



Medicare Advantage and Prescription Drug Plans

April 21, 2010

**Plan Communications
User Guide
Main Guide
Version 5.1**

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

Center for Drug and Health Plan Choice



**Medicare Advantage
and
Prescription Drug
Plan Communications
User Guide
Version 5.1**

(April 21, 2010)

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Change Log

April 21, 2010 Updates

Section	Changes
Global	Changed the version number from 5.0 to 5.1 Changed the publication date to April 21, 2010 Changed Centers for Beneficiary Choices to Center for Drug and Health Plan Choice Updated hyperlinks throughout the Guide with the newly defined www.cms.gov designation Added new Section 4 – <u>Premium Withholding Options for Beneficiaries</u>. As a result, subsequent sections were renumbered from 4 through 11 to 5 through 12. Modified section, table and figure references throughout the Main Guide as a result of inserting new Section 4 and renumbering remaining sections.
1	Expanded Section 1.2 <u>Documentation Organization</u> to include new section 4 and renumbered remaining entries page 1-1
2	Updated link to MAPD Help Desk website in Section 2.1.2.1 – <u>Establishing T1 Line – Connect:Direct Connection</u> to directly access SPOE form page 2-2
3	Removed section 3.3.3.5 previously identified as <u>Premium Withhold Options for Beneficiaries</u> page 3-5 Renumbered section 3.3.3.6 and 3.3.3.7 identified as <u>SSA</u> and <u>RRB</u> page 3-5
4	Created new section 4 entitled <u>Plan Premium Withhold Process</u> page 4-1
5	Replaced Figure 5.1-13: <u>Beneficiary Detail: Snapshot (M203) for Selected Beneficiary</u> with new version page 5-20 Replaced Figure 5.3-4b: <u>Beneficiary Detail: Snapshot (M203) Screen with Payments and Adjustments for Past Payment Month</u> with new version page 5-40 Added Aged/Disabled MSP and ESRD MSP Factor to Table 5.3-6: <u>M203 Screen Inputs, Outputs and Actions</u> page 5-41 Added Aged/Disabled MSP Details to Table 5.3-10: <u>M205 Screen Inputs, Outputs and Actions</u> page 5-48 Replaced Figure 5.3-17: <u>Beneficiary Detail: Utilization (M233) Screen</u> with new version page 5-76 Updated Table 5.3-24: <u>M233 Screen Inputs, Outputs and Actions</u> with new fields for SNF page 5-76 Added new fields under “Beneficiary Identification” and new Section “Enrollment Information” to Table 5.3-34: <u>M232 Screen Inputs, Outputs and Actions</u> page 5-89 Added new Information to Table 5.3-35: <u>M232 Screen Messages</u> page 5-90 Replaced Figure 5.3-24: <u>Beneficiary: Eligibility (M232) Screen (with Eligibility Information)</u> with new version page 5-92 Added “Enrollment Information” to Section 5.3.4 <u>View Beneficiary Eligibility – Beneficiary Eligibility Query via the UI</u> page 5-93
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Appendices	Please refer to the front section of the Appendices document for a complete list of updates

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1: Introduction

1.1 Document Overview

The *Medicare Advantage and Prescription Drug Plan Communications User Guide* (the Guide) provides information to Managed Care Plans (principally Medicare Advantage Plans) and Prescription Drug Plans (both hereafter referred to as Plans) regarding access to and interaction with CMS' enrollment processing. The enrollment processing system is an enhancement of the legacy Medicare Managed Care System (MMCS), with changes for the implementation of the Medicare Modernization Act (MMA).

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

The Guide also provides screen shots and information relative to the User Interface that Plans will use to obtain eligibility and enrollment information online. Chapter 19 of the Medicare Managed Care Manual, Enrollment and Payment Operations, which is currently under revision, provides additional information on the enrollment, disenrollment, and reconciliation processes and policies. Use Chapter 19 in conjunction with this guide to determine appropriate actions. Please refer to Section E.7 of the Plan Communications User Guide Appendices for specific information regarding entering an effective date for a code 51 disenrollment.

Note
Future revision(s) of this document will be provided as information is completed and supplied.

1.2 Document Organization

The Guide includes the following information:

- **Section 1, Introduction**, provides general information about the organization of this document, typographical conventions, and an overview of enrollment processing, including high-level data flows, system architecture, the monthly processing cycle, and data exchange processes and requirements.
- **Section 2, Establishing Communication with CMS**, highlights guidelines for establishing connectivity to the CMS Data Center along with methods for exchanging data with CMS. It also provides various points of contact for policy, procedural, and system questions.
- **Section 3, Enrollment Transaction Processing**, provides information on the operational processes for enrollments.
- **Section 4, Premium Withholding Options for Beneficiaries**, provides information on the premium withholding system.

- **Section 5, Using Online Operations**, describes functionality for the Medicare Advantage and Part-D Inquiry System User Interface.
- **Section 6, Accessing the CMS Systems for Eligibility Verification**, provides information on the UI system and batch component used for eligibility verification.
- **Section 7, Cost Plan Transaction Processing**, provides information on the transaction processes for Cost Plans.
- **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, MA-PD/Cost Plan Full Dual File and Monthly PDP Notification File for Auto- and Facilitated Enrollments**, provides MA-PD and Cost Plans information for accessing files they will receive on enrollees who are full-benefit dual eligible. It also provides information regarding the Monthly PDP Notification File sent to PDPs that qualify for auto/facilitated enrollment.
- **Section 10, Agent Broker Compensation Cycles**, provides Plans information necessary to determine how to pay agents for specific beneficiary enrollments.
- **Section 11, Reporting Coordination of Benefits (COB) Data**, provides an explanation of COB File Data element definitions and instructions for Part D Plans.
- **Section 12, Establishing Low Income Subsidy (LIS) Status**, provides an explanation of Low Income Subsidy Premiums and Co-Pay levels to ensure Part D plans charge LIS beneficiaries the correct premium and cost-sharing amounts.
- **Appendix A** provides a Glossary and List of Abbreviations and Acronyms.
- **Appendix B** provides CMS Central Office Contact Information.
- **Appendix C** provides the Monthly Processing Schedule.
- **Appendix D** provides the Enrollment Data Transmission Schedule.
- **Appendix E** provides Record Layouts.
- **Appendix F** provides an explanation of Common UI Screen Hierarchy.
- **Appendix G** provides Validation Messages.
- **Appendix H** provides tables of Codes.
- **Appendix I** provides Report and File Layouts.

- **Appendix J** provides the Transmissions Overview.
- **Appendix K** provides the MA Plan Connectivity Checklist.
- **Appendix L** provides Valid Election Types for Plan Submitted Transactions.

1.2.1 *Typographical Conventions*

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

Table 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, when you are directed to press the Enter key, you will see <ENTER>.
[Find]	Button Name. Square brackets ([]) are placed around the references to the names of all buttons displayed on the screen. The 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 Common UI main menu or at the top of a screen. A submenu is a list of items below the menu, where the items vary based on which menu item was chosen. These names are shown as mixed-case text with bars on either side.
<i>Beneficiaries: Find (M201)</i>	Screen Name. All screen names will be represented as mixed case, italic text and contain the full description of the screen.
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. Dropdown options are generally presented on the system in upper case.
The claim...	Error Message. The enrollment processing system performs data validation after the user clicks on an action button (such as [Find] or [Submit]). If a problem occurs, an error is posted in red in the upper left-hand corner of the screen. The messages use mixed-case alphanumeric characters.
The request...	Status Message. Status messages are provided in green in the upper left corner of the screen. The messages use mixed-case alphanumeric characters.
<u>06/2002</u>	Link. Links are fields that (when clicked on) access additional information. These fields are displayed on the screen in blue and underlined.
Note	Note. Note denotes important information. Accompanying text is set in a box with a header of Note.
Tip	Tip. Tip alerts you to shortcuts and troubleshooting tips. Accompanying text is set in a box with a header of Tip.

Note

When screens are shown in this document, the browser title, menu, buttons, and other items are hidden to allow the content to be displayed as large as possible. Also, the look of the browser varies by the browser version.

1.3 Additional Information

The following documents – the IACS User Guide, the Data Exchange Preparation Procedures (DEPP), and the Connectivity and Access Configuration Process, provide additional information related to Plan systems-related activities and may be accessed via the following MAPD Help web site links:

For the *IACS User Guide* please refer to the following link:

http://www.cms.gov/IACS/03_General_User_Guides_and_Resources.asp#TopOfPage

For the *DEPP* and the *Connectivity and Access Configuration Process* please refer to the link below:

<http://www.cms.gov/MAPDHelpDesk/PRG/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS056665&intNumPerPage=10>

1.4 Enrollment Transaction Processing Overview

Enrollment Transaction Processing records each individual beneficiary's plan enrollment and calculates the payments to Plans for providing coverage to beneficiaries who are enrolled in their contracts including Part C, Part D, Cost plans and other Medicare Health Plans. Part C contracts are Medicare Advantage Managed Care Plans that provide Part A and B benefits for their beneficiaries. Part D contracts provide drug coverage for beneficiaries who may be enrolled in either fee-for-service (Original Medicare) or in some health plans. A contract may provide services under both Parts C and D. A contract may offer several Plan Benefit Packages (PBPs) with different levels of coverage.

Beneficiaries may need to pay premiums for their Plan benefits. Whether a beneficiary pays premiums depends upon:

- Premium charged by the Plan – This is based upon the level of coverage provided and negotiated with CMS.
- For Part D; beneficiary's participation in the Part D Low Income Subsidy (LIS) – LIS subsidizes Part D premiums and other costs for certain beneficiaries with low income.
- For Part D; Late enrollment penalty – The beneficiary pays a late fee for Part D coverage if he or she did not enroll in a Part D contract when first eligible for it and also did not have other creditable drug insurance coverage for certain periods of time.

This section provides an overview of Plan interactions with the enrollment processing system. These interactions fall into these categories:

Exchange of files – Plans submit transactions in batch files. In response, transaction reports are generated to provide the Plan with details concerning the processing status of the transactions.

These reports include:

Enrollment Transmission Message File (STATUS)

Batch Completion Status Summary (BCSS)
Weekly/Monthly Transaction Reply Report (TRR)
Month-End Processing Reports

This data exchange process is described in further detail in Section 1.4.1.

Online access through a Web-based user interface – Plans query the enrollment processing system via an entry point called the CMS Applications Portal at: <https://applications.cms.gov>. The CMS Applications Portal allows the user to view enrollment, payment, premium, and beneficiary information from the Common User Interface (UI) system. For a detailed description for using the Common UI, please refer to Section 5.

1.4.1 File Submission and Retrieval

1.4.1.1 Batch Transaction File

As shown in **Figure 1-1, Data Flow**, a Plan submits transactions in batch files to CMS. These transaction files include enrollment, disenrollment, correction, and change transactions for beneficiaries enrolled in its contracts. The format for the transaction file is given in Appendix E, Record Layouts. Plans are encouraged to submit transaction files daily. CMS operates on a monthly processing cycle, and submittal of transactions throughout the month alleviates the backlog of requests that occur at the monthly cutoff date. For more information on the production cycle, please see Section 3.3.

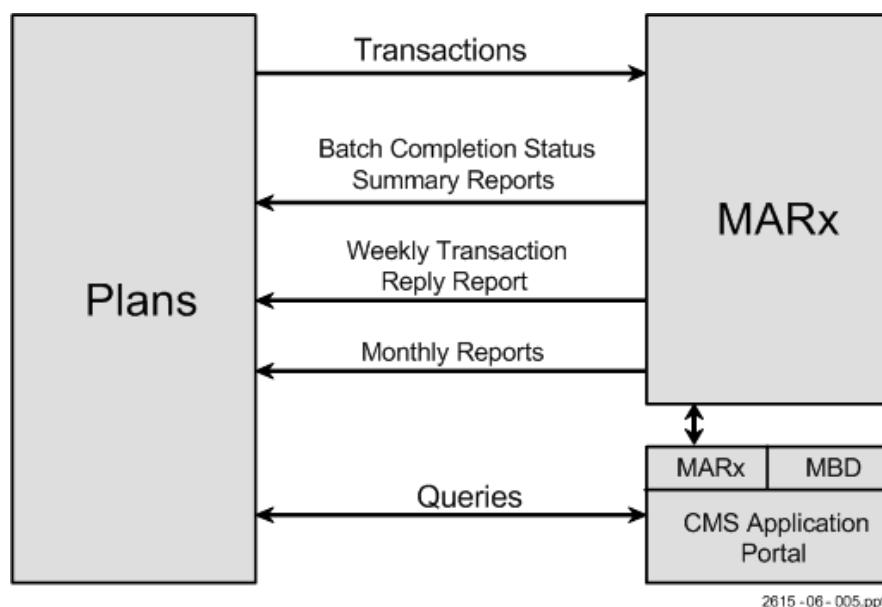


Figure 1-1: Data Flow

Enrollment Processing defines processing windows during which files are submitted for processing for a specific payment month. The Current Payment Month (CPM) is the month for

which Plans receive payment from CMS, not the current calendar month. The current Processing Month (PM) is the current calendar month in which processing occurs to generate payments.

For example: The current Processing Month (PM) for June, 2008 began on April 12, 2008 and ran through 6:00 pm on May 9, 2008. Enrollment transactions processed during this time were for those beneficiaries with an enrollment change/new effective date of June 1, 2008. Plans receive payment in early June for those beneficiaries actively enrolled as of June 1, 2008. In this example, June is the Current Payment Month (CPM).

Transaction files contain a header indicating the CPM. A transaction file may contain transactions for the current payment month or up to three months prospective. Transactions with effective dates that are prior to the CPM are considered retroactive (“retro”). Plans are allowed to include transactions for one month prior to the CPM (i.e. one-month retroactive) in their normal batch transaction files. Plans that are sponsored by employer or union groups (EGHPs) are allowed to submit transactions for the current processing month and the three prior months (i.e. 3 months retroactive) through routine submission of code 60 EGHP Retroactive enrollment transactions. Retroactive transactions that have processing dates outside these parameters require special handling. These transactions are not processed without approval from CMS. For instructions on submitting retroactive transactions, plans must contact their CMS Central Office Health Insurance Specialist. Please refer to Appendix B for a list of the Central Office contacts.

A submitted transaction is assigned one of these statuses: failed, rejected, or accepted. Basic file validation and transaction formatting edits are performed on the transactions before any further processing may occur. These checks verify the correct file header, user authentication, transaction format and data types for the transaction data elements. If a transaction fails these basic edits or cannot be loaded for processing due to formatting errors, it is a failed transaction. Transactions that can be loaded but encounter an error condition during processing are considered rejected. Accepted transactions are transactions that were successfully processed.

Specifics about failed, rejected and accepted transactions are found on the Batch Completion Status Summary Report (BCSS) data file and are reported in the Transaction Reply Report & Data File (TRR).

The following paragraphs provide a high-level description of the reports that provide information about the status of the receipt of the Plan’s file along with the failed, rejected, and accepted transactions.

1.4.1.2 Enrollment Transmission Message File (STATUS)

When a Plan transmits an enrollment file to CMS, the enrollment processing system will acknowledge the receipt of that file by returning a STATUS file to the Plan. The contents of the STATUS file will include a batch ID that uniquely identifies the file, a snapshot of the Plan-submitted header information for the Plan to verify, a recap of the number and types of transactions and a status message as to the disposition of processing (e.g. Missing Header Record, Data Failed, Retro File Detected, etc). Plans should use this file to track the successful (or unsuccessful) processing of their batch transaction files. For information regarding the format of the STATUS file, please see Appendix I, *Report Files*.

1.4.1.3 Batch Completion Status Summary (BCSS) Report

Every transaction file submitted receives a unique batch processing number as the transactions are loaded. Once loaded, the processing of these transactions will result in rejected, accepted, or failed transactions. The Batch Completion Status Summary data file will be generated when each batch has completed processing. This report will provide a count of all transactions within that batch, detailing the number of rejected, accepted and failed transactions. Images of these transactions, along with any generated TRCs, are included.

1.4.1.4 Transaction Reply Report (TRR)

The Transaction Reply Report provides the Plans with details of the rejected and accepted transactions that have been processed for members within its contracts for the time period specified. There are two types of TRR: The Weekly TRR covers the processing week (typically Sunday through Saturday). The Monthly TRR covers the payment processing month. The Weekly TRR also provides details of notifications involving contract members, for example, notification that a beneficiary has died. Failed transactions do not appear on the Weekly TRR; an image of the failed transaction is provided only on the Batch Completion Status Summary (BCSS) data file (see above). Details of the TRR File are provided in Appendix I, *Report Files*.

1.4.1.5 Monthly Reports

Monthly reports provide enrollment and payment information for the transactions submitted. These reports are delivered in both a report format and as a data file which Plans can use for automated processing. These reports provide a final disposition of all transactions that the Plan has transmitted for the processing month. The Transaction Inventory in Appendix J indicates the reports that are transmitted monthly. Details of these reports are provided in Appendix I, *Report Files*.

1.5 Enrollment Transaction Processing System Architecture

As described in Section 1.3, Plans submit transaction files for processing and receive reports detailing the disposition of these transactions. Plans also have the ability to query information on a beneficiary using a user interface (UI). Interaction with the enrollment processing system is accomplished by using the Internet using a Web Browser (see **Figure 1-2**) to access the UI. Further information on the UI can be found in Section 5.

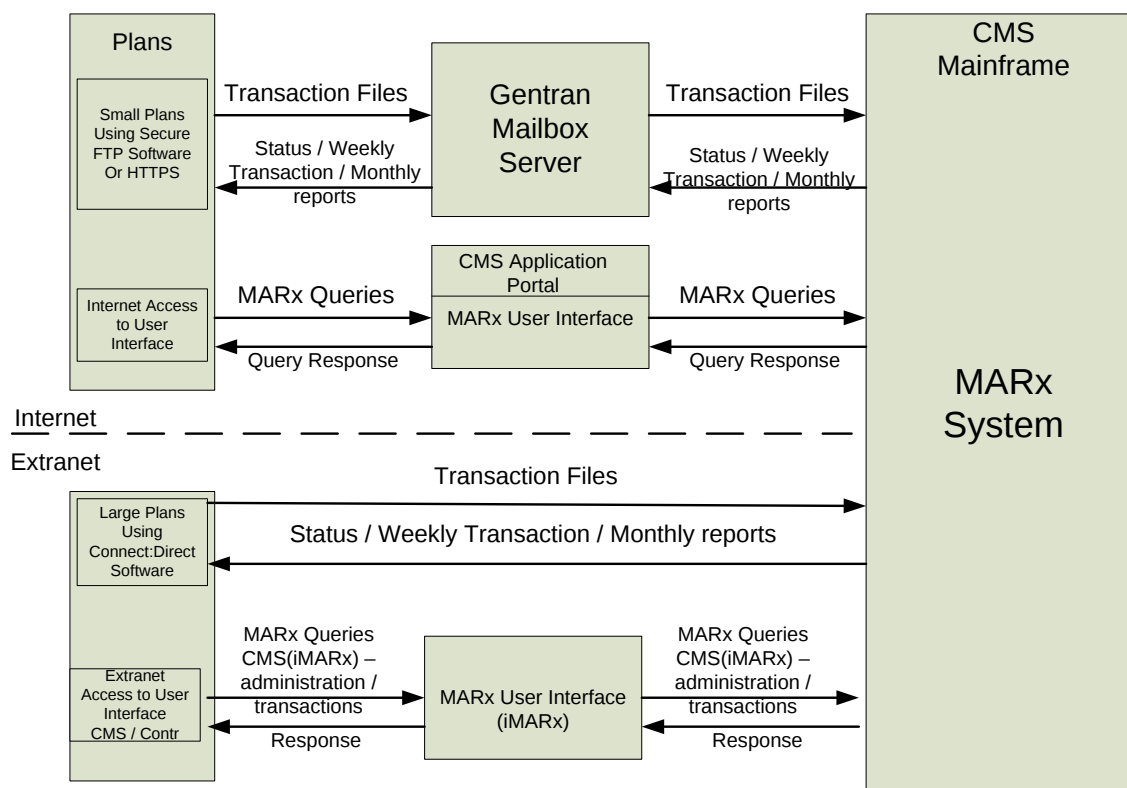


Figure 1-2: Architecture

To determine which method of batch connectivity is appropriate for a Plan, CMS has established guidelines that identify two major categories based on the size of membership. Large Plans are defined as those with more than 100,000 members; small Plans are defined as Plans with 100,000 or fewer members. Large Plans are required to use a dedicated T1 circuit over the AT&T Global Networking System and Connect:Direct software for sending and receiving files from CMS. Small Plans have the option to use the same connectivity as large Plans (typically cost-prohibitive) or use the Internet for exchanging files with CMS. The Internet method requires the use of Secure FTP software or a web browser/HTTPS (Hypertext Transfer Protocol over Secure Socket Layer) to communicate with the Gentran Mailbox Server. Plans may contact the MAPD Help Desk (Customer Support) at (800) 927-8069 or by email at mapdhelp@cms.gov to obtain more information. Please see the following section for an operational description of the use of these connectivity methodologies and Section 2 for additional technical information.

1.6 Exchanging Data with CMS

Plans interact with CMS by sending transactions (enrollments, disenrollments, corrections, and changes). CMS sends reports detailing the status of these transactions as well as monthly reports detailing payment and premium information. Additional information about sending and receiving files and the CMS Applications Portal for both large and small Plans is explained below.

1.6.1 Sending and Receiving Files

The number of beneficiaries enrolled in a Plan determines the method required to communicate with CMS. Plans with enrollment greater than 100,000 beneficiaries are considered large.

1.6.1.1 Large Plans

Large Plans send and receive files using a T1 circuit connected to the AT&T Global Networking System and Sterling Commerce's Connect:Direct data transfer software product. The Connect:Direct software must be purchased and installed at the Plan's site to submit and receive files from CMS. The T1 circuit must be installed and configured by the Plan to establish data connectivity to the CMS Data Center.

Using Connect:Direct, the Plan will transfer their transactions to CMS. After processing the transactions, CMS sends the status reports associated with the transactions to the Plan. A connection is established from the CMS mainframe to the Plan's site for the file transfer.

Plans must contact Sterling Commerce to obtain the Connect:Direct software and for assistance in the configuration of the software. Plans are instructed to contact the MAPD Help Desk for assistance in establishing and testing this connectivity with CMS (see Section 1.3 for the hypertext link to the Data Exchange Preparation Procedures). Once communication is established with CMS, specific setup information for sending and receiving transaction files is provided in Section 2 of this guide.

1.6.1.2 Small Plans

Small Plans have the option of using the Internet for exchanging data with CMS (see **Figure 1-2**). Small Plans will access the Gentran Mailbox server to transfer files to and from CMS, using Secure FTP software or a web browser/HTTPS to connect to the Gentran server. Transaction files are placed on the Gentran server, where they are forwarded to CMS for processing. Report files from the transaction processing will be sent from CMS to the Gentran server. The Plan must log on to the Gentran server to retrieve any files generated from CMS. Transaction response files will be generated under the user identification (UID) of the person who submitted the transactions. A directory on the Gentran server will store the report files so the user can log on to the Gentran server and retrieve the files.

Monthly reports for Small Plans will also be made available on the Gentran server and will be stored in a directory under that Plan's contract number. Any user who has access to that contract will be able to download the contract's monthly reports.

Small Plans using the Internet must obtain and install the Secure FTP software or use a web browser/HTTPS to communicate with CMS. Details on obtaining and configuring Secure FTP software are available from the MAPD Help Desk (Customer Support) (800) 927-8069 or by e-mail at mapdhelp@cms.gov. Once the Plan has installed and configured the software, the Plan must configure the software to send and receive files for processing. Refer to Section 2 for information on configuring the software for file transfers.

1.6.2 Common User Interface (UI)

The Common UI allows access to enrollment, eligibility, and 4Rx information for beneficiaries. CMS has combined this data into a single UI to be referred to as the *Medicare Advantage and Part-D Inquiry System*.

2: Establishing Communication with CMS

This section explains the implementation of the software that is needed to communicate with CMS. In order to use the enrollment processing system, the Plan must be registered in the Health Plan Management System (HPMS) and have one or more valid contract numbers.

2.1 Getting Started

To communicate with CMS systems, a Plan must:

- Obtain an ID and password
- Establish file transfer capabilities
- Establish connection to the UI Portal

2.1.1 Requesting a User ID and Password

Users of the enrollment processing system must obtain a user ID and password. Users request a user ID by using the Individuals Authorized Access to the CMS Computer Services (IACS). For more information regarding IACS, refer to the IACS User Guide on the MAPD Help web site (see Section 1.3 for the hypertext link).

2.1.1.1 Password Management

CMS users will manage their passwords by utilizing the Individuals Authorized Access to the CMS Computer Services (IACS). For more information regarding IACS, refer to the IACS User Guide on the MAPD Help web site (see Section 1.3 for the hypertext link).

2.1.2 File Transfer Setup

As described in Section 1, Plans have two options for establishing connectivity to CMS for purposes of file transfer, based on the size of their membership. Large Plans, defined as greater than 100,000 beneficiaries, must use a T1 circuit with Connect:Direct software (from Sterling Commerce). Small Plans, defined as 100,000 or less beneficiaries, can use T1 Connect:Direct or a Gentran mailbox and SFTP/HTTPS for file transfer.

2.1.2.1 Establishing T1 Line – Connect:Direct Connection

In addition to hardware and software maintenance, each Plan is responsible for supplying CMS with information about its organization and users as well as testing its own interface with CMS.

Although testing and the supply of information primarily apply to the setup stage of the system, this responsibility continues into the operational phase. Each Plan must update its information as changes occur in its organization and report any information regarding the operation or malfunction of the system. Each Plan must repeat test procedures after altering system components, such as the installation of updated software or changes in hardware, network and/or telecommunications provider, and changes to their contracted third party arrangements.

Large Plans will need to establish communications with CMS using the Connect:Direct software prior to configuring the software for transferring files. For more information regarding the setup of Connect:Direct software, please refer to the Data Exchange Preparation Procedures document (see Section 1.3 for the hypertext link). A Plan can download the form requesting access to CMS using NDM/Connect:Direct Secure Point of Entry (SPOE); the instructions for completing the access form may be found on the MAPD Help Desk web site at:

<http://www.cms.gov/MAPDHelpDesk/PRG/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS056665&intNumPerPage=10>

The following section outlines the configuration of the software for testing and production.

2.1.2.1.1 Connect:Direct MARx Setup

Data may be transmitted at any time during the month but Plans should be aware of monthly enrollment/payment cutoff dates. CMS prefers daily file transfers to reduce the workload during the end-of-month cutoff period (see Appendix C - Monthly Schedule). This ensures that your data transmission is received by the cutoff date and gives you time to resolve any transmission problems. Files received after the cutoff date are held for processing once the month-end processing is complete.

NDMWORKS is used by Plans to transmit files to CMS. The NDMWORKS process is executed at the Plan site and programmed on the Plan's mainframe. This process is usually executed in the batch program environment. The Plan programmer can select any name for the NDMWORKS process. The table below represents an example of the NDMWORKS process code. The Logical Record Length (LRECL) is variable and is based on the appropriate record length contained in the dataset.

Table 2-1: NDMWORKS Process Code

PROCNAME	PROCESS	PNODE=plan.nodename - SNODE= cms.nodename - SNODEID=(planuserid,planpw)
STEP1	COPY	FROM (DSN=your.input.dataset.name, - DISP=SHR, - PNODE) - TO (DSN=P#EFT.IN.aaaaaaa.MARXTR.DYYMMDD.THHMMSST, - DISP=(NEW,CATLG,DELETE), - DCB=(RECFM=FB,LRECL=lrecl), - SNODE), - COMPRESS Note: DYYMMDD.THHMMSST must be coded as shown, as it is a literal

The Plan's programmer must fill in the following variable information before executing the NDMWORKS process:

PROCNAME	The programmer may select any name for this process.
plan.nodename	This is the Plan node name.

cms.nodename	This is the node name of the Connect:Direct region at CMS that the plan communicates with to exchange files, typically CD.DDP or NDM.HCFA The CD.DDP region was created to support the Discount Drug Program and most plans communicate with it. NDM.HCFA is the Medicare region with which long time Medicare contractors communicate. Check with the MAPD Help Desk at 1-800-927-8069, if you are not sure which CMS region your Plan communicates with.
planuserid	This is the Plan SPOE (NDMXXXXX) or TW ID (TWXX) security issued by CMS that allows a plan to create data files on the CMS system.
planpw	This is the password of the SPOE or TW userID that was substituted for planuserid.
your.input.dataset.name	The submitter's dataset name.
P#EFT.IN.uuuuuuu.MARXTR.DYYMMDD.THH MMSST.	Target dataset name where uuuuuuu equals the submitter's CMS RACF ID.
Lrecl	This is the Logical Record Length (LRECL) and is based on the appropriate record length contained in the dataset.

2.1.2.2 Establishing a Gentran Connection

Small Plans communicate with CMS using Sterling's Secure FTP software or HTTPS (Hypertext Transfer Protocol over Secure Socket Layer) to transmit and download files from the Gentran Mailbox servers (Small Plans must first establish connectivity with CMS before configuring the system to transfer files. For establishing communications with CMS and configuring software for transferring files, please refer to the Data Exchange Preparation Procedures (see Section 1.3 for the hypertext link). Plans using the Gentran server will follow Gentran Incoming File Naming Convention Standards as defined in Section 2.1.2.2.1 and in Appendix J.

Gentran Outgoing File Naming Conventions (Gentran Back to the Plan)

The filenames of all data files and reports being sent to the Plans from CMS will follow the CMS EFT naming standard (see Appendix J for a complete list). Gentran will then append a unique identifier to the end of the file. When downloading the file from your organizational mailbox, you may change the file name in accordance with your organizational naming requirements. Reference the business application guidelines or transmission inventory document for specific file names.

Gentran File Size Limitation

The inbound file size limitation is 1.5 GB with or without compression. If trading partners are submitting or retrieving larger file sizes, they may need to consider switching to Connect:Direct and acquiring a MDCN/Evpn (MPLS) circuit.

CRLF Considerations

The CRLF (carriage return line feed) characters will be handled by Gentran.

ZIP Utility Software

At the present time Gentran cannot support multiple files within a single compressed file name. Compression utilities must support long file names (i.e., WINZIP Version 9 or higher).

File Path Limitation

A limitation has been found relating to the use of the HTTPS mailbox interface. The ActiveX control used to browse for a file (written by Microsoft) has a limitation of 128 characters for the entire path/file name.

If a path/file name exceeds this 128-character limit, then the file will not be transmitted. The path/file name is the result of the Microsoft browse button and produces a result of "c:\folder1\folder2\folder3\filename.extension." The total character count must remain under the 128-character limit for anyone using the HTTPS mailbox interface.

Gentran Access Requirements

Gentran Access

To access Gentran, please use your Gentran User ID that was provided by the IACS system. This should be your seven-character user ID.

Plans may have only 4 submitters. Designated submitters are identified within the Plan organization and approved by the local External Point of Contact (EPOC).

HTTPS Gentran Mailbox Access and System Requirements

Small Plans and/or those specifically identified will use either HTTPS or the Sterling SFTP Client for file submission or file retrieval.

Internet URL – <https://gis.cms.gov:3443/mailbox>

HTTP Screen Shot User Guides are available through the MAPD Help Desk.

Trading Partner Firewall

Port 3443 is used for connectivity to the Gentran facility (do not use the typical Port 80 for HTTP or Port 443 for HTTPS).

Browser Requirements:

Microsoft Internet Explorer 5.x or later

CMS recommends that EFT users/business partners use a Microsoft Operating System that is currently supported by Microsoft and at the appropriate Service Pack Levels.

To eliminate the HTTPS Security pop-up that appears after you have downloaded the Gentran Certificate, the end user may need to update his/her VeriSign Class 3 Certificate. Instructions are available from the MAPD Help Desk.

FTP SSH Client Gentran Mailbox Access and System Requirements

Small trading partners and/or those specifically identified will use either HTTPS or the SFTP Client for file submission or file retrieval. CMS recommends the Sterling FTP client. If you will be using a client other than what has been recommended, it must also support SSH V2.

Connectivity troubleshooting and/or configuration parameter assistance will be very limited with the use of other FTP clients. Sterling FTP user manuals are available from Sterling Commerce. The MAPD Help Desk will provide the client configuration parameters for accessing the CMS GIS system.

CMS does not procure and/or provide licensing for the Sterling SFTP client. The decision to use HTTPS or FTP client is the responsibility of the end user or trading partner.

Sterling FTP Client minimum platform and hardware requirements may be obtained from the Sterling Commerce web site (<http://www.sterlingcommerce.com>) or by contacting Sterling Commerce. Sterling FTP software support services are available from Sterling Commerce. When calling Sterling Support Services, mention that you are either 1) using a CMS licensed version of the Sterling FTP Client or 2) need assistance with the Sterling GTP Client in relation to a CMS Project/Program. CMS, CMS CITIC Help Desk, and the MAPD Help Desk do not provide Sterling FTP Client installation, configuration, or technical software support services.

Trading Partner Firewall

TCP Port 10022 for SFTP with SSH is used for the SFTP sessions.

