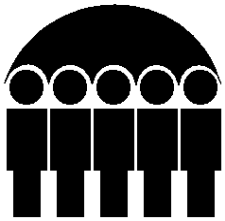
Revised August 14, 2009

Employees' Manual
Title 14
Chapter C

MEDICAL SYSTEMS



Iowa
Department
of
Human Services

Page

Chapter Overview 1
Other Resources Available 2

HREF = Referral System 2
HIPP Referral Screens 3
HIRFLST = HIPP Policyholder Referral List Screen 4
HIRFDET = HIPP Policyholder Referral Information Screen 5
HIPP Referral Case Actions 7
Adding a HIPP Referral 7
Changing or Updating an Existing HIPP Referral 10
Deleting a HIPP Referral the Same Day 11
Viewing Existing HIPP Referrals 12
hawk-i Referral Screens 12
HWKR Identification of People in the Home Screen 13
HWKR Household Income From IABC-BCW2 Screen 15
HWKR Unverified Income For Excluded Children Screen 17
HWKR Comments Screen 19
HWKR History Screen 21
hawk-i Referral Case Actions 22
Making an Automated *hawk-i* Referral 23
Changing a *hawk-i* Referral the Same Day 29
Changing a *hawk-i* Referral After the Day of Referral 30
Deleting a *hawk-i* Referral the Same Day 30
Deleting a *hawk-i* Referral After the Day of Referral 31
Viewing *hawk-i* Referral History 31
Estate Recovery Referral Screens 32
HREFES1 = Estate Recovery Referral Screen 1 32
HREFEST2 = Estate Recovery Referral Screen 2 34
HREFES3 35

Managed Health Care Systems 37
Health Maintenance Organizations 37
Iowa Plan for Behavioral Health 38
Patient Management 39
Notices to Potential and Enrolled Members 40

MediPASS Provider On-Line Display (PROV) 41
PROV Selection 1 Screen 42
PROV Selection 2 Screen 43
PROV Selection 3 Screen 44

Page

MIPS (IowaCare Premium) Billing Screens 45
MIPS Main Menu Screen 46
SUMM = MIPS Summary Screen 47
DETL = MIPS Detail 50
PREF = Unprocessed Payments/Refunds 53
RETR = Retro Screen 55
STMT = Billing Statement Screen 58
MOAK = Monthly Summary Counts Screen 60
HAPL = MIPS Applied Hardships 64

MMCR = Medicare Data Main Menu 66
BSEL = Beneficiary Selection Screen 67
BENE = Beneficiary Information Screen 68
BABI = Additional Beneficiary Information Screen 72
BNTL = Part A & B Entitlement History Screen 74
BTPH = Part A & B Third Party History Screen 79
BPBP = Plan Benefits Package Elections Screen 85
BGHO = Group Health Organization Screen 87
BHSE = Hospice/ESRD Screen 89
BPDH = Part D History Screen 91
BPDE = Additional Part D History Screen 96
SUMM = Enrollment Summary Screen 98
SRCV = DHS/CMS Data Comparison Screen 100
PTDE = Part D Enrollment Information Screen 102

PREM (MEPD) Billing Screens 107
Premium System Main Menu Screen 107
MEPD = MEPD Coverage Group Menu Screen 108
SUMM = MEPD Summary Screen 109
DETL = MEPD Detail 111
STMT = MEPD Billing Statement Screen 114
MOAK = Monthly Summary Counts 117
PVAL = Monthly Valid Premiums 119
PREF = Unprocessed Payments/Refunds 120
RETR = Retro Screen 121

PRSM = Presumptive Medicaid Eligibility 125

SSBI = Buy-In System 128
SSBI Menu Screen 128
Buy-in Master File Inquiry Screen 129
Buy-in History File Inquiry Screen 131

Page

SSNI = Medicaid Eligibility File 133
DETL MTH Screen 143
Title XIX Count Display 147
TPL Screen 148
Insurance Company Detail Screen 150

WIFS Messages 151
Contents of a WIFS Message 152
hawk-i WIFS Messages 152
ISIS WIFS Messages 153
MIPS WIFS Messages 164
PREM WIFS Messages 169
Medicaid Eligibility WIFS Messages 174

Chapter Overview

The purpose of this chapter is to provide information regarding many of the medical-related systems, informational screens, and WIFS messages. This chapter covers the following topics.

- HREF = Referral System, which transmits referrals from the local office IM worker to the HIPP Unit, the ***hawk-i*** program, or the Estate Recovery Program.
- Managed heath care systems. This section provides a brief explanation of:
  - The different managed health care options.
  - How to determine which program a member is enrolled in.
  - When a notice is generated to a member enrolled in a managed health care plan.
- MediPASS Provider On-Line Display (PROV), explaining how to view eligible MediPASS providers.
- MIPS billing screens, which display premium amounts and payments for members in the IowaCare coverage group.
- MMCR = Medicare Data Main Menu, which displays Medicare beneficiary data including data exchanged between the Department of Human Services (DHS) and the Center for Medicare and Medicaid Services (CMS) and Part A, Part B, Part C, and Part D benefit plan enrollment information. Options are BSEL, SRCV, and PTDE.
- PREM (MEPD) billing screens, which displays premium amounts and payments for members in the Medicaid for Employed People with Disabilities coverage group.
- PRSM = Presumptive Medicaid Eligibility, which records eligibility decisions made by qualified providers for pregnant women and women in the breast and cervical cancer treatment group.
- SSBI = Buy-In System, which records the Medicaid payment of Medicare Part A and Part B premiums for eligible beneficiaries.
- SSNI = Medicaid Eligibility File, which displays Medicaid eligibility information used to process Medicaid claims.
- WIFS (warnings, informational, fatal, and summary messages). This section provides information regarding the WIFS system and the WIFS E-mail messages an income maintenance worker could receive from a medical system.

Other Resources Available

There are other systems available that may provide you with information regarding a member's medical coverage.

- The Income Eligibility Verification System (IEVS) is accessed through the ABC system LINK MENU. IEVS allows access to the Beneficiary and Earnings Data Exchange (BENDEX) screens, which provide Medicare coverage information. See 14-G, *EXCHANGE OF DATA WITH OTHER AGENCIES*.
- The Individualized Services Information System (ISIS) provides Medicaid facility and home- and community-based waiver information. This system can be accessed through the Department's DHS Intranet IM web page: http://dhsintranet/field/asp/im.asp. See 14-M, *ISIS USER GUIDE*.
- The Medicaid Management Information System's Medically Needy subsystem provides spenddown information for Medically Needy cases. It is accessed through the CICS System. See 14-I, *MMIS MEDICALLY NEEDY SUBSYSTEM*.
- MEPD Premium Change screen can be accessed from the ABC System Menu (TD00). For more information, see 14-B(4), MEPC = MEPD Premium Change.
- MIPC Premium Change screen can be accessed from the ABC System Menu (TD00). For more information, see 14-B(4), MIPC = IowaCare Premium Change.

HREF = Referral System

The Iowa Referral Systems Menu (HREF) screen is used to allow staff to access:

- HIPP referral screens
- ***hawk-i*** referral screens
- Estate recovery referral screens

The Iowa Referral Systems Menu screen can be accessed:

- From the CICS sign-on screen by clearing the screen, typing "HREF," and pressing the ENTER key. Type the nine-digit ABC case number in the CASE field, type an "X" in the OPTION, and press ENTER; or
- From the ABC case's TD03 screen by pressing PF6=REF MENU. When the system displays the HREF Menu, the case number and the name of the person from the TD03 screen are automatically displayed in the designated fields. Type an "X" in the referral option and press ENTER.

```
HREF                                IOWA REFERRAL SYSTEMS MENU
CASE:  XXXXXX XX X X        LAST:                                   FIRST:
SELECT ONE OF THE FOLLOWING:
 - HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP)
- HAWK-I REFERRAL ON CANCELLED CASE OR CHILD
- HAWK-I REFERRAL ON DENIED APPLICATION OR CHILD
- HAWK-I REFERRAL ON A VOLUNTARILY EXCLUDED CHILD
  -        CHILD WAS EXCLUDED DUE TO INCOME – UNVERIFIED INCOME?  X
  -        CHILD WAS EXCLUDED DUE TO RESOURCES – UNVERIFIED INCOME?  X
- HAWK-I VIEW REFERRAL HISTORY
- ESTATE RECOVERY REFERRAL – STATE ID:
ENTER "X" ON THE APPROPRIATE OPTION AND PRESS ENTER TO BEGIN PROCESSING
PF01=STOP   PF04=TD03
```

To leave the Iowa Referral Systems Menu and the ABC system, press PF01=STOP. To leave the Iowa Referral Systems Menu and return to the TD03 screen from which the referral process began, press PF04=TD03.

NOTE: If you need to make a HIPP referral and an automated ***hawk-i*** referral on a voluntarily excluded child, a denied child, or a canceled child on the same day, for ease of navigation, complete the ***hawk-i*** referral first, then press PF03=MENU. This returns you to the Iowa Referral Systems Menu, and you can then select the referral type HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP).

HIPP Referral Screens

The HIPP referral screens are used to:

- View the current policyholder referral lists that exist for the employed adult by the adult's state identification number.
- System-generate new HIPP referrals for adults that are employed.
- Refer all ending employment to the HIPP referral system. This ensures that a HIPP referral is made whether or not there is an active HIPP case.
- System-generate reports of ending employment.

HIRFLST = HIPP Policyholder Referral List Screen

The Policyholder Referral List screen (HIRFLST) can be accessed only from the Iowa Referral Systems Menu (HREF). Type an "X" in the column next to the HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP) row and press the ENTER key. Referrals created are displayed on this screen with the most recent referral appearing at the top of the list.

```
HIRFLST                    HEALTH INSURANCE PREMIUM PAYMENT
                                POLICYHOLDER REFERRAL LIST
STATE ID:  XXXXXXXX          ABC CASE#: XXXXXX  XX  X  X                SSN: XXX  XX  XXXX
LNAME: XXXXXXXXXX            FNAME:  XXXXXXXXX                     COUNTY:  XX
                                                                EMPLOYMENT  REF   WORKER
S   REF DATE      EMPLOYER                                      END DATE    SRC   CNTY/ID
-----------------------------------------------------------------------------------------
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
_   MM DD CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              MM DD CCYY   X    XX XXXX
-----------------------------------------------------------------------------------------
PF01=          PF02=ADD REF     PF03=      PF04=          PF05=          PF06=
PF07=UP        PF08=DOWN        PF09=      PF10=          PF11=          PF12=TD03
```

The referral system imports six fields of data from the ABC system, based on the information associated to the TD03 that you were using when you moved to the referral system. Those six fields are: STATE ID:, ABC CASE#:, SSN:, LNAME: (last name), FNAME: (first name), and COUNTY: (worker county).

See HIPP Referral Case Actions for instructions on adding, changing, deleting and viewing referrals.

The function keys available on the HIRFLST screen are:

PF02=ADD REF	Initiates adding a referral to the HIPP system. Once the HIPP system updates in nightly batch processing, the only changes that can be made on an existing referral using the PF04=UPDATE key are to: ♦ Add the ending employment date, and ♦ Add the code to indicate COBRA AVAIL information.
PF07=UP	Allows moving backward to Previous Policyholder Referral List screens.
PF08=DOWN	Allows moving forward to additional Policyholder Referral List screens.
PF12=TD03	Returns you back to the TD03 screen where you initiated your referral.

HIRFDET = HIPP Policyholder Referral Information Screen

```
HIRFDET                    HEALTH INSURANCE PREMIUM PAYMENT
                          POLICYHOLDER REFERRAL INFORMATION
REF DATE:  MM DD CCYY
STATE ID:  XXXXXXXX          ABC CASE#: XXXXXX  XX  X  X              SSN: XXX  XX  XXXX
LNAME:                       FNAME:                                 COUNTY:  XX
EMPLOYER:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              EMP CITY:  X
DOES THIS STATE ID BELONG TO THE POLICYHOLDER:   X       REF SOURCE:  X
PH LNAME: XXXXXXXXXXXXX     FNAME: XXXXXXXXX       MI: X
PREGNANT PERSON IN THE HOUSEHOLD:  MM DD CCYY            DUE DATE:  MM DD CCYY
EMPLOYMENT END DATE:  MM DD CCYY                         COBRA AVAIL: X
COMMENTS:


ADD:  MM DD CCYY  XXXXXX                UPD:  MM DD CC YY

PF01=      PF02=ADD   PF03=          PF04=UPDATE   PF05=REFRESH     PF06=LIST
PF07=      PF08=      PF09=DELETE    PF10=         PF11=            PF12=TD03
```

The Policyholder Referral Information (HIRFDET) screen is the screen you will use to:

- Review an existing referral,
- Change the EMPLOYMENT END DATE and COBRA AVAIL fields, or to
- Create a new referral.

Information from the ABC system is automatically displayed at the top of the screen for the following fields: REF DATE:, STATE ID:, ABC CASE#:, SSN:, LNAME:, FNAME:, and COUNTY.

This screen also includes the fields listed below. These fields will either display information entered on previous referrals or require worker entry of the information to change an existing referral or make a new referral. (See HIPP Referral Case Actions.)

- **EMPLOYER** is the employer's name.
- **EMP CITY** is the employer's city of location.
- **DOES THIS STATE ID BELONG TO THE POLICYHOLDER** indicates whether the state identification number listed belongs to the policyholder. Valid codes are "Y" (yes) or "N" (no).
- **REF SOURCE** is the code for the worker that made the referral. Source codes are:

  F Field referral
  H ***hawk-i*** referral

  NOTE: The HIRF system tracks ***hawk-i*** referrals separately.
- **PREGNANT PERSON IN THE HOUSEHOLD** indicates whether there is a pregnant woman in the household.
- **DUE DATE** is the projected month, day, and year of the birth, if known, when there is a pregnant woman in the household.
- **EMPLOYMENT END DATE** is the date employment ended.
- **COBRA AVAIL** indicates whether COBRA benefits are available to the person. Valid values are "Y" (yes), "N" (no), or "U" (unknown).

You may continue to change this screen using the PF04=UPDATE key or delete the referral using the PF09=DELETE key until HIPP processes the information in the nightly batch processing.

The function keys available on the HIRFDET screen are:

PF02=ADD	Used to add a new HIPP referral.
PF04=UPDATE	Used to change an existing HIPP referral before the nightly batch processing or to update the EMPLOYMENT END DATE and COBRA AVAIL fields.
PF05=REFRESH	Gives a "blank" screen so another referral can be added for the current state identification number. The screen will still have the information you brought over from the TD03 screen but you will have to enter the employer information.
PF06=LIST	Returns you to the HIRFLST screen for the displayed state identification number.
PF09=DELETE	Allows deletion of a referral created earlier in the day, before the nightly batch processing.
PF12=TD03	Returns you to the TD03 screen for the displayed state identification number.

HIPP Referral Case Actions

The following sections explain the procedures for:

- Adding a HIPP referral
- Changing or updating an existing HIPP referral
- Deleting a HIPP referral on the same day you made it
- Viewing existing HIPP referrals

Adding a HIPP Referral

A HIPP referral is applicable when an adult has earned income (excluding self-employment). See 8-M, HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP). Use the following step/action chart to add a HIPP referral.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of the person with employment. NOTE: The HIPP referral should be made from the TD03 screen of the policyholder. If the policyholder has no state identification number, there will not be a TD03 screen. In this situation, make the referral from the TD03 screen of any Medicaid-eligible person on the case.
3	On the HREF menu screen, select HIPP referral by entering an "X." Press ENTER.
4	On the HIRFLST screen, check if a referral for this employer has already been completed. If the referral is already on the list, press PF12=TD03 to return to the TD03 screen in ABC. If the referral is not on the list, press PF02=ADD and go to next step.
5	On the HIRFDET screen, make entries in the following fields: ♦ EMPLOYER: Enter the employer's name. ♦ EMP CITY: Enter the employer's city location. ♦ DOES THIS STATE ID BELONG TO THE POLICYHOLDER: Enter a "Y" (yes) or "N" (no). If you enter "Y" for this question, you may enter additional comments in the COMMENTS field or press PF02 to add the referral. ♦ REF SOURCE: The system populates this field by default with an "F" for field. If a ***hawk-i*** worker is making the referral, enter an "H." If you entered "N" for the state ID question, you will be taken to the policyholder (PH) name fields and required to enter the last name (LNAME) and the first name (FNAME) of the actual policyholder. You may enter comments in the COMMENTS field. ♦ PH LNAME: Enter last name of policyholder. ♦ FNAME: Enter first name of policyholder. ♦ MI: Enter first initial of middle name of policyholder.

Step	Action
	♦ PREGNANT PERSON IN THE HOUSEHOLD: Enter a "Y" if there is a pregnant person in the household. NOTE: Leaving this field blank causes the cursor to skip over the DUE DATE: field. If the due date is unknown, no entry is required. ♦ DUE DATE: Enter the due date, if known, in MM/DD/CCYY format. NOTE: This field will not allow an entry if an "N" was entered in the PREGNANT PERSON IN THE HOUSEHOLD: field. ♦ COMMENTS: Enter any additional comments. This field is optional. Press PF02=ADD to add the referral. Check to see if a message is displayed at the bottom of the screen indicating that a referral has been added. If you enter something incorrectly, you will get an error message telling you what to enter.
6	If no other referrals are necessary, go to Step 7. If you have another referral to add for the same state identification number, press PF05=REFRESH. A new blank screen will appear. See Step 5 to complete and add the referral.
7	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

Changing or Updating an Existing HIPP Referral

Use the following step/action chart to make changes on an existing HIPP referral before the nightly batch processing or to update ending employment and COBRA information.

Step	Action
1	Access the case on the ABC system.
2	Go to the TD03 screen of the person whose HIPP referral needs to be changed. Press PF06=LIST.
3	On the HREF menu screen, select HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP) by entering an "X." Press ENTER.
4	On the HIRFLST screen, select the referral that needs to be changed by entering an "S" in the S column. Press ENTER.
5	On the HIRFDET screen, if you are correcting a referral before batch processing, make any necessary changes. If you are updating ending employment information, complete the following fields: ♦ EMPLOYMENT END DATE: Enter date of ending employment in MM/DD/CCYY format. Entering a date will automatically move you to the COBRA AVAIL: field where an entry is mandatory. ♦ COBRA AVAIL: Enter applicable COBRA code. Valid options are: "Y" (yes), "N" (no), or "U" (unknown). NOTE: If an entry is made in the COBRA AVAIL: field when there is no entry in the EMPLOYMENT END DATE: field, the on-line error message "END DATE IS REQUIRED WHEN COBRA AVAIL IS ENTERED" will appear at the bottom of the screen. Press PF04=UPDATE.
6	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

Deleting a HIPP Referral the Same Day

To delete an existing HIPP referral before the nightly batch processing, use the following step/action chart.

Step	Action
1	Access the case on the ABC system.
2	Go to the TD03 screen of the person whose HIPP referral needs to be deleted. Press PF06=LIST.
3	On the HREF menu screen, select HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP) by entering an "X." Press ENTER.
4	On the HIRFLST screen, select the referral that needs to be deleted by entering an "S" in the S column. Press ENTER.
5	On the HIRFDET screen, press PF09=DELETE. The on-line message: "PRESS PF09 AGAIN TO DELETE THE REFERRAL" will appear at the bottom of the screen. If deletion of the referral is intended, press PF09=DELETE again to complete the deletion. The on-line message: "REFERRAL HAS BEEN DELETED" will appear at the bottom of the screen. Attempting to delete a referral entered before the current date will produce the message, "REFERRAL CANNOT BE DELETED, ALREADY PROCESSED BY HIPP." NOTE: The referral information continues to be displayed on the HIRFDET screen after deletion of the referral is complete. If you choose, press PF06=LIST to view that the referral no longer exists on the HIRFLST screen.
6	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

Viewing Existing HIPP Referrals

To view existing HIPP referrals, use the following step/action chart.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of the person whose HIPP referral needs to be viewed. Press PF06=LIST.
3	On the HREF menu screen, select HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP) by entering an "X." Press ENTER.
4	The HIRFLST screen displays all referrals made for this person. To view more details on a referral, select the referral by entering an "S" in the S column. Press ENTER and go to next step. To exit the HIRFLST screen, press PF12=TD03 to return to the TD03 screen in ABC.
5	The HIRFDET screen displays the referral information. (See HIRFDET = HIPP Policyholder Referral Information Screen for more information).
6	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

hawk-i Referral Screens

The ***hawk-i*** referral screens are used to:

- Refer children who:
  - Are eligible for only Medically Needy with a spenddown, or
  - Are voluntarily excluded from the Medicaid eligible group due to their income or resources.
- Reflect the ***hawk-i*** referrals case history.

HWKR Identification of People in the Home Screen

The HWKR Identification of People in the Home screen displays a maximum of 16 people associated with the case.

```
HWKR                    IDENTIFICATION OF PEOPLE IN THE HOME          AS OF     MM/DD/YY
CASE:                          LAST:                                  FIRST:          STATE
IN-THE     CHILD     MEDICAL     FIRST     LAST     AGE    CIT    ID    REL    EMP    INS
HOME       REFERRED  END-DATE    NAME      NAME
-          -         MM DD CCYY  XXXXXX    XXXXX    XXX    X      X     XXX    X      X



PF01=STOP    PF2=ADDREF    PF03=MENU    PF04=TD03    PF05=INCOME    PF06=COMMENTS
PF07=INDIVIDUALS    PF08=BACK    PF09=FORWARD    PF10=REOPEN    PF11=DELETE REFERRAL
```

Screen field descriptions:

- **CASE** is the ABC system's case number associated with the person the referral was made on.
- **LAST** is the last name of the case name on ABC.
- **FIRST** is the first name of the case name on ABC.
- **IN-THE HOME** is used to indicate which people listed are living together.
- **CHILD REFERRED** is used to indicate each child being referred to ***hawk-i***.
- **MEDICAL END DATE** is displayed when a user selects "HAWK-I REFERRAL ON CANCELED CASE OR CHILD" or "HAWK-I REFERRAL ON A VOLUNTARILY EXCLUDED CHILD" and shows the negative date from the TD05 screen, or

  MEDICAL APP DATE is displayed when a user selects "HAWK-I REFERRAL ON DENIED APPLICATION OR CHILD" and shows the application date.
- **FIRST NAME** is the person's first name from the TD03 screen on ABC.
- **LAST NAME** is the person's last name from the TD03 screen on ABC.
- **AGE** is the age of the person as of the current date.
- **CIT** is the person's citizenship status as indicated in the CIT field on the person's ABC TD03 screen.

- **ID** is the person's identity status as indicated in the ID field on the person's ABC TD03 screen.
- **REL** indicates the relationship of listed individuals to the head of household. This field translates the code that is on the REL field on the ABC TD03 screens.
- **STATE EMP** indicates whether or not the person is a state employee. Valid values are "Y" (yes) or "N" (no).
- **INS** indicates if the person in the home has health insurance coding on the ABC system. If there is health insurance coding on ABC, the entry in this field is "Y." If there is no health insurance coding on ABC, this field is blank.

The function keys available on the HWKR Identification of People in the Home screen are:

PF01=STOP	Allows you to leave both the Referral System and the ABC system.
PF02=ADDREF	Submits the ***hawk-i*** referral.
PF03=MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04=TD03	Returns you to the ABC TD03 screen from which you began the referral process.
PF05=INCOME	Displays the HWKR Household Income From IABC-BCW2 and HWKR Unverified Income For Excluded Children screens, as applicable, where you enter income information for the household members.
PF06=COMMENTS	Displays a Comments screen where information can be entered regarding the household that may be useful for the ***hawk-i*** eligibility worker.
PF07=INDIVIDUALS	Displays the HWKR Identification of People in the Home screen that shows all of the people in the household.
PF08=BACK	Used to view the previously viewed HWKR screen.
PF09=FORWARD	Used to move to the next HWKR screen.
PF10=REOPEN	Used to make a change in a ***hawk-i*** referral the same day it was submitted.
PF11=DELETE REFERRAL	Used to delete a referral the same day it was submitted.

HWKR Household Income From IABC-BCW2 Screen

The HWKR Household Income From IABC-BCW2 screen displays income information you enter for the household members.

```
HWKR                          HOUSEHOLD INCOME FROM IABC-BCW2                    MM/DD/YY
CASE: XXXXXX   XX   X   X          LAST: XXXXXX                    FIRST:  XXXX
NRLS MNTHLY PRORATED AMT  0000000  00            LAST MONTH OF PRORATION    MMYY
IF MORE THAN ONE LUMP-SUM EXPLAIN IN COMMENTS
INDIVIDUAL INCOME FOR:    LAST:  XXXXXX                    FIRST:  XXXXX
SELF EMPLOYED Y/N                          DEPRECIATION AMOUNT 0000000   00
              EMPLOYER:
TYPE OF INCOME:   XXXXXXXX                   AMOUNT:    0000.00
PRESS PF09 FOR MORE INCOME RECORDS

PF01=STOP      PF02=ADDREF      PF03=MENU      PF04=TD03      PF05=INCOME      PF06=COMMENTS
PF07=INDIVIDUALS      PF08=BACK      PF09=FORWARD      PF10=REOPEN      PF11=DELETE REFERRAL
```

Screen field descriptions:

- **CASE** is the ABC system's case number associated with the person the referral was made on.
- **LAST** is the last name of the person that is the case name on ABC.
- **FIRST** is the first name of the person that is the case name on ABC.
- **NRLS MNTHLY PRORATED AMT** is used to enter the amount of any non-recurring lump sum income that is prorated monthly.
- **LAST MONTH OF PRORATION** is used to enter the last month of the non-recurring lump sum income proration period.
- **INDIVIDUAL INCOME FOR:**
  - **LAST** is the last name of the person with a BCW2 income record in ABC.
  - **FIRST** is the name of the person with a BCW2 income record in ABC.
- **SELF EMPLOYED Y/N** is used to indicate if the person is self-employed or not.
- **DEPRECIATION AMOUNT** is used to enter the amount of depreciation a self-employed person claims on their tax form Schedule C or F.

- **EMPLOYER** is used to enter the employer's name. If the employer's name is not known, enter UNK and explain on the COMMENTS screen.
- **TYPE OF INCOME** is the income type based on entries from the BCW2 income record. Earned income is listed as earned income. Unearned income is listed by source of income based on the coding in the SR (1-4) BCW2 fields.
- **AMOUNT** is the amount of earned or unearned income based on entries from the EARNED (1-4) and UNEARN (1-4) BCW2 fields.

The function keys available on the Household Income From IABC-BCW2 screen are:

PF01=STOP	Allows you to leave both the Iowa Referral Systems and the ABC System.
PF02=ADDREF	Submits the ***hawk-i*** referral.
PF03=MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04=TD03	Returns you to the ABC TD03 screen from which you began the referral process.
PF05=INCOME	Displays the Household Income From IABC-BCW2 screen and the Unverified Income For Excluded Children screen, as applicable, where you enter income information for the household members.
PF06=COMMENTS	Displays a Comments screen where information can be entered regarding the household that may be useful for the ***hawk-i*** eligibility worker.
PF07=INDIVIDUALS	Displays the Identification of People in the Home screen that shows all of the people in the household.
PF08=BACK	Used to view the previously viewed HWKR screen.
PF09=FORWARD	Used to move to the next HWKR screen.
PF10=REOPEN	Used to make a change in a ***hawk-i*** referral the same day it was submitted.
PF11=DELETE REFERRAL	Used to delete a referral the same day it was submitted.

HWKR Unverified Income For Excluded Children Screen

The HWKR Unverified Income for Excluded Children screen allows workers to enter income information on household members who are not associated with the ABC case number or whose income is not entered on a BCW2 screen.

This screen is viewable only when a "Y" is entered in the UNVERIFIED INCOME field for the "child was excluded due to income" or "child was excluded due to resources" options on the HREF Iowa Referral Systems Menu screen.

```
HWKR                    UNVERIFIED INCOME FOR EXCLUDED CHILDREN                    MM/DD/YY
CASE: XXXXXX   XX   X   X          LAST: XXXXXX                    FIRST:  XXXX
NRLS MNTHLY PRORATED AMT  0000000  00          LAST MONTH OF PRORATION    MMYY
IF MORE THAN ONE LUMP-SUM EXPLAIN IN COMMENTS
INDIVIDUAL INCOME FOR:    LAST:  XXXXXX                    FIRST:  XXXXX
SELF EMPLOYED Y/N                          DEPRECIATION AMOUNT 0000000   00
              EMPLOYER:
TYPE OF INCOME:   UNVERIFIED INCOME                AMOUNT:    0000.00
PRESS PF09 FOR MORE INCOME RECORDS

PF01=STOP      PF02=ADDREF      PF03=MENU      PF04=TD03      PF05=INCOME      PF06=COMMENTS
PF07=INDIVIDUALS      PF08=BACK      PF09=FORWARD      PF10=REOPEN      PF11=DELETE REFERRAL
```

Screen field descriptions:

- **CASE** is the ABC system's case number associated with the person the referral was made on.
- **LAST** is the last name of the person that is the case name on ABC.
- **FIRST** is the first name of the person that is the case name on ABC.
- **NRLS MNTHLY PRORATED AMT** is used to enter the amount of any non-recurring lump sum income that is prorated monthly.
- **LAST MONTH OF PRORATION** is used to enter the last month of the non-recurring lump sum income proration period.
- **INDIVIDUAL INCOME FOR:**
  - **LAST** is the last name of the person with unverified income.
  - **FIRST** is the first name of the person with unverified income.

- **SELF EMPLOYED Y/N** is used to indicate if the person is self-employed or not.
- **DEPRECIATION AMOUNT** is used to enter the amount of depreciation a self-employed person claims on their tax form Schedule C or F.
- **EMPLOYER** is used to enter the employer's name. If the employer's name is not known, enter UNK and explain on the COMMENTS screen.
- **TYPE OF INCOME** displays the default entry of "UNVERIFIED INCOME."
- **AMOUNT** is the amount of unverified earned or unearned income entered by the worker.

The function keys available on the HWKR Unverified Income For Excluded Children screen are:

PF01=STOP	Allows you to leave both the HREF = Referral System and the ABC system.
PF02=ADDREF	Submits the ***hawk-i*** referral.
PF03=MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04=TD03	Returns you to the ABC TD03 screen from which you began the referral process.
PF05=INCOME	Displays the Household Income From IABC-BCW2 and Unverified Income For Excluded Children screens, as applicable, where you enter income information for the household members.
PF06=COMMENTS	Displays a Comments screen where information can be entered regarding the household that may be useful for the hawk-i eligibility worker.
PF07=INDIVIDUALS	Displays the Identification of People in the Home screen that shows all of the people in the household.
PF08=BACK	Used to view the previously viewed HWKR screen.
PF09=FORWARD	Used to move to the next HWKR screen.
PF10=REOPEN	Used to make a change in a hawk-i referral the same day it was submitted.
PF11=DELETE REFERRAL	Used to delete a referral the same day it was submitted.

HWKR Comments Screen

The HWKR Comments screen allows you to:

- Enter any comments that are appropriate for the referral you are making; or
- View any comments associated with the case referral.

```
HWKR                                COMMENTS
CASE: XXXXXX   XX  X  X             LAST:   XXXX                    FIRST:   XXXX
POLICYHOLDER NAME:                                            AP      YES:            NO:
COMMENTS:




                                       WORKER INFORMATION
        NAME                        COUNTY                                      PHONE
XXXXXXX     XXXX                    XX                                        XXX-XXX-XXXX
WORKER EMAIL: XXXXXX     @ dhs.state.ia.us

PF01=STOP      PF02=ADDREF     PF03-MENU     PF04-TD03     PF05=INCOME      PF06=COMMENTS
PF07=INDIVIDUALS        PF08=BACK      PF10=REOPEN     PF11=DELETE REFERRAL
```

Screen field descriptions:

- **CASE** is the ABC system's case number associated with the person on whom the referral was made.
- **LAST** is the last name of the case name on ABC.
- **FIRST** is the first name of the case name on ABC.
- **POLICYHOLDER NAME** is used to enter the first and last name of the health insurance policyholder.
- **AP YES** allows entry of an "X" if the policyholder is an absent parent.
- **AP NO** allows an entry of an "X" if the policy is not an absent parent.
- **COMMENTS** is used to enter additional information and comments concerning the referral.

Under the section WORKER INFORMATION, the system generates from the WKER file the worker's name, county number, phone number, and the worker's e-mail address based on the county number and worker identification number.

The function keys available on the HWKR Comments screen are:

PF01=STOP	Allows you to leave both the HREF = Referral System and the ABC system.
PF02=ADDREF	Submits the ***hawk-i*** referral.
PF03=MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04=TD03	Returns you to the ABC TD03 screen from which you began the referral process.
PF05=INCOME	Displays the Household Income From IABC-BCW2 and Unverified Income for Excluded Children screens as applicable, where you enter income information for the household members.
PF06=COMMENTS	Is not a valid function while on the COMMENTS screen.
PF07=INDIVIDUALS	Displays the Identification of People in the Home screen that shows all of the people in the household.
PF08=BACK	Used to view the previously viewed HWKR screen.
PF09=FORWARD	Used to move to the next HWKR screen.
PF10=REOPEN	Used to make a change in a ***hawk-i*** referral the same day it was submitted.
PF11=DELETE REFERRAL	Used to delete a referral the same day it was submitted.

