- Valid/Audit Record
- Record Add Timestamp
- Record Update Timestamp
- Record Audit Timestamp

STEP 10a: Viewing the Status Detail Screen

Figure 10-73: Status Detail – SSA State and County Codes, Valid Records (M257) Screen

STEP 10b: Viewing the Status Detail Screen Audited Records

Users can select the "View Audit" link to view the audited information history for most of the statuses.

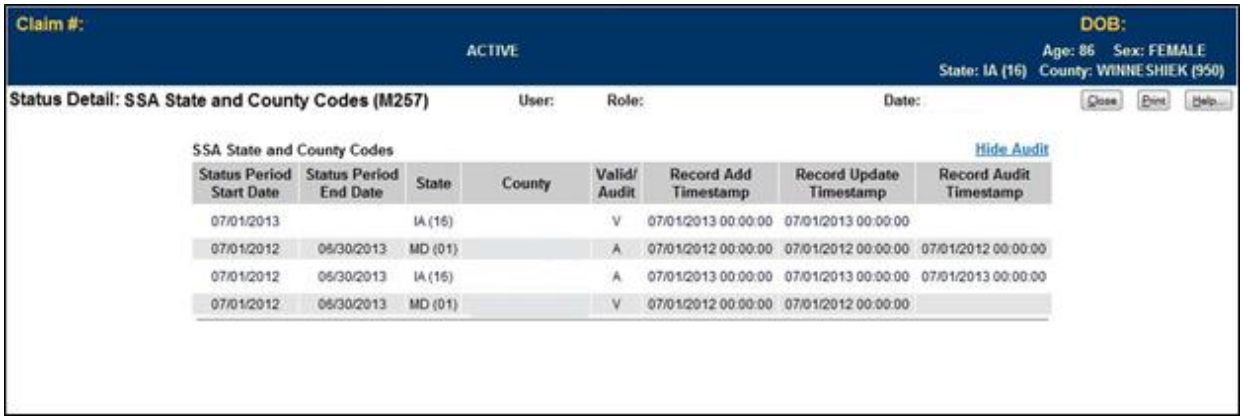


Figure 10-74: Status Detail – SSA State and County Codes Audited Records (M257) Screen

Table 10-83: Status Detail (M257) Field Descriptions and Actions

Item	Type	Description
[Close]	Button	Click this button to exit the active window.
[Print]	Button	Click this button to produce a paper-based copy of the screen content.
[Help]	Button	Click this button to open the MARx Help system.

Item	Type	Description
View Audit/Hide Audit	Link	Click this link to change the default display of valid records to display both valid and audited records for this status category/subcategory
Status Period Start Date	Output	The effective date (MM/DD/YYYY) for this status record.
Status Period End Date	Output	The effective date (MM/DD/YYYY) for this status record.
State	Link	State of residence abbreviation and number as provided by SSA.
County	Output	County of residence abbreviation and number as provided by SSA.
Valid/Audit	Output	A 1-letter indicator to show that the record is valid or audited information. 'V' = Valid information. 'A' = Audited information/
Record Add Timestamp	Output	Date and time (MM/DD/YYYY HH:MM:SS) the record was added.
Record Update Timestamp	Output	Date and time (MM/DD/YYYY HH:MM:SS) the record was updated.
Record Audit Timestamp	Output	Date and time (MM/DD/YYYY HH:MM:SS) the record was audited. Only displays for records with a Valid/Audit status of 'A'.
Premium Subsidy Level	Output	Level at which the premiums are subsidized.
Co-Payment Level	Output	Level of co-payment for which the beneficiary is responsible.
Subsidy Source	Output	The source of Low Income Subsidy (LIS) Subsidy.
Indicator	Output	Indicator showing record type.
Number of Uncovered Months	Output	Number of Uncovered Months.
Total Number of Uncovered Months	Output	Total number of Uncovered Months based on the Indicator.
Primary Insurance Code	Output	A 2-digit code and description of the primary insurer.
Source Code	Output	A 5-digit code to identify the MSP source.
COB Contractor Code	Output	A 5-digit code to identify the contractor.
Coverage Type Code	Output	A 1-letter code and description of the type of coverage.
Start Source	Output	Name of entity (contract or system) that provided notification that the NHC period began.
End Source	Output	Name of entity (contract or system) that provided notification that the NHC period stopped.
Earliest Bill Date	Output	First date (MM/DD/YYYY) that HHC billed.
Latest Bill Date	Output	Last date (MM/DD/YYYY) that HHC billed.
Contractor Number	Output	A 5-digit number to identify the HHC contractor.
Status Code	Output	A 2-digit code and description to identify the status code for the selected status category.
Provider Number	Output	A 7-character alphanumeric code to identify the HHC provider.
Medicaid Source	Output	The source of Medicaid.

Item	Type	Description
State	Output	Current state of residence abbreviation and number as provided by SSA.
Premiums Payer Code	Output	A 3-digit code to identify the premium payer.
Dual Status Code	Output	A 2-digit code and description to identify the dual element status.
Revocation Code	Output	A 1-character code and description to identify Hospice revoked.
XREF Date	Output	Date (MM/DD/YYYY) that the cross-reference event occurred.
XREF Claim #	Output	Claim number related to the cross-reference event.
Change/Merge	Output	Identifies the cross-reference event as either a change or a record merge.
Status Switch	Output	A 1-character code to identify a status switch event for the status detail category. 'Y' = Status switch occurred. 'N' = Status switch did not occur.
Coverage Year	Input	Defaults to current year. Optionally, select the desired LTI year.
Status Month	Output	Name of the month for which the LTI status is being reported.
Entitlement Start Date	Output	Date (MM/DD/YYYY) entitlement began for this status record.
Entitlement End Date	Output	Date (MM/DD/YYYY) entitlement ended for this status record.
Enrollment Reason	Output	A 1-character code and description to identify the reason for enrollment.
Non-Entitlement Reason	Output	A 1-character code and description to identify the reason a beneficiary was not entitlement to enrollment.
Entitlement Status	Output	A 1-character code and description to identify the reason for entitlement.
Eligibility Start Date	Output	Date (MM/DD/YYYY) eligibility began for this status record.
Eligibility End Date	Output	Date (MM/DD/YYYY) eligibility stopped for this status record.
Eligibility Reason	Output	A 1-character code and description to identify the reason for eligibility.
Stop Reason	Output	A 1-character code and description to identify the reason that eligibility stopped.

Table 10-84: Status Detail (M257) Screen Messages

Message Type	Message Text	Suggested Action
No data	No status information found for <claim number>	No corresponding data is available for that contract number.
Software or Database Error	Error occurred retrieving beneficiary results	See contact information to report the error.

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred retrieving beneficiary status history	See contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary status history	See contact information to report the error.
Software or Database Error	Invalid screen ID	See contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	See contact information to report the error.
Software or Database Error	Connection error	See contact information to report the error.

10.4 View Status of Batches Submitted

When a transactions batch file is submitted, the user may track its progress through the enrollment processing. This progress information includes:

- Dates and times when the file was received, when the file was processed, and when the Batch Completion Status Summary (BCSS) Report was generated for the file.
- Counts of transactions by status.
- Counts of transactions by transaction type.

There are three possible batch transaction statuses:

- Successful - Transaction was processed with no errors.
- Rejected - An error occurred when the transaction was processed. The rejected transactions are also saved in the Rejected Transactions File.
- Failed - A failed transaction is one that has an error that is so severe the transaction is not saved.

The *Transactions: Batch Status (M307)* screen displays the status of transaction batch files that were submitted by the user. Additional information about a selected batch is shown in the *Transactions: Batch Status (M307)* screen.

This section describes the following steps for viewing the status of batch submitted beneficiary information by user role:

- *STEP 1: Accessing the Transactions: Batch Status (M307) Screen*.
- *STEP 2: Viewing the Transactions: Batch Status (M307) Screen*.
- *STEP 3: Viewing the Batch File Details (M314) Screen*.
- *STEP 4: Viewing the View Special Batch File Request (M317) Screen*.
- *STEP 5: Viewing the Special Batch Approval Request (M316) Screen*.

10.4.1 STEP 1: Accessing the Transactions: Batch Status (M307) Screen

From the Medicare Advantage and Part D Inquiry System main menu, the user clicks on the |Transactions| menu item to view the *Transactions: Batch Status (M307)* screen.

10.4.2 STEP 2: Viewing the Transactions: Batch Status (M307) Screen

The *Transactions: Batch Status (M307)* screen is used for entering the selection criterion, as shown in **Figure 10-75** and described in **Table 10-85**, with error and validation messages provided in **Table 10-86**.

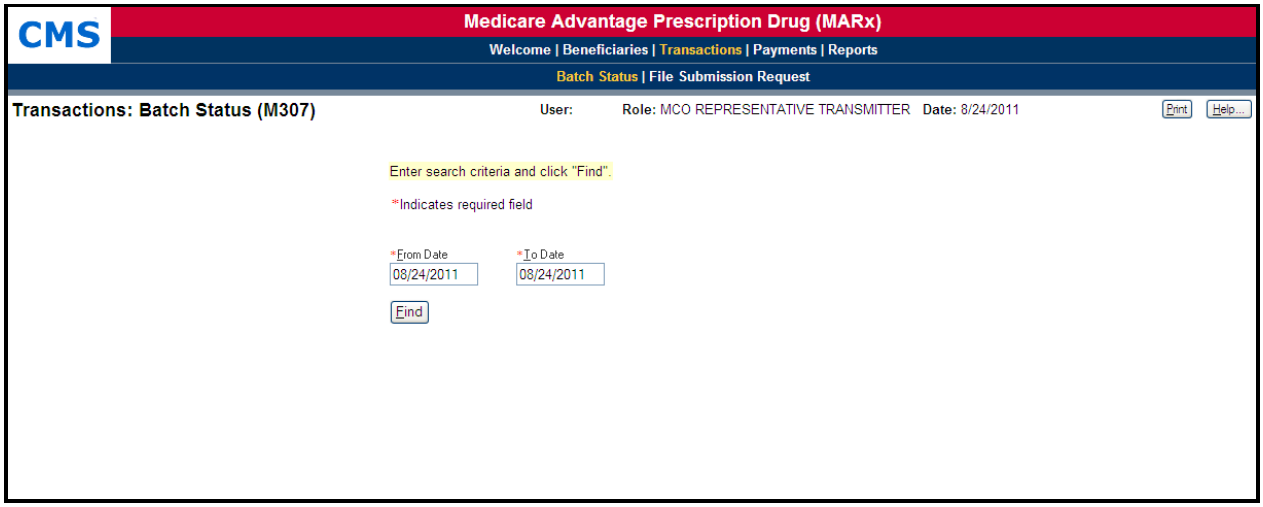


Figure 10-75: MCO Representative (Transmitter) Transactions – Batch Status (M307) Screen, Before Search Criteria Entered

Table 10-85: MCO Representative (Transmitter) (M307) Field Descriptions and Actions

Item	Input/Output	Description
From Date	Required data entry field	Searches for batches that were entered on or after this date. Enter as (M)M/(D)D/YYYY. Defaults to current date.
To Date	Required data entry field	Searches for batches that were entered before or after this date. Enter as (M)M/(D)D/YYYY. Defaults to current date.
[Find]	Button	After the search criteria have been entered, the user clicks on this button to display the list of batch files.
Batch ID in the Batch ID column	Link	The user clicks on a batch ID link to display the *Batch File Details (M314)* screen for that batch file.
User ID	Output	Identifier of user who submitted the batch file.
File Received	Output	Date and time when batch file was received.
File Processed	Output	Date and time when batch file was processed.
Batch Completion Summary Run	Output	Date and time a BCSS report was run for the batch file.

Table 10-86: MCO Representative (Transmitter) (M307) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	From Date must be entered	The user enters a date in the From Date field.
Missing entry	To Date must be entered	The user enters a date in the To Date field.
Invalid format	From Date invalid. Must have format (M)M/(D)D/YYYY	The user re-enters the From Date in one of the required formats.
Invalid format	To Date is invalid. Must have format (M)M/(D)D/YYYY	The user re-enters the To Date in one of the required formats.
No data	No batches found	No action required.
Software or Database Error	Invalid results while retrieving batch status information	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving batch status information	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	See Appendix B for contact information to report the error.
Software or Database Error	Connection error	See Appendix B for contact information to report the error.

After the search criteria are entered, the user clicks on the [Find] button to display the transaction batch files. If there are no batches that satisfy the search criteria, the *Transactions: Batch Status (M307)* screen is re-displayed with the search criteria and a message indicating that no batches were found. The batches that meet the selection criteria are displayed on the same screen below the selection criteria. To view different transaction batches, the user changes the search criteria and clicks on the [Find] button.

The *Transactions: Batch Status (M307*) screen with a list of batch files is shown in **Figure 10-76**. The inputs, outputs, and actions, as well as the error and validation messages, were described previously in **Tables 10-85** and **10-86**, respectively.

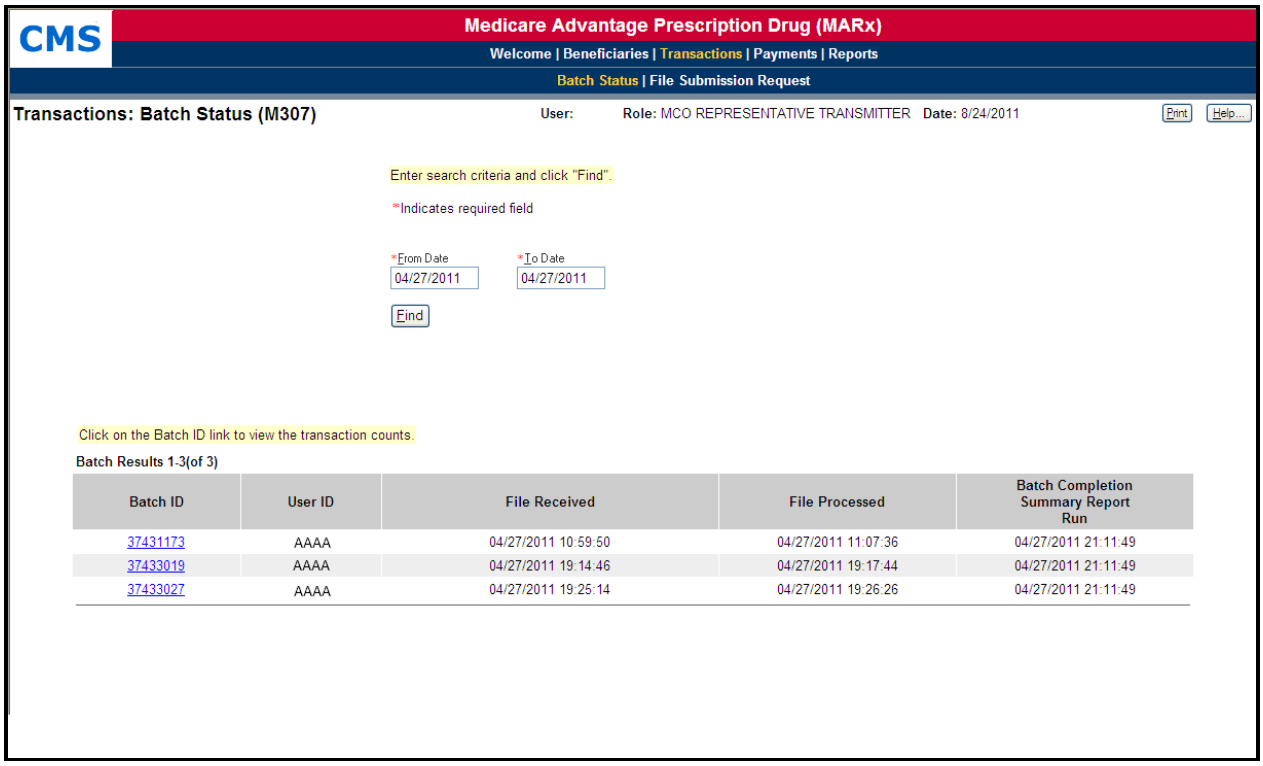


Figure 10-76 : MCO Representative (Transmitter) Transactions: Batch Status (M307) Screen, After Search Criteria Entered

10.4.3 STEP 3: Viewing the Batch File Details

The user clicks on a batch link ID on the *Transactions: Batch Status (M307)* screen to bring up the *Batch File Details (M314)* screen. For batches processed before the May 2009 software release implementation, the screen is shown in **Figure 10-77** and described in **Table 10-87**. For batches processed after the May 2009 software release implementation, the screen is shown in **Figure 10-78** and described in T**able 10-88**. Error and validation messages for both **Figures 10-76** and **Figure 10-77** are provided in **Table 10-89**.

