CHAPTER 8: TROUBLESHOOTING

REGISTERING DLL FILE

If the user receives an error when creating the Summary of Benefits Report, the SB2007.DLL file may not be correctly registered. The instructions on how to register the SB2007.DLL file are as follows:

Step 1: Click on the <WINDOWS START> button.

Step 2: Select <RUN...> from the Start Menu.

Step 3: In the *Open:* textbox, type the following:
Regsvr32 "<APPPATH>\SB2007.DLL"

The <APPPATH> indicates the location of where the PBP tool was installed (i.e., if the PBP tool was installed in the C:\Program Files\PBP2007 directory, the *Open:* textbox entry would be: Regsvr32 "C:\Program Files\PBP2007\SB2007.DLL").

Step 4: Click on the <OK> button.

Step 5: The message stating that the SB2007.DLL file was registered correctly will be displayed. Click on the <OK> button.

If the user continues to receive an error, try reinstalling the PBP software by following Part 1 of the installation instructions. Although the user's data entry should not be overwritten by the installation process, it is recommended that a backup of the PBP2007.MDB file be made prior to reinstalling the software. When reinstalling, the user may be asked to select from three options: Modify, Repair, or Remove. Select the Repair option.

UN-REGISTERING DLL FILE

Step 1: Click on the <WINDOWS START> button.

Step 2: Select <RUN...> from the Start Menu.

Step 3: In the *Open:* textbox, type the following: Regsvr32 /U "<APPPATH>\SB2007.DLL".

The <APPPATH> indicates the location of where the PBP tool was installed (i.e., if the PBP tool was installed on the C:\Program Files\PBP2007 directory, the *Open:* textbox entry would be: Regsvr32 /U "C:\Program Files\PBP2007\SB2007.DLL").

Step 4: Click on the <OK> button.

Step 5: The message stating that the SB2007.DLL file was un-registered correctly will be displayed. Click on the <OK> button.

CORRECTING DISPLAY PROBLEMS

If there is a problem with the display of the PBP data entry variables, it is possible that the Windows Font Size display property is set to "Large Fonts". The property must be set to "Small Fonts" in order for PBP to operate properly. The instructions on how to change this property are as follows:

Step 1: Using the mouse, right-click on the Windows desktop.

Step 2: Select "Properties" from the menu.

Step 3: From the "Display Properties" window, select the "Settings" tab.

Step 4: Locate the Font Size property and ensure that the property is set to "Small Fonts". If the Font Size property is not available on this window, then click on the "Advanced…" button to access.

UNINSTALLING THE PBP

Step 1: Click on the <WINDOWS START> button.

Step 2: Click on the <SETTINGS> menu.

Step 3: Select the <CONTROL PANEL> folder from the SETTINGS menu.

Step 4: Once in the Control Panel, double-click on "Add/Remove Programs". Once the Add/Remove Programs application has been started, select PBP 2007 from the list of software that can be automatically removed by Windows, and click on the <ADD/REMOVE> button.

Step 5: When the Setup window is displayed, select Remove and click on the <NEXT> button. Follow the instructions to continue uninstalling PBP. If prompted whether or not to delete any shared files, the recommended action is to answer "No".

Step 6: Once the PBP is uninstalled, the installation directory (e.g., C:\PROGRAM FILES\PBP2007) may still exist. Using the Windows Explorer, delete this directory and all of its remaining contents. PBP is now completely removed from your computer.

Systems Requirements

To operate the BPT and PBP software with the minimum system requirements, the following hardware and software configuration is required:

Pentium PC 100MHz or higher
Monitor resolution of 800 x 600 pixels
Microsoft Windows™ 95, 98, Me, NT, 2000, or XP
Microsoft or Microsoft-compatible mouse or pointing device
75 megabytes of available hard disk space, plus approximately two megabytes for each BPT spreadsheet
32 megabytes of RAM
Adobe Acrobat Reader 4.0 or higher
MDCN access
Web browser (Microsoft Internet Explorer 5.x or higher) with Secure Socket Layer (SSL)

To operate the PBP Data Entry System with optimum performance, the following hardware and software configuration is strongly recommended:

Pentium PC 600MHz or higher
Monitor resolution of 1024 x 768 pixels

A/B Mandatory Supplemental benefits

A/B Mandatory Supplemental benefits mean health care services not covered by Medicare that an MA enrollee must purchase as part of an MA plan. The benefits may include reductions in cost sharing for Medicare benefits, benefits not covered by Medicare, and Part B and Part D premium buy-downs.

A/B Mandatory Supplemental premium

A/B Mandatory Supplemental premium means the premium charged to an enrollee for A/B Mandatory Supplemental benefits.