HWKR History Screen

The HWKR History screen displays the referral history with the oldest referral displayed first. The history starts with the identification of the people in the home, the BCW2 income, and any comments associated with the referral.

```
HWKR        HISTORY          IDENTIFICATION OF PEOPLE IN THE HOME        AS OF     MM/DD/YY
CASE:                              LAST:                                FIRST:            STATE
IN-THE      CHILD      MEDICAL     FIRST     LAST     AGE    CIT   ID    REL    EMP    INS
HOME        REFERRED   END-DATE    NAME      NAME
X             X        MM DD CCYY  XXXXXX    XXXXX    XXX    X     X     XXX    X      X



PF01=STOP      PF03=MENU      PF04=TD03      PF05=INCOME      PF06=COMMENTS
PF07=INDIVIDUALS      PF08=BACK      PF09=FORWARD
```

This screen displays the same fields as the HWKR Identification of People in the Home screen. See HWKR Identification of People in the Home Screen for a description of the fields.

The function keys available are:

PF01=STOP	Allows you to leave both the Referral and ABC Systems.
PF03=MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04=TD03	Returns you to the ABC TD03 screen where you began the referral process.
PF05=INCOME	Displays the Household Income From IABC-BCW2 and Unverified Income For Excluded Children screens, as applicable, where you entered income information for the household members.
PF06=COMMENTS	Displays the COMMENTS screen where information previously entered regarding the household can be viewed.
PF07=INDIVIDUALS	Returns to the Identification of People in the Home for the oldest referral.
PF08=BACK	Moves to the individual, income, or comments for the referral.
PF09=FORWARD	Moves to the next individual, income, or comments for the referral.

hawk-i Referral Case Actions

Whenever notice reason 205 is generated on a case in the 92-0 aid type, the worker to whom the case is assigned on the case master file will receive a WIFS message by E-mail reminding the worker that a referral to ***hawk-i*** may need to be completed.

Complete a ***hawk-i*** referral even if the children are:

- Insured, or
- Living in families whose income exceeds 133% of the federal poverty level for the family size, regardless of how much over 133% the family income is, or
- Dependents of state of Iowa employees. (See 8-B, REFERRALS TO THE ***hawk-i*** PROGRAM, and 8-G, Referrals to the ***hawk-i*** Program.)

NOTE: Form 470-3565, *Referral to the **hawk-i** Program*, must be completed if:

- The children being referred are currently active for Medicaid; or
- The family of the children you are referring has people who must be marked as "in the home" but do not show up on the Individual screen because they do not have a TD03 record.

1. Mrs. A files a Medicaid application for her children April 4. It is processed June 6. The children are denied Medicaid for the months of April and May due to excess income. The children are approved for Medicaid for June and ongoing months.

   Because the children are active for Medicaid, the ***hawk-i*** referral for May coverage cannot be made via the automated process. A paper referral must be made.

2. Same as Example 1, except that the children are approved for Medicaid for the months of April and May and are denied for June and ongoing months due to excess income.

   The ***hawk-i*** referral for June and ongoing months **can** be made via the automated process because the children being referred are not active for Medicaid. The worker makes the referral using the referral type of "canceled case or child," since Medicaid was approved for some months and then "canceled," even though the *Notice of Decision* says that the application was denied.

3. Ms. C and her children, ages 2 years and 5 years, receive Medicaid under MAC. Ms. C is pregnant. Ms. C reports new income that exceeds 133% of poverty but does not exceed 300%. So, Ms. C remains Medicaid-eligible. The status of her children changes from active to considered persons.

   The ***hawk-i*** referral for the children can be made via the automated process using the referral type of "canceled case or child." However, on the Identification of People in the Home screen, the MEDICAID END DATE column will contain zeros for the dates for the children. This is because the system only changed the status of the children. The worker must enter the MEDICAID END DATE for the children being referred.

   NOTE: In this situation, because notice reason 205 was **not** generated, the worker will **not** receive a WIFS E-mail reminder to do a referral and the *Notice of Decision* will **not** have the ***hawk-i*** language on it.

Making an Automated *hawk-i* Referral

Automated ***hawk-i*** referrals must be made no later than the end of the system month following the month of the NEGATIVE DATE on TD05. Otherwise, the referral must be made using the manual process. Do not complete an automated ***hawk-i*** referral until other ABC transactions are successfully updated on the same case in IABC Real Time.

To make an automated ***hawk-i*** referral, use the following step/action chart.

Step	Action
1	Access the case on the ABC system.
2	Go to the TD03 screen of any person associated with the case. Press PF06=REF MENU.
3	On the HREF menu screen, enter an "X" in the select column by the referral type under which the referral is being made. Press ENTER. NOTE: Pressing ENTER creates transactions. Moving on to other steps in the referral process without pressing ENTER causes no transaction to be created. When you attempt to submit the referral, you will receive an error message. (See Step 12.)

Step	Action
	Referral types are: ♦ **Canceled child or case**. Use when the children being referred are losing full Medicaid eligibility due to excess income and will need to meet a spenddown under Medically Needy. ♦ **Denied application or child**. Use when denying Medicaid eligibility to children on an application due to excess income and the children will need to meet a spenddown under Medically Needy. ♦ **Voluntarily excluded child – due to income**. Use when referring a child who was voluntarily excluded due to **the child's** income. ♦ **Voluntarily excluded child – due to resources**. Use when referring a child who was voluntarily excluded due to **the child's** resources.
4	On the HWKR Identification of People in the Home screen, complete the following fields: ♦ IN-THE HOME: Enter an "X" in this field for each person who lives in the home. (See the example following this chart.) Mark the following people as "in the home": • Anyone who would be an eligible person or a considered person for the MAC coverage group. • Children who are voluntarily excluded from the **Medicaid** eligible group. • Undocumented or ineligible alien children under age 19. • Stepparents. Do **not** include children living in the home who are 19 or older. Do **not** mark an SSI recipient as "in the home" or as a "child referred." Explain family composition on the COMMENTS screen. ♦ CHILD REFERRED: Enter an "X" in this field for each child being referred. (See example following this chart.) NOTE: Failure to enter an "X" in the IN-THE HOME: field for the child causes an "X" to default into the IN-THE HOME: field when you enter an "X" in the CHILD REFERRED: field.

Step	Action
	♦ MEDICAL END-DATE: and MEDICAL APP-DATE: If the dates in these fields are incorrect or blank for a child being referred, enter the correct date. Do not attempt to correct the date for people not being referred or for people not marked as "in the home." ♦ STATE EMP: Enter the code indicating whether or not the person is a state employee. Valid values are "Y" (yes) or "N" (no). ♦ INS: If there is a "Y" in this field, no further action is required. If the field is blank, enter one of the codes below for people marked "in the home": N No, this person does not have health insurance, or Y Yes, this person has health insurance. If you enter "Y," go to the COMMENTS screen to enter the policyholder's name and whether or not the policyholder is an absent parent. Press ENTER. NOTE: If you attempt to submit a referral without codes in the STATE EMP or INS fields, you will receive an edit message stating either, "State employee code must be 'Y' or 'N'" or "Individuals in the home require an insurance code of 'Y' or 'N.'"
5	Move to the next HWKR screen by pressing PF09=FORWARD or PF05=INCOME.
6	On the HWKR Household Income From IABC-BCW2 or Unverified Income For Excluded Children screens, complete the following fields, if applicable: ♦ NRLS MNTHLY PRORATED AMT: Enter the prorated monthly amount of nonrecurring lump-sum income. **Do not** list prorated contract income or prorated recurring lump-sum income. Explain the circumstances surrounding these types of income on the COMMENTS screen. ♦ LAST MONTH OF PRORATION: Enter the last month of the nonrecurring lump-sum income proration period in MMYY format. ♦ SELF EMPLOYED Y/N: If a person is self-employed, enter a "Y." If a person is not self-employed, leave blank. ♦ DEPRECIATION AMOUNT: Enter the amount of depreciation a self-employed person claims on tax form Schedule C or F. If the person claims no depreciation, leave zeros in the amount field.

Step	Action
	♦ EMPLOYER: Entry of the name of the employer is required used if the type of income is earned income. The system uses the employer's name when printing the ***hawk-i*** annual review form and to identify dependents of state of Iowa employees. Leave this field blank if the income is not earned income. ♦ AMOUNT: This field is completed only on the Unverified Income for Excluded Children screen. Enter the amount of unverified income as reported by the household. NOTE: If you want to enter unverified income on an income screen but failed to enter a "Y" in the UNVERIFIED INCOME field on the HREF menu, you must delete the current referral using the PF11=DELETE REFERRAL key and start a new referral. Press ENTER.
7	If anyone else in the household has income, press PF09=FORWARD. Repeat Steps 5 and 6 until the message "You have reached the last income record for this case" appears at the bottom of the screen. Go to Step 8.
8	For referral of a canceled case or child or of a denied application or child, go to Step 10 if no additional comments are needed. If additional comments are needed, press PF06=COMMENTS and go to Step 9. For referral of child who is voluntarily excluded due to income or resources, the system requires you to go to the COMMENTS screen. Press PF06=COMMENTS. Go to Step 9.
9	On the COMMENTS screen, enter any additional information for the referral type selected. Press ENTER. For referral of stepparent families, indicate which of the adults is the stepparent and what household size you used in determining Medicaid eligibility. For referral of a canceled case or child or of a denied application or child, include information such as household composition when there is an SSI member and whether the child is covered by any health insurance.

Step	Action
	For referral of child who is voluntarily excluded due to income or resources, include information not entered on an Unverified Income For Excluded Children screen about the income of the voluntarily excluded child and whether it has been verified. Include the following, if applicable: ♦ Source of the income, ♦ Monthly amount of the income, ♦ A statement that the income has NOT been verified, and ♦ Any other information about the income you feel is important, including why the child was voluntarily excluded and if the child is covered under any health insurance. For referral of child voluntarily excluded due to resources: ♦ If the child has income, include the same information as required for a child voluntarily excluded due to income unless the information was entered on an Unverified Income For Excluded Children screen. ♦ If the child doesn't have income, include a statement to confirm the lack of income.
10	Press PF02=ADD REF to submit the referral.
11	If successful, the message "Success – Your referral will be sent this evening" will appear at the bottom of the screen. Go to Step 14.
12	If the message "Invalid Referral – Enter Employer name," "Unknown" or "N/A'" appears at the bottom of the screen, review the income screens using one of these options: ♦ From a Household Income from IABC-BCW2 or Unverified Income For Excluded Children screen, press PF08=BACK to scroll back through the income records, or ♦ From the Comments screen, press PF05=INCOME to return to the income screens and use PF09=FORWARD to scroll forward through the income screens. Look for records with the income type of earned income where the EMPLOYER: field is blank. Make the appropriate entries and press ENTER.

Step	Action
13	Press PF02=ADD REF to submit referral. If the referral is successful, go to Step 14. Otherwise, repeat Steps 12 and 13.
14	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the HREF and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

1. Family composition is Mr. and Mrs. S, and their two children, ages 3 months and 4 years. The 3-month-old child receives Medicaid as the newborn child of a Medicaid-eligible mother. All four people should be marked as "in the home" but only the 4-year-old should be marked as a "child referred."

   If the family continues to be over 133% of poverty when the newborn turns age 1, a new ***hawk-i*** referral should be completed. The referral should list the parents and the other sibling as "in the home" but list only the 1-year-old as a "child referred," and should contain notes explaining the situation.

2. Mr. M's children receive Medicaid under MAC. Medicaid is canceled effective May 31 for failure to return an annual review form. The *Notice of Decision* is dated May 12. The negative date on TD05 is May 31.

   On May 24, Mr. M returns a complete annual review form. The worker attempts to reinstate Medicaid using a new amount of projected income. However, the new income amount exceeds 133% of poverty. The case remains canceled and a new *Notice of Decision* is generated. This action causes a new negative date of June 30 to be displayed on TD05.

   When the worker makes the automated ***hawk-i*** referral, the MEDICAL END DATE will show June 30. The worker must change the date to May 31 to reflect the correct date on which Medicaid ended. If the date is NOT changed, ***hawk-i*** coverage will not begin until July 1 and the children will not have coverage under ***hawk-i*** or Medicaid for the month of June.

Changing a *hawk-i* Referral the Same Day

You can make changes in an automated ***hawk-i*** referral the same day it was submitted. Use the following step/action chart.

Step	Action
1	Access the case on the ABC system.
2	Go to any TD03 screen for the case.
3	Press PF06=REF MENU.
4	On the HREF menu screen, type an "X" in the select column by the referral type you used earlier to make the original referral. Press ENTER.
5	On the Identification of People in the Home screen, press PF10=REOPEN.
6	Make any changes needed. Press ENTER before proceeding to the next step in the referral process.
7	Once all changes have been made, press PF02=ADD REF.
8	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the Referral and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

Changing a *hawk-i* Referral After the Day of Referral

If you need to make a change on an automated ***hawk-i*** referral on a day other than the day it was referred, use one of these procedures:

- Contact the ***hawk-i*** Customer Service Unit at 1-800-257-8563. Be sure to identify yourself as an income maintenance worker. This will prevent the customer service representative from requesting a signed release of information from the member before talking to you.
- To correct information already submitted in an automated referral, make a new **complete** automated referral with corrected information. Enter "Corrected Referral" in the COMMENTS: section, and a brief, but complete, comment about what was corrected.

Deleting a *hawk-i* Referral the Same Day

You can delete an automated ***hawk-i*** referral the same day it was submitted. Use the following step/action chart.

Step	Action
1	Access the case on the ABC system.
2	Go to any TD03 screen for the case. Press PF06=REF MENU.
3	On the HREF menu screen, type an "X" in the select column by the referral type you used earlier to make the original referral. Press ENTER.
4	On the Identification of People in the Home screen, press PF11=DELETE REFERRAL. The message "Success – Your referral record has been deleted" will appear at the bottom of the screen.
5	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the Referral and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

Deleting a *hawk-i* Referral After the Day of Referral

If an automated ***hawk-i*** referral needs to be deleted on a day other than the day it was submitted, contact the ***hawk-i*** Customer Service Unit at 1-800-257-8563. Be sure to identify yourself as an income maintenance worker. This will prevent the customer service representative from requesting a signed release of information from the member before talking to you.

Viewing *hawk-i* Referral History

To view a history of the automated referrals made on a case, use the following step/action chart.

Step	Action
1	Access the case on the ABC system. SSNI = Medical Eligibility File ASCI = Medicaid Eligibility File1
2	Go to any TD03 screen for the case. Press PF06=REF MENU.
3	On the HREF menu screen, type an "X" in the select column by "Hawk-i View Referral History." Press ENTER.
4	At the HWKR History screen, press PF09=FORWARD to go to the next referral. Continue through all referrals by pressing PF09. When the last referral is reached, the message "You have reached the last history record" will appear at the bottom of the screen.
5	Press the PF08=BACK key to return to a previous history record. When the oldest record is reached, the message "You have reached the first history period" will appear at the bottom of the screen.
6	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the Referral and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

Estate Recovery Referral Screens

the estate recovery referral screens are used to allow more timely referrals to notify the Estate Recovery section of the Iowa Medicaid Enterprise (IME) Revenue Collection Unit about the death of a Medicaid member when the deceased's estate is subject to estate recovery according to 8-D, Estate Recovery.

Complete a referral at the time of death for all Medicaid members who:

- Were 55 years of age or older, or
- Were under age 55, residing in a long-term care facility, and not expected to return home.

HREFES1 = Estate Recovery Referral Screen 1

The HREFES1 screen is used to enter information on the deceased member and the member's contact person.

```
HREFES1          ESTATE RECOVERY REFERRAL FOR MEDCAID MEMBERS

WORKER COUNTY - NUMBER      XX XXXX                    CASE NUMBER XXXXXX XX X X
YOU ARE NOTIFIED OF THE DEATH OF:
FIRST NAME     LAST NAME                               STATE ID:
 XXXXXXXXX      XXXXXXXXXX                             XXXXXXXX

DATE OF DEATH    DATE OF BIRTH    SSN
XX XX XXXX       XX XX XXXX       XXX XX XXXX
     LAST KNOWN ADDRESS:
XXXXXXXXXX  XXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX                CITY                STATE    ZIP
XXXXXXXXXXXXXXXXXXXXXX                XXXXXXXXX            XX      XXXXX XXXX
X  SURVIVING SPOUSE    X  BLIND CHILD    X  DISABLED CHILD    X  MINOR CHILD

CONTACT PERSON FOR THE DECEASED:
FIRST NAME        LAST NAME                            RELATIONSHIP
XXXXXXXXXX        XXXXXXXXX                            XXXXXXXXXX
ADDRESS                CITY                STATE    ZIP            PHONE
XXXXXXXXXX             XXXXXXXXXXXX        XX       XXXXX XXXX     XXX XXX XXXX


PF01=          PF02=          PF03=          PF04=IABC      PF05=          PF06=
PF07=          PF08=NEXT      PF09=          PF10=          PF11=          PF12 =
```

The system imports several fields of data from the ABC system, based on the information associated to the case you were using when you moved to the Referral system. Those fields are: WORKER COUNTY – NUMBER, CASE NUMBER, FIRST NAME (member's), LAST NAME (member's), STATE ID:, DATE OF DEATH, DATE OF BIRTH, SSN, LAST KNOWN ADDRESS: CITY, STATE, ZIP.

Fields to be completed by the worker, if known, are:

- **SURVIVING SPOUSE:** Enter "X" if the deceased member has a surviving spouse.
- **BLIND CHILD:** Enter "X" if the deceased member has a blind child.
- **DISABLED CHILD:** Enter "X" if the deceased member has a disabled child.
- **MINOR CHILD:** Enter "X" if the deceased member has a minor child.
- **FIRST NAME:** Enter the first name of the contact person for the deceased member.
- **LAST NAME:** Enter the last name of the contact person for the deceased member.
- **RELATIONSHIP:** Enter the relationship of the contact person to the deceased member.
- **ADDRESS:** Enter the mailing/street address of the contact person.
- **CITY:** Enter the city of residence for the contact person.
- **STATE:** Enter the state of residence for the contact person.
- **ZIP:** Enter the zip code for the contact person's mailing address.
- **PHONE:** Enter the complete phone number for the contact person.

The function keys available on the HREFES1 screen are:

PF04=IABC	Returns user to the ABC screen from which user entered the Referral system.
PF08=NEXT	Moves user to the next estate recovery referral screen.

HREFEST2 = Estate Recovery Referral Screen 2

The HREFEST2 screen is used to enter information regarding services the deceased member or the member's estate may have used.

```
HREFEST2          ESTATE RECOVERY REFERRAL FOR MEDCAID MEMBERS

THE MEMBER USED OR THE ESTATE MAY USE THESE SERVICES:
BANK NAME                 BANK CITY          ACCOUNT NUMBER
XXXXXXXXXX                XXXXXXXXX          XXXXXXXXXXXXXXX
                                             AMOUNT X XXX XXX XXX XX
FUNERAL HOME              CITY                BURIAL FUND AMOUNT
XXXXXXXXXXXXXXXXX         XXXXXXXXXXXXX       X XXX XXX XXX XX

ATTORNEY                                      CITY
XXXXXXXXXXXXXX                                XXXXXXXXXXX
          ESTATE NUMBER          ATTORNEY COUNTY

          XXXXXXXXXXXX           XXXXXXXXXXX

PF01=        PF02=       PF03=        PF04=IABC    PF05=        PF06=
PF07=PREV    PF08=NEXT   PF09=        PF10=        PF11=        PF12 =
```

Fields to be completed by the worker, if known, are:

- **BANK NAME:** Enter name of bank used by deceased member or the member's estate.
- **BANK CITY:** Enter the name of the city in which the bank is located.
- **ACCOUNT NUMBER:** Enter the account number.
- **AMOUNT:** Enter the bank account amount.
- **FUNERAL HOME:** Enter name of funeral home used by estate.
- **CITY:** Enter the name of the city in which the funeral home is located.
- **BURIAL FUND AMOUNT:** Enter the amount of the burial trust fund.
- **ATTORNEY:** Enter name of the attorney for the deceased member or the member's estate.
- **CITY:** Enter the name of the city in which the attorney is located.
- **ESTATE NUMBER:** Enter the estate number.
- **ATTORNEY COUNTY:** Enter the name of the county in which the attorney is located.

The function keys available on the HREFEST2 screen are:

PF04=IABC	Returns user to the ABC screen from which user entered the Referral system.
PF07=PREV	Returns user to the previous estate recovery referral screen.
PF08=NEXT	Moves user to the next estate recovery referral screen.

HREFES3

The HREFES3 screen is used to enter information concerning the assets held by the deceased member at the time of the member's death.

```
HREFES3          ESTATE RECOVERY REFERRAL FOR MEDICAID MEMBERS
THE MEMBER HAD THE FOLLOWING ASSETS AT THE TIME
REAL ESTATE, E.G., HOUSE, LIFE ESTATE, JOINT INTEREST:
   HOUSE X     LIFE ESTATE X     JOINT X     OTHER X     VALUE X XXX XXX XXX XX
   LOCATION XXXXXXXXXXXXXXXXXXX
INSURANCE PAYABLE TO ESTATE X     VALUE X XXX XXX XXX XX          COMPANY XXXXXXXXXX
MILLER TRUST X     VALUE X XXX XXX XXX XX     LOCATION XXXXXXXXXXXXXXXXXX
SPECIAL NEEDS TRUST X     VALUE X XXX XXX XXX XX
LOCATION XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ANNUITIES X     POTENTIAL LITIGATION X     INHERITANCE X     OTHER TRUST X
DATE VERIFIED MM DD YYYY
OTHER INFORMATION XXXXXXXXXXXXXXXXXXXXX
PF01=     PF02=     PF03=     PF04=IABC     PF05=SEND     PF06=
PF07=PREV     PF08=NEXT     PF09=     PF10=     PF11=     PF12 =
```

Fields to be completed, if known, by worker are:

- **HOUSE:** Enter an "X" if deceased owned a house.
- **LIFE ESTATE:** Enter an "X" if the deceased had a life estate.
- **JOINT:** Enter an "X" if the assets are jointly owned.
- **OTHER:** Enter an "X" if other situations apply.
- **VALUE:** Enter the value of the assets marked.

- **LOCATION:** Enter the location of where the assets are held or located.
- **INSURANCE PAYABLE TO ESTATE:** Enter "X" if there is insurance to be paid to the estate.
- **VALUE:** Enter the value of the life insurance payment.
- **COMPANY:** Enter name of the life insurance company.
- **MILLER TRUST:** Enter "X" if a Miller trust was established for the deceased.
- **VALUE:** Enter the value of the Miller trust.
- **LOCATION:** Enter the location where the Miller trust is held.
- **SPECIAL NEEDS TRUST:** Enter "X" if a special-needs trust was established.
- **VALUE:** Enter the value of the special-needs trust.
- **LOCATION:** Enter the location where the special-needs trust is held.
- **ANNUITIES:** Enter an "X" if deceased owned any annuities.
- **POTENTIAL LITIGATION:** Enter an "X" if deceased's estate is involved in any legal actions.
- **INHERITANCE:** Enter an "X" if the deceased received any inheritance.
- **OTHER TRUST:** Enter an "X" if the deceased established any other types of trusts.
- **DATE VERIFIED:** Enter verification date for the entered assets.
- **OTHER INFORMATION:** Enter any other information that may be helpful to the Estate Recovery Unit.

The function keys available on the HREFEST2 screen are:

PF04 = IABC	Returns user to the ABC screen from which user entered the Referral system.
PF05 = SEND	Used to submit the referral to the Estate Recovery unit.
PF07 = PREV	Returns user to the previous estate recovery referral screen.
PF08 = NEXT	Moves user to the next estate recovery referral screen.

Managed Health Care Systems

This section discusses the Managed Health Care (MHC) System. Income maintenance workers do not make system entries. The MHC administrative contractors make those entries.

Traditionally, Medicaid members have been entitled to all medical services in the state's Medicaid plan if those services are received from a provider willing to accept the established fee as payment in full. However, alternative means by which members receive their medical services are becoming increasingly important.

The managed health care code (MHC CD) on the SSNI screen designates the type of alternate delivery organization in which the member participates. The code may reflect the member's participation in one or more of the following Medicaid programs:

- Health maintenance organization (HMO)
- Iowa Plan for Behavioral Health
- Medicaid Patient Access to Services System (MediPASS)
- Lock-in program

See SSNI = Medicaid Eligibility File, for a list of the managed health care status codes. Policy information, including definitions of county types (voluntary, default, or mandatory) and the counties involved with managed health care, is covered in 8-M, MANAGED HEALTH CARE.

Health Maintenance Organizations

A health maintenance organization (HMO) is a group of medical providers that has contracted with the Department to serve Medicaid members who enroll in the HMO. The HMO Medicaid alternative differs from traditional Medicaid in that a capitation payment is paid to the HMO on the member's behalf for each month the member is eligible to receive Medicaid services through the HMO.

This capitation payment is calculated to be less than the fee-for-service (regular Medicaid) cost experience. The rate covers all contracted services, regardless of how often the services are used by the member. The capitation payment is considered payment for medical services and is subject to overpayment recovery.

Members are enrolled in an HMO through entries made to the ABC system that are sent over the Medicaid Eligibility System. If the SSNI screen does not show a member as enrolled in an HMO, the HMO does not receive a capitation payment for the member.

Iowa Plan for Behavioral Health

The Iowa Plan for Behavioral Health (Iowa Plan) is a statewide Medicaid managed care plan for mental health and substance abuse treatment services. The Iowa Plan contractor operates under a capitated, risk-based contract.

A capitation payment is paid to the contractor for each month the member is eligible to receive Medicaid services through the Iowa Plan. The capitation payment is considered payment for medical services and is subject to overpayment recovery.

Medicaid beneficiaries enrolled with the Iowa Plan must access mental health and substance abuse treatment services through providers that have contracted with the Iowa Plan contractor to provide Iowa Plan Medicaid services.

Enrollment with the Iowa Plan is mandatory. The Medicaid Eligibility system automatically generates enrollment when Medicaid eligibility is initially identified for each month. Iowa Plan enrollment is designated on the SSNI screen in the MHC CODE column. Any letter in the MHC CODE column designates Iowa Plan enrollment. A number designates that the member is not enrolled with the Iowa Plan.

Enrollment begins with the month of application and does not cover months of retroactive Medicaid eligibility. Exceptions:

- For members residing in a substance-abuse-licensed PMIC or a child or adolescent treatment unit at Cherokee MHI or Independence MHI, enrollment begins with the month of admission, even when that is a month of retroactive Medicaid eligibility.
- For members whose Medicaid eligibility is based on determination of SSI, enrollment will not be granted for months before the Department receives notice from the State Data Exchange of the person's new SSI eligibility.

Once determined, enrollment may not be altered for current or past months of service, and may not be updated through Quality Assurance. Changes or corrections to ABC affect future months of enrollment only.

Most Medicaid members under the age of 65 are enrolled with the Iowa Plan. The following are excluded from enrollment:

- People who are medically needy with a cash spenddown.
- People residing at Glenwood or Woodward Resource Centers.
- People whose Medicaid benefit package is limited, such as QMB or SLMB members, presumptive eligibles, and illegal aliens.

When a Medicaid beneficiary is NOT enrolled with the Iowa Plan, the Medicaid fee-for-service program covers mental health and substance abuse treatment services in accordance with regular Medicaid (fee-for-service) program policies and procedures.

Patient Management

Medicaid Patient Access to Service System (MediPASS) is a program in which primary-care physicians enrolled for Medicaid agree to serve as a managed health care provider (called a patient manager) for enrolled members.

Under MediPASS, the Medicaid member selects or is assigned one primary care physician to be the member's patient manager. This physician is responsible for authorizing payment to other providers and monitoring necessary medical care. Care provided by other medical providers without the authorization of the patient manager is not payable under Medicaid.

MediPASS is not a capitation program like a health maintenance organization. All providers who give properly authorized service to the member are paid on a fee-for-service basis, including the patient manager. The patient manager receives a monthly "management" fee for each enrolled member, in addition to the normal fee-for-service reimbursement.

See MediPASS Provider On-Line Display (PROV), for instructions on how to access information on physicians enrolled as patient health managers.

Notices to Potential and Enrolled Members

The managed health care contractor generates notices regarding managed health care activity. Refer all members with questions on MHC notices to the IME Member Services Unit.

The managed health care contractor sends notices with a standard template when a member:

- Is due to be enrolled or is forced into enrollment.
- Changes enrollment from one managed health care option or provider to another.
- Moves to a county designated as mandatory or default for managed health care enrollment.

The managed health care contractor also sends notices when any of the following occurs:

- A member disenrolls from managed health care by choice. (In mandatory counties, this requires approval of the Managed Health Care Review Committee. It is allowed without approval in voluntary counties.)
- The Managed Health Care Review Committee approves a provider's request to disenroll a member from managed health care.
- The Managed Health Care Review Committee denies a request for disenrollment.
- A person with an excluded aid type makes a request for enrollment on form 470-2168 or 470-2168(S), *Iowa Medicaid Managed Health Care Enrollment Form*.
- A person living in a nonparticipating county makes a request for enrollment on form 470-2168 or 470-2168(S), *Iowa Medicaid Managed Health Care Enrollment Form*.

NOTE: Because each instance is reviewed individually, no standard template is used.

MediPASS Provider On-Line Display (PROV)

The purpose of the Provider Informational Inquiry System (PROV) is to display eligible MediPASS providers so the member may select one provider for a case or a different provider for each individual. To sign on to the system, see 14-B(4), Signing on to the ABC System. After reaching the IABC MENU, enter "PROV" for the option and press ENTER key.

```
PROV                    DEPARTMENT OF HUMAN SERVICES
                   MANAGED HEALTH CARE PROVIDER INQUIRY
                                MENU


        1.   DISPLAY PROVIDER INFORMATION USING PROVIDER NUMBER
        2.   LIST PROVIDERS BY NAME WITHIN COUNTY
        3.   LIST PROVIDERS BY PROVIDER TYPE WITHIN COUNTY

                 SELECT: X  (ENTER 1 THRU 3)

SERVICE COUNTY NUMBER: xx                PROVIDER NUMBER: xxxxxxx

PROVIDER LAST NAME: xxxxxxxxxxxxxx       PROVIDER TYPE: xx

FOR SELECTION 1 ENTER ONLY THE PROVIDER NUMBER.
     WILL DISPLAY ALL AVAILABLE INFORMATION FOR THAT PROVIDER.
FOR SELECTION 2 ENTER THE COUNTY NUMBER AND THE LAST NAME OF THE PROVIDER.
     WILL LIST PROVIDER NAMES AND PROVIDER NUMBERS FOR THAT COUNTY.
FOR SELECTION 3 ENTER THE COUNTY NUMBER AND THE PROVIDER TYPE.
     WILL LIST PROVIDER NAMES AND PROVIDER NUMBERS FOR THE SELECTED TYPE.
          (EXAMPLE OF PROVIDER TYPES: GP, FP, OB, IN, PD)
*** 1=STOP      3=NEXT SCREEN                    CD/SCRN: X XXXX
xxxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxx
```

Use the PROV Menu screen as follows:

- For selection 1, enter the provider number field only.
- For selection 2, enter the service county number and the provider last name field. If the last name is not entered, the program will start with the first provider for the county selected.
- For selection 3, enter the service county number and the provider type.
- Return to the originating ABC screen by making a CD entry of "3" and SCRN entry of "IABC" or "LINK."

PROV Selection 1 Screen

The PROV Selection 1 screen gives specific information about a provider.

```
PROV                                DEPARTMENT OF HUMAN SERVICES
                              MANAGED HEALTH CARE PROVIDER DISPLAY SCREEN

NAME:  xxxxxxxxxxxxxxxxxxxxxxxxxxx                    PROVIDER TYPE: xx
OTHER CO SERVED: xx xx xx

CO: XX   PROVIDER NUMBER: xxxxxxx                    ADDRESS: xxxxxxxxxxxxxxxxxxxxxxxxx
24  HOUR PHONE:  (xxx) xxx-xxxx                              xxxxxxxxxxxxxxxxxxxxxxxxx
EFFECTIVE START DATE:  xx xx xx                              xxxxxxxxxxxxxxx xxxxx-xxxx
MAXIMUM NO. OF CLIENTS: xxxx                             TOTAL NO. OF CLIENTS: xxxx

CO: XX  PROVIDER NUMBER: xxxxxxx                     ADDRESS:     xxxxxxxxxxxxxxxxxxxxxxxxx
24  HOUR PHONE: (xxx) xxx-xxxx                               xxxxxxxxxxxxxxxxxxxxxxxxx
EFFECTIVE START DATE: xx xx xx                               xxxxxxxxxxxxxxx xxxxx-xxxx
MAXIMUM NO. OF CLIENTS: xxxx                             TOTAL NO. OF CLIENTS: xxxx

CO: XX  PROVIDER NUMBER: xxxxxxx                     ADDRESS:     xxxxxxxxxxxxxxxxxxxxxxxxx
24  HOUR PHONE: (xxx) xxx-xxxx                               xxxxxxxxxxxxxxxxxxxxxxxxx
EFFECTIVE START DATE: xx xx xx                               xxxxxxxxxxxxxxx xxxxx-xxxx
MAXIMUM NO. OF CLIENTS: xxxx                             TOTAL NO. OF CLIENTS: xxxx
*** 1=STOP       3=NEXT SCREEN     4=MORE DATA                          CD/SCRN: x xxxx
SELECT: x        SERV CO: xx     PROV: xxxxxxx          TYPE: xx              LST NME: xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxxx
```

The information displayed includes:

- The provider's name.
- The provider's specialty type.
- The other counties that the provider will serve.
- The county where the provider's office is located.
- The provider's Medicaid vendor number.
- The 24-hour phone number at which the provider can be reached.
- The date that the provider started working with Medicaid members.
- The address of the provider's office.
- The total number of members for which the provider acts as health manager.
- The total number of members currently enrolled with this provider.