Sterling SFTP Client Minimum Requirements for CMS Gentran Access

At the minimum, you must use the Sterling SFTP Client Version 1.3.00, dated May 2005 with patch. The patch may be applied to versions higher than 1.3.00, dated May 2005; however, do not apply the patch to Version 1.3.00, dated March 2005.

The patch and directions for installation are available through the MAPD Help Desk.

Plans using the Gentran mailboxes submit their files to CMS and receive reports from CMS through their mailboxes. Plans go to their mailboxes to retrieve their files and files are available within the mailbox for a specific period of time. The following chart displays the retention periods for the various file types:

Table 2-2: Mailbox File Retentions

Application	Minimum Retention
Enrollment Processing	Monthly reports 30 days total, all other reports 6 days (including weekends)
MBD (BEQ/4RX/Auto Assign)	All files 6 days (including weekends)
DDPS PDE/RAPS	All files 14 days (including weekends)
COBA/VDSA	All files 6 days (including weekends)
HPMS	All files 6 days (including weekends)
ECRS	All Files 6 days (including weekends)

2.1.2.2.1 Incoming File Name Convention

Files sent to the Enterprise File Transfer Facility (Gentran mailboxes) should follow the naming convention below.

Filename IN ALL CAPITAL LETTERS

Example: GUID.RACFID.APPID.X.UNIQUEID.FUTURE.W.ZIP

Incoming File Name Convention:

File Name Convention	Description
GUID	Seven-character alphanumeric user ID generated by the Individuals Authorized Access to CMS Computer Services (IACS).
RACFID	Four-character RACF user ID. Note: If a RACF ID was not assigned, insert NONE.
APPID	Application Identifier
X	D – DAILY W – WEEKLY M – MONTHLY Q – QUARTERLY Y – YEARLY A – AD HOC Note: This field indicates type of data, e.g., Daily, Monthly. However, multiple file types may be transmitted on the same day. (e.g., two daily submissions).
UNIQUE ID	If no UNIQUE ID, insert DEFAULT refer to business applications guidelines and/or transmissions inventory
FUTURE	FUTURE unless otherwise specified. This field is reserved for future use. (For additional reference, see business application guidelines and/or transmissions inventory).
W	Code T for test data Code P for production data
ZIP (Optional)	Only used when file compression is used and automatically added to the file name by the ZIP application, e.g., WINZIP or PKZIP. Note: WINZIP version 9 or higher is required to support long file names.
. (Periods)	Delineators

2.1.3 CMS Applications Portal Access Setup

The CMS Applications Portal provides the gateway for users to query both eligibility and enrollment data. The CMS Applications Portal is available on the Internet. Instructions for accessing it can be found in Section 5 of this guide.

2.1.4 Points of Contact

Contact Information

CMS is providing a technical customer support mechanism for all of its external customers. The MAPD Help Desk will provide you with quality support for all of your connectivity needs, as well as aid in resolving technical application needs. The Help Desk is currently available via a toll-free line, (800) 927-8069, and email, mapdhelp@cms.hhs.gov.

3: Enrollment Transaction Processing

Enrollment Transaction Processing occurs on a monthly cycle where transactions are received until a cutoff date (refer to the discussion of “current processing month” and “current payment month” in section 1.4.1.1 of this guide). Plan submitted transactions including beneficiary enrollments (code 60, 61, 62 and 71 transactions) and disenrollments (code 51), enrollment record update (code 72, 73, 74 and 75), Part D Opt-Out (41) and corrections (code 01) are processed as they are entered into the system, and payments are calculated immediately. Transactions also enter the system throughout the processing month from other sources, such as the 1-800 Medicare Customer Service center (type 54 transactions) and CMS or its contractors. Once the submittal period for the CPM ends (after the cut-off), CMS completes the month-end processing. In the month-end cycle, the enrollment processing system writes the monthly reports and calculates the final summary beneficiary payments and adjustments, which ultimately become payments to the Plans.

3.1 Transaction Processing

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

- A Plan submits transaction files using Connect:Direct, Secure FTP software, or Web Browser/Hypertext Transfer Protocol Secure (HTTPS). The transaction files are read and loaded into internal tables for processing (posting).
- CMS processes the submitted transactions, resulting in actions that affect beneficiary enrollment, payment and statuses.
- Accepted transactions are returned to the User in the Batch Completion Status Summary (BCSS). These are annotated with any resultant Transaction Reply Codes (TRCs).
- If a transaction is accepted, the enrollment processing system immediately calculates payment (and/or adjustments) and adds or subtracts the net dollar amount to the totals for the contract 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 final.
- If a transaction is not accepted, it may either fail or be rejected.
 - A **failure** results when incoming data is not consistent 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 not a valid format, the transaction cannot be saved in the database and therefore fails. The transaction is written to the BCSS and transmitted to the submitter (user) for review.
 - A **reject** results when incoming data is of the correct type but cannot be 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, the enrollment processing system would reject the transaction. Rejected

transactions are reported on the Batch Completion Status Report that is transmitted to the submitter (user).

- Multiple batch transaction files can be submitted each month, and a Plan's transactions are processed as they are received. Reviewing the processing results of a batch file using the BCSS, gives the user time to review any errors, correct records, and resubmit them before the monthly processing is completed and final payment is calculated.
- Details of batch-submitted transactions will appear on the Weekly and Monthly Transaction Reply Reports and Data Files. The Weekly and Monthly Transaction Reply Reports and Data Files also include transaction replies which are the result of system notifications and CMS actions.
- Monthly enrollment and payment files are generated.
- For all aforementioned reports, please see Appendix I, *Report Files*.
- Record layouts for transactions are provided in Appendix E, *Record Layouts*.

3.2 Enrollment Transaction Reports

The enrollment processing system communicates the disposition of a transaction through a variety of reports transmitted to the Plan. Upon receipt of a transaction file, the STATUS Data report is transmitted to the Plan representative-transmitter who submitted the file. The Batch Completion Status Summary Data Files are transmitted to the transmitter upon completion of processing a batch. In addition, the Plan receives weekly Transaction Reply Reports (TRRs) which provide a disposition for the transactions submitted each week, along with results from various system notifications and CMS actions. Subsequent monthly reports reflect enrollment and payment status at the completion of the month-end processing.

Many of the weekly and monthly reports are provided to plans in a data file format to allow the Plan to automate processing, if desired. Details for the reports and data files are given in Appendices E and I. Failed and rejected transactions can be corrected and resubmitted for processing. Plans validate payments at the beneficiary level based on information (enrollment, disenrollment, applicable health statuses, etc.) in effect at the time of processing. This information is available via the TRR and several payment reports and data files. Payment reports include the Monthly Membership Detail and Monthly Membership Summary reports.

3.3 Production Schedule

The following section describes the processing flows for submitting transactions to CMS and receiving reports from CMS. In general, transaction processing occurs during the first few weeks of the submittal period for a CPM until a cutoff date, which changes each month. At the cutoff date, the processing of new transactions is suspended. The month-end process performs final summarization of beneficiary level payments to plan level payments. While CMS is reviewing monthly payments for approval, plan transaction processing resumes for the next month. Once CMS approves the monthly payments, reports are distributed to the Plans.

3.3.1 Daily Processing

- Plans transmit beneficiary enrollment, disenrollment, PBP change, plan change, and correction (to identify Medicaid and Institutional/Nursing Home Certifiable (NHC) statuses) transactions to the CMS Data Center via Connect:Direct, Secure FTP, or Web Browser/HTTPS. For information regarding transmissions to CMS, refer to Appendix J.
- Plans verify processing of data via various returned reports. The Plans receive STATUS reports, which acknowledge receipt of a transmitted file from the Plan. Failed transactions do not appear on any report other than the Batch Completion Status Summary (BCSS) data file. The STATUS report and the BCSS data file are transmitted to the users who submitted the file.
- A list of accepted and rejected transactions for a submitted batch is provided on the Batch Completion Status Summary (BCSS) data file. CMS will generate one BEQ Response File for a Plan every time a BEQ Request is processed during a regular business day.
- Throughout the month, the enrollment processing system processes enrollment, disenrollment, plan change, and correction data as this data is received, and updates individual beneficiary records.
- Throughout the month, the enrollment processing system computes beneficiary-level payments and premiums, based on updated enrollment, disenrollment, PBP change, plan change, and correction data, and summarizes them at the contract level. This summary includes any applicable adjustments, subsidies, and penalties.
- Each Plan receives a Weekly Transaction Reply Report and a corresponding data file that summarizes the disposition of its transactions, MBD notifications, and CMS actions affecting its enrolled beneficiaries. Plans may also use this report to correct and resubmit failed and rejected transactions.

3.3.2 Monthly Processing

- The reporting system creates contract payment validation reports.
- The reporting system provides the monthly reports to the Plans.
- The Automated Plan Payment System (APPS) transmits Plan payment data to the CMS financial control system. From there, a file is transmitted to the U.S. Treasury, where funds are electronically dispersed to Plan banking institutions.

The Monthly Processing Schedule is provided in Appendix C.

3.3.3 Interfaces

3.3.3.1 Health Plan Management System (HPMS)

- HPMS contains complete information about contracts between Plans and CMS. As such, it provides a basis for validating contract, PBP, and segment numbers and service areas. Most importantly, it identifies the type of contract and the Payment Bill Option (PBO)

code which is linked to rules for enrollment and payment. HPMS also provides the enrollment processing system, i.e. MARx, with information about terminations, rollovers (where some or all beneficiaries in one contract are automatically moved to another contract), payment rates, and rebates amounts. Changes to contract and plan information are reported to MARx. If the changes affect payment, MARx calculates a new payment and any appropriate adjustments.

3.3.3.2 Risk Adjustment System

- The Risk Adjustment System (RAS) provides the enrollment processing system with beneficiary-specific risk adjusted factors that are used in calculating Part C and D payments. The factors are based on each beneficiary's medical history, as reflected in claims and encounter data.
- Risk-adjusted factors are calculated annually. They are updated midyear and reconciled a few months after the end of the year. When these changes occur, the enrollment processing system will automatically recalculate payments and appropriate adjustments.

3.3.3.3 Automated Plan Payment System (APPS)

- Upon successful enrollment the processing system 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 the APPS.

Note
New transactions for the next payment month can be submitted and they will be processed when normal daily processing resumes.

- If CMS finds no problems during month-end payment validation, they certify (approve) the month's processing and allow APPS to generate a file of payment records. This file is passed to CMS's main accounting system, then to the U.S. Treasury where wire transfers to the Plans are initiated.
- If CMS finds a problem, built-in backup procedures allow all or part of the monthly production run to be reprocessed.

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

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

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

The MBD notifies MARx when the beneficiary information changes, so that MARx can determine whether the beneficiary's enrollment is still valid and whether payments need to be adjusted. Details of the MARx-MBD interface are described in the ICD between MARx and MBD.

3.3.3.5 Social Security Administration (SSA)

MARx communicates certain Part B, Part C, and Part D data from CMS to SSA, and then communicates SSA acceptance or rejection of the transactions associated with that premium back to the Plans. Transmissions to SSA occur periodically throughout a "Current Operation Month" (COM). The bulk of these transmissions occur during the COM in a schedule window called the "Can Meet" period. Changes in beneficiary status that occur in the period since the last "Can Meet" transmission window are captured and sent to SSA in the "Can Meet" period. Also, in this period, special populations that CMS determines should be sent to SSA are transmitted as well. In the COM, but outside of the "Can Meet" period, MARx communicates Part B, Part C, and Part D data from CMS to SSA only if these are congressional requests and subject to SSA volume thresholds.

3.3.3.6 Railroad Retirement Board (RRB)

MARx PWS is also used to communicate Part B Reduction and Part D information to the Railroad Retirement Board (RRB). MARx receives and processes transaction requests impacting RRB beneficiaries and forwards them to RRB for processing. Once RRB completes processing the request, a response for each transaction is sent back to MARx informing whether or not the request was accepted or rejected.

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4: Plan Premium Withhold Process

Beneficiaries may elect to have their Part C and Part D premiums withheld from their monthly Social Security benefit if the benefit amount is as much as or more than the premiums.

The premium withhold process relies on data reported by the plans and on an interface between the Social Security Administration (SSA) and CMS. The process begins when plans submit premium information for new members on the enrollment transaction and for current members on the Premium Withhold Option Change Transaction type 75. Plans report the Part C and D premiums as applicable and the premium withhold option selected by the member. Currently the options are SSA Withholding or Direct Bill (self pay).

The Part C premium amount reported by the plan to CMS includes additional premium amounts for any optional supplemental benefits selected by the member. The Part D premium amount reported is the base premium or the base plus enhanced premium, depending on the beneficiary's plan election.

During processing MARx will compare the submitted Part D premium to the amount assigned to the PBP by the plan bid information in HPMS. If it does not match, MARx will change the submitted amount to the amount in HPMS and notify the plan with a TRC 181. On the Part C premium side, the presence of optional supplemental benefit premiums precludes MARx from being able to identify the exact amount. Therefore, MARx edits the Part C premium using a range defined by the lowest Part C premium amount (could be zero) for the PBP and the highest Part C premium amount (this 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 will be accepted unchanged. If it is not within this range, MARx will change it to the lowest possible Part C premium for the PBP and notify the plan with a TRC 182.

If the beneficiary has elected the direct bill (self pay) option, the plan receives payment directly from the member. If the beneficiary has elected SSA premium withhold, CMS transmits this information to the SSA. On a monthly basis SSA withholds the premiums and sends them to CMS, where the premiums are verified and then passed (paid) 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 instructing to bill the member for the premiums.

Refer to Appendices Section H Table H-2 for a list of current Transaction Reply Codes.

NOTE: Withholding requests may be rejected 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 2 or 3 months. Another factor is that SSA limits premium withholding to \$200 a month per beneficiary. This could also impact SSAs ability to accept and process premium withholding for a member.

4.1 Low-Income Premium Subsidy (LIPS)

If a member is determined to be eligible for LIPS and has elected the withholding option, SSA withholds the non subsidized amount (if any) and CMS pays the plan the subsidy. If the member has elected the direct billing option, the plan bills the non-subsidized amount (if any) and CMS pays the plan the subsidy. Plans can see the LIPS payments on their Monthly Membership Reports (MMRs). Copies of the detail and summary MMR file layouts can be found in Appendices E.9 and E.10.

4.2 Late Enrollment Penalty (LEP)

If a member is assessed a LEP their premium will include the penalty. If the member elects the withholding option, SSA withholds the penalty amount and CMS retains it. Plans can see the amounts on the Monthly Premium Withhold Report or data file (MPWRD). If the member has elected 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 see the amounts on the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) report. This file layout can be found in Appendices E.17.

4.3 All or Nothing Rule

The all or nothing rule means that the entire premium amount due must be able to be deducted from the beneficiary's monthly SSA benefit. This means the sum of the Part C and the Part D premiums for one plan (if applicable) must be able to be withheld. Partial deductions are not allowed. No deduction will occur even if a portion of the premium amount due could be withheld. 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 (self pay) for the full amount of premiums due and for subsequent monthly premiums. MARx will notify the Plan with a modified TRC 213 - Exceed SNET Amt - for transactions that are rejected due to the \$200 'safety net'.

4.4 Single Payment Option Rule

The single payment option rule requires both the Part C and Part D premiums to be either direct bill or withhold as only one payment option can be elected by the member. This rule applies to a single plan enrollment. If a beneficiary is legally enrolled in two different plans, two payment options can be elected.

EXAMPLES:

- Beneficiary enrolls in a MA-PD plan for Part C and Part D coverage. This results in a single premium and the member must elect one payment option (withholding or direct bill).
- Beneficiary enrolls in a Private Fee for Service plan for Part C coverage and a PDP for Part D coverage. This results in enrollment in two different types of plans and two different premiums. The member may elect to have the Part C premium option as direct bill (self pay) and the Part D premium option as withhold from the SSA benefit.

5: Using the Medicare Advantage and Part-D Inquiry System Online Operations

Important:

The Medicare Advantage and Part-D Inquiry System User Interface (hereafter referred to as the Common UI) enables access to enrollment, eligibility, and 4Rx information for beneficiaries. CMS has combined this data into a single user interface.

The Common UI accommodates online and batch processing. Online capabilities are used to view beneficiary or contract information. Batch capabilities are used to submit data, such as enrollment and disenrollment transactions. This section addresses the online capabilities. See Section 1.3.1 for information on batch processing.

Common 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 starting from the start of the program.

The following sections describe online processing.

Note

This section may be read in its entirety, but it is also designed to be used for reference. Each topic provides content that is specific to that particular topic. The majority of the general information (such as common buttons, navigation processes, and messages) is provided either in Section 5.1 or in the appendices, and is not duplicated in the remainder of this section.

Note

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.

Note

On certain screens, if there is no end date displayed for the subsidy period, this does not mean the beneficiary's status has terminated; rather, a blank Subsidy End date indicates that the status has rolled over to the current year.

5.1 Getting Started

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

- Accessing the Common UI and logging onto the system
- Changing your password
- Logging out of the system
- Understanding roles and privileges
- Using the screens
- Navigating the system

5.1.1 Accessing the Common UI and Logging On to the System

5.1.1.1 How Do I Get Started Using the Common UI?

After you have obtained a CMS user ID and password (see Section 2.1.1), a Common UI user profile will be created for you. Your profile will define what tasks you are allowed to perform. One or more roles will be assigned to you based on your job responsibilities. One of these roles is marked as the default. When you log on, you may accept the default role or choose one of the other roles assigned to you. The profile also defines which contracts you may access.

To use the Common UI, you must have the following software installed on your 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 you do not have Adobe Acrobat Reader Version 4 or higher, please download a free version at www.adobe.com.

Also, you must:

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

5.1.1.2 How Do I Log On?

The Common UI is accessed via the CMS Applications Portal (<https://applications.cms.gov>). A user will log on to the CMS Applications Portal and then select the Medicare Advantage and Part-D Inquiry System link.

5.1.2 Changing Your Password

Password management will be handled using the CMS Individuals Authorized Access to CMS Computer Services (IACS). For more information on IACS, refer to the IACS User Guide on the MAPD Help web site (see Section 1.3 for the hypertext link).

5.1.3 Logging Out of the System

When you are ready to exit the Medicare Advantage and Part-D Inquiry system, logging out will close your browser windows. See Section 5.2.4 for the steps to log out. Closing the browser will also log you out.

5.1.4 Understanding Roles and Privileges

5.1.4.1 What Are the Different Roles and Privileges?

The Medicare Advantage and Part-D Inquiry System is a role-based system, which provides a secure environment for data. A role describes a user's job by the tasks that a user may perform. 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:

- MCO Representative — an individual who works for a Plan managing beneficiaries in the Medicare program via MARx. MCO representatives can access detailed enrollment data only for their own membership and minimal current enrollment data for other beneficiaries. They cannot transmit batch files containing membership changes and health status corrections.
- MCO Representative Transmitter — this role has the same capabilities as the MCO Representative role, with the additional ability to transmit batch files containing membership changes and health status corrections.

Note
Common 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, MA-PD plans), and PDPs).

5.1.4.2 Can I Change My Role?

When you log on to the Medicare Advantage and Part-D Inquiry System, the first screen you will see is the User Security Role Selection (M002) screen. It appears only at logon; you cannot get to this screen using the menu system. However, each time you log on to the system, you will be presented with the list of roles in your user profile. **Figure 5.1-1** lists roles for the user XXXX, who is eligible to choose either of the MCO roles.

The screenshot shows the 'User Security Role Selection (M002)' screen within the CMS Medicare Advantage Prescription Drug (MARx) interface. The header bar is red with the CMS logo on the left and the title 'Medicare Advantage Prescription Drug (MARx)' in the center. Below the header, the screen title 'User Security Role Selection (M002)' is on the left, and 'User: XXXX' and 'Date: 1/12/2006' are on the right. The main content area contains two radio button options: 'MCO REPRESENTATIVE' (which is selected, indicated by a green dot) and 'MCO REPRESENTATIVE TRANSMITTER' (which is unselected, indicated by a grey dot). Below these options is a button labeled 'Logon with Selected Role'.

Figure 5.1-1: User Security Role Selection (M002) Screen

5.1.5 Using the Screens

5.1.5.1 General Properties of Screens

Common UI screens share many properties. After you understand how the screens are organized, you can quickly and easily find the information you need.

There are two main types of general screen layout: primary and secondary (pop up). The principal differences between a primary window and a secondary window are the design and content of the headers and the manner in which you navigate among the screens.

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

5.1.5.2 Screen Layout – Primary Screens

The main window contains a primary screen with a menu and submenu. Only one primary screen will be open at a time. When you navigate 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 Common UI main menu (see **Figure 5.1-2**). 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.

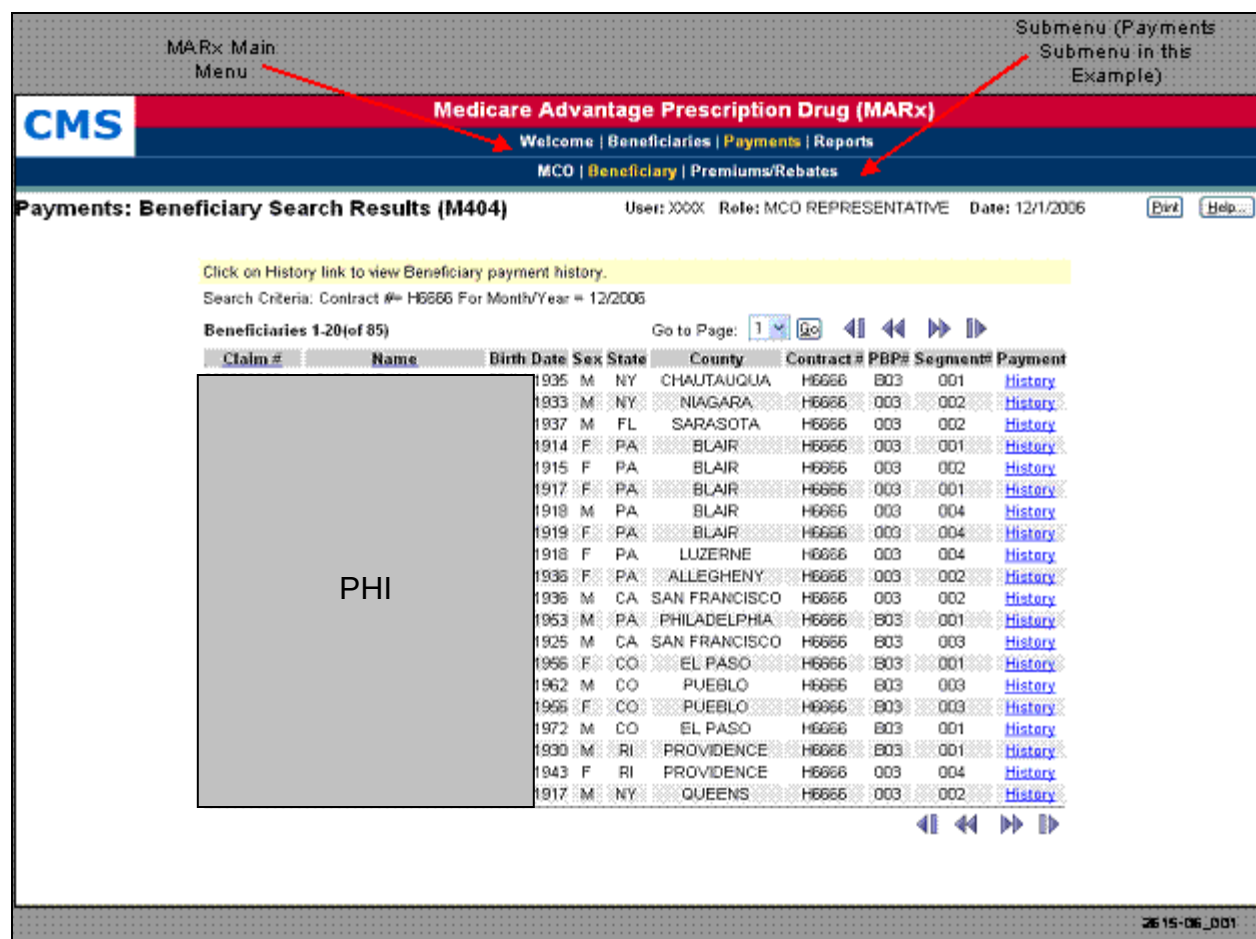


Figure 5.1-2: Example of a Primary Window

5.1.5.3 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. Multiple pop-up windows may be open at a time. When you switch primary screens, any open secondary screens associated with that primary screen will be closed automatically.

Secondary screens do not have the menu/submenu headers shown on primary screens. Instead, they have headers that vary based on the screen. Many secondary screens have a header that provides information specific to the contents of the screen. In the example shown in **Figure 5.1-3**, 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.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944		Beneficiary Name		DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)					
Snapshot Enrollment Status Payments Adjustments Premiums Factors Utilization									
Beneficiary Detail: Enrollment (M204)			User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2006		Close Print Help...				
Enrollments 1-3 (of 3) (Click on Contract# to view details)									
	Contract	PBP #	Seg #	Drug Plan	Start	End	Source	Disenroll Reason	Action
1	H6666	A01	123	N	08/01/2006		H6666		Payment
2	S1234	B01	000	Y	08/01/2006		S1234		Payment
3	H9999	013	000	N	01/01/2006	07/31/2006	H9999	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	Payment

Figure 5.1-3: 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]. You can move 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 secondary window.

5.1.5.4 Some Common Features of the Screens

Below the headings, most of the screens have the same format. The top of the screen contains a title line with the following information, as shown in **Figure 5.1-4**.

Claim # **Beneficiary Name** **DOB:**

112 E WILLOW AVE
ALTOONA, PA 16601-3944

Age: 91 Sex: FEMALE
State: PA (39) County: BLAIR (120)

Snapshot | Enrollment | Status | **Payments** | Adjustments | Premiums | Factors | Utilization

Beneficiary Detail: Payments (M206) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2006

Enter required field information below and click "Find."

*Indicates required field

*Payment Date

Payments 1-9 (of 9) (Click on payment date to view details)

Payment Date	Contract	PBP#	Seg#	Payments				Adjustments				Total Pay+Adj	Part B Premium Reduction	Regional MA BSF
				Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj			
11/2006	H6666	A01	123	\$0.00	\$0.00	\$0.00	\$0.00	\$86.76	\$39.54	\$0.00	\$126.30	\$126.30	-	\$0.00
11/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
10/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
10/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
09/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
09/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
08/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
08/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
07/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
06/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
05/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
04/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
03/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$739.68	\$505.02	\$0.00	\$1,244.70	\$1,867.05	-	\$0.00

Figure 5.1-4: Common Features of a Screen

- Screen name, which describes the screen's purpose. A primary screen's name reflects how the screen was reached using the menu and submenu.
- Screen identifier, which starts with an 'M'. This identifier can be useful when asking for help, reporting a problem to the help desk, or using this guide.
- User ID
- User's current role
- Current date
- [Print] and [Help] buttons (and the [Close] and other buttons for secondary windows)

Some windows also display additional buttons.

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

Many screens have instructions at the top, which are displayed on the screen with a yellow background to provide information on how to use 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, tables, etc. **Figure 5.1-5** shows an example of a screen with links that display:

- Additional information on the same screen (the 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).

Claim #
 112 E WILLOW AVE
 ALTOONA, PA 16601-3944

Beneficiary Name

DOB:
 Age: 91 Sex: FEMALE
 State: PA (39) County: BLAIR (120)

Snapshot | **Enrollment** | Status | Payments | Adjustments | Premiums | Factors | Utilization

Beneficiary Detail: Enrollment (M204)
 User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2006
 Close Print Help...

Enrollments 1-3(of 3) (Click on Contract# to view details)

	Contract	PBP #	Seg #	Drug Plan	Start	End	Source	Disenroll Reason	Action
1	H6666	A01	123	N	08/01/2006		H6666		Payment
2	S1234	B01	000	Y	08/01/2006		S1234		Payment
3	H9999	013	000	N	01/01/2006	07/31/2006	H9999	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	Payment

Payments 1-5(of 5) for Contract# H9999
 (Click on Payment date for details)

Payment Date	Contract#	Payments	Adjustments	Hospice	ESRD	Working Aged	Inst	NHC	Medicaid	Disability	CHF	Part B Premium Reduction
07/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
06/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
05/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
04/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
03/2006	H9999	\$622.35	\$1,244.70	-	-	-	-	-	-	-	-	-

Figure 5.1-5: Example of a Screen with Links

There may be additional buttons that perform operations on the screen. For an example, refer to **Figure 5.1-4**.

Some screens show information using a numerical code. When there is room on the screen, a description of the code is also displayed. In cases where there is no room, a description is available by placing the mouse pointer over the code, which will cause a description to pop up. See **Figure 5.1-6** for an example.

Code and Pop-Up Description

CMS Medicare Advantage Prescription Drug (MARx)

Request ID : 11111111	User ID : YYYY	Group ID :	Status : SUCCESSFUL
Entry Date : 09/05/2003	Effective Date : 10/01/2003	Expiration Date:	Status Date : 09/05/2003
Request Type Code : 3	Origin CD : 1	SSA DO :	Priority CD : 8

Transaction Reply Codes (M313) User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006 [Close](#) [Print](#) [Help...](#)

Code	Description
011	ENR ACC AS SUBMITTED
014	DISENROLLMENT DUE TO ENROLLMENT IN ANOTHER PLAN
016	COND ENR STARTED, OUT OF AREA

Figure 5.1-6: Example of a Code with a Pop-Up Description

5.1.5.5 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 is used to order 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 you fill out and buttons you click on to carry out an action. Some fields are required and others are optional. In some cases, it is required that one of several fields be entered, though none of the fields is individually required. 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 must be entered.

Sometimes there are additional rules regarding what combination of fields is acceptable and those rules are often indicated in instructions on the form.

There are different ways to enter information into a field:

- Text entry. Most fields (such as claim number or contract) allow you to type in the information.
- Dropdown list. Some fields (such as file type) provide a list of values from which you can select. Click on the down arrow next to the field to display the list, and then click on a value to select it. To delete your selection, select the blank value, which is at the top of the dropdown list for an optional field.
- Radio buttons. Choose one of the items in a group by clicking on the circle next to that item.
- Check boxes. Select any number of the items in a group by clicking on the box next to each item to be selected.

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

The information that you enter on a form is validated to ensure that your request is valid, and an error message is displayed to let you know when something is wrong.

Information that you enter into a field is validated when you exit that field (such as when you tab or click elsewhere on the screen). The field is color coded — *yellow* for a valid field and *pink* for an invalid field. When a field is invalid, it is selected (i.e., highlighted), and an error message is displayed in red below the title line.

Some validation is not performed when you exit the field, but rather when you click on a button. 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 button's action is not carried out.

After validation is complete, the user's action is submitted. The buttons on the screen (except for the [Print], [Help], [Close], and [Cancel] buttons) are disabled (grayed out) until the action is complete, to prevent a button from being clicked multiple times. Also, a message is shown, asking that you wait until the requested action is completed. If the processing succeeds, a message indicating that the action was successfully completed is displayed in green. If the processing encountered an error, a message explaining the problem is displayed in red and the user's inputs are displayed on the screen again.

5.1.5.6 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 information on multiple beneficiaries or transactions, that information is displayed in a table. When there are too many rows in the table to fit on one screen, only a portion of the table is displayed at one time. The [screen navigation arrows](#) at the top and bottom of the table allow you 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. You can also go directly to a particular page 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 number list.

If a column heading in a table is underlined, the table can be sorted by the information in that column. Click 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 done for all rows in the list, not just for the rows on the current page, so you may see different rows on the screen after sorting.

5.1.5.7 Accessibility

Though most users will use 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 can be used 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, hold down the <SHIFT> key when tabbing. To select a particular radio button, use 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, use the tab keys to move to the check box, and then use the space bar to toggle between selected and deselected.

In addition, buttons and fields have keyboard shortcuts that allow you 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 Medicare Advantage and Part-D Inquiry System meets the U.S. regulations (Section 508 of the Rehabilitation Act Amendments of 1998) requiring all U.S. Federal agencies to make their 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 (that is only visible with a screen reader) is placed at the start of the page, which, when clicked, skips over the menu and submenu.

The other Section 508 requirements are not applicable to this application.

5.1.5.8 Commonly Referenced Buttons and Links

Table 5.1-1 describes buttons and links used on many of the screens.

Table 5.1-1: 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 that is specific to the current screen. Below that link are links for topics that are displayed for each screen. When you click on a link, the help is displayed 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 Common 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 are used to 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 be displayed, and click on the [Go] button. The page numbers in the dropdown list reflect the actual number of pages in the list.

Example	Description
[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.

5.1.5.9 Common Fields

Table 5.1-2 describes the formats of input fields that are used on many of the screens. The field labels vary among screens. For example, a contract field may be labeled as “Contract #” or “Contract,” or a date field may be labeled “Birth Date” or “Effective Date.”

Table 5.1-2: 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). Depending on the screen and format, the BIC may or may not be optional: 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, MH, PH, WH, WCH) followed by a 6- or 9-digit number (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 9 characters (CAN) followed by a 2-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 4 characters: <i>H = local MA, local MA-PD, or non-MA plan</i> <i>9 = non-MA plan (no longer assigned)</i> <i>R = regional MA or MA-PD plan</i> <i>S = regular standalone PDP plan</i> <i>E = employer direct PDP plan</i> <i>F = fallback plan</i>
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. Length is up to 40 characters.