Authorization

MA plan approval necessary prior to the receipt of care. (Generally, this is different from a referral in that an authorization can be a verbal or written approval from the MA plan, whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)

Basic Benefits

Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.

Benefits Description (Medicare Services)

The scope, terms and/or condition(s) of Medicare coverage including any limitation(s) associated with Medicare fee-for-service.

Benefits Description (Plan)

The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.

Brand Only Deductible

A brand only deductible allows a plan to lower or eliminate generic cost share in the deductible so that beneficiaries have access to generic medication prior to meeting the deductible. Beneficiaries would still be required to meet the brand deductible prior to the reduced cost share for brand medications. This benefit can be offered under Basic Alternative and Enhanced Alternative Plan designs.

Coinsurance

A fixed percentage of the total amount paid for a health care service that can be charged to a beneficiary on a per service basis.

Continuation of Enrollment

Allows MAs to offer enrollees the option of continued enrollment in the MA plan when enrollees leave the plan's service area to reside elsewhere. CMS has interpreted this to be on a permanent basis. MA Organizations that choose the continuation of enrollment option must explain it in marketing materials and make it available to all enrollees in the service area. Enrollees may choose to exercise this option when they move or they may choose to disenroll.

Copayment

A fixed dollar amount charged on a per service basis.

Coverage Basis

The MA Plan charge schedule used to base the maximum dollar coverage or coinsurance level for a service category (e.g., a $500 annual coverage limit for a prescription drug benefit may be based on a Published Retailed Price schedule, or 20% coinsurance for DME benefit may be based on a Medicare FFS fee schedule).

Data Entry User

A Data Entry User is any user that the Super User designates within PBP to assist the Super User with data entry.

Deductible

Initial specified dollar amount required to be paid by enrollee for a service category.

Dictionary

A system database that drives the data entry variables and screens.

Drug Tiers

Drug tiers are definable by the plan. The option "tier" was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the "tier" option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Enhanced Benefits

Defined as Mandatory or Optional Supplemental benefits.

Excluded Drugs

Drugs or classes of drugs that may currently be excluded or otherwise restricted include: (1) agents when used for anorexia, weight loss, or weight gain; (2) agents when used to promote fertility; (3) agents when used for cosmetic purposes or hair growth; (4) agents when used for the symptomatic relief of coughs and colds; (5) prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; (6) nonprescription drugs; (7) outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale; (8) barbiturates; and (9) benzodiazepines. Also excluded are any drugs, for which, as prescribed and dispensed or administered to an individual, payment would be available under Parts A or B of Medicare for that individual.

Facility Charge

Some plans may vary cost shares for services based on place of treatment; in effect, charging a cost for the facility in which the service is received.

Formulary

A list of covered Medicare Part D drugs provided by a plan to meet patient needs.

Local Plan

A Local Plan is an MA plan other than a Regional PPO plan. Payment areas are defined by county.

MA-Prescription Drug (MA-PD) Plan

MA-Prescription Drug (MA-PD) Plan means a MA plan that provides qualified prescription drug coverage under Part D of the Social Security Act. Effective January 1, 2006, MA plan sponsors (except MA private fee-for service and MSA plans) must offer at least one plan in each of their service areas that includes basic Part D coverage or Part D coverage that includes supplemental benefits, the costs of which are offset by a rebate for Part A and B benefits.

Mandatory Supplemental Benefits

Services not covered by Medicare that enrollees must purchase as a condition of enrollment in a plan. Usually, those services are paid for by premiums and/or cost sharing. Mandatory supplemental benefits can be different for each MA plan offered by an MA Organization. MA Organizations must ensure that any particular group of Medicare beneficiaries does not use mandatory supplemental benefits to discourage enrollment.

Maximum Enrollee Out-of-Pocket Costs

The beneficiary's maximum dollar liability amount for a specified period.

Maximum Plan Benefit Coverage

The maximum dollar amount per period that a plan will cover towards a particular service(s). This is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

Medicare Benefits

Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.

Medicare Part B Premium Reduction Amount

As of CY 2006, MAs are able to use their rebates to reduce the Medicare part B premium for beneficiaries. This amount must match the corresponding amount in the MA Bid Pricing Tool, and the amount cannot be greater than the Medicare Part B premium.

Navigation Bar

The Navigation Bar indicates the screen labels (e.g., Section A-1 is used for retrieving the Section A Part 1 screen).

Non-Formulary Drugs

Drugs **not** on a plan-approved list.

Optional Supplemental Benefits

Services not covered by Medicare that enrollees can choose to buy or reject. Enrollees that choose such benefits pay for them directly, usually in the form of premiums and/or cost sharing. Those services can be grouped or offered individually and can be different for each MA plan offered.