A provider may work out of more than one office. The screen has been designed to display up to three office locations. If the provider has more than three office locations, the remaining locations may be viewed by using the option (4=MORE DATA).

Navigate to another screen as follows:

- For PROV selection 1, enter the provider number field only.
- For PROV selection 2, enter the service county number and the provider's last name. If no last name is entered, the program will start with the first provider for the county selected.
- For PROV selection 3, enter the service county number and the provider type.
- Return to the PROV MENU screen using the PF1 key.
- Return to the originating ABC screen by making a CD entry of "3" and SCRN entry of "IABC" or "LINK."

PROV Selection 2 Screen

The PROV Selection 2 screen displays a list of providers for a specific county in name order. The information displayed is the provider's name, specialty type, and number. Up to 32 providers are displayed.

```
PROV                    DEPARTMENT OF HUMAN SERVICES
                MANAGED HEALTH CARE PROVIDER NAME FOR COUNTY XX

NAME                          TYPE NUMBER   NAME                          TYPE NUMBER
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx     xx xxxxxxx
*** 1=STOP          3=NEXT SCREEN     4=MORE DATA                CD/SCRN: x xxxx
SELECT: x        SERV CO: xx     PROV: xxxxxxx     TYPE: xx    LST NME: xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxxx
```

To find the rest of the provider's information, use option 1 and enter the provider's number. If there are more providers to be displayed, the remaining providers may be viewed by using option 4=MORE DATA.

Navigate to another screen as follows:

- For PROV selection 1, enter the provider number field only.
- For PROV selection 2, enter the service county number and the provider's last name. If no last name is entered, the program will start with the first provider for the county selected.
- For PROV selection 3, enter the service county number and the provider type.
- Return to the PROV MENU screen using the PF1 key.
- Return to the originating ABC screen by making a CD entry of 3 and SCRN entry of IABC or LINK.

PROV Selection 3 Screen

The PROV Selection screen displays a list of providers for a specific county and provider specialty. The information displayed on this screen is the provider's name and the provider's number. Up to 32 providers are displayed.

```
PROV                    DEPARTMENT OF HUMAN SERVICES
                MANAGED HEALTH CARE PROVIDER TYPE XX FOR COUNTY xx

NAME                                  NUMBER   NAME                                  NUMBER
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxx          xxxxxxx
*** 1=STOP        3=NEXT SCREEN      4=MORE DATA                    CD/SCRN: x xxxx
SELECT: x      SERV CO: xx      PROV: xxxxxxx      TYPE: xx      LST NME: xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxxx
```

To find the rest of the provider's information, use option 1 and enter the provider's number. If there are more providers to be displayed, the remaining providers may be viewed by using option 4=MORE DATA.

Navigate to another screen as follows:

- For PROV selection 1, enter the provider number field only.
- For PROV selection 2, enter the service county number and the provider's last name. If no last name is entered, the program will start with the first provider for the county selected.
- For PROV selection 3, enter the service county number and the provider type.
- Return to the PROV MENU screen using the PF1 key.
- Return to the originating ABC screen by making a CD entry of "3" and SCRN entry of "IABC" or "LINK."

MIPS (IowaCare Premium) Billing Screens

The Medicaid IowaCare Premium System (MIPS) is a set of screens that are used to record premiums, billing statements, payments, and granting hardship claims made for each IowaCare member who is assessed a monthly premium payment. The following sections explain:

- The MIPS Main Menu screen
- The SUMM = MIPS Summary screen
- The DETL = MIPS Detail screen
- The PREF = Unprocessed Payments/Refunds screen
- The RETR = MIPS Retro screen
- The STMT = Billing Statement screen
- The MOAK = MIPS Monthly Summary Counts screen
- The HAPL = MIPS Applied Hardships screen

MIPS Main Menu Screen

The MIPS Main Menu shows a list of the available MIPS screens.

```
                    DEPARTMENT OF HUMAN SERVICES          DATE: MM/DD/YY
                    MIPS MAIN MENU

                      X  SUMM    MIPS SUMMARY
                      X  DETL    MIPS DETAIL
                      X  PREF    MIPS UNPROCESSED PYMTS/REFND
                      X  RETR    MIPS RETR  SCREEN
                      X  STMT    MIPS BILLING STMT
                      X  MOAK    MIPS MONTHLY SUMMARY COUNTS
                      X  HAPL    MIPS APPLIED HARDSHIPS

NEXT SCREEN  XXXX          PF12=SSNI, CLEAR=QUIT                ###
```

The MIPS Main Menu can be accessed the following ways:

- From a blank screen, enter MIPS.
- From the SSNI Selection Menu by pressing the PF11 key.
- From any of the MIPS screens by pressing the PF1 key.

To use the menu screen, place an 'X' in front of the screen you wish to view **or** enter a four-digit screen name of "SUMM," "DETL," "PREF," "RETR," "STMT," "MOAK," or "HAPL" in the NEXT SCREEN field and press the ENTER key.

Screen field descriptions:

- **SUMM** is the field to access the SUMM screen.
- **DETL** is the field to access the DETL screen.
- **PREF** is the field to access the PREF screen.
- **RETR** is the field to access the RETR screen.
- **STMT** is the field to access the STMT screen.
- **MOAK** is the field to access the MOAK screen.
- **HALP** is the field to access the HALP screen.
- **NEXT** screen is the field to move you to another screen in the MIPS system.

The function keys available on the MIPS Main Menu screen are:

PF12=SSNI	Transfers to the SSNI Selection Menu.
CLEAR=QUIT	Exits the MIPS screen.

NOTE: Press the PF1 function key to return to the MIPS Main Menu from the other screens.

SUMM = MIPS Summary Screen

The SUMM screen shows a summary for each month of the premium amount, the amount applied, the hardship indicator, and the last activity date. The SUMM screen can be accessed the following ways:

- From the MIPS MENU by placing an 'X' by the SUMM field and pressing the ENTER key.
- From any MIPS screen by typing "SUMM" in the NEXT SCREEN field and pressing the ENTER key.
- From the DETL screen by pressing the PF5 key.
- From the PREF screen by pressing the PF6 key.

```
SUMM                    DEPARTMENT OF HUMAN SERVICES          DATE:  MM/DD/YY
                        MIPS SUMMARY                          TIME:  99:99:99
STATE ID:                    CASE #                   LAST NAME FIRST NAME
CREDIT:            OWES:     WORKER:     XXXX     CNTY:  XXX
STATUS:
              PREM    PAYMENT    AMOUNT    AMOUNT    DATE      REFUND    HRDSH   MD    POSTMARK
DATE    ELG   AMT     DUE DATE   RCVD      APPLIED   APPLIED   AMOUNT    IN  RS  MO    DATE
mm/yy         xxx xx  mm/dd/yy   xxx.xx    xxx.xx    mm/dd/yy  xxx.xx

NEXT SCREEN_____ PF5=DETL,    PF6=PREF,    PF7=PG BACK,    PF8=PG FORW,    PF13=CODES HELP
                                                                                  ###
```

Data displayed includes:

- **STATE ID** is the member's MIPS identifying number.
- **CASE #** is the member's MIPS case number and the member's last and first name.
- **CREDIT** is the dollar amount that has not been applied to premium payments.

- **OWES** is the dollar amount the member owes under the state identification number.
- **WORKER** is the identifying number assigned to the income maintenance worker.
- **CNTY** is the county number assigned to the income maintenance worker.
- **STATUS** displays the status of the member's premium payments. Valid remarks are:

  PAST DUE BEFOR 10 DAYS: The IowaCare member did not pay the premium by the due date, but has **not** received a notice of cancellation because the date is before timely notice in the grace period month.

  PAST DUE AFT 10 DAYS: The IowaCare member has received a notice of cancellation due to failure to pay premiums or to ask timely for a hardship.

  NO PAST DUE MONTHS: The IowaCare member is up to date on premium payments.
- **DATE** is the month and the year for the summary.
- **ELG** is the field that shows the eligibility for MIPS (60-E or 60-P). You can access a list of these codes by pressing the SHIFT and PF1 keys together. Valid codes are:

  B Blocked; the month will not be billed, nor will money be applied to this month.

  C This month is blocked, but the ABC system has not sent an eligibility record for this month.

  D Eligibility record received; the member has died.

  E Mandatory month, but the ABC system has not sent an eligibility record and the Medicaid Eligibility system has received record that member has died. MIPS will stop billing.

  F Mandatory month, but the ABC system has not sent an eligibility record, and full Medicaid eligibility exists. MIPS will stop billing.

  N An "N" at month-end means no IowaCare activity.

  O Eligibility received, but full Medicaid eligibility exists. MIPS will stop billing.

  R Premium owed; no member eligibility.

  Y Month of IowaCare eligibility ($0 premium or paid premium).
- **PREM AMT** is the current dollar amount of the premium for that month and year.

- **PAYMENT DUE DATE** is the due date that the premium is to be paid.
- **AMOUNT RCVD** is the total dollar amount of the payment received during that system month.
- **AMOUNT APPLIED** is the amount applied to each month.
- **DATE APPLIED** is the date premium payment is entered on the system.
- **REFUND AMOUNT** is the dollar amount of the refunds in the month and year shown.
- **HRDSH IN** shows whether hardship was granted for the monthly premium. Codes are:

  Y Hardship granted for the month
  N No hardship for the month

- **HRDSH RS** displays codes that are used to make changes or corrections. You can access a list of these codes by pressing the SHIFT and PF1 keys together. Valid codes are:

  AE Agency error
  AP Appeal
  EX Exception to policy
  LT Hardship received too late
  OT Other
  PD Month already paid
  RA Reopen due to appeal
  RC Remove hardship correction
  RH Remove hardship
  TR Transfer of funds

- **MD MO** shows whether this is a mandatory month for premium payment. Codes are:

  Y Mandatory month
  N Nonmandatory month

- **POSTMARK DATE** displays the postmark for hardship requests received by Iowa Medical Enterprise (IME) **after** the due date.
- **NEXT SCREEN** allows entry of the one of the four-character names on the MIPS menu to go to another MIPS screen.
- A display of both informational and error messages may appear at the bottom of the screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF05=DETL	Transfers to the DETL screen.
PF06=PREF	Transfers to the PREF screen.
PF07=PG BACK	Scrolls backwards to other SUMM screens.
PF08=PG FORW	Scrolls forward to other SUMM screens.
PF13=CODES HELP (SHIFT + F1)	Displays the valid eligibility and hardship reason codes.

DETL = MIPS Detail

The DETL screen shows detailed information for the STATE ID for the specified month and year. You can access DETL in the following ways:

- From the MIPS MENU, place an "X" by DETL field and press the ENTER key.
- From any MIPS SCREEN, type "DETL" in the NEXT SCREEN field and press the ENTER key.
- From the SUMM screen, place the cursor on the detail line for the month to be detailed, and press the PF5 key.

```
DETL                                    DEPARTMENT OF HUMAN SERVICES      DATE:  MM/DD/YY
                                        MIPS DETAIL                       TIME:  99:99:99
STATE ID: xxxxxxxx                      MM/YY: 99 99   CASE #:  xxxxxxxxxx LAST NAME FIRST NAME
                                                                          MO BALANCE: 999999.99
                                                                          INIT PREM.....: 999.99
TRANS      TRANS      TRANS      B/U    HARDSHP      MAND                CURR PREM..: 999.99
TYPE       DATE       AMOUNT            IND RSN    MO. IND               DUE DATE.....: 99/99/9999

xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x                   WORKER.....:  XXXX
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x                   COUNTY.......:  99
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x
xxxxxxxxxx 99/99/9999 999999.00  x      x    xx      x

                    PF5=SUMM, PF7=PG UP, PF8=PG DN, PF10-PRI  MNTH, PF11=NXT MNTH
NEXT SCREEN  xxxx   PF13=HARDSHIP REASONS                                      ###
```

Screen field descriptions:

- **STATE ID** is the member's MIPS identifying number.
- **MM/YY** is the month and year you request MIPS detail information.
- **CASE # NAME** is the member's MIPS case number and last and first name.
- **MO BALANCE** is the net dollar amount of the balance for the month and year listed.
- **INIT PREM** is the dollar amount of the original premium for the month and year listed.
- **CURR PREM** is the dollar amount of the current premium for the month and year listed.
- **DUE DATE** is the payment due date.
- **WORKER** is the unique identifying number assigned to the income maintenance worker.
- **COUNTY** is the county number assigned to the income maintenance worker.
- **TRANS TYPE** is the description for the type of transaction that is taking place for the specified month and year. Valid types of transactions are:
  - **FUTUR PREM:** The premium amount will be processed in the MIPS system for the next system month.
  - **DEMOGR CHG:** A change in name, case number, or worker number is processed in MIPS system.
  - **PREMIUM:** MIPS has received the premium amount from the ABC system.
  - **NW FUT CLT:** The premium will be processed in the MIPS system for the next system month. (The effective date of initial eligibility is in the future.)
  - **RETRO:** Eligibility for a month before the current system month has been entered on the RETR screen and processed in the MIPS system.
  - **MIPC CHG:** A change in premium amount, income, poverty level, or hardship has been entered on the MIPC screen.
  - **ACTIV ELIG:** MIPS has received an active eligibility record from the ABC system for a month.
  - **MAN NOELIG:** A mandatory month is being billed for the premium amount, but no eligibility record has been received from the ABC system.

- **PYMT RECVD:** The date the payment is entered into the MIPS system.
- **AMT APPLD:** The amount of payment applied in the MIPS system.
- **AUTO CLOSE:** Date the MIPS billing system sent notification to the ABC system verifying no payment has been made for a specific due date.
- **LT PMT RCV:** Notification (WIFS) to the IM worker that a late payment has been received.
- **REFUND:** A refund has been processed in the MIPS system.
- **STMT PRINT:** A billing statement has been generated.
- **REMIND NTC:** The date an *IowaCare Premium Notice Reminder* was sent to the member.
- **MIPS ROLL:** Month-end has occurred and rolled data to the next system month.

♦ **TRANS DATE** is the date the transaction occurred.

♦ **TRANS AMOUNT** is the dollar amount of the transaction for a given month and year.

♦ **B/U** Reserved for future use.

♦ **HARDSHP IND** is the field that shows if hardship was granted for the monthly premium. Valid codes are:

Y	Hardship granted for the month
Blank	No hardship for the month

♦ **HARDSHP RSN** displays codes that are used to make changes or corrections. You can access a list of these codes by pressing the SHIFT and PF1 keys together. Valid codes are:

AE	Agency error
AP	Appeal
EX	Exception to policy
LT	Hardship received too late
OT	Other
PD	Month already paid
RA	Reopen due to appeal
RC	Remove hardship correction
RH	Remove hardship
TR	Transfer of funds

- **MAND MO. IND** is the field that shows if this is a mandatory month. Valid codes are:

  Y Mandatory month
  N Nonmandatory month

- **NEXT SCREEN** is the option that you can enter the four-character names on the MIPS Menu to go to another MIPS screen.

- A display of informational or error messages may appear at the bottom of the screen. ### is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF05=SUMM	Transfers to the SUMM screen.
PF07=PG UP	Scrolls backwards to other SUMM screens.
PF08=PG DN	Scrolls forward to other SUMM screens.
PF10=PRI MNTH	Scrolls backwards to previous month.
PF11=NXT MNTH	Scrolls forward to next month.
PF13=HARDSHIP REASONS (SHIFT + F1)	Displays the valid eligibility and hardship reason codes.

PREF = Unprocessed Payments/Refunds

Premium payments are entered into the MIPS system daily when received. The PREF screen displays in real time for the entered state identification number a payment or refund that is entered in the MIPS system but has not been processed yet. When the payment or refund has updated in overnight processing, the information is no longer displayed on the PREF screen but is instead displayed on the SUMM screen.

The PREF screen can be accessed in the following ways:

- From the MIPS menu by placing an 'X' by the PREF field and pressing the enter key.
- From any of the MIPS screens by typing PREF in the next screen field and pressing the enter key.
- From the SUMM screen by pressing the PF6 function key.

```
PREF                                    DEPARTMENT OF HUMAN SERVICES
                                        MIPS UNPROCESSED PYMT/REFNDS
STATE ID: xxxxxxxx

RCVD  DATE          PMT AMT     TYPE     CHECK NBR   NAME ON CHECK    METHOD
MM/DD/CCYY          XXXX.XX     XXXXX      XXXX        XXXX XXXX      XXXX
MM/DD/CCYY          XXXX.XX     XXXXX      XXXX        XXXX XXXX      XXXX




NEXT SCREEN         PF6=SUMM,   PF7=BACK,   PF8=FORW
                                                                        ###
```

Screen field descriptions:

- **STATE ID** is the member's MIPS identifying number.
- **RCVD DATE** is the date the payment or refund was entered.
- **PMT AMT** is the dollar amount of the payment entered.
- **TYPE** is the method of payment or refund. Valid entries are: CHECK, CASH, MO (money order), TC (traveler's checks).
- **CHECK NBR** is the number of the check or money order.
- **NAME ON CHECK** is the name of the person given on the check, money order, or receipt for cash.
- **METHOD** is reserved for future use.
- **NEXT SCREEN** allows entry of a four-character screen name from the MIPS Menu to go to another MIPS screen.
- A display of informational or error messages may appear at the bottom of the screen. **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF06=SUMM	Transfers to the SUMM screen.
PF07=BACK	Scrolls backwards to view more payment or refund entries.
PF08=FORW	Scrolls forward to view more payment or refund entries.

RETR = Retro Screen

The RETR screen is actually two screens in one.

- A block of information that is pulled from the ABC system's TD01 screen fields when the case has already been entered and processed on ABC; and
- The RETRO MONTH box, which is used to approve month-by-month retroactive eligibility for MIPS or to change entries previously made for a month.

The RETR screen is used to:

- Enter retroactive eligibility for IowaCare premiums only.
- Change past retroactive MIPS entries when the entry for retroactive eligibility was made on or after July 1, 2005.
- Display past MIPS retroactive eligibility information when the entry for retroactive was made on or after July 1, 2005.

RETR can be accessed in the following ways:

- From the MIPS MENU by placing an 'X' by the RETR field and pressing the ENTER key.
- From any MIPS screen by typing RETR in the NEXT SCREEN field and pressing the ENTER key.

```
RETR                                IOWA DEPARTMENT OF HUMAN SERVICES      DATE:  99/99/99
                                    IOWACARE RETRO ELIGIBILITY             TIME:  99:99:99

STATE ID: xxxxxxxx        RECIPIENT NAME (FML)……..:  xxxxxxxx x xxxxxxxxxxxx
AID TYPE: XXX             CASE NAME (FML)……..:  xxxxxxxx x xxxxxxxxxxxx
FUND CODE: X              PAYEE NAME…….. : xxx xxxxxxxxxxxxxxxxxxxxxxxx
BIRTH DATE…….:99  99  9999        SEX: X
SSN……..: 999  99  9999                                   RETRO MONTH
INSURANCE……: 000 9               ETHNIC: X
CASE NUMBER:  XXXXXXXXX           PERSON NUMBER: XX       ELIG DATE……..: 99 9999
ADDRESS:      XXXXXXXXXXXXXXXXXXXX                        PREMIUM AMOUNT..:99999.99
              XXXXXXXXXXXXXXXXXXXX                        UNEARNED INCOME:99999.99
CITY:  XXXXXXXXXXXXX                                      EARNED INCOME…..:99999.99
STATE:         XX    ZIP:  99999 9999
                                                          PF10-BACK PF11-FORWARD
RES COUNTY:    99

                                                  DO YOU WANT TO ENTER ANOTHER RET-
WORKER NUM.:  XXXX                                RO MONTH FOR THIS STATE ID?  (Y/N)
WORKER CNTY:  99                                  IF Y, ENTER NEW ELIG DATE AND PF3
                                                  IF N, PRESS ENTER

NEXT SCREEN  XXXX         PF3=UPD, PF4=DELETE, PF1=MAIN MENU
                                                                                  ###
```

Enter the state identification number and the ELIG DATE to view information or make entries. All fields must be completed for the screen to update. When using RETR to make retroactive entries, complete the state identification number on the upper left side of the screen and the eligibility date in the RETRO MONTH box and press the ENTER key. This ensures that further entries will be preserved.

Enter the information in the RETRO MONTH box separately for each month of retroactive eligibility that is being approved or changed. When entries are complete, press the PF3 key twice so entries will take.

NOTE: When a retroactive month needs to be added to an IowaCare case after the initial approval entries are made in the ABC system, the eligibility months will not be added to the MIPS Billing system unless the entries are made on the MIPS RETR screen.

So, even when months of eligibility have been added using form 470-0397, *Request for Special Update*, RETR screen entries are needed to add months for premiums to be billed. Note that months added on the RETR screen will also update eligibility on SSNI. If SSNI already shows IowaCare eligibility, you may add the months on RETR for billing purposes.

Screen field descriptions:

- **STATE ID** is the member's MIPS identifying number.
- **RECIPIENT NAME (FML)** is the member's name in first, middle, and last name order.
- **AID TYPE** is the medical aid type. Valid types are 60-E and 60-P.
- **CASE NAME (FLM)** is the case name in first, middle, and last name order.
- **FUND CODE** is the member's fund code.
- **PAYEE NAME** is the name of the payee for the state identification number. A payee modifier field is located in front of the payee Name field. The modifier field displays any modification to the payee name, e.g. FOR.
- **BIRTH DATE** is the member's date of birth.
- **SEX** is the member's gender.
- **SSN** is the member's social security number.
- **INSURANCE** is the member's insurance code. Only the last character is modifiable.

- **ETHNIC** is the member's ethnic code. Valid codes for the MEPD/MIPS RETR screens **only** are:

  1 White
  2 Black
  3 American-Indian
  4 Asian
  5 Hispanic-Latino
  6 Pacific Islander
  9 Unknown

- **CASE NUMBER** is the member's most recent IowaCare case number.
- **ADDRESS** consists of two lines displaying the member's mailing address as displayed on ABC TD01 Address Line 1 and 2.
- **CITY** is the mailing address city.
- **STATE** is the mailing address state.
- **ZIP** is the mailing address zip code and zip+4 digits.
- **RES COUNTY** is the county number where the person resides.
- **WORKER NUM** is the identifying number assigned to the income maintenance worker.
- **WORKER CNTY** is the county number assigned to the income maintenance worker.
- **RETRO MONTH** box:
  - **ELIG DATE** is the actual retroactive month and year.
  - **PREMIUM AMOUNT** is the dollar amount of the premium for the retroactive month.
  - **UNEARNED INCOME** is the unearned income dollar amount for the person.
  - **EARNED INCOME** is the earned income dollar amount for the member.
  - **PF10-BACK** is the function key to move to the previous month.
  - **PF11-FORWARD** is the function key to move to the next month.
- **DO YOU WANT TO ENTER ANOTHER RETRO MONTH FOR THIS STATE ID?** allows entry to indicate if you want to enter an additional retroactive month of coverage for the member or not. If so, enter the month and year and press PF3. If not, press ENTER.

- **NEXT SCREEN** allows entry of a four-character name on the MIPS menu to go to another MIPS screen.
- A display of informational or error messages may appear at the bottom of the screen. ### is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF03=UPD	Adds the record. Must be entered twice to record entry.
PF04=DELETE	Deletes the record.
PF01=MAIN MENU	Transfers to the MIPS MAIN MENU.

STMT = Billing Statement Screen

The STMT screen displays the current and previous statements. STMT can be accessed in the following ways:

- From the MIPS MENU, place an 'X' by the STMT field and press the ENTER key.
- From any MIPS screen, type "STMT" in the NEXT SCREEN field and press the ENTER key.

Enter the state identification number and the approximate billing date. If a billing date is not entered, the most recent statement will be displayed.

```
STMT                                IOWA DEPARTMENT OF HUMAN SERVICES      DATE:  MM/DD/YY
                                          BILLING STATEMENT                TIME:  99:99:99
XXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX              BILLING DATE:   99 99 99                CREATE STMT X
XXXXXXXXXXXXXXXXXXXXXX              STATE ID  :     XXXXXXXX
XXXXXXXXXXXXXX XX   99999-9999      AMT DUE  :     +99999.99              REPRINT (CLNT) X
                                    CREDIT AMT:     99999.99              REPRINT (WRKR) X
ELIG        PREMIUM       DUE       PAYMENT       PAYMENT      DATE        REFUND
MONTH       AMOUNT        DATE      RECEIVED      APPLIED      APPLIED     AMOUNT
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99
XXX  99     $999.99       99/99/9999 $999999.99   $999999.99   99/99/9999  $999999.99

NEXT SCREEN XXXX      PF3=PRINT,  PF7=PG UP, PF8=PG DN, PF10=PRI STMT,  PF11=NXT STMT
                                                                                  ###
```

Screen field descriptions are as follows:

- **NAME** is the member name.
- **ADDRESS** is the first line of the mailing address.
- **BILLING DATE** is the date the bill is written.
- **CREATE STMT** is used to generate a new billing statement that has not been previously generated. Enter a 'Y' and press the PF3 key; then check the information that you entered and press the PF3 key again.

  NOTE: A screen message stating "STATEMENT WILL BE CREATED FOR THIS STATE ID" will appear when successfully entered. The new statement will show billing information as of the date you request the statement.
- **ADDRESS** is the second line of the mailing address.
- **STATE ID** is the member state identification number.
- **CITY, STATE, ZIP** is the city, state, zip, and zip+4 of the mailing address.
- **AMT DUE** is the total dollar amount outstanding.
- **REPRINT (CLNT)** may be used to request a printed duplicate statement for the member by entering a 'Y' and pressing PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen.

  NOTE: If the address is changed, the new address must be on the ABC system to have the duplicate statement for the member go to the correct address.
- **CREDIT AMT** is the total dollar amount that has not been applied to premium payments.
- **REPRINT (WRKR)** may be used to request a printed duplicate statement for the worker by entering a 'Y' and pressing PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen.
- **ELIG MONTH** is the eligibility month and year.
- **PREMIUM AMOUNT** is the premium dollar amount for that ELIG MONTH.
- **DUE DATE** is the date payment is due for that ELIG MONTH.
- **PAYMENT RECEIVED** is the dollar amount received during the ELIG MONTH.
- **PAYMENT APPLIED** is the dollar amount applied to premium for that ELIG MONTH.
- **DATE APPLIED** is the date the payment was applied to premium for that ELIG MONTH.

- **REFUND AMOUNT** is the total amount of any refunds issued during that ELIG MONTH.
- **NEXT SCREEN** allows entry of a four-character name on the MIPS Menu to go to another MIPS screen.
- A display of both informational and error messages may appear at the bottom of the screen. ### is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF3=PRINT	Used to generate a duplicate billing statement.
PF07=PG UP	Scrolls backwards to view more eligibility months on a statement.
PF08=PG DW	Scrolls forward to view more eligibility months on a statement.
PF10=PRI STMT	Scrolls to prior billing statement screen (STMT).
PF11=NXT STMT	Scrolls to next billing statement screen (STMT).

MOAK = Monthly Summary Counts Screen

The MOAK screen displays various summary counts for the IowaCare program. This screen is for review by policy personnel. MOAK can be accessed in the following ways:

- From the MIPS MENU, place an 'X' by the MOAK field and press the ENTER key
- From any MIPS screen, type "MOAK" in the NEXT SCREEN field and press the ENTER key.

The system automatically brings up the current system month information.

```
MOAK                    DEPARTMENT OF HUMAN SERVICES
                        IOWACARE MONTHLY SUMMARY COUNTS
 MOAK MM/YY: MM YY
                         AMOUNTS COUNTS                                COUNTS
 ONGOING BILLED.:     XXX,XXX.XX XX,XXX   CURRENT ACTIVE CLIENTS..:  XX,XXX
 DAILY BILLED...:      XX,XXX.XX  X,XXX
                                           PAST DUE ADDED..........:     XXX
 PAYMENTS.......:      XX,XXX.XX  X,XXX   STOP BILLING............:     XXX
 ELEC PAYMENTS..:      XX,XXX.XX  X,XXX
 MANUAL PAYMENTS:      XX,XXX.XX    XXX   BILL STMT PRINT.........:   X,XXX
 OFFSITE PAYMNTS:       X,XXX.XX    XXX   BILL STMT CLIENT REPRINT:      XX
 CREDITS APPLIED:      XX,XXX.XX  X,XXX   BILL STMT WORKER REPRINT:       X

 REFUNDS.MANUAL.:         XXX.XX      X   REMINDER NOTICE STMTS...:   X,XXX
         AUTO             XXX.XX     XX   MEDICAL ID CARDS PRINTED        X
 HARDSHIPS DCLRD:      XX,XXX.XX  X,XXX
 HARDSHIPS ACCPT:      XX,XXX.XX  X,XXX   HARDSHIP OVERRIDES......:       X
 HARDSHIPS RJCTD:       X,XXX.XX     XX   HARDSHIPS REMOVED.......:       X

 MAND WITH ELIG.:      XX,XXX.XX  X,XXX   INACTIVE CLIENTS........:  XX,XXX
 MAND W/O ELIG..:       X,XXX.XX    XXX   CURR OFFSITE RECEIPT NBR: XXXXXXX
                                           CURR OFFSITE DEPOSIT DTE: MM DD CCYY
 NEXT SCREEN             PF10=PRI MNTH     PF11=NXT MNTH                   ###
```

Screen field descriptions:

- **MOAK MM/YY** is the month and year of the summary counts being viewed.
- **ONGOING BILLED** is the total amount billed at the beginning of a system month.
- **DAILY BILLED** is the total amount of premiums billed for the current system month, during current system month, as cases are added to the MIPS system.
- **PAYMENTS AMOUNTS** is the total amount of payments received **in** a system month. One payment may be applied to multiple months.
- **PAYMENTS COUNTS** is the total number of payments processed in a month.
- **ELEC PAYMENTS AMOUNTS** is the total amount of electronic payments processed in a month.
- **ELEC PAYMENTS COUNTS** is the total number of electronic payments processed in a month.
- **MANUAL PAYMENTS AMOUNTS** is the total amount of manual payments entered into the MIPS system in a month.
- **MANUAL PAYMENTS COUNTS** is the total number of manual payments entered into the MIPS system in a month.
- **OFFSITE PAYMNTS AMOUNTS** is the total amount of offsite payments processed in a month.

- **OFFSITE PAYMNTS COUNTS** is the total number of offsite payments processed in a month.
- **CREDITS APPLIED AMOUNTS** is the total sum of credits applied in a system month.
- **CREDITS APPLIED COUNTS** is the total number of credits applied in a system month.
- **REFUNDS MANUAL AMOUNTS** is the total sum of manual refunds issued in a system month.
- **REFUNDS MANUAL COUNTS** is the total number of manual refunds applied in a system month.
- **REFUNDS AUTO AMOUNTS** is the total sum of automated refunds issued in a system month.
- **REFUNDS AUTO COUNTS** is the total number of automated refunds applied in a system month.
- **HARDSHIPS DCLRD AMOUNTS** is the total value of months that a hardship was entered into the MIPS system, in a month.
- **HARDSHIPS DCLRD COUNTS** is the total number of hardships declared in a month.
- **HARDSHIPS ACCPT AMOUNTS** is the total value of months that have been granted hardship.
- **HARDSHIPS ACCPT COUNTS** is the total number of months that have been granted hardship.
- **HARDSHIPS RJCTD AMOUNTS** is the total value of hardships not granted in a month.
- **HARDSHIPS RJCTD COUNTS** is the total number of hardships **not** granted for a month, for whatever reason (i.e. too late, premium = $0, already paid, etc.)
- **MAND WITH ELIG AMOUNTS** is the total amount of premiums for mandatory months with eligibility from ABC in a month.
- **MAND WITH ELIG COUNTS** is the total number of mandatory months with an eligibility record from ABC in the month.
- **MAND W/O ELIG AMOUNTS** is the total amount of premiums billed for mandatory months that have no eligibility record from ABC in the month.
- **MAND W/O ELIG COUNTS** is the total number of mandatory months billed that have no eligibility record from ABC in the month.

- **CURRENT ACTIVE CLIENTS** is the total number of current active IowaCare members on the MIPS system.
- **PAST DUE ADDED** is the total number of members whose premiums are past due.
- **STOP BILLING** is the total number of IowaCare members to whom the MIPS system has sent a final billing statement.
- **BILL STMT PRINT** is the total number of billing statements mailed to IowaCare members in the month.
- **BILL STMT CLIENT REPRINT** is the total number of reprinted billing statements mailed to IowaCare members in the month.
- **BILL STMT WORKER REPRINT** is the total number of reprints of billing statements generated to go to IM workers in the local office. These are not mailed.
- **REMINDER NOTICE STMTS** is the total number of *IowaCare Premium Notice Reminder* forms (the "friendly reminder" letter) sent to the IowaCare members in a month.
- **MEDICAL ID CARDS PRINTED** is the total number of medical cards issued to IowaCare members.
- **HARDSHIP OVERRIDES** are number of exceptions to policy granted in a month on cases where policy dictates the case was not eligible for hardship.
- **HARDSHIPS REMOVED** are the corrections showing the total count of hardships that are removed in a month.
- **INACTIVE CLIENTS** is the total number of inactive IowaCare members on the MIPS system when rolling into a new month.
- **CURR OFFSITE RECEIPT NBR** is the current receipt number for payments entered at Broadlawns Medical Center for IowaCare members.
- **CURR OFFSITE DEPOSIT DTE** is the current deposit date for Broadlawns payments to be deposited into the bank.
- **NEXT SCREEN** allows entry of a four-character name on the MIPS menu to go to another MIPS screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF10=PRI MNTH	Scrolls to the previous month's summary counts screen.
PF11=NEXT STMT	Scrolls to the next month's summary counts screen.