Table 10-87: MCO Representative (Transmitter) (M314) Field Descriptions and Actions

Item	Input/Output	Description
Batch File Status Message	Output	Message describing the file processing status.
Enrollment	Output	Count of enrollment transactions in the batch file.
Disenrollment	Output	Count of disenrollment transactions in the batch file.
PBP Change	Output	Count of PBP change transactions (TC 71) in the batch file.
Plan Change	Output	Count of Plan change (TC 72) transactions in the batch file.
Correction	Output	Count of correction (TC 01) transactions in the batch file.
Unknown	Output	Count of transactions of unknown type in the batch file.
Accepted	Output	Count of accepted transactions in the batch file.
Rejected	Output	Count of rejected transactions in the batch file.

Item	Input/Output	Description
Pending	Output	Count batch file transactions for which processing not yet completed.
Failed	Output	Count of failed transactions in the batch file.

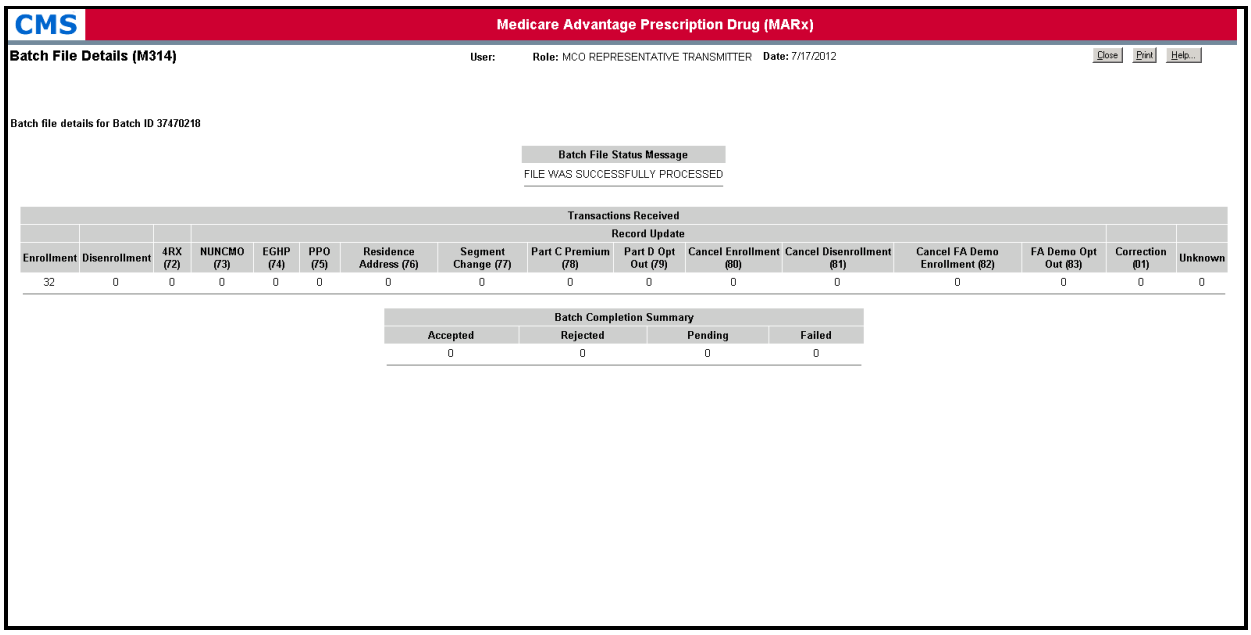


Figure 10-77: MCO Representative (Transmitter) Batch File Details (M314) Screen (For batches processed after May 2009)

Table 10-88: MCO Representative (Transmitter) (M314) Field Descriptions and Actions

Item	Input/Output	Description
Batch File Status Message	Output	Describes the status of file processing.
Enrollment	Output	Count of enrollment transactions in the batch file.
Disenrollment	Output	Count of disenrollment transactions in the batch file.
PBP Change	Output	Count of PBP change (TC 71) transactions in the batch file.
4Rx	Output	Count of 4Rx data update (TC 72) transactions in batch file.
NUNCMO	Output	Count of NUNCMO data update (TC 73) transactions in batch file.
Premium Withhold	Output	Count of Premium Payment data update (TC 75) transactions in the batch file.
Other	Output	Count of EGHP data update (TC 74) transactions in the batch file.
Correction	Output	Count of correction (TC 01) transactions in the batch file.
Unknown	Output	Count of transactions of unknown type in the batch file.
Accepted	Output	Count of accepted transactions in the batch file.
Rejected	Output	Count of rejected transactions in the batch file.
Pending	Output	Count of transactions in the batch file with incomplete processing.
Failed	Output	Count of transactions in the batch file that failed.

Table 10-89: MCO Representative (Transmitter) (M314) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Invalid results while retrieving batch status information	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving batch status information	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

The following screen is new and is accessible only by users with MCO Representative Transmitter authorization.

10.4.4 STEP 4: Viewing Special Batch File Requests (M317) Screen

Plans use the UI to request CMS approval of three types of special batch files: Plan Submitted Rollovers, Retroactive Files, and Organization Special Review. The View Special Batch File Request (M317) screen allows the MCO Representative Transmitter to view the status of these requests. The New Request button on the M317 screen navigates to the Special Batch Approval Request (M316) screen where the user may enter a new special request.

To access the *View Special Batch File Request (M317)* screen from the *Welcome* screen, select *Transactions: File Submission Request*. Once the screen is displayed, search criteria allow the user to find a specific set of requests. These requests are shown in the lower portion of the screen.

Figure 10-78: MCO Representative (Transmitter) View Special Batch File Request (M317) Screen

Table 10-90: MCO Representative (Transmitter) (M317) Field Descriptions and Actions

Item	Input/Output	Description
Find Criteria – These fields are used to find previously submitted Special Batch File Requests		
Header Date	Input (optional)	Header date in a file.
Request Date	Input (optional)	Date a request was submitted.
Request Type	Input (optional)	Type of special file for the request: - Retroactive - Plan Submitted Rollover - Organization Special Review
Request Status	Input (optional – drop down)	Status of the requests to find.
Request ID	Input (optional)	ID of a request.
File Status	Input (optional)	Status of file processing to use in the search.
Find	Button	Finds all requests that meet the above search criteria.
Content Description: The following fields are repeated for each request that meets the Find criteria.		
Select	Input	Check box to select a line. This is usually used in coordination with the *Cancel Request* button.
Request Date	Output	Date the request was submitted.
Request ID	Output (Link)	Unique Request ID Clicking on a Request ID takes the user to the *Special Batch Approval Request (M316)* screen, which displays the details of the selected request.
Batch File Type	Output	Type of special file for the request: - Retroactive - Plan Submitted Rollover - Organization Special Review.
Header Date	Output	Header date for the special file.
Submitter	Output	ID and Name of the person who submitted the Special Batch File Request.
Request Status	Output	Status of the request: - Approved - Disapproved - Hold - New Request.
File Status	Output	Processing status of the special file associated with this request: - Received - Processed - Received/Pending Review.
Date Processed	Output	For processed special files, date of processing.
Total Count	Output	Total count of transactions in the special file.
Approver	Output	For an approved request, the ID and name of the person who approved the request.
Selection Buttons		
New Request	Button	This button navigates to the Special Batch Approval Request (M316) screen where the user may enter a special request.
Cancel Request	Button	This button cancels the request on the line indicated by a selected checkbox.

Table 10-91: MCO Representative (Transmitter) (M317) Screen Messages

Message Type	Message Text	Suggested Action
No data.	No special batch file submission requests to display.	None.
Missing entry.	User must select a request to cancel.	Select a request.
Invalid selection	Unable to cancel the request. This request file was already received.	Contact MAPD Help Desk for assistance.
Invalid format.	Header Date is invalid. Must have format (M)M/YYYY.	Re-enter the date.
Invalid format.	Request Date is invalid. Must have format (D)D/(M)M/YYYY.	Re-enter the date.
Software or Database Error	Unexpected error code from database = <error code>	Contact MAPD Help Desk for assistance.

The following screen is new and is accessible only by users with MCO Representative Transmitter authorization**.**

10.4.5 STEP 5: Viewing Special Batch Approval Request (M316) Screen

The *Special Batch Approval Request (M316)* screen allows a user with the MCO Representative Transmitter role to enter the details for batch files that need special approval. These include Plan Submitted Rollover files, Retroactive files, and Organizational Special Review files. After entering the details about the special file, the user submits the request for approval. Once submitted, the user may view the approval status for the requests via the *View Special Batch File Request (M317)* screen.

To access the *Special Batch Approval Request (M316)* screen from the *Welcome* screen, select the |*Transactions*| *tab* followed by the |*File Submission Request*| *tab*. This opens the *View Special Batch File Request (M317)* screen where the user may select the *New Request* button. This screen also displays the details of previously submitted requests when a specific Request ID link is selected on the *Special Batch File Request (M317)* screen.

There are three varieties of Special Batch Approval Requests: Plan Submitted Rollovers, Retroactive Files, and Organization Special Review. The screen layouts for the Retroactive and Organization Special Review file requests are identical. An example of an Organization Special Review file is shown in **Figure 10-79**. The Plan Submitted Rollover request version includes Application Date as a file-level value, in addition to Batch File Type and Header date.

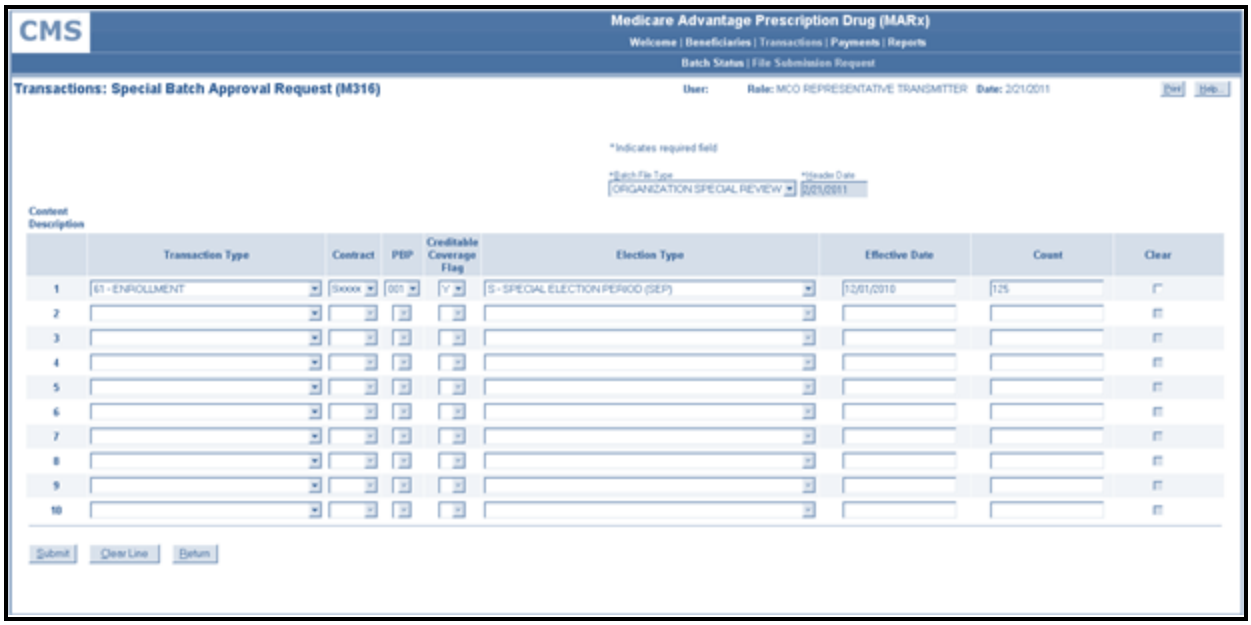


Figure 10-79: MCO Representative (Transmitter) View Special Batch Approval Request (M316) Screen (Retroactive and Organization Special Review version)

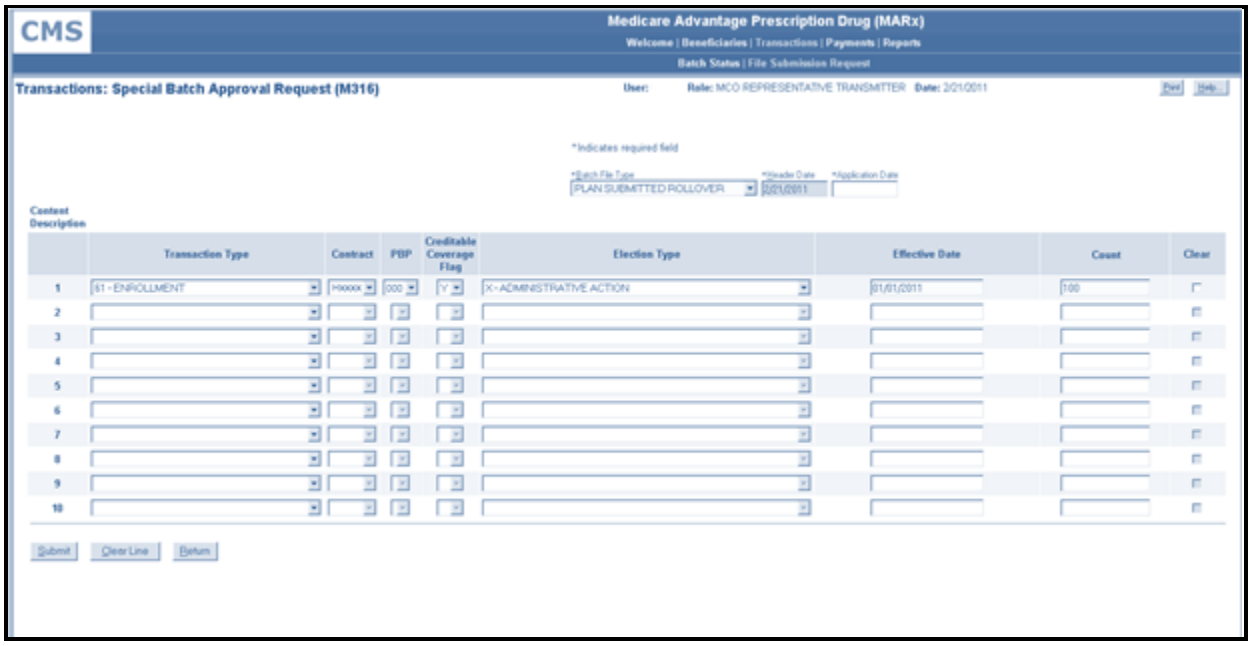


Figure 10-80: MCO Representative (Transmitter) View Special Batch Approval Request (M316) Screen (Plan Submitted Rollover version)

Table 10-92: MCO Representative (Transmitter) (M316) Field Descriptions and Actions

Item	Input/Output	Description
Batch File Type	Required Input	Indicate the type of special file: • Retroactive • Plan Submitted Rollover • Organization Special Review.
Header Date	Required Input	Enter the header date on the special file.
Application Date	Required Input for Plan Submitted Rollover requests	Enter the application date for all file transactions. **Note:** This field does not display for Organization Special Review or Retroactive requests.
Content Description: Transactions in the file are grouped by Transaction Type, Contract, PBP, Creditable Coverage Flag, Election Type, and Effective Date. Each line represents one unique combination of these. Additional lines are populated until all transactions are submitted in the special file described. The user must populate at least one line.		
Transaction Type	Input (Dropdown)	The type of transactions on this line.
Contract	Input (Dropdown)	The contract number for transactions on this line.
PBP	Input (Dropdown)	The PBP number for the transactions on this line.
Creditable Coverage Flag	Input (Dropdown)	The Creditable Coverage Flag (Y or N) for the transactions on this line.
Election Type	Input (Dropdown)	The Election Type for transactions on this line.
Effective Date	Input (For Plan Submitted Rollover requests only)	The Effective Date for transactions on this line.
Count	Input	The number of transactions with the unique combination represented on the line.
Clear	Input	Selects lines to clear with the Clear Line button.
Buttons		
Clear Line	Button	When selected, clears input from selected lines
Submit	Button	Submits the request for approval for the special file described in the Content Description lines.
Return	Button	Returns the user to the View Special Batch File Request (M317) screen.

Table 10-93: MCO Representative (Transmitter) (M316) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry.	User must select a row to clear	Select a row and reselect the Clear Line button.
Invalid format	Application Date is invalid. Must have format (D)D/(M)M/YYYY	Re-enter the date in one of the required formats.
Invalid format	Header Date is invalid. Must have format (D)D/(M)M/YYYY	Re-enter the date in one of the required formats.
Invalid format	Effective Date is invalid. Must have format (D)D/(M)M/YYYY	Re-enter the date in one of the required formats.
Invalid format	Count is invalid; user must enter a number	Re-enter the count as a number.
Software or Database Error	Unexpected error code from database=<error code>	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input error	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error	Contact MAPD Help Desk for assistance.