5.1.5.10 Error Message Screens

This section covers screens that report errors that could occur with the system. See Appendix B for contact information to report the error.

If a screen is unavailable for display, the Page Not Found screen (as shown in **Figure 5.1-7**) is displayed to notify the user of the problem.

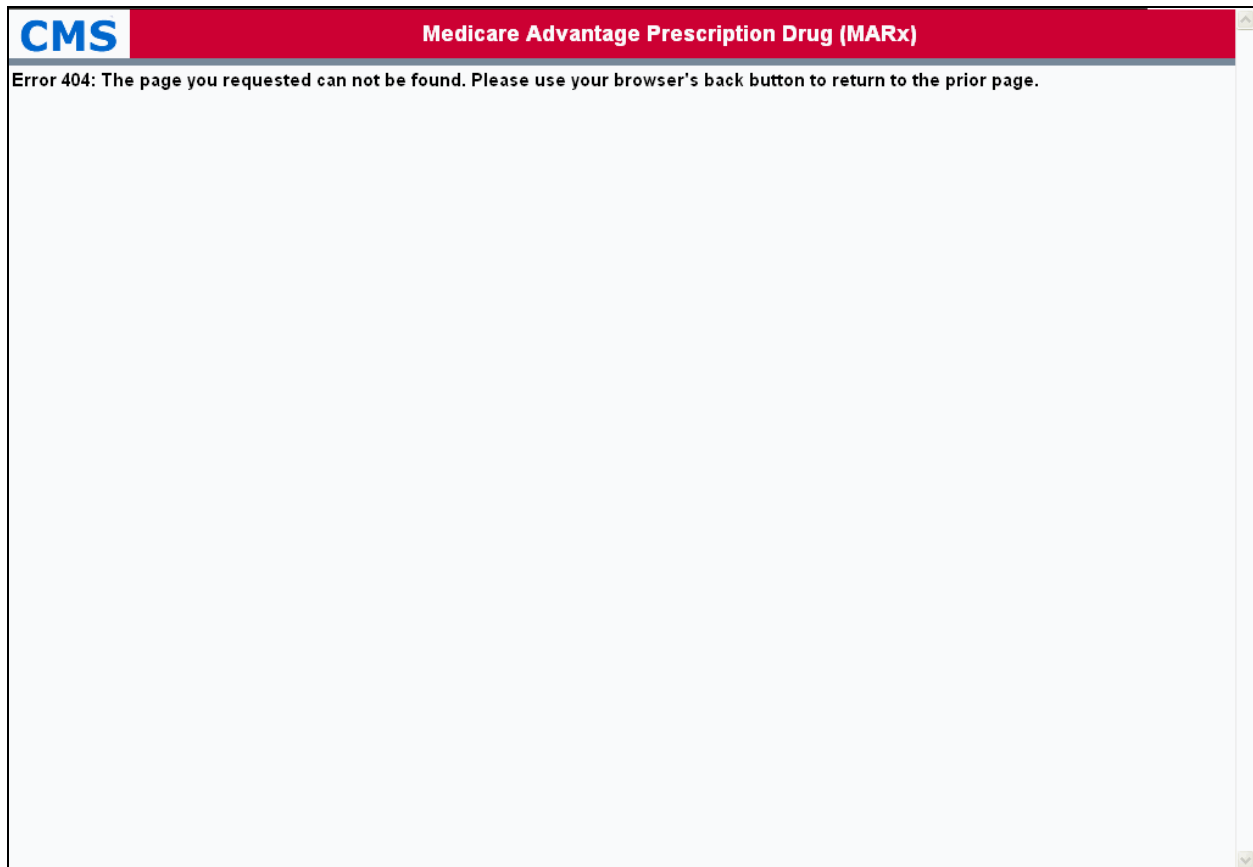


Figure 5.1-7: Page Not Found Screen

If a time-out occurs during an attempt to display a screen, the Page Time-Out screen (as shown in **Figure 5.1-8**) appears, to notify the user of the problem.

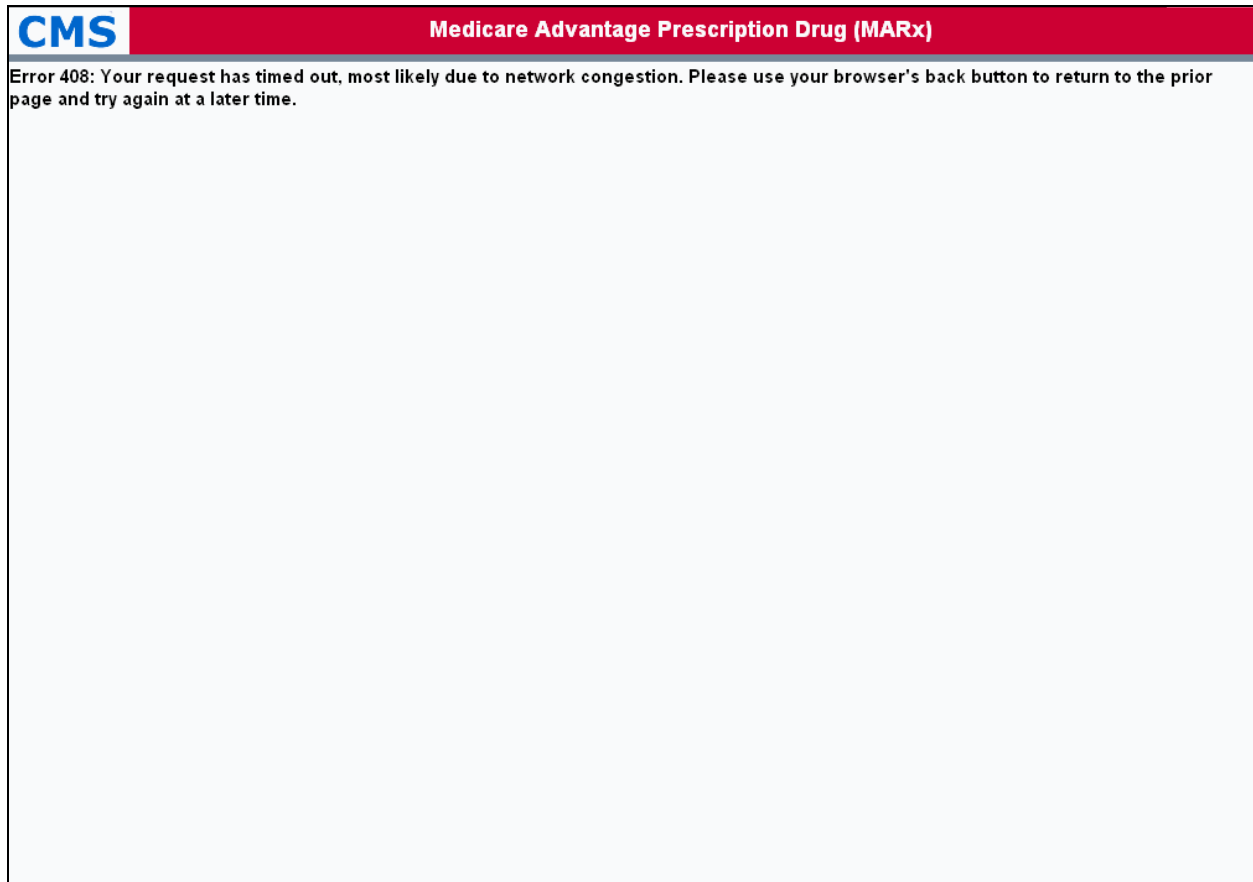


Figure 5.1-8: Page Time-Out Screen

5.1.6 Navigating the System

5.1.6.1 How Do I Get Where I Want To Go?

The functions to which you have access vary depending on your role. Only those functions available to your role will appear in the menu and submenus. The tasks within each function may also vary based on your role. **Table 5.1-3** lists the names of the main menu items and provides a general description of the functions you will find under each item.

Table 5.1-3: Main Menu Items

Menu Item	Description
Welcome	Messages, current payment month, 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.

5.1.6.2 How Do I Find Specific Information?

The Medicare Advantage and Part-D Inquiry System uses a type of drill-down system. What this means is that you start at a very high level — an overview of the major subdivisions — and narrow your way down to more specific detailed information.

5.1.6.3 Navigating Menus and Submenus

The menus and submenus all work in the same way, as follows.

When you first view the Common UI main menu, shown in **Figure 5.1-9**, it appears with the |Welcome| menu item highlighted on the screen.



Figure 5.1-9: MARx Main Menu with Welcome Selected

When you select an item from the Common UI main menu by clicking on the general area you want to view (e.g., the |Beneficiaries| menu item) the screen changes as displayed in **Figure 5.1-10**.

- 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)* screen is displayed in the form area.
- To view any of the other selections, just click the menu or submenu item (for example the |Payment| menu item) to see the associated screen.

CMS Medicare Advantage Prescription Drug (MARx)
Welcome | **Beneficiaries** | Payments
Find | Eligibility

Beneficiaries: Find (M201) User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006 [Print] [Help...]

Enter the claim number of the beneficiary and click "Find."
*Indicates required field
*Claim # (B/C is Optional)

[Find] [Reset]

Figure 5.1-10: Beneficiaries: Find (M201) Screen

Tip

The first-level screen names are made up of the names of the "Menu: Submenu" selection that brought you to that screen. This can help with navigating to a particular screen.

5.1.6.4 Navigating Using the Screens

After you get to a screen, you may do a search to find information about a particular beneficiary or month. After you have narrowed your search to this more specific level, you may be able to find even more detail by clicking on links and/or buttons on the screens that lead to additional screens.

5.1.6.5 An Example

The following example is provided to demonstrate this drill-down navigation method used by the enrollment processing system in its online processing. Note that the screens are used to help show the flow. Specific information about the contents of the screens is not provided here. However, this particular function is described in detail in Section 5.3.

In this example you will see how to view the details of an adjustment for a selected beneficiary during a selected month.

Consider a scenario where you want to determine the reason a specific beneficiary has a particular adjustment. Starting at the top level (the MARx main menu), select the general area in which you are interested. For this example, you would look at the screens having to do with beneficiaries, so click on the [Beneficiaries] menu item, as in **Figure 5.1-9**. *The Beneficiaries: Find (M201)* screen is displayed, as in **Figure 5.1-10**. Because you want to find a specific beneficiary, you would enter the selection data, as shown in **Figure 5.1-11**, and click on the [Find] button.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | **Beneficiaries** | Payments

Find | Eligibility

Beneficiaries: Find (M201) User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006 [Print](#) [Help...](#)

Enter the claim number of the beneficiary and click "Find."

*Indicates required field

*Claim # (BIC is Optional)

997

[Find](#) [Reset](#)

Figure 5.1-11: Beneficiaries: Find (M201) Screen with Claim Number Entered

This displays the *Beneficiaries: Search Results (M202)* screen, as in **Figure 5.1-12**. In this example, there is only one beneficiary who meets the selection criteria, but there may be more than one (for example, if BIC is not entered on the search).

The screenshot shows the CMS Medicare Advantage Prescription Drug (MARx) interface. The header includes the CMS logo and navigation links: Welcome, Beneficiaries, Payments, Find, and Eligibility. The main content area displays 'Beneficiaries: Search Results (M202)' with user information (User: XXXX, Role: MCO REPRESENTATIVE, Date: 1/12/2006) and buttons for Print and Help. A yellow instruction box says 'Click on Claim # link to view Beneficiary Enrollment Details.' Below this, the search criteria are shown as 'Claim # = 997' with a text input field. A table titled 'Beneficiaries 1-1(of 1)' lists one beneficiary with the following details:

Claim #	Name	Birth Date	Date of Death	Sex	State	County
997		04/16/		F	IN	HOWARD

Figure 5.1-12: Beneficiaries: Search Results (M202) for the Claim Number Specified

From here, you can view summary information about all of the beneficiaries returned from the search based on the input criteria, or you can drill down deeper to find more detailed information about a specific beneficiary. In this example we are going to look at adjustment information for a beneficiary. The first step to viewing this information is to click on the linked Claim # associated with the beneficiary ([997](#)). This displays the *Beneficiary Detail: Snapshot (M203)* screen, as shown in **Figure 5.1-13**. Notice that this is a secondary (pop-up) window and has a different header with the Beneficiary's name, claim number, DOB, street address, age, sex, state, and county. Also note that 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 # 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

Beneficiary Name

DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | SSA - RRB | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: Snapshot (M203) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2007 [Close](#) [Print](#) [Help](#)

The latest available Snapshot information is for payment month of 02/2007.

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

As Of: 11/15/2007 [Find](#)

Contract: H6666	Contract: S1234
MCO Name: TRI-STAR INSURANCE	MCO Name: HOWARD HEALTH, INC.
PBP Number: A01	PBP Number: B01
Segment Number: 123	Segment Number: 000
Special Needs Type:	Special Needs Type:
Bonus Payment Portion Percent: 0%	Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 70%	Demographic Blend Portion Percent: 0%
Residency Status: Out of Area	Residency Status: In Area
Part B Premium Reduction Benefit: \$0.00	Part B Premium Reduction Benefit: \$0.00

Residence for Payments: State: MN(24) County: ANOKA (10)

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

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

Low Income Subsidy: Subsidy Start: 01/01/2006 Subsidy End: 12/31/2006 LI Premium Subsidy Level: 100.00%
LI Co-payment Level: 1

Original Reason for Entitlement: 1
Aged/Disabled MSP Factor: 0.00
ESRD MSP Factor: 0.00

Payments For Payment Date 02/2007

Rate Used	Part A	Part B	Part D	Total
DEMOGRAPHIC	\$358.20	\$244.65	\$0.00	\$602.85
RISK ADJUSTED	\$447.00	\$304.16	\$0.00	\$751.16
* NET PAYMENTS	\$384.84	\$262.51	\$0.00	\$647.35
* PART D DIRECT SUBSIDY	\$0.00	\$0.00	\$59.62	\$59.62
* PART D REINSURANCE	\$0.00	\$0.00	\$26.97	\$26.97
* PART D COST SHARING	\$0.00	\$0.00	\$104.78	\$104.78
* PART D LIP	\$0.00	\$0.00	\$30.90	\$30.90
PART D BASIC PREMIUM	\$0.00	\$0.00	\$30.90	\$30.90
* TOTAL PDP	\$0.00	\$0.00	\$227.27	\$227.27

Adjustments Applied to 02/2007

Rate Used	Part A	Part B	Part D	Total
	\$0.00	\$0.00	\$0.00	\$0.00

Entitlement Information

	Start Date	End Date	Option
Part A:	10/01/1995		E
Part B:	10/01/1995		Y

Enrollment Information

Contract	Start Date	End Date
H4506	03/01/2007	

Eligibility Information

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

Premiums

Premium Withholding Option:	DIRECT SELF-PAY
Part C Premium (from enrollment):	\$32.15
Part D Premium (from HPMS):	\$32.00
De minimis:	\$2.00
Part D Net of De minimis:	\$30.00
Low Income Subsidy:	\$30.00
Late Enrollment Penalty:	\$0.00
Late Enrollment Penalty Waived Amount:	\$0.00
Late Enrollment Penalty Subsidy:	\$0.00
Beneficiary's Total Part D Premium:	\$0.00
Total C+D Premium (paid by beneficiary):	\$32.15

Figure 5.1-13: Beneficiary Detail: Snapshot (M203) for Selected Beneficiary

To view adjustment information specific to a beneficiary, select the |Adjustments| menu item, located just below the header. The screen is then displayed as in **Figure 5.1-14**.

Claim # 112 E WILLOW AVE
ALTOONA, PA 16601-3944

Beneficiary Name

DOB: Age: 91 Sex: FEMALE
State: PA (39) County: BLAIR (120)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | Factors | Utilization

Beneficiary Detail: Adjustments (M207) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2006

Enter required field information below and click "Find."

*Indicates required field

*Payment Month

Figure 5.1-14: Beneficiary Detail: Adjustments (M207) Screen for the Selected Beneficiary

Next, to get the adjustments for a particular payment date, enter the Payment Month (in this case 11/2006) and click on the [Find] button. This displays adjustment information for that beneficiary for months up through the payment month, as shown in **Figure 5.1-15**.

Claim #: 112 E WILLOW AVE
ALTOONA, PA 16601-3944 **Beneficiary Name** DOB: Age: 91 Sex: FEMALE
State: PA (39) County: BLAIR (120)

Snapshot | Enrollment | Status | Payments | **Adjustments** | Premiums | Factors | Utilization

Beneficiary Detail: Adjustments (M207) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2006 Close Print Help...

Enter required field information below and click "Find."

*Indicates required field

*Payment Month

Find Reset

Adjustment 1-5(0f 5) (Click on adjustment date to view details)

Adjustment Date	Contract	PBP	Segment	Description	Adjustment Code	Adjustments				Paid for Month
						Part A	Part B	Part D	Total	
11/2006	H6666	A01	123	RETROACTIVE ENROLLMENT	02	\$28.92	\$13.18	\$0.00	\$42.10	10/2006
11/2006	H6666	A01	123	RETROACTIVE ENROLLMENT	02	\$28.92	\$13.18	\$0.00	\$42.10	09/2006
11/2006	H6666	A01	123	RETROACTIVE ENROLLMENT	02	\$28.92	\$13.18	\$0.00	\$42.10	08/2006
03/2006	H9999	013	000	RETROACTIVE ENROLLMENT	02	\$369.84	\$252.51	\$0.00	\$622.35	02/2006
03/2006	H9999	013	000	RETROACTIVE ENROLLMENT	02	\$369.84	\$252.51	\$0.00	\$622.35	01/2006

Figure 5.1-15: Beneficiary Detail: Adjustments (M207) Screen for Selected Beneficiary Expanded for Specified Payment Month

Finally, you can select a particular adjustment by clicking on the month/year link in the Adjustment Date column ([03/2006](#), in this case) to display **Figure 5.1-16**.

At this point you have reached a display-only screen. There are no other links or ways to drill down, but you now have access to all you need regarding this beneficiary's adjustment information.

Again, the drill-down method enables you to navigate from very general information to very specific information just by following a path of menu and submenu items, links, and searches. For more information and for a complete description of the system navigational hierarchy, refer to Appendix F, *Screen Hierarchy*.

Claim #: [REDACTED]		Beneficiary Name [REDACTED]		DOB: [REDACTED]				
112 E WILLOW AVE ALTOONA, PA 16601-3944				Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)				
Payment/Adjustment Detail (M215)			User: XXXX Role: MCO REPRESENTATIVE Date: 4/12/2006		Close Print Help...			
Payments/Adjustment Table - Contract# H9999								
Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month
03/2006	PAYMENT COMPONENT	DEMOGRAPHIC	-	\$326.36	\$323.17	-	\$649.53	03/2006
03/2006	PAYMENT COMPONENT	RISK ADJUSTED	-	\$180.21	\$159.62	-	\$339.83	03/2006
03/2006	PAYMENT	BLEND	-	\$216.75	\$200.51	-	\$417.26	03/2006
03/2006	PAYMENT	BASIC PART C PREMIUM	-	\$44.00	\$36.00	-	\$80.00	03/2006
03/2006	PAYMENT COMPONENT	BASIC PART D PREMIUM	-	-	-	\$30.00	\$30.00	03/2006
03/2006	PAYMENT	REBATE FOR PART B PREMIUM REDUCTION	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR A/B COST SHARING	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR A/B MANDATORY SUPPLEMENTAL BENEFITS	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR PART D BASIC PREMIUM REDUCTION	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR PART D SUPPLEMENTAL BENEFITS	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	PART D DIRECT SUBSIDY	-	-	-	\$6.14	\$6.14	03/2006
03/2006	PAYMENT	LIS COST SHARING	-	-	-	\$12.00	\$12.00	03/2006
03/2006	PAYMENT	REINSURANCE AMOUNT	-	-	-	\$3.00	\$3.00	03/2006
03/2006	PAYMENT COMPONENT	TOTAL PART D PAYMENTS	-	-	-	-	\$21.14	03/2006
03/2006	PAYMENT	BSF MONTHLY	-	\$6.05	\$3.95	-	\$11.00	03/2006
03/2006	PAYMENT	BONUS PAYMENTS	-	-	-	-	\$31.14	03/2006
03/2006	PAYMENT	PACE PREMIUM ADD-ON	-	-	-	\$40.98	\$40.98	03/2006
03/2006	PAYMENT	PACE COST SHARING ADD-ON	-	-	-	\$51.32	\$51.32	03/2006
03/2006	ADJUSTMENT COMPONENT	DEMOGRAPHIC	-	\$326.36	\$323.17	-	\$649.53	02/2006
03/2006	ADJUSTMENT COMPONENT	RISK ADJUSTED	-	\$180.21	\$159.62	-	\$339.83	02/2006
03/2006	ADJUSTMENT	RETROACTIVE ENROLLMENT	02	\$216.75	\$200.51	-	\$417.26	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO BASIC PART D PREMIUM	30	-	-	\$30.00	\$30.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO LIS COST SHARING	32	-	-	\$12.00	\$12.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO REINSURANCE AMOUNT	33	-	-	\$3.00	\$3.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO BASIC PART C PREMIUM	34	\$44.00	\$36.00	-	\$80.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO REBATE AMOUNT	35	\$0.00	\$0.00	-	\$0.00	02/2006

Figure 5.1-16: Payment/Adjustment Detail (M215) Screen for the Selected Adjustment

5.2 Logging On and Viewing Messages

To use the Medicare Advantage and Part-D Inquiry System online, you must first log on. After you are logged on, you are presented with a screen from which you can view messages and the calendar.

5.2.1 Logging On

STEP 1: Accessing the Logon screen

See Section 5.1.1 for instructions on logging onto the CMS applications portal and navigating to the Medicare Advantage and Part-D Inquiry System. If that is successful, the *User Security Role Selection (M002)* screen will be displayed, from which you select your role (see step 2). If the system is down when you try to log on, your browser will display a message, stating that the “page is unavailable” or the “page cannot be found.” The content of this message is dependent on your browser, not on the system.

If the system is up and log on is not successful, then the *Logon Error (M009)* screen will be displayed with an error message describing why logon failed. This screen is shown in **Figure 5.2-1**.



Figure 5.2-1: Logon Error (M009) Screen

STEP 2: Selecting a Role

The *User Security Role Selection (M002)* screen displays the roles that are available to the user. Typically, a user will have only one role available, and that role will be selected. This screen is shown in **Figure 5.2-2** and described in **Table 5.2-1**, with error and validation messages provided in **Table 5.2-2**.

CMS Medicare Advantage Prescription Drug (MARx)	
User Security Role Selection (M002)	User: XXXX Date: 1/12/2006
☒ MCO REPRESENTATIVE ☐ MCO REPRESENTATIVE TRANSMITTER Logon with Selected Role	

Figure 5.2-2: User Security Role Selection (M002) Screen

Table 5.2-1: M002 Screen Inputs, Outputs, and Actions

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

Table 5.2-2: M002 Screen Messages

Message Type	Message Text	Suggested Action
Workstation setup	Click on the message 'Pop-up blocked. To see 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 Common UI. When a message is displayed asking if you want to allow pop-ups from the site, click [Yes]. Next, a message is displayed asking if you want to close the window. Click [No]. The <i>Welcome (M101)</i> screen is then displayed.
Missing data	No contracts are defined for this role	Your user profile must be updated. See Appendix B for contact information to report the error.
Software or Database Error	No security roles are defined for your user ID	See Appendix B for contact information to report the error.

Message Type	Message Text	Suggested Action
Software or Database Error	Error retrieving your security roles from the database	See Appendix B for contact information to report the error.
Software or Database Error	Your user ID does not exist	See Appendix B for contact information to report the error.
Software or Database Error	Your user ID was not supplied	See Appendix B for contact information to report the error.
Software or Database Error	Your user ID profile is inactive	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database while retrieving your security roles	See 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>	See Appendix B for contact information to report the error.
Software or Database Error	No screen items defined for this role	See Appendix B for contact information to report the error.
Software or Database Error	Error retrieving your security settings	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database while retrieving your security settings	See 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>	See Appendix B for contact information to report the error.
Software or Database Error	The dropdown lists results set is empty	See Appendix B for contact information to report the error.
Software or Database Error	Error retrieving dropdown lists from the database	See Appendix B for contact information to report the error.
Software or Database Error	No current payment month has been set	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database while retrieving the dropdown lists	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.

Your default role is selected on the screen. If you have more than one role available to you, you may change from the default to another role. The selected role will be shown on the title line of subsequent screens. Once a role is selected, click on the [Logon with Selected Role] button. After you select your role, you will be brought to the *Welcome (M101)* screen, as shown in **Figure 5.2-3** and described in **Table 5.2-3**, with error and validation messages provided in **Table 5.2-4**.

CMS		Medicare Advantage Prescription Drug (MARx)	
		Welcome Beneficiaries Payments Reports	
Welcome (M101)		User: XXXX Role: MCO REPRESENTATIVE	Date: 10/12/2007 Print Help...
Broadcast Messages	Routine maintenance Sunday 6am to 8am		
Current Payment Month	CPM: 11/2007		
MARx Version	Region: Production (PROD) Release: MMA R11.07		
MARx Calendar			

Figure 5.2-3: Welcome (M101) Screen

Table 5.2-3: M101 Screen Inputs, Outputs, and Actions

Item	Type	Description
Broadcast Messages	Output	Provides general information about what is happening in the system (such as month-end processing has started). The list of messages will be refreshed every time you return to the screen.
Current Payment Month	Output	The month/year currently being processed by the system.
MARx Version	Output	The region and release information of the MARx UI are displayed.
MARx Calendar	Link	Displays the <i>Calendar (M105)</i> screen.

Table 5.2-4: M101 Screen Messages

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

Message Type	Message Text	Suggested Action
Software or Database Error	Connection error	See Appendix B for contact information to report the error.

See the following sections for information provided on the *Welcome (M101)* screen:

- Broadcast message – see the next section, Viewing System Broadcast Messages
- Calendar – see Section 5.2.3

5.2.2 Viewing System Broadcast Messages

Broadcast messages are displayed for all users. They 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: Getting to the *Welcome (M101)* screen

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

STEP 2: Viewing the broadcast messages

The broadcast messages are shown on the *Welcome (M101)* screen under the Broadcast Messages heading. The list of messages will be refreshed every time you return to the screen.

5.2.3 Viewing the Calendar

From the calendar, you can see a list of operational events scheduled for any month.

STEP 1: Getting to the *Calendar (M105)* screen

From the system main menu, click on the |Welcome| menu item. This automatically selects the *Welcome (M101)* screen. Click on the [MARx Calendar](#) link to display the *Calendar (M105)* screen, as shown in **Figure 5.2-4** and described in **Table 5.2-5**, with error and validation messages provided in **Table 5.2-6**.


Medicare Advantage Prescription Drug (MARx)
Welcome | Beneficiaries | Payments | Reports

MARx Calendar (M105)
User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006
Print Help...

January
2006

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

MARx Operational Calendar for January 2005
Re-display

1. Jan 19 - System down for routine maintenance
2. Jan 26 - System down for software upgrade

Figure 5.2-4: Calendar (M105) Screen

Table 5.2-5: M105 Screen Inputs, Outputs, and Actions

Item	Type	Description
Above Line		
Month	Required dropdown list	Defaults to current calendar month. When this is changed, the pictorial calendar is automatically updated to the selected month and year.
Year	Required dropdown list	Defaults to current calendar year. When this is changed, the pictorial calendar is automatically updated to the selected month and year.
Calendar	Output	Pictorial calendar for selected month and year. If it is 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, click on this button to display the operational calendar for the newly selected month.

Table 5.2-6: M105 Screen Messages

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

STEP 2: Viewing the calendar events

The top part of the screen shows a pictorial calendar for one month. When the screen is first displayed, the current month is shown with the current day highlighted in blue.

The bottom part of the screen (the operational calendar) shows the calendar events that are 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.

5.2.4 Logging Out of the Medicare Advantage and Part-D Inquiry System

When you are finished with your activities, you should log out. If you do not explicitly log out, your session will eventually time out. However, logging out as soon as you are finished with the system is a more secure process to follow and is therefore recommended.

If you close the browser windows, you will be logged out automatically. To simplify logging out, you may use the logout screen to close all of your windows in one step.

When you log on to the system, your logon screen is replaced with a logout screen as shown in **Figure 5.2-5** and described in **Table 5.2-7**, with error and validation messages provided in **Table 5.2-8**. This logout screen is behind the Common UI primary window and can be used at any time by selecting the window.

Click on the [Logout] button. The browser will then ask if you want to close the window.

**Figure 5.2-5: Logout Screen****Table 5.2-7: Logout Screen Inputs, Outputs, and Actions**

Item	Type	Description
[Logout]	Button	Click on this button to log out of the system, closing all windows.

Table 5.2-8: 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]	Click on the [Yes] button to close the window. Click on the [No] button to keep the window open.

5.3 Viewing Beneficiary Information

You can search for a particular beneficiary by specifying one or more selection criteria. After you have found the beneficiary of interest, you can view detailed information. This section describes the following steps for viewing beneficiary information:

- STEP 1: Getting to 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 information for a beneficiary
 - STEP 4a: Viewing the *Beneficiary Detail: Snapshot (M203)* screen
 - STEP 4b: Viewing the *Beneficiary Detail: Enrollment (M204)* screen
 - STEP 4c: Viewing the *Beneficiary Detail: Status (M205)* screen
 - STEP 4d: Viewing the *Beneficiary Detail: Payments (M206)* screen
 - STEP 4e: Viewing the *Beneficiary Detail: Adjustments (M207)* screen
 - STEP 4f: Viewing the *Beneficiary Detail: Premiums (M231)* screen
 - STEP 4g: Viewing the *Beneficiary Detail: SSA/RRB Transaction Status (M237)* screen
 - STEP 4h: Viewing the *Beneficiary Detail: Factors (M220)* screen
 - STEP 4i: Viewing the *Beneficiary Detail: Utilization (M233)* screen
 - STEP 4j: Viewing the *Beneficiary Detail: Medicaid (M236)* screen
 - STEP 4k: Viewing the *Beneficiary Detail: MSA Lump Sum (M235)* screen
- STEP 5: Viewing the *Payment/Adjustment Detail (M215)* screen
- STEP 6: Viewing the *Enrollment Detail (M222)* screen

5.3.1 Finding a Beneficiary

To find information about a beneficiary who is enrolled in one of your contracts (either currently, in the past, or the future), use the *Beneficiaries: Find (M201)* screen to search for the beneficiary. Once you find the person, you may then view information on that beneficiary.

STEP 1: Getting to the *Beneficiaries: Find (M201)* screen

From the main menu, click on the |Beneficiaries| menu item. The |Find| submenu item is already selected and displays the *Beneficiaries: Find (M201)* screen as shown in **Figure 5.3-1** and described in **Table 5.3-1**, with error and validation messages provided in **Table 5.3-2**.

STEP 2: Using the *Beneficiaries: Find (M201)* screen

Enter search criteria and click on the [Find] button.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | **Beneficiaries** | Payments

Find | Eligibility

Beneficiaries: Find (M201) User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006 [Print](#) [Help...](#)

Enter the claim number of the beneficiary and click "Find."

*Indicates required field

*Claim # (BIC is Optional)

[Find](#) [Reset](#)

Figure 5.3-1: Beneficiaries: Find (M201) Screen

Table 5.3-1: M201 Screen Inputs, Outputs, and Actions

Item	Type	Description
Claim #	Required data entry field	Find beneficiaries who currently have this claim number. Note: The BIC is optional except when a RRB number is entered.
[Find]	Button	After a claim number has been entered, click on this button to initiate the search for beneficiaries.

Table 5.3-2: M201 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Enter a claim number.	Make sure to enter a valid claim number.

Message Type	Message Text	Suggested Action
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	Re-enter the claim number.
No data	No beneficiary records found for the search criteria	1. Verify that you have entered the information accurately. 2. Perform a more general search — your constraints may be too restricting.
Software or Database Error	Error occurred while retrieving beneficiary search results.	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary records.	See Appendix B for contact information to report the error.
Software or Database Error	Missing input	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.

5.3.2 Viewing Summary Information about a Beneficiary

The beneficiaries who meet your search criteria are displayed on the *Beneficiaries: Search Results (M202)* screen.

STEP 3: Using the *Beneficiaries: Search Results (M202)* screen

If your search is successful, the *Beneficiaries: Search Results (M202)* screen is displayed, as shown in **Figure 5.3-2** and described by **Table 5.3-3**. Because any error associated with the search would be displayed on the *Beneficiaries: Find (M201)* screen, there are no error messages. If a user enters an inactive Claim Number for the Beneficiary, a message will display to that effect as shown in **Table 5.3-4**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | [Beneficiaries](#) | [Payments](#)

[Find](#) | [Eligibility](#)

Beneficiaries: Search Results (M202) User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006 [Print](#) [Help...](#)

Click on Claim # link to view Beneficiary Enrollment Details.

Search Criteria: Claim # = 999876543

Beneficiaries 1-1(of 1)

Claim #	Name	Birth Date	Date of Death	Sex	State	County
999		04/06/		F	PA	BLAIR

Figure 5.3-2: Beneficiaries: Search Results (M202) Screen

Table 5.3-3: M202 Screen Inputs, Outputs, and Actions

Item	Type	Description
Claim # column heading	Sorter	Sorts the results by claim numbers.
Claim # in the Claim # column	Link	Click on a Claim # link to display the <i>Beneficiary Detail: Snapshot (M203)</i> 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 (as 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 5.3-4: 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 and adding additional selection criteria may narrow search results.