HAPL = MIPS Applied Hardships

The HAPL screen shows the 'breakdown' of partial payment hardships for eligible members. HAPL can be accessed in the following ways:

- From the MIPS MENU, place an 'X' by the HAPL field and press the ENTER key
- From any MIPS screen, type "HAPL" in the NEXT SCREEN field and press the ENTER key.

```
HAPL                     DEPARTMENT OF HUMAN SERVICES
                             MIPS APPLIED HARDSHIPS
 STATE ID :

 ELIG DATE........:
 APPLIED DATE.....:
 ORIG ENTERED DATE:

 PREMIUM AMT......:
 PARTIAL PREM PAID:
 PREM AMT FORGIVEN:

 TSO ID...........:

 HARDSHIP ENTERED
    HARDSHIP IND.....:
    HARDSHIP RSN CODE:
    POSTMARKED DATE..:

 OVERRIDE SW......:


 NEXT SCREEN XXXX      PF10=PRI HAPL, PF11=NXT HAPL, PF13=RSN CODES
                                                                   ###
```

Screen field descriptions:

- **STATE ID** is the member's state identification number.
- **ELIG DATE** is the month of eligibility.
- **APPLIED DATE** is the date the hardship was applied to the month.
- **ORIG ENTERED DATE** is the date hardship was entered into the system.
- **PREMIUM AMT** is the billed premium amount.
- **PARTIAL PREM PAID** is the amount of partial payment applied to the month.
- **PREM AMT FORGIVEN** is the amount of premium forgiven (the amount of the premium the IowaCare member is not responsible to pay, as hardship was applied; this could be the full amount of the premium or a partial amount).

- **TSO ID** is not applicable.
- **HARDSHIP IND** is the hardship indicator. Valid codes are:

  H Hardship entered
  R Hardship removed

- **ENTERED HARDSHIP RSN CODE** is the hardship reason code. Valid codes are:

  AE Agency error
  AP Appeal
  EX Exception to policy
  LT Hardship received too late
  OT Other
  PD Month already paid
  RA Reopened due to appeal
  RC Remove hardship (correction)
  RH Remove hardship
  TR Transfer of funds

- **HARDSHIP ENTERED POSTMARKED DATE** is the postmark date on the billing statement which the member claimed hardship.
- **OVERRIDE SW** indicates with a 'Y' if an override was performed for this date of eligibility. An override can only be completed by Central Office staff and can either allow or remove a hardship.
- **NEXT SCREEN** allows entry of a four-character name on the MIPS menu to go to another MIPS screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF10=PRI HAPL	Scrolls to the previous month's hardship screen.
PF11=NXT HAPL	Scrolls to the next month's hardship screen.
PF13=RSN CODES (SHIFT + F1)	Displays the valid hardship reason codes. See HARDSHIP ENTERED RSN CODE for a list of the codes.

MMCR = Medicare Data Main Menu

The MMCR menu allows workers to view Medicare beneficiary data. Options available on the menu are:

- BSEL Beneficiary Selection Screen
- SRCV DHS/CMS Data Comparison
- PTDE Part D Enrollment
- QUIT Exit MMCR

You can access the MMCR main menu from a blank ABC screen by typing MMCR and pressing the ENTER key.

```
MMCR                    IOWA DEPARTMENT OF HUMAN SERVICES          DATE:  MM DD CCYY
                              MEDICARE DATA MAIN MENU              TIME:  HH MM SS

                   ___    BSEL        BENEFICIARY SELECTION SCREEN
                   ___    SRCV        DHS/CMS DATA COMPARISON
                   ___    PTDE        PART D ENROLLMENT
                   ___    QUIT        EXIT MMCR

NEXT SCREEN _________   ENTER=BSEL,  PF12=SSNI, CLEAR=QUIT, <SHIFT-F1>=HELP          XXX
```

Screen field descriptions:

- **BSEL** is the field to access the BSEL Selection screen.
- **SRCV** is the field to access the SRCV - DHS/CMS Data Comparison screen.
- **PTDE** is the field to access the PTDE – Part D Enrollment screen.
- **QUIT** is the field to exit MMCR and ABC systems.
- **NEXT SCREEN** is the field you enter the four-letter name to go to a different screen. Options are: BSEL, SRCV, or PTDE.
- ### is a three-digit program code used by the Division of Data Management.

The function keys available on the MMCR main menu are:

ENTER=BSEL	Displays the BSEL Selection screen.
PF12=SSNI	Returns you to the SSNI screen.
CLEAR=QUIT	Allows you to leave MMCR and ABC systems.
<SHIFT-F1>= HELP	Allows viewing of field or screen information in a pop-up box.

BSEL = Beneficiary Selection Screen

The BSEL is used to search for Medicare information using a member's state identification number or social security number. Medicare information includes, but is not limited to, Medicare Parts A, B, and D and third-party history.

The BSEL screen is accessed as follows:

- From the MMCR main menu and PTDE screen by pressing the ENTER key,
- From the MMCR main menu by typing an "X" in the BSEL selection field and press the ENTER key,
- From the MMCR main menu by typing "BSEL" in the NEXT SCREEN field and press ENTER.

On the BSEL screen, enter the beneficiary's state identification number or social security number and press ENTER to access the numerous beneficiary information screens. To scroll between the beneficiary screens, press ENTER or to go to a specific page use the applicable function key command listed at the bottom of the screen.

```
BSEL                          MEDICARE BENEFICIARY SELECTION          DATE:  MM DD CCYY
                                                                      TIME:  HH MM SS

                    STATE ID:

                        <OR>

                         SSN:


KEYS ENTER=BENEFICIARY DISPLAY,   1=MENU, 12=SSNI, <SHIFT-F1>=HELP                  ###
XXXXXXXXXXXXXXXXX
```

Screen fields descriptions:

- **STATE ID** is used to enter the beneficiary's state identification number.
- **SSN** is used to enter the beneficiary's social security number.
- A display of informational and error messages may appear at the bottom of the screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available on the BSEL Selection screen are:

ENTER=BENEFICIARY DISPLAY	Displays the BSEL Selection screen.
1=MENU	Returns you to the MMCR main menu.
12=SSNI	Returns you to the SSNI screen.
<SHIFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.

BENE = Beneficiary Information Screen

The BNE screen displays beneficiary information on the selected beneficiary. The top half of the screen displays information from the Iowa Medicaid (TXIX) system. The lower half of the screen displays information received from the Centers for Medicare and Medicaid Services (CMS).

```
BENE        CTRL:                    MEDICARE BENEFICIARY DATABASE                    DATE:  MM DD CCYY
                                          BENEFICIARY INFORMATION                     TIME:  HH MM SS
STATE ID:  XXXXXXXX
                                             TXIX INFORMATION
LNAME:  XXXXX                                                        LAST TXIX UPDATE:   MM DD CCYY
FNAME:  XXXXX                                   MI:  X     SEX:  X        BIRTH DATE:   MM DD CCYY
ADDR1:  XXXXXXXXXXXXXXXX                                                 DEATH DATE:   MM DD CCYY
ADDR2:  XXXXXXXXXXXXXXXX                                               SOC SEC NUM:   XXX XX XXXX
ADDR3:  XXXXXXXXX            XX     ZIP:  XXXXX                          CLAIM NUM:   XXXXXXXXXX

                                    FEDERAL MEDICARE INFORMATION       DATE RECVD:   MM DD CCYY
LNAME:  XXXXX
FNAME:  XXXXX                                   MI:  X     SEX:  X
ADDR1:  XXXXXXXXXXXXXXXX
ADDR2:  XXXXXXXXX    XX                                 RP PAYEE: X          BIRTH:   MM DD CCYY
ADDR3:                                                  ADDR CHNG          DEATH:   MM DD CCYY
ADDR4:                                                  MM DD CCYY           SSN:   MM DD CCYY
ADDR5:                                                                 SSA CLAIM NUM:   #########X
ADDR6:                                                  LANG:  X        RRB CLAIM:   XXXXXXX
CITY:                                                   ST: XX             ZIP:   XXXXX XXXX
KEYS 1=MENU, ENTER=ADDL INFO, 2=A&B ENTL, SHFT2=AB 3DPTY, 3=GHO, SHFT3=PKG ELE,
4=HOSPICE, 5=PTD HISTORY, 6=ADDL PTD HIST, 7=OLDER, SHFT7=OLDER T19, 8=NEWER,
SHFT8=NEWER T19, 9=SUMM, 11=BSEL, 12=SSNI, SHFT1=HELP
XXXXXXXXXXXXXXXXXXXXXX                                                                          ###
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.

TXIX (Medicaid eligibility) information:

- **LNAME** is the beneficiary's last name.
- **LAST TXIX UPDATE** is the date the beneficiary's Medicaid eligibility information was last changed on the Medicaid Eligibility system.
- **FNAME** is the beneficiary's first name.
- **MI** is the first initial of the beneficiary's middle name.
- **SEX** is the beneficiary's gender. Valid codes are:

  F Female
  M Male

- **BIRTHDATE** is the beneficiary's date of birth entered into the ABC system.
- **ADDR1-2** is the beneficiary's mailing address information.
- **DEATH DATE** is the date of the beneficiary's death.
- **SOC SEC NUM** is the beneficiary's social security number.
- **ADDR3** is the beneficiary's mailing address city and state.
- **ZIP** is the zip code for the beneficiary's mailing address.
- **CLAIM NUM** is the beneficiary's social security or Railroad Board claim number. Press <SHIFT-F1> to view additional information.

Federal Medicare Information:

- **DATE RECVD** is the date the beneficiary information was received from CMS.
- **LNAME** is the beneficiary's last name.
- **FNAME** is the beneficiary's first name.
- **MI** is the first initial of the beneficiary's middle name.
- **SEX** is the beneficiary's gender. Valid codes are:

  M OR 1 Male
  F OR 2 Female
  0 Unknown

- **ADDR1-6** is the beneficiary's mailing address information.

- **RP PAYEE** displays whether the beneficiary has designated a representative payee. Valid codes are:

Y	Yes
N or space	No

- **BIRTH** is the beneficiary's date of birth.
- **ADDR CHNG** is the date a new or corrected address becomes effective for the beneficiary.
- **DEATH** is the date of the beneficiary's death.
- **SSN** is the beneficiary's social security number.
- **SSA CLAIM NUM** is the beneficiary's social security or Railroad Board claim number. Press <SHIFT-F1> to view additional information.
- **LANG** identifies the language the beneficiary requested the Social Security Administration to use for beneficiary notices: Valid codes are:

Blank/null	English assumed.	J	Japanese
E	English requested.	N	Norwegian
C	Chinese	P	Polish
D	German	R	Russian
F	French	S	Spanish
G	Greek	V	Swedish
I	Italian	W	Serb-Croatian

- **RRB CLAIM** displays the beneficiary's Railroad Board claim number, if applicable. If no, then displays "Not RRB."
- **CITY** is the beneficiary's mailing address city.
- **STATE** is the beneficiary's mailing address state.
- **ZIP** the zip code for the beneficiary's mailing address.
- A display of informational and error messages may appear at the bottom of the screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available on the BENE screen are:

1=MENU	Returns you to the MMCR main menu.
ENTER=ADDL INFO	Moves you to the BABI screen.
2=A&B ENTL	Moves you to the BNTL screen.
SHFT2=AB 3DPTY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
SHFT3=PKG ELE	Moves you to the BPBP screen.
4=HOSPICE	Moves you to the BHSE screen.
5=PTD HISTORY	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from BPDE screen to SUMM screen.
7=OLDER	Scrolls back through federal Medicare information on BENE based on the date the information was received as shown in the DATE RECVD field.
SHFT7=OLDER T19	Scrolls back through Medicaid eligibility information on BENE based on the date information was last updated on ABC as shown in the LAST TXIX UPDATE field.
8=NEWER	Scrolls forward through Federal Medicare Information on BENE based on the date the information was received as shown in the DATE RECVD field.
SHFT8=NEWER T19	Scrolls forward through Medicaid eligibility information on BENE based on the date information was last updated on ABC as shown in the LAST TXIX UPDATE field.
9 =SUMM	Moves you to the SUMM screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
SHFT1=HELP	Allows viewing of field or screen information in a pop-up box.

BABI = Additional Beneficiary Information Screen

The BABI screen displays additional information on the beneficiary.

```
BABI                    MEDICARE BENEFICIARY DATABASE                DATE:    MM DD CCYY
                      ADDITIONAL BENEFICIARY INFORMATION             TIME:    HH MM SS
STATE ID:  XXXXXXXX                                            CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X
PRIMARY CLAIM ACCOUNT NUMBER:   XXXXXXXXX
CROSS REFERENCED CLAIM ACCOUNT NUMBERS:
XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
SOCIAL SECURITY NUMBERS:
XXX XX XXXX
RESIDENCE ADDRESS: XXXXXXXXXXXXXXXX
ADDR1:                                                          --- INCARCERATION ---
ADDR2                                                          START          END
ADDR3:                                                         MM DD CCYY     MM DD CCYY
ADDR4:
ADDR5:
ADDR6:
CITY:  XXXXXXXXXXXXXXX                          ST: XX          ZIP:    XXXXX XXXX
ADDRESS CHANGE DATE:   MM DD CCYY

KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HISTORY, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                    ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **PRIMARY CLAIM ACCOUNT NUMBER** displays the beneficiary's primary claim account number.
- **CROSS REFERENCED CLAIM ACCOUNT NUMBERS** displays an additional beneficiary claim account number associated with the beneficiary. The beneficiary's entitlement has been cross-referenced from this number to the beneficiary's active claim account number.

- **SOCIAL SECURITY NUMBERS** displays the beneficiary's social security number that was assigned by the Social Security Administration. The first occurrence is the active or most recent social security number.
- **RESIDENCE ADDRESS** displays the beneficiary's living address.
- **ADDR1–6** displays the beneficiary's mailing addresses.
- **INCARCERATION START** is the start date that a beneficiary became incarcerated. Provided solely to inform why a dual eligible is not auto-enrolled.
- **INCARCERATION END** is the date that the beneficiary's incarceration period ended. This is provided solely to explain why a dual eligible is not auto-enrolled. If the incarceration start date has a value, and the term date has not been populated in CMS' systems, the term date will be populated with nines (99 99 9999).
- **CITY** displays the beneficiary's mailing address city.
- **ST** displays the beneficiary's mailing address state.
- **ZIP** the zip code for the beneficiary's mailing address.
- **ADDRESS CHANGE DATE** displays the date a new or corrected address becomes effective for the beneficiary.
- **###** is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BABI screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from BPDE screen to the SUMM screen.

7=OLDER	Scrolls back through additional beneficiary information on BABI based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on BABI based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Remain on the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.

Press the ENTER key to move to the BNTL screen.

BNTL = Part A & B Entitlement History Screen

The BNTL Part A & B Entitlement History screen displays the beneficiary's Medicare Part A and B entitlement history.

```
BNTL                                MEDICARE BENEFICIARY DATABASE                    DATE:    MM DD CCYY
                                    PART A & B ENTITLEMENT HISTORY                   TIME:    HH MM SS
STATE ID:  XXXXXXXX                 DEATH DATE:  MM DD CCYY                CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X
      - - ENTITLEMENT CHANGES - -                        - - - - - DISABILITY INSURANCE - - - - -
      CHG REASON          DATE                             START       END              JST CD
            X           MM DD CCYY                     MM DD CCYY  MM DD CCYY          X



      PART A – PREMIUM PAYER:                          PART B – PREMIUM PAYER:
         NON-ENTITLEMENT STAT:                           NON-ENTITLEMENT STAT:
      - - - - - ENTITLEMENT PERIODS - - - - -          - - - - - ENTITLEMENT PERIODS - - - - -
      START          END          RSN    STS             START          END          RSN     STS
   MM DD CCYY     MM DD CCYY      X      X            MM DD CCYY     MM DD CCYY      X       X


KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                                  ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **ENTITLEMENT CHANGES CHG REASON** identifies the reason for the beneficiary's entitlement to Medicare benefits. Valid codes are:

  0 Beneficiary insured due to age (Old Age Survivor's Insurance -OASI)

  1 Beneficiary insured due to disability.

  2 Beneficiary insured due to end stage renal disease (ESRD).

  3 Beneficiary insured due to disability and current ESRD.
- **ENTITLEMENT CHANGES DATE** is the date the reason for entitlement was changed for a beneficiary. This is **not** the effective date of entitlement.
- **DISABILITY INSURANCE START** is the date the beneficiary covered by the Social Security Administration disability program becomes entitled to Medicare benefits.
- **DISABILITY INSURANCE END** the date that Medicare benefits due to disability end for a beneficiary who was covered by the Social Security Administration disability program. This field will be populated with zeros if the DISABILITY START date is zeros or if the disability entitlement period is open (not ended).
- **DISABILITY INSURANCE JST CD** displays the justification for a beneficiary's Part A or Part B Medicare entitlement dates based upon the beneficiary's disability insurance benefits (DIB) status. This field is blank if no disability entitlement period is found. Valid codes are:

  1 Beneficiary is entitled to Medicare coverage due to prior periods of Social Security disability entitlement.

  A Beneficiary is entitled to Medicare based upon Social Security disability and the 24 month waiting period has been waived.

  Blank Not applicable

- **PART A-PREMIUM PAYER** start is the date a beneficiary became entitled to Part A Medicare.
- **PART A-PREMIUM PAYER END** is the Medicare program entitlement termination date for a beneficiary. The last day that a beneficiary is entitled to benefits. After this day, the benefits are terminated.
- **PART A-PREMIUM PAYER RSN** is the code used by the Social Security Administration to reflect information about a specific Part A enrollment and is based upon equitable relief. (Medicare's usual business rules for the Part B start date may not be appropriate.) NOTE: This field will be blank if no entitlement period is found. Valid codes are:

A	Attainment of age 65
B	Equitable relief
D	Disability
G	General enrollment period
I	Initial enrollment period
J	MQGE entitlement
K	Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability
L	Late filing
M	Termination based on renal entitlement but entitlement based on disability continues
N	Age 65 and uninsured
P	Potentially insured beneficiary is enrolled for Medicare coverage only
Q	Quarters of coverage requirements are involved
R	Residency requirements are involved
T	Disabled working individual
U	Unknown
Blank	Not applicable

- **PART A-PREMIUM** payer **STS** is the Medicare Part A entitlement status for the beneficiary. This field will be blank if no entitlement period is found. Valid codes are:

E	Free Part A entitlement
G	Entitled due to good cause
Y	Currently entitled, premium is payable

When Part A entitlement effective date and termination date are present, the valid codes are:

C No longer entitled due to disability cessation
S Terminated, no longer entitled under ESRD provision
T Terminated for non-payment of premiums
W Voluntary withdrawal from premium coverage
X Free Part A terminated or refused health insurance

- **PART B-PREMIUM PAYER START** is the date a beneficiary became entitled to Part B Medicare benefits.

- **PART B-PREMIUM PAYER END** is the Medicare program entitlement termination date for a beneficiary. The last day that a beneficiary is entitled to benefits. After this day, the benefits are terminated.

  If this field and the entitlement start date are both populated with zeros, then no entitlement period was found. If this field is populated with zeros and the entitlement start date is a valid date, then the entitlement period is not ended.

- **PART B-PREMIUM PAYER RSN** is the code used by the Social Security Administration to reflect information about a specific Part B enrollment and is based upon equitable relief. (Medicare's usual business rules for Part B start date may not be appropriate.) NOTE: This field will be blank if no entitlement period is found. Valid codes are:

  B Equitable relief
  C Good cause
  D Deemed date of birth
  F Working aged
  G General enrollment period
  I Initial enrollment period
  K Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability
  M Termination based on renal entitlement but entitlement based on disability continues
  R Residency requirements are involved
  S State buy-in
  U Unknown

- **PART B-PREMIUM PAYER STS** is a code representing the Part B Medicare entitlement status for the beneficiary. This field will be blank if no entitlement period is found.

  When Part B entitlement effective date is present and termination date is 99999999, the valid codes are:

  G Entitled due to good cause
  Y Currently entitled, premium is payable

  When Part B entitlement effective date and termination date are present, the valid codes are:

  C No longer entitled due to disability cessation
  F Terminated due to invalid enrollment or enrollment voided
  S Terminated, no longer entitled under ESRD provision
  T Terminated for non-payment of premiums
  W Voluntary withdrawal from premium coverage

- ### is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BNTL screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Remain on the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from BPDE screen to SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on BNTL based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on BNTL based on the date the information was received as shown in the create date field.

9 = SUMM	Moves you to the SUMM screen.
10 = BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the BTPH screen.

BTPH = Part A & B Third Party History Screen

The BTPH Part A & B Third Party History screen displays the beneficiary's Part A and B third-party coverage history.

```
BTPH                                MEDICARE BENEFICIARY DATABASE                DATE:    MM DD CCYY
                                      PART A & B THIRD PARTY HISTORY             TIME:    HH MM SS
STATE ID:  XXXXXXXX                 DEATH DATE:  MM DD CCYY                CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X
      ----------- PART A -----------                          --------- PART B ---------
      START       PYR        END       BUY                    START       PYR       END            BUY
  MM DD CCYY     XXX     MM DD CCYY     X                 MM DD CCYY     XXX     MM DD CCYY       X


KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                                  ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **PART A START** is the start date of a private third-party group's or state's liability for a beneficiary's Part A premium.

- **PART A PYR** identifies the third-party agency (either a private group or state buy-in agency) responsible for paying a beneficiary's Medicare Part A premium. Valid codes are:

S01 – S99 State billing

S01	Alabama	S20	Maine	S39	Pennsylvania
S02	Alaska	S22	Massachusetts DMA	S40	Puerto Rico[1]
S03	Arizona	S2A	Massachusetts Blind	S41	Rhode Island
S04	Arkansas	S23	Michigan	S42	South Carolina
S05	California	S24	Minnesota	S43	South Dakota
S06	Colorado	S25	Mississippi	S44	Tennessee
S07	Connecticut	S26	Missouri	S45	Texas
S08	Delaware	S27	Montana	S46	Utah
S09	District of Columbia	S28	Nebraska	S47	Vermont
S10	Florida	S29	Nevada	S48	Virgin Islands[2]
S11	Georgia	S30	New Hampshire	S49	Virginia
S12	Hawaii	S31	New Jersey	S50	Washington
S13	Idaho	S32	New Mexico	S51	West Virginia
S14	Illinois	S33	New York	S52	Wisconsin
S15	Indiana	S34	North Carolina	S53	Wyoming
S16	Iowa	S35	North Dakota	S64	Northern Mariana Islands[2]
S17	Kansas	S36	Ohio	S65	Guam[2]
S18	Kentucky	S37	Oklahoma		
S19	Louisiana	S38	Oregon		
[1] Puerto Rico does not have a Buy-In agreement.					
[2] The Virgin Islands, Commonwealth of the Northern Mariana Islands, and Guam have not elected to cover QMBs.					

T01 – Z98 Private third-party billing

Z99 Conditional state group payer enrollment

- **PART A END** is the termination date of a private third-party group's or state's liability for a beneficiary's Part A premium.

- **PART A BUY** is the code that indicates the reason for Part A state buy-in eligibility. Valid codes are:

  A Aged recipient of SSI payments (CMS to state)
  B Blind recipient of SSI payments (CMS to state)
  C Entitled to Part A of Title IV (AFDC) (state to CMS)
  D Disabled recipient of SSI payments (CMS to state)
  E Aged recipient of supplemental payment administered by the Social Security Administration (CMS to state)
  F Blind recipient of supplemental payment administered by the Social Security Administration (CMS to state)
  G Disabled recipient of supplemental payment administered by the Social Security Administration (CMS to state)
  H Aged, blind, or disabled recipient of a one-time payment (OTP) (CMS to state)
  M Entitled to medical assistance only (MAO), non-cash recipient (state to CMS)
  P Qualified Medicare beneficiary (QMB)
  Z Deemed categorically needy (state to CMS)

- **PART B START** is the start date of a private third-party group's or state's liability for a beneficiary's Part B premium.

  PART B PYR identifies the third-party agency (either a private group, state buy-in agency, or the Office of Personnel Management (OPM)) responsible for paying a beneficiary's Medicare Part B premium. Valid codes are:

  Blank No bill determined
  000 Beneficiary is having Part B premium deducted from Title II check
  001 Uninsured beneficiary
  005 Insured beneficiary
  006 Program Service Center control, no bill
  007 Special age 72 enrollee
  008 PSC annual billing

010 – 650 State billing

010	Alabama	200	Maine	390	Pennsylvania
020	Alaska	220	Massachusetts DMA	400	Puerto Rico[1]
030	Arizona	22A	Massachusetts Blind	410	Rhode Island
040	Arkansas	230	Michigan	420	South Carolina
050	California	240	Minnesota	430	South Dakota
060	Colorado	250	Mississippi	440	Tennessee
070	Connecticut	260	Missouri	450	Texas
080	Delaware	270	Montana	460	Utah
090	District of Columbia	280	Nebraska	470	Vermont
100	Florida	290	Nevada	480	Virgin Islands[2]
110	Georgia	300	New Hampshire	490	Virginia
120	Hawaii	310	New Jersey	500	Washington
130	Idaho	320	New Mexico	510	West Virginia
140	Illinois	330	New York	520	Wisconsin
150	Indiana	340	North Carolina	530	Wyoming
160	Iowa	350	North Dakota	640	Northern Mariana Islnds[2]
170	Kansas	360	Ohio	650	Guam[2]
180	Kentucky	370	Oklahoma		
190	Louisiana	380	Oregon		
[1] Puerto Rico does not have a Buy-In agreement.					
[2] The Virgin Islands, Commonwealth of the Northern Mariana Islands, and Guam have not elected to cover QMBs.					

700 Office of Personnel Management (OPM)

A01 – R99 Group payers for Part B premiums

- **PART B END** is the last date of a private third-party group's or state's liability for a beneficiary's Part B premium.
- **PART B BUY** is the code that indicates the reason for Part B state buy-in eligibility. Valid codes are:

  A Aged recipient of SSI payments (CMS to state)

  B Blind recipient of SSI payments (CMS to state)

  C Entitled to Part A of Title IV (AFDC) (state to CMS)

  D Disabled recipient of SSI payments (CMS to state)

  E Aged recipient of supplemental payment administered by the Social Security Administration (CMS to state)

  F Blind recipient of supplemental payment administered by the Social Security Administration (CMS to state)

  G Disabled recipient of supplemental payment administered by the Social Security Administration (CMS to state)

  H Aged, blind, or disabled recipient of a one-time payment (OTP) (CMS to state)

  M Entitled to medical assistance only (MAO), non-cash recipient (state to CMS)

  P Qualified Medicare beneficiary (QMB)

  Z Deemed categorically needy (state to CMS)
- ### is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BTPH screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Remains on the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from BPDE screen to SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on BTPH based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on BTPH based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the BPBP screen.

BPBP = Plan Benefits Package Elections Screen

The BPBP Plan Benefits Package Elections screen displays the beneficiary's plan benefits package elections.

```
BPBP                          MEDICARE BENEFICIARY DATABASE          DATE:    MM DD CCYY
                            PLAN BENEFITS PACKAGE ELECTIONS          TIME:    HH MM SS
STATE ID:  XXXXXXXX           DEATH DATE:  MM DD CCYY        CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X

                ENROLL DATE    START DATE    END DATE     NUM     COVG
                MM DD CCYY     MM DD CCYY    MM DD CCYY   XXX      XX     X

KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                    ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **ENROLL DATE** is the date the beneficiary enrolled in the service elections.
- **START DATE** is the date the plan benefits package (PBP) election started.
- **END DATE** is the date the plan benefits package (PBP) election ended.
- **NUM** is a unique identifier for the managed care benefit package.
- **COVG** identifies the type of managed care enrollment code or fee-for-service period. Valid codes are:

  3 Coordinated care plan (CCP)
  6 Program of all-inclusive care for the elderly (PACE)
  8 Demonstration (DEMO)
  5 Private fee for service (PFFS)
  9 Fee for service (FFS)
  10 Cost/HCPPCOST/health care prepayment plan
  11 PDP election

- ### is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BPBP screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Remains on the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from the BPDE screen to the SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on the BPBP screen based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on the BPBP screen based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the BGHO screen.

BGHO = Group Health Organization Screen

The BGHO Group Health Organization screen displays the beneficiary's group health organization information.

```
BGHO                          MEDICARE BENEFICIARY DATABASE          DATE:    MM DD CCYY
                                GROUP HEALTH ORGANIZATION            TIME:    HH MM SS
STATE ID:  XXXXXXXX           DEATH DATE:  MM DD CCYY          CREATE DATE:   MM DD CCYY
NAME:  XXXXXXX, XXXXXX X


   START        END        CONTRACT    SNP        START        END        CONTRACT     SNP
MM DD CCYY   MM DD CCYY    XXXXX       X       MM DD CCYY   MM DD CCYY    XXXXX        X

KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                    ###
XXXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **START** is the date the beneficiary enrolled in the service elections.
- **END** is the date the beneficiary disenrolled in the service elections.
- **CONTRACT** is a unique identification for an agreement between CMS and a managed care organization (MCO) enabling the MCO to provide Medicare + Choice coverage to eligible beneficiaries. This field is blank only if neither Medicare Part C nor Medicare Part D enrollment has been found.

  NOTE: Use <Shift – F1> to view more information regarding the contract number and types of plans.
- **SNP** relates to the beneficiary's group health organization contract number (special-needs plan). Valid codes are:

  Y Special-needs plan
  N Not a special-needs plan

- ### is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BGHO screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Remains on the BGHO screen.
<SHFT-3>=PKG ELECT	Remains on the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from the BPDE screen to the SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on the BGHO screen based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on the BGHO screen based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the BHSE screen.

BHSE = Hospice/ESRD Screen

The BHSE Hospice/ESRD screen displays information regarding hospice coverage and coverage, dialysis, and transplant information on end stage renal disease (ESRD).

```
BHSE                                MEDICARE BENEFICIARY DATABASE                DATE:    MM DD CCYY
                                          HOSPICE/ESRD                           TIME:    HH MM SS
STATE ID:  XXXXXXXX            DEATH DATE:  MM DD CCYY                   CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X

      - - HOSPICE COVERAGE - -
         START          END
    MM DD CCYY     MM DD CCYY



- - - - - - - - - - - - - - - - - - - - - - - - - - - - - END STAGE RENAL DISEASE - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
- - - - - - - - COVERAGE - - - - - - - -          - - - - - - - - DIALYSIS - - - - - - - -          - - - - - TRANSPLANT - - - - -
      START          END        RSN    START                END                START          END
   MM DD CCYY     MM DD CCYY     X     MM DD CCYY     MM DD CCYY         MM DD CCYY     MM DD CCYY


KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                                  ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **HOSPICE COVERAGE START** is the elected start date of a beneficiary's period of hospice coverage.
- **HOSPICE COVERAGE END** is the termination date of a beneficiary's period of hospice coverage.
- **ESRD COVERAGE START** is the date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of ESRD.

- **ESRD COVERAGE END** is the date on which the beneficiary is no longer entitled to Medicare under ESRD provisions.
- **ESRD COVERAGE RSN** is a code indicating the reason Medicare-based end stage renal disease coverage was terminated. Valid codes are:

  A Month of transplant plus 36 months
  B Last month of chronic dialysis
  C Part A termination
  D Death
  E ESRD ended

- **ESRD DIALYSIS START** is the date indicating when ESRD dialysis started.
- **ESRD DIALYSIS END** is the date indicating when ESRD dialysis ended.
- **ESRD TRANSPLANT START** is the date indicating when a kidney transplant operation occurred.
- **ESRD TRANSPLANT END** is the date indicating when a kidney transplant failed.
- ### is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BHSE screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Remain on the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Remains on the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from the BPDE screen to the SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on the BHSE screen based on the date the information was received as shown in the CREATE DATE field.

8=NEWER	Scrolls forward through additional beneficiary information on the BHSE screen based on the date the information was received as shown in the create date field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the BPDH screen.

BPDH = Part D History Screen

The BPDH Part D History screen displays the beneficiary's Medicare Part D history.

