TRANSCRIPT
ECRS TOWN HALL TELECONFERENCE FOR DRUG PLAN SPONSORS

DATE OF CALL: June 24, 2010

SUGGESTED AUDIENCE: MAPD Plans

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Vanessa Jackson
June 24, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Sarah) and I will be your conference operator today.

At this time, I would like to welcome everyone to the ECRS Teleconference Q&A Session for the Drug Plan Sponsors. All lines have been placed on mute to prevent any background noise.

After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time simply press star then the number one on your telephone keypad. If you would like to withdraw your question press the pound key.

Ms. Vanessa Jackson, you may begin.

Vanessa Jackson: Thank you, (Sarah).

Again, I'd like to welcome to the ECRS Teleconference Q&A Session for the Drug Plan Sponsors. Just for the record, today is June 24, 2010.

This forum is being provided to answer questions and engage in dialogue regarding ECRS user experience with the application and the MSP reporting process.

Initially we will be answering the pre-submitted questions. And, should time permit, we will open up the lines for additional questions. I will remind everyone that we cannot necessarily provide direct replies to every question

that we receive, but we will try to use those questions we feel will be most helpful with the ECRS process.

Since this teleconference is being recorded, we will have a written transcript. We will notify the plans as to when and where the transcript will be made available.

Today we have with us on the call Deb Larwood, Stacie Brackett, (Chris Hines) of the CM. We have Alberta Smythe and Bill Ford from the COBC. John Albert, Patricia Gillespie and myself, Vanessa Jackson, from the division of Medicare benefit coordination.

I will now provide a brief overview of the ECRS purpose and process. The Center for Medicare Medicaid services is requiring that health and drug plan sponsors submit their Medicare secondary payer data to the coordination of benefits contractor electronically via the ECRS system. Utilizing ECRS for your MSP requests will alleviate submission requirements and is a more efficient submission method than paper.

ECRS allows MSP representatives at the Medicare contractor sites and at authorized regional offices to complete various online forms and electronically transmit requests for changes to the existing CWF MSP information, inquiries concerning possible MSP coverage, and inquiries concerning drug information.

The COB enhanced the ECRS process to allow users to also submit flat files. The flat file submission method allows submitters to send a large number of requests via flat file. The COB provides the submitters with the flat file layout that will be utilized. The submitter will receive a flat file response, which will contain the status of each request.

Online ECRS allows users to enter requests and view the progress of each request online. Transactions submitted through online ECRS are automatically stored on the COB contractor system. Each evening a batch process reads the transaction and processes their requests. The status on each transaction is updated as it moves through the system.

That's just a brief overview of the ECRS process. What we would like to do now in the interest of time is to proceed with our pre-submitted questions.

Our first question is, that was pre-submitted, was how will the health plan be notified that a member MSP status has changed, including retroactive changes? Will the health plan receive a TRR indicating the change or some other form of notification? Will special TRC codes be used?

Alberta Smythe: This is Alberta. And I'm assuming that on the daily – if an MSP record changes, you will, it'll, you'll be notified on your daily MSP file for the Part D plan.

If it's a request that you submitted via ECRS, then you'll be notified via either if you use the flat file process, you'll receive a response file. That'll give you a resolution code telling you what the status is of your request.

If you use the online ECRS, you can periodically check the status of your request.

If we honored the request and take the action that you requested, the resolution code would, the status resolution code would be CM50.

Vanessa Jackson: Our second question is, how will the health plan be notified of CBLC determinations? Must be COBC. Yes. How will the health plan be notified of COBC determinations?

For example, if a member MSP occurrence is disputed with an action code (VO) to delete the record and the health plan sends information to the COBC to dispute the status.

Bill Ford: Alberta – this is Bill Ford. Alberta pretty much answered that question with her answer. But, if you're a flat file submitter, you'll be notified via an ECRS response file.

And Alberta pointed out, every response file that comes with a status code and a reason code. And the status and reason codes can be found on page 62 of the flat file installation guide. And there you'll see a status code and one of

the statuses is CM for completed. And as Alberta pointed out, a reason code of 50 would mean it was posted to CWF.