From this screen you can see summary information about each beneficiary that meets the search criteria. The list can be sorted 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, click 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 of which provides specific details about the beneficiary's enrollment or payment history. These screens will be described in more detail later in this section.

5.3.3 Viewing Detailed Information for a Beneficiary

Find the beneficiary on the *Beneficiaries: Search Results (M202)* screen and drill 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, click on the associated [Claim #](#).

Note

Instead of seeing a screen in the same area as previously displayed, you will see a new window appear with a new screen and a new header. This is a pop-up window, and it will have 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. The header, by itself, is shown in **Figure 5.3-3**.

Claim #	Beneficiary Name	DOB:
112 E WILLOW AVE ALTOONA, PA 16601-3944		Age: 89 Sex: FEMALE State: PA (39) County: BLAIR (120)

Figure 5.3-3: Sample Header for the Beneficiary Detail Screens

In addition, just below the header is a set of menu items, described in **Table 5.3-5**. You 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. See **Figure 5.3-4a** for an example of the menu items.

Table 5.3-5: Menu Items for Viewing Beneficiary Detail Information

Menu Item	Screen Name	Description
Snapshot	<i>Beneficiary Detail: Snapshot (M203)</i>	Displays an overall summary of payment information for the beneficiary as of the date you specified. If the beneficiary is not currently enrolled, the summary of last available payments and adjustments information is displayed. When the screen is first displayed, the date defaults to the current date.

Menu Item	Screen Name	Description
[Enrollment]	<i>Beneficiary Detail: Enrollment (M204)</i>	Displays a summary list of enrollment information, by contract, for the enrollments to which you have access. It also provides links to drill down to more detailed payment, adjustment, and enrollment information for the beneficiary on a selected contract.
[Status]	<i>Beneficiary Detail: Status (M205)</i>	Displays a summary list of enrollment and health status, by contract, for the enrollments to which you have access.
[Payments]	<i>Beneficiary Detail: Payments (M206)</i>	Displays a list (ordered by month as of the specified payment date) of payment and adjustment information, broken down by Parts A, B, and 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]	<i>Beneficiary Detail: Adjustments (M207)</i>	Displays a list (ordered by adjustment month as of the specified payment month) of adjustment information, broken down by Parts A, B, and 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]	<i>Beneficiary Detail: Premiums (M231)</i>	Displays a list of premium information for the specified month. The payment month defaults to the current month.
[Premium Withhold]	<i>Beneficiary Detail: Premium Withhold Transactions (M237)</i>	Displays a list of premium withhold transaction information for the beneficiary. The initial display is defaulted to the information for CPM year.
[Factors]	<i>Beneficiary Detail: Factors (M220)</i>	Displays the factors (beneficiary-specific or default) used in payment calculation.
[Utilization]	<i>Beneficiary Detail: Utilization (M233)</i>	Displays information on the beneficiary's use of Medicare services.
[MSA]	<i>Beneficiary Detail: MSA Lump Sum (M235)</i>	Displays Medical Savings Account Lump Sum information for a beneficiary for which you have access.
[Medicaid]	<i>Beneficiary Detail: Medicaid (M236)</i>	Displays a summary list of Medicaid information for a beneficiary for which you have access.

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

5.3.3.1 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 not available 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 5.3-4a** and **Figure 5.3-4b** and described in **Table 5.3-6**, with error and validation messages provided in **Table 5.3-7**, provides payment, status, adjustment, entitlement, eligibility, enrollment, and premium information for the beneficiary as of the date you specify. When the beneficiary is enrolled in two contracts (one for Parts A and/or B and the other for Part D), information on both contracts is displayed. On the initial display, the current date is used. To view the details as of a different date, update the date in the **As Of** data entry area and click on the [Find] button. If the beneficiary is enrolled with an effective date in the future, no status information will be available. Change the **As Of** date to the future date to view the snapshot information. If the beneficiary is not currently enrolled, a status message is displayed stating that “the latest available snapshot information is for a payment month in the past and last available payments are adjustments” is shown on the screen.

Claim # 1125 LAUGHING SNAIL LN KOKOMO, IN 46902-3803	Beneficiary Name	DOB: Age: 95 Sex: FEMALE State: IN (15) County: HOWARD (330)																																																		
Snapshot Enrollment Status Payments Adjustments Premiums Transactions Factors Utilization MSA Lump Sum Medicaid																																																				
Beneficiary Detail: Snapshot (M203) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2007 Close Change... Print Help...																																																				
Change date to re-display Beneficiary Details and click "Find."																																																				
As Of: 11/15/2007 Find																																																				
<table style="width: 100%;"> <tr> <td style="width: 50%;"> Contract: H6666 MCO Name: TRI-STAR INSURANCE PBP Number: A01 Segment Number: 123 Special Needs Type: Bonus Payment Portion Percent: 0% Demographic Blend Portion Percent: 70% Residency Status: Out of Area </td> <td style="width: 50%;"> Contract: S1234 MCO Name: HOWARD HEALTH, INC. PBP Number: B01 Segment Number: 000 Special Needs Type: Bonus Payment Portion Percent: 0% Demographic Blend Portion Percent: 0% Residency Status: In Area </td> </tr> </table>			Contract: H6666 MCO Name: TRI-STAR INSURANCE PBP Number: A01 Segment Number: 123 Special Needs Type: Bonus Payment Portion Percent: 0% Demographic Blend Portion Percent: 70% Residency Status: Out of Area	Contract: S1234 MCO Name: HOWARD HEALTH, INC. PBP Number: B01 Segment Number: 000 Special Needs Type: Bonus Payment Portion Percent: 0% Demographic Blend Portion Percent: 0% Residency Status: In Area																																																
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Residence for Payments: State: MN (24) County: ANOKA (010)																																																				
Status Flags: ☐ Hospice ☐ ESRD ☐ Working Aged ☐ Inst ☐ NHC																																																				
Payment Flags: ☐ Disabled ☐ CHF ☐ Part B Premium Reduction ☒ Long Term Institutional ☐ BIPA																																																				
Low Income Subsidy: Subsidy Start: 01/01/2006 Subsidy End: 12/31/2006 LI Premium Subsidy Level: 100.00% LI Co-payment Level: 1																																																				
Original Reason for Entitlement: 1																																																				
Payments For Payment Date 02/2007																																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Rate Used</th> <th style="width: 20%;">Part A</th> <th style="width: 20%;">Part B</th> <th style="width: 20%;">Part D</th> <th style="width: 25%;">Total</th> </tr> </thead> <tbody> <tr> <td>DEMOGRAPHIC</td> <td>\$368.20</td> <td>\$244.65</td> <td>\$0.00</td> <td>\$602.85</td> </tr> <tr> <td>RISK ADJUSTED</td> <td>\$447.00</td> <td>\$304.16</td> <td>\$0.00</td> <td>\$751.16</td> </tr> <tr> <td>* NET PAYMENTS</td> <td>\$364.84</td> <td>\$262.51</td> <td>\$0.00</td> <td>\$647.35</td> </tr> <tr> <td>* PART D DIRECT SUBSIDY</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$59.62</td> <td>\$59.62</td> </tr> <tr> <td>* PART D REINSURANCE</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$26.97</td> <td>\$26.97</td> </tr> <tr> <td>* PART D COST SHARING</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$104.78</td> <td>\$104.78</td> </tr> <tr> <td>* PART D LIP</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$30.90</td> <td>\$30.90</td> </tr> <tr> <td>* PART D BASIC PREMIUM</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$30.90</td> <td>\$30.90</td> </tr> <tr> <td>* TOTAL PDP</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$222.27</td> <td>\$222.27</td> </tr> </tbody> </table>			Rate Used	Part A	Part B	Part D	Total	DEMOGRAPHIC	\$368.20	\$244.65	\$0.00	\$602.85	RISK ADJUSTED	\$447.00	\$304.16	\$0.00	\$751.16	* NET PAYMENTS	\$364.84	\$262.51	\$0.00	\$647.35	* PART D DIRECT SUBSIDY	\$0.00	\$0.00	\$59.62	\$59.62	* PART D REINSURANCE	\$0.00	\$0.00	\$26.97	\$26.97	* PART D COST SHARING	\$0.00	\$0.00	\$104.78	\$104.78	* PART D LIP	\$0.00	\$0.00	\$30.90	\$30.90	* PART D BASIC PREMIUM	\$0.00	\$0.00	\$30.90	\$30.90	* TOTAL PDP	\$0.00	\$0.00	\$222.27	\$222.27
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Figure 5.3-4a: Beneficiary Detail: Snapshot (M203) Screen

Claim #: 1125 LAUGHING SNAIL LN KOKOMO, IN 46902-3803	Beneficiary Name	DOB: Age: 95 Sex: FEMALE State: IN (15) County: HOWARD (330)		
Snapshot Enrollment Status Payments Adjustments Premiums SSA - RRB Factors Utilization MSA Medicaid				
Beneficiary Detail: Snapshot (M203) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2007				
The latest available Snapshot information is for payment month of 02/2007.				
Change date to re-display Beneficiary Details and click "Find."				
As Of: 11/15/2007 Find				
Contract: H6666 MCO Name: TRI-STAR INSURANCE PBP Number: A01 Segment Number: 123 Special Needs Type: Bonus Payment Portion Percent: 0% Demographic Blend Portion Percent: 70% Residency Status: Out of Area Part B Premium Reduction Benefit: \$0.00 Contract: S1234 MCO Name: HOWARD HEALTH, INC. PBP Number: B01 Segment Number: 000 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: MN(24) County: ANOKA (10)				
Status Flags: ☐ Hospice ☐ ESRD ☐ ESRD MSP ☐ Aged/Disabled MSP ☐ Inst ☐ NHC				
Payment Flags: ☐ Disabled ☐ CHF ☐ Long Term Institutional ☐ Part B Premium Reduction				
Low Income Subsidy: Subsidy Start: 01/01/2006 Subsidy End: 12/31/2006 LI Premium Subsidy Level: 100.00% LI Co-payment Level: 1				
Original Reason for Entitlement: 1 Aged/Disabled MSP Factor: 0.00 ESRD MSP Factor: 0.00				
Payments For Payment Date 02/2007				
Rate Used	Part A	Part B	Part D	Total
DEMOGRAPHIC	\$358.20	\$244.65	\$0.00	\$602.85
RISK ADJUSTED	\$447.00	\$304.16	\$0.00	\$751.16
* NET PAYMENTS	\$384.84	\$262.51	\$0.00	\$647.35
* PART D DIRECT SUBSIDY	\$0.00	\$0.00	\$59.62	\$59.62
* PART D REINSURANCE	\$0.00	\$0.00	\$26.97	\$26.97
* PART D COST SHARING	\$0.00	\$0.00	\$104.78	\$104.78
* PART D LIP	\$0.00	\$0.00	\$30.90	\$30.90
PART D BASIC PREMIUM	\$0.00	\$0.00	\$30.90	\$30.90
* TOTAL PDP	\$0.00	\$0.00	\$227.27	\$227.27
Adjustments Applied to 02/2007				
Rate Used	Part A	Part B	Part D	Total
	\$0.00	\$0.00	\$0.00	\$0.00
Entitlement Information				
	Start Date	End Date	Option	
Part A:	10/01/1995		E	
Part B:	10/01/1995		Y	
Enrollment Information				
	Contract	Start Date	End Date	
	H4506	03/01/2007		
Eligibility Information				
	Start Date	End Date		
Part D:	01/01/2006			
Premiums				
Premium Withholding Option: DIRECT SELF-PAY				
Part C Premium (from enrollment):				\$32.15
Part D Premium (from HPMS):				\$32.00
De minimis:				\$2.00
Part D Net of De minimis:				\$30.00
Low Income Subsidy:				\$30.00
Late Enrollment Penalty:				\$0.00
Late Enrollment Penalty Waived Amount:				\$0.00
Late Enrollment Penalty Subsidy:				\$0.00
Beneficiary's Total Part D Premium:				\$0.00
Total C+D Premium (paid by beneficiary):				\$32.15

Figure 5.3-4b: Beneficiary Detail: Snapshot (M203) Screen with Payments and Adjustments for Past Payment Month

Table 5.3-6: M203 Screen Inputs, Outputs, and Actions

Item	Type	Description
As Of	Required data entry field	Enter a valid date in the form (D)D/(M)M/YYYY. You may change the As Of date. After you change the date, click 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 2) 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	The PBP number on the contract for this beneficiary on the As Of date.
Segment Number	Output	The 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 be paid to the MCO. This is not applicable to a Prescription Drug Plan (PDP).
Demographic Blend Portion Percent	Output	When the blended payment is calculated, this percentage of the demographic rate is used. The remaining percentage of the blended payment is based on the risk-adjustment amount. This is not applicable to a PDP.
Residency Status	Output	The residency status for this beneficiary on the As Of date.
Residence for Payments: State	Output	State used for payment calculation (which may be different from the state in the mailing address that is displayed in the screen header).
Residence for Payments: County	Output	County used for payment calculation (which may be different from the county in the mailing address that is displayed 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 and amount of the low income subsidy 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.

Item	Type	Description
Payments for Payment Date <mm/yyyy>	Output	Payment amount for each applicable calculation method (such as Demographic, Risk Adjustment, Blended, ESRD, Hospice, premium, and subsidy) for Part A, Part B, Part D, and the Net Payments for the beneficiary. Payments have asterisks, but components used in the payment calculation do not (e.g., a blended payment has an asterisk, but the demographic and risk-adjusted components used in the blend do not have an asterisk). The Net Payments amount includes additions and subtractions based on rebates, subsidies, and bonuses. Payments were made in the As Of month.
Adjustments Applied to <mm/yyyy>	Output	Adjustment amount for each applicable calculation method (such as Demographic, Risk Adjustment, Blended, ESRD, Hospice, premium, and subsidy) for Part A, Part B, Part D, and the Net Adjustments for the beneficiary. Adjustments have asterisks, but components used in the adjustment calculation do not (e.g., a blended adjustment has an asterisk, but the demographic and risk-adjusted components used in the blend do not have an asterisk). The Net Adjustments amount includes additions and subtractions based on rebates, subsidies, and bonuses. Adjustments apply to the As Of month but were paid in a later month.
Part B Premium Reduction Benefit	Output	The Part B Premium Reduction Benefit amount is shown only for non drug contractor. For the Pre 2006 Part B Premium Reduction Benefit multiply the BIPA amount by 0.80
Entitlement Information	Output	Eligibility 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 contracts on the As Of date.
Premium Information	Output	Premium information for the beneficiary on the As Of date. Includes premium withholding option, premiums for Parts C and D (as entered on the enrollment transaction), low income subsidy, late enrollment penalty, waiver of the penalty, subsidy of the penalty, and total premium as paid by the beneficiary.

Table 5.3-7: M203 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	As Of Date must be entered.	Enter the date.

Message Type	Message Text	Suggested Action
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 prospective payment data 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 you are expecting to see payment data, you should verify the date and month and re-enter the corrected information.
Software or Database Error	Error occurred while retrieving beneficiary snapshot data for claim number <claim number> and coverage date as of <date>.	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.

5.3.3.2 Viewing Enrollment Information

An enrollment history displays all of the times that the beneficiary is, was, or will be enrolled in any of your contracts.

STEP 4b: Viewing the *Beneficiary Detail: Enrollment (M204)* screen

To get to the *Beneficiary Detail: Enrollment (M204)* screen, click on the |Enrollment| menu item. This displays a screen, as shown in **Figure 5.3-5**, with a summary list of enrollment information by contract (and PBP and segment numbers, as applicable). When the beneficiary is enrolled in two contracts (one for Parts A and/or B and the other for Part D), two rows covering the same time period are displayed. This is how the screen looks when it initially appears. The screen is described in **Table 5.3-8** (note that the Payments section is not yet displayed), with error and validation messages provided in **Table 5.3-9**.

Note

You can see only contracts to which you have access. Therefore, there may be gaps in your list where you cannot see the enrollment information.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944	Beneficiary Name	DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)						
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid								
Beneficiary Detail: Enrollment (M204)								
User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007								
Close Print Help...								
Enrollments 1-3 (of 3) (Click on Contract# to view details)								
Contract	PBP #	Seg #	Drug Plan	Start	End	Source	Disenroll Reason	Action
1 H6666	A01	123	N	08/01/2006		H6666		Payment
2 S1234	B01	000	Y	08/01/2006		S1234		Payment
3 H9999	013	000	N	01/01/2006	07/31/2006	H9999	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	Payment

Figure 5.3-5: Beneficiary Detail: Enrollment (M204) Screen (Initial Display)

Table 5.3-8: M204 Screen Inputs, Outputs, and Actions

Item	Type	Description
Enrollments		
Contract column	Output	Contracts in which the beneficiary has been enrolled.
Contract # in the Contract column	Link	Click on a Contract # link to display the <i>Enrollment Details (M222)</i> screen for that contract and this beneficiary.
PBP # column	Output	PBP number for the contracts for the beneficiary.
Segment # column	Output	Segment number for the contracts for the beneficiary.
Drug Plan column	Output	Indicates whether each contract/PBP provides drug insurance coverage. Set to Y or N.
Start column	Output	Start date for each contract (plus PBP and segment, as applicable) for the beneficiary.
End column	Output	End date for each contract (plus PBP and segment, as applicable) for the beneficiary.
Source column	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)].
Disenroll Reason column	Output	Disenrollment reason for each contract from which the beneficiary has disenrolled.

Item	Type	Description
Payment in the Action column	Link	Click on a Payment link to display on this same screen the payment information associated with the selected contract/PBP/segment for this beneficiary.
Payments		
Payment Date column	Output	Month/year in which the payments and adjustments were made.
Month/Year in the Payment Date column	Link	Click on a month/year to display the pop-up screen <i>Payment/Adjustment Detail (M215)</i> discussed in Section 5.3.3.9. This will display detail payment and adjustment information for the contract/PBP/segment selected for this beneficiary.
Contract # column	Output	The selected contract.
Payments column	Output	Payments, broken out by month, for the selected contract (plus PBP and segment, as applicable) for the beneficiary.
Adjustments column	Output	Adjustments, broken out by month, for the selected contract (plus PBP and, as applicable) for the beneficiary.
Hospice column	Output	Checked if the beneficiary has the status of Hospice that month.
ESRD column	Output	Checked if the beneficiary has the status of ESRD that month.
Working Aged column	Output	Checked if the beneficiary has the status of Working Aged that month.
Inst (Institutional) column	Output	Checked if the beneficiary has the status of Institutional that month.
NHC column	Output	Checked if the beneficiary has the status of NHC that month.
Medicaid column	Output	Checked if the beneficiary has the status of Medicaid that month.
Disability column	Output	Checked if the beneficiary has the status of Disability that month.
CHF column	Output	Checked if the beneficiary has the status of congestive heart failure (CHF) that month.
Part B Premium Reduction column	Output	Checked if a Part B premium [formerly called Benefits Improvement & Protection Act of 2000 (BIPA)] reduction was applied to the payment and/or adjustments for the beneficiary that month.

Table 5.3-9: 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 you are expecting to see enrollment data, you should verify the date and month and re-enter the corrected information.

Message Type	Message Text	Suggested Action
No data	No payments found for claim number <claim number> and contract number <contract #>.	No corresponding payment data is available for that claim number and contract through the end of the enrollment or the current processing month.
Software or Database Error	Error occurred while retrieving enrollment results for claim number <claim number> and coverage date <coverage date>.	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving enrollment history for claim number <claim number> and coverage date <coverage date>.	See Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary enrollment history	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving payment results for claim number <claim number> and contract number <contract #>.	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving payment information for claim number <claim number> and contract number <contract #>.	See Appendix B for contact information to report the error.
Software or Database Error	Prospective payment information missing for claim number <claim number> and contract number <contract #>.	See Appendix B for contact information to report the error.
Software or Database Error	Payment profile information missing for claim number <claim number> and contract number <contract #>.	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.

To see details of the transaction that enrolled the beneficiary in a contract, click on a [Contract](#) link. This will display the *Enrollment Detail (M222)* screen for that contract and this beneficiary.

To see a summary of payment and adjustment information for a particular contract, click 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 5.3-6** and previously described in **Table 5.3-8**, with error and validation messages previously provided in **Table 5.3-9**.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944		Beneficiary Name 		DOB: 								
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid		Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)										
Beneficiary Detail: Enrollment (M204)				User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007								
Enrollments 1-3 (of 3) (Click on Contract# to view details)												
	Contract	PBP #	Seg #	Drug Plan	Start	End	Source	Disenroll Reason	Action			
1	H6666	A01	123	N	08/01/2006		H6666		Payment			
2	S1234	B01	000	Y	08/01/2006		S1234		Payment			
3	H9999	013	000	N	01/01/2006	07/31/2006	H9999	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	Payment			
Payments 1-5 (of 5) for Contract# H9999 (Click on Payment date for details)												
Payment Date	Contract#	Payments	Adjustments	Hospice	ESRD	Working Aged	Inst	NHC	Medicaid	Disability	CHF	Part B Premium Reduction
07/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
06/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
05/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
04/2006	H9999	\$622.35	\$0.00	-	-	-	-	-	-	-	-	-
03/2006	H9999	\$622.35	\$1,244.70	-	-	-	-	-	-	-	-	-

Figure 5.3-6: Beneficiary Detail: Enrollment (M204) Screen (Expanded)

To see the payment and adjustment information in further detail, click on one of the [month/year](#) links in the Payment Date column to display the *Payment/Adjustment Detail (M215)* screen, as described in Section 5.3.3.9.

5.3.3.3 Viewing the Status of a Beneficiary

A status history shows the beneficiary's statuses while enrolled in any of your contracts.

STEP 4c: Viewing the *Beneficiary Detail: Status (M205)* screen

To get to the *Beneficiary Detail: Status (M205)* screen, click on the |Status| menu item. This displays a screen, as shown in **Figure 5.3-7**, with a list of enrollment and health status periods by enrollment period (contract/PBP/segment) for this beneficiary. The information is displayed as follows:

- When more than one status applies to the beneficiary during an enrollment (such as when the beneficiary is in a hospice and has ESRD status), each status is shown on a separate row.
- If there are non-contiguous periods for a status (such as a break in Medicaid coverage), then each period is displayed on a separate row.
- If the details for a status change (such as a change in hospice provider), the contiguous status periods are combined and displayed as one period. When the details of a period are requested, this combined period is expanded to show how those details have changed.

- If there is no status information for an enrollment period, then that enrollment period is not displayed.
- When the beneficiary is enrolled in two contracts (one for Parts A and/or B and the other for Part D) and there is an applicable status for each contract, then rows for each contract are displayed.

This is how the screen appears when it initially displays. This screen is described in **Table 5.3-10** (note that the details section is not yet displayed), with error and validation messages provided in **Table 5.3-11**.

Claim #: 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

Beneficiary Name

DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | **Status** | Payments | Adjustments | Premiums | Premium Withhold | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: Status (M205) User: XXXX Role: MCO REPRESENTATIVE Date: 6/4/2008 [Close] [Change...] [Print] [Help...]

Status 1-2(of 2)(Click on Status to view details)

Contract	PBP	Segment	Enrollment Period		Status Period		Status
			Start Date	End Date	Start Date	End Date	
S5884	090	000	01/01/2006		01/01/2006		ESRD Transplant
H9030		000	04/01/1991	07/31/1991	04/01/1991	07/31/1991	ESRD Transplant

Figure 5.3-7: Beneficiary Detail: Status (M205) Screen (Initial Display)

Table 5.3-10: M205 Screen Inputs, Outputs, and Actions

Item	Type	Description
Statuses		
Contract column	Output	Contract for an enrollment period for which there is an applicable status. A contract/PBP/segment may be listed more than once if there was a change in status. The contract/PBP/segment will not be listed 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.

Item	Type	Description
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 (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	Click on this link to display details about the status period. For some status types, there are no additional details to be displayed, so the status is displayed 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 be blank).
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 be blank).
Start Source column	Output	Who (contract or system) provided notification that the ESRD period started.
Termination Reason column	Output	The reason ESRD coverage was 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.
End Date column	Output	When the selected third party Medicaid period ended (may be blank).
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 be blank).
Start Source column	Output	Who (contract or system) provided notification that the institutional period started.

Item	Type	Description
End Source column	Output	Who (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 be blank).
Start Source column	Output	Who (contract or system) provided notification that the NHC period started.
End Source column	Output	Who (contract or system) provided notification that the NHC period ended.
ESRD MSP Details		
Medical Coverage Type column	Output	Insurance type of the medical savings plan (MSP).
Start Date column	Output	Start date for the selected MSP period.
End Date column	Output	End date for the selected MSP period (may be blank).
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 medical savings plan (MSP).
Start Date column	Output	Start date for the selected MSP period.
End Date column	Output	End date for the selected MSP period (may be blank).
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 5.3-11: 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 retrieving beneficiary results for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving beneficiary status history for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary status history	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	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.

Note

You can see only contracts to which you have access. Therefore, there may be gaps in your list where you cannot see the enrollment information.

To see the details of a particular status period, click 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 5.3-8** and was previously described in **Table 5.3-10**, with error and validation messages previously provided in **Table 5.3-11**.

Claim #: 112 E WILLOW AVE ALTOONA, PA 16601-3944		Beneficiary Name		DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)				
Snapshot Enrollment Status Payments Adjustments Premiums Factors Utilization MSA Lump Sum Medicaid								
Beneficiary Detail: Status (M205)			User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007		Close Change... Print Help...			
Status 1-2(of 2)(Click on Status to view details)								
Contract		PBP	Segment	Enrollment Period		Status Period		Status
Start Date	End Date	Start Date	End Date	Start Date	End Date			
H6666	A01	123	08/01/2006		02/22/2006			Hospice
Hospice Details								
Start Date	End Date	Provider Number	Revocation Code	Record Add Timestamp				
05/01/2006		222222	0	05/15/2006 01:10:11 PM				
02/22/2006	04/30/2006	111111	0	03/11/2006 02:02:09 PM				

Figure 5.3-8: Beneficiary Detail: Status (M205) Screen (Expanded)

5.3.3.4 Viewing the Payment Information for a Beneficiary

A payment history shows the payments made for the beneficiary while enrolled in any of your contracts.

STEP 4d: Viewing the *Beneficiary Detail: Payments (M206)* screen

To get to the *Beneficiary Detail: Payments (M206)* screen, click on the |Payments| menu item. This displays a screen, as shown in **Figure 5.3-9** that provides a field for entering a payment month and year. 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 are displayed. Upon initial display, the current month appears in that field. This screen is described in **Table 5.3-12** (note that the Payments section is not yet displayed), with error and validation messages provided in **Table 5.3-13**.

Figure 5.3-9: Beneficiary Detail: Payments (M206) Screen (Initial Display)

Table 5.3-12: M206 Screen Inputs, Outputs, and Actions

Item	Type	Description
Search Criteria		
Payment Date	Required data entry field	Enter a month and year in the form (M)M/YYYY.
[Find]	Button	Click 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	Click on a month/year link to display the pop-up screen <i>Payment/Adjustment Detail (M215)</i> screen discussed in Section 5.3.3.7.

Item	Type	Description
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 Parts A, B, and 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 Parts A, B, and 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 MA BSF column	Output	Lists the bonus paid from the regional Medicare Advantage Bonus Stabilization Fund (MA BSF).

Table 5.3-13: M206 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Payment Date must be entered.	Enter the date.
Invalid format	Payment Date is invalid. Must have format (M)M/YYYY.	Re-enter 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 you are expecting to see payment data, you should verify the date and month and re-enter the corrected information.
Software or Database Error	Error occurred retrieving composite payment results for claim number <claim number> and coverage date <coverage date>.	See Appendix B for contact information to report the error.

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving composite payment information for claim number <claim number and coverage date <coverage date>.	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID.	See Appendix B for contact information to report the error.
Software or Database Error	Missing input.	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database.	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.

To expand the *Beneficiary Detail: Payments (M206)* screen and display a list (ordered by payment month) of payment and adjustment information, enter the month and year of the payment date and click on the [Find] button. The information is displayed by Part A, B, and D for months up through the payment date, as shown in **Figure 5.3-10** and previously described in **Table 5.3-12**, with error and validation messages previously provided in **Table 5.3-13**.

Claim #: 112 E WILLOW AVE ALTOONA, PA 16601-3944		Beneficiary Name		DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)										
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid														
Beneficiary Detail: Payments (M206) User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007 Close Print Help... 														
Enter required field information below and click "Find." *Indicates required field *Payment Date 11/2006 Find Reset														
Payments 1-9(0f 9) (Click on payment date to view details)														
Payment Date	Contract	PBP#	Seg#	Payments				Adjustments				Total Pay+Adj	Part B Premium Reduction	Regional MA BSF
				Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj			
11/2006	H6666	A01	123	\$0.00	\$0.00	\$0.00	\$0.00	\$86.76	\$39.54	\$0.00	\$126.30	\$126.30	-	\$0.00
11/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
10/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
10/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
09/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
09/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
08/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
08/2006	S1234	B01	000	\$0.00	\$0.00	\$222.27	\$222.27	\$0.00	\$0.00	\$0.00	\$0.00	\$222.27	-	\$0.00
07/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
06/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
05/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
04/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
03/2006	H9999	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$739.68	\$505.02	\$0.00	\$1,244.70	\$1,867.05	-	\$0.00

Figure 5.3-10: Beneficiary Detail: Payments (M206) Screen (Expanded)

To see the payment and adjustment information in more detail, click on one of the month/year links in the Payment Date column to display the *Payment/Adjustment Detail (M215)* screen, as described in Section 5.3.3.9.

5.3.3.5 Viewing the Adjustment Information for a Beneficiary

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

STEP 4e: Viewing the *Beneficiary Detail: Adjustments (M207)* screen

To get to the *Beneficiary Detail: Adjustments (M207)* screen, click on the |Adjustments| menu item. This displays a screen, as shown in **Figure 5.3-11**, that provides a field for entering a payment month and year. 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 are displayed. Upon initial display, the current date appears in that field. This screen is described in **Table 5.3-14** (note that the Adjustments section is not yet displayed), with error and validation messages provided in **Table 5.3-15**.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944	Beneficiary Name	DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid		
Beneficiary Detail: Adjustments (M207)		
User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007 Close Print Help...		
Enter required field information below and click "Find."		
*Indicates required field *Payment Month 11/2006		
Find Reset		

Figure 5.3-11: Beneficiary Detail: Adjustments (M207) Screen (Initial Display)

Table 5.3-14: M207 Screen Inputs, Outputs, and Actions

Item	Type	Description
Search Criteria		
Payment Month	Required data entry field	Enter a month and year in the form (M)M/YYYY.
[Find]	Button	Click 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	Click on a month/year link to display the pop-up screen <i>Payment/Adjustment Detail (M215)</i> discussed 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.

Item	Type	Description
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 5.3-15: M207 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 adjustments found for claim number <claim number> and payment month <month>.	No adjustment data is available for that claim number up through that month. If you are expecting to see payment data, you 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>.	See 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>.	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	See Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary adjustment history	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.

To expand the screen to display a list (ordered by adjustment month) of adjustment information that occurred up through the payment month you entered, enter the month and year of the payment date and click on the [Find] button. The Part A, B, and D adjustments are listed in adjustment code as shown in **Figure 5.3-12**, which was previously described by **Table 5.3-14**, with error and validation messages previously provided in **Table 5.3-15**.

Claim #
112 E WILLOW AVE
ALTOONA, PA 16601-3944

Beneficiary Name
DOB:
Age: 91 Sex: FEMALE
State: PA (39) County: BLAIR (120)

Snapshot | Enrollment | Status | Payments | **Adjustments** | Premiums | Premium Withhold | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: Adjustments (M207) User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007 Close Print Help...

Enter required field information below and click "Find."

*Indicates required field
*Payment Month

Find Reset

Adjustment 1.5(0f 5) (Click on adjustment date to view details)

Adjustment Date	Contract	PBP	Segment	Description	Adjustment Code	Adjustments				Paid for Month
						Part A	Part B	Part D	Total	
11/2006	H6666	A01	123	RETROACTIVE ENROLLMENT	02	\$28.92	\$13.18	\$0.00	\$42.10	10/2006
11/2006	H6666	A01	123	RETROACTIVE ENROLLMENT	02	\$28.92	\$13.18	\$0.00	\$42.10	09/2006
11/2006	H6666	A01	123	RETROACTIVE ENROLLMENT	02	\$28.92	\$13.18	\$0.00	\$42.10	08/2006
03/2006	H9999	013	000	RETROACTIVE ENROLLMENT	02	\$369.84	\$252.51	\$0.00	\$622.35	02/2006
03/2006	H9999	013	000	RETROACTIVE ENROLLMENT	02	\$369.84	\$252.51	\$0.00	\$622.35	01/2006

Figure 5.3-12: Beneficiary Detail: Adjustments (M207) Screen (Expanded)

To see the payment and adjustment information in more detail, click on one of the [month/year](#) links in the Adjustment Date column to display the *Payment/Adjustment Detail (M215)* screen, as described in Section 5.3.3.9.