10.5 Viewing Payment Information

This section describes how to view MCO and beneficiary payment information.

10.5.1 Viewing MCO Payment Information

Total payments to MCOs are calculated as part of month-end processing. This section describes how to view the MCO payment information. These payment amounts are based on the beneficiary capitation amounts and may differ from the actual payment to the MCO due to contract-level payment adjustments, such as the Balanced Budget Act (BBA) User Fee adjustment. For the Current Processing Month, the payments reflect the transactions processed to date. This section describes the following steps for viewing MCO payment information by user role:

- *STEP 1: Accessing the Payments: MCO (M401) Screen*.
- *STEP 2: Viewing payment summary information by MCO*.
- *STEP 3: Viewing detailed payment information for a selected MCO*.
- *STEP 4: Viewing adjustment information for a selected MCO*.

STEP 1: Accessing the Payments: MCO (M401) Screen

From the main menu, the user clicks on the |Payments| menu item. The |MCO| submenu item is already selected and displays the *Payments: MCO (M401)* screen.

STEP 2: Viewing payment summary information by MCO

The *Payments: MCO (401)* screen is used for entering selection criteria, as shown in **Figure 10-81** and described in **Table 10-94**, with error and validation messages provided in **Table 10-95.**

The user enters the month and year for the payments along with the contract number that the user wishes to view. Another option is for the user to break down the payments by PBP. If that option is not selected, the payments for a contract are summarized at the contract level. If breakdown by PBP is selected, contracts without PBPs are included on the display but summarized at the contract level. Similarly, there is an option to break down the payments by segment. If that option is not selected, the payments for a contract are summarized at the contract or PBP level, based on whether the breakdown by PBP option was selected. If breakdown by segment is selected, PBPs without segments are included but summarized at the PBP level. The user clicks on the [Find] button to access the *Payments: MCO Payments (M402)* screen showing all of the contracts that meet the criteria.

Because the results from this search can vary based on the criteria, the examples following **Table 10-95** provide alternate screen shots for various inputs.

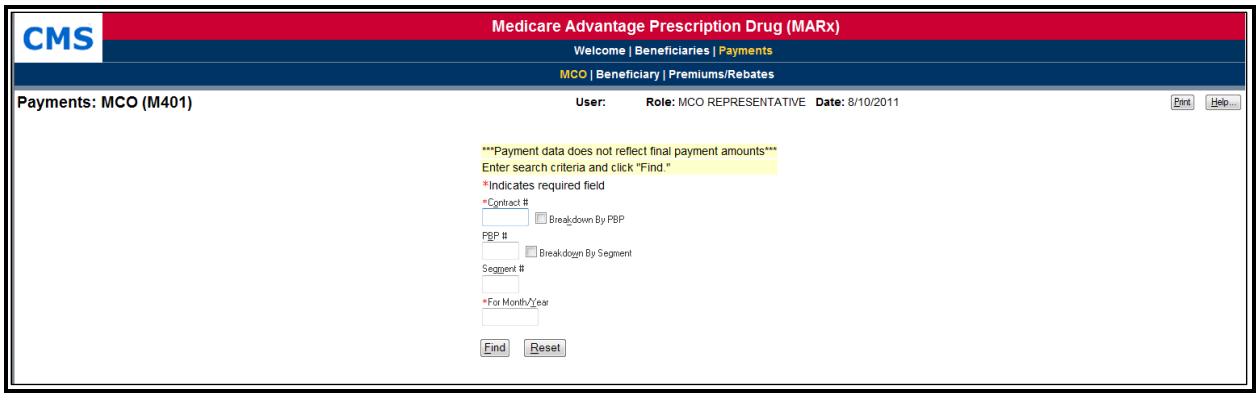


Figure 10-81: MCO Representative (View Only) Payments: MCO (M401) Screen

Table 10-94: MCO Representative (View Only) (M401) Field Descriptions and Actions

Item	Input/Output	Description
Contract #	Required data entry field	Request is for contract. The user enters the contract number.
Breakdown By PBP	Checkbox	If checked, the payment information is listed by PBP within each contract. Otherwise, the payment information is summarized at the contract level. **Note:** When Breakdown By Segment is checked, payments are shown by PBP, whether or not this option is checked.
PBP #	Data entry field	The user may specify a PBP to request the payment information for this PBP only. If a PBP is not entered, then payment information for all PBPs in a contract, if applicable, is displayed, either at the contract or PBP level, depending on whether Breakdown By PBP is checked. The user must specify a contract number when a PBP number is specified.
Breakdown By Segment	Checkbox	If checked, the payment information is listed by segment within the PBP. If not checked, the payment information is summarized at the PBP level when Breakdown by PBP is checked and summarized at the contract level otherwise.
Segment #	Data entry field	The user may specify a segment to request the payment information for this segment only. If a segment is not entered, then payment information for all segments in a PBP, if applicable, are displayed, at the contract, PBP, or segment level, depending on whether Breakdown By PBP and Breakdown by Segment is checked. The user must specify a contract number when a PBP number is specified.
For Month/Year	Required data entry field	Request is for payments made in this month. The user enters the date in the form (M)M/YYYY.
[Find]	Button	After the search criteria are entered, the user clicks on this button to display the list of reports.

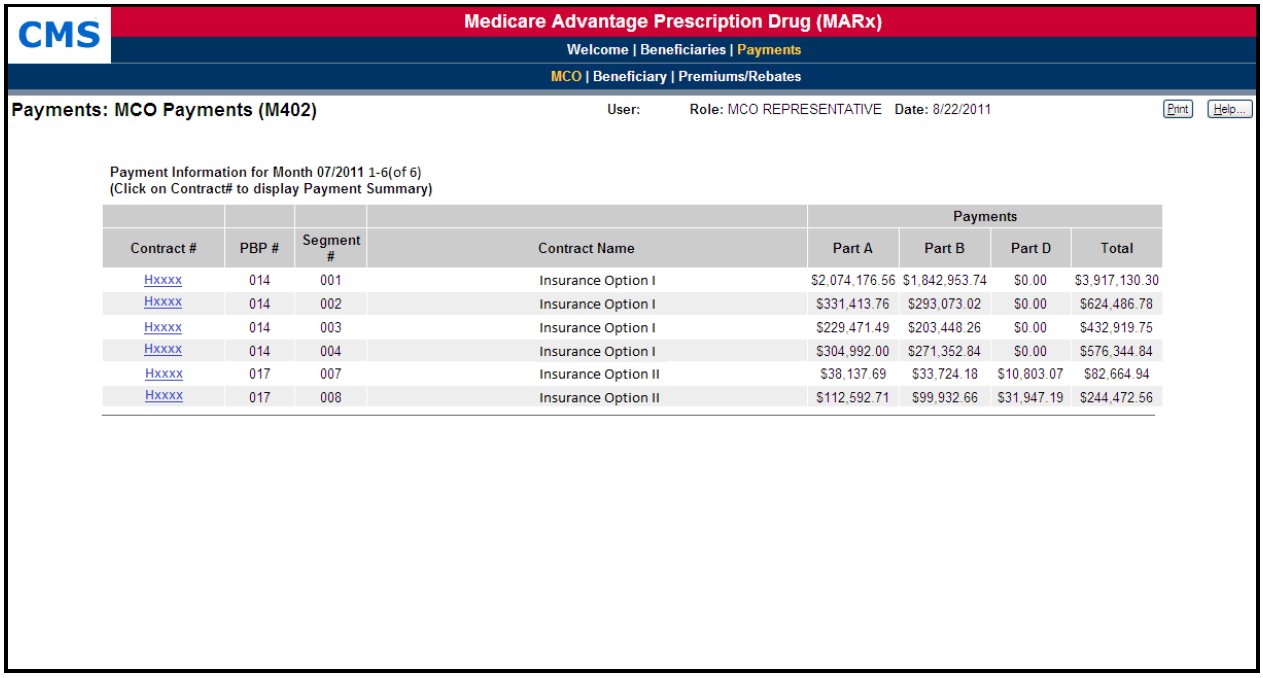
Table 10-95: MCO Representative (View Only) (M401) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Month/Year must be entered	The user enters the month/year.
Invalid format	Month/Year is invalid. Must have format (M)M/YYYY	The user re-enters the month/year in one of the required formats.
Missing entry	A contract number must be entered	The user enters the contract number.
Invalid format	A contract number must start with an 'H', '9', 'R', 'S', 'F,' or 'E' and be followed by four characters	The user re-enters the contract number.
Invalid format	PBP number must be 3 alpha-numeric characters	The user re-enters the PBP.
Invalid format	Segment number must be a three digit number	The user re-enters the segment.
Invalid entry	When a PBP is entered, a contract number must also be entered	The user enters a contract number.
Invalid entry	When a segment is entered, contract and PBP numbers also must be entered	The user must make sure to enter a PBP if entering a segment.
Invalid entry	Invalid contract/PBP combination	The user must make sure the PBP is in the contract.
Invalid entry	Invalid contract/PBP/segment combination	The user must make sure the PBP is in the contract and the segment is in the PBP.
Invalid entry	You do not have access rights to this Contract.	The user should determine if the contract number was entered correctly. If it was entered correctly and if the user should have rights to this contract, the user should see the CMS Central Office (CO) Computer Specialist, who can update the user profile to give user these rights.
No data	No summary payment data found for specified criteria	The user verifies the selection criteria. If criteria were entered incorrectly, the user re-enters the data.
Software or Database Error	The result set that contains the summary payment data is empty.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving summary payment data results from database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input to stored procedure	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input.	The user should access Appendix B for contact information to report the error.
Software or Database Error	No records returned from the database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database = <error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.5.1.1.1 Example 1: Multiple contracts and no PBP breakdown

Figure 10-82 provides an example of the *Payments: MCO Payments (M402)* screen, which results when only a month/year and contract number are entered on the *Payments: MCO (M401)* screen, PBP is not entered, and Breakdown by PBP is not specified. Note that only the Contracts section is displayed on the screen; the Current Payments and Adjustment Payments sections are displayed in STEP 3. This screen is described in **Table 10-96**. There are no error messages for the initial display of the screen, as any messages are displayed on *Payments: MCO (M401)* screen. **Table 10-97** shows the error and validation messages that may display when the screen is expanded to show sections below the Contracts section.

Note: To avoid possible internal server or database manager errors that can result when large Plans submit a query request that takes too long to execute or runs out of resources, it is recommended that users input information in the Contract #, PBP # and the Month/Year fields on the *Payments: MCO (M401)* screen. Once this information is submitted, the *Payments: MCO Payments (M402)* displays and the user can then click on the Contract # to display the details.



				Payments			
Contract #	PBP #	Segment #	Contract Name	Part A	Part B	Part D	Total
Hxxxx	014	001	Insurance Option I	$2,074,176.56	$1,842,953.74	$0.00	$3,917,130.30
Hxxxx	014	002	Insurance Option I	$331,413.76	$293,073.02	$0.00	$624,486.78
Hxxxx	014	003	Insurance Option I	$229,471.49	$203,448.26	$0.00	$432,919.75
Hxxxx	014	004	Insurance Option I	$304,992.00	$271,352.84	$0.00	$576,344.84
Hxxxx	017	007	Insurance Option II	$38,137.69	$33,724.18	$10,803.07	$82,664.94
Hxxxx	017	008	Insurance Option II	$112,592.71	$99,932.66	$31,947.19	$244,472.56

Figure 10-82: MCO Representative (View Only) Payments: MCO Payments (M402) Screen for Single Contract and No PBP or Segment Breakdown (Initial Display, Example 1)

Table 10-96: MCO Representative (View Only) (M402) Field Descriptions and Actions

Item	Input/Output	Description
Contracts		
Contract # in the Contract # column	Link	Expands this screen to show the breakdown for the selected contract.
PBP # column	Output	When selected, information displays for this PBP in the contract.
Segment # column	Output	When selected, information displays for this segment in the contract and PBP.
Payments Part A column	Output	Part A payments for the contract.
Payments Part B column	Output	Part B payments for the contract.
Payments Part D column	Output	Part D payments for the contract.
Payments Total column	Output	Part A, Part B, and Part D payment totals for the contract.
Current Payments		
Amount shown in parentheses after Part A Total Payments row heading	Output	Average Part A payment this month.
Amount shown in parentheses after Part B Total Payments row heading	Output	Average Part B payment this month.
Amount shown in parentheses after Part D Total Payments row heading	Output	Average Part D payment this month.
Payments Part A Members column	Output	Number of members in the contract with Part A payments this month; provides total plus breakdown by status.
Payments Part A Total Amount column	Output	Payments and adjustments, for all beneficiaries, in the contract for Part A this month; provides total plus breakdown by status.
Payments Part B Members column	Output	Number of members in the contract with Part B payments this month; provides total plus breakdown by status.
Payments Part B Total Amount column	Output	Payments and adjustments, for all beneficiaries, in the contract for Part B this month; provides total plus breakdown by status.
Payments Part D Members column	Output	Number of members in the contract with Part D payments this month; provides total plus breakdown by status.
Payments Part D Total Amount column	Output	Payments and adjustments, for all beneficiaries, in the contract for Part D this month; provides total plus breakdown by status.
Total Out of Area	Output	Number of beneficiaries living out of the service area for the contract this month.
Adjustment Payments (only displayed if there are any adjustments)		
Code column	Output	Adjustment reason code.
Code in the Code Column	Link	Opens the *Adjustment Detail (M408)* screen to display a breakdown of the adjustments for the contract/PBP and month by beneficiary.

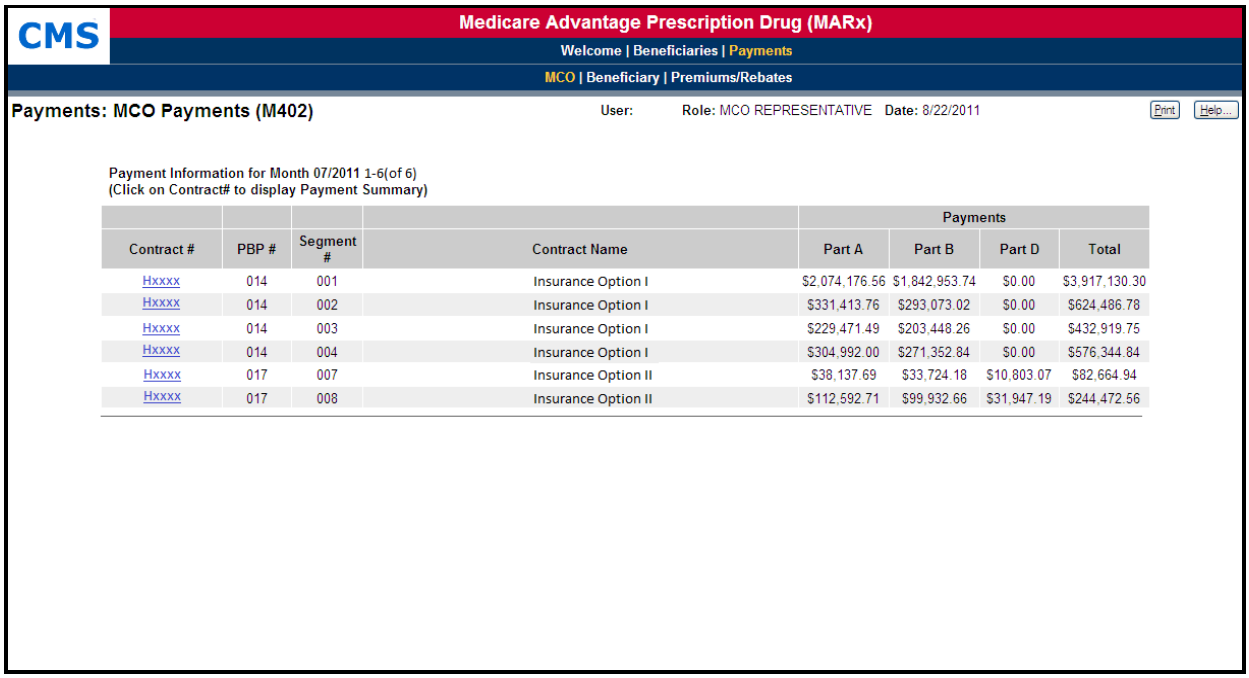
Item	Input/Output	Description
Adjustment Reason column	Output	Description of the adjustment reason code.
# column	Output	Number of adjustments by adjustment reason for the contract this month.
Months A column	Output	Total months over all beneficiaries for which adjustments are made for Part A by adjustment reason.
Months B column	Output	Total months over all beneficiaries for which adjustments are made for Part B by adjustment reason.
Months D column	Output	Total months over all beneficiaries for which adjustments are made for Part D by adjustment reason.
Part A column	Output	Total amount of Part A adjustments by adjustment reason.
Part B column	Output	Total amount of Part B adjustments by adjustment reason.
Part D column	Output	Total amount of Part D adjustments by adjustment reason.
Total Amount column	Output	Total amount of Part A, Part B, and Part D adjustments by adjustment reason.