```
BDPH                                MEDICARE BENEFICIARY DATABASE                DATE:    MM DD CCYY
                                          PART D HISTORY                         TIME:    HH MM SS
STATE ID:  XXXXXXXX                 DEATH DATE:  MM DD CCYY                CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X
          FIRST ELIGIBILITY DATE:  MM DD CCYY                    AFFIRMATIVELY DECLINE:

    PART D ORG NAME:    XXXXXXX
```

- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **FIRST ELIGIBILITY DATE** is the first date on which a beneficiary became eligible for Medicare Part D, whether or not enrolled on a Medicare Part D plan.
- **AFFIRMATIVELY DECLINE** indicates whether or not a beneficiary has chosen not to be automatically enrolled in a Medicare Part D plan. Valid codes are:

  Y Yes
  N No (may be blank)

  Currently, the system is programmed to populate this field to "N" by default, so the beneficiary will automatically be enrolled. When a beneficiary contacts the Part D plan the beneficiary is enrolled in or calls CMS at 1-800-MEDICARE to affirmatively decline enrollment into Part D, the indicator is set to "Y" and is left that way.

  Beneficiaries who affirmatively decline automatic enrollment may enroll on their own voluntarily or may choose not to enroll. This indicator explains to states why a full-benefit dual eligible does not have a Part D plan (i.e. declined to be auto-enrolled and did not enroll on their own).

  If a beneficiary has an indicator of "Y" and no Part D plan enrollment, then the state can conclude that the beneficiary has affirmatively declined. If the indicator is set to "Y," but there is Part D enrollment, the state can conclude the beneficiary decided to enroll in a plan voluntarily.

  To re-enroll, the beneficiary needs only to enroll with a Part D plan, as this indicator does not prevent voluntary enrollment. The indicator **will not** be set back to "N."
- **PART D ORG NAME** is the name of the Part D organization in the first occurrence of beneficiary's Part D plan benefit package contract number.
- **PART D PLAN NAME** is the name of the Part D plan in the first occurrence of beneficiary's Part D plan benefit package contract number.
- **PART D PLAN HISTORY START** is the effective date that the beneficiary was enrolled in the service elections (PBP).

  For Medicare Part C plans that offer Part D (e.g. Medicare Advantage MA-PD), the beginning date of enrollment in the Part C plan may be earlier than January 1, 2006, which was the start of the Medicare Part D program.

- **PART D PLAN HISTORY END** is the end date of the beneficiary's enrollment in the service elections (PBP).
- **PART D PLAN HISTORY CONTR** is the unique identification for an agreement between CMS and a managed care organization (MCO) enabling the MCO to provide Medicare + Choice Coverage to eligible beneficiaries. This field will be populated with space only if neither Medicare Part C nor Medicare Part D enrollment has been found.

  NOTE: Use <Shift–F1> to view more information regarding the contract number and types of plans.
- **PART D PLAN HISTORY PLN** is a unique identifier for the managed care benefit package. For Medicare Part D, this number identifies an agreement between CMS and a Medicare Part D provider, enabling the Medicare Part D provider to provide prescription drug coverage to eligible beneficiaries.
- **PART D PLAN HISTORY TYP** is an indicator providing the type of enrollment performed. Valid codes are:

A	Part D automatic enrollment by CMS
B	Beneficiary election
C	Part D facilitated enrollment by CMS
D	System-generated enrollment (rollover)
E	Plan-submitted automatic enrollments
F	Plan-submitted facilitated enrollments
G	Point-of-sale (POS) submitted enrollments
H	CMS-submitted or plan-submitted re-assignment enrollments
I	Assigned to plan; submitted transactions with enrollment source other than any of the following: B, E, F, G, H, and blank
Blank	Valid value
- **CO-PAY HISTORY START** is the effective date of the copayment period.
- **CO-PAY HISTORY END** is the end date of the copayment period.
- **CO-PAY HISTORY LIS** indicates whether the beneficiary was determined eligible for low-income subsidy or deemed eligible. Valid codes are:

L	Low-income subsidy (LIS)
D	Deemed

- **CO-PAY HISTORY SRC** indicates the source of the LIS/deeming action.

  Valid codes for deemed (D) are:

  01 MBD third-party
  02 EEVS (state data in baseline)
  03 Social Security Administration
  04 State
  05 Deemed source is contingency contractor
  06 CMS user

  Valid codes for low-income subsidy (L) are:

  SS Social Security Administration
  <ST> State code abbreviation

- **CO-PAY HISTORY LVL** indicates the level of copayment granted to the beneficiary.

  If LIS type is **L**, the valid codes are:

  1 High
  4 15%

  If LIS type is **D**, the valid codes are:

  1 High
  2 Low
  3 0 (zero)

- **CO-PAY HISTORY AMT** is the LIS premium subsidy amount. If the information in the copayment history is deemed information, the default for subsidy is 100%. Valid codes are:

  100 100%
  075 75 %
  050 50 %
  025 25 %

- ### is a three-digit program code used by the Division of Data Management.

- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BPDH screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Remain on the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from the BPDE screen to the SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on the BPDH screen based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on the BPDH screen based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL Selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the BPDE screen.

BPDE = Additional Part D History Screen

The BPDE screen displays the beneficiary's additional Medicare Part D history.

```
BPDE                                MEDICARE BENEFICIARY DATABASE                DATE:    MM DD CCYY
                                      ADDITIONAL PART D HISTORY                  TIME:    HH MM SS
STATE ID:  XXXXXXXX                 DEATH DATE:  MM DD CCYY                CREATE DATE:    MM DD CCYY
NAME:  XXXXXXX, XXXXXX X

          PART D ELIGIBILITY DATES                          RDS  (RETIREE DRUG SUBSIDY)  PERIODS
            START            END                                   START            END
          MM DD CCYY      MM DD CCYY                          MM DD CCYY      MM DD CCYY


KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                                  ###
XXXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **PART D ELIGIBILITY START** indicates the start date for the most recent Part D eligibility span.
- **PART D ELIGIBILITY END** indicates the end date for the most recent Part D eligibility span.
- **RDS START** is the start date of the employer plan period for the beneficiary.
- **RDS END** is the end date of the employer plan period for the beneficiary.
- **###** is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the BPDE screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the SUMM screen. Press again to return to the BPDE screen.
7=OLDER	Scrolls back through additional beneficiary information on the BPDE screen based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on the BPDE screen based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Moves you to the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Allows viewing of field or screen information in a pop-up box.
ENTER=ADDL INFO	Moves you to the SUMM screen.

SUMM = Enrollment Summary Screen

The SUMM Enrollment Summary screen displays a 24-month summary of the beneficiary's enrollment in a Medicare Part A, Part B, or Part D plan benefits package.

```
SUMM                          MEDICARE BENEFICIARY DATABASE          DATE:   MM DD CCYY
                                   ENROLLMENT SUMMARY                TIME:   HH MM SS
STATE ID:  XXXXXXXX           DEATH DATE:  MM DD CCYY        CREATE DATE:   MM DD CCYY
NAME:  XXXXXXX, XXXXXX X

 ENRL MO    PART A    PART B    PART D    ENRL MO    PART A    PART B    PART D
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X
 MM CCYY      X         X         X       MM CCYY      X         X         X

KEYS 1=MAIN MENU, 2=A&B ENTITLEMENT HIST, <SHFT-2>=A&B 3RD PTY HISTORY, 3=GHO,
<SHFT-3>=PKG ELECT, 4=HOSP/ESRD, 5=PTD HIST, 6=ADDL PTD HIST, 7=OLDER, 8=NEWER,
9=SUMM, 10=BENE, <SHFT-10>=ADDL BENE, 11=BSEL, 12=SSNI, <SHFT-F1>=HELP                ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.
- **DEATH DATE** is the date of the beneficiary's death.
- **CREATE DATE** is the date the beneficiary information was received from CMS.
- **NAME** is the beneficiary's name displayed last name, first name, and middle name initial.
- **ENRL MO** is the benefit period month.
- **PART A, B, D** is the code indicating whether or not the beneficiary was enrolled in a Part A, Part B, or Part D benefit plan during the enrollment month. Valid codes are:

  Y Yes
  N No

- ### is a three-digit program code used by the Division of Data Management.
- A display of informational and error messages may appear at the bottom of the screen.

The function keys available on the SUMM screen are:

1=MAIN MENU	Returns you to the MMCR main menu.
2=A&B ENTITLEMENT HIST	Moves you to the BNTL screen.
<SHFT-2>=A&B 3RD PTY HISTORY	Moves you to the BTPH screen.
3=GHO	Moves you to the BGHO screen.
<SHFT-3>=PKG ELECT	Moves you to the BPBP screen.
4=HOSP/ESRD	Moves you to the BHSE screen.
5=PTD HIST	Moves you to the BPDH screen.
6=ADDL PTD HIST	Moves you to the BPDE screen. Press again to move from the BPDE screen to the SUMM screen.
7=OLDER	Scrolls back through additional beneficiary information on the SUMM screen based on the date the information was received as shown in the CREATE DATE field.
8=NEWER	Scrolls forward through additional beneficiary information on the SUMM screen based on the date the information was received as shown in the CREATE DATE field.
9=SUMM	Remain on the SUMM screen.
10=BENE	Moves you to the BENE screen.
<SHFT-10>=ADDL BENE	Moves you to the BABI screen.
11=BSEL	Returns you to the BSEL selection screen.
12=SSNI	Returns you to the SSNI screen.
<SHFT-F1>=HELP	Disabled on this screen.
ENTER=ADDL INFO	Moves you to the BENE screen.

SRCV = DHS/CMS Data Comparison Screen

The SRCV DHS/CMS Data Comparison screen was developed to display a comparison of beneficiary information currently stored on the Medicaid Eligibility system along with the beneficiary information DHS sends to and receives from CMS.

```
SRCV                    IOWA DEPARTMENT OF HUMAN SERVICES        DATE:  MM DD CCYY
                          MEDICARE BENEFICIARY DATABASE          TIME:  HH MM SS
                           DHS/CMS DATA COMPARISON

STATE ID:  XXXXXXXX

DATA        LAST NAME/                          DATE OF     SSN/        DATE LAST
SOURCE      FIRST NAME                  SEX     BIRTH       CLAIM 3      ACTION

CURR T19 | XXXXXXXXX                    X     MM DD CCYY   XXX-XX-XXXX   MM DD CCYY
 DATA    | XXXXXXXXX                                      XXXXXXXXXX

DHS TO   | XXXXXXXXX                    X     MM DD CCYY   XXX-XX-XXXX   MM DD CCYY
CMS      | XXXXXXXXX                                      XXXXXXXXXX

CMS TO   | XXXXXXXXX                    X     MM DD CCYY   XXX-XX-XXXX   MM DD CCYY
DHS      | XXXXXXXXX                                      XXXXXXXXXX

KEYS 1=MAIN 10=BENEFICIARY INFORMATION                                          ###
XXXXXXXXXXXXXXXXXXXXXX
```

Screen field descriptions:

- **STATE ID** is the beneficiary's state identification number.

Data Source: Current T19 Data:

- **LAST NAME** is the beneficiary's last name as entered into the ABC system.
- **FIRST NAME** is the beneficiary's first name in the ABC system .
- **SEX** is the beneficiary's gender in the ABC system. Valid codes are:

  M Male
  F Female

- **DATE OF BIRTH** is the beneficiary's date of birth entered into the ABC system.
- **SSN/CLAIM #** is the beneficiary's social security number **and** the beneficiary's social security or Railroad Board claim number as entered into the ABC system.
- **DATE LAST ACTION** is the date the beneficiary information was last updated on the ABC system.

Data Source: DHS to CMS:

- **LAST NAME** is the beneficiary's last name as sent to CMS.
- **FIRST NAME** is the beneficiary's first name as sent to CMS .
- **SEX** is the beneficiary's gender as sent to CMS. Valid codes are:

  M or 1 Male
  F or 2 Female

- **DATE OF BIRTH** is the beneficiary's date of birth as sent to CMS.
- **SSN/CLAIM #** is the beneficiary's social security number **and** social security or Railroad Board claim number as sent to CMS.
- **DATE LAST ACTION** is the date the beneficiary information was last sent to CMS.

Data Source: CMS to DHS:

- **LAST NAME** is the beneficiary's last name as received from CMS.
- **FIRST NAME** is the beneficiary's first name as received from CMS.
- **SEX** is the beneficiary's gender as received from CMS. Valid codes are:

  M or 1 Male
  F or 2 Female
  0 Unknown

- **DATE OF BIRTH** is the beneficiary's date of birth as received from CMS.
- **SSN/CLAIM #** is the beneficiary's social security number **and** social security or Railroad Board claim number as received from CMS.
- **DATE LAST ACTION** is the date the beneficiary information was last received from CMS.
- A display of informational and error messages may appear at the bottom of the screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available on the SUMM screen are:

1 = MAIN	Returns you to the MMCR main menu.
10 = BENEFICIARY INFORMATION	Moves you to the BENE screen.

PTDE = Part D Enrollment Information Screen

The PTDE Part D Enrollment Information screen was developed to display information on a beneficiary's enrollment in a Medicare Part D plan and eligibility for Extra Help. Only Medicaid beneficiaries with Part D coverage appear on this screen.

DHS sends a tape of all Medicare and Medicaid dual-eligible beneficiaries to CMS monthly. CMS automatically enrolls these persons into Medicare Part D plans and establishes eligibility for Extra Help. Once these tasks are completed, CMS returns the information to the Department.

The PTDE screen can be accessed in the following ways:

- From the SSNI TXIX Inquiry screens (pages 1 & 2) by pressing the PF10 key.
- From the MMCR Main Menu by placing an "X" in the PTDE field and pressing the ENTER key.
- From the MMCR Main Menu by typing "PTDE" in the NEXT SCREEN field and pressing the ENTER key.

```
PTDE                                    PART D ENROLLMENT INFORMATION
 SSN:    XXXXXXXXX        STATE ID:    XXXXXXXX                                  CREATE DATE:    MM DD CCYY
TXIX INFORMATION      CLAIM NUMBER:    XXXXXXXXXX            DOB:    MM DD CCYY        SSN:    XXX XX XXXX
FIRST NAME:    XXXXXXX    INITIAL:  X    LAST NAME:      XXXXXXX                          SEX:    X

CMS INFORMATION       CLAIM NUMBER:    XXXXXXXXXX            DOB:    MM DD CCYY      DOD:    MM DD CCYY
FIRST NAME:    XXXXXXX                    INITIAL:  X     LAST NAME:    XXXXXXX                        SEX:    X
  MAIL ADDR:    XXXXXXXXXXXXXXXX                                          REP PAYEE – SS CASH BEN:    X
                XXXXXXXXXX  XX                                            CLAIM NUM:    XXXXXXXXXX
        CITY:   XXXXXXXXXXXX                                            ST:    XX       ZIP:    XXXXX XXXX
XREF CLAIM NUMBERS:      XXXXXXXXXX

     ALTERNATE SSNS:      XXX XX XXXX

     PART D INFORMATION                                    CO-PAYMENT HISTORY
       FIRST ELIGIBLE DATE:    MM DD CCYY                          LIS TYPE:    XXXXXX
     AFFIRMATIVE DECLINE:    X                                CO-PAYMENT LEVEL    XXXX
 ENROLLMENT START DATE:    MM DD CCYY                    CO-PAYMENT START DATE:    MM DD CCYY
   ENROLLMENT END DATE:    MM DD CCYY                      CO-PAYMENT END DATE:    MM DD CCYY
       CONTRACT NUMBER:    XXXXX   XXXXXXXXXXXXXXXXX
                PLAN ID:    XXX   XXXXXXXXXXXXXXXXXXX
        ENROLLMENT TYPE:
                                                                                        F10 - SSNI
XXXXXXXXXXXXXXXXXXXXXXX                                                                                  ###
```

On the PTDE screen, type the social security number or state ID, if applicable, in the appropriate field and press the ENTER key to view Part D information.

If the beneficiary is not enrolled in a Part D plan, the following message will appear at the bottom of the screen: "No Part-D information found for this State ID."

The screen is divided into the following sections and fields:

- The query section is used to search for Part D enrollment information on a beneficiary by entering the person's social security number or state identification number. The section fields are:
  - **SSN:** Enter the beneficiary's social security number and press ENTER if not displayed.
  - **STATE ID:** Enter the beneficiary's state identification number and press ENTER if not displayed.
  - **CREATE DATE:** Displays the date the information was last updated.
- The TXIX Information section displays the information the Department sent to CMS. The fields are:
  - **CLAIM NUMBER:** Displays the beneficiary's social security claim number.
  - **DOB:** Displays the beneficiary's date of birth.
  - **SSN:** Displays the beneficiary's social security number.
  - **FIRST NAME:** Displays the beneficiary's first name.
  - **INITIAL:** Displays the first letter of the beneficiary's middle name, if applicable.
  - **LAST NAME:** Displays the beneficiary's last name.
  - **SEX:** Displays the beneficiary's gender.
- The CMS Information section displays the information CMS sent back to the Department. The fields are:
  - **CLAIM NUMBER:** Displays the beneficiary's social security or Railroad Board claim number.
  - **DOB:** Displays the beneficiary's date of birth.
  - **DOD:** Displays the beneficiary's date of death.

- **FIRST NAME:** Displays the beneficiary's first name.
- **INITIAL:** Displays the first letter of the beneficiary's middle name, if applicable.
- **LAST NAME:** Displays the beneficiary's last name.
- **SEX:** Displays the beneficiary's gender.
- **MAIL ADDR:** Displays the beneficiary's mailing address.
- **REP PAYEE / SS CASH BEN:** Displays a code indicating whether the beneficiary has a representative payee or is receiving social security benefits. Valid codes are:

Y	Yes
N or space	No

- **CITY:** Displays the beneficiary's mailing address city.
- **STATE:** Displays the beneficiary's mailing address state.
- **ZIP CODE:** Displays the nine-digit zip code for the beneficiary's mailing address.
- **XREF CLAIM NUMBERS:** Displays the cross-reference claim number, if applicable.
- **ALTERNATE SSNS:** Displays any alternate social security numbers, if applicable.

♦ The Part D Information section appears on the bottom left section of the screen and displays the Part D enrollment and Extra Help information. The fields are:

- **FIRST ELIGIBLE DATE:** Displays the date the beneficiary was first eligible for Medicare Part D, regardless of whether or not the beneficiary was enrolled in Part D plan.
- **AFFIRMATIVE DECLINE:** Indicates whether or not a beneficiary has chosen not to be auto-enrolled by CMS in a Medicare Part D plan. Valid codes are:

Y	Yes
N	No (may be blank)

Currently, the system is programmed to default populate this field to "N," so the beneficiary would be auto-enrolled. When a beneficiary contacts the Part D plan the beneficiary is enrolled in or calls CMS at 1-800-MEDICARE to affirmatively decline enrollment into Part D, the indicator is set to "Y" and is left that way. The beneficiary will not be automatically enrolled.

Beneficiaries who affirmatively decline auto-enrollment may enroll on their own voluntarily or may choose not to enroll. This indicator explains to states why a full-benefit dual eligible does not have a Part D plan (i.e. declined to be automatically enrolled and did not enroll voluntarily).

If a beneficiary has an indicator of "Y" and no Part D plan enrollment, then the state can conclude that the beneficiary has affirmatively declined. If the indicator is set to "Y," but there is Part D enrollment, the state can conclude the beneficiary decided to enroll in a plan voluntarily.

To re-enroll, a beneficiary needs only to enroll with a Part D plan, as this indicator in no way prevents voluntary enrollment. The indicator **will not** be set back to "N."

- **ENROLLMENT START DATE:** Displays the start date for the beneficiary's enrollment in a Part D plan.
- **ENROLLMENT END DATE:** Displays the end date for the beneficiary's enrollment in a Part D plan. If no end date is known, the system will display 99/99/9999.
- **CONTRACT NUMBER:** Displays the number and name of the Part D plan contractor.
- **PLAN ID:** Displays the benefit package identifier.
- **ENROLLMENT TYPE:** This entry indicates the type of enrollment. Valid entries are:

Auto	Indicates a full Medicaid benefit beneficiary that was automatically enrolled in a Part D plan.
Beneficiary election	Indicates the beneficiary chose a Part D plan.
Facilitated	Indicates enrollment into a Part D plan for those beneficiaries not eligible for full Medicaid, but are eligible for the Extra Help.
System-generated (rollover)	Indicates annual rollover from previous Part D enrollment.

- CO-PAYMENT HISTORY section appears on the bottom right portion of the screen and displays the beneficiary's co-payment information. The fields are:
  - **LIS TYPE:** This entry indicates whether the beneficiary was determined eligible for Extra Help or deemed eligible. Valid entries are:

    Deemed — Indicates the beneficiary is deemed eligible for Extra Help because the person is:
    - Dually eligible for Medicare and Medicaid, or
    - On a Medicare savings program.

    LIS — Indicates the state or Social Security Administration determined the beneficiary's eligibility for Extra Help.
  - **CO-PAYMENT LEVEL:** Displays the beneficiary's co-pay level. Valid entries are:

    High — Highest copayment amount.

    Low — Lower copayment amount.

    Zero — No copayment. These are people that are dually eligible and living in an institution.

    15% — The lesser of 15% or the copayment cost.
  - **CO-PAYMENT START DATE:** Displays the effective date of the copayment level.
  - **CO-PAYMENT END DATE:** DIsplays the date the copayment level is no longer effective.
  - A display of informational and error messages may appear at the bottom of the screen.
  - ### is a three-digit program code used by the Division of Data Management

The function key available on the PTDE screen is:

F10 = SSNI — Returns you to SSNI screen.

PREM (MEPD) Billing Screens

The following sections explain:

- The Premium System Main Menu
- The MEPD = MEPD Coverage Group menu screen
- The PREF = Unprocessed Payments/Refunds screen
- The RETR = Retro Eligibility screen

Premium System Main Menu Screen

The Premium System Main Menu shows a list of the available screens.

```
                    DEPARTMENT OF HUMAN SERVICES                DATE: MM/DD/YY
                       PREMIUM SYSTEM MAIN MENU

                X   MEPD     MEPD COVERAGE GROUP MENU
                X   PREF     UNPROCESSED PAYMENTS/REFUNDS
                X   RETR     RETRO ELIGIBILITY

NEXT SCREEN XXXX                      PF12=SSNI, CLEAR=QUIT
```

The Premium System Main Menu can be accessed the following ways:

- From a blank screen, enter "MEPD."
- From the SSNI Selection menu, press the PF12 key.
- From the MEPD Coverage Group menu, PREF, or RETR screen, press the PF1 key.

Place an 'X' in front of the screen you wish to view **or** enter the screen name "MEPD," "PREF," or "RETR" in the NEXT SCREEN field and press the ENTER key.

Screen field descriptions:

- **MEPD** is the field to access the MEPD menu screen.
- **PREF** is the field to access the PREF screen.
- **RETR** is the field to access the RETR screen.
- **NEXT SCREEN** is the field to move you to another screen in the MEPD system.

The function keys available are:

PF12=SSNI	Returns to the SSNI Selection Menu.
CLEAR=QUIT	Exits the Premium System Main Menu.

MEPD = MEPD Coverage Group Menu Screen

The MEPD Coverage Group Menu shows a list of the available MEPD screens.

```
                    DEPARTMENT OF HUMAN SERVICES                DATE: MM/DD/YY
                      MEPD COVERAGE GROUP MENU


                  X   SUMM     SUMMARY
                  X   DETL     STATEMENT DETAIL
                  X   STMT     BILLING STATEMENT
                  X   MOAK     MONTHLY SUMMARY COUNTS
                  X   PVAL     MONTHLY VALID PREMIUMS



NEXT SCREEN XXXX      PF1=RETURN TO MAIN MENU, PF12=SSNI, CLEAR=QUIT
```

The MEPD Coverage Group Menu can be accessed the following ways:

- From the PREMIUM SYSTEM MENU, place an 'X' by the MEPD field and press the ENTER key.
- From any of the MEPD screens, type "MEPD" in the NEXT SCREEN field and press the ENTER key.
- From any of the MEPD screens, press the PF1 key.

Place an 'X' in front of the screen you wish to view **or** enter the screen name "SUMM," "DETL," "STMT," "MOAK," or "PVAL" in the NEXT SCREEN field and press the ENTER key.

Screen field descriptions:

- **SUMM** is the field to access the SUMM screen.
- **DETL** is the field to access the DETL screen.
- **STMT** is the field to access the STMT screen.
- **MOAK** is the field to access the MOAK screen.
- **PVAL** is the field to access the PVAL screen.
- **NEXT SCREEN** is the field to move to another screen name in the MEPD system.

The function keys available are:

PF1=RETURN TO MAIN MENU	Returns to the Premium System Main Menu.
PF12=SSNI	Returns to the SSNI Selection Menu.
CLEAR=QUIT	Exits the Premium System Main Menu.

SUMM = MEPD Summary Screen

The SUMM screen shows a summary for each month which includes the premium amount, the amount applied, and the last activity date. The SUMM screen can be accessed the following ways:

- From the MEPD MENU by placing an 'X' by the SUMM field and pressing the ENTER key.
- From any MEPD screen by typing SUMM in the NEXT SCREEN field and pressing the ENTER key.
- From the DETL screen by pressing the PF5 key.
- From the PREF screen by pressing the PF6 key.

```
SUMM                                DEPARTMENT OF HUMAN SERVICES        DATE: 04/04/02
                                          MEPD SUMMARY                  TIME: 09:10:23
STATE ID:                                CASE #:                   LAST NAME, FIRST NAME
CREDIT:                     OWES:        WORKER: XXXX              CNTY: XXX
                            PREM   DUE          AMOUNT     AMOUNT     DATE       REFUND
     DATE    ELIG           AMT    DATE         RECEIVED   APPLIED    APPLIED    AMOUNT
     mm/yy   X              xxx.xx mm/dd/ccyy     xxx.xx     xxx.xx     mm/dd/ccyy xxx.xx

NEXT SCREEN _________ PF5=DETL,   PF6 = PREF,   PF7=PG BACK,   PF8=PG FORWARD
                                                                            821
```

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **CASE #** is the person's MEPD case number and the person's last and first name.
- **CREDIT** is the dollar amount that has not been applied to pay a monthly premium to the person's state identification number.

- **OWES** is the dollar amount the person owes under the state identification number.
- **WORKER** is the identifying number assigned to the income maintenance worker.
- **CNTY** is the county number assigned to the income maintenance worker.
- **DATE** is the month and the year for the summary.
- **ELIG** is the field that shows the eligibility for MEPD.

  Valid active codes are:

  B Month has been blocked
  Y Month of MEPD eligibility ($0 premium or paid premium)
  P Month of potential MEPD eligibility (unpaid premium)

  Valid inactive codes are:

  N No MEPD activity.
  X Terminated months at conversion of initial MEPD system.
  M Month has reached maximum due date. The system cannot apply a payment to this month.
  O Member became eligible for another full coverage group for the month.
  R Retroactive entry. It takes two days after the date retroactive eligibility is entered on the RETR screen for the eligibility to show as "Y" or "P."
- **PREM AMT** is the current dollar amount for the premium for the month and year.
- **DUE DATE** is the due date for the premium payment. NOTE: The DETL screen displays the date the payment was received by DHS.
- **AMOUNT RECEIVED** is the total dollar amount of the payments received in this month.
- **AMOUNT APPLIED** displays the amount paid. Only full payment amounts are listed. Partial payments are held in credit.
- **DATE APPLIED** is the date the premium payment is entered on the system.
- **REFUND AMOUNT** is the dollar amount of the refunds in the month and year shown. NOTE: A payment reversal is also shown in this field.
- **NEXT SCREEN** is the field that you enter the one of the four-character names on the MEPD menu to go to another MEPD screen.

- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF01=MENU	Returns to the MEPD Coverage Group Menu. (Not shown)
PF05=DETL	Transfers to the DETL screen
PF06=PREF	Transfers to the PREF screen.
PF07=PG BACK	Scrolls backward to other SUMM screens.
PF08=PG FORW	Scrolls forward to other SUMM screens.

DETL = MEPD Detail

The DETL screen shows detailed information for a state identification number for the specified month and year. You can access DETL in the following ways:

- From the MEPD MENU, place an 'X' by DETL field and press the ENTER key,
- From any MEPD screen, type "DETL" in the NEXT SCREEN field and press the ENTER key.
- From the SUMM screen, place the cursor on a detail line, and press the PF5 key.

```
DETL                                DEPARTMENT OF HUMAN SERVICES        DATE:  99/99/99
                                              MEPD DETAIL                TIME:  99:99:99
STATE ID: xxxxxxxx                  MM/YY 99 99   CASE #: xxxxxxxxxx xxxxxxxxxxxxxxxxxxxx
                                                            MO BALANCE.......:999999.99
                                                            INIT PREM............:999.99
TRANS        TRANS       TRANS       B/U                    CURR PREM.........: 999.99
TYPE         DATE        AMOUNT      x                      MAX DUE DATE...: 99/99/9999
xxxxxxxxxx   99/99/9999  999999.00   x                      NXT MTH PREM...: 9.99
xxxxxxxxxx   99/99/9999  999999.00   x                      WORKER.....:  XXXX
xxxxxxxxxx   99/99/9999  999999.00   x                      COUNTY.......:  99
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x
xxxxxxxxxx   99/99/9999  999999.00   x

NEXT SCREEN   xxxx   PF5=SUMM, PF7=PG UP, PF8=PG DN, PF10-PRI  MNTH, PF11=NXT MNTH
                                                                                  820
```

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **MM/YY** is the month and year of the MEPD detail information.
- **CASE #** is the member's MEPD case number and last and first name.
- **MO BALANCE** is the net dollar amount of the balance for the month and year listed.
- **INIT PREM** is the dollar amount of the original premium for the month and year.
- **CURR PREM** is the dollar amount of the current premium for the month and year.
- **MAX DUE DATE** is the last date that a payment can be applied to the specified month. This is three months beyond the due date for ongoing premiums.
- **NXT MTH PREM** is the dollar amount of the premium for the next system month.
- **WORKER** is the unique identifying number assigned to the income maintenance worker.
- **COUNTY** is the county number assigned to the income maintenance worker.
- **TRANS TYPE** is the description for the type of transaction that takes place for the specified month and year. Valid types of transactions are:

FUTUR PREM	The MEPD system will process the premium amount for the next system month.
DEMOGR CHG	A change processed in MEPD system is for name, case number, or worker number.
PREMIUM	MEPD has received the premium from the ABC system.
MEDID	The MEPD system has received an eligibility record from the Medicaid Eligibility system.
NW FUT CLT	The MEPD system will process the premium for the next system month (the effective date of initial eligibility is in the future).
RETRO	Eligibility for a month before the current system month has been entered on the RETR screen and processed in the MEPD system.

MEPC CHG	A change has been entered on the MEPC screen (i.e., premium amount, income, poverty level, or a month was blocked or unblocked).
POTEN ELIG	MEPD has received the eligibility record from the Medicaid Eligibility system.
PYMT RECVD	The date the payment was entered into the MEPD system.
AMT APPLD	The amount of payment applied to the specified month.
OTH AID TP	Another active aid type has overplayed 60-M eligibility for this month.
ADJUSTMENT	An adjustment is being made to the premium amount through the MEPC screen.
REFUND	A refund has been processed in the MEPD system.
STMT PRINT	A billing statement has been generated.
MEPD ROLL	Month end has occurred and rolled data to the next system month.
STOP ROLL	MEPD system is no longer rolling an inactive ledger. This occurs when there has been no active eligibility on MEPD for 24 months.

- **TRANS DATE** is the date the transaction occurred.
- **TRANS AMOUNT** is the dollar amount of the transaction for the specified month and year.
- **B/U** is the field that indicates if the month is "blocked" or "unblocked." The codes are B for "blocked" or U for "unblocked."
- **NEXT SCREEN** is the option that you can enter the four-character names on the MEPD Menu to go to another MEPD screen.
- A display of both informational and error messages may appear at the bottom of the screen.
- **###** is a three-digit program code used by Division of Data Management.

The function keys available are:

PF01=MENU	Returns to the MEPD coverage Group menu (Not shown)
PF05=SUMM	Transfers to the SUMM screen
PF07=PG UP	Scrolls backward to other DETL screens for the specified month.
PF08=PG DN	Scrolls forward to other DETL screens for the specified month.
PF10=PRI MNTH	Scrolls to a prior month.
PF11=NXT MNTH	Scrolls to the next month.

STMT = MEPD Billing Statement Screen

The STMT screen displays the current and previous statements. STMT can be accessed in the following ways:

- From the MEPD MENU, place an 'X' by the STMT field and press the ENTER key.
- From any MEPD screen, type "STMT" in the NEXT SCREEN field and press the ENTER key.

```
STMT                                DEPARTMENT OF HUMAN SERVICES        DATE:  99/99/99
                                        MEPD BILLING STATEMENT          TIME:  99:99:99
XXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX              BILLING DATE: 99 99 99               CREATE STMT X
XXXXXXXXXXXXXXXXXXXXXX              STATE ID :     XXXXXXXX
XXXXXXXXXXXXXX XX   99999-9999      AMT DUE :    +99999.99             REPRINT (CLNT)  X
                                    CREDIT AMT:   99999.99             REPRINT (WRKR) X
DUE DATE:  MM DD YY                 CANCEL DATE:  MM DD YY

ELIG      FUT   PREMIUM   DUE        PAYMENT    PAYMENT    DATE       REFUND
MONTH     MO    AMOUNT    DATE       RECEIVED   APPLIED    APPLIED    AMOUNT
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99
XXX  99   X     $999.99   99/99/9999 $999999.99 $999999.99 99/99/9999 $999999.99

NEXT SCREEN XXXX      PF3=PRINT,  PF7=PG UP, PF8=PG DN, PF10=PRI STMT,  PF11=NXT STMT
                                                                                ###
```

Enter the state identification number and the approximate billing date. If a billing date is not entered, the most recent statement will be displayed. NOTE: There may be multiple billing dates per month.

The top left corner of the screen displays the member's name and mailing address including city, state, and zip code.

Screen field descriptions:

- **BILLING DATE** is the date the bill is generated.
- **CREATE STMT** is used to generate a new billing statement that has not been previously generated. Enter a 'Y' and press the PF3 key, then check the information that you entered and press the PF3 key again.

  NOTE: A screen message stating "STATEMENT WILL BE CREATED FOR THIS STATE ID" will appear when entries are successful. The new statement will show billing information as of the date you request the statement.
- **STATE ID** is the member's state identification number.
- **AMT DUE** is the total dollar amount for all unpaid months.
- **REPRINT (CLNT)** may be used to request a printed duplicate statement for the member by entering a 'Y' and pressing the PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen.

  NOTE: If the address is changed, the new address must be on the ABC system to have the duplicate statement go to the correct address.
- **CREDIT AMT** is the total dollar amount that has not been applied to any assessed month.
- **REPRINT (WRKR)** may be used to request a printed duplicate statement for the worker by entering a 'Y' and pressing the PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen.
- **DUE DATE** is the date payment is due for initial and past months.
- **CANCEL DATE** is the date payment is due. A WIFS message is generated instructing worker to cancel case if the premium is not paid by this date.
- **ELIG MONTH** is the eligibility month and year.

- **FUT MO** indicates if the eligible month is a future month.
- **PREMIUM AMOUNT** is the premium dollar amount for that ELIG MONTH.
- **DUE DATE** is the date payment is due for that ELIG MONTH.
- **PAYMENT RECEIVED** is the dollar amount of each payment received during the ELIG MONTH.
- **PAYMENT APPLIED** is the dollar amount applied for that ELIG MONTH. Payments are applied in full premium amounts. Partial premiums are held as a credit.
- **DATE APPLIED** is the date the dollar amount was applied to premium for that ELIG MONTH.
- **REFUND AMOUNT** is the total dollar amount of refunds issued during that ELIG MONTH.
- **NEXT SCREEN** is the field you enter the four-letter name to go to another MEPD screen. Options are: SUMM, DETL, RETR.
- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF01=MENU	Returns to the MEPD Coverage Group menu. (Not shown)
PF03=PRINT	Generates a duplicate or new billing statement for the member or a duplicate for the worker.
PF07=PG UP	Scrolls backward to view more eligibility months on a statement.
PF08=PG DN	Scrolls forward to view more eligibility months on a statement.
PF10=PRI STMT	Scrolls to the previous billing statement (STMT) screen.
PF11=NXT STMT	Scrolls to the next billing statement (STMT) screen.

MOAK = Monthly Summary Counts

The MOAK Monthly Summary Counts screen displays various summary counts for the MEPD program. This screen is for review by policy personnel. MOAK can be accessed in the following ways:

- From the MEPD COVERAGE GROUP MAIN MENU, place an 'X' by the MOAK field and press the ENTER key.
- From any MEPD screen, type "MOAK" in the NEXT SCREEN field and press the ENTER key.

The system automatically brings up the current system month information.