So, always look at the status and the reason code. And refer back to the flat file layout on page 62.

Vanessa Jackson: OK. Next question is how can a supplemental record be modified using the flat file layout? The current layout indicates only primary records can be modified.

Bill Ford: The key with the flat file is getting past our front end edits. And what you would do, you could default the MSP type to A and then use the trans comments section to provide an explanation as to what you would like to take on the supp record. So MSP type A, and in the trans comments field just indicate that it's a supplemental record. And that action you're looking for us to take.

Vanessa Jackson: Thank …

Bill Ford: And trans comments field is very important piece of the flat file.

Vanessa Jackson: Thank you, Bill.

Who can we speak to in regards to specific errors we receive back on the ECRS response file? For example, we received the error code of \PE03) on a MSP file submission. However, we submitted I in position 25 per the layout instructions.

Another example is the error code of PE03. We have received this error on MSP file submissions and it does not apply. It is an error specific to the assist file.

Bill Ford: You could contact myself – this is Bill Ford. You could contact Alberta Smythe, (Ernie Rapsman).

But a PE03 error on an MSP file for the trans type code I, it shouldn't happen. Trans type code I is the correct trans type code for an MSP inquiry. However,

on the CWF assistance request, you've, a trans type code is R. So I think the requestor may have been talking about a CWF assistance request PE03 error.

Vanessa Jackson: OK.

And how can we obtain a response file for all submissions generated from our company?

Bill Ford: Well, you should get a response file back within 24 to 48 hours. Now, doesn't mean every record will be on that response file because there are sometimes we have to take some action on the assistance request.

So an assistance request could take up to 15 business days for a record to be updated. However, if it's necessary that we go out and develop that record, it could take up to a hundred days.

If you're missing response files though and you should just contact myself of Alberta.

Vanessa Jackson: Sir, do you want to give you e-mail address please?

Bill Ford: Sure, wford@ehMedicare.com.

Vanessa Jackson: Thank you.

Alberta Smythe: And also just keep in mind that you won't receive a one-to-one response. So if you submitted a hundred records, you'll receive a response file as those records are being updated.

So if 20 got update today, tomorrow you'll receive a response for those 20 that were updated. If 20 more get updated the next day, the following day you'll receive another response file.

So you're not going to see, receive one response file per file that you submitted.

Vanessa Jackson: OK. Thank you, Alberta.

Our next question is, there are 30 CWF assistance requests that were submitted that are still in IPO2 status. What is the actual timeframe for these requests to be completed?

Alberta Smythe: And I think, yes. Bill just said that. It's 15 business days or a hundred days if we have to develop for additional information.

Vanessa Jackson: When does the timeframe start? And when we submit the inquiry or when the – does it start when we submit the inquiry or when the inquiry is received?

Alberta Smythe: Well, generally when you submit the inquiry, depending on which method you're using, it's an overnight. So if you submit it today, we receive it tomorrow. And the clock starts then.

Vanessa Jackson: Is research being done before the request goes into complete status?

Alberta Smythe: Yes.

Vanessa Jackson: OK.

For requests that are in completed status, CM50 which means completed posted to CWF, response received with no errors, does posted mean completely done or posted for CWF department to work on it?

Alberta Smythe: It means that we have received your request and we have taken the action that you have asked us to. And if it's a drug record, it's actually posted to MBD. If it's an MSP record it's posted to CWF.

Vanessa Jackson: If the request was to delete or term a coverage, would we see the changes in our maintenance field (B) file?

Alberta Smythe: And that would depend on, you know, when the update was taken versus when that file was generated. So if the update was performed before the file is generated, then yes, you should see that.

Vanessa Jackson: If it's not on the COBC file, where is it? How do we validate?

Alberta Smythe: Again, if you're submitting your request through ECRS, you are going to get a response if you're using the flat file you'll receive a response file or files. And if you're using online ECRS then you have to check ECRS and follow the status of your request.

Vanessa Jackson: OK.

One returned a CM83 with a response from COB 162 saying unable to update record, not on file. This record was found on a full file sent in February March by CMS for their annual Part D notification. However, GHI is saying there is no record on file.