5.3.3.6 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 4f: Viewing the Beneficiary Detail: Premiums (M231) screen

To get to the *Beneficiary Detail: Premiums (M231)* screen, click on the |Premiums| menu item. This displays a screen, as shown in **Figure 5.3-13**, that provides a field for entering a payment month and year. 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 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 5.3-16** and **Table 5.3-17** (note that the premiums section is not yet displayed), with error and validation messages provided in **Table 5.3-18**.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944	Beneficiary Name	DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid		
Beneficiary: Detail Premiums (M231)		
User: XXXX Role: MCO REPRESENTATIVE Date: 10/05/2007 Close Print Help...		
Enter the month of the premiums to be viewed and click "Find." *Indicates required field *Payment Date 11/2006 Find Reset		

Figure 5.3-13: Beneficiary Detail: Premiums (M231) Screen (Initial Display)

Table 5.3-16: M231 Screen Inputs, Outputs, and Actions

Item	Type	Description
Search Criteria		
Payment Date	Required data entry field	Enter a month and year in the form (M)M/YYYY.
[Find]	Button	Click on this button to display premium information in the lower portion of the screen.
Payments		
Start Date column	Output	When the premium charge began.
End Date column	Output	When the premium charge end.
Creation Date column	Output	When the premium information was provided.
Contract column	Output	Contract for which premiums were charged.
PBP column	Output	PBP for which premiums were charged.
Seg column	Output	Segment for which premiums were charged.
Premium Withholding Option column	Output	Option that the beneficiary chose for paying the premiums.
Enrollment Premiums Part C column	Output	Part C premium paid by the beneficiary.
Enrollment Premiums Part D column	Output	Part D premium paid by the beneficiary.
Premiums De Minimis	Output	Part D De Minimis amount
Part D Net of De Minimis	Output	Amount of Part D Minus the De Minimis amount.

Item	Type	Description
Low-Income Subsidy column	Output	Amount of Part D premiums that were subsidized.
Low-Income Subsidy % column	Output	Percentage of the Part D premiums that were subsidized.
Low-Income Subsidy Adj column	Output	Indicates whether the Part D premiums were subsidized.
# of Uncov Months column	Output	Number of months during which the beneficiary was not covered by drug insurance.
Late Enrollment Penalty column	Output	Penalty charged for late enrollment in Part D coverage.
Late Enrollment Penalty Adj column	Output	Indicates whether late enrollment penalties were charged.
LEP Subsidy column	Output	Amount of the late enrollment penalty that was subsidized.
LEP Waiver column	Output	Amount of the late enrollment penalty that was waived.
Total Premiums column	Output	Total premium charged for Parts C and/or D (as applicable), taking into account subsidies and penalties
SSA Accepted Month	Link	Date on which premium transaction was accepted by SSA. <u>For a 'beneficiary of interest' for SSA:</u> *If the beneficiary's premium information is not sent to SSA the 'SSA Accepted Month' field will be blank. *If SSA accepted the Premium withhold transaction, the SSA Accepted Month field will be populated with a value that will represent the month SSA accepted the beneficiary's premiums. *If SSA did not accept the Premium transaction, the SSA Accepted Month field will be blank. <u>For a beneficiary who is not a beneficiary of interest for SSA,</u> the 'SSA Accepted Month' field will be blank. Click on the link to display <i>Beneficiary Detail: Premium Withhold Transactions (M237)</i> screen. The M237 - Beneficiary Detail Premiums Screen will display the Premium Withhold Transactions that were accepted by SSA for that specific premium period.

Table 5.3-17: M231 Screen Premium Detail Dropdown Inputs, Outputs, and Actions

Item	Type	Description
[>>]	Button	Click on this button on a particular transaction status row to display dropdown premium detail transaction information view
[^] [^]	Button	Click on this button on a particular transaction status row to close the already opened dropdown premium detail transaction information view
Creation Date column	Output	Date on which the transaction is sent to SSA
De-Minimis column	Output	De-Minimis amount that was charged
Part D Net of De-Minimis column	Output	Net De-Minimis amount that was charged for Part D
LEP Subsidiary column	Output	Amount of the late enrollment penalty that was subsidized.
LEP Wavier column	Output	Amount of the late enrollment penalty that was waived.

Table 5.3-18: 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 that claim number on that date. If you are expecting to see payment data, you should verify the date and month and re-enter the corrected information.
Software or Database Error	Error occurred retrieving beneficiary premium results for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving beneficiary premium information for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Missing input data to retrieve premiums	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.

To expand the *Beneficiary Detail: Premiums (M231)* screen and display a list of premium information, enter the month and year of the payment date and click on the [Find] button. The information for the contracts in which the beneficiary was enrolled that month is displayed, as shown in **Figure 5.3-14** and previously described in **Table 5.3-16** and **Table 5.3-17**, with error and validation messages previously provided in **Table 5.3-18**.

Claim #
 112 E WILLOW AVE
 ALTOONA, PA 16601-3944

Beneficiary Name
 Age: 91 Sex: FEMALE
 State: PA (39) County: BLAIR (120)

DOB:

[Snapshot](#) | [Enrollment](#) | [Status](#) | [Payments](#) | [Adjustments](#) | [Premiums](#) | [SSA - RRB](#) | [Factors](#) | [Utilization](#) | [MSA](#) | [Medicaid](#)

Beneficiary: Detail Premiums (M231) User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 [Close](#) [Print](#) [Help...](#)

Enter the month of the premiums to be viewed and click "Find."

* Indicates required field

*Payment Date

[Find](#) [Reset](#)

Premiums 1-3 (of 3)

Start Date	End Date	Contract	PBP	Seg	Premium Withholding Option	Part C	Part D	LIS	LIS %	NUN CMO	LEP	Total Premium	Part B Premium Reduction	SSA Accepted Month(C/D)	SSA Accepted Month (B)										
*07/01/2008	12/31/2008	H5803	001	000	DIRECT SELF-PAY	\$20.00	\$12.15	\$0.00	100%	0	\$0.00	\$32.15	\$20.00												
Premium Details <table border="1"> <thead> <tr> <th>Creation Date</th> <th>De minimis</th> <th>Part D Net of De minimis</th> <th>LEP Subsidy</th> <th>LEP Waiver</th> </tr> </thead> <tbody> <tr> <td>04/04/2008</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> </tr> </tbody> </table>																Creation Date	De minimis	Part D Net of De minimis	LEP Subsidy	LEP Waiver	04/04/2008	\$0.00	\$0.00	\$0.00	\$0.00
Creation Date	De minimis	Part D Net of De minimis	LEP Subsidy	LEP Waiver																					
04/04/2008	\$0.00	\$0.00	\$0.00	\$0.00																					
*01/01/2008	06/30/2008	H5809	001	000	DEDUCT FROM SSA BENEFITS	\$20.00	\$10.00	\$0.00	100%	0	\$0.00	\$30.00	\$45.00	04/2008	04/2008										
*01/01/2007	12/31/2007	H1234	001	000	DEDUCT FROM SSA BENEFITS	\$20.00	\$0.00	\$0.00	100%	0	\$0.00	\$20.00	\$20.00	03/2008	03/2008										

Figure 5.3-14: Beneficiary Detail: Premiums (M231) Screen (Expanded)

5.3.3.7 View the Premium Withhold Transactions for a Beneficiary

Beneficiary Premium Withhold Status (M237) screen displays the SSA processing status for the Part C/D premium withhold and Part B Premium Reduction transactions sent by CMS and RRB to SSA for a specific beneficiary with premium year range in three different views. These three separate views are to display all SSA-RRB transactions, SSA Part C/D Premium Withhold transactions and SSA Part B Premium Reduction transactions. SSA either accepts or rejects the transaction. If the transaction is rejected, CMS continues to resubmit those transactions to SSA. Plans will be able to determine the progression of rejected transactions from first submission to retry to Facilitated direct bill (FDB). If the first submission (Tran Type = Initial) is rejected, CMS will re-send the transaction (Tran Type = Retry). If the retry is rejected, CMS will then send a Facilitated Direct Bill (Tran Type = FDB).

STEP 4g: 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 a screen, as shown in **Figure 5.3-15a**, which provides a list of Premium withhold transactions. By clicking the right arrows before the start of a status, it will display more detail transactions as described in **Table 5.3-20**. This screen is described in **Table 5.3-19** and **Table 5.3-20** with error and validation messages provided in **Table 5.3-21**.

Claim #: 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

Beneficiary Name

DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | **SSA - RRB** | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: SSA/ RRB Transaction Status (M237) User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 [Close] [Print] [Help...]

Enter the search criteria click "Find."

PremiumStart year: 2007 PremiumEnd year: 2008 Contract: [] [Find]

☒ All SSA - RRB ☐ SSA Part C/D Premium Withhold ☐ SSA Part B Premium Reduction

SSA Part C/D Premium Withhold, Part B Premium Reduction and RRB Transaction Results 1-7(of 7)

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 Withholding Option	Part B Premium Reduction	Total Premiums
» Accepted	FDB		SSA Part C/D	05/03/2008	05/04/2008									
» Rejected	Retry		SSA Part C/D	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	Y	S - DEDUCT FROM SSA		\$32.15
» Rejected	Initial		SSA Part B	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000			\$20.00	
» Accepted	Initial		SSA Part B	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000			\$45.00	
» Accepted	Initial		SSA Part C/D	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	Y	S - DEDUCT FROM SSA		\$30.00
» Accepted	Initial		SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	S - DEDUCT FROM SSA	\$20.00	\$20.00
» Rejected	Initial		RRB Part C/D/B	02/01/2008	02/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	D - DIRECT SELF PAY	\$20.00	\$20.00

Figure 5.3-15a: Beneficiary Detail: Premium Withhold Transactions (M237) Screen**Table 5.3-19: M237 Screen Inputs, Outputs, and Actions**

Item	Type	Description
Premium Start Year	Optional data entry field	Enter year in the form YYYY.
Premium End Year	Optional data entry field	Enter year in the form YYYY.
Contract	Optional data entry field	Enter a valid contract number
Item	Type	Description
[Find]	Button	Click on this button to display premium transaction information for the search criteria

Item	Type	Description
Status column	Output	SSA Transaction Status is shown as "Accepted" for SSA Accepted Transaction and "Rejected" for SSA Rejected Transaction.
Item	Type	Description
Type column	Output	Transaction Type (Initial, Retry or FDB). 'Initial' – Initial indicates a first submission of a Premium Withhold transaction from CMS to SSA. The transaction can be accepted or rejected. The rejection can be because of a mismatch in demographic information between CMS and SSA or can be because of a new enrollment that SSA does not have the information yet. 'Retry' - Retry indicates a transaction that was transmitted to SSA after the first submission was rejected by SSA. The transaction can be accepted or rejected by SSA. Transactions that are rejected by SSA in 'retry' will be re-submitted to SSA as an FDB (Facilitated Direct Bill) transaction. Prior Year Transaction rejects are not submitted for FDB. 'FDB' - FDB (Facilitated Direct-Bill) indicates a transaction was transmitted to SSA after the second attempt was rejected by SSA. The FDB transaction can be accepted or rejected by SSA.
Closed	Output	Transaction Closed indicator. Shown as 'Y' for closed transactions.
Request File Creation Date column heading	Sorter	Sorts the results by SSA sent 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 on which the transaction is sent to SSA
Response File Date column	Output	Date on which response is received from SSA (Header date on SSA Response File)
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)
Item	Type	Description
Premium Start Date column	Output	When the premium charge began.
Premium End Date column	Output	When the premium charge end.
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	This displays for only SSA Part C,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.
Item	Type	Description
Part B Premium Reduction column	Output	This displays for only SSA Part B Premium Reduction - Part B Premium Reduction Amount of the transaction
Total Premiums column	Output	Total premium charged to the beneficiary for Parts C and/or D (as applicable), for SSA Part C, D Premium Withhold or total premium charged to the Part B Reduction or total premium charged to both the SSA and RRB Part B,C,D Premiums taking into account subsidies, waivers, and penalties.

Note: For FDB transactions only SSA Status, Transaction Type, SSA Sent date, SSA Response File Date and Premium Withhold Option are displayed.

Table 5.3-20: M237 Screen Transaction Details Dropdown Inputs, Outputs, and Actions

Item	Type	Description
[>>]	Button	Click on this button on a particular transaction status row to display dropdown premium detail transaction information view
[^] [^]	Button	Click 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 reject of the transaction. Shown only for rejected transaction
Part C Premium column	Output	This displays for only SSA Part C,D Premium Withhold – Cost charged by plan to beneficiary for Part C coverage.
Part D Enhanced Premium column	Output	This displays for only SSA Part C,D Premium Withhold – Cost to beneficiary for Part D coverage. This amount may be adjusted by CMS with subsidies, waivers, and/or penalty.
Part D Enhanced Premium column	Output	This displays for only SSA Part C,D Premium Withhold - Part D enhanced Premium Amount of the transaction.
LEP column	Output	This displays for only SSA Part C,D Premium Withhold – Penalty charged for late enrollment in Part D coverage.

Item	Type	Description
LEP Subsidy column	Output	This displays for only SSA Part C,D Premium Withhold – Amount of the late enrollment penalty that was subsidized.
LIS Column	Output	This displays for only SSA Part C,D Premium Withhold – Amount of Part D premiums that were subsidized under Low Income Subsidiary.

Table 5.3-21: M237 Screen Messages

Message Type	Message Text	Suggested Action
Invalid format	Year must be a 4-digit number	Enter 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	Re-enter the contract number.
Invalid Entry	You do not have access rights to this Contract.	Determine if the contract number was entered correctly. If it was entered correctly and if the user should have rights to this contract see the Security Administrator, who can update the user profile to give him/her 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	Premium Withhold Transactions are currently being held for this beneficiary for the year <blocked years or all years>. This may be due to a mismatch between CMS and SSA/RRB data.	None needed.
Software or Database Error	Error occurred retrieving beneficiary premium withhold transaction 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.

Additional search criteria can be provided by clicking on the [Find] button. The list of Premium Withhold Transactions for the search criteria entered are displayed, as shown in **Figure 5.3-15b**, **Figure 5.3-15c**, **Figure 5.3-15d**, **Figure 5.3-15e**, **Figure 5.3-15f** and **Figure 5.3-15g** and as previously provided in **Table 5.3-19** and **Table 5.3-20** with error and validation messages previously described in **Table 5.3-21**.

Claim # 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803 **Beneficiary Name** DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | **SSA - RRB** | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: SSA/ RRB Transaction Status (M237) User: XXXX Role: MCO REPRESENTATIVE Date: Close Print Help...

Enter the search criteria click "Find."

Premium Start year: 2007 Premium End year: 2008 Contract: Find

☒ All SSA - RRB ☐ SSA Part C/D Premium Withhold ☐ SSA Part B Premium Reduction

SSA Part C/D Premium Withhold, Part B Premium Reduction and RRB Transaction Results 1-7(of 7)

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 Withholding Option	Part B Premium Reduction	Total Premiums
Accepted	FDB		SSA Part C/D	05/03/2008	05/04/2008									
* Rejected	Retry		SSA Part C/D	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	Y	S - DEDUCT FROM SSA		\$32.15

Transaction Details									
Reason for Reject				Part C Premium	Part D Premium	Part D Enhanced Premium	LEP	LEP Subsidy	LIS
R018 - Plan Number does not match SSA database				\$0.00	\$32.15	\$0.00	\$0.00	\$0.00	\$0.00

* Rejected	Initial	SSA Part B	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000				\$20.00	
* Accepted	Initial	SSA Part B	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000				\$45.00	
* Accepted	Initial	SSA Part C/D	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	Y	S - DEDUCT FROM SSA		\$30.00	
* Accepted	Initial	SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	S - DEDUCT FROM SSA	\$20.00	\$20.00	
* Rejected	Initial	RRB Part C/D/B	04/10/2008	04/13/2008	01/01/2007	12/31/2007	H1234	001	000	N	D - DIRECT SELF PAY	\$20.00	\$20.00	

Figure 5.3-15b: Beneficiary Detail: Premium Withhold Transactions (M237) Screen for All SSA-RRB Transaction Options

Claim # 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803 **Beneficiary Name** DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | **SSA - RRB** | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: SSA/ RRB Transaction Status (M237) User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 Close Print Help...

Transactions are currently being held for this beneficiary for the year: 2006. This may be due to a mismatch between CMS and SSA/RRB data.

Enter the search criteria click "Find."

Premium Start year: Premium End year: Contract: Find

☒ All SSA - RRB ☐ SSA Part C/D Premium Withhold ☐ SSA Part B Premium Reduction

SSA Part C/D Premium Withhold, Part B Premium Reduction and RRB Transaction Results 1-7 (of 7)

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 Withholding Option	Part B Premium Reduction	Total Premiums
Accepted	FDB		SSA Part C/D	05/03/2008	05/04/2008									
* Rejected	Retry		SSA Part C/D	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	Y	S - DEDUCT FROM SSA		\$32.15

Transaction Details

Reason for Reject	Part C Premium	Part D Premium	Part D Enhanced Premium	LEP	LEP Subsidy	LIS
R018 - Plan Number does not match SSA database	\$0.00	\$32.15	\$0.00	\$0.00	\$0.00	\$0.00

* Rejected	Initial	SSA Part B	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000				\$20.00	
* Accepted	Initial	SSA Part B	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000				\$45.00	
* Accepted	Initial	SSA Part C/D	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	Y	S - DEDUCT FROM SSA			\$30.00
* Accepted	Initial	SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	S - DEDUCT FROM SSA	\$20.00		\$20.00
* Rejected	Initial	RRB Part C/D/B	04/10/2008	04/13/2008	01/01/2007	12/31/2007	H1234	001	000	N	D - DIRECT SELF PAY	\$20.00		\$20.00

Figure 5.3-15c: Beneficiary Detail: Premium Withhold Transactions (M237) Screen for All SSA-RRB Transaction Options with Blocked Beneficiary

Claim #: 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

Beneficiary Name

DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | **SSA - RRB** | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: SSA/ RRB Transaction Status (M237) User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 Close Print Help...

Enter the search criteria click "Find."

Premium Start year: 2007 Premium End year: 2008 Contract: Find

☐ All SSA - RRB ☒ SSA Part C/D Premium Withhold ☐ SSA Part B Premium Reduction

SSA Part C/D Premium Withhold Transaction Results 1-4(of 4)

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 Withholding Option	Total Premiums
Accepted	FDB		SSA Part C/D	05/03/2008	05/04/2008								
*Rejected	Retry		SSA Part C/D	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	Y	S - DEDUCT FROM SSA	\$32.15
Transaction Details													
Reason for Reject				Part C Premium		Part D Premium		Part D Enhanced Premium		LEP	LEP Subsidy	LIS	
R018 - Plan Number does not match SSA database				\$20.00		\$12.15		\$0.00		\$0.00	\$0.00	\$0.00	
*Accepted	Initial		SSA Part C/D	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	Y	S - DEDUCT FROM SSA	\$30.00
*Accepted	Initial		SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	S - DEDUCT FROM SSA	\$20.00

Figure 5.3-15d: Beneficiary Detail: Premium Withhold Transactions (M237) Screen for Part C/D Premium Withhold Transaction Options

Claim # 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803 **Beneficiary Name** DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | **SSA - RRB** | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: SSA/ RRB Transaction Status (M237) User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 Close Print Help...

Transactions are currently being held for this beneficiary for the year: 2006. This may be due to a mismatch between CMS and SSA/RRB data.

Enter the search criteria click "Find."

PremiumStart year: PremiumEnd year: Contract: Find

☐ All SSA - RRB ☒ SSA Part C/D Premium Withhold ☐ SSA Part B Premium Reduction

SSA Part C/D Premium Withhold Transaction Results 1-4 (of 4)

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 Withholding Option	Total Premiums
Accepted	FDB		SSA Part C/D	05/03/2008	05/04/2008								
*Rejected	Retry		SSA Part C/D	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	Y	S - DEDUCT FROM SSA	\$32.15

Transaction Details

Reason for Reject	Part C Premium	Part D Premium	Part D Enhanced Premium	LEP	LEP Subsidy	LIS
R018 - Plan Number does not match SSA database	\$20.00	\$12.15	\$0.00	\$0.00	\$0.00	\$0.00

*Accepted Initial	SSA Part C/D	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	Y	S - DEDUCT FROM SSA	\$30.00
*Accepted Initial	SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	S - DEDUCT FROM SSA	\$20.00

Figure 5.3-15e: Beneficiary Detail: Premium Withhold Transactions (M237) Screen for Part C/D Premium Withhold Transaction Option with Blocked Beneficiary

Claim # 1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

Beneficiary Name

DOB: Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | **SSA - RRB** | Factors | Utilization | MSA | Medicaid

Beneficiary Detail: SSA/ RRB Transaction Status (M237) User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 [Close](#) [Print](#) [Help...](#)

Enter the search criteria click "Find."

Premium Start year: 2007 Premium End year: 2008 Contract: [Find](#)

☐ All SSA - RRB ☒ SSA Part C/D Premium Withhold ☐ SSA Part B Premium Reduction

SSA Part C/D Premium Withhold Transaction Results 1-4(of 4)

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 Withholding Option	Total Premiums
Accepted	FDB		SSA Part C/D	05/03/2008	05/04/2008								
* Rejected	Retry		SSA Part C/D	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	Y	S - DEDUCT FROM SSA	\$32.15

Transaction Details

Reason for Reject	Part C Premium	Part D Premium	Part D Enhanced Premium	LEP	LEP Subsidy	LIS
R018 - Plan Number does not match SSA database	\$20.00	\$12.15	\$0.00	\$0.00	\$0.00	\$0.00

* Accepted	Initial	SSA Part C/D	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	Y	S - DEDUCT FROM SSA	\$30.00
* Accepted	Initial	SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	N	S - DEDUCT FROM SSA	\$20.00

Figure 5.3-15f: Beneficiary Detail: Premium Withhold Transactions (M237) Screen for SSA Part B Premium Reduction Transaction Option

Claim #: 1125 LAUGHING SNAIL LN KOKOMO, IN 46902-3803	Beneficiary Name	DOB: Age: 95 Sex: FEMALE State: IN (15) County: HOWARD (330)									
Snapshot Enrollment Status Payments Adjustments Premiums SSA - RRB Factors Utilization MSA Medicaid											
Beneficiary Detail: SSA/ RRB Transaction Status (M237)											
User: XXXX Role: MCO REPRESENTATIVE Date: 04/08/2008 Close Print Help... 											
Transactions are currently being held for this beneficiary for the year: 2006. This may be due to a mismatch between CMS and SSA/RRB data.											
Enter the search criteria click "Find."											
PremiumStart year	PremiumEnd year	Contract									
2007	2008										
Find											
☐ All SSA - RRB ☐ SSA Part C/D Premium Withhold ☒ SSA Part B Premium Reduction											
SSA Part B Premium Reduction Transaction Results 13(of 3)											
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
✖ Rejected	Initial		SSA Part B	05/01/2008	05/03/2008	07/01/2008	12/31/2008	H5803	001	000	\$20.00
Transaction Details											
Reason for Reject											
E0004 - Dual SSA HICNs											
» Accepted	Initial		SSA Part B	04/01/2008	04/04/2008	01/01/2008	06/30/2008	H5809	001	000	\$45.00
» Accepted	Initial		SSA Part C/D/B	03/01/2008	03/03/2008	01/01/2007	12/31/2007	H1234	001	000	\$20.00

Figure 5.3-15g: Beneficiary Detail: Premium Withhold Transactions (M237) Screen for SSA Part B Premium Reduction Transaction Option with Blocked Beneficiary

5.3.3.8 Viewing Beneficiary Factors

STEP 4h: Viewing the *Beneficiary Detail: Factors (M220)* screen

A factors history shows the factors used to calculate payments made for the beneficiary while enrolled in any of your contracts.

To get to the *Beneficiary Detail: Factors (M220)* screen, click on the |Factors| menu item. This displays a screen, as shown in **Figure 5.3-16**, that provides the factors that were used to calculate payments. This screen is described in **Table 5.3-22**, with error and validation messages provided in **Table 5.3-23**.

Factor Type	Part A	Part B	Standard Part D	PIP-DCG	Start Date	End Date
1 RA FACTOR	0.5820	0.5820	0.5820	04	01/01/2005	12/31/2005
2 RA FACTOR	0.5770	0.5770	0.5770	04	01/01/2006	12/31/2006

Figure 5.3-16: Beneficiary Detail: Factors (M220) Screen

Table 5.3-22: M220 Screen Inputs, Outputs, and Actions

Item	Type	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.

Item	Type	Description
Start Date column	Output	First day the factors were effective.
End Date column	Output	Last day the factors were effective.

Table 5.3-23: M220 Screen Messages

Message Type	Message Text	Suggested Action
No data	No factors found for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving beneficiary-specific factors results for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving beneficiary-specific factors information for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Invalid input	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	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.

5.3.3.9 Viewing Beneficiary Utilization

A beneficiary's utilization information shows how the beneficiary used Medicare, including home health care, billings, deductibles, remaining days of coverage, and additional coverage by Medicaid. When a beneficiary was covered by Medicare under different claim numbers, those numbers are listed.

STEP 4i: Viewing the *Beneficiary Detail: Utilization (M233)* screen

To get to the *Beneficiary Detail: Utilization (M233)* screen, click on the |Utilization| menu item. This displays a screen, as shown in **Figure 5.3-17** and described in **Table 5.3-24**, with error and validation messages provided in **Table 5.3-25**.

Claim #: 1125 LAUGHING SNAIL LN KOKOMO, IN 46902 3803		Beneficiary Name		DOB:							
				Age: 95 Sex: FEMALE State: IN (15) County: HOWARD (330)							
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid											
Beneficiary Detail: Utilization (M233)			User: XXXX Role: MCO REPRESENTATIVE Date: 6/4/2008		Close Print Help...						
SSN: 561846185											
Mailing Foreign Address Consular Code:											
Representative Payee Name:											
<table border="1"> <tr> <th colspan="2">Claim Number Cross References (XREF)</th> </tr> <tr> <th>Claim Number</th> <th>XREF Type</th> </tr> <tr> <td>549464606C1</td> <td>Valid</td> </tr> </table>						Claim Number Cross References (XREF)		Claim Number	XREF Type	549464606C1	Valid
Claim Number Cross References (XREF)											
Claim Number	XREF Type										
549464606C1	Valid										
Home Health Detail Information											
Start Date	End Date	Earliest Billing Date	Latest Billing Date	Contractor Number	Patient Status Code	Provider Number					
There are no home health care periods											
Benefit Period/Deductible Information											
Lifetime Reserve Days Remaining: 60			Lifetime Psychiatric Days Remaining: 190								
Part A Spell											
Earliest Billing Date	Latest Billing Date	Inpatient Deductible Remaining	Full Days Remaining	Coinsurance Days Remaining	SNF Days Remaining	SNF Coinsurance Remaining					
02/07/1991	02/28/1991	\$0.00	40	30	20	80					
01/29/1980	02/10/1980	\$0.00	48	30	20	80					
11/12/1976	11/27/1976	\$0.00	45	30	20	80					
01/18/1976	01/19/1976	\$0.00	59	30	20	80					

Figure 5.3-17: Beneficiary Detail: Utilization (M233) Screen

Table 5.3-24: M233 Screen Inputs, Outputs, and Actions

Item	Type	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.

Item	Type	Description
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 for inpatient (hospital) care that is remaining to be met 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.
SNF Days Remaining	Output	Number of days of Skilled Nursing Facilities remaining in the benefit period.
SNF Coinsurance Remaining	Output	Number of coinsurance covered days of Skilled Nursing Facilities remaining in the benefit period.

Table 5.3-25: M233 Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred retrieving beneficiary utilization for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Invalid cross reference results	See Appendix B for contact information to report the error.
Software or Database Error	Invalid home health period results	See Appendix B for contact information to report the error.
Software or Database Error	Invalid benefit/deductible period results	See Appendix B for contact information to report the error.
Software or Database Error	Invalid Medicaid eligibility results	See Appendix B for contact information to report the error.
Software or Database Error	Missing input data to retrieve utilization	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.

5.3.3.10 Viewing the Medicaid of a Beneficiary

A Medicaid history shows the beneficiary's Medicaid source while enrolled in any of your contracts.

STEP 4j: Viewing the *Beneficiary Detail: Medicaid (M236)* screen

To get to the *Beneficiary Detail: Medicaid (M236)* screen, click on the |Medicaid| menu item. This displays a screen, as shown in **Figure 5.3-18**, with a list of Medicaid periods for this beneficiary. The information is displayed as follows:

- When more than one Medicaid applies to the beneficiary during an enrollment (such as when the beneficiary is in a Dual Medicaid and has Third Party Medicaid), each Medicaid is shown on a separate row.
- If there are non-contiguous periods for a Medicaid (such as a break in Medicaid coverage), then each period is displayed on a separate row.
- If the details for a Medicaid change (such as a change in Third Party Medicaid), the contiguous Medicaid periods are combined and displayed as one period. When the details of a period are requested, this combined period is expanded to show how those details have changed.
- If there is no Medicaid information for an enrollment period, then that enrollment period is not displayed.

This is how the screen appears when it initially displays. This screen is described in **Table 5.3-26** (note that the details section is not yet displayed), with error and validation messages provided in **Table 5.3-27**.

Start Date	End Date	Medicaid Source
01/01/2007	12/31/2007	CMS User
06/01/2005	12/31/2006	State
10/01/1995		Third Party

Figure 5.3-18: Beneficiary Detail: Medicaid (M236) Screen (Initial Display)

Table 5.3-26: M236 Screen Inputs, Outputs, and Actions

Item	Type	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 (Plan Medicaid, Third Party Medicaid, CMS User Medicaid, Point of Sale, Low Income Territory, or State) for each Medicaid period.
Medicaid in the Medicaid source column	Link	Click on this link to display details about the Medicaid period. For some Medicaid types, there are no additional details to be displayed, 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
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

Item	Type	Description
Low Income Territory		
Start Date column	Output	Start Date column
End Date column	Output	End Date column

Table 5.3-27: 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 retrieving beneficiary results for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving beneficiary Medicaid history for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Missing input on retrieval of beneficiary Medicaid history	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	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.

Note

You can see only contracts to which you have access. Therefore, there may be gaps in your list where you cannot see the Medicaid information.

To see the details of a particular status period, click 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 were combined into a single period on the initial display, that period is now expanded 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 5.3-19** and was previously described in **Table 5.3-26**, with error and validation messages previously provided in **Table 5.3-27**.

Claim #:	Beneficiary Name	DOB:															
1125 LAUGHING SNAIL LN KOKOMO, NH 46902-3803		Age: 95 Sex: FEMALE State: IN (15) County: HOWARD (330)															
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold History Transactions Factors Utilization MSA Medicaid																	
Beneficiary Detail: Medicaid (M236)																	
User: XXXX	Role: REGIONAL OFFICE USER	Date: 9/16/2008															
Close Change... Print Help...																	
<table border="1"> <thead> <tr> <th>Start Date</th> <th>End Date</th> <th>Medicaid Source</th> </tr> </thead> <tbody> <tr> <td>10/01/1995</td> <td></td> <td>Third Party</td> </tr> <tr> <td>01/01/2007</td> <td>12/31/2007</td> <td>Plan Reported</td> </tr> </tbody> </table>			Start Date	End Date	Medicaid Source	10/01/1995		Third Party	01/01/2007	12/31/2007	Plan Reported						
Start Date	End Date	Medicaid Source															
10/01/1995		Third Party															
01/01/2007	12/31/2007	Plan Reported															
<table border="1"> <thead> <tr> <th colspan="3">Third Party Medicaid Details</th> </tr> <tr> <th>Start Date</th> <th>End Date</th> <th>Premiums Payer Code</th> </tr> </thead> <tbody> <tr> <td>10/01/1995</td> <td>09/30/2000</td> <td>220</td> </tr> <tr> <td>10/01/2000</td> <td>02/28/2001</td> <td>220</td> </tr> <tr> <td>03/01/2001</td> <td></td> <td>220</td> </tr> </tbody> </table>			Third Party Medicaid Details			Start Date	End Date	Premiums Payer Code	10/01/1995	09/30/2000	220	10/01/2000	02/28/2001	220	03/01/2001		220
Third Party Medicaid Details																	
Start Date	End Date	Premiums Payer Code															
10/01/1995	09/30/2000	220															
10/01/2000	02/28/2001	220															
03/01/2001		220															
<table border="1"> <thead> <tr> <th colspan="4">Plan Reported</th> </tr> <tr> <th>Start Date</th> <th>End Date</th> <th>Start Source</th> <th>End Source</th> </tr> </thead> <tbody> <tr> <td>01/01/2007</td> <td>12/31/2007</td> <td>XXXX</td> <td>XXXX</td> </tr> </tbody> </table>			Plan Reported				Start Date	End Date	Start Source	End Source	01/01/2007	12/31/2007	XXXX	XXXX			
Plan Reported																	
Start Date	End Date	Start Source	End Source														
01/01/2007	12/31/2007	XXXX	XXXX														

Figure 5.3-19: Beneficiary Detail: Medicaid (M236) Screen (Expanded)

5.3.3.11 View Beneficiary MSA Lump Sum

A beneficiary's MSA Lump Sum screen shows the Medical Savings Account enrollment and payment information effective January 1, 2008.