```
MOAK                     DEPARTMENT OF HUMAN SERVICES
                        MEPD MONTHLY SUMMARY COUNTS
MOAK MM/CCYY: MM CCYY
                         AMOUNTS COUNTS                                COUNTS
ONGOING BILLED.:     XXX,XXX.XX XX,XXX   CURRENT ACTIVE CLIENTS..:  XX,XXX
FUTURE BILLED..:           X.XX  X,XXX
DAILY BILLED...:      XX,XXX.XX  X,XXX   BILL STMT PRINT.........:   X,XXX
                                         BILL STMT CLIENT REPRINT:      XX
PAYMENTS.......:      XX,XXX.XX  X,XXX   BILL STMT WORKER REPRINT:       X
ELEC PAYMENTS..:      XX,XXX.XX  X,XXX
MANUAL PAYMENTS:      XX,XXX.XX    XXX   PREMIUM NOTIFICATIONS...:      XX
                                         OTHER MAILERS...........:       X
CREDITS APPLIED:      XX,XXX.XX  X,XXX

REFUNDS........:         XXX.XX      X   AUTOMATIC REFUNDS.......:   X,XXX
                                         MANUAL REFUNDS.........….:   X,XXX

                                         INACTIVE CLIENTS........:  XX,XXX


NEXT SCREEN          PF10=PRIOR MONTH, PF11=NEXT MONTH                  ###
```

Screen field descriptions:

- **MOAK MM/CCYY** is the month and year of the summary counts being viewed.
- **ONGOING BILLED** is the total amount billed at the beginning of a system month.
- **FUTURE BILLED** is the total amount billed for the next calendar month.
- **DAILY BILLED** is the total amount of premiums billed for the current system month, during current system month, as cases are added to the MEPD system.

- **PAYMENTS AMOUNTS** is the total amount of payments received **in** a system month. One payment may be split to apply to multiple unpaid months.
- **PAYMENTS COUNTS** is the total number of payments processed in a month.
- **ELEC PAYMENTS AMOUNTS** is the total amount of electronic payments processed in the system month.
- **ELEC PAYMENTS COUNTS** is the total number of electronic payments processed in the system month.
- **MANUAL PAYMENTS AMOUNTS** is the total amount of manual payments entered into the MEPD system in the system month.
- **MANUAL PAYMENTS COUNTS** is the total number of manual payments entered into the MEPD system in the system month.
- **CREDITS APPLIED AMOUNTS** is the total sum of credits applied in a system month.
- **CREDITS APPLIED COUNTS** is the total number of credits applied in a system month.
- **REFUNDS AMOUNTS** is the total sum of refunds issued in a system month.
- **REFUNDS COUNTS** is the total number of refunds issued in a system month.
- **CURRENT ACTIVE CLIENTS** is the total number of current active MEPD members on the MEPD system.
- **BILL STMT PRINT** is the total number of billing statements mailed to MEPD members in the system month.
- **BILL STMT CLIENT REPRINT** is the total number of reprinted billing statements mailed to MEPD members in the system month.
- **BILL STMT WORKER REPRINT** is the total number of reprints of billing statements generated to go to IM workers in the local office. These are not mailed to the MEPD member.
- **PREMIUM NOTIFICATIONS** is the total number of form 470-3928, *Important Information About Premium Payments for Medicaid for Employed People with Disabilities Program*, sent to the MEPD members in a month. This form is issued to all new MEPD premium payers and current MEPD members who go from zero premiums to having to pay a premium. IM workers do not get a copy.

- **OTHER MAILERS** is the count for any other mailings that are generated for MEPD members. Currently, we have no other mailings.
- **AUTOMATIC REFUNDS** are the number of automatic refunds issued during the month. Automatic refunds are issued when there is a credit and the premium has been reduced to zero for two months or there has been two consecutive months of inactivity on an MEPD case.
- **MANUAL REFUNDS** are the number of manual refunds issued in the month. These are entered when a member requests a refund of the amount they have in credits.
- **INACTIVE CLIENTS** is the total number of inactive MEPD members on the MEPD system when rolling into a new month.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF01=MENU	Returns to the MEPD Coverage Group menu. (Not shown)
PF10=PRIOR MONTH	Scrolls to previous month's summary counts screen.
PF11=NEXT MONTH	Scrolls to the next month's summary counts screen.

PVAL = Monthly Valid Premiums

The PVAL Monthly Valid Premiums screen displays the number and amounts of valid premiums for the MEPD program. This screen is for review by policy personnel. PVAL can be accessed in the following ways:

- From the MEPD COVERAGE GROUP MAIN MENU, place an 'X' by the PVAL field and press the ENTER key
- From any MEPD screen, type "PVAL" in the NEXT SCREEN field and press the ENTER key.
- Pres the ENTER key again to bring up the current system month information.

The function keys available are:

ENTER	Displays the Monthly Valid Premiums screen for the month and year entered in the MO/YEAR field.
PF01=MENU	Returns to the MEPD Coverage Group menu. (Not shown)
PF10=PRIOR	Scrolls to the previous month's Monthly Valid Premiums screen.
PF11=NEXT	Scrolls to the next month's Monthly Valid Premiums screen.

PREF = Unprocessed Payments/Refunds

The PREF Unprocessed Payments/Refunds screen is used to display in real time a payment or refund for the entered state identification number that is entered in the MEPD system but has not been applied yet.

Premium payments are entered into the MEPD system during the afternoon. When the payment or refund has updated in overnight processing, the information no longer displays on the PREF screen but will be displayed on the SUMM screen.

PREF can be accessed the following ways:

- From the Premium System menu, place an 'X' by the PREF field and press the ENTER key.
- From any MEPD screen, type PREF in the NEXT SCREEN field and press the ENTER key.
- From the SUMM screen, press the PF6 function key.

```
PREF                                DEPARTMENT OF HUMAN SERVICES
                                     UNPROCESSED PAYMENTS/REFUNDS
STATE ID: xxxxxxxx
                                                                                COV
RCVD  DATE          PMT AMT      TYPE      CHECK NBR   NAME ON CHECK   METH     GRP
MM/DD/CCYY          XXXX.XX      XXXXX       XXXX        XXXX XXXX     XXXX     XXXX
MM/DD/CCYY          XXXX.XX      XXXXX       XXXX        XXXX XXXX     XXXX     XXXX

NEXT SCREEN         PF6=SUMM,   PF7=BACK,   PF8=FORW
```

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **RCVD DATE** is the date the payment/refund was entered.
- **PMT AMT** is the dollar amount of the payment entered.
- **TYPE** is the method of payment or refund. Valid entries are: CHECK, CASH, MO (money order), TC (travelers checks), or REFND (refund).

- **CHECK NBR** is the number of the payment made by a check.
- **NAME ON CHECK** is the name of the account shown on the check.
- **METH** is the field used to display if a refund is made. Valid codes used to display the method of the refund payment are 1 = Entered on TD06, 2 = Manual (rare), or 3 = Payment reversal.
- **COV GRP** is coverage group eligibility was determined under for that month.
- **NEXT SCREEN** is the option that you can use to enter the four-character screen names from the MEPD Menu to go to another MEPD screen.
- A display of informational and error messages may appear at the bottom of the screen.
- **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF01 = MENU	Returns to the Premium System Main menu. (Not shown)
PF06 = SUMM	Transfers to the SUMM screen.
PF07 = BACK	Scrolls backward to view more payment/refund entries.
PF08 = FORW	Scrolls forward to view more payment/refund entries.

RETR = Retro Screen

The RETR Retro screen is really two screens in one, including:

- A block of information that is pulled from TD01 fields when the case has already been entered and processed on the ABC system; and
- The RETRO MONTH box, which is used to approve month-by-month retroactive eligibility for MEPD or to change entries that were previously made for a month.

The Retro screen is used to:

- Enter retroactive eligibility for MEPD only.
- Change past retroactive entries for MEPD when the entry for retroactive eligibility was made on or after June 1, 2002.
- Display past MEPD retroactive eligibility information when the entry for retroactive eligibility was made on or after June 1, 2002.

RETR can be accessed in the following ways:

- From the Premium System Main menu, place an 'X' by the RETR field and press the ENTER key.
- From any MEPD screen, type RETR in the NEXT SCREEN field and press the ENTER key.

```
RETR                                   DEPARTMENT OF HUMAN SERVICES        DATE:  99/99/99
                                                RETRO ELIGIBILITY          TIME:  99:99:99

STATE ID: xxxxxxxx                   RECIPIENT NAME (FML):  xxxxxxxx x xxxxxxxxxxxxx
AID TYPE:  XXX                 CASE NAME (FML)……..:  xxxxxxxx x xxxxxxxxxxxxx
                               PAYEE NAME…….. : xxx xxxxxxxxxxxxxxxxxxxxxxxx
BIRTH DATE……..:99  99  9999    SEX: X
                                                          RETRO MONTH
SSN……..: 999  99  9999
INSURANCE……: 000 9                ETHNIC: X              ELIG DATE……..: 99 9999
CASE NUMBER:   XXXXXXXXX                                  PREMIUM AMOUNT..:99999.99
ADDRESS:       XXXXXXXXXXXXXXXXXXXX                       UNEARNED INCOME:99999.99
               XXXXXXXXXXXXXXXXXXXX                       EARNED INCOME…..:99999.99
CITY:          XXXXXXXXXXXXX                              PREMIUM PCT POV..:999
STATE:         XX     ZIP:  99999 9999                    RESOURCES……..:      0.00
                                                          PF10-BACK PF11-FORWARD
RES COUNTY:    99
EMPL HRS:      X
EMPL TYPE:     X
FAMILY SIZE:   99                                   DO YOU WANT TO ENTER ANOTHER RET-
WORKER NUM.:  XXXX                                  RO MONTH FOR THIS STATE ID?  (Y/N)
WORKER CNTY:  99                                    IF Y, ENTER NEW ELIG DATE AND PF3
                                                    IF N, PRESS ENTER

NEXT SCREEN  XXXX          PF3=UPD, PF4=DELETE
                                                                                      ###
```

Enter the state identification number and the eligibility date to view information or make entries. All fields must be completed for the screen to update. When using RETR to make retroactive entries, enter the state identification number on the upper left side of the screen and the eligibility date in the RETRO MONTH box and press ENTER. This ensures that further entries will be preserved.

Enter the information in the RETRO MONTH box separately for each month of retroactive eligibility that is being approved or changed. When entries are complete, press the PF3 key twice so entries will take.

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **RECIPIENT NAME (FML)** is the person's first, middle, and last name.
- **AID TYPE** is the medical aid type. The only valid type is 60-M.
- **CASE NAME (FML)** is the case name in first, middle, and last order.
- **PAYEE NAME** is the name of the payee for the state identification number.
- **BIRTH DATE** is the person's date of birth.
- **SEX** is the person's gender.
- **SSN** is the person's social security number.
- **INSURANCE** is the person's insurance code. Only the last character is modifiable.
- **ETHNIC** is the person's ethnic code. Valid codes for the MEPD/MIPS RETR screens **only** are:

  1 White
  2 Black
  3 American-Indian
  4 Asian
  5 Hispanic-Latino
  6 Pacific Islander
  9 Unknown
- **CASE NUMBER** is the person's MEPD case number.
- **ADDRESS LINE 1** is the first line of the person's mailing address.
- **ADDRESS LINE 2** is the second line of the person's mailing address.
- **CITY** is the mailing address city.
- **STATE** is the mailing address state.
- **ZIP** is the mailing address zip code and zip+4 digits.
- **RES COUNTY** is the number of the county where the person resides.
- **EMPL HRS** is the number of hours the person is employed. Valid codes are:
  A Zero to ten hours employment per month.
  B Above ten hours through 80 hours of employment per month.
  C More than 80 hours of employment per month.

- **EMPL TYPE** is the type of employment of the person. Valid codes are:

  O Business outside the home.
  S Self-employment business.
  I Working for an individual.
  U Not employed.

- **FAMILY SIZE** is the number of people in the person's family. See 8-F for more information on determining the family size for MEPD members.

- **WORKER NUM** is the identifying number assigned to the income maintenance worker.

- **WORKER CNTY** is the county number assigned to the income maintenance worker.

- **RETRO MONTH** box:

  - **ELIG DATE** is the actual retroactive month and year.
  - **PREMIUM AMOUNT** is the dollar amount for the premium for the retroactive month.
  - **UNEARNED INCOME** is the unearned income dollar amount for the person.
  - **EARNED INCOME** is the earned income dollar amount for the person.
  - **PREMIUM PCT POV** is the percent of poverty for the person.
  - **RESOURCES** is the resource amount for the person.
  - **PF10 BACK** is the function key to move to the previous month.
  - **PF11 FORWARD** is the function key to move to the next month.

- **DO YOU WANT TO ENTER ANOTHER RETRO MONTH FOR THIS STATE ID?** (Y/N) Appears after a month of retroactive eligibility is updated. Use this field to indicate if you want to enter an additional month of retroactive coverage for the person. If so, enter the month and year and press the PF3 key. If not, press the ENTER key.

- **NEXT SCREEN** is the field you enter the four-character screen name on the MEPD menu to go to from another MEPD screen.

- A display of informational and error messages may appear at the bottom of the screen.

- **###** is a three-digit program code used by the Division of Data Management.

The function keys available are:

PF01 = MAIN MENU	Returns to the PREMIUM SYSTEM MAIN MENU. (Not shown)
PF03 = UPD	Adds the record. Must be entered twice to record entry.
PF04 = DELETE	Deletes the record.

PRSM = Presumptive Medicaid Eligibility

The Presumptive Medicaid Eligibility program allows certain providers to:

- Qualify pregnant women for prenatal medical treatment, excluding inpatient hospital services and services for birth and delivery, or
- Qualify women with breast or cervical cancer for full Medicaid services (not just services related to cancer treatment).

Unless the member applies for Medicaid, the initial eligibility period ends the last day of the month following the month of the presumptive determination. If the member files a formal Medicaid application in the initial period of presumptive eligibility, coverage is extended until an eligibility determination is made on the application.

PRSM displays demographic information and dates of eligibility for members of this program as determined by qualified providers. The menu is shown below.

```
DIALOG:                                                          PAGE: 1 OF: 1
DATE:                                                            NEXT PAGE:
                          PRESUMPTIVE ELIGIBILITY MENU

__ 1          (ENTER)     DISPLAY EPISODES
__ 9          (ENTER)       LINK
__ R474M261   (CLEAR)     LEAVE APPLICATION

RESPONSE:                 SEND DATA-->                           MODE: STEP
```

To display or view the presumptive Medicaid eligibility information, enter an 'X' (or any character) beside selection 1 and press the ENTER key. The PRSM screen (following) returns empty with a message that prompts for a valid state ID. Type in the member's state identification number and press the ENTER key. The following screen is returned:

```
STATE ID 0000000x              RECIPIENT NAME LAST  xxxxxxxxxxxxx        LAST UPDATE 000000
                                              FIRST  xxxxxxxx MI x
SOCIAL SECURITY 000000000                  ADDRESS  xxxxxxxxxxxxxxxxxxxxx
                                                    xxxxxxxxxxxxxxxxxxxxx
BIRTHDATE mm dd yyyy                                xxxxxxxxxxxxxxxx 000000000
CO     WORKER     SEX     ETHNIC     HANDICAP
00      0000       F        0          0000
                                                                                  DECISION
TYPE   BEGIN DATE     END DATE    COUNTY    INSURANCE     PROVIDER   CASE        STATUS     REASON
 X      mm dd yy       00 00 00     00         0000         000000   XXXXXX XXXX

                                                                                PF1-MAIN MENU
```

This screen contains the presumptive Medicaid eligibility information concerning a member that was entered when a qualified provider determined presumptive eligibility. The creation or addition of presumptive eligibility records or episodes is restricted to Quality Assurance staff of the Division of Data Management.

The actual episode information (beginning and ending dates, county, etc.) is displayed in chronological order, with the most recent or current episode at the TOP of the list.

- **CO** is the county number of the worker, if there is a case for the woman on the ABC system.
- **WORKER** is the worker number of the caseworker, if there is a case for the woman on the ABC system.
- **SEX** is always "F" for female.
- **ETHNIC** is the ethnic code for the woman. Valid codes are:

  H Hispanic or Latino ethnicity
  W White race
  B Black or African American race
  A Asian race
  I American Indian or Alaska Native
  N Native Hawaiian or other Pacific Islander race

- **HANDICAP** is the handicap code for the woman. Valid codes are

  A Mental retardation
  B Mental health problem or mental illness
  C Speech, language, or communication impairment
  D Learning disability
  E Substance abuse
  F Hearing impairment
  G Visual handicap
  H Physical handicap: nonorthopedic
  I No known disability
  J Physical handicap: orthopedic

- **TYPE** is the presumptive code. Valid codes are:

  P Pregnant
  T Treatment
  W Worker determined Medicaid eligible

- **BEGIN DATE** is the date presumptive eligibility begins. This is usually the date that the presumptive application was taken.

- **END DATE** is the date of termination for presumptive eligibility.

- **COUNTY** is the member's county of residence.

- **INSURANCE** is the health coverage code for the woman.

- **PROVIDER** is the vendor number of the provider that made the presumptive eligibility determination.

- **CASE** is the case number assigned to the person that has a TYPE code of "W."

- **STATUS** represents the status of a Medicaid application recorded on the ABC system. If no Medicaid application has been pended, approved, or denied on ABC, an "E" appears in this field. Codes are as follows:

E	Eligible under presumptive Medicaid eligibility
A, B, or C	Active
D	Pending
M or N	Denied

- **DECISION REASON** is the notice reason from the ABC system for the Medicaid denial or approval for qualified pregnant women.

The function key available is PF1-MAIN MENU. This returns you to the Presumptive Eligibility Menu.

SSBI = Buy-In System

The SSBI system displays Medicare Part A and B buy-in information and history.

"Buy-in" is the payment of Medicare Part A and B premiums by the state for Medicaid-eligible members. Data transmitted by the state to CMS for buy-in is processed once a month, two working days before ABC month end. CMS then responds to this data, once a month, in the following month around the 10th or 12th of the month.

SSBI Menu Screen

SSBI menu is used to view buy-in information for a specific person, by entering either the Medicare claim number or the state identification number and pressing the ENTER key.

```
SSBI                    IOWA DEPARTMENT OF HUMAN SERVICES   PAGE
                              BUYIN SYSTEM MENU             TODAYS DATE   XX/XX/XX
TO DISPLAY INFORMATION ON THE BUYIN MASTER FILE, FILL IN
SSA CLAIM NUMBER OR STATE ID IN THE FIELDS PROVIDED BELOW,
AND DEPRESS THE ENTER KEY.




SSA CLAIM NUMBER            STATE ID                LINK
CLEAR KEY = END SESSION
MESSAGES:
```

The function key available is CLEAR KEY=END SESSION. This clears the screen.

Buy-in Master File Inquiry Screen

The Buy-in Master File Inquiry screen displays the most recent buy-in activity.

```
SSBI                                IOWA DEPARTMENT OF HUMAN SERVICES    PAGE
                                          BUYIN MASTER FILE INQUIRY      TODAYS DATE   XX/XX/XX
     FOR:
            SOC. SEC.     DOB      SEX    MEDICARE ENTITLE DATE
     CASE INFORMATION:
     STATE ID    CASE NUMBER    AID TYPE   ELIG CODE    COUNTY    WORKER     SPEC PROC

     PART B STATUS  X  XXXXXXXXXXXXX  X      BUYIN  XX-XXXX       BUYOUT  XX-XXXX
        TRANS DATE  XX-XXXX

     PART A STATUS  X  XXXXXXXXXXXXX  X      BUYIN  XX-XXXX       BUYOUT  XX-XXXX
        TRANS DATE   XX-XXXX
     REMIT OR REFUND AMOUNT  XXX.XX
SSA CLAIM NUMBER                        STATE ID XXXXXXXX                LINK
CLEAR=END          PF1=MENU                                            PF8=HISTORY
MESSAGES:
```

The Buy-in Master File Inquiry screen includes the following information:

- **FOR** displays the beneficiary's first name, initial, and last name.
- **SOC. SEC.** displays the beneficiary's social security number.
- **DOB** displays the beneficiary's date of birth.
- **SEX** displays the beneficiary's gender (M or F).
- **MEDICARE ENTITLEMENT DATE** displays the month and year the beneficiary became entitled to Medicare.
- **STATE ID** displays the beneficiary's state identification number.
- **CASE NUMBER** displays the beneficiary's case number.
- **AID TYPE** displays the beneficiary's aid type.
- **ELIG CODE** indicates the reason the beneficiary is eligible for buy-in (used in determining federal financial participation).

  Mandatory buy-in codes are:

  L Specified low-income Medicare beneficiary (SLMB)
  M Entitled to Medicaid only (non-cash recipients who are not QMBs)
  P Qualified Medicare beneficiary (QMB)
  U Expanded SLMB

Optional buy-in eligibility codes are:

C Entitled to Part A of Title IV (AFDC)
Z Deemed categorically needy

Federally generated buy-in eligibility codes (based on the SSI record) are:

A Aged recipient of federal SSI payments
B Blind recipient of federal SSI payments
D Disabled recipient of federal SSI payments
E Aged recipient of supplemental payment administered by Social Security
F Blind recipient of supplemental payment administered by Social Security
G Disabled recipient of supplemental payment administered by Social Security
H Aged, blind, or disabled recipient of a one-time payment

- **COUNTY** is the county number for the county carrying the person's case.
- **WORKER** is the worker number for the worker carrying the person's case.
- **SPEC PROC** is a special processing code.
- **PART B STATUS:** The first entry reflects the current phase in relation to Medicare Part B, either "1 Buy-in" or "2 Buy-out," followed by a code indicating the reason for the status. Valid codes are:

  1 Pending
  2 Complete
  3 Future
  4 Social Security Administration pending (reject)
  5 Death

- **BUY-IN** is the date that represents the first month the premium was paid.
- **BUY-OUT** is the date that represents the last month the premium was paid.
- **TRANSACTION DATE** is the month and year that the latest transaction was done.
- **PART A STATUS** includes the same fields as for Medicare Part B. The status may be "1 Buy-in," "2 Buy-out," or "none found." This may be followed by a descriptive code:

  1 Pending
  2 Complete
  3 Future
  4 Social Security Administration pending (reject)
  5 Death

- **BUY-IN** is the date that represents the first month the premium was paid.
- **BUY-OUT** is the date that represents the last month the premium was paid.
- **REMIT OR REFUND AMOUNT** represents the amount the state is being billed for a buy-in. (You can use this information to estimate the amount of refund the member will receive if the member previously paid premiums.) On a buy-out, this amount represents the refund due the state.
- **MESSAGES** indicates if there are multiple records for the individual.

The function keys available are:

CLEAR=END	Clears the screen.
PF1-MENU	Returns to the Buy-in System menu.
PF8=HISTORY	Goes to the Buy-in History File Inquiry screen.

Buy-in History File Inquiry Screen

The Buy-in History File Inquiry screen can be accessed through the SSBI screen (if a record exists) by pressing the PF8=HISTORY key.

```
SSBH XXXXXXXXXX                IOWA DEPARTMENT OF HUMAN SERVICES    PAGE
                                     BUYIN HISTORY FILE INQUIRY     TODAYS DATE   XX/XX/XX
NAME:  LAST      FIRST     I          SOC. SEC.        DOB            SEX
XXXXXXXXXX  XXXXXXX   X               XXX XX XXXX      XX XX XXXX     X
STATE ID            CASE NUMBER                 COUNTY        WORKER
XXXXXXXXXX          XXXXXX XX XX                  XX            XXXX
HISTORIES:  STATE CODE/DESC.          START     STOP     ELIG CODE   BUYIN  LAST UPD
    IOWA      XXX  XXXXXX             XX-XXXX   XX-XXXX     X         X     XX-XXXX
    HCFA      XXX  XXXXXX             XX-XXXX   XX-XXXX     X         X     XX-XXXX
    IOWA      XXX  XXXXXX             XX-XXXX   XX-XXXX     X         X     XX-XXXX

CLEAR=END          PF1=MENU                                   PF8=RETURN (SSBI)
MESSAGES:
```

This screen contains the following fields:

- **SSBH** displays the beneficiary's Medicare claim number.
- **NAME** displays the beneficiary's last name, first name, and initial.
- **SOC. SEC.** displays the beneficiary's social security number.

- **DOB** displays the beneficiary's date of birth.
- **SEX** displays the beneficiary's gender (M or F).
- **STATE ID** displays the beneficiary's state identification number.
- **CASE NUMBER** displays the beneficiary's case number.
- **COUNTY** is the county number for the county carrying the person's case.
- **WORKER** is the worker number for the worker carrying the person's case.
- **HISTORIES** tells what agency provided the information: CMS or Iowa.
- **STATE CODE/DESC** gives a code and name of the state.
- **START** gives the month and year that buy-in began.
- **STOP** gives the month and year that buy-in stopped.
- **ELIG CODE** identifies the reason for federal financial participation in the buy-in.

  Mandatory buy-in codes are:

  L Specified low-income Medicare beneficiary (SLMB)
  M Entitled to Medicaid only (non-cash recipients who are not QMBs)
  P Qualified Medicare beneficiary (QMB)
  U Expanded SLMB

  Optional buy-in eligibility codes are:

  C Entitled to Part A of Title IV (AFDC)
  Z Deemed categorically needy

  Federally generated buy-in eligibility codes (based on the SSI record) are:

  A Aged recipient of federal SSI payments
  B Blind recipient of federal SSI payments
  D Disabled recipient of federal SSI payments
  E Aged recipient of supplemental payment administered by Social Security
  F Blind recipient of supplemental payment administered by Social Security
  G Disabled recipient of supplemental payment administered by Social Security
  H Aged, blind, or disabled recipient of a one-time payment

- **BUYIN** identifies whether the buy-in is for Part A or Part B of Medicare.
- **LAST UPD** for an Iowa entry is the date when the buy-in was added. For a CMS entry, it is the date Iowa received the history file from CMS.
- **MESSAGES** indicates if there are multiple records for this person.

The function keys available are:

PF1=MENU	Returns to the Buyin System Menu
PF8=RETURN (SSB1)	Returns to the Buyin Master File Inquiry screen

SSNI = Medicaid Eligibility File

The ABC System passes data daily to the Medicaid Eligibility System and the Individualized Services Information System (ISIS). Some data is, in turn, transmitted to other parts of the Medicaid Management Information System (MMIS).

- The eligibility information on MMIS is updated the day after the data is received from the SSNI Medicaid Eligibility file.
- The Eligibility Verification System (ELVS) is updated the same day MMIS is updated.
- The pharmacy Point of Sale (POS) Eligibility System is updated the day after MMIS or ELVS has updated.

SSNI screens are available for review of Medicaid data. The screens display eligibility information used to process provider claims for services other than facility care. SSNI displays:

- Medicaid eligibility information for an individual (Title XIX inquiry)
- Medicaid eligibility counts for the current and prior month (Title XIX count display)

SSNI also links to the following systems:

- MEPD (Medicaid for Employed People with Disabilities)
- MIPS (Medicaid IowaCare Premium System)

The SSNI menu is used to view the eligibility information for a member. If you are on a person's ABC TD03 screen and then enter CODE/SCREEN option 3 SSNI, you move to the SSNI Menu screen. Place an 'x' in front of selection 1 and press the ENTER key to display the eligibility information for the person.