How will we be able to delete or term this record that is on our COBC file but GHI does not have this record on file?

Alberta Smythe: GHI receives information from many different sources. And it is possible that the record was updated since you received the file. If you find that you're still receiving the record on your daily file or monthly file, whichever, then, and you're disputing our response, just contact one of your Consortia contacts. You should have received a list that has Consortia contacts that you can call. And they will walk through that record with you.

Vanessa Jackson: OK. Thank you.

This next question is, does GHI refer to the COB-C file when processing an inquiry? If not, what do you reference? If we reference the COB-C file, how does GHI know what PRM or FUP, F-U-P line we are trying to update?

Bill Ford: Well, we don't reference the COBC file since we don't have access to that file.

(Female): Right.

Bill Ford: What we do reference is CWF and our own COB subsystem. And again, I'll go back to the trans comments section where you tell us exactly what you'd like us to do. You can tell us whether it's a primary record, a supplemental record.

Keep in mind that when we look at the, when we do these updates to these requests, we look at the entire member history. So we look at every record that's on the file.

Alberta Smythe: And just one other thing to keep in mind is that we believe that the COB-C file that you are receiving from CMS is generated from MBD and CWF. We actually send the transaction to CWF and to MBD. So we do have those transactions in our internal files.

Vanessa Jackson: OK.

One returned as CM53, duplicate ECRS request. We do not believe that this request is a duplicate. Can you tell us why this request is being returned as duplicate? How can we ensure that we get past pre edits for same members with different requests?

Alberta Smythe: Again, it's very important, as Bill said, that you use the comments section. If you have a beneficiary that has multiple records and you need to update multiple records, you should submit one request. And in the comments indicate please update all records for this beneficiary.

The dup check looks for if there is a request that is open for the same (hiken) number, for the same auxiliary number and the MSP type. If there is one open and another one comes in, it rejects it back as a duplicate. So if it is for a duplicate record, then you should just indicate that, again, in the comments section. And only submit one request.

Vanessa Jackson: If we needed a request to be done immediately we were told that customer service would be able to do up to five requests instantly. What is the correct customer service line to call for this?

Alberta Smythe: OK. We asked that the Medicare contractors do not contact our customer service line. That's why they all have assigned Consortias. So if you have a record that it needs immediate action, you should call one of your Consortia contacts.

On the Consortia list most plans have more than one person. So if you can't reach that one person you, you know, can try the next person under your plan. But we ask that for immediate, for any records that need immediate action, please use the, your Consortia list. If they are unable to update them over the phone they will also accept a fax as well.

Vanessa Jackson: We will make sure that we attach the Consortia list to the written transcript once it's made available.

OK.

Is there a way we can put in future effective dates? Is this done through CWF, MSP and all prescription drugs?

Alberta Smythe: I don't believe that CWF or MBD will accept a future date.

Vanessa Jackson: OK.

Can we send multiple requests for one (hikan) number on the same CWF inquiry? We've already pretty much addressed that with using the comments for that.

Alberta Smythe: And the Consortia list was attached to that June 14 (inaudible).

Vanessa Jackson: (They wouldn't have gotten that).

Alberta Smythe: OK.

Vanessa Jackson: Some of them. Some of them would have, some …

Alberta Smythe: (Inaudible).

Vanessa Jackson: OK. We'll make sure we get a Consortia listing out to you.

Our next question is, we are getting conflicting information about the auto liability and workers comp records. We were told by Consortia to send our findings to the MSP RC. The MSP RC told us they don't handle Part D.

And on the ECRS form we were told for Part C plans that they were never, are never to contact MSP RC for anything. And that they are responsible for those MSP types and are actively working all occurrences.

Please help clarify what the correct procedure is for the health plan regarding these MSP types.

Part D, we have quite a large number of members – no let's first answer this first question in reference to MSP RC.

(John), can you help us out?

John Albert: Yes. This is (John). I'm not sure like, you know, this is, the question is a little fuzzy to me. But essentially the MSP RC ultimately works on fee for service recoveries. It does not do recoveries for Part C and D. And there may be some confusion over that.

But in terms of, you know, updating information on a case the MSP RC is the one, entity responsible for updating information regarding a particular auto liability workers comp no fault case, etcetera.