STEP 4k: Viewing the *Beneficiary Detail: MSA Lump Sum (M235)* screen

To get to the *Beneficiary Detail: MSA Lump Sum (M235)* screen, click on the [\[MSA Lump Sum\]](#) menu item. This displays a screen, as shown in **Figure 5.2-20** and described in **Table 5.2-28**, with error and validation messages provided in **Table 5.2-29**.

Claim #	Beneficiary Name	DOB						
1125 LAUGHING SNAIL LN KOKOMO, IN 46902 3803		Age: 95 Sex: FEMALE State: IN (15) County: HOWARD (330)						
Snapshot Enrollment Status Payments Adjustments Premiums Premium Withhold Factors Utilization MSA Medicaid								
Beneficiary Detail: MSA Lump Sum (M235)								
User: XXXX	Role: MCO REPRESENTATIVE	Date: 6/4/2008						
Close Print Help...								
Change year to re-display MSA Lump Sum Deposit/Recovery Details and click "Find."								
Year:	2008	Find						
MSA Lump Sum Deposit/Recovery 1-2(0f 2)								
Enrollment				Lump Sum				
Contract	PBP #	Seg #	Disenroll Reason	CPM	Start Date	End Date	Deposit	Recovery
H8011	001	000	99	12/01/2008	12/01/2008	12/31/2008		\$400.00
H8011	001	000	99	12/01/2008	04/01/2008	10/31/2008		\$2,800.00

Figure 5.3-20: Beneficiary Detail: MSA Lump Sum (M235) Screen

Table 5.2-28: M235 Screen Inputs, Outputs, and Actions

Item	Type	Description
Search Criteria		
Year	Required data entry field	Enter a year in the form YYYY.
[Find]	Button	Click 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
CPM	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 5.2-29: 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>	Enter a year that is greater than the one previously entered and search again.
Software or Database Error	Error occurred retrieving MSA Lump Sum results for claim number <claim number>	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.

5.3.3.12 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 5: Viewing the *Payment/Adjustment Detail (M215)* screen

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 5.3-21**, provides payment and adjustment details for the selected month and contract. Adjustments are listed by adjustment reason code and are shown on the screen for the month in which they are paid, not the month to which they apply. When a blended rate is displayed, the demographic and risk-adjusted components used in the blending calculation are also displayed. Any additions and subtractions for bonuses, rebates, and/or subsidies are listed on separate lines. The screen is described in **Table 5.3-30**, with error and validation messages provided in **Table 5.3-31**.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944		Beneficiary Name 		DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)				
Payment/Adjustment Detail (M215)			User: XXX Role: MCO REPRESENTATIVE Date: 4/12/2006		Close Print Help...			
Payments/Adjustment Table - Contract# H9999								
Payment Date	Type	Description	Adjustment Code	Payment/Adjustments			Total	Paid for Month
03/2006	PAYMENT COMPONENT	DEMOGRAPHIC	-	\$326.36	\$323.17	-	\$649.53	03/2006
03/2006	PAYMENT COMPONENT	RISK ADJUSTED	-	\$180.21	\$159.62	-	\$339.83	03/2006
03/2006	PAYMENT	BLEND	-	\$216.75	\$200.51	-	\$417.26	03/2006
03/2006	PAYMENT	BASIC PART C PREMIUM	-	\$44.00	\$36.00	-	\$80.00	03/2006
03/2006	PAYMENT COMPONENT	BASIC PART D PREMIUM	-	-	-	\$30.00	\$30.00	03/2006
03/2006	PAYMENT	REBATE FOR PART B PREMIUM REDUCTION	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR A/B COST SHARING	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR A/B MANDATORY SUPPLEMENTAL BENEFITS	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR PART D BASIC PREMIUM REDUCTION	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	REBATE FOR PART D SUPPLEMENTAL BENEFITS	-	\$0.00	\$0.00	-	\$0.00	03/2006
03/2006	PAYMENT	PART D DIRECT SUBSIDY	-	-	-	\$6.14	\$6.14	03/2006
03/2006	PAYMENT	LIS COST SHARING	-	-	-	\$12.00	\$12.00	03/2006
03/2006	PAYMENT	REINSURANCE AMOUNT	-	-	-	\$3.00	\$3.00	03/2006
03/2006	PAYMENT COMPONENT	TOTAL PART D PAYMENTS	-	-	-	-	\$21.14	03/2006
03/2006	PAYMENT	BSF MONTHLY	-	\$6.05	\$3.95	-	\$11.00	03/2006
03/2006	PAYMENT	BONUS PAYMENTS	-	-	-	-	\$31.14	03/2006
03/2006	PAYMENT	PACE PREMIUM ADD-ON	-	-	-	\$40.98	\$40.98	03/2006
03/2006	PAYMENT	PACE COST SHARING ADD-ON	-	-	-	\$51.32	\$51.32	03/2006
03/2006	ADJUSTMENT COMPONENT	DEMOGRAPHIC	-	\$326.36	\$323.17	-	\$649.53	02/2006
03/2006	ADJUSTMENT COMPONENT	RISK ADJUSTED	-	\$180.21	\$159.62	-	\$339.83	02/2006
03/2006	ADJUSTMENT	RETROACTIVE ENROLLMENT	02	\$216.75	\$200.51	-	\$417.26	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO BASIC PART D PREMIUM	30	-	-	\$30.00	\$30.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO LIS COST SHARING	32	-	-	\$12.00	\$12.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO REINSURANCE AMOUNT	33	-	-	\$3.00	\$3.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO BASIC PART C PREMIUM	34	\$44.00	\$36.00	-	\$80.00	02/2006
03/2006	ADJUSTMENT	RETROACTIVE CHANGE TO REBATE AMOUNT	35	\$0.00	\$0.00	-	\$0.00	02/2006

Figure 5.3-21: Payment/Adjustment Detail (M215) Screen

Table 5.3-30: M215 Screen Inputs, Outputs, and Actions

Item	Type	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 premiums 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 5.3-31: M215 Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred while retrieving payments/adjustments from database.	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving payments/adjustments detail results.	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	See Appendix B for contact information to report the error.
Software or Database Error	Missing input for retrieval of payments/adjustments.	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database.	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.

5.3.3.13 Viewing Enrollment Details

The enrollment details show the information on the enrollment, disenrollment (as applicable), and Part D insurance information for a beneficiary in a plan.

STEP 6: Viewing the Enrollment Detail (M222) screen

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 5.3-22**, provides details of the selected enrollment or enrollment period. The screen is described in **Table 5.3-32**, with error and validation messages provided in **Table 5.3-33**.

Claim # 112 E WILLOW AVE ALTOONA, PA 16601-3944	Beneficiary Name	DOB: Age: 91 Sex: FEMALE State: PA (39) County: BLAIR (120)
Enrollment Detail (M222)		
User: XXXX Role: MCO REPRESENTATIVE Date: 8/1/2006		
Contract: H9999 MCO Name: ACME HEALTH SERVICES PBP Number: 013 Segment Number: 000 Drug Plan: Y Effective Start Date: 01/01/20006 Effective End Date: 07/31/2006 EGHP: Y Enrollment Forced Code: Disenrollment Reason Code: 13 Application Date: 12/01/2005 Enrollment Election Type: ANNUAL ELECTION PERIOD (AEP) Disenrollment Election Type: SPECIAL ELECTION PERIOD (SEP) Special Needs Type: Enrollment Source: BENEFICIARY ELECTION Part D Auto-Enrollment Opt-Out: Part D Rx Bin: 610014 Part D Rx PCN: MEDDPRIME Part D Rx Group: WPSDP Part D Rx ID: 000117958		

Figure 5.3-22: Enrollment Detail (M222) Screen

Table 5.3-32: M222 Screen Inputs, Outputs, and Actions

Item	Type	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. Set 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 employer group health plan (EGHP). Set to Y or N.

Item	Type	Description
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 (Institutional, Dual Eligible, or Chronic or Disabling Condition)
Enrollment Source	Output	What 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 5.3-33: M222 Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	Error occurred retrieving beneficiary enrollment information	See Appendix B for contact information to report the error.
Software or Database Error	Invalid input retrieving beneficiary enrollment information	See Appendix B for contact information to report the error.
Software or Database Error	Beneficiary enrollment information is missing	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.

5.3.4 View Beneficiary Eligibility – Beneficiary Eligibility Query via the UI

Eligibility information provides information regarding a beneficiary's entitlement for parts A, B, and eligibility for Part D, as applicable and relevant to the plan. If the beneficiary is eligible for the Part D low income subsidy, then the number of uncovered months are shown, then the details of that subsidy are shown. Periods when a beneficiary is covered in a plan that qualifies for the Retiree Drug Subsidy 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 1: Getting to the *Beneficiary: Eligibility (M232)* screen

From the main menu, click on the |Beneficiaries| menu item, then click on the |Eligibility| submenu item to view the *Beneficiary: Eligibility (M232)* screen.

STEP 2: Displaying eligibility for a selected beneficiary

The beneficiary must first be identified by claim number on the *Beneficiary: Eligibility (M232)* screen, which is shown in **Figure 5.3-23** (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 5.3-34**, with error and validation messages provided in **Table 5.3-35**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | **Beneficiaries** | Payments

Find | **Eligibility**

Beneficiary: Eligibility (M232) User: XXXX Role: MCO REPRESENTATIVE Date: 2/15/2007 [Print] [Help...]

Enter the claim number of the beneficiary.

*Indicates required field

* Claim #

Date

[Find]

Figure 5.3-23: Beneficiary: Eligibility (M232) Screen (Initial)

Table 5.3-34: M232 Screen Inputs, Outputs, and Actions

Item	Type	Description
Search Criteria		
Claim #	Required data entry field	Identifies the beneficiary whose eligibility information is to be displayed.
Date	Date field	Provide eligibility information as of this date.
[Find]	Button	Click 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.
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 this parts A and 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.
Number of Uncovered Months		
Start Date	Output	Start Date for uncovered months period

Item	Type	Description
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
Record Add-Timestamp	Output	Timestamp for when the record was added.
Employer Subsidy		
Start Date column	Output	When a Retiree Drug Subsidy coverage period began.
End Date column	Output	When a Retiree Drug Subsidy 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 5.3-35: M232 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.
Invalid format	The claim number is missing the required BIC.	Change the claim number to include both CAN and BIC.
Invalid date	Date is invalid. Must have format (M)M/(D)D/YYYY	Re-enter 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.

Message Type	Message Text	Suggested Action
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	Check the claim number. If it is incorrect, re-enter it.
Software or Database Error	Error occurred retrieving beneficiary entitlement information	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving Part D Enrollment information for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving number of uncovered months information for claim number <claim number>	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving beneficiary low income status information for claim number <claim number>	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 claim number is entered, click 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 Retiree Drug Subsidy 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 5.3-24**.

CMS Medicare Advantage Prescription Drug (MARx)
 Welcome | [Beneficiaries](#) | [Transactions](#) | [Payments](#) | [Rates](#) | [Reports](#)
[Find](#) | [New Enrollment](#) | [Eligibility](#) | [Part D AE-FE Opt-Out](#)

Beneficiary: Eligibility (M232) User: XXXX Role: CMS CENTRAL OFFICE USER Date: 1/15/2010 [Print](#) [Help...](#)

Enter the claim number of the beneficiary.
 *Indicates required field

*Claim #
 Date
[Find](#)

Claim Number:
 Claim Number Cross Reference:
 Name:
 Birth Date: 08/
 Date of Death:
 Sex: F
 Address: 29 WALKER AVE
 BALTIMORE, MD 21212-0213
 Most recent State: MA (22)
 Most recent County: ESSEX (040)

Enrollment Information for 01/15/2010		
Contract	Start	Drug Plan
S5820	12/01/2006	Y
H2222	12/01/2006	N

Entitlement Information			
Part	Start	End	Option
A	12/01/2006		E
B	12/01/2006		Y

Eligibility Information		
Part	Start	End
D	12/01/2006	

Number of Uncovered Months View Audit					
Start Date	Indicator	Number of Uncovered Months	Total Number of Uncovered Months	Record Add-Time Stamp	Record Type
12/01/2006	C	0	0	10/11/2006 8:54:2	V

Employer Subsidy	
Start	End
There are no employer subsidies for the beneficiary	

Part D Enrollment	
Start	End
12/01/2006	

Low Income Status				
Subsidy Start Date	Subsidy End Date	Premium Subsidy Level	Co-Payment Level	Subsidy Source
01/01/2009	12/31/2010	050%	2	SSA LI APPLICANT

Figure 5.3-24: Beneficiary: Eligibility (M232) Screen (with Eligibility Information)

Entitlement, Eligibility, employer subsidy, and low income status are displayed 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 Retiree Drug Subsidy, a message is displayed in the Employer Subsidy section.
- When the beneficiary does not receive a Part D low income subsidy, a message is displayed in the Low Income Status section.

Number of Uncovered Months section is displayed as follows:

- Tooltips are displayed when hovering over the Indicator and Record Type columns Part

D enrollments are displayed as follows:

- The ten 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 will display 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 is displayed in the Part D Enrollment section.

Enrollment Information is displayed as follows:

- The Contract number, Effective date and Drug Plan indicator of the beneficiary's current enrollment in the PBP will be displayed.
- If the beneficiary is dual enrolled, the system shall display 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 shall be displayed.
- If the user enters a date in the "Date" field, the system shall consider the entered date the "current date" when displaying the beneficiary's current enrollment information as of the date entered.

The inputs, outputs, and actions, as well as the error and validation messages, were described previously in **Tables 5.3-34** and **5.3-35**, respectively.

5.4 View Status of Batches Submitted

When a transactions batch file is submitted, its progress through the enrollment processing system can be tracked. This progress information includes:

- Dates and times when the file was received, when the file was processed, and when a Batch Completion Summary report was generated for the file
- Counts of transactions by status
- Counts of transactions by transaction type

A batch transaction can have a status of:

- Successful - the transaction was processed with no errors.

- Rejected - an error occurred when the transaction was being 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.

STEP 1: Accessing the *Transactions: Batch Status (M307)* screen

From the Medicare Advantage and Part-D Inquiry System main menu, click on the [Transactions] menu item to view the *Transactions: Batch Status (M307)* screen.

STEP 2: Getting a list of batches

The *Transactions: Batch Status (M307)* screen is used for entering the selection criterion, as shown in **Figure 5.4-1** and described in **Table 5.4-1**, with error and validation messages provided in **Table 5.4-2**.

The screenshot displays the 'Transactions: Batch Status (M307)' screen within the Medicare Advantage Prescription Drug (MARx) system. The header includes the CMS logo and navigation links: Welcome, Beneficiaries, Transactions (highlighted), Payments, and Reports. Below the header, the screen title is 'Transactions: Batch Status (M307)'. The user information shows 'User: XXXX', 'Role: MCO REPRESENTATIVE TRANSMITTER', and 'Date: 6/19/2006'. There are 'Print' and 'Help...' buttons. The main content area contains a yellow highlighted instruction: 'Enter search criteria and click "Find".' Below this, a note states '*Indicates required field'. There are two date input fields: '*From Date' with the value '06/19/2006' and '*To Date' with the value '06/19/2006'. A 'Find' button is located below the date fields.

Figure 5.4-1: Transactions: Batch Status (M307) Screen, Before Search Criteria Entered

Table 5.4-1: M307 Screen Inputs, Outputs, and Actions

Item	Type	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, click on this button to display the list of batch files.
Batch ID in the Batch ID column	Link	Click on a batch ID link to display the <i>Batch File Details (M314)</i> 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 when a Batch Completion Status Summary report was run for the batch file.

Table 5.4-2: M307 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	From Date must be entered	Enter a date in the From Date field.
Missing entry	To Date must be entered	Enter a date in the To Date field.
Invalid format	From Date is invalid. Must have format (M)M/(D)D/YYYY	Re-enter the From Date in one of the required formats.
Invalid format	To Date is invalid. Must have format (M)M/(D)D/YYYY	Re-enter 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 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, click 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, change the search criteria and click on the [Find] button.

The *Transactions: Batch Status (M307)* screen with a list of batch files is shown in **Figure 5.4-2**. The inputs, outputs, and actions, as well as the error and validation messages, were described previously in **Tables 5.4-1** and **5.4-2**, respectively.

Medicare Advantage Prescription Drug (MARx)
Welcome | Beneficiaries | **Transactions** | Payments | Reports
Batch Status

Transactions: Batch Status (M307)
User: XXXX Role: MCO REPRESENTATIVE TRANSMITTER Date: 6/19/2006
Print Help...

Enter search criteria and click "Find".
*Indicates required field
*From Date 06/01/2006 *To Date 06/19/2006
Find

Click on the Batch ID link to view the transaction counts.

Batch Results 1-20(of 24)
Go to Page: 1 Go

Batch ID	User ID	File Received	File Processed	Batch Completion Summary Report Run
17901711	XXXX	06/01/2006 10:50:39	06/01/2006 10:50:57	06/01/2006 19:10:54
17901720	XXXX	06/01/2006 12:11:37	06/01/2006 12:18:42	06/01/2006 19:12:02
17901745	XXXX	06/01/2006 13:36:37	06/01/2006 13:55:42	06/01/2006 19:13:15
17901848	XXXX	06/02/2006 13:41:00	06/02/2006 13:44:02	06/02/2006 19:25:34
17901877	XXXX	06/02/2006 14:28:26	06/02/2006 14:38:31	06/02/2006 19:25:52
17902243	XXXX	06/05/2006 09:37:16	06/05/2006 09:37:20	06/05/2006 20:15:21
17902260	XXXX	06/05/2006 14:52:17	06/05/2006 14:52:21	06/05/2006 20:15:58
17902310	XXXX	06/06/2006 14:56:44	06/06/2006 14:56:49	06/06/2006 20:01:42
17902501	XXXX	06/08/2006 15:40:25	06/08/2006 15:40:51	06/08/2006 21:11:53
17902550	XXXX	06/09/2006 14:59:08	06/09/2006 15:02:33	06/09/2006 19:14:12
17902560	XXXX	06/09/2006 19:43:28	06/09/2006 19:49:27	06/09/2006 19:14:45
17902575	XXXX	06/09/2006 03:06:22	06/09/2006 08:07:12	06/09/2006 19:15:31
17902622	XXXX	06/12/2006 03:45:32	06/12/2006 03:46:01	06/12/2006 19:34:22
17902688	XXXX	06/12/2006 10:51:42	06/12/2006 10:52:04	06/12/2006 19:35:12
17902695	XXXX	06/12/2006 15:00:07	06/12/2006 15:05:17	06/12/2006 19:37:34
17902720	XXXX	06/12/2006 15:05:23	06/12/2006 15:16:34	06/12/2006 19:38:44
17902787	XXXX	06/13/2006 15:16:37	06/13/2006 15:17:58	06/13/2006 20:25:33
17902815	XXXX	06/14/2006 09:04:45	06/14/2006 09:09:30	06/14/2006 20:36:36
17902830	XXXX	06/14/2006 09:09:33	06/14/2006 09:30:27	06/14/2006 20:39:46
17902832	XXXX	06/14/2006 09:30:44	06/14/2006 09:33:37	06/14/2006 20:40:24

Figure 5.4-2: Transactions: Batch Status (M307) Screen, After Search Criteria Entered

STEP 3: Viewing the Batch File Details

To view the transaction counts by transaction type and by status, click on a batch ID link 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 5.4-3a** and described in **Table 5.4-3a**. For batches processed after the May 2009 software release implementation, the screen is shown in **Figure 5.4-3b** and described in **Table 5.4-3b**. Error and validation messages for both **Figures 5.4-3a** and **Figure 5.4-3b** are provided in **Table 5.4-4**.

CMS		Medicare Advantage Prescription Drug (MARx)			
Batch File Details (M314)		User: XXXX	Role: MCO REPRESENTATIVE TRANSMITTER	Date: 6/19/2006	Close Print Help...
Batch File Status Message FILE WAS SUCCESSFULLY PROCESSED					
Transactions Received					
Enrollment	Disenrollment	PBP Change (71)	Plan Change (72)	Correction (01)	Aged/Disabled MSP (85)
121	51	71	34	2	0
Batch Completion Summary					
Accepted	Rejected	Pending	Failed		
152	6	0	1		

Figure 5.4-3a: Batch File Details (M314) Screen for batches processed prior to May 2009

Table 5.4-3a: M314 Screen Inputs, Outputs, and Actions

Item	Type	Description
Batch File Status Message	Output	Message describing the status of processing the file.
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 (71 transaction type) in the batch file.
Plan Change	Output	Count of plan change (72 transaction type) transactions in the batch file.
Correction	Output	Count of correction (01 transaction type) transactions in the batch file.
Unknown	Output	Count of transactions of unknown type in the batch file.
Accepted	Output	Count of transactions in the batch file that were accepted.
Rejected	Output	Count of transactions in the batch file that were rejected.
Pending	Output	Count of transactions in the batch file for which processing has not been completed.
Failed	Output	Count of transactions in the batch file that were failed.

CMS Medicare Advantage Prescription Drug (MARx)									
Batch File Details (M314)			User: XXXX Role: MCO REPRESENTATIVE TRANSMITTER			Date: 6/19/2009		Close Print Help...	
Batch File Status Message FILE WAS SUCCESSFULLY PROCESSED									
Transactions Received									
Record Update									
Enrollment	Disenrollment	PBP Change (71)	4RX (72)	NUNCMO (73)	Premium Withhold (75)	Other (74)	Correction (01)	Aged/Disabled MSP (85)	Unknown
12	1	0	0	7	5	0	5	0	0
Batch Completion Summary									
Accepted	Rejected	Pending	Failed						
152	6	0	1						

Figure 5.4-3b: Batch File Details (M314) Screen for batches processed after May 2009

Table 5.4-3b: M314 Screen Inputs, Outputs, and Actions

Item	Type	Description
Batch File Status Message	Output	Message describing the status of processing the file.
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 (71 transaction type) transactions in the batch file.
4Rx	Output	Count of 4Rx data update (72 transaction type) transactions in the batch file.
NUNCMO	Output	Count of number of uncovered months data update (73 transaction type) transactions in the batch file
Premium Withhold	Output	Count of Premium Withhold data update (75 transaction type) transactions in the batch file
Other	Output	Count of miscellaneous data update (74 transaction type) transactions in the batch file
Correction	Output	Count of correction (01 transaction type) transactions in the batch file.
Unknown	Output	Count of transactions of unknown type in the batch file.
Accepted	Output	Count of transactions in the batch file that were accepted.
Rejected	Output	Count of transactions in the batch file that were rejected.

Item	Type	Description
Pending	Output	Count of transactions in the batch file for which processing has not been completed.
Failed	Output	Count of transactions in the batch file that were failed.

Table 5.4-4: M314 Screen Messages

Message Type	Message Text	Suggested Action
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 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.

5.5 Viewing Payment Information

This section discusses how to view MCO and beneficiary payment information.

5.5.1 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.

STEP 1: Getting to the *Payments: MCO (M401)* screen

From the main menu, click 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 5.5-1** and described in **Table 5.5-1**, with error and validation messages provided in **Table 5.5-2**.

Enter the month and year for the payments along with the contract # you want to see. Another option is to break down the payments by PBP. If that option is not selected, the payments for a contract will be summarized at the contract level. If breakdown by PBP is selected, contracts without PBPs will be 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 will be 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 will be included but summarized at the PBP level. Click on the [Find] button to bring up 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 5.5-2** provide alternate screen shots for various inputs.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | **Payments** | Reports

MCO | Beneficiary | Premiums/Rebates

Payments: MCO (M401) User: XXXX Role: MCO REPRESENTATIVE Date: 3/1/2006 [Print](#) [Help...](#)

Payment data does not reflect final payment amounts

Enter search criteria and click "Find."

*Indicates required field

*Contract # ☐ Breakdown By PBP

PBP # ☐ Breakdown By Segment

Segment #

*For Month/Year

[Find](#) [Reset](#)

Figure 5.5-1: Payments: MCO (M401) Screen

Table 5.5-1: M401 Screen Inputs, Outputs, and Actions

Item	Type	Description
Contract #	Required data entry field	Request is for contract. Enter the contract number.
Breakdown By PBP	Checkbox	If checked, the payment information will be listed by PBP within each contract. Otherwise, the payment information will be summarized at the contract level. NOTE: When Breakdown By Segment is checked, payments will be shown by PBP, whether or not this option is checked.
PBP #	Data entry field	A PBP may be specified 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) will be displayed (either at the contract or PBP level, depending on whether Breakdown By PBP is checked). A contract number must be specified when a PBP number is specified.
Breakdown By Segment	Checkbox	If checked, the payment information will be listed by segment within the PBP. If not checked, the payment information will be summarized at the PBP level when Breakdown by PBP is checked and summarized at the contract level otherwise.

Item	Type	Description
Segment #	Data entry field	A segment may be specified 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) will be displayed (at the contract, PBP, or segment level, depending on whether Breakdown By PBP and Breakdown by Segment are checked). A PBP must be specified when a segment number is specified.
For Month/Year	Required data entry field	Request is for payments made in this month. Enter the date in the form (M)M/YYYY.
[Find]	Button	After the search criteria have been entered, click on this button to display the list of reports.

Table 5.5-2: M401 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Month/Year must be entered	Enter the month/year.
Invalid format	Month/Year is invalid. Must have format (M)M/YYYY	Re-enter the month/year in one of the required formats.
Missing entry	A contract number must be entered	Enter 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	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 three digit number	Re-enter the segment.
Invalid entry	When a PBP is entered, a contract number must also be entered	Enter a contract number.
Invalid entry	When a segment is entered, contract and PBP numbers also must be entered	Make sure to enter a PBP if you are entering a segment.
Invalid entry	Invalid contract/PBP combination	Make sure the PBP is in the contract.
Invalid entry	Invalid contract/PBP/segment combination	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.	First, make sure that you entered the contract number correctly. If you entered it correctly and if you should have rights to this contract see the CO Computer Specialist, who can update your user profile to give you these rights.
No data	No summary payment data found for specified criteria	Verify the selection criteria. If criteria were entered incorrectly, re-enter the data.

Message Type	Message Text	Suggested Action
Software or Database Error	The result set that contains the summary payment data is empty.	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving summary payment data results from database	See Appendix B for contact information to report the error.
Software or Database Error	Invalid input to stored procedure	See Appendix B for contact information to report the error.
Software or Database Error	Missing input.	See Appendix B for contact information to report the error.
Software or Database Error	No records returned from the database	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.

EXAMPLE 1: Multiple contracts and no PBP breakdown

Figure 5.5-2 provides an example of the *Payments: MCO Payments (M402)* screen that results when only a month/year and contract number are entered on the *Payments: MCO (M401)* screen, PBP are 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 5.5-3**. There are no error messages for the initial display of the screen, as any messages are displayed on *Payments: MCO (M401)* screen. **Table 5.5-4** shows the error and validation messages that may be displayed 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)* will display and the user can then click on the Contract # to display the details.

CMS

Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Payments | Reports

MCO | Beneficiary | Premiums/Rebates

Payments: MCO Payments (M402)

User: XXXX Role: MCO REPRESENTATIVE Date: 3/1/2006

Print Help...

Payment Information for Month 3/2006 1.6(of 6)
(Click on Contract# to display Payment Summary)

Contract #	PBP #	Contract Name	Payments			
			Part A	Part B	Part D	Total
H1111	001	COLUMBIA HEALTH CARE	\$5,793.21	\$14,315.45	\$3,253.87	\$23,362.53
H1111	002	COLUMBIA HEALTH CARE	\$4,396.12	\$16,439.08	\$2,255.07	\$23,090.27
H1111	003	COLUMBIA HEALTH CARE	\$1,869.04	\$6,431.10	\$4,069.13	\$12,369.27

Figure 5.5-2: Payments: MCO Payments (M402) Screen for Single Contract and No PBP or Segment Breakdown (Initial Display, Example 1)

Table 5.5-3: M402 Screen Inputs, Outputs, and Actions

Item	Type	Description
Contracts		
Contract # in the Contract # column	Link	Expands this screen to show the breakdown for the selected contract.
PBP # column	Output	When displayed, information is displayed for this PBP in the contract.
Segment # column	Output	When displayed, information is displayed 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	Parts A, B, and D payment totals for the contract.

Item	Type	Description
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. Gives 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. Gives total plus breakdown by status.
Payments Part B Members column	Output	Number of members in the contract with Part B payments this month. Gives 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. Gives total plus breakdown by status.
Payments Part D Members column	Output	Number of members in the contract with Part D payments this month. Gives 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. Gives 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 <i>Adjustment Detail (M408)</i> screen to display a breakdown of the adjustments for the contract/PBP and month by beneficiary.
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.

Item	Type	Description
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 Parts A, B, and D adjustments by adjustment reason.

Table 5.5-4: M402 Screen Messages

Message Type	Message Text	Suggested Action
No data	No payment data for the criteria entered	Verify the selection criteria. If criteria were entered incorrectly, re-enter the data.
Software or Database Error	The result set that contains the Payment MCO Payments is empty.	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving MCO payment details for contract <contract>	See Appendix B for contact information to report the error.
Software or Database Error	Invalid input to the stored procedure	See Appendix B for contact information to report the error.
Software or Database Error	Missing input	See Appendix B for contact information to report the error.
Software or Database Error	No records returned from the database	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.

EXAMPLE 2: Single Contract with Segment Breakdown

Figure 5.5-3 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 is displayed, and the payments are shown at the Segment level. (Note that only the Contracts section is displayed on the screen; the Current Payments and Adjustment Payments sections are displayed in STEP 3.) The inputs, outputs, and actions are described previously in **Table 5.5-3**. There are no error messages for the initial display of the screen, as any messages are displayed on *Payments: MCO (M401)* screen. See **Table 5.5-4** for the error and validation messages that may be displayed when the screen is expanded to show sections below the contracts.

CMS

Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Payments | Reports

MCO | Beneficiary | Premiums/Rebates

Payments: MCO Payments (M402)

User: XXXX Role: MCO REPRESENTATIVE Date: 3/1/2006

Print Help...

Payment Information for Month 3/2006 1-20(of 28)
(Click on Contract# to display Payment Summary)

Contract #	PBP #	Segment #	Contract Name	Payments			
				Part A	Part B	Part D	Total
H5555	001	001	LYNX HEALTH PLANS PREMIUM	\$10,260.00	\$9,110.43	\$859.01	\$20,364.44
H5555	001	002	LYNX HEALTH PLANS PREMIUM	\$7,370.22	\$6,245.13	\$791.41	\$14,406.76
H5555	002	001	LYNX HEALTH PLANS BASIC	\$2,177.37	\$1,963.59	\$1,550.99	\$5,691.95
H5555	002	002	LYNX HEALTH PLANS BASIC	\$8,972.98	\$5,562.71	\$2,930.99	\$17,466.68

Figure 5.5-3: 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, find the contract or contract/PBP that you 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](#). Select the contract/PBP by clicking on the [contract #](#) link.

The following information is displayed for the selected contract (and, when applicable, PBP). The information is shown below the summary information by contract.

- Part A, Part B, Part D, and total payments
- Breakdown by health status, separated into Parts A, B, and D, with both the number of members and the payment amounts
- Breakdown by adjustment reason, separated into Parts A, B, and D, with both the number of members and the payment amounts (this section of the screen is only included when there are adjustments)

To see the details section for a selected MCO, see **Figure 5.5-4**. The inputs, outputs, and actions, as well as the error and validation messages, are previously described in **Table 5.5-3** and **Table 5.5-4**, respectively.

CMS		Medicare Advantage Prescription Drug (MARx)							
		Welcome Beneficiaries Payments Reports							
		MCO Beneficiary Premiums/Rebates							
Payments: MCO Payments (M402)		User: XXXX		Role: MCO REPRESENTATIVE		Date: 3/1/2006		Print Help...	
Payment Information for Month 3/2006 1-1(of 1) (Click on Contract# to display Payment Summary)									
Contract #		Contract Name		Payments					
				Part A	Part B	Part D	Total		
H8888		CHAMPION INSURANCE		\$169,042.76	\$149,644.83	\$85,010.45	\$403,698.04		
Payments to plan H8888, CHAMPION INSURANCE, for 3/2006									
Part A :		\$169,042.76							
Part B :		\$149,644.83							
Part D :		\$85,010.45							
Total :		\$403,698.04							
Current Payments for 3/2006									
Part A	Members	Total Amount	Part B	Members	Total Amount	Part D	Members	Total Amount	
Total Payments (\$325.71)	519	\$169,042.76	Total Payments (\$288.33)	519	\$149,644.83	Total Payments (\$163.80)	519	\$85,010.45	
Total Hospice	1	\$0.00	Total Hospice	1	\$0.00	Total Hospice	1	\$0.00	
Total ESRD	2	\$3,810.46	Total ESRD	2	\$5,922.95	Total ESRD	2	\$12,904.15	
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	22	\$9,998.42	Total Medicaid	22	\$7,775.70	Total Medicaid	22	\$5,3120.24	
Total Out of Area	4								
Adjustment Payments for 3/2006									
Code	Adjustment Reason	#	Months A	Months B	Months D	Part A	Part B	Part D	Total Amount
02	RETROACTIVE ENROLLMENT	5	8	8	0	\$1,407.96	\$1,254.35	\$1001.96	\$3,664.27
03	RETROACTIVE DISENROLLMENT	9	0	0	0	(\$3,301.63)	(\$2,891.54)	(1,399.50)	(\$7,592.67)
	Total Adjustments	14	8	8	0	(\$1,893.67)	(\$1,637.19)	(\$397.54)	(\$3,928.40)

Figure 5.5-4: Payments: MCO Payments (M402) Screen with Details for MCO

STEP 4: Viewing adjustment information for a selected MCO

To see further details about adjustments, click 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 5.5-5**, is displayed, listing all adjustments by beneficiary to show how the adjustment amount was calculated. The screen is described in **Table 5.5-5**, with error and validation messages provided in **Table 5.5-6**.