```
DIALOG:                                                                  PAGE: 1 OF 1
DATE:99/99/9999                    SSNI SELECTION MENU                   NEXT PAGE:

      _____1                       (ENTER)      TITLE XIX INQUIRY
      _____3                       (PF3)        TITLE XIX COUNT DISPLAY
      _____7                       (PF7)        LINK
      _____QUIT                    (CLEAR)      EXIT

RESPONSE:                          SEND DATA - ->                        MODE:  STEP
```

Otherwise, SSNI screen 1 returns with a message prompt to enter a state identification number. Type in the state identification number for the desired person and then press the ENTER key. The following screen is returned:

```
XXXXXXX                                CASE NO                          UPDATED  000000     TYPE
                                                          MHC
MM/YY   RC   AID  F  INS   SP   CASE NO   SD   PR   LC   PP MP  CD  MHC    PROV & OPT  OR LOCKIN PROV

BEGIN MEDICAID     END MEDICAID     CASE APPL     CASE CERT     LAST ID     BIRTHDATE      WORKER
000 00 00 00       000 00 00 00     00 00 00       00 00 00     00 00 00    00 00 0000

                                                 PF1 MENU                  PF2-PG 2     PF5-DETL MTH
                          SCREENING              SOCIAL SECURITY                     PF6-TPL
  BUY-IN X   BUY-OUT X  INITIAL X    CURRENT X    ACCT NO                             PF10-PTDE
  00 00 00    00 00 00   00 00 00     00 00 00    CLAIM NO                            PF11-MIPS
                                                                                     PF12-MEPD
                                                                                                  238
```

The 'page one' screen reflects eligibility information for the most recent 12 months. This includes any lock-in or managed health care (MHC) information for these months.

View the SSNI monthly details file for a given month by placing the cursor on the month and pressing the PF5-DETL MNTH key. See DETL MTH Screen for information.

View third party coordination of benefits information for the current member displayed on the SSNI screen by pressing the PF6-TPL key. See TPL Screen for information on the screen.

Please note the following items:

- **RC** is the county of residence.
- **AID** is the medical aid type. See 14-B-Appendix, TD01 MED AID, for codes, except for the chronic pre-existing condition group, family planning waiver cases, breast and cervical cancer treatment (BCCT) cases, IowaCare hardships, and foster care and adoption cases.

  The presumptive BCCT aid type 88-9, ongoing BCCT aid type of 37-3, and the 88-8 aid type for presumptive for pregnant women are entered through the PRSM screen.

  For the pre-existing chronic condition group, the Medicaid type of 77-7 is entered through the PRSM screen or is entered by the Quality Assurance Unit when processing a *Request for Special Update*, form 470-0397.

  The family planning waiver aid type of 90-6 is entered on SSNI through the Family Planning Waiver system.

  For IowaCare members declaring hardship, SSNI converts the worker entered aid type to:

  - 60-H for the IowaCare 200% group for people ages 19 to 64 hardship (formerly 60-E).
  - 60-T for the IowaCare 300% group for pregnant and newborns hardship (formerly 60-P).

  For members with concurrent eligibility under two or more limited benefit aid types, the TXIX system enters a "blended" aid type on SSNI. IM workers **are not** to enter blended aid types. The "blended" aid types and the applicable coverage groups are shown below:

Blended Aid Type	**Concurrent Eligibility Aid Types**		
	Coverage Group 1	Coverage Group 2	Coverage Group 3
86E	60-E, IowaCare 200%	90-6, Family planning	
86H	60-H, IowaCare 200% hardship	90-6, Family planning	
88E	60-E, IowaCare 200%	88-8, Pregnancy presumptive	

Blended Aid Type	Concurrent Eligibility Aid Types		
	Coverage Group 1	Coverage Group 2	Coverage Group 3
88H	60-H, IowaCare 200% hardship	88-8, Pregnancy presumptive	
88P	60-P, IowaCare OB/NB	88-8, Pregnancy presumptive	
88T	60-T, IowaCare OB/NB hardship	88-8, Pregnancy presumptive	
88F	90-6, Family planning	88-8, Pregnancy presumptive	
89E	60-E, IowaCare 200%	88-9, BCCT presumptive	
89H	60-H, IowaCare 200% hardship	88-9, BCCT presumptive	
89P	60-P, IowaCare OB/NB	88-9, BCCT presumptive	
89T	60-T, IowaCare OB/NB hardship	88-9, BCCT presumptive	
89-F	90-6, Family planning	88-9, BCCT presumptive	
8PE	60-E, IowaCare 200%	90-6, Family planning	88-8, Pregnancy presumptive
8PH	60-H, IowaCare 200% hardship	90-6, Family planning	88-8, Pregnancy presumptive
8BE	60-E, IowaCare 200%	90-6, Family planning	88-9, BCCT presumptive
8BH	60-H, IowaCare 200% hardship	90-6, Family planning	88-9, BCCT presumptive
87P	77-7, Chronic care DSH	88-8, Pregnancy presumptive	
87B	77-7, Chronic care DSH	88-9, BCCT presumptive	
87F	77-7, Chronic care DSH	90-6, Family planning	
8PF	77-7, Chronic care DSH	90-6, Family planning	88-8, Pregnancy presumptive
8BF	77-7, Chronic care DSH	90-6, Family Planning	88-9, BCCT presumptive

The family planning waiver aid type of 90-6 is entered on SSNI through the Family Planning Waiver system.

For foster care and adoption cases, the Quality Assurance Unit enters the SSNI aid type based on the characteristics of the FACS and ABC cases, as follows:

MEDICAL AID TYPE	SSNI AID TYPE	FUND CODE
IV-E Foster Care 30-8 IV-E Medicaid	42-1 Foster family 42-3 Foster group 42-8 Shelter care 42-9 Interstate IV-E foster care	2 Child, receives maintenance payment
Adoption Presubsidy or Subsidy 30-8 IV-E Medicaid 64-0 SSI, disabled	46-2 Subsidized adoption 46-4 Presubsidy 46-5 Interstate IV-E adoption	2 Child, receives maintenance payment C Child, Medicaid only
CMAP 37-2 Child Medical Assistance Program 37-4 CMAP-Refugee	40-1 Foster family 40-3 Foster group 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Foster group* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption 46-3 Presubsidy	R Child, CMAP
Mothers and Children 92-0 MAC	40-1 Foster family 40-3 Foster group 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Foster group* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption 46-3 Presubsidy	A Adult, Medicaid only (pregnant woman regardless of age) C Child, Medicaid only
Medically Needy 37-E Medically Needy 37-F Medically Needy-Refugee	40-1 Foster family 40-3 Foster group 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Foster group* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption * Payment-only (JCO) case	C FIP-related child, medical only R CMAP-related child, medical only

MEDICAL AID TYPE	SSNI AID TYPE	FUND CODE
SSI 64-0 SSI, disabled	41-1 Foster family 41-3 Group care 41-8 Shelter care 41-7 Independent living 46-2 Subsidized adoption 46-4 Presubsidy 48-1 Foster family 48-3 Group care 48-8 Shelter care 48-7 Independent living 46-2 Subsidized adoption 46-4 Presubsidy	2 Child, receives cash assistance
Unaccompanied Refugee Minors 06-3 Refugee Medical Assistance Only	02-1 Foster family 02-3 Foster group 02-8 Shelter care 02-7 Independent	2 Child, receives cash assistance
Children Who Do Not Qualify for Federally Funded Medicaid 40-9 State-only medical assistance	40-1 Foster family 40-3 Group care 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Group care* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption 46-3 Presubsidy 40-9 Medical only case	4 Child, state-only medical assistance

- **F** is the fund code. See 14-B-Appendix, TD03 FUND, for valid codes.
- **INS** shows whether the member has any health insurance other than Medicaid. See 14-B-Appendix, TD03 HEALTH, for valid codes for the first, third, and fourth position. For the second position, the following system-generated values may be found:

  D Indicates Part D coverage.

  X Indicates member has 'confirmed' (from the Part D MMA response file) Medicare Part A or Part B coverage, but no Part D coverage. An 'X' will be present only on eligibility months 01/2006 and later.

  W Indicates that ABC has indicated Part A or B coverage, but has not been 'confirmed' by information received from CMS.

  N Member has 'affirmatively declined' Part D coverage.

  V Indicates Medicare enrollment was verified from CMS when codes D, X, W and N are not applicable. If the member is not on Medicare, then this code indicates that "no Medicare coverage" has been verified.

- **SP** is the special claims processing field, which identifies a person whose claims need to be processed in a unique way, i.e., enhanced services, illegal aliens, or qualified Medicare beneficiaries. A "J" in this field indicates that the person is covered under the state supplement for Medicare and Medicaid eligibles group. (See 14-B-Appendix, TD03 SRV, for other codes.)
- **CASE NUMBER** displays the ABC case number.
- **SD** indicates whether the member's case has spenddown or not for the month.
- **PR** is the Medically Needy program relationship. (See 14-B-Appendix, TD03 MN, for codes.)
- **LC** is the county of legal settlement to be billed for services. If the member is receiving intellectual disability (ID) waiver, brain injury (BI) waiver, habilitation services (, or intermediate care facility/mental retardation (ICF/MR) services, then the county of legal settlement is passed to the Medicaid Eligibility system from the ISIS system. Otherwise, the field is populated with the information from ABC COS field on TD03.
- **PP** is the percentage of the federal poverty level represented by the member's income.
- **MP** shows the type of foster care Medicaid eligibility the member has, or the code for transitional Medicaid that shows the number of months of eligibility. Valid codes are:

  F IV-E
  G FMAP cash grants
  H CMAP
  I MAC
  K Other FMAP-related
  L SSI and SSI-related
  M PMIC
  N State only
  P Refugee Resettlement Program
  0 Transitional Medicaid, no extended Medicaid coverage
  1 Transitional Medicaid, first six months (additional allowed)
  2 Transitional Medicaid, second six months
  3 Transitional Medicaid, first six months (no additional allowed)
  4 Extended coverage but not transitional Medicaid

- **MHC CD** designates the type of alternate delivery organization in which the member participates. The MHC code may reflect the member's participation in one or more of the following Medicaid programs:

  - Iowa Plan for Behavioral Health (implemented January 1999)
  - Health maintenance organization (HMO)
  - Medicaid Patient Access to Services System (MediPASS)
  - Lock-in program

  The following codes are used for months of service beginning January 1, 1999:

  A FMAP, ages 0-17, Iowa Plan
  B FMAP, ages 18-64, Iowa Plan
  C FMAP, ages 0-17, Iowa Plan, HMO
  D FMAP, ages 18-64, Iowa Plan, HMO
  E FMAP, ages 0-17, Iowa Plan, MediPASS
  F FMAP, ages 18-64, Iowa Plan, MediPASS
  G FMAP, ages 0-17, Iowa Plan, lock-in
  H FMAP, ages 18-64, Iowa Plan, lock-in
  J SSI, ages 0-17, Iowa Plan
  K SSI, ages 18-64, Iowa Plan
  L SSI, ages 0-17, Iowa Plan, lock-in
  M SSI, ages 18-64, Iowa Plan, lock-in
  N SSI, ages 0-17, Iowa Plan, HMO
  P SSI, ages 18-64, Iowa Plan, HMO
  Q SSI, ages 0-17, Iowa Plan, MediPASS
  R SSI, ages 18-64, Iowa Plan, MediPASS
  S Dual Medicaid and Medicare, age 0-64, Iowa Plan
  T Dual Medicaid and Medicare, age 0-64, Iowa Plan, lock-in
  V Foster care, PMIC, or MHI and lock-in, ages 0-22, Iowa Plan
  W Foster Care, PMIC, or MHI, ages 0-9, Iowa Plan
  X Foster Care, PMIC, or MHI, ages 10-22, Iowa Plan
  0 Any coverage group, any age, no alternate delivery organization
  1 Any coverage group, any age, HMO, no Iowa Plan
  2 Any coverage group, any age, lock-in, no Iowa Plan
  4 Any coverage group, any age, MediPASS, no Iowa Plan

  Beginning July 1, 2001, new MHC codes V, W, and X were added to designate Iowa Plan coverage for children in foster care, PMIC, MHI, and lock-in. Before that date, children in foster care, PMIC, and MHI were included as FMAP, ages 0-17, Iowa Plan, codes A or G.

- **MHC PROV & OPT OR LOCKIN PROV** is the number associated with the provider for either managed health care or lock-in. This is a two-digit number following the plan for an HMO or a seven-digit number for MediPASS or lock-in.

  A member may be 'locked in' to up to four providers in a given month. A member may participate in up to three alternate delivery organizations in a given month. However, the combination of lock-in and alternate delivery may never exceed four in any month.

- **BEGIN MEDICAID** is the first date the member was eligible for Medicaid.
- **END MEDICAID** is the date the member died. This date shows zeros until the date of death is entered.
- **CASE APPL** is the original date of Medicaid application.
- **CASE CERT** is for central office use.
- **LAST ID** is the date on which the system last created a medical ID card.
- **BIRTHDATE** is the member's date of birth.
- **WORKER** is the worker number of the worker carrying the member's case.
- **BUY-IN** is the date that represents the first month the premium was paid. See SSBI = Buy-In System for more information. Following the BUY-IN field is a one-byte field that shows buy-in coding. Valid code is 2: Buy-in is complete.
- **BUY-OUT** is the date that represents the last month the premium was paid. See SSBI = Buy-In System for more information. Following the BUY-OUT field is a one-byte field that shows buy-out coding. Valid code is X: Buy-out is complete.
- **SCREENING INITIAL** indicates date that ABC screening information was originally passed to the TXIX system.
- **SCREENING CURRENT** indicates date that ABC screening information was passed to and updated on the TXIX system.
- **SCREENING INITIAL AND CURRENT ONE-BYTE FIELD** indicates the member's medical screening status as of the date indicated. Valid codes are:

Blank/space	Not assigned
C	Screening accepted
G	Screening refused
K	Purchased EPSDT informing and care coordination services for specific aid-types

- **SOCIAL SECURITY ACCT NO** is the member's social security account number.
- **SOCIAL SECURITY CLAIM NO** is the member's social security claim number.

The PF function keys displayed on the SSNA screen 1 are:

PF1=MENU	Moves you to the main menu of the SSNI-Medicaid Eligibility File.
PF2=PG2X	Moves you to SSNI Medicaid Eligibility File for the preceding 12 months of eligibility.
PF5=DETL MTH	Moves you to the specified SSNI detail monthly screen to view specific information for a month.
PF6=TPL	Moves you to the TPL history screen for the current month.
PF10=PTDE	Moves you to the Part D Enrollment Information (PTDE) screen if a State Identification (SID) number is entered on SSNI. If no SID number is entered, the Medicare Data Main Menu (MMCR) screen is displayed.
PF11=MIPS	Moves you to the MIPS Main Menu screen.
PF12=MEPD	Moves you to the MEPD Main Menu screen.

To access the 'PG2' screen to view the preceding 12 months of eligibility, press the PF2 key. The following screen is displayed. It includes demographic and address data.

```
 xxxxxxx                        CASE NAME                                  WORKER CO
                                                          MHC
MM/YY   RC  AID   F   INS  SP   CASE NO    SD   PR   LC   PP   MP  CD  MHC  PROV & OPT OR LOCKIN PROV




SEX         ETHNIC       HANDICAP       RECIPIENT ADDRESS-                        PF1- MENU  PF2-PG 1
                                                                                             PF5-DETL MTH
                                                                                             PF6-TPL
US    ID                                                                                     PF10-PTDE
<SHIFT-PF1>=US LIST                                                                          PF11-MIPS
<SHIFT-PF2>=ID LIST                                                                          PF12-MEPD
                                                                                                      ###
```

DETL MTH Screen

The DETL MTH screen displays detailed information for a state identification number for a selected month on the SSNI screen. The screen displays the primary eligibility listed on SSNI (page 1 or page 2), plus all the underlying eligibility (all eligibility sent from the ABC system) and all transactions entered on the MEPD RETR screen on either a daily batch process or in the month end process.

```
XXXXXXXX   XXXXX, XXXXX                          DOB 99/99/9999 X

MEDICAID FOR  99/9999                                UNDERLYING ELIGIBILITY
AID  XXX   FUND X   XXXXX                      AID  F  SP  SD  PR  MP  MHC  WV  P/M  FAC #       CAID  DATE
                                               XXX X  X    X   X   X   X     X   X    XXXXXXX    XXX  99/99/9999
CASE NO    XXXXXXXXX  XX                       XXX X  X    X   X   X   X     X   X    XXXXXXX    XXX  99/99/9999
HEALTH INS XXXX                                XXX X  X    X   X   X   X     X   X    XXXXXXX    XXX  99/99/9999
CASE AID     XXX                               XXX X  X    X   X   X   X     X   X    XXXXXXX    XXX  99/99/9999
WKR #/CO    XXXX  XX                           XXX X  X    X   X   X   X     X   X    XXXXXXX    XXX  99/99/9999
MN SPEND DOWN
SPEC PROCESS                                     MEDID DATE    99 / 99 / 9999
                                                 MEDID AID       XXX  XXX
        ENH SERV      ALIEN
        QMB/SLMB      $1 SUPP                                          SYS DATE   99/99
PROGRAM REL
MED PROGRAM                                    IOWA PLAN     XX    X                    ONLINE UPDATE
MED STATUS        X                            PMIC/MHI IND                   BY              ON  99 99 9999
ISS COLS   XX     BILL CO   XX                 FACILITY NO                    BY              ON  99 99 9999
                                               XXXXXXX
CO-PAY IND                                     PCT POV         XXX                          BATCH UPDATE
HAWK-I                                         WAIVER IND                     TYPE            ON  99 99 9999
MHC TYPE    XXXXXXXX                           PACE MFP                       TYPE            ON  99 99 9999
XX XXXXXXX XXXXXXXXXXXXXXXXX
XX XXXXXXX XXXXXXXXXXXXXXXXX
                                                PF1 – MAIN MENU              PF5 - RETURN
                                                                                                  283
```

Screen data and field descriptions:

- The person's state identification (ID) number and name in last-name, first-name order appear at the top of the screen.
- **DOB** is the member's date of birth in MM/DD/CCYY format.
- The one-byte field to the right of DOB denotes the person's gender.
  F Female;
  M Male.
- **MEDICAID FOR** is the month and year of eligibility.
- **AID** is the medical primary aid type.

- **FUND** is the fund code for the medical primary aid type. See 14-B-Appendix, TD03 FUND, for valid codes.
- **UNDERLYING ELIGIBILITY FIELDS** indicate if there is any underlying Medicaid eligibility and what type of coverage it is.
  - **AID (1-5)** is the underlying medical aid type.
  - **F (1-5)** is the fund code for underlying medical eligibility. See 14-B-Appendix, TD03 FUND, for valid codes.
  - **SP (1-5)** is the underlying eligibility special claims processing field. See 14-B-Appendix, TD03 QMB and TD03 SRV, for valid codes.
  - **SD (1-5)** indicates whether the member's case has a spenddown (value "Y") or does not have a spenddown (value "N") for the underlying eligibility for the month.
  - **PR (1-5)** is the underlying program relationship code for Medically Needy. See 14-B-Appendix, TD03 MN, for codes.
  - **MP (1-5)** shows the underlying type of foster care Medicaid eligibility the person has, or the underlying eligibility code for transitional Medicaid that shows the number of months of eligibility for primary eligibility. Refer to the description of the MP field at SSNI = Medicaid Eligibility File for the valid codes.
  - **MHC (1-5)** is the managed health care code for the underlying medical coverage. It displays the type of MHC coverage: spaces, "HMO," LOCK-IN," or "MEDIPASS."
  - **WV (1-5)** is the eligibility waiver indicator for the underlying medical coverage. See 14-B-Appendix, TD03 WVR, for valid codes.
  - **P/M (1-5)** is the underlying eligibility PMIC or MHI indicator.
  - **FAC # (1-5)** is the facility, hospice, or waiver vendor number for the underlying coverage. See 14-B-Appendix, TD05 VENDOR CODE.
  - **CAID (1-5)** is the case aid type for the underlying medical coverage.
  - **DATE (1-5)** is the date the underlying eligibility was processed or date of the last update.
- **CASE NO** is the Medicaid member's identifying case number. The person number will display after the case number. See 14-B-Appendix, TD03 PER.

- **HEALTH INS** shows whether the member has any health insurance other than Medicaid. See 14-B-Appendix, TD03 HEALTH, for valid codes for the first, third, and fourth position. For the second position, the following system-generated values may be found:

  D Indicates Part D coverage.

  X Indicates beneficiary has 'confirmed' (from the Part D MMA response file) Medicare Part A or Part B coverage, but no Part D coverage. An 'X' will be present only on eligibility months 01/2006 and later.

  W Indicates that the ABC system shows Medicare Part A or B coverage, but this has not been 'confirmed' by information received from CMS.

  N Beneficiary has 'affirmatively declined' Part D coverage.

  V Indicates Medicare enrollment was verified from CMS when codes D, X, W, and N are not applicable. If the member is not on Medicare, then this code indicates that "no Medicare coverage" has been verified.

- **CASE AID** is the primary case aid type.

- **WKR#/CO** is the four-digit number assigned to the worker who is responsible for the case along with the two-digit county number.

- **MN SPEND DOWN** indicates whether a Medically Needy spenddown is required for primary eligibility to exist. Valid codes are: "Y" for yes there is a spenddown and "N" for no there is no spenddown.

- **SPEC PROCESS** is the special processing field for primary eligibility. The fields below are included as part of this field. The entry in this field is based on a hierarchy established for special processing based on the following sub-fields.

  - **ENH SERV** is the enhanced service code. See 14-B-Appendix, TD03 SRV, for codes.

  - **ALIEN** is the alien code. See 14-B-Appendix, TD03 SRV, for codes.

  - **QMB/SLMB** is the QMB/SLMB code. See 14-B-Appendix, TD03 QMB for codes.

  - **$1 SUPP** is for members receiving assistance through the supplement for Medicare and Medicaid eligibles group. If enrolled, a "J" will be present.

- **MEDID DATE** is the date medical card was issued.

- **MEDID AID** is the type of medical card. The space after the MEDID AID field gives the kind of card. Values are: "space" or "ICA" (IowaCare)

- **SYSTEM DATE** is the eligibility system date or "MNTH-END."
- **PROGRAM REL** is the program relationship code for Medically Needy for primary eligibility. See 14-B-Appendix, TD03 MN, for valid codes.
- **MED PROGRAM** is the field that shows the type of foster care Medicaid eligibility the member has, or the code for TM indicating the number of months of eligibility for primary eligibility. Refer to SSNI = Medicaid Eligibility File for the description of the MP field for the valid codes.
- **IOWA PLAN** indicates whether the person is enrolled in Iowa Plan. An entry beginning with a letter indicates the Iowa Plan; one starting with a number means the person is not in the Iowa Plan. The second position displays gender (F = female and M = male). (The third character is for central office use only and comes from the next space on the screen.)
- **MED STATUS** is used to identify the worker-determined status of the individual's Medicaid eligibility. See 14-B-Appendix, TD03 MED/ST, for valid codes.
- **PMC/MHI IND** is for central office use only.
- **ONLINE UPDATE BY** is the user ID number for the last update processed on line by Quality Assurance for primary eligibility.
- **ONLINE UPDATE ON** is the date of the last update for primary eligibility processed on line by Quality Assurance.
- **ISIS COLS** is the Medicaid member's county of legal settlement.
- **BILL CO** is the eligibility billing county.
- **FACILITY NO** is the facility, hospice, or waiver vendor number. See 14-B-Appendix, TD05 VENDOR.
- **ONLINE UPDATE BY (2)** is the user ID number of the last update processed on line.
- **ONLINE UPDATE ON (2)** is the date of the last update processed on line.
- **CO-PAY IND** is code used to determine the member's copayment for medical services. See 14-B-Appendix, TD03 COPAY.
- **PCT POV** is the member's percent of poverty level.
- **HAWK-I** displays the code that indicates whether the member was referred to Medicaid from ***hawk-i***. Valid codes are: Y = Yes, ***hawk-i*** referral. N = Non ***hawk-i*** referral.

- **WAIVER IND** displays the type of waiver eligibility. See 14-B-Appendix, TD03 WVR, for valid waiver codes.
- **BATCH UPDATE TYPE** indicates which update process occurred. "M" is for monthly. "D" for daily.
- **BATCH UPDATE ON** is the date the last update of that type processed.
- **MHC TYPE** is the field used to display the type of managed health care coverage: spaces for none, "HMO," "LOCK-IN," or "MEDIPASS"
- The next space has a two-digit value that is for central office use only.
- The vendor number is displayed. The vendor number is a unique identifier for each provider that gives services in the Medicaid program.
- The name of the Medicaid provider is displayed.
- **PACE** indicates if member is enrolled in a PACE (program of all-inclusive care for the elderly) organization. Valid values are:

  Y Member is in PACE
  Blank Member is not in PACE

- **MFP** indicates if the member is participating in the MFP (Money Follows the Person) program. Valid values are:

  Y Member is participating in MFP
  Blank Member is not participating in MFP

- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three–digit program code used by the Division of Data Management.

The PF function keys displayed on the DETL MTH screen are:

PF1 = MAIN MENU	Transfers to the main menu of the SSNI-Medicaid Eligibility File.
PF5 = RETURN	Returns to SSNI (screen 1 or 2) whichever was started at. The screen page where the PF-5 DETL MNTH of time was initiated.

Title XIX Count Display

The TITLE XIX COUNT DISPLAY screen provides the total Medicaid eligibility file counts for the current month and the preceding month on specified data elements. The current counts are updated by entries made in Quality Assurance and by daily processing. The preceding month counts are updated in daily processing.

To access the TITLE XIX COUNT DISPLAY, press the PF3 key from the SSNI Selection menu. The system displays the following:

```
TITLE XIX COUNTS FOR PROCESS MONTH                    CURRENT COUNTS
TOTAL COUNTS
TOTAL ELIGIBLE RECIPIENTS                        TOTAL ELIGIBLE ON LOCKIN
TOTAL INELIGIBLE RECIPIENTS                      TOTAL ELIGIBLE IN AN HMO
TOTAL RECORDS                                 TOTAL ELIGIBLE IN MEDIPASS
MONTH TO DATE COUNTS
TOTAL RECIPIENTS ADDED
TOTAL RECIPIENTS ENDED DUE DEATH
TOTAL RECIPIENTS MADE ELIGIBLE FOR CURRENT MONTH
TOTAL NUMBER OF PRIOR MONTHS MADE ELIGIBLE
                    PF1 = RETURN TO MAIN MENU
                    PF2 = DISPLAY PRIOR MONTH COUNTS
```

TPL Screen

The TPL screen displays third-party coordination of benefits information for the current member displayed on the SSNI screen. This screen is accessed from SSNI (screen 1 or 2) by pressing the PF6 key.

```
TPL INFO FOR:    9999999X  XXXXXXXX,          XXXXXXXXXXXXXXXXXXXXXX          BIRTHDATE:  MM/DD/CCYY

     BEGIN DATE:   MM/DD/CCYY        END:    MM/DD/CCYY                ADDED:    MM/DD/CCYY
COMPANY CODE:   XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     POLICY NBR:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  POL HLDR SSN:   999-99-9999                RELATIONSHIP:    X  XXXXXXXXXXXXXXX      HIPP IND:    X
      COVERAGE:   99       XXXXXXXXXXXXXX      99       XXXXXXXXXXXXXX         99       XXXXXXXXXXXXXX
                  99       XXXXXXXXXXXXXX      99       XXXXXXXXXXXXXX

     BEGIN DATE:   MM/DD/CCYY        END:    MM/DD/CCYY                ADDED:    MM/DD/CCYY
COMPANY CODE:   XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     POLICY NBR:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  POL HLDR SSN:   999-99-9999                RELATIONSHIP:    X  XXXXXXXXXXXXXXX      HIPP IND:    X
      COVERAGE:   99       XXXXXXXXXXXXXX      99       XXXXXXXXXXXXXX         99       XXXXXXXXXXXXXX
                  99       XXXXXXXXXXXXXX      99       XXXXXXXXXXXXXX

     BEGIN DATE:   MM/DD/CCYY        END:    MM/DD/CCYY                ADDED:    MM/DD/CCYY
COMPANY CODE:   XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     POLICY NBR:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  POL HLDR SSN:   999-99-9999                RELATIONSHIP:    X  XXXXXXXXXXXXXXX      HIPP IND:    X
      COVERAGE:   99       XXXXXXXXXXXXXX      99       XXXXXXXXXXXXXX         99       XXXXXXXXXXXXXX
                  99       XXXXXXXXXXXXXX      99       XXXXXXXXXXXXXX
PF1=MENU,    PF5=COMPANY DTL,    PF6=SSNI INQ,    PF7=PREV,    PF8=NEXT                                XXX
```

TPL screen data and field descriptions are:

- **TPL INFO FOR** is the person's state identification number and name in last name, first name order.
- **BIRTHDATE** is the member's date of birth in MM/DD/CCYY format.
- **BEGIN DATE** is the date the coverage began in MM/DD/CCYY format.
- **END DATE** is the date the coverage ended in MM/DD/CCYY format. A blank date indicates open-ended coverage.
- **ADDED** is the date this information was added in MM/DD/CCYY format.
- **COMPANY CODE** is the insurance company's unique identification number and name.
- **POLICY NBR** is the policy number.
- **POL HLDR SSN** is social security number of the policyholder.
- **RELATIONSHIP** specifies the relationship between the policyholder and the member. Values are:

1	Self	6	Brother/sister
2	Absent parent	7	Uncle/aunt
3	Other	8	Grandparent
4	Parent	9	Legal Guardian
5	Spouse		

- **HIPP IND** is a one-byte space reserved for future use.
- **COVERAGE** is the type of coverage this policy provides. Values are:

01	Basic hospital	17	Medicaid trust
02	Basic medical	18	Veterans Affairs benefits
05	Hosp. indemnity	19	Pharmacy
06	Major medical	20	Vision
07	Accident only	23	Medicare Part A
12	Medicare supplement	24	Medicare Part B
13	Nursing home supplement	25	Casualty
15	Dental	99	Pseudo
16	CHAMPUS		

- **###** is a three–digit program code used by the Division of Data Management.

The PF functions keys displayed are:

PF1=MENU	Transfers to the main menu of the SSNI-Medicaid Eligibility File.
PF5=COMPANY DTL	Transfers to the Insurance Company Detail screen **if** the cursor is placed anywhere on a populated TPL record occurrence.
PF6=SSNI INQ	Returns to SSNI (screen 1 or 2) whichever was started at. The screen page where the PF-6 TPL screen request was initiated.
PF7=PREV	Scrolls backwards to previous TPL Information screen, if any.
PF8=NEXT	Scrolls forwards to next TPL Information screen, if any.

Insurance Company Detail Screen

The Insurance Company Detail screen displays provider name, address and phone number. Placing the cursor on any populated TPL record occurrence on the TPL screen and pressing the PF5 key allows access to this screen.