So I'm not sure when someone, the questioner, is saying that they don't handle Part D, which is true and that never contact MSP RC for anything, which is kind of a, kind of a blanket accusatory statement. So, I'd like to know personally more what that's about. We would have to consult with the folks that actually run that piece of it.

Because, again, you're dealing right with the COB contractor, which has nothing to do with the recovery process other than to build the records that are used to essentially perform fee for service recoveries for Part A and B and the (second) payments.

Vanessa Jackson: OK.

(Inaudible).

(Female): If, because I've gotten these questions from Part D sponsors. When they send out the COB notifications, they include instances of MSP coverage. And

perhaps the beneficiary comes back and says, no that's not, that's not accurate. You know, this was a WC claim that terminated or, you know, the (self fault) is no longer, is no longer in existence.

And the sponsor wants to get it off. And apparently COBC doesn't make those changes. And how is that change made? The part D sponsor doesn't know who to go to to initiate the correction to the record. Or, you know, even initiate any action so that it, that can be the beneficiaries assertions that it's no longer a valid record can be pursued and verified.

John Albert: I mean, I mean and that beneficiary should be contact MSP RC because if the case has been established …

(Female): OK.

John Albert: … they would have received, that or their attorney, would have received communication from the MSP RC basically notifying that, you know, we have your information. And until there's, you know, a settlement, judgment or award, we will continue to work with you until they come up with whatever Medicare amount would be owed. Because until there's a settlement, judgment or award, we really don't do any recovery.

But I'm not, when, you know, a Part D plan, I don't, I'm not, like I said, I'm not on the MSP RC but I'm not sure like in terms of who they would take information from. I would say that's limited to the (benis) or their authorized reps that are involved in the case. Not some other third party. You know …

(Female): Right. And that's, yes.

John Albert: So.

(Female): So …

John Albert: So we've booked, I can take that back and pass that information on and hopefully get a little bit clearer chain of like what you should do when you discover a situation that you, you as a Part D plan may dispute upon the payments record.

But basically, that beneficiary, or more likely their attorney, should be working with the MSP RC can forward that information, which the MSP RC then makes judgment on as to whether that information should be updated. And when they do, they use ECRS themselves. That's if COB and COBC makes the call.

(Female): OK.

John Albert: But basically, in terms of the recovery process for, or essentially the blanket of non-group health plan, which is workers comp, liability, no fault, what, all the COB does is then to take in the initial information. But to make sure that we don't have a lot of conflicting information, only MSP RC works the case because it gets very detailed in the (weeds) when you're dealing with a particular recovery case.

So that's life. It's done that way. But in terms of the thickness of that question, I'm not really sure …

(Female): Right. I think that's where it came from.

John Albert: Yes.

(Female): And I think the background that you provided is really helpful. Thanks, (John).

Vanessa Jackson: Thank you.

Our next question is, we have a quite a large number of members on our COBC file that are no longer our members. What can we do to get these members off of the COBC file? Many of these members termed years ago.

(Female): And again, we don't generate that COBC file. That file is, we can't even speak on how it's generated, what the criteria is.

(Female): So it basically should not happen. And I don't know how you think it's stopped. But we can certainly look into it.

(Female): OK. Right. OK.

(Female): This shouldn't be happening.

Vanessa Jackson: So we'll research. And hopefully we'll be able to provide an answer included within the transcript that will clarify the procedures for you.

We have received conflicting information from the Consortia group, CMS and the MSP RC – this is a duplicate. OK. Great.

We've gone over this scenario before. So we're going to keep it moving.

OK. How do we remove DTL records on the COBC file? In some instances there are duplicate DTL records for the same member.

Alberta Smythe: And again, I think we've spoken about this. Submit your CWS to delete those records. And again, use the comments for the multiple records.

Vanessa Jackson: OK.

When the plan lines of auto liability or workers comp cases that do not appear on the MSP file, should an MSP record be sent to ECRS? Or should the information be sent to the MSP RC? If we should send it to the MSP RC, how can we do this?