CMS		Medicare Advantage Prescription Drug (MARx)					
Adjustment Detail (M408)		User: XXXX Role: MCO REPRESENTATIVE		Date: 3/1/2006		Close Print Help...	
Contract Number: H8888 Payment Date: 3/2006 For: 02 RETROACTIVE ENROLLMENT Adjustment Details of Beneficiaries 1-5 (of 5)							
Claim #	Name	Create Date	Payment Period		Adjustments		
			Start	End	Part A	Part B	Part D
PHI		06/04/2003	03/2002	03/2002	\$401.16	\$292.45	\$203.35
		06/04/2003	04/2002	04/2002	\$401.16	\$292.45	\$203.35
		06/04/2003	05/2002	05/2002	\$201.88	\$223.15	\$198.42
		06/04/2003	06/2002	06/2002	\$201.88	\$223.15	\$198.42
		06/04/2003	07/2002	07/2002	\$201.88	\$223.15	\$198.42

Figure 5.5-5: Adjustment Detail (M408) Screen

Table 5.5-5: M408 Screen Inputs, Outputs, and Actions

Item	Type	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 when 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 5.5-6: M408 Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	No adjustment data for the reason code clicked.	See Appendix B for contact information to report the error.
Software or Database Error	There was a systems problem retrieving your data	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving results from data	See Appendix B for contact information to report the error.
Software or Database Error	Invalid input to stored procedure	See Appendix B for contact information to report the error.
Software or Database Error	Missing input	See Appendix B for contact information to report the error.
Software or Database Error	No records returned from the database	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database	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.

5.5.2 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. When changes are made to payments that have already been paid, adjustments are calculated.

The steps below show how to find these payments and adjustments for a particular beneficiary. After that information is found, you can view the complete history of payments and adjustments (see Section 5.5.2.1).

STEP 1: Getting to the *Payments: Beneficiary (M403)* screen

From the main menu, click on the *Payments* menu item. If not already selected, click on the *Beneficiary* submenu item to view the *Payments: Beneficiary (M403)* screen.

STEP 2: Getting a list of beneficiaries

The *Payments: Beneficiary (M403)* screen is used for entering search criteria, as shown in **Figure 5.5-6** and described in **Table 5.5-7**, with error and validation messages provided in **Table 5.5-8**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | **Payments** | MCO | Beneficiary | Premiums/Rebates

Payments: Beneficiary (M403) User: XXXX Role: MCO REPRESENTATIVE Date: 12/1/2006 [Print](#) [Help...](#)

Enter search criteria and click "Find."

* Indicates required field
+ Indicates at least one of these is required

* For Month/Year

+ Claim # (BIC is Optional)

+
Contract # PBP #
Last Name
First Name

[Find](#) [Reset](#)

Figure 5.5-6: Payments: Beneficiary (M403) Screen

Table 5.5-7: M403 Screen Inputs, Outputs, and Actions

Item	Type	Description
For Month/Year	Required data entry field	Find beneficiaries with payments/adjustments in this month. Enter the date in the form (M)M/YYYY.
Claim #	Required data entry field	If entered, find beneficiaries who currently have this claim number. NOTE: The BIC is optional except when a RRB number is entered. NOTE: At least one of these is required: Claim # <u>or</u> combination of Contract #, Last Name, and First Name.
Contract #(s)	Required data entry field	If entered, find beneficiaries enrolled in this contract in a past, current, or future enrollment. NOTE: At least one of these is required: Claim # <u>or</u> combination of Contract #, Last Name, and First Name.
PBP #	Data entry field	If entered, find beneficiaries currently enrolled in this PBP. The PBP is applicable only when a contract number is entered.

Item	Type	Description
Last Name	Required data entry field	If entered, find beneficiaries who currently have this last name. NOTE: At least one of these is required: Claim # <u>or</u> a combination of Contract #, Last Name, and First Name.
First Name	Required data entry field	If entered, find beneficiaries who currently have this first name. NOTE: At least one of these is required: Claim # <u>or</u> a combination of Contract #, Last Name, and First Name.
[Find]	Button	Click 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 5.5-8: M403 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Month/Year must be entered	Enter the month.
Missing entry	Enter claim # <u>or</u> a combination of contract #, last name, and first name.	Enter one of the fields.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	Re-enter 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	Re-enter the contract number.
Invalid format	PBP number must be 3 alpha-numeric characters	Re-enter the PBP.
Invalid format	Month/Year is invalid. Must have format (M)M/YYYY	Re-enter the date in one of the required formats.
Invalid format	The last name contains invalid characters	Re-enter the name using only letters, apostrophes, hyphens, or blanks
Invalid entry	When a PBP is entered, a contract number must also be entered	Enter a contract number.
Invalid entry	Invalid contract/PBP combination	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	Enter 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.	First, make sure that you entered the contract number correctly. If you entered it correctly and if you should have rights to this contract; see the CO Computer Specialist, who can update your user profile to give you these rights.

Message Type	Message Text	Suggested Action
No data	No payment beneficiary data found for the search criteria.	Verify the information that was entered. If an error was made, re-enter the information.
Software or Database Error	Error occurred validating contract/PBP combination	See Appendix B for contact information to report the error.
Software or Database Error	Invalid results when retrieving beneficiary payment data	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving beneficiary payment data from database.	See Appendix B for contact information to report the error.
Software or Database Error	Missing input	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.

Enter search criteria to find the beneficiary or beneficiaries that you want to view and the payment month/year in which you are interested, and then click the [Find] button. The beneficiaries that meet the search criteria and have payments and/or adjustments calculated for that month will then be displayed on the *Payments: Beneficiary Search Results (M404)* screen, as shown in **Figure 5.5-7** and described in **Table 5.5-9**. 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 are displayed. If a user enters an inactive Claim Number with a BIC, the system will try to find a more recent active Claim Number for the Beneficiary. A message will display to that effect as shown in **Table 5.5-10**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | **Payments**

MCO | **Beneficiary** | Premiums/Rebates

Payments: Beneficiary Search Results (M404) User: XXXX Role: MCO REPRESENTATIVE Date: 12/1/2006 [Print](#) [Help...](#)

Click on History link to view Beneficiary payment history.

Search Criteria: Claim # = 999881032A For Month/Year = 12/2006

Beneficiaries 1-1(of 1)

Claim #	Name	Birth Date	Sex	State	County	Contract #	PBP#	Segment#	Payment
		02/17	M	PA	BLAIR	H6666	A01	123	History

Figure 5.5-7: Payments: Beneficiary Search Results (M404) Screen

Table 5.5-9: M404 Screen Inputs, Outputs, and Actions

Item	Type	Description
Claim # column heading	Sorter	Sorts beneficiaries by their claim numbers.
Name column heading	Sorter	Sorts beneficiaries by their names.
Birth Date column	Output	When 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	Click on a History link to open the <i>Beneficiary Payment History (M406)</i> screen to see payments for the beneficiary up through the month/year indicated in the For Month/Year field.

Table 5.5-10: 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, you 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.

5.5.2.1 Viewing Beneficiary Payment History

This section discusses how to view the payment and adjustment history for a beneficiary. From the history, you can view the details of the payments and adjustments for a particular month.

STEP 1: Getting to the *Beneficiary Payment History (M406)* screen

From the *Payments: Beneficiary Search Results (M404)* screen (see **Figure 5.5-7**), click on the beneficiary's [History](#) link to open the *Beneficiary Payment History (M406)* screen, as shown in **Figure 5.5-8** and described in **Table 5.5-11**, with error and validation messages provided in **Table 5.5-12**. 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 are displayed.

Claim #

800 POPLAR AVE APT 8

ALTOONA, PA 16602-3052

Beneficiary Name

DOB:

Age: 85 Sex: MALE

State: PA (39) County: BLAIR (120)

Beneficiary Payment History (M406)

User: XXXX Role: MCO REPRESENTATIVE Date: 12/1/2006

Close

Print

Help...

Payments 1-1(of 1)

Payment Date	Contract	PBP#	Seg#	Payments				Adjustments				Total	BIPA	Regional MA BSF
				Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj			
11/2006	H6666	A01	123	\$0.00	\$0.00	\$0.00	\$0.00	\$86.76	\$39.54	\$0.00	\$126.30	\$126.30	-	\$0.00
10/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
09/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
08/2006	H6666	A01	123	\$384.84	\$262.51	\$0.00	\$647.35	\$0.00	\$0.00	\$0.00	\$0.00	\$647.35	-	\$0.00
07/2006	H6666	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
06/2006	H6666	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
05/2006	H6666	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
04/2006	H6666	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$0.00	\$0.00	\$0.00	\$0.00	\$622.35	-	\$0.00
03/2006	H6666	013	000	\$369.84	\$252.51	\$0.00	\$622.35	\$739.68	\$505.02	\$0.00	\$1244.70	\$1867.05	-	\$0.00

Figure 5.5-8: Beneficiary Payment History (M406) Screen

Table 5.5-11: M406 Screen Inputs, Outputs, and Actions

Item	Type	Description
Payment Date column	Output	Indicates when payment/adjustments were paid.
Month/Year in Payment Date column	Link	Click on a month/year link to open the <i>Payment/Adjustment Detail (M215)</i> 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 Parts A, B, and 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 Parts A, B, and 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 Medicare Advance Bonus Stabilization Fund.

Table 5.5-12: M406 Screen Messages

Message Type	Message Text	Suggested Action
Software or Database Error	No payment history records found.	See Appendix B for contact information to report the error.
Software or Database Error	The result set that contains the history data is empty	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred while retrieving payment history results from database.	See Appendix B for contact information to report the error.
Software or Database Error	Invalid screen ID	See Appendix B for contact information to report the error.
Software or Database Error	Missing input	See Appendix B for contact information to report the error.

Message Type	Message Text	Suggested Action
Software or Database Error	Unexpected error code from database	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.

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 Medicare Advantage Benefit Stabilization Fund (MA BSF)

To view a further breakdown of the payments and adjustments, click on the [month/year](#) link to open the *Payment/Adjustment Detail (M215)* screen (see Section 5.3.3.9).

5.5.3 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 that were negotiated with a MCO. They are not the premiums and rebates that are calculated for a beneficiary.

STEP 1: Getting to the *Basic Premiums and Rebates (M409)* screen

From the main menu, click on the |Payments| menu item. If not already selected, click on the |Premiums/Rebates| submenu item to view the *Basic Premiums and Rebates (M409)* screen, as shown in **Figure 5.5-9** and described in **Table 5.5-13**, with error and validation messages provided in **Table 5.5-14**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Payments | Reports

MCO | Beneficiary | Premiums/Rebates

Basic Premiums and Rebates (M409) User: XXXX Role: MCO REPRESENTATIVE Date: 1/12/2006 [Print](#) [Help...](#)

Enter search criteria and click "Display."

*Indicates required field

*Date *Contract PBP Segment

01/12/2006 [Display](#)

Figure 5.5-9: Basic Premiums and Rebates (M409) Screen, Before Search Criteria Entered

Table 5.5-13: M409 Screen Inputs, Outputs, and Actions

Item	Type	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	Premiums and rebates that apply to this contract are displayed.
PBP	Data entry field	If entered, premiums and rebates that apply to this contract and PBP are displayed. Otherwise, the premiums and rebates at the contract level are displayed.
Segment	Data entry field	If entered, premiums and rebates that apply to this contract, PBP, and segment are displayed. Otherwise, the premiums and rebates at the contract or contract/PBP level are displayed.
[Display]	Button	Click 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 MCOs contract.
Basic Part D Premium	Output	Part D premium in MCOs contract.

Item	Type	Description
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 Parts A/B cost sharing.
Rebate for A/B Mandatory Supplemental Benefits	Output	Rebate paid to MCO for providing Parts A/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 5.5-14: M409 Screen Messages

Message Type	Message Text	Suggested Action
Missing entry	Date must be entered	Enter the date.
Missing entry	A contract number must be entered	Enter a contract number.
Invalid format	Date is invalid. Must have format (M)M/YYYY.	Re-enter 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	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.
Invalid entry	When a segment is entered, a PBP must be entered also	Make sure to enter a PBP if you are entering a segment.
Invalid entry	Invalid contract/PBP combination	Make sure the PBP is in the contract.
Invalid entry	Invalid contract/PBP/segment combination	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.	First, make sure that you entered the contract number correctly. If you entered it correctly and if you should have rights to this contract see the CO Computer Specialist, who can update your user profile to give you these rights.
No data	No basic premiums and rebates were found for this contract	Verify the information that was entered. If an error was made, re-enter the information.
No data	No basic premiums and rebates were found for this contract and PBP	Verify the information that was entered. If an error was made, re-enter the information.

Message Type	Message Text	Suggested Action
No data	No basic premiums and rebates were found for this contract, PBP, and segment	Verify the information that was entered. If an error was made, re-enter the information.
Software or Database Error	Error occurred validating contract/PBP/segment combination	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred retrieving basic premiums and rebates	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 criteria are entered, click on the [Display] button to show the premiums and rebates. These premiums and rebates are displayed on the same screen, below the criteria, as shown in **Figure 5.5-10**. The inputs, outputs, and actions, as well as the error and validation messages, are described previously in **Tables 5.5-13** and **5.5-14**, respectively. To view different premiums and rebates, change the search criteria and click on the [Display] button.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | **Payments** | Reports

MCO | Beneficiary | **Basic Premiums**

Payments: Basic Premiums and Rebates (M409) User: XXXX Role: MCO REPRESENTATIVE Date: 01/12/2006 [Print] [Help...]

Enter search criteria and click "Display."

*Indicates required field

*Date *Contract PBP Segment

01/12/2006 H0524 013 100 [Display]

Contract #: H0524

PBP: 013

Segment: 100

Basic Part C Premium: \$25.05

Basic Part D Premium: \$32.50

Rebate for Part B Premium Reduction \$11.00

Rebate for A/B Cost Sharing: \$1.00

Rebate for A/B Mandatory Supplemental Benefits: \$2.00

Rebate for Part D Basic Premium Reduction: \$3.00

Rebate for Part D Supplemental Benefits: \$3.50

Figure 5.5-10: Basic Premiums and Rebates (M409) Screen, After Search Criteria Entered

5.6 Reports

This section describes how to order copies of reports and data files generated for previous months. The ordered reports will be delivered via Connect:Direct or Gentran (see Section 1.6.1). There are various types of reports in the enrollment processing system:

- Daily (or randomly-occurring) reports and data files are generated each day for events that occurred that day. These events include processing of a batch transaction file or receipt of a report.
- Weekly reports and data files are scheduled and automatically generated to reflect transactions that were processed that week for a contract.
- Month-end reports and data files are scheduled and automatically generated as part of monthly payment processing.
- Year-end reports and data files are scheduled and automatically generated as part of monthly payment processing.

See Appendix E and I for descriptions and samples of data and report files.

Note
Only MCO Representative Transmitters may order reports.

STEP 1: Getting to the Reports: Find (M601) screen

From the main menu, click on the |Reports| menu item.

STEP 2: Getting a list of reports

From the *Reports: Find (M601)* screen, choose the report frequency first—monthly, weekly, daily or yearly—as the selection criteria displayed is affected by the frequency chosen. Enter the selection criteria that characterize the reports being requested. Click 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 5.6-1** and described in **Table 5.6-1**, with error and validation messages provided in **Table 5.6-2**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Transactions | Payments | Reports

Find

Reports: Find (M601) User: N2D2 Role: MCO REPRESENTATIVE TRANSMITTER Date: 5/23/2007 [Print](#) [Help...](#)

Pick frequency.
Once a frequency is selected, enter criteria and click "Find."

*Indicates required field

*Frequency

☒ MONTHLY
☐ WEEKLY
☐ DAILY
☐ YEARLY

*Start Payment Month 09/2002 *End Payment Month 09/2007

File Type

Report/Data File

Contract #

[Find](#) [Reset](#)

Figure 5.6-1: Reports: Find (M601) Screen

Table 5.6-1: M601 Screen Inputs, Outputs, and Actions for Monthly and Weekly Reports

Item	Type	Description
Frequency	Required radio button	Select MONTHLY or WEEKLY.
Start Payment Month	Required data entry field	Searches for reports for this payment Start month through the End Payment Month. Enter as (M)M/YYYY. For monthly reports, defaults to the previous processing month. For weekly reports, defaults to the 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 weekly reports, defaults to the current processing month.
File Type	Dropdown list	Click on arrow and select value to narrow search to report or data file. Note: When the File Type is selected, the Report/Data File should not be selected. If both are selected, an error message is displayed and the Find does not proceed.

Item	Type	Description
Report/Data File	Dropdown list	Click on arrow and select value to narrow search to type of report or data file. Note: When the Report/Data File is selected, the File Type should not be selected. If both are selected, an error message is displayed and the Find does not proceed.
Contract #	Data entry field	Enter to narrow search to a particular contract
[Find]	Button	After the search criteria have been entered, click on this button to display the list of reports.

Table 5.6-2: M601 Screen Messages for Monthly and Weekly Reports

Message Type	Message Text	Suggested Action
Missing entry	Start Payment Month must be entered	Enter the month.
Missing entry	End Payment Month must be entered	Enter the month.
Invalid format	Start Payment Month is invalid. Must have format (M)M/YYYY	Re-enter the month in one of the required formats.
Invalid format	End Payment Month is invalid. Must have format (M)M/YYYY	Re-enter 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	Re-enter the contract number.
Invalid entry	Cannot specify both file type and report/data file	Deselect one of the selections.
Invalid entry	You do not have access rights to this Contract	First, make sure that you entered the contract number correctly. If you entered it correctly and if you should have rights to this contract see the CO Computer Specialist, who can update your user profile to give you these rights.
No data	No files meet the search criteria	Verify the criteria that you have entered.
Software or Database Error	Error occurred retrieving list of files	See Appendix B for contact information to report the error.
Software or Database Error	Database error occurred finding list of files	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.

The results list of reports is shown in **Figure 5.6-2** and described in **Table 5.6-3**, with error and validation messages provided in **Table 5.6-4**. From this list, you can select a report or data file

and click the [Order] button. You will receive a message letting you know that the order has been submitted.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Transactions | Payments | **Reports**

Find

Reports: Search Results (M602) User: N2D2 Role: MCO REPRESENTATIVE TRANSMITTER Date: 5/23/2007 [Print](#) [Help...](#)

Select a file before clicking on a button.

Available Files 1-1(of 1) from 09/2002 to 09/2007

Select	File Name	Payment Month	Contract	Report/Data File	File Type
☐	HKH.@BGD5050.PLNH0102.R012004.HCCMODD	01/2004	H0102	RISK ADJUSTMENT MODEL OUTPUT RPT AND DATAFILE	DATA FILE

[Order](#)

Figure 5.6-2: Reports: Search Results (M602) Screen for Monthly and Weekly Reports

Table 5.6-3: M602 Screen Inputs, Outputs, and Actions for Monthly and Weekly Reports

Item	Type	Description
Select column	Radio button	Click on one of the buttons to indicate which file is to be ordered.
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 (report or data).
[Order]	Button	After a file has been selected, click on this button to request that the file be placed in the mailbox.

Table 5.6-4: M602 Screen Messages for Monthly and Weekly Reports

Message Type	Message Text	Suggested Action
Missing entry	Select a file to order	Find the file to order and click 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	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting that the file be ordered	See 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>	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.
Software or Database Error	A security violation has occurred. You do not have access rights to this file.	See Appendix B for contact information to report the error.
Success	Request submitted for order of <file name>.	No action required.

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 5.6-1** (except that the WEEKLY frequency is selected) and it is described in **Table 5.6-1**, with error and validation messages provided in **Table 5.6-2**. The results list of weekly reports is similar to **Figure 5.6-2** (except that the report/data files names are different) and described in **Table 5.6-3**, with error and validation messages provided in **Table 5.6-4**.

Special TRRs

Special TRRs are accessed like the weekly reports. Set the report frequency to WEEKLY and enter a date range that covers the payment month when the special TRR was run. The special TRR will appear in the list of reports on the *Reports: Search Results (M602)* screen.

Daily Reports

The *Reports: Find (601)* screen with selection criteria for daily reports is shown in **Figure 5.6-3** and described in **Table 5.6-5**, with error and validation messages provided in **Table 5.6-6**.

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Transactions | Payments | **Reports**

Find

Reports: Find (M601) User: N2D2 Role: MCO REPRESENTATIVE TRANSMITTER Date: 5/23/2007 [Print](#) [Help...](#)

Pick frequency.
Once a frequency is selected, enter criteria and click "Find."
* Indicates required field

*Frequency

☐ MONTHLY
☐ WEEKLY
☒ DAILY
☐ YEARLY

*Start Request Date 01/01/2002 *End Request Date 05/23/2007

*Report/Data File

Contract #

[Find](#) [Reset](#)

Figure 5.6-3: Reports: Find (M601) Screen for Daily Reports

Table 5.6-5: M601 Screen Inputs, Outputs, and Actions for Daily Reports

Item	Type	Description
Frequency	Required radio button	Select DAILY.
Start Request Date	Required data entry field	Searches for reports generated on or after this date. Enter as (M)M/(D)D/YYYY. Defaults to current date.
End Request Date	Required data entry field	Searches for reports generated on or before this date. Enter as (M)M/(D)D/YYYY. Defaults to current date.
Report/Data File	Required dropdown list	Click on arrow and select value to narrow search to type of report or data file.
Contract #	Data entry field	Enter to narrow search to a particular contract.
[Find]	Button	After the search criteria have been entered, click on this button to display the list of reports.

Table 5.6-6: M601 Screen Messages for Daily Reports

Message Type	Message Text	Suggested Action
Missing entry	Start Request Date must be entered	Enter the date.
Missing entry	End Request Date must be entered	Enter the date.
Missing entry	A report or data file must be selected	Select the type of report or data file to be ordered.
Invalid format	Start Request Date is invalid. Must have format (M)M/(D)D/YYYY	Re-enter the date in one of the required formats.
Invalid format	End Request Date is invalid. Must have format (M)M/(D)D/YYYY	Re-enter 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	Re-enter the contract number.
Invalid data	Cannot specify both file type and report/data file	Deselect one of the selections.
Invalid entry	You do not have access rights to this Contract	First, make sure that you entered the contract number correctly. If you entered it correctly and if you should have rights to this contract see the CO Computer Specialist, who can update your user profile to give you these rights.
No data	No files meet the search criteria	Verify the criteria entered.
Software or Database Error	Error occurred retrieving list of files	See Appendix B for contact information to report the error.
Software or Database Error	Database error occurred finding list of files	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.

The results list of daily reports is shown in **Figure 5.6-4** and described in **Table 5.6-7**, with error and validation messages provided in **Table 5.6-8**. From this list, you can select a report or data file and click the [Order] button. You will receive a message letting you know that the order has been submitted.



Medicare Advantage Prescription Drug (MARx)
Welcome | Beneficiaries | Transactions | Payments | **Reports**

Find

Reports: Search Results (M602)
User: N2D2 Role: MCO REPRESENTATIVE TRANSMITTER Date: 5/23/2007
Print Help...

Select a file before clicking on a button.

Available Files 1-11(of 11) from 01/01/2002 to 05/23/2007

Select	File Name	Requested	Contract	Report/Data File	File Type
☐	D@MMA.TESTDV1.PLNH0104.YM200705.D16.T1421.C	05/17/2007	H0104	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0150.YM200705.D16.T1421.C	05/17/2007	H0150	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0151.YM200705.D16.T1421.C	05/17/2007	H0151	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0154.YM200705.D16.T1421.C	05/17/2007	H0154	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0302.YM200705.D16.T1421.C	05/17/2007	H0302	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0303.YM200705.D16.T1421.C	05/17/2007	H0303	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0319.YM200705.D16.T1421.C	05/17/2007	H0319	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0320.YM200705.D16.T1421.C	05/17/2007	H0320	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0354.YM200705.D16.T1421.C	05/17/2007	H0354	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0401.YM200705.D16.T1421.C	05/17/2007	H0401	COORDINATION OF BENEFITS DATA FILE	DATA FILE
☐	D@MMA.TESTDV1.PLNH0504.YM200705.D16.T1421.C	05/17/2007	H0504	COORDINATION OF BENEFITS DATA FILE	DATA FILE

Order

Figure 5.6-4: Reports: Search Results (M602) Screen for Daily Reports

Table 5.6-7: M602 Screen Inputs, Outputs, and Actions for Daily Reports

Item	Type	Description
Select column	Radio button	Click on one of the buttons to indicate which file is to be ordered.
File Name column heading	Sorter	Sorts all files by file name.
Requested column heading	Sorter	Sorts all files by date the file was requested.
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 (report or data).
Order	Button	After a file has been selected, click on this button to request that the file be placed in the mailbox.

Table 5.6-8: M602 Screen Messages for Daily Reports

Message Type	Message Text	Suggested Action
Missing entry	Select a file to order	Find the file to order and click 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	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting that the file be ordered	See 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>	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.
Software or Database Error	A security violation has occurred. You do not have access rights to this file.	See Appendix B for contact information to report the error.
Success	Request submitted for order of <file name>	No action required.

Yearly Reports

The *Reports: Find (M601)* screen with selection criteria for yearly reports is shown in **Figure 5.6-5** and described in **Table 5.6-9**, with error and validation messages provided in **Table 5.6-10**.

Reports: Find (M601) - Microsoft Internet Explorer

File Edit View Favorites Tools Help

CMS Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Transactions | Payments | **Reports**

Find

Reports: Find (M601) User: N2D2 Role: MCO REPRESENTATIVE TRANSMITTER Date: 5/22/2007 [Print] [Help...]

Pick frequency.
Once a frequency is selected, enter criteria and click "Find."

*Indicates required field

*Frequency

☐ MONTHLY
☐ WEEKLY
☐ DAILY
☒ YEARLY

*Start Year
2004

*End Year
2006

File Type
[v]

Report/Data File
[v]

Contract #
[]

[Find] [Reset]

Figure 5.6-5: Reports: Find (M601) Screen for Yearly Reports

Table 5.6-9: M601 Screen Inputs, Outputs, and Actions for Yearly Reports

Item	Type	Description
Frequency	Required radio button	Select YEARLY
Start Year	Required data entry field	Searches for report for this year through the End year. Enter as (YYYY). For yearly reports, defaults to the previous processing year.
End Year	Required data entry field	Searches for report for the Start Year through this Year. Enter as (YYYY). For yearly reports, defaults to the previous processing year.
File Type	Dropdown list	Click on arrow and select value to narrow search to report, data file, or combined. Note: When the File Type is selected, the Report/Data File should not be selected. If both are selected, an error message is displayed and the Find does not proceed.

Item	Type	Description
Report/Data File	Dropdown list	Click on arrow and select value to narrow search to type of report or data file. Note: When the Report/Data File is selected, the File Type should not be selected. If both are selected, an error message is displayed and the Find does not proceed.
Contract #	Data entry field	Enter to narrow search to a particular contract.
[Find]	Button	After the search criteria have been entered, click on this button to display the list of reports.

Table 5.6-10: M601 Screen Messages for Yearly Reports

Message Type	Message Text	Suggested Action
Missing entry	A year must be entered	Enter the year.
Missing entry	A year must be entered	Enter the year.
Invalid format	Year must be a 4-digit number	Re-enter the year in one of the required formats.
Invalid format	Year must be a 4-digit number	Re-enter the year 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	Re-enter the contract number.
Invalid entry	Cannot specify both file type and report/data file	Deselect one of the selections.
Invalid entry	You do not have access rights to this Contract.	First, make sure that the user entered the contract number correctly. If he/she entered it correctly and if he/she should have rights to this contract see the Security Administrator, who can update the user profile to give the user these rights.
No data	No files meet the search criteria	Verify the criteria that the user has entered.
Software or Database Error	Error occurred retrieving list of files	See Appendix B for contact information to report the error.
Software or Database Error	Database error occurred finding list of files	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.

The results list of reports is shown in **Figure 5.6-6** and described in **Table 5.6-11**, with error and validation messages provided in **Table 5.6-12**. If a report has not been accessed for several years, it must first be retrieved before it can be accessed. The screen is divided into two sections:

reports immediately available and reports needing to be retrieved. If no files meet the criteria for a section, that section is not displayed.

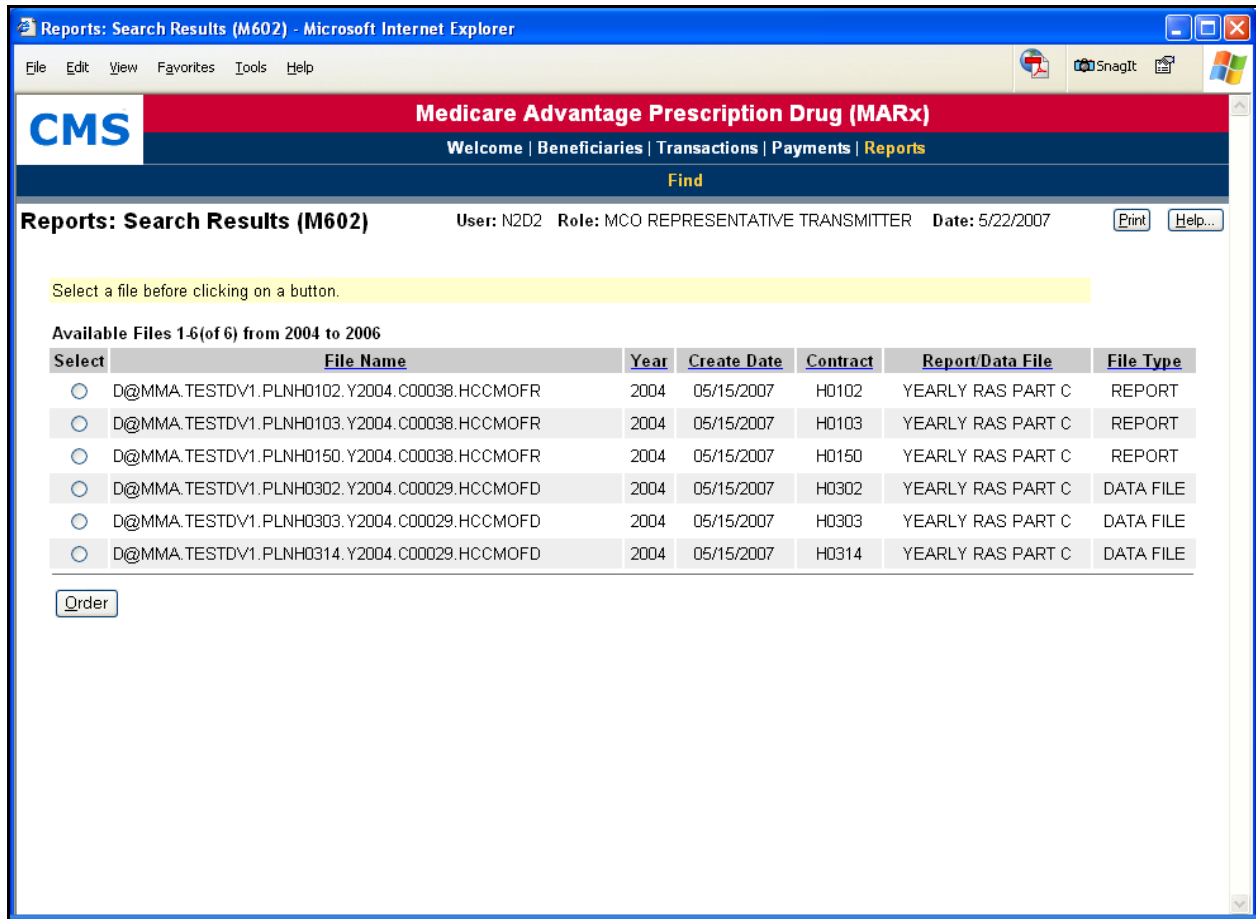


Figure 5.6-6: Reports: Search Results (M602) Screen for Yearly Reports

Table 5.6-11: M602 Screen Inputs, Outputs, and Actions for Yearly Reports

Item	Type	Description
Select column	Radio button	Click on one of the buttons to indicate which file is to be ordered.
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 (report or data).

Item	Type	Description
[Order]	Button	After a file has been selected, click on this button to request that the file be placed 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 be connected to the Internet to download Acrobat.

Table 5.6-12: M602 Screen Messages for Yearly Reports

Message Type	Message Text	Suggested Action
Missing entry	Select a file to view/print	Find the file to view/print and click on the file selection radio button next to the file name.
Missing entry	Select a file to download	Find the file to download and click on the file selection radio button next to the file name.
Missing entry	Select a file to print	Find the file to print on a mainframe printer and click on the file selection radio button next to the file name.
Missing entry	Select a file to write to tape	Find the file to write to tape and click on the file selection radio button next to the file name.
Missing entry	Select a file to retrieve	Find the file to retrieve and click on the file selection radio button next to the file name.
Software or Database Error	Invalid input to database when requesting retrieval of file	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting retrieval of file	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error code from database when requesting retrieval of file	See Appendix B for contact information to report the error.
Software or Database Error	Invalid input to database when requesting that the group be printed	See Appendix B for contact information to report the error.
Software or Database Error	Error occurred requesting that the group be printed	See Appendix B for contact information to report the error.
Software or Database Error	Unexpected error occurred requesting that the group be printed	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.
Software or Database Error	A security violation has occurred. You do not have access rights to this file.	See Appendix B for contact information to report the error.