Table 10-97: MCO Representative (View Only) (M402) Screen Messages

Message Type	Message Text	Suggested Action
No data	No payment data for the criteria entered	The user verifies the selection criteria. If criteria entered incorrectly, the user re-enters the data.
Software or Database Error	The result set that contains the Payment MCO Payments is empty.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving MCO payment details for contract <contract>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input to the stored procedure	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input	The user should access Appendix B for contact information to report the error.
Software or Database Error	No records returned from the database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database <error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.5.1.1.2 Example 2: Single Contract with Segment Breakdown

Figure 10-83 provides an example of the *Payments: MCO Payments (M402)* screen that results when a contract number is entered and Breakdown by Segment is specified. Only one contract displays and the payments are shown at the Segment level. Only the Contracts section displays on the screen; the Current Payments and Adjustment Payments sections display in STEP 3. The inputs, outputs, and actions are described previously in **Table 10-95.** No error messages appear on the screen initial display, as any messages display on *Payments: MCO (M401)* screen. **Table 10-96** includes the error and validation messages that may display when the screen is expanded to show sections below the contracts.



				Payments			
Contract #	PBP #	Segment #	Contract Name	Part A	Part B	Part D	Total
Hxxxx	014	001	Insurance Option I	$2,074,176.56	$1,842,953.74	$0.00	$3,917,130.30
Hxxxx	014	002	Insurance Option I	$331,413.76	$293,073.02	$0.00	$624,486.78
Hxxxx	014	003	Insurance Option I	$229,471.49	$203,448.26	$0.00	$432,919.75
Hxxxx	014	004	Insurance Option I	$304,992.00	$271,352.84	$0.00	$576,344.84
Hxxxx	017	007	Insurance Option II	$38,137.69	$33,724.18	$10,803.07	$82,664.94
Hxxxx	017	008	Insurance Option II	$112,592.71	$99,932.66	$31,947.19	$244,472.56

Figure 10-83: MCO Representative (View Only) Payments: MCO Payments (M402) Screen for Single Contract and Segment Breakdown (Initial Display, Example 2)

STEP 3: Viewing detailed payment information for a selected MCO

From the *Payments: MCO Payments (M402)* screen, the user finds the contract or contract/PBP that they wish to view. If the list does not fit on the screen, finding the contract/PBP may require scrolling through the list using the screen navigation arrows. The user selects the contract/PBP by clicking on the contract # link. The following information displays for the selected contract and, when applicable, PBP. The information is shown below the contract summary information:

- Part A, Part B, Part D, and total payments.
- Breakdown by health status, separated into Part A, Part B, and Part D, with both the number of members and the payment amounts.
- Breakdown by adjustment reason, separated into Part A, Part B, and Part D, with both the number of members and the payment amounts. Note that this section of the screen is only included when there are adjustments.

Figure 10-84 shows the details section for a selected MCO**.** The inputs, outputs, and actions, as well as the error and validation messages, are previously described in **Table 10-95** and **Table 10-96**, respectively.

CMS

Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Payments

MCO | Beneficiary | Premiums/Rebates

Payments: MCO Payments (M402) User: Role: MCO REPRESENTATIVE Date: 8/22/2011 Print Help...

Payment Information for Month 07/2011 1-1(of 1)
(Click on Contract# to display Payment Summary)

		Payments			
Contract #	Contract Name	Part A	Part B	Part D	Total
Hxxxx	Insurance Plan	$383,995.39	$341,670.66	$79,063.87	$804,729.92

Payments to plan Hxxxx, Insurance Plan, PBP 001, for 07/2011

Part A :	$383,995.39
Part B :	$341,670.66
Part D :	$79,063.87
Total :	$804,729.92

Current Payments for 07/2011

Part A	Members	Total Amount	Part B	Members	Total Amount	Part D	Members	Total Amount
Total Payments ($599.99)	640	$383,995.39	Total Payments ($533.86)	640	$341,670.66	Total Payments ($123.54)	640	$79,063.87
Total Hospice	0	$0.00	Total Hospice	0	$0.00	Total Hospice	0	$0.00
Total ESRD	7	$20,195.76	Total ESRD	7	$19,958.76	Total ESRD	7	$1,266.62
Total WA	0	$0.00	Total WA	0	$0.00	Total WA	0	$0.00
Total Institutional	0	$0.00	Total Institutional	0	$0.00	Total Institutional	0	$0.00
Total NHC	0	$0.00	Total NHC	0	$0.00	Total NHC	0	$0.00
Total CHF	0	$0.00	Total CHF	0	$0.00	Total CHF	0	$0.00
Total Medicaid	38	$29,120.98	Total Medicaid	38	$25,752.05	Total Medicaid	38	$10,755.43
Total Out of Area	8							

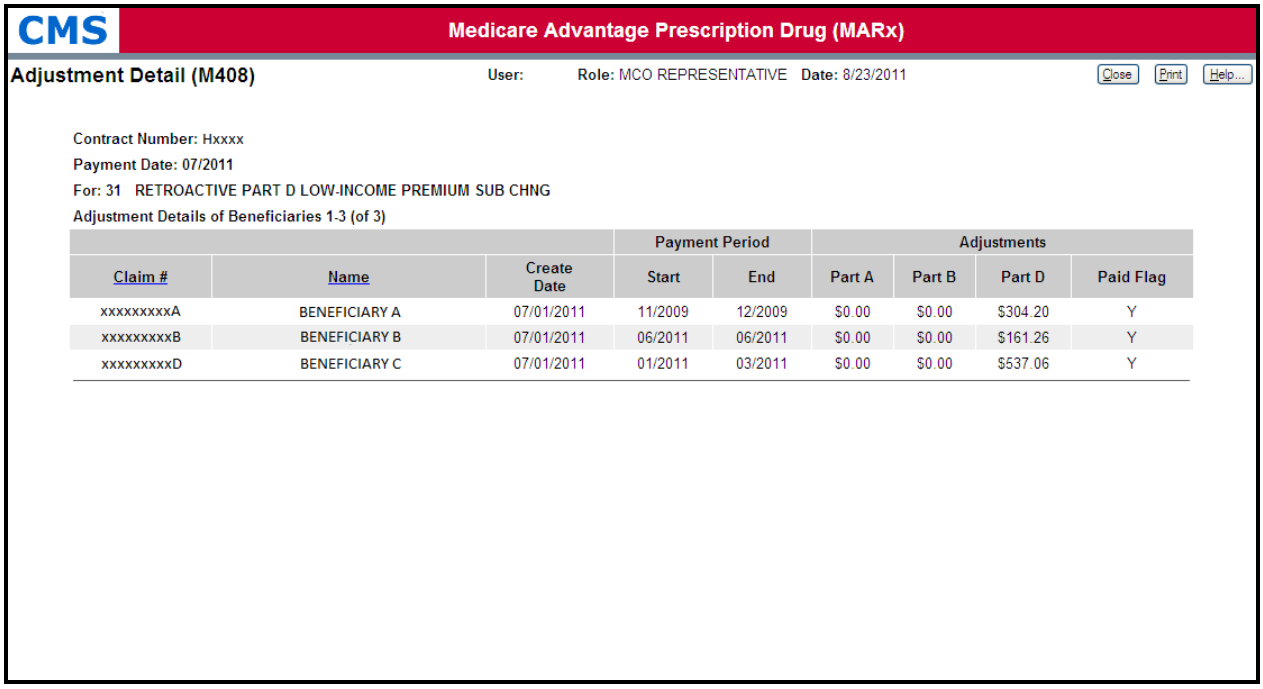
Adjustment Payments for 07/2011

Code	Adjustment Reason	#	Months A	Months B	Months D	Part A	Part B	Part D	Total Amount
01	NOTIFICATION OF DEATH	1	1	1	1	($1,308.44)	($1,157.05)	($120.96)	($2,586.45)
02	RETROACTIVE ENROLLMENT	35	58	58	58	$31,109.01	$27,510.08	$7,046.31	$65,665.40
03	RETROACTIVE DISENROLLMENT	4	9	9	9	($4,308.24)	($3,809.77)	($1,016.70)	($9,134.71)
11	RETROACTIVE SCC CHANGE	1	1	1	0	($0.09)	($0.08)	$0.00	($0.17)
26	PART C RISK ADJUSTMENT FACTOR CHANGE (MID-YEAR)	332	1662	1662	0	$67,495.77	$60,102.72	$0.00	$127,598.49
31	RETROACTIVE PART D LOW-INCOME PREMIUM SUB CHNG	4	0	0	13	$0.00	$0.00	$2,264.86	$2,264.86
36	PART D RATE CHANGE	2	0	0	12	$0.00	$0.00	$158.76	$158.76
41	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	408	0	0	2052	$0.00	$0.00	$4,429.82	$4,429.82
42	RETROACTIVE MSP STATUS	7	31	31	0	$4,025.58	$3,559.77	$0.00	$7,585.35
	Total Adjustments	794	1762	1762	2145	$97,013.59	$86,205.67	$12,762.09	$195,981.35

Figure 10-84: MCO Representative (View Only) Payments: MCO Payments (M402) Screen with Details for MCO

STEP 4: Viewing adjustment information for a selected MCO

To see further details about adjustments, the user clicks on an adjustment reason Code link at the bottom of the *Payments: MCO Payments (M402)* screen. The *Adjustment Detail (M408)* screen, as shown in **Figure 10-85**, is displayed, listing all adjustments by beneficiary to show how the adjustment amount was calculated. The screen is described in **Table 10-98**, with error and validation messages provided in **Table 10-99**.



			Payment Period		Adjustments			
Claim #	Name	Create Date	Start	End	Part A	Part B	Part D	Paid Flag
xxxxxxxxxA	BENEFICIARY A	07/01/2011	11/2009	12/2009	$0.00	$0.00	$304.20	Y
xxxxxxxxxB	BENEFICIARY B	07/01/2011	06/2011	06/2011	$0.00	$0.00	$161.26	Y
xxxxxxxxxD	BENEFICIARY C	07/01/2011	01/2011	03/2011	$0.00	$0.00	$537.06	Y

Figure 10-85: MCO Representative (View Only) Adjustment Detail (M408) Screen

Table 10-98: MCO Representative (View Only) (M408) Field Descriptions and Actions

Item	Input/Output	Description
Claim # column heading	Sorter	Sorts adjustment information by beneficiary claim number.
Name column heading	Sorter	Sorts adjustment information by beneficiary name.
Create Date column	Output	Date adjustment was created for beneficiary.
Payment Period Start column	Output	Start of period to which adjustment was made for beneficiary.
Payment Period End column	Output	End of period to which adjustment was made for beneficiary.
Adjustments Part A column	Output	Part A adjustment amount for beneficiary.
Adjustments Part B column	Output	Part B adjustment amount for beneficiary.
Adjustments Part D column	Output	Part D adjustment amount for beneficiary.

Table 10-99: MCO Representative (View Only) (M408) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	No adjustment data for the reason code clicked.	The user should access Appendix B for contact information to report the error.
Software or Database Error	There was a systems problem retrieving your data	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving results from data	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input to stored procedure	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input	The user should access Appendix B for contact information to report the error.
Software or Database Error	No records returned from the database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

10.5.2 Viewing Beneficiary Payment Information

Payments are calculated or recalculated for a beneficiary when there is a change in enrollment, demographics, health status, factors, or other information used in the calculation. Adjustments are made to previously made payments that require changes.

The steps below show how to find these payments and adjustments for a particular beneficiary. After the user finds that information, they can view the complete history of payments and adjustments.

STEP 1: Accessing the Payments: Beneficiary (M403) screen

From the main menu, the user clicks on the |Payments| menu item. If not already selected, the user clicks on the |Beneficiary| submenu item to view the *Payments: Beneficiary (M403)* screen.

STEP 2: Getting a list of beneficiaries

The user accesses the *Payments: Beneficiary (M403)* screen for entering search criteria, as shown in **Figure 10-86** and described in **Table 10-100,** with error and validation messages provided in **Table 10-101**.

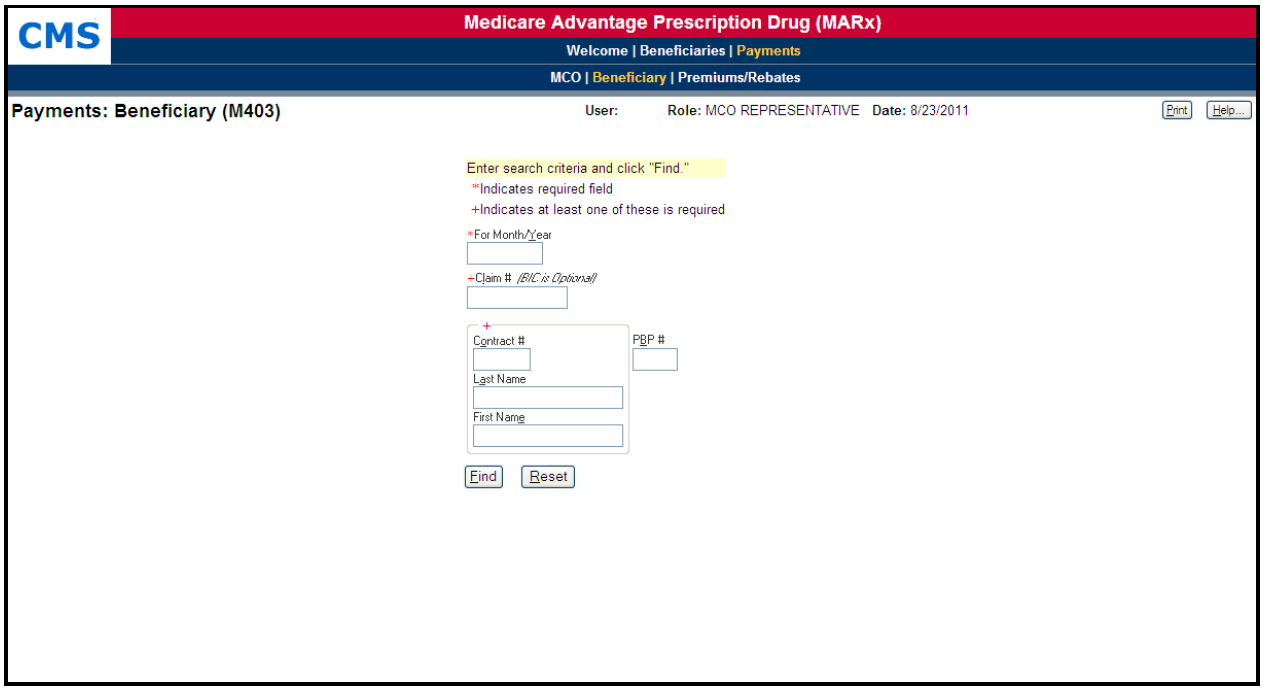


Figure 10-86: MCO Representative (View Only) Payments: Beneficiary (M403) Screen

Table 10-100: MCO Representative (View Only) (M403) Field Descriptions and Actions

Item	Input/Output	Description
For Month/Year	Required data entry field	The user finds beneficiaries with payments/adjustments in this month. The user enters the date in the form (M)M/YYYY.
Claim #	Required data entry field	If entered, the user finds beneficiaries with this claim number. **Note:** The BIC is optional except when an RRB number is entered. **Note:** At least one of these is required: Claim # *or* combination of Contract #, Last Name, and First Name.
Contract #(s)	Required data entry field	If entered, the user finds beneficiaries enrolled in this contract in a past, current, or future enrollment. **Note:** At least one of these is required: Claim # *or* combination of Contract #, Last Name, and First Name.
PBP #	Data entry field	If entered, the user finds beneficiaries currently enrolled in this PBP. The PBP is applicable only when a contract number is entered.
Last Name	Required data entry field	If entered, the user finds beneficiaries who currently have this last name. **Note:** At least one of these is required: Claim # *or* a combination of Contract #, Last Name, and First Name.
First Name	Required data entry field	If entered, the user finds beneficiaries who currently have this first name. **Note:** At least one of these is required: Claim # *or* a combination of Contract #, Last Name, and First Name.
[Find]	Button	The user clicks on this button to find the beneficiaries meeting the search criteria with payments/adjustments in the month/year indicated in the For Month/Year field.