Again, we will, ECRS, it'll be ECRS. But we will send out additional information to even clarify …

John Albert: When there's no record on the system, you need to notify the COBC (inaudible).

Vanessa Jackson: (Inaudible).

John Albert: Just that when there is a record and you're somehow needing to dispute that or try to modify, that's when you would have to work the MSP RC.

Vanessa Jackson: When we are updating the supp records, SUP records, what MSP type, if any, should we use?

Bill Ford: We answered that. Default A.

Alberta Smythe: Yes.

Vanessa Jackson: OK. Default A.

During the CBTs we noticed the phase health plans MSP occurrence used. Can you clarify what the definition of that is? Would that include non-group MSP occurrences?

Alberta Smythe: It does not include non-group, non-group MSP occurrences. It's pretty much your employer group health plans. And you would be submitting requests for disability, ESRD and working aged.

Vanessa Jackson: OK.

Let's move on to question six here. I think it's six. Do you want to go through that?

OK. Let's go, let's go through this one. We may duplicate some of the questions. But let's go through it for all intents and purposes.

I work for Medicare Advantage health plan that has a MA, MAPD and PDP plan. It also has several employer group products. We are receiving hundreds of repeat COBs and nothing appears to be different. This is especially the case with COB supplemental coverage with TRICARE. Is anything being done to reduce the amount of duplicates going out to plans?

(Male): (Inaudible).

John Albert: Yes. They're just duplicate drug records. Yes. Again, I guess the way to clean them up was via the ECRS assistance request. And as Alberta had mentioned earlier, use the trans comments field and tell us there are, you have multiple rows that you'd like to have deleted.

That's a little surprising that they would have the exact same information though. I'm surprised the effective dates (inaudible).

(Female): So we will take this back and look into our editing process to see if there's anything that we can do to help eliminate some of the duplicates.

John Albert: I mean we have seen situations where the way people pass up data, they're passing us blocks of a coverage period when in fact they should be passing us just one record. We've seen that (in the past).

(Female): Yes.

John Albert: Which, what I'm thinking may have happened.

(Female): … TRICARE.

John Albert: Some of the TRICARE ones where, you know, say it is the TRICARE, yes. I mean, it's just not sure. We'd have to look at that.

But if it's the same effective date, coverage type, all that, it should not be duplicating. So.

(Female): Right.

Vanessa Jackson: OK. Great.

OK. Thank you, (John).
We're going to move on to question six. It was stated on the MSP ECRS conference call that COBC will only accept ECRS updates for MSP entitlement codes of A, B and G. Is the same true for the Part D ECRS file?

(Female): That's the same thing as far as the non-EGHP that we're going to get back to everyone on.

Vanessa Jackson: OK. Great.

We began disputing letters to members flags on the VCOB file per the 2010 call letter. We received feedback from CMS that we should send all data sent on the VCOB file. If we can only update with entitlement codes of A, B and G, then should we provide only this VCOB data to our members? We are

concerned about member frustration since we do not have the ability to change the data if incorrect.

(Female): That's not our call.

Vanessa Jackson: That's not, that's you, (Deb).

Deb Larwood: Yes. That's mine.

Actually, we had a policy discussion about this. And I think we would like to know if all the, all the, we would like all the information to get reported on (non) notification to the beneficiary. This will enable us to verify that all the information is correct. And if there is a need to correct MSP information that is non-group health related, then as (John) had indicated, the beneficiary will have to do this.

And we thought what we might do is, and I'm not committing to do this this week or next, but what we'll do is come up with some standard language that you can send to the beneficiary that would have directions to them as to who to contact and how they can make the contact. And get the MSP non-group health MSP corrected. The rest of the occurrences of other coverage would be correctable by you through ECRS.

Vanessa Jackson: OK. Thank you, (Deb).

OK. Our next question is, we see many instances of information passed to us on the CMS COB file where there is an effective date and no information for group ID, group number, (ben) or PCN. Members confirm they have no secondary coverage. What is the recommended process/screen to use in ECRS to remove this timeline?

(Female): And we're not sure when you say remove timeline, are you referring to the timeline on the COB file that you're receiving. If that's the case, then you should use the ECRS CWF process to submit a request to delete that timeline if you find that it is invalid.