Message Type	Message Text	Suggested Action
Success	Request submitted for retrieval of <file name>. Check the Welcome page for a message that retrieval is complete.	No action required.

6: Accessing the CMS Systems for Eligibility Verification

The CMS System for Beneficiary Eligibility Verification is comprised of a user interface component, described in Section 5 of this guide, and a batch component, known as the Batch Eligibility Query (BEQ). The BEQ provides a vehicle for all Plans, regardless of type or size, to submit batches of queries for individuals in order to obtain timely confirmation of Medicare eligibility, prescription drug program eligibility, Low Income Subsidy (LIS) information, and past drug coverage period information so that plans can determine the number of uncovered months relating to Late Enrollment Penalty (LEP) determinations. The BEQ provides a vehicle for all Plans, regardless of type or size, to submit batches of queries for individuals in order to obtain timely confirmation of Medicare eligibility, prescription drug program eligibility, Low Income Subsidy (LIS) information, and past drug coverage period information. This section of the guide describes the BEQ and response process in detail and Appendices E and H provide users with BEQ file layouts and error code information, respectively.

6.1 Batch Eligibility Query (BEQ) Process

Note: Detailed File/Record Formats are located in Appendix E; detailed Error Code Tables for the BEQ Response File are located in Appendix H. Plans may also access Medicare eligibility information via the Common UI; please refer to Section 5 of this guide for more information.

6.1.1 Batch Eligibility Query (BEQ) Request Processing

Plans may submit multiple BEQ (Batch Eligibility Query) Request Files to CMS during any CMS business day (Monday thru Friday) via Connect:Direct (NDM) or the Sterling Electronic Mailbox (Gentran). Plan transactions will be processed as received and there is no minimum or maximum limit to the number of BEQ Request Transactions that may be submitted in a day.

The BEQ Request Files should comply with the record formats and field definitions described in the Batch Eligibility Query (BEQ) Request File included in Appendix E. The BEQ Request Files should be in flat file structure and conform to CMS naming conventions as described in Appendix J. Detailed BEQ Error Code Tables are included in Appendix H.

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

Each Transaction (Detail Record) 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 will generate one BEQ Response File for a Plan every time a BEQ Request is processed during a regular business day. This BEQ Response File will include BEQ Request transactions (Detail Records) 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 will receive multiple BEQ Response files (corresponding to each BEQ Request File) during that same business day. It should be noted:

- 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 processing a previous one, a C:D transmission error will result and the file will have to be manually retransmitted. Plans must call the MAPD Help Desk for assistance.

The “Detail Record Sequence Number” located in each Transaction (Detail Record) can be used by the Plan to track individual Transactions sent to and received from CMS.

6.2 Batch Eligibility Query (BEQ) Response File (From CMS to Plans)

6.2.1 Batch Eligibility Query (BEQ) Response Process

CMS will analyze a received Batch Eligibility Query (BEQ) Request File to determine if the BEQ Request file can be accepted or if it must be rejected. The Transactions (Detail Records) of an accepted BEQ File will be processed and a Batch Eligibility Query (BEQ) Response File will be created as a result. If a BEQ Request File is rejected, then a BEQ Response File will not be generated.

The system will determine if a BEQ Request File shall be accepted or rejected based upon the Request File Error Conditions, as documented in Appendix H. Upon determining if a BEQ Request File is to be accepted or rejected, the BEQ process will generate an email acknowledgement of receipt indicating one of the following outcomes:

- If the Batch Eligibility Query (BEQ) Request File has been accepted, the email notification shall inform the Plan that the specific BEQ Request File has been accepted and shall be processed.
- If the Batch Eligibility Query (BEQ) Request File has been rejected, the email notification shall inform the Plan of the first File Error Condition that had caused the BEQ Request File to be rejected. A rejected file will not be returned.

This email acknowledgement/notification will be issued to all submitters registered in IACS for the Sending Entity contract.

CMS shall process all Transactions (Detail Records) of an accepted BEQ Request File. Each Transaction shall be uniquely identified and tracked throughout the CMS processing service by the combination of the Contract ID of the Plan (Sending Entity), File Control Number, File

Creation Date, and Detail Record Sequence Number as provided by the Plan on the BEQ Request File. Each Detail Record of the BEQ Response File maintains these four critical fields.

When CMS processes a Transaction, CMS first verifies that all critical data is provided and valid on the record (See Appendix E, Batch Eligibility Query (BEQ) Request File). CMS then attempts to perform a Beneficiary Match, in which the beneficiary identifying fields on the Transaction are used to locate a single beneficiary and verify Medicare entitlement.

- If all critical data elements are not provided, subsequent processing will be terminated for that transaction, including any attempt to locate (perform match) the Beneficiary on the database (and verify Medicare entitlement). The Processed Flag in the BEQ Response Detail Record will be set to “N” and the Beneficiary Match Flag will have a space. All Error Return Codes will be assigned the appropriate values (see Appendix H, Request Transaction (Detail Record) Error Conditions).
- If all critical data elements are provided, CMS will then attempt to perform a Beneficiary Match, in which the beneficiary identifying fields on the Transaction are used to 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 (Detail) Record will be set to “Y.” All Error Return Codes will be assigned the appropriate values (see Appendix H, Request Transaction (Detail Record) Error Conditions). The Processing Flag will be set to the value “Y”.
- If the beneficiary is not matched, the Beneficiary Match Flag will be set to “N.” All Error Return Codes will be assigned the appropriate values (see Appendix H, Request Transaction (Detail Record) Error Conditions). The Processing Flag will be set to the value “N”.

If CMS **successfully locates** the beneficiary on the database tables, then CMS will perform the following steps.

- Create a Detail Record to be returned to the Plan in a Batch Eligibility Query (BEQ) Response File as specified in Appendix E, BEQ Response File (From CMS to Plans);
- Assign values to the Match Flag fields as defined in Appendix E; and
- Populate 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 Low Income Subsidy (LIS) information. During an open enrollment period, CMS is not aware 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 will be submitting the enrollment transaction.

If CMS is ***unsuccessful in locating*** the beneficiary on the database tables or the Batch Eligibility Query (BEQ) Request File Transaction contains one or more critical errors (e.g. a critical field is invalid), then CMS will perform the following steps.

- Create a Detail Record to be returned to the Sending Entity in a Batch Eligibility Query (BEQ) Response File as specified in Appendix E, BEQ Response File (From CMS to Plans);
- Assign values to the Match Flag fields as defined in Appendix E; and
- Not populate the additional Eligibility Query fields of the Response File Detail Record

The Batch Eligibility Query (BEQ) Response File will be issued to the Plan in the same transmission mechanism that the Plan had used to deliver the BEQ Request file to CMS. This mechanism is either through the Sterling Mailbox (Gentran) or through NDM (Connect:Direct).

The BEQ Response File will conform to the file naming conventions outlined in Appendix J.

7: Cost Plan Transaction Processing

Because beneficiaries can choose to enroll in a separate or “stand-alone” PDP and enroll in or remain enrolled in a Cost Plan, CMS uses PBP-level processing for cost plan organizations. The following steps accomplish this:

- HPMS provides available drug and non-drug PBP numbers for Cost Plans to the enrollment processing system. If the Cost plan does not have an approved non-drug PBP, HPMS will generate a ‘dummy’ non-drug PBP number of 999 for this plan. This will not be necessary 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. The Cost Plan will use the following transactions for beneficiary enrollments:

- If a current member elects to obtain Part D through the Cost Plan, submit a 71 transaction to move the member from the non-drug PBP to the drug PBP. Include 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 61 transaction to enroll the beneficiary, CMS will 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), submit a code 71 transaction to move the member and include 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, submit a 61 with a non-drug PBP number. (Use 999 if you do not have a non-drug PBP approved in HPMS.)
- If a new member elects to enroll in the drug portion of the Cost Plans, submit a 61 with the drug PBP number, election type and Part D premium-related information.

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

- Enrollment into a Cost Plan’s non-drug PBP from FFS or a non-MA plan does not require that an election type be specified. 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 an election type to be specified if the member is currently enrolled in a MA or MA-PD. This is 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 a Medicare Advantage plan.

- Enrollment into, or disenrollment from, a Cost Plan's drug PBP always requires a Part D election type of AEP, IEP, or SEP to be specified. The beneficiary must request enrollment during an enrollment period.

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 sale (POS) and other pharmacy related information needs. The objective of this exchange is to make 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 in order to properly adjudicate the claim with all payers that cover the beneficiary. In addition, many pharmacies have automated their billing based on eligibility data. The sooner plans can submit their 4Rx data to CMS, the faster complete data can be available from the E1 eligibility query (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 TRR reporting these enrollments.

One of the most difficult issues for CMS and the TrOOP Facilitator has been collecting the 4Rx data from the Plans and ensuring a steady flow of the information to the TrOOP Facilitator to enable 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 ID, which is a National Council for Prescription Drug Program (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 to CMS / 4Rx Notification

Note: Detailed File/Record Formats are located in Appendix E; detailed Transaction Reply Codes (TRCs) for 4Rx Notification are located in Appendix H.

8.1.1 Submitting 4Rx Data

Plans must submit 4Rx data using Plan transactions for enrollment (60/61/62) and PBP changes (71). The previous practice of submitting 4Rx Notification Files is no longer accepted.

Plan transactions for enrollment (60/61/62), disenrollment (51/54), and PBP changes (71) now include the 4Rx fields of *Primary Rx BIN*, *Primary Rx ID*, *Primary Rx PCN*, *Primary Rx Group*, *Secondary Rx BIN* and *Secondary Rx PCN*.

Note: The layout for disenrollment (51/54) transactions has also been modified to include the new 4Rx fields. However, Plans are not required to submit 4Rx data as part of a disenrollment transaction. See Appendix E.7.3 layout for Disenrollment required fields.

The Primary Rx BIN and Primary Rx ID fields are mandatory and must be submitted with enrollment transactions (60/61/62) and PBP changes (71). The other noted fields (*Primary Rx PCN*, *Primary Rx Group*, *Secondary Rx BIN* and *Secondary Rx PCN*) are optional.

Note: PACE Plans and Plans without a drug benefit are not required to submit 4Rx data. However, if a PACE Plan with drug coverage does submit insurance data; all insurance field edits will be applied.

Transaction files should be formulated to the record formats and field definitions described in Appendix E. The files should be in flat file structure and conform to CMS naming conventions (refer to Section 2 and Appendix J for more information on naming standards).

8.1.2 *Making Changes to 4Rx Data*

Plans are required to use the Plan change (72) transaction type 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 customarily included in the enrollment transaction, such as RO/CO actions, IntegriGuard actions, reassignment, and annual rollover activity

Note: If any of the above three scenarios apply, 4Rx Data must be submitted to CMS within 72 hours of the Plan's receipt of the TRR reflecting the enrollment.

The file layout for Plan change (72) transactions now includes the 4Rx fields of *Primary Rx BIN*, *Primary Rx ID*, *Primary Rx PCN*, *Primary Rx Group*, *Secondary Rx BIN* and *Secondary Rx PCN*. As with enrollment transactions (60/61/62/71), the *Primary Rx BIN* and *Primary Rx ID* fields are mandatory and must be submitted; the other noted fields (*Primary Rx PCN*, *Primary Rx Group*, *Secondary Rx BIN* and *Secondary Rx PCN*) are optional.

Important: Plans must submit changes to 4Rx data as a separate transaction; Plan change (72) transactions submitted with data in both 4Rx and non-4Rx fields will be rejected.

When submitting 4Rx changes, only the following fields, which are required for 4Rx processing, should be populated:

- Beneficiary Identification Fields (HICN, Name, DOB)
- Surname
- First Name
- Sex

- Birth Date
- 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 effective dates submitted with Plan change (72) transactions are currently required to be within a date range of the Current Payment Month (CPM) minus one month (CPM-1) through CPM plus two months (CPM+2). This is referred to as the “allowable range”.

Editing for “allowable range” will not be performed on Plan change (72) transactions 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 (72) transaction submitted with 4Rx data will be accepted as long as the effective date in the transaction falls within the Plan’s enrollment period.

Plan change (72) transactions that include non-4Rx data items such as Part C premium amount, Premium Withhold Option for parts C and D, Part D premium amount, EGHP flag, Segment ID, and creditable coverage information will adhere to the “allowable range” requirement of CPM-1 through CPM+2.

8.1.3 CMS Editing of 4Rx Data

CMS will edit against all 4Rx data fields. Any fields on an enrollment (60/61/62), PBP change (71), or Plan change (72) transaction containing invalid information will be rejected with an appropriate TRC.

Note: If 4Rx data is submitted as part of a disenrollment transaction (51/54), that data will not be edited for validity.

Important: CMS will not edit against any 4Rx data fields for MA-only Plans, along with other Plans that do not provide Part D benefits; these Plans should submit blanks in the 4Rx data fields for submission.

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 transactions (60/61/62/71/72) submitted for Part D Plan enrollments (any contract and PBP combination with Part D coverage) that must include 4Rx data elements for enrollment are edited as follows for the 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 to be accepted:

- Rx BIN for primary drug coverage must be 6 characters in length and numeric
- Rx ID for primary drug coverage must be 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 fields should be left blank. However, if submitted, the data is required to meet the following specific criteria to be accepted:

- Rx GRP for primary drug coverage must be no longer than 15 characters, alphanumeric, left justified, and contain spaces in the empty positions when the value in the field is less than 15 characters in length
- Rx PCN for primary drug coverage must be no longer than 10 characters, alphanumeric, left justified, and contain 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 transactions (60, 61, 62 or 71) submitted by Plans that do not include Part D coverage
- Plan enrollment change transactions (72), unless at least one field is submitted (then all edits apply)

Note: PACE Plans with Part D coverage are not required to submit 4Rx data; however, if any 4Rx field is submitted, all preceding edits apply.

8.2 CMS to Plans / 4Rx Response

CMS responses to Plan submission of 4Rx data is provided in regular transaction processing response files, including the Batch Completion Status Summary (BCSS) and the Weekly/Monthly Transaction Reply Report (TRR). Refer to Appendix E for file/record layouts.

8.3 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. The file layout CMS uses to inform Plans of the incomplete 4Rx information is the standard 4Rx Response File Format. To distinguish the difference 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 Plans using the same methodology that is used to transmit the normal 4Rx Response File.

For more information on naming standards, refer to Appendix J, Transmissions Inventory.

CMS will be discontinuing the Monthly NoRx File at some point in the future with the expectation that plans are immediately working and resolving error reports for rejected 4Rx Plan enrollment or update transactions when necessary.

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9: MA-PD/Cost Plan Full Dual File and PDP Notification File for Auto- and Facilitated Enrollments (including Beneficiary Addresses)

9.1 MA-PD/Cost Plan Full Dual File

CMS has directed the following organizations to auto/facilitate enroll LIS beneficiaries in their MA-only plan into MA-PD plans or cost plan Part D optional supplemental benefit:

- Medicare Advantage organizations that offer MA-only plans;
- MA Private Fee for Service 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.

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 subsets that are full-dual eligible, which can be done by consulting the monthly MA full dual file. Please note the MA full dual file identifies those who have been full-benefit dual eligible 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 the organization auto-enrolls versus non-full dual eligible with LIS for whom the organization facilitates enrollment.

Details on the requirements for MA auto/ and facilitated enrollment can be found in the §40.1.5 of Chapter 2 of the Medicare Managed Care Manual (Medicare Advantage Enrollment and Disenrollment. The manual is on the web at:

http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp

9.2 PDP Notification File for Auto- and Facilitated Enrollments (including Beneficiary Addresses)

The auto- and facilitated-assign PDP notification file provides an additional early notification to PDPs of beneficiaries receiving CMS auto-/facilitated enrollment notices indicating assignment to your plan. Each October, it also provides information on individuals being gained and lost due to reassignment. It provides LIS information and immediate access to full name and address data for these beneficiaries. The data on this file should be made available to Customer Service Representatives so they can answer beneficiary queries prior to the PDP receiving and uploading the Weekly Transaction Reply Report (TRR) that confirms auto/facilitated enrollments were successfully processed. Finally, having this file will assist your plan in expediting the submission of the 4Rx records for these beneficiaries.

PDPs may receive this file up to daily throughout the month. Please note that this file only contains assignments, not confirmation that auto- or facilitated enrollment transactions for the

beneficiaries have been processed by the CMS enrollment processing system. You will still need to check your weekly Transaction Reply Reports (TRRs) to determine whether the assignments were accepted or rejected as actual enrollments into your PDP. On these reports, there are two ways for you to differentiate between the full and non-full dual eligible beneficiaries assigned to you. First, on both the monthly PDP notification file and the Transaction Reply Report (TRR), Enrollment Type = **A** (auto-enrollment) or **C** (facilitated enrollment). Second, on the TRR, the Transaction Reply Code (TRC) for the record will be 117 = Auto-enrollment, and 118 = Facilitated enrollment.

For information on the file layout, refer to Appendix E. For information on this file's naming standards, refer to Appendix J.

10: Agent Broker Compensation Cycles

For Plan enrollments, the MARx system has established a status of initial or renewal as well as a 6 year compensation cycle which provides Plans with the information necessary to determine how to pay agents for specific beneficiary enrollments. Plans can 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 in conjunction with their internal payment and enrollment tracking systems to determine if an agent was used and how much the agent should be paid.

The Agent Broker Compensation Report Data File is generated and sent to plans along with the first weekly Transaction Reply Report (TRR) of each calendar month and will report the following:

- All new enrollments, whether retroactive, current, or prospective, having 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

The Agent Broker Compensation Report Data File can be re-ordered by plans via the UI.

The detailed file layout for the Agent Broker Compensation Report Data File is located in **Appendix E** as report #29.

The file naming convention for this data file is located in **Appendix J – All Transmissions Overview** – as report #63.

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11: Reporting Coordination of Benefits (COB) Data

CMS provides Coordination of Benefits (COB) information for your enrollees. The COB file can be provided as often as daily and will contain only members for whom there is COB information available. For each member on the file, there can be multiple records associated with primary and supplemental insurers. This section defines the order of the records in the file.

Please refer to Appendix E for COB file layouts and Appendix J for file naming information.

11.1 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 has been collected by the COB Contractor through its DSAs, COBAs, and other data exchanges with non-Part D payers (PBMs, Employer GHP sponsors, Section 111 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 COB Contractor and provided to the Part D Plan is meant to assist 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 number, and identifying information for the enrollee whose OHI is contained in the records attached to the DTL record. Two types of records may be subordinate (attached) to the DTL record: up to twenty (20) Primary (PRM) records and up to twenty (20) Supplemental (SUP) records. 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 (primary to) Part D. There may be multiple occurrences of primary insurance. Each occurrence of primary insurance will be contained in PRM records subordinate to the DTL record. SUP records contain all supplemental insurance that pays after (supplemental to) Part D. Each occurrence of supplemental insurance will be contained in SUP records subordinate to the DTL record.

The COB File will contain full-record replacements for enrollees with newly discovered or changed OHI. If an enrollee's OHI record has been added, changed, or deleted, this will trigger a full replacement of that enrollee's DTL and subordinate PRM and SUP records. The Part D Plan will replace 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 the enrollment processing system. 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 had previously sent to Plan A will be automatically sent to Plan B in the COB File.

Note: When the beneficiary disenrolls from Plan A, Plan A will no longer receive updates for the beneficiary.

The COB File will be sent out to Part D Plans as the COB Contractor 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, and if it does it will only receive records for enrollees with changed or newly discovered OHI. Most of the data exchanges that the COB Contractor administers for CMS are on a monthly frequency. Each data exchange partner has a unique submission schedule, however. The COB Contractor can receive file submissions from data exchange partners on any given day.

The COB Contractor conducts development (phone calls, mailed questionnaires) on a continual basis. The COB Contractor 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 will be sent to the Part D Plan of the enrollee with OHI.

The Part D Plan will use 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 TrOOP, and to populate the reply to the pharmacy.

CMS is currently drafting specific guidelines for secondary payments by Part D Plans and recovery of mistaken payments made by the Part D Plan when additional insurance was statutorily required to make primary payment. The Medicare Secondary Payer (MSP) rules can be found at 42 U.S.C. § 1395y(b). Under provisions found in § 1860D-2(a) (4) of the MMA, the MSP rules have been incorporated in the MMA and are applicable 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.

In some cases, the Part D plan will make mistaken primary payments (if the COB Contractor, CMS, and the Part D plan are all unaware of any primary coverage). Under other circumstances, the Part D plan will make conditional payments. These circumstances include:

- When the Part D plan is aware that the enrollee has WC/no-fault/liability coverage but does not know whether the drugs for which a bill is sent are related to the WC/no-fault/liability incident.
- When the Part D plan has learned of potential primary coverage and has sent information to the COBC for development and it chooses to wait for validation before considering itself a secondary payer. Note that this option is entirely up to the plan; it may act as a secondary payer immediately or wait for validation, depending upon how confident it is that the information it received is valid.
- When the Part D plan is aware that the primary WC/no-fault/liability coverage applies but the primary payer will 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 will also be subject to audit or reporting requirements. CMS is currently writing and will shortly publish further guidance on these and other Medicare Secondary Payer procedures.

11.2 PRM Record Layout Elements

OHI contained in the PRM record is primary to (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 (* indicates that the element is found in both), but may have slightly different definitions and instructions. Not all element fields will be populated, depending on the information that the COB Contractor possesses when it applied the record to the MBD.

RxID Number*

The NCPDP standard Rx Identification Number used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify an individual in the recovery of mistaken payments. CMS will provide guidance for recoveries to Part D Plans.

RxGroup Number*

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

RxBIN Number*

The NCPDP standard International Benefit Identification Number used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify an individual in the recovery of mistaken payments, as well.

RxPCN Number*

The NCPDP standard Processor Control Number used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify an individual in the recovery of mistaken payments, as well.

Rx Plan Toll Free Number*

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

Sequence Number*

The unique identifier for the primary PRM occurrence. This may be used to identify the PRM occurrence when inquiring about a record to the COB Contractor.

COB Source Code*

The code for the COB Contractor, Common Working File, and MBD are used to identify which process the COB Contractor received primary insurance information from. This may be used for customer service and when inquiring about a record to the COB Contractor.

Note: There may be instances where an unknown COB Source Code will be provided. Plans should contact COBC for clarification on any unknown Source Codes.

MSP Reason

The reason for Medicare Secondary Payer, i.e., why the insurance is primary to Medicare. For GHP MSP Reason codes (A, B, G), the Part D Plan rejects primary payment. The GHP is statutorily required to make primary payment. The Part D Plan makes secondary payment. For non-GHP MSP Reason codes (C, D, E, F, H, I, L), the Part D Plan makes conditional primary payment, as these MSP types may be incident related, so without a diagnosis code the Part D Plan cannot determine whether or not the non-GHP 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.

Coverage 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 will include routing information (BIN and PCN, when available). When the primary insurance is a non-network drug benefit coverage type (V & Z) the Group and Individual Policy Number Fields may be populated.

Insurer's Name*

The name of the primary insurance carrier. It may be used in the recovery of mistaken payments, as well. CMS will provide 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. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Insurer TIN

The Tax Identification Number (TIN) of primary insurance carrier. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Individual Policy Number*

The Individual Policy Number used for non-network drug benefit primary insurance. The Part D Plan uses this to identify non-network drug benefit primary insurance. It may be used to identify an individual in the recovery of mistaken payments, as well. CMS will provide 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. It may be used to identify an individual in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Effective Date*

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

Termination Date*

Medicare Secondary Payer end date. Identifies whether or not the primary insurance has terminated. If the insurance is open, the field will be populated with all zeros.

Relationship Code*

Relationship to primary insurance policyholder used for MSP determinations.

01=Self

02=Spouse

03=Child

04=Other

Payor ID*

Future

Person Code*

The NCPDP standard Person code the plan uses to identify specific individuals on the primary insurance policy. Used for routing of network drug benefit. The Part D Plan displays this in the reply to the pharmacy. It may be used in the recovery of mistaken payments, as well.

Payer Order*

The order of payment for primary insurance. The Part D Plan displays in the reply to the pharmacy in order according to Payment Order Indicator. The lowest number in ascending order (001 to 400) is the first primary insurance to be displayed in the reply to the pharmacy. OHI with a payment order less than 401 will be displayed prior (primary to) to the Part D Plan. The rules that the COB Contractor will 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. It may be used in the recovery of mistaken payments, as well. CMS will provide 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. It may be used to identify an individual in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Policy Holder's SSN

The Social Security Number of the primary GHP (MSP Types: A, B, G) insurance policy holder. It may be used to identify an individual in the recovery of mistaken payments, as well. CMS will provide 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. It may be used in the recovery of mistaken payments, as well. CMS will provide 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. It may be used in the recovery of mistaken payments, as well. CMS will provide 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

ICD-9-CM Diagnosis code – International Classification of Diseases, 9th Edition, Clinical Modification. 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: Workers' Compensation, L: Liability) for the enrollee. It may be used in the recovery of mistaken payments, as well. CMS will provide 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. It may be used in the recovery of mistaken payments, as well. CMS will provide 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. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Class Action Type

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

Administrator Name

The administrator of Workers' Compensation (WC) Set Aside 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 Worker's Compensation Set-Asides.

Administrator Address 1

Administrator Address 2

Administrator City

Administrator State

Administrator Zip

The address, city, state, and zip code of the WC Set-Aside Settlement. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

WCSA Amount

Worker's Compensation Set-Aside Amount. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

WCSA Indicator

Worker's Compensation Set-Aside Indicator. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

A= Approved

D= Denied

P = Pending

Z = Zero set aside amount

11.3 SUP Record Layout Elements

OHI contained in the SUP record is supplemental to (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 will be populated, depending on the information that the COB Contractor possesses when it applied the record to the MBD.

RxID Number*

The 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*

The 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*

The NCPDP standard International Benefit Identification Number 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 help desk number of the pharmacy benefit. The Part D Plan displays this in the reply to the pharmacy.

For Supplemental Insurance Type Code P, this field will instead be populated with contact information for the patient assistance program.

Sequence Number*

The unique identifier for the supplemental SUP occurrence. This may be used to identify the SUP occurrence when inquiring about a record to the COB Contractor.

COB Source Code*

The code the COB Contractor, Common Working File, and MBD use to identify which process the COB Contractor received supplemental insurance information from. This may be used for customer service and when inquiring about a record to the COB Contractor.

Supplemental Type Code

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

Coverage Code*

Identifies whether the drug benefit offered by supplemental insurance is a network drug or non-network drug benefit. When the supplemental insurance is a network drug benefit coverage type (U), the record will include 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 will be populated.

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. This may be used for customer service.

Individual Policy Number*

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

Group Policy Number*

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

Effective Date*

The supplemental insurance start date.

Termination Date*

The supplemental insurance end date. Identifies whether or not the supplemental insurance has terminated. If the insurance is open, the field will be populated with all zeros.

Relationship Code*

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

Payor 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 this in the reply to the pharmacy.

Payer Order*

The order of payment for supplemental insurance. The Part D Plan displays in the reply to the pharmacy in order according to the Payment Order Indicator. The lowest number in ascending order (401 to 999) is the first supplemental insurance to be displayed in the reply to the pharmacy. OHI with a payment order greater than or equal to 401 will be displayed after (secondary/supplemental to) the Part D Plan. The rules that the COB Contractor will use to assign the Payer Order are in Table 11.3-1.

Table 11.3-1: Payment Order Rules

Payment Order Range	Payment Type	MSP Reason	Supplemental Insurance Type	Coverage (to Medicare)
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, L		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	ADAPs, PAPs, Charities		N, P, R, S	Secondary
801 – 900	SPAPs		Q	Secondary
901 – 999	Medicaid		1	Secondary

1. The 'Payment Order Indicator' will indicate payment ordering; the lowest number in ascending order (001 to 999) is the first coverage to be billed at the pharmacy.
2. All drug coverage with a payment order less than 401 will be billed (using the COB to MBD – Other Insurance PRM format) prior (primary to) to the Part D Plan; all drug coverage with a payment order greater than or equal to 401 will be billed (using the COB to MBD – Other Insurance SUP format) after (secondary to) the Part D Plan.
3. Employer Group Health Plans (EGHP) will include MSP Types A (Working Aged), B (ESRD) and G (Disabled). These will be applied payment orders in the 001 to 200 range.
4. Non-EGHP will include MSP Types D (Automobile Insurance, No Fault), E (Workers' Compensation), L (Liability) and H (Black Lung). These will have applied payment orders in the 201 to 300 range.
5. If there are two GHPs with a Patient Relationship Code of '1', the GHP with the earlier effective date shall go before the GHP with the later effective date.
6. If there are two GHPs with Patient Relationship Code of '1', and with the same effective date, the GHP with the first accretion date (validated against the date timestamp or DCN) shall go before the later accretion date.
7. If there are two GHPs with Patient Relationship Code of '2' or more, the GHP with the earlier effective date shall go before the GHP with the later effective date.

8. If there are two GHPs with Patient Relationship Code of '2' or more, and with the same effective date, the GHP with the first accretion date (validated against the date timestamp or DCN) shall go before the later accretion date.
9. If there are two insurers with Person Code of '1', the insurer with the first accretion date (validated against the date timestamp or DCN) shall go before the later accretion date.
10. If there are two insurers with Person Code of '2' or more, the insurer with the first accretion date shall go before the later accretion date.
11. If the record represents a supplemental insurer, the Insurance Type code shall determine the order. Within the list of Supplemental Types, those for Federal Government Programs shall take precedence over those for ADAPs, PAPs and Charities, which shall take precedence over those for SPAPs, which shall take precedence over Medicaid.

12: Establishing Low Income Subsidy (LIS) Status

In order 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 Transaction Reply Activity Data File (Weekly & Monthly) (TRR). The HPMS memo entitled “*Announcement of Spring 2009 Software Release*” dated January 9, 2009 outlined the technical changes to the TRR related to LIS status that will be effective July, 2009.

As discussed in Section 1 of the memo, the Weekly and Monthly TRRs will provide full replacement Low Income Subsidy (LIS) profiles to Plans in response to Part D enrollments and PBP changes as well as any LIS change that impacts a Part D enrollment period. Therefore, the TRR will become 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 TRR, LIS eligibility information will not be based on current payment month (CPM) reporting.

12.1 Changes in LIS Data Reporting

- CMS will no longer return LIS data in association with the Transaction Reply Codes (TRCs) generated in response to enrollment and Plan Benefit Package (PBP) change transactions. Specifically, LIS data will no longer accompany enrollment and PBP change TRCs 011, 100, 117, 118, 210, and 212. Instead, LIS TRCs will independently accompany enrollment and PBP change transaction responses.
- CMS will also no longer identify specific LIS changes. Instead, Plans will be provided full replacement LIS profiles in response to low income changes that accumulate over the weekly and monthly reporting cycles. Replacement profiles will be established using data known to CMS at the end of each reporting cycle. Reported data will span a PBP enrollment.
- To more clearly communicate these changes, CMS will eliminate TRCs 167 and 168. Two existing TRCs (121 and 194) have been retained but the definition of each has been slightly modified. One new TRC (223) has been added and will identify LIS periods that have been removed from and are no longer affecting an enrollment. For more detailed information and a complete list of changes regarding these TRCs, please refer to the Plan Communications User Guide Appendices Section H - *Codes* and Table H-2: *Transaction Reply Codes*.
- Full replacement LIS profiles will be represented by an ensemble composed of one or more of the TRCs 121, 194, and 223. Each profile will return LIS period start and end dates, premium subsidy percentage, co-payment level, enrollee type flag, and low income subsidy source code. Low income premium subsidy percentage and co-payment level values retain their current definitions. The enrollee type flag will now identify a beneficiary as being a prior, current, or prospective enrollee. The source code will now identify whether the LIS period is the result of CMS deeming or Social Security Administration (SSA) approval.

12.2 Other Sources of LIS Data

Although the TRR will become the primary source of LIS eligibility information, Plans will 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 TRR.

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 to be a source of LIS data.
2. **Low Income Subsidy/Late Enrollment Penalty Data File:** This data file contains beneficiary level low income subsidy and the late enrollment penalty payment and adjustment details. Late enrollment penalty 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 who have a low income designation. It is provided on a bi-weekly basis and is the reference file that is used to determine the LIS Match Rate.
4. **LIS History Data File (LISHIST):** This report provides a comprehensive list of a sponsor's current LIS membership. The data on each beneficiary spans most recent 36 consecutive months of contract enrollment. Near year end, this report will also inform plan whether beneficiary is LIS in the next calendar year.
5. **Low Income Subsidy Weekly Activity History Data File (LISAHD):** This report informs plans holding current, prior, and prospective enrollments that some element of LIS changed during the beneficiary's enrollment in the contract.

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. The TRC used for this special file type will be TRC 996. A copy of the record layout for this file may be found in Appendix E.18.