Table 10-101: MCO Representative (View Only) (M403) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Month/Year must be entered	The user enters the month.
Missing entry	Enter claim # *or* a combination of contract #, last name, and first name.	The user enters one of the fields.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	The user re-enters the claim number.
Invalid format	A contract number must start with an 'H', '9', 'R', 'S', 'F,' or 'E' and be followed by 4 characters	The user re-enters the contract number.
Invalid format	PBP number must be 3 alpha-numeric characters	The user re-enters the PBP.
Invalid format	Month/Year is invalid. Must have format (M)M/YYYY	The user re-enters the date in one of the required formats.
Invalid format	The last name contains invalid characters	The user re-enters the name using only letters, apostrophes, hyphens, or blanks
Invalid entry	When a PBP is entered, a contract number must also be entered	The user enters a contract number.
Invalid entry	Invalid contract/PBP combination	The user must make sure the PBP is in the contract.
Invalid entry	When last name is entered, additional search criteria (besides For Month/Year) must also be entered	The user enters a claim number or contract in addition to or instead of a last name.
Invalid entry	You do not have access rights to this Contract.	The user must ensure that the contract number is entered correctly. If the user entered it correctly and should have rights to this contract, the user should contact the CO Computer Specialist, who can update the user profile to provide access to these rights.
No data	No payment beneficiary data found for the search criteria.	The user verifies the information entered. If an error was made, the user re-enters the information.
Software or Database Error	Error occurred validating contract/PBP combination	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid results when retrieving beneficiary payment data	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary payment data from database.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database = <error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

The user enters the search criteria to find the beneficiary or beneficiaries and the payment month/year in which the user is interested, and then clicks on the [Find] button. The beneficiaries that meet the search criteria and have payments and/or adjustments calculated for that month then display on the *Payments: Beneficiary Search Results (M404)* screen, as shown in **Figure 10-87** and described in **Table 10-102**. When the beneficiary is enrolled in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed. If a user enters an inactive Claim Number with a BIC, the system tries to find a more recent active Claim Number for the Beneficiary. See an example of this message in **Table 10-103.**

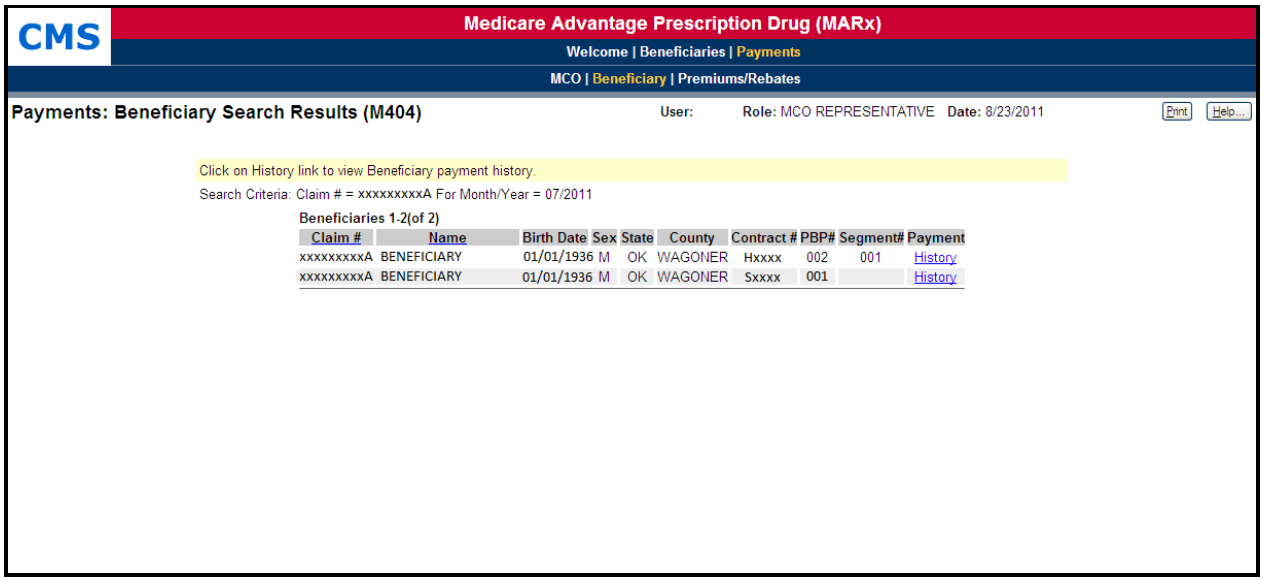


Figure 10-87: MCO Representative (View Only) Payments: Beneficiary Search Results (M404) Screen

Table 10-102: MCO Representative (View Only) (M404) Field Descriptions and Actions

Item	Input/Output	Description
Claim # column heading	Sorter	Sorts beneficiaries by their claim numbers.
Name column heading	Sorter	Sorts beneficiaries by their names.
Birth Date column	Output	Date beneficiary was born.
Sex column	Output	Sex of beneficiary.
State column	Output	State where beneficiary lived that month.
County column	Output	County where beneficiary lived that month.
Contract # column	Output	Payment is made for enrollment in this contract.
PBP# column	Output	Payment is made for enrollment in this PBP.
Segment# column	Output	Payment is made for enrollment in this segment.
History in the Payment column	Link	The user clicks on a History link to open the *Beneficiary Payment History (M406)* screen and views payments for the beneficiary up through the month/year indicated in the For Month/Year field.

Table 10-103: MCO Representative (View Only) (M404) Screen Messages

Message Type	Message Text	Suggested Action
Informational	The beneficiary's active claim number is displayed for the claim number entered.	None required

From this list of beneficiaries, the user can see how the rate calculations were made, investigate how the payments would change if information about the beneficiary changed, and review the payment history, as discussed in the sections below.

10.5.3 Viewing Beneficiary Payment History

This section discusses how to view the payment and adjustment history for a beneficiary. From the history, the user can view the details of the payments and adjustments for a particular month. This section describes the following steps for viewing Beneficiary Payment History by user role:

- STEP 1: Accessing the Beneficiary Payment History (M406) screen
- STEP 2: Understanding the payment history

STEP 1: Accessing the Beneficiary Payment History (M406) screen

From the *Payments: Beneficiary Search Results (M404)* screen (see **Figure 10-88**), the user clicks on the beneficiary's History link to open the *Beneficiary Payment History (M406)* screen, as shown in **Figure 10-88** and described in **Table 10-104**, with error and validation messages provided in **Table 10-105.** When the beneficiary is enrolled in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed.

Claim #:

DOB:

Age: **Sex:**

State: **County:**

Beneficiary Payment History (M406) **User:** **Role:** MCO REPRESENTATIVE **Date:** 11/3/2011 Close Print Help...

Payments 1-20(of 20) Go to Page: 1 Go

				Payments				Adjustments					
Payment Date	Contract	PBP#	Seg#	Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj	Total	Regional MA BSF
10/2011	Sxxxx	005	000	$0.00	$0.00	$113.26	$113.26	$0.00	$0.00	$0.00	$0.00	$113.26	$0.00
10/2011	Hxxxx	001	000	$307.93	$272.31	$0.00	$580.24	$0.00	$0.00	$0.00	$0.00	$580.24	$0.00
09/2011	Sxxxx	005	000	$0.00	$0.00	$113.26	$113.26	$0.00	$0.00	$0.00	$0.00	$113.26	$0.00
09/2011	Hxxxx	001	000	$307.93	$272.31	$0.00	$580.24	$0.00	$0.00	$0.00	$0.00	$580.24	$0.00
08/2011	Sxxxx	005	000	$0.00	$0.00	$113.26	$113.26	$0.00	$0.00	$0.00	$0.00	$113.26	$0.00
08/2011	Hxxxx	001	000	$307.93	$272.31	$0.00	$580.24	$0.00	$0.00	$0.00	$0.00	$580.24	$0.00
07/2011	Sxxxx	005	000	$0.00	$0.00	$113.26	$113.26	$0.00	$0.00	($68.46)	($68.46)	$44.80	$0.00
07/2011	Hxxxx	001	000	$307.93	$272.31	$0.00	$580.24	($1,017.06)	($899.40)	$0.00	($1,916.46)	($1,336.22)	$0.00
06/2011	Sxxxx	005	000	$0.00	$0.00	$124.67	$124.67	$0.00	$0.00	$0.00	$0.00	$124.67	$0.00
06/2011	Hxxxx	001	000	$477.44	$422.21	$0.00	$899.65	$0.00	$0.00	$0.00	$0.00	$899.65	$0.00
05/2011	Sxxxx	005	000	$0.00	$0.00	$124.67	$124.67	$0.00	$0.00	$0.00	$0.00	$124.67	$0.00
05/2011	Hxxxx	001	000	$477.44	$422.21	$0.00	$899.65	$0.00	$0.00	$0.00	$0.00	$899.65	$0.00
04/2011	Sxxxx	005	000	$0.00	$0.00	$124.67	$124.67	$0.00	$0.00	$0.00	$0.00	$124.67	$0.00
04/2011	Hxxxx	001	000	$477.44	$422.21	$0.00	$899.65	$0.00	$0.00	$0.00	$0.00	$899.65	$0.00
03/2011	Sxxxx	005	000	$0.00	$0.00	$124.67	$124.67	$0.00	$0.00	$0.00	$0.00	$124.67	$0.00
03/2011	Hxxxx	001	000	$477.44	$422.21	$0.00	$899.65	$0.00	$0.00	$0.00	$0.00	$899.65	$0.00
02/2011	Sxxxx	005	000	$0.00	$0.00	$124.67	$124.67	$0.00	$0.00	$0.00	$0.00	$124.67	$0.00
02/2011	Hxxxx	001	000	$477.44	$422.21	$0.00	$899.65	$0.00	$0.00	$0.00	$0.00	$899.65	$0.00
01/2011	Sxxxx	005	000	$0.00	$0.00	$124.67	$124.67	$0.00	$0.00	$0.00	$0.00	$124.67	$0.00
01/2011	Hxxxx	001	000	$477.44	$422.21	$0.00	$899.65	$0.00	$0.00	$0.00	$0.00	$899.65	$0.00

Figure 10-88: MCO Representative (View Only) Beneficiary Payment History (M406) Screen

Table 10-104: MCO Representative (View Only) (M406) Field Descriptions and Actions

Item	Input/ Output	Description
Payment Date column	Output	Indicates when payment/adjustments were paid.
Month/Year in Payment Date column	Link	The user clicks on a month/year link to open the *Payment/Adjustment Detail (M215)* screen.
Contract column	Output	Contracts for which payments/adjustments were made.
PBP # column	Output	PBPs for which payments/adjustments were made.
Seg # column	Output	Segments for which payments/adjustments were made.
Part A Payments column	Output	Part A payments for the beneficiary by month.
Part B Payments column	Output	Part B payments for the beneficiary by month.
Part D Payments column	Output	Part D payments for the beneficiary by month.
Total Pay column	Output	Totals of Part A, Part B, and Part D payments for the beneficiary by month.
Part A Adjustments column	Output	Part A adjustments for the beneficiary by month.
Part B Adjustments column	Output	Part B adjustments for the beneficiary by month.
Part D Adjustments column	Output	Part D adjustments for the beneficiary by month.
Total Adj column	Output	Totals of Part A, Part B, and Part D adjustments for the beneficiary by month.
Total Pay+Adj column	Output	Payments plus adjustments for the beneficiary by month.
Part B Premium Reduction column	Output	Is checked if a Part B premium, formerly called BIPA, reduction was applied to the payment and/or adjustments for the beneficiary that month.
Regional MA BSF column	Output	Lists the bonus paid from the regional MA BSF.

Table 10-105: MCO Representative (View Only) (M406) Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	No payment history records found.	The user should access Appendix B for contact information to report the error.
Software or Database Error	The result set that contains the history data is empty	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving payment history results from database.	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	The user should access Appendix B for contact information to report the error.
Software or Database Error	Missing input	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

STEP 2: Understanding the payment history

The *Beneficiary Payment History (M406)* screen lists the payments and adjustments for the beneficiary, starting with the month selected on the *Payments: Beneficiary (M403)* screen and going back in time. Each entry in the history includes:

- Month in which the payments/adjustments were made
- Enrollment contract and, as applicable, PBP, and segment
- Payments made that month, itemized by Part A, Part B, Part D, and combined
- Adjustments made that month for previous months, itemized by Part A, Part B, Part D, and combined
- Total amount paid in the month
- Indicator of whether a Part B premium reduction was taken
- Payment from the regional MA BSF

To view a further breakdown of the payments and adjustments, the user clicks on the month/year link, which opens the *Payment/Adjustment Detail (M215)* screen, **Section 10.3.19**.

10.5.4 Viewing Basic Premiums and Rebates

This section describes how to view the basic premiums and rebates for a contract, contract/PBP, or contract/PBP/segment combination. These are the premiums and rebates negotiated with an MCO, not the premiums and rebates calculated for a beneficiary.

STEP 1: Accessing the Basic Premiums and Rebates (M409) screen

From the main menu, the user clicks on the |Payments| menu item. If not already selected, the user clicks on the |Premiums/Rebates| submenu item to view the *Basic Premiums and Rebates (M409)* screen, as shown in **Figure 10-89** and described in **Table 10-106**, with error and validation messages provided in **Table 10-107**.

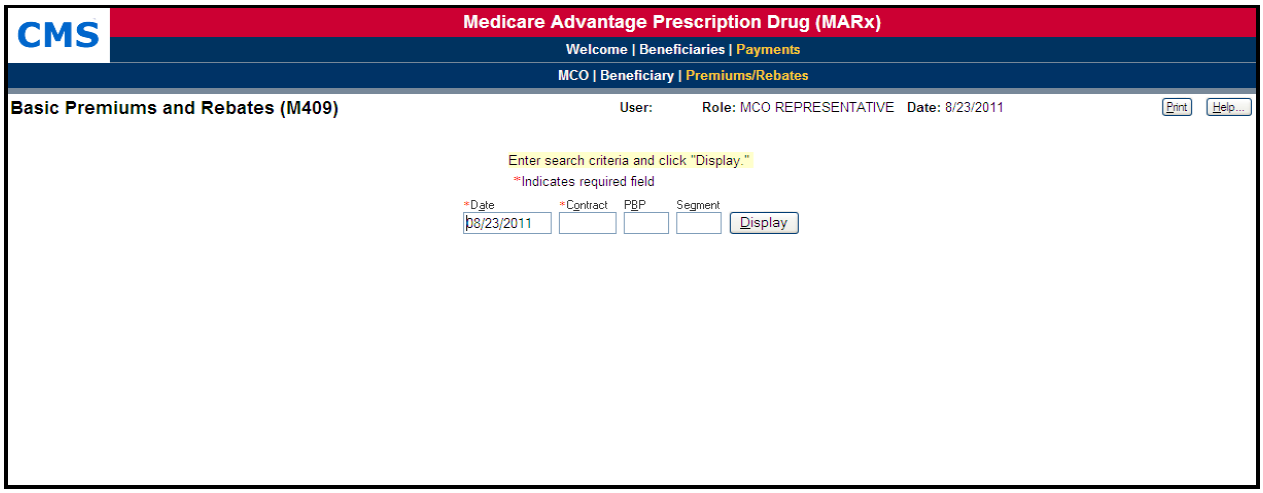


Figure 10-89: MCO Representative (View Only) Basic Premiums and Rebates (M409) Screen, Before Search Criteria Entered

Table 10-106: MCO Representative (View Only) (M409) Field Descriptions and Actions

Item	Input/Output	Description
Date	Required data entry field	Premiums and rebates are effective during this month; enter the date in the form (M)M/YYYY.
Contract	Required data entry field	Displays premiums and rebates that apply to this contract.
PBP	Data entry field	If entered, displays premiums and rebates that apply to this contract and PBP. Otherwise, displays the premiums and rebates at the contract level.
Segment	Data entry field	If entered, displays premiums and rebates that apply to this contract, PBP, and segment. Otherwise, displays the premiums and rebates at the contract or contract/PBP level.
[Display]	Button	The user clicks on this button to display the premiums and rebates for the contract and, if provided, PBP and segment.
Basic Part C Premium	Output	Part C premium in MCO contract.
Basic Part D Premium	Output	Part D premium in MCO contract.
Rebate for Part B Premium Reduction	Output	Rebate paid to MCO for reduction in Part B premium.
Rebate for A/B Cost Sharing	Output	Rebate paid to MCO for Part A/Plan B cost sharing.
Rebate for A/B Mandatory Supplemental Benefits	Output	Rebate paid to MCO for providing Part A/Part B mandatory supplemental benefits.
Rebate for Basic Part D Premium Reduction	Output	Rebate paid to MCO for reduction in basic Part D premium.
Rebate for Part D Supplemental Benefits	Output	Rebate paid to MCO for providing Part D supplemental benefits.