(Male): So we do receive records that are classified as out of network that don't have NPC (inaudible). Keep in mind, not that may not be correct but we have received in the past drug records that don't contain ben PCNs. That's because they were indicated to us through certain processes like data exchanges we have with other payers. Things like that. That it was a non-network prescription drug benefit.

Now that is fairly rare these days it seems. But if they tell us that and there is no ben, you know, then we will post it as such. So it's not that its necessarily incorrect. It may not be complete.

(Female): But here they said they confirmed.

(Male): Oh. OK.

(Female): … member.

(Female): And how would they remove that then?

(Male): Yes.

(Female): They would submit it through ECRS.

(Male): Yes.

(Female): Through the CWF file.

(Female): OK.

(Male): Yes.

(Male): (Inaudible) requested.

(Female): DEO transaction codes.

(Male): Transaction. Right.

(Male): Didn't mean to jump ahead.

Vanessa Jackson: OK.

Let's move to our next question. If a plan submits a discrepancy to the COBC and then discovers that it needs to make a correction to the original submission, is it necessary to wait for a rejection from the COBC before resubmitting a corrected record to the COBC?

Alberta Smythe): No. If you realize you submitted either the wrong code or you gave the incorrect information and you have the correct information, please contact your Consortia. Do not submit another request. That request most likely will reject, CM53 as a duplicate. So, in that situation you should contact your Consortia.

Vanessa Jackson: OK. And that was a segue into our next question. Which probably is answered. But I'm going to take the question.

How does the plan find out why they received a CM53, return duplicate ECRS request. Sometimes the plan receives a CM53 and when we look in (marks), the MSP occurrence has been removed. Other times the plan receives a CM53 and when we look in (marks), the MSP occurrence still exists.

Alberta Smythe: OK. Again, the CM53 is just saying that you're submitting a duplicate request. And there is a request in process. So it could be by time you get your next file that request that was in process caused those records to be updated and that's why they're not on, no longer on the file.

If they're still on the file it could be that that in process request has not been processed as of yet.

But again, you should, if it's multiple records you should use the comments file. I can tell you the CM53 what the system looks at, it looks at your plan ID or your contractor number. It looks at of course the beneficiaries (hikan) number. It looks at the auxiliary record number or occurrence number. And the transaction code. If they all are the same and one is in process, it will reject any incoming requests.

Vanessa Jackson: Thank you.

How does the plan find out why they received a CM52, returned rejected by CWS?

Alberta Smythe: A CM52 means that your, most likely your request was auto processed and submitted to CWS. It could be that the action you've requested has already been taken. So if you're trying to send a delete and we send that delete transaction to CWS and the record is already deleted, CWS is going to reject that transaction.

It could also be that there are records that are closed with a special contractor number that we don't want anyone to update but COB. It could be that the record is updated with that contractor number. And you send it to CWS again automatically and it will reject as well.

And I know have spoken to a few plans and they have given me some examples. And mostly what we're finding is that the records they're trying to update are already updated.

Vanessa Jackson: OK.

Our next question is, what does a plan do if it has received a MSP information data file that contains members on it with open MSP occurrences that have never appeared on a previous other health coverage information data file or a COB data file.

For example, the plan received MSP information data file that contained 65 more members with an open MSP occurrence than the other health coverage information data file showed. We normally have less than 100 total members with an open MSP occurrence. So 65 member discrepancy appears to be significant.

Shouldn't the monthly MSP information data file and the other health coverage information data file contain fairly comparable information about members with open occurrences because they are both monthly files cut at about the same time.

Alberta Smythe: Again, we can't speak on the files that you are receiving. But I can say that, again, we get information from many different sources. And it is possible that from the time you got one file we received information from another source that caused new records to be created that are opened once you received the second file. So, that is a possibility as to why there may be a difference. But again, I can't speak because I don't know the criteria for those (fields).

(Male): In terms of like recently, I mean, with the expansion of the manner to ensure reporting and the fact that a lot of GHPs are giving us data during the early part of this year that they had never given us before there were some significant spikes in the volume of data coming in.