Out of Area

Services provided to enrollees by providers that have no contractual or other relationship with MA Organizations.

Out of Network Benefit

Generally, an out-of-network benefit provides a beneficiary with the option to access

plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

Plan ID

The Plan ID is a unique, sequential identifier beginning with 001 that is automatically generated when a user defines their plans on the HPMS Web site. Once an organization deletes a plan in HPMS, the Plan ID is no longer available. The Plan ID is displayed in Section A of the PBP.

Point of Service (POS)

A mandatory supplemental or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network.

Premium

The monthly cost charged to the enrollee.

Prescription Drug Plan (PDP)

Prescription Drug Plan (PDP) refers to a private prescription drug plan that offers drug-only Part D coverage under a policy, contract, or plan that has been approved as meeting the requirements specified in the rule and that is offered by an MA organization that has a contract with CMS that meets the contract requirements and does not include a fallback plan unless specifically identified as a prescription drug plan.

Provider Network

The providers with which an MA Organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an MA coordinated care or network MSA plan.

Reference Based pricing

Reference based pricing allows a Plan to set a price for a drug within a therapeutic category as the reference point. The reference point then identifies and becomes the reimbursement rate for all therapeutically equivalent drugs in that category

Referral

A plan may restrict certain health care services to an enrollee unless the enrollee receives a **referral** from a plan-approved caregiver, on paper, referring them to a specific place/person for the service. Generally, a referral is defined as an <u>actual document</u> obtained from a provider in order for the beneficiary to receive additional services.

Regional Plan

Regional Plan means a coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire regions. An MA regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services whether provided in or out-of-network. Payment areas are defined by region.

SB Crosswalk

The SB Crosswalk document is available from the PBP HELP menu and provides a detailed explanation of how each SB sentence is derived from the PBP variables.

Screens

A screen is an area beneath the navigation bar where variables are presented. The navigation bar enables a user to select a particular screen for data entry.

Segment ID

The unique identifier for the segment within the plan within the organization. The Segment ID is a read-only field in Section A and will be pre-populated with the information entered during the plan setup process performed over the Internet.

Segment

Segments are composed of one or more local MA payment areas (counties) under a plan. Segments must be mutually exclusive – they must not overlap. In other words, a county may not be included in more than one segment in a plan's service area. Under a Local MA plan, the segments must have the same benefit structure but may have different cost sharing and/or premiums for A/B and non-drug supplement benefits. If the local MA plan offers Part D in the segments, no elements (formulary or cost sharing) of the Part D benefit design may vary throughout the segments.

Service Category Definition

A general description of the types of services provided under a particular benefit and/or the characteristics that define the benefits.

Special Needs Plan (SNP)

MA organizations are permitted to offer plans that serve special needs individuals known as "Special Needs Plans" or "SNPs". SNPs can be offered to three specific segments of the Medicare population: (1) institutionalized individuals, (2) dually eligible individuals, and/or (3) chronically ill and disabled individuals.

Specialty Drug

Specialty Drugs are covered Part D drugs with plan negotiated prices that exceed $500 per month. These high cost drugs are placed in the specialty tier. Plans do not need to identify a preferred drug in the specialty tier.

Specialty Tier

The specialty tier allows a plan to place very high cost and unique items on a designated tier. Only 1 tier can be identified as a specialty tier and this tier is exempt from tier cost sharing exceptions. Cost-sharing is limited to 25% in the initial coverage range for defined standard and actuarially equivalent plans. Cost-sharing has an upper limit of 33% in the initial coverage range for plans offering a reduced or no deductible benefit under alternative plan designs.

Step-Up Benefits

Benefit Offerings are considered step-up benefits if a plan benefit package includes one of the following benefit structures in a particular service category: 1) more than one optional supplemental benefit; or 2) both a mandatory and optional benefit. For example, a plan may offer three dental optional supplemental benefits, which offer varying levels of coverage; in this case, two of the optional benefit offerings would be considered step-up benefits. Alternatively, a plan may offer dental benefits as a mandatory benefit and then an optional benefit; in this case, the optional benefit would be considered a step-up benefit.

Super User

A Super User is the user who defined the plans in HPMS and downloaded from the HPMS Web site.

Update

A process by which contract and plan information is updated on HPMS over MDCN and downloaded to the client.

Upload

Upload is a process by which the PBP data and BPT spreadsheets are submitted over MDCN to HPMS.

Validation

The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.

Variable

A variable is a data entry field that accepts data according to the specifications and rules specified by the dictionary.

Variable Type

Variable types and attributes determine the type of data the system will accept during data entry (e.g., the variable **Indicate Coinsurance Percentage Amount** accepts only data that are in numeric format).