Table 10-107: MCO Representative (View Only) (M409) Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Date must be entered	The user enters the date**.**
Missing entry	A contract number must be entered	The user enters a contract number.
Invalid format	Date is invalid. Must have format (M)M/YYYY.	The user re-enters the date in one of the required formats.
Invalid format	A contract number must start with an ‘H’, ‘9’, ‘R’, ‘S’, ‘F,’ or ‘E’ and be followed by 4 characters	The user re-enters the contract number.
Invalid format	PBP number must be 3 alpha-numeric characters	The user re-enters the PBP.
Invalid format	Segment number must be a 3-digit number	The user re-enters the segment.
Invalid entry	When a segment is entered, a PBP must be entered also	The user makes sure to enter a PBP if the user is entering a segment.
Invalid entry	Invalid contract/PBP combination	The user makes sure the PBP is in the contract.

Message Type	Message Text	Suggested Action
Invalid entry	Invalid contract/PBP/segment combination	The user makes sure the PBP is in the contract and the segment is in the PBP.
Invalid entry	You do not have access rights to this Contract.	The user must ensure that the contract number is entered correctly. If the user entered it correctly and should have rights to this contract, the user should contact the CO Computer Specialist, who can update the user profile to provide access to these rights.
No data	No basic premiums and rebates were found for this contract	The user verifies the information entered. If an error was made, the user re-enters the information.
No data	No basic premiums and rebates were found for this contract and PBP	The user verifies the information entered. If an error was made, the user re-enters information.
No data	No basic premiums and rebates were found for this contract, PBP, and segment	The user verifies the information entered. If an error was made, the user re-enters the information.
Software or Database Error	Error occurred validating contract/PBP/segment combination	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving basic premiums and rebates	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

After entering the criteria, the user clicks on the [Display] button to show the premiums and rebates, which display on the same screen, below the criteria, as shown in **Figure 10-90**. The inputs, outputs, actions, error and validation messages, are described previously in **Tables 10-106** and **10-107**, respectively. To view different premiums and rebates, the user changes the search criteria and clicks on the [Display] button.

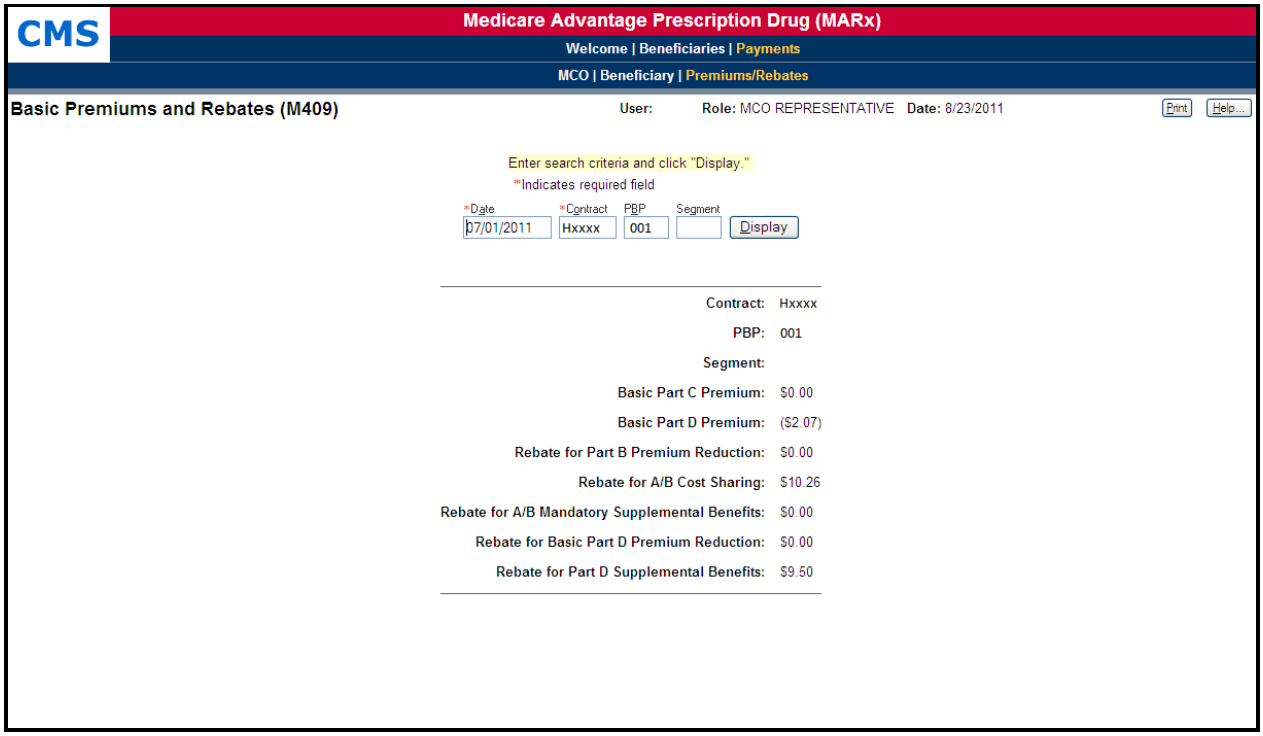


Figure 10-90: MCO Representative (View Only) Basic Premiums and Rebates (M409) Screen, After Search Criteria Entered

10.6 Reports

This section describes how to order copies of reports and data files generated for previous months. The ordered reports deliver via Connect:Direct NDM; Sterling Electronic Mailbox, Gentran; or TIBCO MFT Internet Server. See Section 1.6.1. There are various types of reports in MARx:

- Daily or randomly occurring reports and data files generate each day for events that occurred that day, including batch transaction file processing or report receipt.
- Weekly reports and data files are scheduled and automatically generate to reflect transactions processed that week for a contract.
- Month-end reports and data files are scheduled and automatically generate as part of monthly payment processing.
- Year-end reports and data files are scheduled and automatically generate as part of monthly payment processing.

Note: Only MCO Representative Transmitters may order reports. Appendices F and J provide descriptions and samples of data and report files.

10.6.1 STEP 1: Accessing the Reports: Find (M601) screen

From the main menu, the user clicks on the |Reports| menu item.

10.6.2 STEP 2: Getting a list of reports

From the *Reports: Find (M601)* screen, the user chooses the report frequency; monthly, weekly, daily or yearly. The selection criteria displayed is affected by the frequency chosen. The user enters the selection criteria that characterize the reports requested. The user clicks on the [Find] button to bring up the *Reports: Search Results (M602)* screen showing all of the reports that meet the criteria.

The *Reports: Find (M601)* screen with selection criteria for monthly reports is shown in **Figure 10-91** and described in **Table 10-108**, with error and validation messages provided in **Table 10-109.**

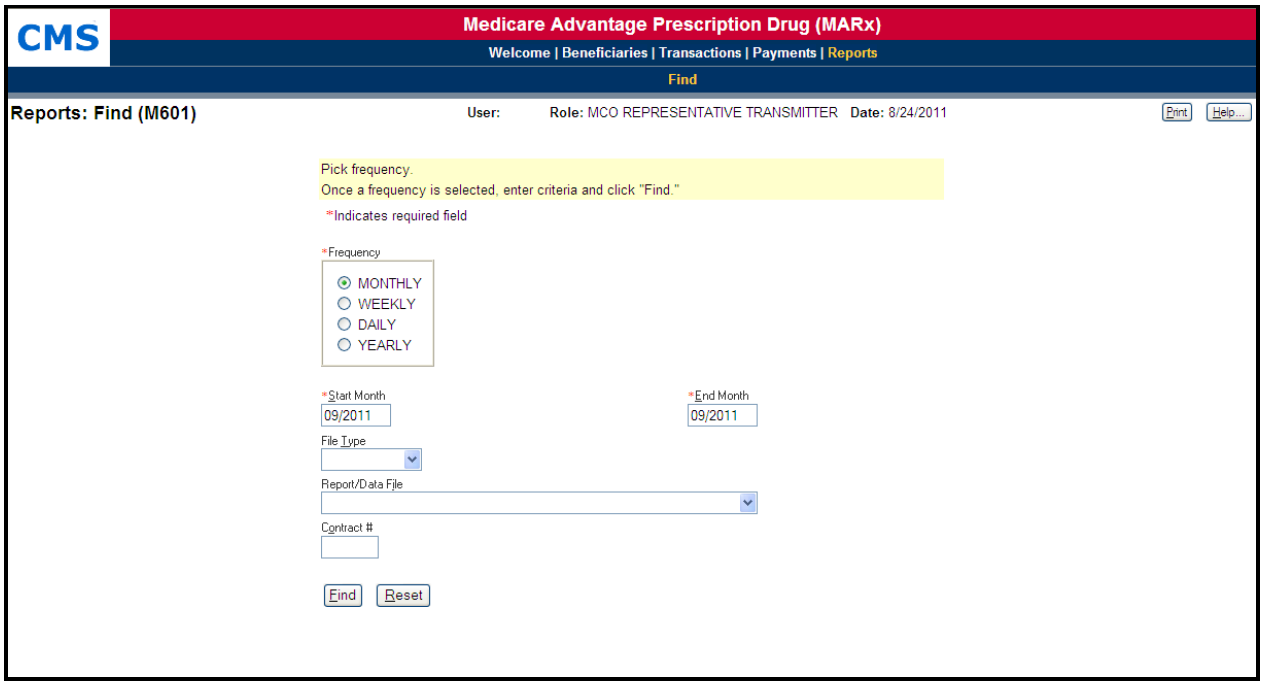


Figure 10-91: MCO Representative (Transmitter) Reports: Find (M601) Screen

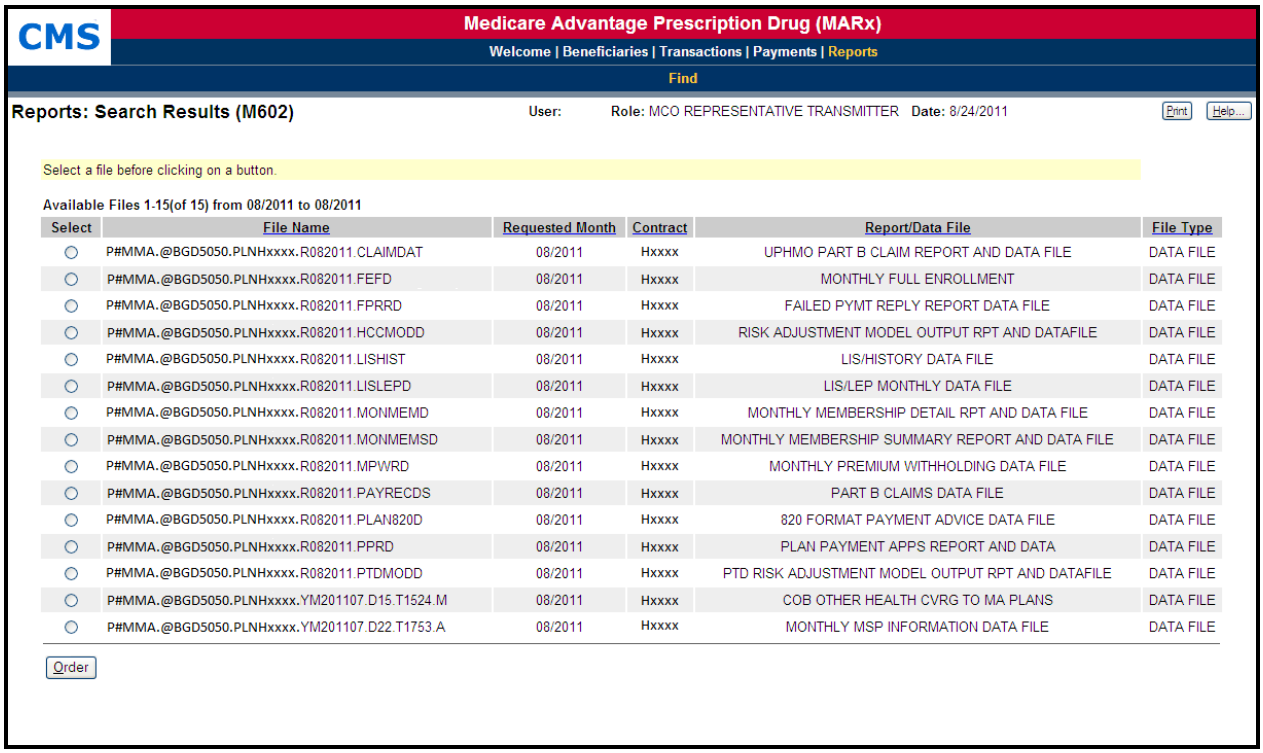
Table 10-108: MCO Representative (Transmitter) (M601) Field Descriptions and Actions for Monthly and Weekly Reports

Item	Input/Output	Description
Frequency	Required radio button	Select MONTHLY or WEEKLY.
Start Payment Month	Required data entry field	Search for reports for this payment Start month through End Payment Month. Enter as (M)M/YYYY. For monthly reports, defaults to the previous processing month. For daily and weekly reports, defaults to Current Processing Month.
End Payment Month	Required data entry field	Searches for reports for the Start Payment Month through this Payment End month. Enter as (M)M/YYYY. For monthly reports, defaults to the previous processing month. For daily and weekly reports, defaults to Current Processing Month.
File Type	Dropdown list	The user clicks on arrow and selects value to narrow search to report or data file. **Note:** When the File Type is selected, the user does not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Report/Data File	Dropdown list	The user clicks on arrow and selects value to narrow search to type of report or data file. **Note:** When the File Type is selected, the user does not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Contract #	Data entry field	The user enters to narrow search to a particular contract
[Find]	Button	After entering the search criteria, the user clicks on this button to display the list of reports.

Table 10-109: MCO Representative (Transmitter) (M601) Screen Messages for Monthly and Weekly Reports

Message Type	Message Text	Suggested Action
Missing entry	Start Payment Month must be entered	The user enters the month.
Missing entry	End Payment Month must be entered	The user enters the month.
Invalid format	Start Payment Month is invalid. Must have format (M)M/YYYY	The user re-enters the month in one of the required formats.
Invalid format	End Payment Month is invalid. Must have format (M)M/YYYY	The user re-enters the month in one of the required formats.
Invalid format	A contract number must start with an 'H', '9', 'R', 'S', 'F,' or 'E' and be followed by 4 characters	The user re-enters the contract number.
Invalid entry	Cannot specify both file type and report/data file	The user deselects one of the selections.
Invalid entry	You do not have access rights to this Contract	The user must ensure that the contract number is entered correctly. If the user entered it correctly and should have rights to this contract, the user should contact the CO Computer Specialist, who can update the user profile to provide access to these rights.
No data	No files meet the search criteria	The user verifies the criteria that they entered.
Software or Database Error	Error occurred while retrieving list of files	The user should access Appendix B for contact information to report the error.
Software or Database Error	Database error occurred finding list of files	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

The results list of reports is shown in **Figure 10-92** and described in **Table 10-110**, with error and validation messages provided in **Table 10-111**. From this list, the user can select a report or data file and click the [Order] button. The user receives a message that the order was submitted.



Select	File Name	Requested Month	Contract	Report/Data File	File Type
○	P#MMA.@BGD5050.PLNHxxxx.R082011.CLAIMDAT	08/2011	Hxxxx	UPHMO PART B CLAIM REPORT AND DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.FEFD	08/2011	Hxxxx	MONTHLY FULL ENROLLMENT	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.FPRRD	08/2011	Hxxxx	FAILED PYMT REPLY REPORT DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.HCCMODD	08/2011	Hxxxx	RISK ADJUSTMENT MODEL OUTPUT RPT AND DATAFILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.LISHIST	08/2011	Hxxxx	LIS/HISTORY DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.LISLEPD	08/2011	Hxxxx	LIS/LEP MONTHLY DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.MONMEMD	08/2011	Hxxxx	MONTHLY MEMBERSHIP DETAIL RPT AND DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.MONMEMSD	08/2011	Hxxxx	MONTHLY MEMBERSHIP SUMMARY REPORT AND DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.MPWRD	08/2011	Hxxxx	MONTHLY PREMIUM WITHHOLDING DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.PAYRECDS	08/2011	Hxxxx	PART B CLAIMS DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.PLAN820D	08/2011	Hxxxx	820 FORMAT PAYMENT ADVICE DATA FILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.PPRD	08/2011	Hxxxx	PLAN PAYMENT APPS REPORT AND DATA	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.R082011.PTDMODD	08/2011	Hxxxx	PTD RISK ADJUSTMENT MODEL OUTPUT RPT AND DATAFILE	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.YM201107.D15.T1524.M	08/2011	Hxxxx	COB OTHER HEALTH CVRG TO MA PLANS	DATA FILE
○	P#MMA.@BGD5050.PLNHxxxx.YM201107.D22.T1753.A	08/2011	Hxxxx	MONTHLY MSP INFORMATION DATA FILE	DATA FILE

Figure 10-92: MCO Representative (Transmitter) Reports: Search Results (M602) Screen for Monthly, Weekly, and Daily Reports

Table 10-110: MCO Representative (Transmitter) (M602) Field Descriptions and Actions for Monthly, Weekly, and Daily Reports

Item	Input/Output	Description
Select column	Radio button	The user clicks on one of the buttons to indicate which file to order.
File Name column heading	Sorter	Sorts all files by file name.
Payment Month column heading	Sorter	Sorts all files by payment month.
Contract column heading	Sorter	Sorts all files by contract number.
Report/Data File column heading	Sorter	Sorts all files by type of report or data file.
File Type column heading	Sorter	Sorts all files by file type, either report or data.
[Order]	Button	After selecting a file, the user clicks on this button to request that the file is placed in the mailbox.