So, at least at this point in time, that would not be totally unexpected because we're dealing with a lot of new large insurers that have never reported certain sets of data to us. And suddenly they're appearing. So, that's one of the possibilities though in terms of the other stuff.

(Female): You know, I was also thinking the possibility that between, and I don't, I'm not confident about exactly what files we're talking about here. But it is possible that between like C and D there may also be differences. Because D is only going to have coverage where there's drug coverage. And the C file will contain any other, will contain all the other coverage.

So …

(Female): Right.

(Female): … there could be differences between the two.

(Male): Yes.

(Female): Between the C and D.

(Male): (Inaudible) to use a lot (inaudible) medical only records.

(Female): Yes.

(Male): And so, of course, the C side would see an increase …

(Female): Right.

(Male): And the D side would not see those.

(Female): Right.

(Female): And there's also a difference in the timing for the C and D files.

(Male): Yes. Yes.

Vanessa Jackson: OK.

On the monthly COB files, if a member is termed MSP term they populate it. Why do they keep appearing on the monthly files?

We're on number 10.

(Female): (Inaudible).

Vanessa Jackson: Oh.

(Female): We continue to show terminated information. With a term date.

(Male): I don't know, I mean, in terms of what gets pushed out to the plans I'm not sure. I mean, you know, in terms of stuff that the COB says, I mean I guess if there was an update to a termed record, that could result in it showing up again.

I thought they only received the plans, the plans only received newer updated information. I don't, I can't answer that question. (Inaudible).

That's an MDE (Mark) question.

Vanessa Jackson: OK. We'll have to research that and try to add that as well to the transcript. We'll provide, we'll find the answer for that question.

If a member only has an occurrence for workers comp why are they appearing on our MMR report as a retro adjusted charge?

(Female): No knowledge of MMR.

Vanessa Jackson: OK. OK.

Let's, yes. We're going to have to get back with you on that particular, on these questions. We'll post the answers to these questions somewhere for you.

(Female): (Inaudible).

Vanessa Jackson: That's what I'm thinking. They're Part C questions. Yes.

OK. Our next question, are MAPD plans expected to submit a brand new employee group health plan with Rx coverage through MSP input for medical coverage and PDI layout for prescription coverage, Rx coverage?

This policy is not stored yet by CWF system. If not both, which layout should the, should the record be submitted?

(Female): And I think they indicate Bill already …

Vanessa Jackson: Yes. Bill responded to that. But I'm going to, I'm going to say, give you what the response was.

Is there an updated ECRS flat file installation guide? And where is it posted?

Bill Ford responded.

You should submit brand new coverages by utilizing the MSP input file layout. If the member has both health and Rx coverage, you can use insurance type code of W, which is comprehensive coverage. This will ensure that both the health coverage screens and the drug coverage screens get populated.

OK.

Bill Ford: As far as the updated flat file installation guide. The latest version was April of 2010. So, if you don't have the April 2010 version, send me an e-mail and I'll get it off to you.

Vanessa Jackson: OK.

What if we are not eligible to utilize the MSP input layout? We received the OHI from the survey process and the coverage is not from one of our commercial policies. Do we submit on MSP inquiry PDI, or both? Is there a summary of the updates and version 2.0.1?

We want to make sure we review all the changes and update our systems accordingly.

Bill Ford: Yes. I'm not really sure of the question. But, you should submit all other health coverages to the COBC. Not just your commercial business. If you receive information from your member and they're not on your current COB file, and they have other coverages, you should report that to the COBC.

And again, if it's MSP, you'd want to use the MSP file. And if it's drug coverage only, you'd want to use the PDI layout.

And the latest version does not, there's no summary of what those updates were to the latest versions. I can tell you though that they're very minimal changes. The biggest one being the trans source code for the, or the trans type code on the assistance request layout. That was the biggest change. It went form I to R.

Vanessa Jackson: OK.

Our next question, can someone have access to ECRS for inquiry purposes if they aren't the submitter? If so, how?

(Female): (Inaudible).

(Female): Currently, access for ECRS is granted to the Medicare contractors and the CMS central and regional offices only.

Vanessa Jackson: Can the, can there be two ECRS submitters for a single contract?

(Female): Yes.