```
                          INSURANCE COMPANY DETAIL                DATE:   MM/DD/CCYY

   COMPANY NUMBER:  9999

     COMPANY NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

            ADDR1:  XXXXXXXXXXXXXXXXXXXXXXXX

            ADDR2:  XXXXXXXXXXXXXXXXXXXXXXXX

             CITY:  XXXXXXXXXXXXXXXXX    ST:    XX    ZIP:    99999 9999

   CONTACT PHONE:   999 999 9999


PF1=MENU      PF5=BACK      PF6=SSNI INQ                                        XXX
```

The PF function keys displayed are:

PF1=MENU	Transfers to the main menu of the SSNI-Medicaid Eligibility File.
PF5=BACK	Transfers back to the TPL information screen.
PF6=SSNI INQ	Returns to SSNI (screen 1 or 2) whichever was started at. The screen page where the PF-6 TPL screen request was initiated.

WIFS Messages

This section contains information regarding WIFS messages. "WIFS" stands for "warnings, informational, fatal, and summary." WIFS messages are E-mail messages sent to inform workers that action may need to be taken on a designated system.

Although WIFS E-mail indicates that it was sent from the SPIRS Help Desk or IM Systems Mainframe, it is actually system-generated by one of the following systems or processes:

- ABC
- ***hawk-i*** Referral
- ISIS
- MIPS Billing
- PREM (MEPD) Billing
- TXIX (SSNI)

Three types of WIFS messages are sent to income maintenance workers:

- **W** = warning message: A "W" message indicates a possible problem with the billing system or a person's medical record. You need to check the system to make sure all the information entered is correct.
- **I** = informational message: An "I" message alerts you to certain conditions or provides information important to you.
- **F** = fatal message: An "F" message notifies you that the billing system has not updated for an individual. You should take an action to allow the system to update.

S = summary messages are not sent to income maintenance workers. These messages are by program and are printed in a report for use by data processing staff.

The following sections explain:

- The contents of a WIF message,
- The identification and resolution for messages issued from:
  - The ***hawk-i*** referral screens
  - ISIS
  - The MIPS Billing System
  - The PREM (MEPD) Billing System
  - The TXIX (SSNI) System

(See 14-B-Appendix for an explanation of WIFS issued from the ABC system.)

Contents of a WIFS Message

Each WIFS E-mail you receive contains information about only one person. Each WIFS message may contain the following information:

- Your worker number
- Your county number
- The member's state identification number
- The member's case name
- The member's case number
- The system that generated the message (HWKI, ISIS, MIPS, PREM, TXIX, or ABC)
- The type of message (warning, informational, or fatal)
- The program number (located after the type of message). This is used for research purposes only.
- The WIFS message number (located after the program number). This number corresponds to the message that is included in the E-mail.
- A generic field that is used to relay specific information in addition to the WIFS message, such as an aid type, a benefit month, or a worker number/county number.
- The actual WIFS message that informs you of the reason the WIFS was issued.

hawk-i WIFS Messages

The table below shows all of the ***hawk-i*** eligibility-related WIFS messages an income maintenance worker could receive.

WIFS No.	Message Sent To Worker	Definition/Resolution
4000 HWKI	Medicaid for some/all of the children was denied/canceled due to excess income.	The specified case has a 92-0 aid type and has been canceled or denied using notice reason 205. This message reminds you that the children on the case are ineligible for Medicaid due to income exceeding the 133% of poverty. Complete a referral to the ***hawk-i*** program.

ISIS WIFS Messages

The table below shows all of the WIFS messages sent to workers from the Individualized Services Information System (ISIS). If you are unable to resolve the issue using information given below, contact the SPIRS Help Desk.

WIFS No.	Message Sent To Worker	Definition/Resolution
11001 ISIS	The existing pend must be closed in ISIS before pending another program.	One waiver program was still pending in ISIS when action to pend a different waiver program was entered in ABC. ISIS accepts only one pended program at a time. Decide which waiver you want to work through the workflow in ISIS and make sure that is the one passed to ISIS.
11002 ISIS	The pend failed because the consumer is already active for the program.	The action to pend had the same waiver type as the waiver active in ISIS. This occurs if the waiver code is not changed when the action to pend is entered in ABC on a person that is active on another case for a waiver program.
11099 ISIS	Action taken did not pass to ISIS. Send request to ISIS field support.	Entries made to pend the case in ABC did not roll to ISIS.
21002 ISIS	Begin dates overlap.	The beginning date on the ABC activity to approve is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
21003 ISIS	Incorrect program type on approval.	The waiver code at the time approval was entered is not a valid waiver code. Entries made to the case in ABC did not roll to ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
21004 ISIS	ISIS end date overlaps the begin date on this action.	The beginning date on the ABC approval is earlier than the end date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
22001 ISIS	Begin dates overlap.	The beginning date on the ABC approval is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
22002 ISIS	ISIS end date overlaps the begin date on this action.	Entries made to approve the case in ABC did not roll to ISIS because there was an end date on ISIS that is later than the effective date on the ABC approval. Verify the end date on ISIS and ask to have it corrected if it is wrong.
22003 ISIS	A pend program request exists. Possible incorrect waiver type on this action.	The waiver code at the time approval was entered is different than the program request that is pending in ISIS. Check ISIS to make sure the right program was approved.
22004 ISIS	The most recent program request is a pend. Missing approval may need to be added.	The approval may not have passed to ISIS. Check ISIS to make sure the right program and effective date was approved in ISIS.
23099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made to change a provider number on the case in ABC did not "roll" to ISIS.
31001 ISIS	The eligibility record was not found. Missing approval may need to be added.	Client participation was changed but there was no active program request in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
31002 ISIS	The eligibility record was not found. Missing approval may need to be added.	Client participation was changed but there was no active program request in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.
31003 ISIS	CP change. Begin date overlaps ISIS date. Complete vendor adjustment.	The beginning date on the ABC entries to change client participation is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
31004 ISIS	All eligibility is closed. Missing approval may need added before CP change.	Entries were made in ABC to change client participation on a case that is closed in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.
31005 ISIS	CP change. The program type must match ISIS.	The waiver code at the time client participation was changed is different than the program request that is active in ISIS. Check ISIS to make sure the right program is active.
31006 ISIS	CP change. ISIS already has the requested CP information.	The client participation change passed to ISIS already matches the client participation amount shown on the active program request in ISIS. Check ISIS to make sure all client participation amounts are correct.
31099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made to change client participation on the case in ABC did not "roll" to ISIS.
31101 ISIS	CP correction. Program request not found.	Client participation was corrected but there was no active program request in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
31102 ISIS	CP correction. Begin date overlaps ISIS date. Submit vendor adjustment form.	The beginning date in the ABC entries to correct client participation is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
31103 ISIS	CP correction. All program requests are closed.	Entries were made in ABC to correct client participation on a case that is closed in ISIS.
31104 ISIS	CP correction. The program type does not match ISIS.	Entries to correct client participation were made in ABC, but the program passed from ABC does not match program on the active ISIS program request.
32001 ISIS	Change of ownership. The program and provider must match.	When change of ownership takes place, central office staff will send instructions.
32002 ISIS	Change of ownership. The begin date must match.	When change of ownership takes place, central office staff will send instructions.
33001 ISIS	COLS change. The eligibility was not found.	The county of legal settlement was changed but there are no active program requests in ISIS.
33002 ISIS	Change is COLS. Begin date overlaps ISIS dates.	The county of legal settlement was changed and the beginning date passed from ABC is earlier than the beginning date on the latest program request in ISIS.
33003 ISIS	Change in COLS. All program requests are closed.	The county of legal settlement was changed but all program requests in ISIS are closed.

WIFS No.	Message Sent To Worker	Definition/Resolution
33004 ISIS	COLS change. The COLS matches ISIS.	The county of legal settlement was changed and the county entered in ABC already matches the county of legal settlement in ISIS.
34001 ISIS	The worker is not on ISIS or is not enabled.	The worker number was changed in ABC but the new worker does not have current access to ISIS. The supervisor will need to request access for this worker.
34002 ISIS	More recent eligibility already exists.	The worker number has changed. Verify that the worker assigned on the Roles page in ISIS is correct.
34003 ISIS	All program requests are closed.	The worker number has changed. Verify that the worker assigned on the Roles page in ISIS is correct.
34004 ISIS	No eligibility record found.	Worker number changed but there are no program requests in ISIS. Verify that the program approved in ABC is active in ISIS.
34005 ISIS	Worker county missing.	The worker number was changed but the worker county was left blank. Verify that the worker assigned in ABC matches the worker on the Roles page in ISIS.
34006 ISIS	Supervisor missing.	The IM worker number on the ABC case when entries were made does not have access to ISIS, and no supervisor is assigned to that worker's county in ISIS. The supervisor needs to make sure that: ♦ The supervisor is assigned to the correct county in ISIS; ♦ The IM worker has access to ISIS; and ♦ The worker number assigned to that worker for ABC is also assigned to that worker in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
40001 ISIS	Denial. There is no pended program request.	No program requests were pending in ISIS when the denial was passed from ABC. If the denial did not get to ISIS, pend and then deny the case again in ABC.
40002 ISIS	Denial. Program types do not match.	This message usually means that the waiver code on the TD03 screen was not correct when the denial was entered in ABC.
51001 ISIS	Cancellation. Eligibility not found. Missing program needs to be added.	Cancellation entries were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
51002 ISIS	Cancellation. Eligibility not found. Missing program needs added.	Cancellation entries were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
51003 ISIS	Cancel. Eligibility already cancelled. Check for missing program request.	Cancellation entries were made in ABC but all program requests in ISIS are already closed. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
51004 ISIS	Cancel. No matching eligibility found. Check for missing program request.	Cancellation entries were made in ABC but the program requests for this waiver or facility type are already closed in ISIS. The TD03 screen may have had an incorrect waiver code when entries were made. Make sure the correct program request was closed in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
51005 ISIS	Cancel. Program types do not match. Possible incorrect waiver code.	Cancellation entries were made in ABC but the program requests for this waiver or facility type is already closed in ISIS. The TD03 screen may have had an incorrect waiver code when entries were made. Make sure the correct program request was closed in ISIS.
51099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made in ABC did not "roll" to ISIS.
52001 ISIS	Cancellation. Eligibility not found. Check for missing program request.	Cancellation entries due to death were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
52002 ISIS	Cancellation. Death date is prior to eligibility start date.	Entries were made in ABC to cancel the person due to death and the date of death entered is before the beginning date of the waiver. Verify that the date of death entered is correct.
52003 ISIS	Cancel. Eligibility already cancelled. Check for missing program request.	Cancellation entries due to death were made in ABC but all program requests in ISIS are already closed. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
52004 ISIS	Cancellation. Eligibility not found. Check for missing program request.	Cancellation entries due to death were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
52099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made in ABC to cancel due to death did not "roll" to ISIS.
61001 ISIS	Program eligibility not found. Check for missing program request.	Entries made to correct the provider number but there are no program requests in ISIS. Check to make sure the program approved in ABC is active in ISIS.
61002 ISIS	Correction. Program start date did not match.	Entries were made to correct the provider number but the beginning date on the program request in ISIS does not match the date passed from ABC. Send request for correction of the provider number in ISIS.
62001 ISIS	Program eligibility not found. Check for missing program request.	Entries were made to correct client participation, but there are no program requests in ISIS. Check to make sure the program approved in ABC is active in ISIS.
62002 ISIS	Correction. Program start date did not match.	Entries were made to correct client participation, but the beginning date passed from ABC does not match the beginning date on the program requests in ISIS. Send a request for correction of client participation.
62101 ISIS	Program eligibility not found. Check for missing program request approval.	Entries were made to correct client participation, but there is no program request in ISIS. Make sure the program approved in ABC is active in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
63001 ISIS	Program eligibility not found. Check for missing program request approval.	Entries were made to correct the aid type, but there are no program requests in ISIS. Check ISIS to make sure the program approved in ABC is active in ISIS.
63002 ISIS	Correction. Program start date did not match.	Entries were made to correct the aid type, but there are no program requests in ISIS. Check ISIS to make sure the program approved in ABC is active in ISIS.
90001 ISIS	A previous activity errored for this consumer. This was bypassed.	Check ISIS to make sure the information in ABC matches ISIS.
90002 ISIS	Residence county error.	The county of residence was invalid.
90003 ISIS	IABC action could not be interpreted in ISIS.	Check ISIS to make sure the information in ABC matches ISIS.
90004 ISIS	IABC action could not be interpreted in ISIS.	With message **99920**: the aid type is for facility care but there was a waiver code on the TD03 screen when the entries were made, e.g., the aid type is 63-8, ICF/MR, but the waiver code is D for MR waiver. With message **98904**: the aid type and provider or program type disagree. Verify that the correct waiver code and aid type were present when entries were made. With message **99921**: the facility waiver status on TD05 didn't match the facility waiver status for the person on TD05. Check to see if you entered the TD03 status but failed to enter the TD05 status.

WIFS No.	Message Sent To Worker	Definition/Resolution
90004 ISIS (Cont.)		With message **99908**: you entered another change (such as correcting the waiver code) along with a client participation change. This message may also be received when: ♦ The case used to approve a waiver includes additional inactive individuals. ♦ Entries are made on a consumer's TD01 or TD03 screen but no entries are made on the TD05 screen, so ISIS is unable to determine whether the action taken in ABC affects ISIS information.
90005 ISIS	Invalid provider number, or provider number found on HCBS waiver activity.	This message is issued when: ♦ The waiver code is not changed when actions are entered on a person who is pending on a waiver and active for facility care; or ♦ The person is active on a waiver and facility care is pended without changing the waiver code.
90006 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	With message **98902**: the vendor number and waiver code are an invalid combination. For example, a blank vendor number indicates a waiver case, so the waiver code can't be blank. For a facility case, the waiver code can be blank but a vendor number must be present. With message **98912**: the aid type was changed when the client participation was changed. Currently ISIS does not allow aid type changes at the same time as client participation is changed.

WIFS No.	Message Sent To Worker	Definition/Resolution
90006 ISIS (Cont.)		With message **98915**: IM entered an aid type change. Verify that the aid type is correct for the program and the person's age. With message **99901**: There was no individual on the case. If this is a hospital-only aid type (73-4), the case was pulled into ISIS in error and may be ignored. If this is an entry for death, it may be issued for other case numbers the deceased person was associated with in the person's lifetime. With **99966**: the positive date in ABC was invalid or missing. With message **99969**: Entries on the TD05 screen were left to roll to the TD03 screen. (For example, you denied the case on TD05 and let the denial roll to the TD03, rather than making the A entry reason and M status code entries on TD03.) ISIS is sometimes unable to apply the activity when the TD03 individual entries are not actually entered. The message may also be issued when: ♦ The waiver code was left blank when the denial of a waiver was entered. ♦ Information is entered for the same person on more than one case in the same day. ♦ The case is denied on the TD05 screen but no denial entries are entered in the TD03 screen. Denial entries roll to TD03 in ABC, but this may result in ISIS' inability to identify the individual.

WIFS No.	Message Sent To Worker	Definition/Resolution
99998 ISIS	A previous activity record errored for this consumer.	Check ISIS to make sure the information in the ABC system matches ISIS.
99999 ISIS	ISIS was not able to interpret your request.	Check ISIS to make sure the information in the ABC system matches ISIS.

MIPS WIFS Messages

The table below lists all of the MIPS-related WIFS messages an income maintenance worker could receive.

WIFS No.	Message Sent To Worker	Definition/Resolution
27 MIPS	No MIPS billing information for this state ID	The MIPS billing system has not receive a premium record from the ABC system for this member. Review the case. Determine why a premium record was not generated from ABC. Resubmit the ABC entry or make entries on the RETR screen to update MIPS.
29 MIPS	No MIPS billing information for this elig. Month	The MIPS billing system has not received a premium record from the ABC system for this member. This could be due to either: ♦ Entry of a RETRO code on TD05 **after** the IowaCare case has been approved on ABC, or ♦ Entry that backdates medical eligibility on the TD03. Use the RETR screen to add this month for billing.

WIFS No.	Message Sent To Worker	Definition/Resolution
100 MIPS	Date invalid	ABC has transferred an invalid date. (The WIFS message indicates which date.) Reenter the correct date into ABC.
101 MIPS	Field invalid	ABC has transferred an invalid code. Reenter the correct code into ABC.
102 MIPS	Date not numeric	ABC has transferred a date that is not numeric. (The WIFS message indicates which date.) Correct the date in ABC.
103 MIPS	Field not numeric	ABC has transferred a code that must be numeric and an alphabetical code was passed instead. (The WIFS message indicates which field.) Correct the code in the ABC system.
3002 MIPS	MIPS – late payment received, hardship, death, or other Medicaid elig overlaid IACare. Possible reinstate/reopen/re-fund. Check ELG code on SUMM screen. Take appropriate action.	This message is generated when: ♦ A late payment is received, ♦ A hardship is granted, ♦ An IowaCare member dies, or ♦ Other full Medicaid eligibility overlays IowaCare. Determine what action to take: reinstate, reopen, or authorize refund.
3005 MIPS	Already active on TXIX	Medicaid is already active for the premium date month.
3013 MIPS	Block paid month – Possible recoupment	Someone has blocked a paid month. Therefore, the money is put back into the credit. Review the case to determine if a recoupment needs to be completed.
3016 MIPS	Requested refund greater than base credit	A refund has been issued for an amount that is greater than the credit amount in the MIPS system. Determine if recoupment is appropriate.

WIFS No.	Message Sent To Worker	Definition/Resolution
3020 MIPS	Not updated via ABC entry/see MIPC or RETR to update current/prior month	A reapplication was completed on a MIPS case and the positive action date is for a month that is already established on MIPS. Change the premium amount for the month indicated in the WIFS message using the MIPC or RETR screen, whichever is appropriate.
3021 MIPS	Only system month updated via ABC entry/see MIPC or RETR to update prior months	A premium has been approved for a month that is already established on MIPS. The new premium did not update for the months before the current system month. (EXAMPLE: In July, you approve a premium with a positive date of June 1. If June is already established on MIPS, the system will not update June with the new premium. The current system month, July, will update with the new premium because it was never previously updated on MIPS.) Change the premium amount for the months before the current month using the MIPC screen.

WIFS No.	Message Sent To Worker	Definition/Resolution
3039 MIPS	Billing month set up with possible incorrect premium. Use MEPC to correct each mnth. Correct ongoing premium via ABC. Must receive ABC correction to ensure correct premium amt for next mnth.	The Medicaid Eligibility system has received an invalid premium record from ABC. The MEPD Billing system uses the previous premium record received to establish premium amount and set up billing for this individual. Review the case. If the premium is correct, no action is necessary. If the premium is incorrect, the specific billing month must be corrected through MEPC, and the ongoing premium amount must be corrected in the ABC system.
3043 MIPS	Userid not on worker table – Retro not processed	Someone who does not have authorization to enter a month on the RETR screen attempted to enter eligibility. The system did not process it, as the person was not authorized to make that entry.
3074 MIPS	Overlapping mandatory periods – Initial mandatory period remains in effect	MIPS has received a record overlapping a previous mandatory period already established on MIPS. The billing system will ignore the new mandatory period and simply process this premium record as normal.
3075 MIPS	New mandatory period record. Previous mandatory period is unpaid.	A case has been approved that should not have been approved because there are still months from a mandatory period that remain unpaid.
3078 MIPS	Transaction record received, transaction should not have been allowed due to unpaid month	MIPS has received a record of eligibility for a person who has unpaid premiums. MIPS has sent an automatic notification to the ABC system that premium payment has not been received, and the case must be closed due to nonpayment of premium. Review the case to determine if the case should be closed or if it can remain open.

WIFS No.	Message Sent To Worker	Definition/Resolution
3084 MIPS	Hardship cannot be removed	Someone attempted to remove a hardship from a month. This action is not allowed.
3092 MIPS	ABC sent a premium record to TXIX, but no eligibility record was received for this individual.	ABC has sent a premium record to the Medicaid Eligibility system, but the MEPD billing system has not received an eligibility record. No billing occurs. No eligibility will be established for this individual. A medical eligibility record must be generated from the ABC system or through the RETR screen
3099 MIPS	Reported date of death – eligibility received for month after month of death. Please review case.	MIPS has received an eligibility record for a month after the month that has already been recorded in the Medicaid Eligibility system as the month of the client's death. The Medicaid Eligibility system has set up eligibility on SSNI and the MIPS system has also processed the information. Determine if the client is truly deceased or if you are correct in approving eligibility.
3100 MIPS	Premium information not found. Unable to start billing.	MEPD has received an eligibility record but no premium record. The eligibility record is recycled until a premium record is received. A new premium record must be generated from the ABC system or through the RETR screen. This message is sent daily until the premium record is received.

PREM WIFS Messages

The table below lists all of the MEPD-related WIFS messages an income maintenance worker could receive.

NOTE: PREM 3001 is also sent to the worker's supervisor. This is a safeguard to ensure that action is taken to cancel the case before timely notice day, in the event that the worker is out of the office.

WIFS No.	Message Sent To Worker	Definition/Resolution
27 PREM	No PREM billing information for this state ID	The Medicaid Eligibility system has not received a premium record for the person from the ABC system. This usually occurs when there is more than one person on the active MEPD case. Review the case. Close the individual who is not the case-name person. Reopen that person on a separate ABC case if appropriate. If the person is not eligible for Medicaid, simply close the person on this case.
29 PREM	No PREM billing information for this elig. month	The Medicaid Eligibility system has not received a premium record for this month. This can occur when two people are on the same MEPD case. Review the case. Close the individual who is not the case-name person. Reopen that person on a separate ABC case if appropriate. If the person is not eligible for Medicaid, simply close the person on this case.
100 PREM	MEPD Date invalid	ABC has transferred an invalid date. (The WIFS message indicates which date.) Reenter the correct date into ABC.

WIFS No.	Message Sent To Worker	Definition/Resolution
101 PREM	MEPD Field invalid	ABC has transferred an invalid code. Reenter the correct code into ABC.
102 PREM	MEPD – Date not numeric	ABC has transferred a date that is not numeric. (The WIFS message indicates which date.) Correct the date in the ABC system.
103 PREM	MEPD – Field not numeric	ABC has transferred an alphabetical code in a field that must be numeric. (The WIFS message indicates which field.) Correct the code in the ABC system.
3001 PREM	Cancel case due to nonpayment of current month premium (Also sent to the worker's supervisor – See 3072 PREM)	Cancel the case by the timely notice date, because the current month premium has not been paid by the due date.
3002 PREM	Late payment received – 484 reinstate or 485 reopen	Review the case because a late payment has been received. If all other eligibility requirements are met, then reopen or reinstate the case.
3003 PREM	MEPD – Positive action date less than 03/01/2000	The positive action date is before the beginning of the MEPD program. Correct the positive action date.
3004 PREM	MEPD – Approval date less than 03/01/2000	The positive action date is before the beginning of the MEPD program. Correct the positive action date.
3005 PREM	MEPD – Already active on TXIX for start month	Medicaid is already active for the month of positive action date.
3009 PREM	MEPD – ESTD/Fiscal agent to release spenddown	Reserved for future use.

WIFS No.	Message Sent To Worker	Definition/Resolution
3013 PREM	MEPD – Block paid month – possible recoupment	A paid month has been blocked on the MEPC screen. Determine if a recoupment is appropriate.
3016 PREM	MEPD – Requested refund greater than base credit	A refund has been issued for an amount that is greater than the credit amount in the MEPD system. Determine if recoupment is appropriate.
3020 PREM	MEPD – No months updated via ABC entry/see MEPC or RETR to update prior months	A reapplication has been completed on an MEPD case and the positive action date is for a month that is already established on MEPD. If the current system month has already been established on MEPD, the only month that has been updated on the MEPD system is the next system month. Change the premium amount for the current or previous month using the MEPC screen.
3021 PREM	MEPD – Only system month updated via ABC entry/see MEPC or RETR to update prior months	MEPD has been approved for a month that is already established on MEPD. The new premium did not update for the months before the current system month. (For example, in July, you approve MEPD with a positive date of June 1. If June is already established on MEPD, the system will not update June with the new premium. July, which is the current system month, will update with the new premium because it was never previously updated on MEPD.) Change the premium amount for the months before the current month using the MEPC screen.

WIFS No.	Message Sent To Worker	Definition/Resolution
3026 PREM	MEPD – Percent of poverty cannot be zero if income greater than zero	There is income entered on the RETRO screen for this person, but the poverty level entered is 000. Since this person has income, the poverty level must be greater than 0. Determine the poverty level and use the MEPC screen to correct it.
3041 PREM	MEPD – E-mails were sent to workers to cancel for nonpayment of current premium	Review case and cancel if appropriate.
3047 PREM	MEPD – Premium payment received after automatic refund was issued in the previous month	Payment has been received, but there are no active months for which to apply it. This may happen if the client is canceled from MEPD but does not realize it and continues to pay a premium. Review the case and instruct the client to stop making payments if the case is closed.
3050 PREM	Aid type now primary eligible. Past max due date.	Medically Needy with a "P" fund code is in underlying eligibility with MEPD ('P' fund code) in primary eligibility. The time limit to pay the MEPD premium has gone past the MAX DUE DATE, so the 60-M record goes to underlying eligibility, and the 37-E 'P' becomes the primary eligibility.
3055 PREM	Mnth is inactive in PREMIUM system – use RETR screen to update medical eligibility	The month in the MEPD system has gone past its maximum due date, or there is already other medical eligibility on SSNI for this month. Verify that the member wants MEPD for this month and make entries on the RETR screen in the MEPD system to activate eligibility.

WIFS No.	Message Sent To Worker	Definition/Resolution
3056 PREM	MEPD – Premium is invalid for month/year stated. Use MEPC to correct premium.	The MEPD system has determined that the member has been billed an incorrect premium amount for the specified month and may already have received Medicaid eligibility for the month. Correct the premium amount and income using the MEPC screen. Recoup the difference between what has been paid and the total amount owed.
3072 PREM	Cancel case due to nonpayment of current month premium. (Also sent to IM worker – see 3001 PREM)	Cancel the case by the timely notice date, because the current month premium has not been paid by the due date.
3074 PREM	ABC sent a premium record to TXIX, but no eligibility record was received for the individual.	ABC has sent a premium record to the Medicaid Eligibility system, but the MEPD Billing system has not received an eligibility record. No billing will occur. No eligibility will be established for this individual. A medical eligibility record must be generated from the ABC system or through the RETR screen.
3080 PREM	MEPD - Billing month set up with possible incorrect premium. Use MEPC to correct each mnth. Correct ongoing prem via ABC. Must receive ABC correction by mnth end to ensure correct premium amt for next mnth.	The Medicaid Eligibility system received an invalid premium record from ABC. The MEPD billing system used the previous premium record received to establish premium amount and set up billing for this person. Review the case. If the premium is correct, no action is necessary. If it is wrong, the specific billing month must be corrected on MEPC, and the ongoing premium amount must be corrected on ABC.

WIFS No.	Message Sent To Worker	Definition/Resolution
3100 PREM	Premium information not found. Unable to start billing.	MEPD received an eligibility record but no premium record. The eligibility record is recycled until a premium record is received. A new premium record must be generated from the ABC system or through the RETR screen. This WIFS message will be sent out daily until the premium record is received.

Medicaid Eligibility WIFS Messages

The table below shows all of the Medicaid eligibility-related WIFS messages an income maintenance worker could receive.

WIFS No.	Message Sent To Worker	Definition/Resolution
3000 TXIX	Med Needy w/SD and active aid type aid type – ESTD/IME MN unit to release spenddown	The Medicaid Eligibility system has received an active medical aid type and a Medically Needy record with spenddown for the same month. Ask the IME Medically Needy Unit to release the spenddown amount. See 14-I, Changes and Corrections.
3001 TXIX	Potential Med Needy with no spenddown	The Medicaid Eligibility system has received a Medically Needy record with a "P" fund code but no spenddown amount. Either enter spenddown needs in the ABC system, or correct the fund code.
3002 TXIX	Aid type becomes primary aid type over Med Needy w/no spenddown	There is already active Medically Needy eligibility on SSNI when another active medical record is received for the same benefit month. The active medical aid type will be the primary eligibility on SSNI for that month.

WIFS No.	Message Sent To Worker	Definition/Resolution
3004 TXIX	Foster care/adoption & MN/SD. ESTD/IME MN unit to release SD for the month of FC/A eligibility	A foster care or adoption record and a Medically Needy record with spenddown have been received for the same month. Determine if the Medically Needy case should remain open. Notify the IME Medically Needy Unit to release the spenddown for the month that foster care or adoption eligibility has been approved. See 14-I, Changes and Corrections.
3005 TXIX	Foster care/Adopt – primary aid type active – no accompanying active aid type	When foster care is approved for a child, the Medicaid Eligibility system should receive two records to process: the foster care record and a medical record. The Medicaid Eligibility system did not receive both records and was unable to process medical eligibility without the two records. Determine which record was not received.
3006 TXIX	Aid type not valid with Foster care/adoption. No active medical eligibility.	The Medicaid Eligibility system has received a foster care or adoption record and no valid medical record. The medical record the Medicaid Eligibility system has received is either a Medically Needy case with a spenddown or an MEPD case with a premium. If a child is approved for foster care or adoption medical assistance, Medically Needy with a spenddown or MEPD with a premium is not allowed. The medical eligibility has to be approved under a different aid type, or Medically Needy without a spenddown, or MEPD without a premium.

WIFS No.	Message Sent To Worker	Definition/Resolution
3007 TXIX	Review all addresses on active ABC cases. All addresses must match.	The addresses received for one person for a specific month do not match on all medical cases. (If a person has a separate Food Assistance case, the Food Assistance case is not included.) Correct the addresses on the ABC system so all addresses are written the same. This ensures that the billing statements are mailed to the correct address.
3012 TXIX	Facility & MEPD, review all cases. Determine if all cases should remain open.	The Medicaid Eligibility system has received a facility record and a MEPD record for the same benefit month. The system assumes the facility eligibility is based on MEPD. If the MEPD premium is not paid, MEPD stays in as the primary eligibility and facility is the underlying eligibility. Once the premium is paid, the facility record will become the primary eligibility and MEPD will become the underlying eligibility. If the MEPD premium is $0, the facility record will be the primary eligibility and MEPD will be underlying. View both case records to verify that both cases should remain open.
3013 TXIX	Corrections required on ABC-Check DOB & aid type – Under age 65 with elderly aid type	This message contains the person's date of birth, age, and aid type. It is possible that the wrong aid type was used for this person or the wrong date of birth was entered in ABC. Check the aid type and date of birth and make corrections for the following month.

WIFS No.	Message Sent To Worker	Definition/Resolution
3016 TXIX	Medicaid for Independent Young Adults (MIYA) cannot be established for months prior to 07/2006.	The Medicaid Eligibility system has received a MIYA eligibility record for a month before the start date of the program. The eligibility is not processed.
3017 TXIX	Family planning Eligibility cannot be established for months prior to 02/2006.	The Medicaid Eligibility system has received an FPW eligibility record for a month before the start date of the program. The eligibility is not processed.
3020 TXIX	Eligibility month requested is more than 24 months ago	The Medicaid Eligibility system has received an eligibility record for a month that is more than 24 months before the current system month. The system can only hold 24 months. (For example, 3/05 back through 4/03. A record received in 3/05 for 3/03 cannot be processed.) Review the case to determine if an incorrect date was entered. If so, make ABC entries to generate a new record to be sent to the Medicaid Eligibility system.
3022 TXIX	Medical card was not generated – client's state-ID is not on SSNI	The Medicaid Eligibility system has received a record requesting reprinting of a medical card for a person who has no state ID number. This should never happen. If you receive this message, contact the SPIRS Help desk.

WIFS No.	Message Sent To Worker	Definition/Resolution
3023 TXIX	Medical card was not generated – no active eligibility on SSNI for month requested	The Medicaid Eligibility system has received a record requesting reprinting of a medical card for a month that has no active eligibility on the system. An entry has been made into the ID GEN field for a month that has no active eligibility in the Medicaid Eligibility system. Review the entry and reenter the appropriate code for the month the member wishes to have a medical card reprinted.
3039 TXIX	Poverty level and QMB IND do not correspond. If client is not eligible for QMB/SLMB, please remove the QMB IND and close any active QMB/SLMB case. Otherwise enter the correct QMB IND and POV level.	Review the case and the ABC entries. If the member is not eligible for QMB or SLMB, remove the QMB indicator and close any active QMB or SLMB case. Otherwise enter the correct QMB indicator and poverty level.
3040 TXIX	Invalid Medically Needy characteristic code on TD03 – enter valid code	ABC has sent a medical eligibility record to the Medicaid Eligibility system with an invalid MN characteristic code. Check the ABC entry and correct the MN characteristic code on TD03.
3041 TXIX	Invalid fund code – enter valid fund code	ABC has sent a medical eligibility record to the Medicaid Eligibility system with an invalid fund code. Check the ABC entry and correct the FUND code on TD03.
3042 TXIX	Invalid aid type – enter valid aid type	ABC has sent a medical eligibility record to the Medicaid Eligibility system with an invalid aid type. Check the ABC entry and correct the aid type on TD01.

WIFS No.	Message Sent To Worker	Definition/Resolution
3043 TXIX	Percent of poverty is invalid for QWDP	ABC has sent a record to the Medicaid Eligibility system with an invalid poverty level for QWDP. Check the ABC entry and correct the POV LEV entry on TD03.
3044 TXIX	QMB/SLMB eligibility not established on SSNI – POV level and QMB IND do not correspond. If client is not eligible for QMB/SLMB, close the QMB/SLMB case. Otherwise enter the correct QMB IND and POV LVL.	Review the case and the ABC entries. If the member is not eligible for QMB or SLMB, close the QMB or SLMB case. Otherwise, correct the QMB IND and POV LEV entries.
3045 TXIX	QMB indicator is not entered on IABC. If client is not eligible for QMB/SLMB, please close the QMB/SLMB case. Otherwise, enter the correct QMB indicator and poverty level.	ABC has sent a record to the Medicaid Eligibility system with spaces in the QMB indicator field. If the member is not eligible for QMB or SLMB, please close the QMB or SLMB case. Otherwise, correct the QMB IND and POV LEV entries.
3046 TXIX	Poverty and QMB indicator may be incorrect. If client is not eligible for QMB/SLMB, remove the QMB indicator and close any active QMB/SLMB case. Otherwise enter the correct QMB indicator and poverty.	Review the case and the ABC entries. If the member is not eligible for QMB or SLMB, please remove the QMB indicator and close any active QMB or SLMB case. Otherwise, correct the QMB IND and POV LEV entries.

WIFS No.	Message Sent To Worker	Definition/Resolution
3047 TXIX	Facility aid type, no facility number received	ABC has sent a record to the Medicaid Eligibility system with a facility-only aid type but no facility number. Enter the correct facility number in the WVR field on TD03 for this case. This will cause the Medicaid Eligibility system to update with the correct information.
3048 TXIX	Waiver aid type, no waiver indicator received	ABC has sent a record to the Medicaid Eligibility system with a waiver only aid type but no waiver indicator. Enter the correct code in the WVR field on TD03 for this case. This will cause the Medicaid Eligibility system to update with the correct information.
3049 TXIX	Facility/waiver aid type, no facility number or waiver indicator received	ABC has sent a record to the Medicaid Eligibility system with a facility or waiver aid type but no facility number or waiver indicator. Enter the correct facility number or waiver code in the WVR field on TD03 for this case. This will cause the Medicaid Eligibility system will update with the correct information.
3050 TXIX	Foster care and MEPD – MEPD billing stops/possible refund	The system has received an MEPD record and a foster care record for the same month. MEPD billing will be stopped for that month. Determine if a refund is due to the member for that month and close the MEPD case if appropriate.

WIFS No.	Message Sent To Worker	Definition/Resolution
3058 TXIX	ESTD/IME unit to release spenddown	The Medicaid Eligibility system has received an active MEPD record and a Medically Needy record with spenddown for the same month. Ask the IME Medically Needy Unit to release the spenddown amount. See 14-I, Changes and Corrections.
3059 TXIX	Active aid type and MEPD. MEPD billing stops/possible refund.	An MEPD record and another medical aid type have been received for the same month. The system will stop MEPD billing for that month. Review the case and determine if MEPD should be closed.
3060 TXIX	Med Needy with spenddown and MEPD with unpaid premium – check ABC and SSNI	An MEPD record with a premium and a Medically Needy record with a spenddown have been received for the same month. Review these cases and determine if any should be closed.
3061 TXIX	Active aid type and MEPD – MEPD becomes or remains primary	An MEPD record and a Medically Needy record without a spenddown have been received for the same month. Review the cases to determine if MEPD should be closed or remain open, as it will remain as primary eligibility.
3062 TXIX	Active retro MEPD and other active aid type	The system has received an MEPD record and another active medical record (any kind except a facility or waiver record) for the same month. MEPD billing will be stopped for that month. Determine if one of these cases needs to be closed.

WIFS No.	Message Sent To Worker	Definition/Resolution
3063 TXIX	Retro MEPD w/prem & other active aid. Determine if MEPD should continue billing	The system has received an active medical aid type and the worker has entered a month of eligibility with a premium on the RETR screen for the same month. Determine if the billing system must keep billing for that month, or if MEPD should be stopped.
3064 TXIX	Active Aid Type and IowaCare—IowaCare billing stops/possible refund	Full Medicaid eligibility has overlaid IowaCare eligibility. MIPS will stop billing. Determine if a refund is appropriate.
3076 TXIX	The following are invalid aid types (021, 023, 027, 028). Please review case and take appropriate action to correct the medical aid type.	The listed medical aid types are invalid for foster care cases. Contact the SPIRS Help Desk for assistance in making the correction, since FACS corrections are required.
3110 TXIX	TXIX member is currently active on PACE. TXIX received eligibility for IACARE, Chronic Care, or QMB/SLMB. Please review and open case with a PACE aid type, if appropriate.	ISIS has sent information showing the member is actively participating in PACE for a specific month, but information the Medicaid Eligibility system received from ABC shows eligibility only for IowaCare, chronic care, QMB, or SLMB. Review the person's eligibility. If the person truly is on PACE, change the ABC case to a PACE aid type.

WIFS No.	Message Sent To Worker	Definition/Resolution
3111 TXIX	TXIX member is currently active on PACE. TXIX received eligibility under a non-PACE aid type. Please review and open case with a PACE aid type, if appropriate.	ISIS has sent information showing the member is actively participating in PACE for a specific month, but information the Medicaid Eligibility system received from ABC shows only eligibility with a non-PACE aid type(other than IowaCare, chronic care, QMB, SLMB, or PACE aid types). Review the person's eligibility. If the person truly is on PACE, change the ABC case to a PACE aid type.
3112 TXIX	TXIX member is currently active on PACE. More than one aid type was received by TXIX, but no PACE aid types received. Please review and open case with PACE aid type, if appropriate.	ISIS has sent information showing the member is actively participating in PACE for a specific month. The Medicaid Eligibility system received multiple eligibility records from ABC, but no records with a PACE aid type. Review the person's eligibility. If the person truly is on PACE, change the ABC case to a PACE aid type.
4030 TXIX	Mismatch found – TXIX information does not match Medicare information. Please review this case and make appropriate corrections via ABC system or request special update, if necessary.	This WIFS will list the mismatched data from Medicare and the Medicaid Eligibility system for the following: ♦ BDT (birth date) ♦ LNM (last name) ♦ FNM (first name) ♦ SEX Review the case and verify the data. If the data is not correct and the case is active, make corrections in the ABC system. For closed cases, request a special update. If the information is correct, please E-mail Joanne Rockey. Include the member's name, county of residence, and social security number. IME will work with CMS to resolve the discrepancies.

WIFS No.	Message Sent To Worker	Definition/Resolution
4031 TXIX	Medicare shows this client is deceased. TXIX does not show the same information.	This WIF shows the date of death that Medicare reports. Review the case and verify the information. If case is incorrect, make appropriate entries in the ABC system to cancel the person or case using death coding.
4032 TXIX	TXIX shows this client is deceased. Medicare does not show the same information	Contact the Social Security Administration with information concerning the member's death.
4048 TXIX	Medicare coverage is indicated, but no Medicare info was returned from CMS. Please verify the Medicare coverage and validate SSN and claim #.	This Medicare Part D response file validation error occurs when DHS sends a Part D record and the Medicare coverage is "unverified," meaning a "W" is in the 2nd byte of INS. This indicates that the ABC system entry "1," "2," or "A," but the Medicaid Eligibility system has not been able to verify any Medicare coverage with CMS. This occurs due to one of these reasons: ♦ The social security number or claim number is not correct. The person may or may not be eligible for Medicare, but there is no way to verify due to the incorrect number. Check these fields and make any necessary corrections on the ABC system and on SSNI via special update. ♦ The Medicare code on the ABC system is in error. The person is not actually eligible for Medicare. Remove the "1," "2," or "A" from the person's ABC TD03 screen.