Table 10-111: MCO Representative (Transmitter) (M602) Screen Messages for Monthly, Weekly, and Daily Reports

Message Type	Message Text	Suggested Action
Missing entry	Select a file to order	The user finds the file to order and clicks on the file selection radio button next to the file name.
Software or Database Error	Invalid input to database when requesting that the file be ordered	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting that the file be ordered	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database when requesting order of file=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.
Software or Database Error	A security violation has occurred. You do not have access rights to this file.	The user should access Appendix B for contact information to report the error.
Success	Request submitted for order of <file name>.	No action required.

10.6.3 Weekly Reports

Weekly reports are accessed the same way as monthly reports. Note the selection criteria require the payment month, not the report generation month. The *Reports: Find (M601)* screen is the same as shown in **Figure 10-92,** except that the WEEKLY frequency is selected. The results list of weekly reports is similar to **Figure 10-92,** except that the report/data files names are different, and described in **Table 10-110**, with error and validation messages in **Table 10-111**.

10.6.4 Daily Reports

The *Reports: Find (601)* screen with selection criteria for daily reports is shown in **Figure 10-93** and described in **Table 10-112**, with error and validation messages in **Table 10-111.**

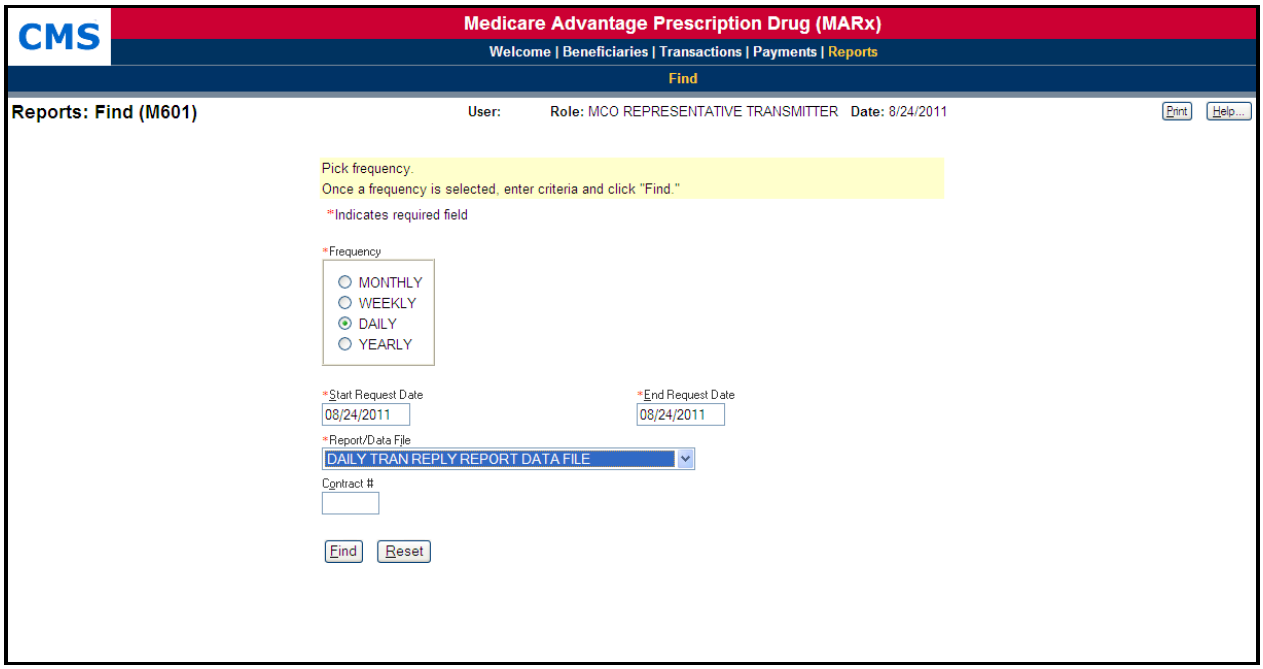


Figure 10-93: MCO Representative (Transmitter) Reports: Find (M601) Screen for Daily Reports

Table 10-112: MCO Representative (Transmitter) (M601) Field Descriptions and Actions for Daily Reports

Item	Input/Output	Description
Frequency	Required radio button	The user selects DAILY.
Start Request Date	Required data entry field	Search for reports generated on or after this date. The user enters as (M)M/(D)D/YYYY. Defaults to current date.
End Request Date	Required data entry field	Search for reports generated on or before this date. The user enters as (M)M/(D)D/YYYY. Defaults to current date.
Report/Data File	Required dropdown list	The user clicks on arrow and selects value to narrow search to type of report or data file.
Contract #	Data entry field	The user enters to narrow search to a particular contract.
[Find]	Button	After entering the search criteria, the user clicks on this button to display the list of reports.

10.6.5 Yearly Reports

The *Reports: Find (M601)* screen with selection criteria for yearly reports is shown in **Figure 10-94** and described in **Table 10-113**, with error and validation messages in **Table 10-114.**

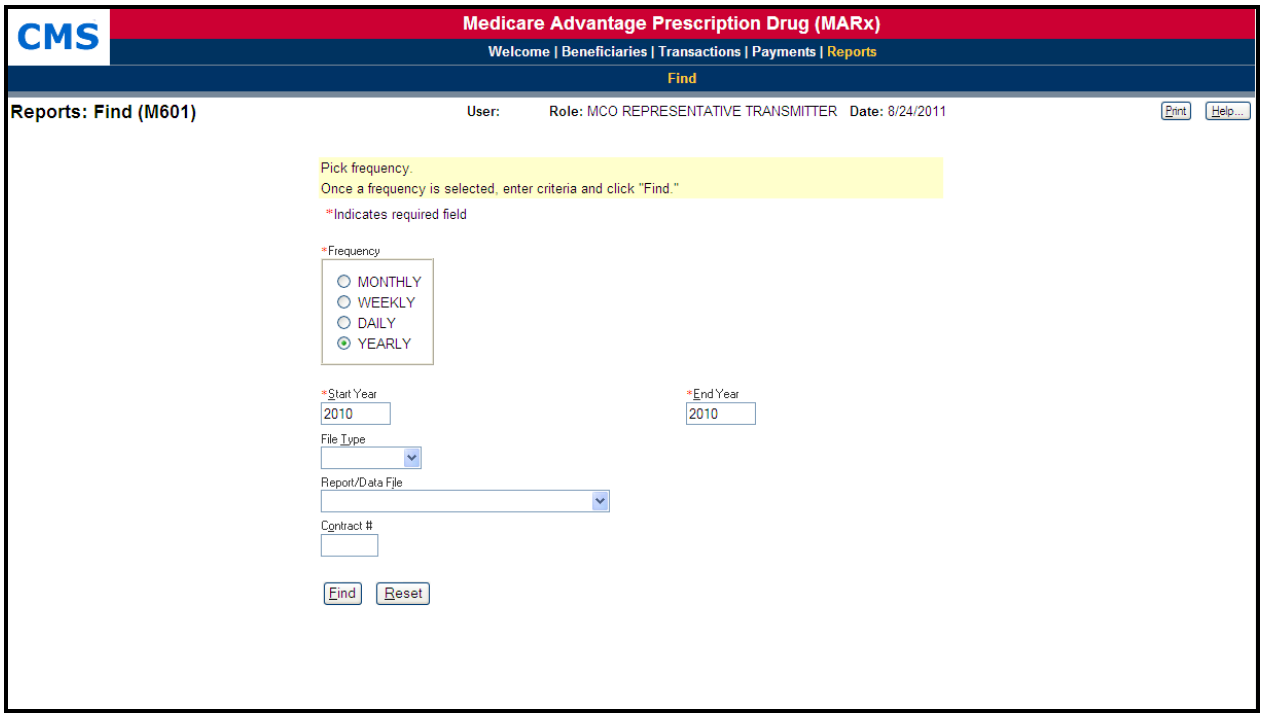


Figure 10-94: MCO Representative (Transmitter) Reports: Find (M601) Screen for Yearly Reports

Table 10-113: MCO Representative (Transmitter) (M601) Field Descriptions and Actions for Yearly Reports

Item	Input/Output	Description
Frequency	Required radio button	The user selects YEARLY
Start Year	Required data entry field	Searches for report for this year to End year. Enter as (YYYY). For yearly reports, defaults to the previous processing year.
End Year	Required data entry field	Searches for Start Year to this Year report. Enter as (YYYY). For yearly reports, defaults to previous processing year.
File Type	Dropdown list	The user clicks on arrow and selects value to narrow search to report, data file, or combined. **Note:** When the File Type is selected, do not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Report/Data File	Dropdown list	The user clicks on arrow and selects value to narrow search to type of report or data file. **Note:** When the File Type is selected, the user does not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Contract #	Data entry field	The user enters to narrow search to a particular contract.
[Find]	Button	After the search criteria are entered, the user clicks on this button to display the list of reports.

Table 10-114: MCO Representative (Transmitter) (M601) Screen Messages for Yearly Reports

Message Type	Message Text	Suggested Action
Missing entry	A year must be entered	The user enters the year.
Missing entry	A year must be entered	The user enters the year.
Invalid format	Year must be a 4-digit number	The user re-enters the year in a required format.
Invalid format	Year must be a 4-digit number	The user re-enters the year in a required format.
Invalid format	A contract number must start with an 'H', '9', 'R', 'S', 'F', or 'E' and be followed by 4 characters	The user re-enters the contract number.
Invalid entry	Cannot specify both file type and report/data file	The user deselects one of the selections.
Invalid entry	You do not have access rights to this Contract.	The user must ensure that the contract number is entered correctly. If the user entered it correctly and should have rights to this contract, the user contacts the CO Computer Specialist, who updates the user profile to provide access to these rights.
No data	No files meet the search criteria	The user verifies the criteria that the user entered.
Software or Database Error	Error occurred while retrieving list of files	The user should access Appendix B for contact information to report the error.
Software or Database Error	Database error occurred finding list of files	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database=<error code>	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.

The results list of reports is shown in **Figure 10-95** and described in **Table 10-115**, with error and validation messages provided in **Table 10-116**. If a report was not accessed for several years, the user must first retrieve it before accessing it. The screen is divided into two sections: reports immediately available and reports that need retrieval. If no files meet the criteria for a section, that section is not displayed.

Figure 10-95: MCO Representative (Transmitter) Reports: Search Results (M602) Screen for Yearly Reports

Table 10-115: MCO Representative (Transmitter) (M602) Field Descriptions and Actions for Yearly Reports

Item	Input/Output	Description
Select column	Radio button	The user clicks on one of the buttons to indicate which file to order.
File Name column heading	Sorter	Sorts all files by file name.
Year column heading	Sorter	Sorts all files by year.
Create Date column heading	Sorter	Sorts all files by create date.
Contract column heading	Sorter	Sorts all files by contract number.
Report/Data File column heading	Sorter	Sorts all files by type of report or data file.
File Type column heading	Sorter	Sorts all files by file type, either report or data.
[Order]	Button	After selecting a file, the user clicks on this button to request placement of the file in the mailbox.
www.Adobe.com	Link	A Web link to the Adobe Web site, where the user can download a free copy of the Adobe Acrobat Reader, required for viewing or local printing. **Note:** The user must connect to the Internet to download Acrobat.

Table 10-116: MCO Representative (Transmitter) (M602) Screen Messages for Yearly Reports

Message Type	Message Text	Suggested Action
Missing entry	Select a file to view/print	The user finds the file to view/print and clicks on the file selection radio button next to the file name.
Missing entry	Select a file to download	The user finds the file to download and clicks on the file selection radio button next to the file name.
Missing entry	Select a file to print	The user finds the file to print on a mainframe printer and clicks on the file selection radio button next to the file name.
Missing entry	Select a file to write to tape	The user finds the file to write to tape and click son the file selection radio button next to the file name.
Missing entry	Select a file to retrieve	The user finds the file to retrieve and clicks on the file selection radio button next to the file name.
Software or Database Error	Invalid input to database when requesting retrieval of file	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting retrieval of file	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database when requesting retrieval of file	The user should access Appendix B for contact information to report the error.
Software or Database Error	Invalid input to database when requesting that the group be printed	The user should access Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting that the group be printed	The user should access Appendix B for contact information to report the error.
Software or Database Error	Unexpected error occurred requesting that the group be printed	The user should access Appendix B for contact information to report the error.
Software or Database Error	Connection error	The user should access Appendix B for contact information to report the error.
Software or Database Error	A security violation has occurred. You do not have access rights to this file.	The user should access Appendix B for contact information to report the error.
Success	Request submitted for retrieval of <file name>. Check the Welcome page for a message that retrieval is complete.	No action required.

11 Reporting Identified Drug Overutilizers

In the section entitled, "Improving Drug Utilization Review Controls in Part D" of the Final Contract Year (CY) 2013 Call Letter issued on April 2, 2012 and in supplemental guidance issued on September 6, 2012, CMS described how Medicare Part D sponsors can comply with drug utilization management (DUM) requirements of 42 C.F.R §423.153 et seq. to prevent overutilization of opioids.[3] In general, the guidance addressed the following expectations for sponsors to address overutilization of opioids effective January 1, 2013:

- Appropriate controls at point of sale (POS), including beneficiary-level claim edits.
- Improved retrospective drug utilization review (DUR) to identify at-risk beneficiaries.
- Case management with the beneficiaries' prescribers.
- Data-sharing between Part D sponsors regarding beneficiary overutilization.

This chapter provides instructions for sponsors to submit beneficiary-level POS drug edit information to CMS, which will automate the current process of providing this information to CMS as well as data-sharing regarding such edits between Part D sponsors.

11.1 CMS Notification of Identified Drug Overutilizers with a POS Drug Edit by Sponsors

(General Instructions)

Sponsors will submit beneficiary-level POS drug edit information for Identified Drug Overutilizers of opioids to CMS through a new POS Drug Edit batch transaction (Transaction Type 90). Sponsors should continue to provide a copy of the notification letter and beneficiary data to the CMS mailbox and their CMS account manager per previous CMS guidance.

POS Drug Edit transactions are submitted in the same way enrollment transactions are submitted to MARx using the MARx Batch Input Transaction Data File. They can be incorporated into batches of enrollment transactions or submitted as a separate batch file. Transaction Reply Codes (TRCs) are returned in the Daily Transaction Reply Report (DTRR) data file to relay the results of the transaction processing. For an overview of transaction processing see Chapter 4 Transaction Processing within the PCUG.

Sponsors should submit POS Drug Edit data to MARx when any of the following occurs:

- The sponsor notifies the beneficiary of a POS Drug Edit implementation (Notification).
- The sponsor implements the POS Drug Edit (Implementation).
- The sponsor terminates the POS Drug Edit (Termination).
- The sponsor modifies the POS Drug Edit record after Notification or Implementation.

Appendix F, Table 3.5.5, provides the POS Drug Edit (TC 90) Detailed Record Layout.

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[3] *Additional information about the CMS overutilization policy is available on the CMS Web site at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html.*

Appendix F, Table F.3.7 provides valid values for All Plans-Submitted Transaction Types.

POS Drug Edits are at the contract level (not contract/PBP). Contracts are only allowed to access or modify beneficiary POS Drug Edit information during periods of the beneficiary's enrollment within that contract with a drug Plan. If a beneficiary changes from a PBP with a drug Plan to a PBP without a drug Plan and the contract remains the same, the contract is only allowed to submit POS Drug Edit records for the time period when the beneficiary is enrolled in the PBP with a drug Plan. A Plan can submit a TR 90 record after the beneficiary disenrolls, as long as the notification, implementation and/or termination dates occur during the beneficiary's enrollment within the contract with a drug Plan.

11.1.1 Contract Notification of Active POS Drug Edit

MARx associates an Active POS Drug Edit indicator with a beneficiary-contract enrollment if the latest POS Drug Edit status for at least one drug class is either Notification (Status = 'N') or Implementation (Status = 'I'). When a beneficiary enrolls in a new contract, the new contract ("gaining") is notified if a newly enrolled beneficiary had an Active POS Drug Edit indicator while enrolled in the immediately preceding Part D contract ("losing"). This notification is provided to the new contract via the DTRR with TRC 322, New Enrollee POS Drug Edit Notification. The reply with TRC 322 accompanies the TRCs associated with the enrollment acceptance and has a transaction type code of 61 (Enrollment).

Once the New Enrollee POS Drug Edit Notification (TRC 322) is provided to the new contract, an Active POS Drug Edit indicator is no longer associated with the beneficiary. Since the reply does not include the drug class or real-time status of the POS Drug Edit, identification of the prior contract is provided in the DTRR to facilitate communication between the contracts. The contract is advised to contact the previous contract's Medicare Part D overutilization contact for more information about the beneficiary's POS opioid edit and overutilization case file. The 'gaining' contract uses this information to determine if a beneficiary-specific POS drug edit is appropriate per previous CMS guidance. If so, the contract should provide 30-day advance notice to the beneficiary per previous CMS guidance and submit the information through MARx to CMS per the instructions above.

LiNet or retrospective short-enrollments are not considered a 'losing' contract or new enrollment for purposes of the New Enrollee POS Drug Edit Notification, and are therefore excluded, i.e., they will not receive TRC 322.

Appendix I, Table I-2 lists the current TRCs.

Appendix F, Table F.5.1 provides the DTRR layout.

11.1.2 CMS and Contract Communications

CMS users have the ability to flag information that is possibly erroneous. After the CMS user flags the information, the contract is notified via the DTRR with TRC 720, CMS Audit Review POS Drug Edit. If the contract has questions after receiving TRC720, they should contact CMS via e-mail at PartDPolicy@cms.hhs.gov with subject "POS Edit Reporting" to discuss the POS Drug Edit information.

An example of a situation that may be flagged by CMS is receipt of two notification records for the same contract, beneficiary, POS Drug Edit Class and Code but neither notification is implemented or terminated.

11.1.3 Notification, Implementation, and Termination of POS Drug Edits (Specific Instructions)

The contract should submit the POS Drug Edit Notification, Implementation, and Termination records to CMS when issuing the written notification of a POS Drug Edit to the beneficiary, implementing such an edit, and deciding that a termination record is warranted. (Deletion of POS Drug Edits Records and Modified POS Drug Edit Code Implementations are covered in Sections 11.2 and 11.4 respectively below).

Notification Status 'N'

POS Drug Edit Notification record (status = 'N') should be submitted to CMS using a POS Drug Edit transaction (TC 90). In addition to beneficiary and contract information, the following details are required for a notification record:

- POS Drug Edit Status = 'N'
- POS Drug Edit Drug Class = 'OPI' (opioids)
- POS Drug Edit Code either
  - PS1 = No drugs in this class are approved by the Plan or
  - PS2= Selected drugs in this class are approved by the Plan
- POS Drug Edit Notification Date
  - Actual date of the POS Drug Edit Notification written notice that was sent to the beneficiary
- POS Drug Edit Update/Delete Flag = 'U'

Since the beneficiary has 30 days to contest the POS Drug Edit, at the end of this time period, the POS Drug Edit will be:

- Implemented as stated in the POS Drug Edit Notification provided to the beneficiary, or
- Implemented with a modified POS Drug Edit (see 11.4), or
- Terminated – not implemented.

Therefore, the contract should submit a POS Drug Edit Implementation (status = 'I') or Termination (status = 'T') record to CMS using a POS Drug Edit transaction (TC 90).

Notification Status "I"

A contract should submit a POS Drug Edit Implementation (status 'I') if the edit is implemented as stated in the POS Drug Edit Notification provided to the beneficiary. In addition to beneficiary and contract information, the following details are required for an Implementation record:

- POS Drug Edit Status = 'I'
- POS Drug Edit Drug Class = 'OPI' (opioids)
- POS Drug Edit Code – must be the same or less restrictive than the POS Drug Edit Notification Record, either
  - PS1 = No drugs in this class are approved by the Plan, or
  - PS2= Selected drugs in this class are approved by the Plan
    Note: PS2 is less restrictive than PS1.
- POS Drug Edit Notification Date
  - Actual date the POS Drug Edit Notification was sent to the beneficiary
    - MUST match an existing POS Drug Edit Notification record for the beneficiary and contract
- POS Drug Edit Implementation Date

    - Actual date the POS Drug Edit was implemented
- POS Drug Edit Update/Delete Flag = 'U'

Notification Status 'T'

A contract should submit a POS Drug Edit Termination (status = 'T') record if a determination was made not to implement a POS Drug Edit for a beneficiary who was notified of a potential POS Drug Edit. A contract may also terminate a POS Drug Edit that was implemented if the contract determines at any point that it is no longer appropriate. In addition to beneficiary and contract information, the following details are required for a termination record:

- POS Drug Edit Status = 'T'
- POS Drug Edit Drug Class = 'OPI'
- POS Drug Edit Code – must be the same as an existing notification or implementation (if it exists) record(s), either
    - PS1 = No drugs in this class are approved by the Plan, or
    - PS2= Selected drugs in this class are approved by the Plan
- POS Drug Edit Notification Date
    - Actual date the POS Drug Edit Notification was sent to the beneficiary
        - MUST match an existing POS Drug Edit Notification record for the beneficiary and contract
- POS Drug Edit Implementation Date (if it exists)
    - Actual date the POS Drug Edit was implemented
        - MUST match an existing POS Drug Edit Implementation record for the beneficiary and contract
- POS Drug Edit Termination Date
    - Actual date the POS Drug Edit was terminated
- POS Drug Edit Update/Delete Flag = 'U'

11.2 Deletion of POS Drug Edit Records

There are instances when an existing POS Drug Edit record must be removed from the MARx system. A deletion record can be submitted via batch.

Examples of scenarios when the deletion of a POS Drug Edit record is appropriate:

- Date, Class, or Code corrections following a data-entry error.
    - The Plan must then submit the correct record AFTER deleting the record.
- "Future-dated" (Status 'I') records that are determined to be incorrect.
- A record is erroneously submitted.

The deletion of a POS edit record is not appropriate if the sponsor modifies the POS Drug Edit after Notification or Implementation. A record should not be deleted if a POS Drug Edit determination was made by the sponsor, the beneficiary was notified, and the edit was or was not implemented.

For example, if a beneficiary is notified of a potential POS Drug Edit and the sponsor subsequently decides not to implement the POS Drug Edit, then the notification record should NOT be deleted. The contract should terminate the POS Drug Edit by submitting a termination record as described above. However, if the Notification record is erroneous, such as a notification record for the wrong beneficiary was submitted, then that Notification record should be deleted.

For the record to be deleted, a deletion record is submitted by providing all of the applicable fields with matching values to the original record with a POS Drug Edit Update/Delete Flag = 'D'. For example, a future-dated 'Implementation' record was submitted to CMS, and the POS edit was never implemented. In this case, the contract should provide the following information in addition to beneficiary and contract information:

- POS Drug Edit Status = 'I'
- POS Drug Edit Drug Class = 'OPI'
- POS Drug Edit Code
    - MUST match an existing POS Drug Edit Implementation record
- POS Drug Edit Notification and Implementation Dates
    - MUST match an existing POS Drug Edit Notification and Implementation record
- POS Drug Edit Update/Delete Flag = 'D'

A deletion record must have the same beneficiary data, contract, POS Drug Edit Class, Code, Status and Dates as an existing POS Drug Edit record.

11.3 General Rules for POS Drug Edit Records

The user may read this section in its entirety, but it is also designed as a reference.

It is important that contracts note that Notification, Implementation, and Termination records are associated with each other in the MARx system. A POS Drug Edit Event consists of a POS Drug Edit Notification and any POS Drug Edit Implementation and Termination records that are associated with that POS Drug Edit Notification. Below is a list of rules for submitting updated records:

- A POS Drug Edit Notification record can only be associated with one Implementation and Termination record at a time (see section 11.4 Modified POS Drug Edit Implementation).
- An Implementation record must contain the POS Drug Edit Notification Date of the associated POS Drug Edit Notification record.
- An Implementation record must have the same or less restrictive POS Drug Edit Code as the associated POS Drug Edit Notification record.
    - PS2 is less restrictive than PS1.
- A POS Drug Edit Termination record must contain the POS Drug Edit Notification Date and Implementation Date (if it exists) of the associated POS Drug Edit Notification and POS Drug Edit Implementation (if it exists) records.

In order to make any corrections via batch, an existing erroneous POS Drug Edit Record should be deleted and then the corrected record should be submitted, if applicable. If a POS Drug Edit determination was made, the notification letter was mailed to the beneficiary, and CMS has the correct POS Drug Edit Notification dates, there is usually no valid reason for deleting the POS Drug Edit Notification record (an exception is if the wrong beneficiary was sent a POS Drug Edit Notification letter). This is because, in order to avoid unassociated records and to improve efficiency, the system will automatically perform deletes for POS Drug Edit Notification and Implementation Records as detailed below:

- If a delete (update/delete flag = 'D') transaction is received for a POS Drug Edit Notification (status = 'N') record with associated POS Drug Edit Implementation and/or Termination records, the associated POS Drug Edit Implementation and/or Termination records are also deleted.

- If a delete transaction (update/delete flag = 'D') is received for a POS Drug Edit Implementation (status = 'I') record with an associated POS Drug Edit Termination record, the associated POS Drug Edit Termination record will also be deleted.

If a POS Drug Edit Event contains POS Drug Edit Notification and Termination records without a POS Drug Edit Implementation record, it is not possible to add a POS Drug Edit Implementation record without first deleting the existing POS Drug Edit Termination record. After adding the POS Drug Edit Implementation record, the POS Drug Edit Termination record can be re-submitted, if appropriate.

POS Drug Edit records received on a batch file are sorted in the following order by the MARx system:

- Delete records are sorted before update (add) records and are sorted in the following order:
  - POS Drug Edit Termination records
  - POS Drug Edit Implementation records
  - POS Drug Edit Notification records
- Update (add) records are sorted in the following order:
  - POS Drug Edit Notification records
  - POS Drug Edit Implementation records
  - POS Drug Edit Termination records

Duplicate update (add) POS Drug Edit records are not allowed. A duplicate POS Drug Edit record is one with the same beneficiary data, Contract, POS Drug Edit Class, Status, Code and dates as an existing record.

If a beneficiary disenrolls from the contract that notified the beneficiary of the POS, the Plan should not submit a POS Drug Edit Termination record. If a Termination record is submitted, the "gaining" contract will not receive the Active POS Drug Edit indicator. In addition, if the beneficiary dies it is un-necessary for the Plan to submit a termination record.

"Future Dated" Notification, Implementation or Termination records are allowed (but not recommended) and limited to the current and upcoming calendar month.

> For example, if the current date is 12/19/2013, a notification date that is between 12/20/2013 and 1/31/2014 is accepted but a notification date of 2/1/2014 would be rejected. Similarly, if the current date and notification date are 1/20/2014, the "future-dated" implementation date must be between 2/20/2014 and 2/28/2014.

Below are rules related to POS Drug Edit **dates**:

- A POS Drug Edit Notification (status = 'N') record must have blank POS Drug Edit Implementation and Termination dates.
- A POS Drug Edit Implementation ('I') record must have a blank POS Drug Edit Termination date.
- POS Drug Edit Notification, Implementation and Termination dates must be within the beneficiary's contract enrollment period of an applicable drug Plan.
- A POS Drug Edit Implementation (status = 'I') record's Implementation date must be 30 or more days after the associated POS Drug Edit Notification record's notification date.
- A POS Drug Edit Termination (status = 'T') record's Termination date must be on or after the associated POS Drug Edit Notification record's notification date if there is not an associated POS Drug Edit Implementation record.
- A POS Drug Edit Termination (status = 'T') record's Termination date must be on or after the associated POS Drug Edit Implementation record's Implementation date.

11.4 Modified POS Drug Edit Code Implementations

This section discusses situations where the modifications to records would be appropriate.

Situation 1: A contract determines that a more restrictive POS Drug Edit (PS1) is appropriate, provides written notice to the beneficiary, but before or after implementation, determines that a less restrictive POS Drug Edit (PS2) is appropriate.

If the contact determines that a less restrictive POS Drug Edit (PS2) is appropriate than was stated in the original submitted POS Drug Edit (PS1) Notification record, and the POS Drug Edit (PS1) Implementation record was not submitted, the contract should provide the following information in addition to beneficiary and contract information:

- POS Drug Edit Status = 'I'
- POS Drug Edit Drug Class = 'OPI'
- POS Drug Edit Code = PS2
- POS Drug Edit Notification Date
    - MUST match an existing POS Drug Edit Notification Record (originally submitted with PS1 Drug Edit Code)
- POS Drug Edit Update/Delete Flag = 'U'

In the scenario above, if the POS Drug Edit (PS1) Implementation record was submitted, the contract should submit a POS Drug Edit Termination record with the following information in addition to beneficiary and contract information:

- POS Drug Edit Status = 'T'
- POS Drug Edit Drug Class = 'OPI'
- POS Drug Edit Code = PS1
- POS Drug Edit Notification Date
    - MUST match the existing POS Drug Edit Notification record for the beneficiary and contract
- POS Drug Edit Implementation Date
    - MUST match the existing POS Drug Edit Implementation record for the beneficiary and contract
- POS Drug Edit Termination date
    - Actual date the POS Drug Edit was terminated
- POS Drug Edit Update/Delete Flag = 'U'

Next, the contract should submit a new POS Drug Edit Implementation record with the less restrictive POS Drug Edit Code (PS2) and the original POS Drug Edit Notification date (same as above example implementation).

Situation 2: A contract determines that a more restrictive POS Drug Edit (PS1) is appropriate after providing written notice to the beneficiary that a less restrictive POS Drug Edit (PS2) would be implemented. The more restrictive POS Drug Edit (PS1) may or may not have been implemented.

If a contract notified the beneficiary that a less restrictive POS Drug Edit (PS2) would be implemented, the contract **cannot** implement a more restrictive POS Drug Edit (PS1) than was stated in the notice without providing the beneficiary additional 30-day advance notice that a more restrictive POS Drug Edit (PS1) would be implemented. In this instance, the Plan has two options after sending the beneficiary a new notification letter and submitting a new POS Drug Edit Notification record with the new notification date and the more restrictive POS Drug Edit Code (PS1):

- Implement the less restrictive POS Drug Edit (PS2) on the date noted in the original notification letter to the beneficiary which overlaps with the 30-day advance notice for the more restrictive POS Drug Edit.
    - When the more restrictive POS Drug Edit (PS1) is implemented and the implementation record is submitted to MARx, the contract should also terminate the less restrictive POS Drug Edit record by submitting a POS Drug Edit Termination record with the Notification and Implementation dates of the less restrictive POS Drug Edit (PS2).
- Terminate the less restrictive POS Drug Edit Notification (PS2) by submitting a POS Drug Edit Termination record with the Notification date of the less restrictive POS Drug Edit Notification (PS2). Then, implement the more restrictive POS Drug Edit (PS1) following the 30-day advance notice.

If the less restrictive POS Drug Edit (PS2) was implemented following the 30-day notification, the contract can keep the less restrictive POS Drug Edit (PS2) in place while the new 30 day notification period is in effect. Once the contract implements the more restrictive POS Drug Edit (PS1), the less restrictive POS Drug Edit (PS2) Implementation record should be terminated by submitting a POS Drug Edit Termination record with the Notification and Implementation dates of the less restrictive POS Drug Edit (PS2)

Contracts should only submit POS Drug Edit changes that result in either a more or less restrictive POS Drug Edit code. Modifications that only modify the condition (e.g., quantity, strengths) of a current active POS edit that would result in the same POS Drug Edit code should not be submitted.

11.5 Future Enhancements

The user interface (UI) is in development for direct entry of POS Drug Edit information as an alternative to batch transactions. The expected release date is unknown at this time.

If you have any questions, please contact the Part D Policy mailbox at PartDPolicy@cms.hhs.gov and put "User Guide" in the subject line.