(Female): Yes. The plan can have as many ECRS users as they would like. And they would assign them their user IDs.

Vanessa Jackson: OK.

(Female): (Inaudible) does the first question really mean is there more than two submitters? In other words, if you submitted something, could I go in and see it?

(Male): You could only see your contract number. So you couldn't see what somebody else may have submitted.

(Female): But even if we work for the same contract?

(Female): If you're, for the same contract you have the same contractor number. Yes. If you …

(Female): OK.

(Female): … submit requests and someone else in your office wants to go look up the status of your requests, yes.

(Female): Yes. OK.

Vanessa Jackson: OK.

Can a plan submit via online ECRS and the file FTP submission?

(Male): Yes.

Vanessa Jackson: OK.

It is my understanding that certain action can only be initiated by the originating contractor of a record on ECRS. Therefore, how do we know who the originating contractor of a record on ECRS is if we are using a flat file submit if we can't see the record online on ECRS?

In addition, is it possible for an organization other than the originating contractor to delete a record from ECRS if the MAPD plan determines the record submitted, was submitted incorrectly?

Bill Ford: It's tough to answer this one because the, again, we've never seen the COBC file that you're – everyone refers to. I know on the Part C side the originating contractor number is provided on that file. I'm not sure if it's provided on the COB (marks) file.

However, there are only a handful of originating contractor numbers. An the only ones that require additional information are the 1102s and 7777s. And it is possible for an MA MAPD plan to update or delete a record that they were not the originating contractor for.

Vanessa Jackson: OK. All right. Thank you, Bill.

Per section 50.13.1 of chapter 14, when the funds in our workers comp set aside are exhausted the Part D sponsors must notify CMS so that the MSP occurrence may be terminated. This is currently accomplished by reporting the exhaustion of the workers comp set aside to the COB contractor. Once the entire CMS approved workers comp set aside has been properly exhausted, the Medicare Part D plan sponsor will resume responsibility for paying claims for covered Part D drugs as though there were no workers comp settlement.

Per the ECRS manual, the Part D sponsor does not have access to the screens to update this, only the regional office. How is this process supposed to work?

(Female): That is the policy for a workers comp set aside currently. The, they're approved by the CMS regional offices. The attorneys that are handling these cases are notified. As well as if – well, see I don't think MSP RC monitors, again, the drug claims. They only monitor the fee for service claims.

Vanessa Jackson: OK.

Then we'll have to research this one as well. Not research it but see if we can provide more information and support in reference to that question.

OK. Let's move forward. Our next question is, how do we correct the invalid originating contractor ID?

Bill Ford: You really can't. There's really no reason to.

Vanessa Jackson: OK.

Alberta Smythe: And this may, and I don't know, you know, about this question. It's possible that they're asking this because they're getting the PE96.

Bill Ford: The 1102 …

Alberta Smythe: And if you're getting a PE96 error, which is a front end error, that means the originating contractor on that record is a 11102 and there is special processing instructions for MSP records where the originating contractor is 11102. You must include the employer EIN number as well as the employee ID number on your ECRS submissions.

Vanessa Jackson: OK.

And how do we correct the invalid termination date?

Bill Ford: Assistance request with a transaction code of CT.

Vanessa Jackson: OK. Thank you. OK.

The June 24, 2010 memo that was sent from (Sherry Rice) stated that termination and deletion transactions submitted via the ECRS system should take 24 to 48 hours to process under normal circumstances. Does this two-day turnaround time only refer to transmissions by mainframe? Or is it applicable to flat file transmission as well? What constitutes normal circumstances?

Alberta Smythe: And this memo, I believe, was addressed to the Part C plans. And this is in reference to ECRS submissions for certain transaction codes, which would be TD and DO. And in order for the automation there's mandatory fields that they are required to give. And that is included in that June 14 memo that they must be included. This does not apply to any drug records.

Vanessa Jackson: OK.

We are changing our Rx (bin) number and need to know how to update the COB data for our members. Do we as a Part D plan need to initiate this change through ECRS? Or is this communicated to GHI through (four) Rx submissions?

Alberta Smythe: If the Rx (bin) is the Rx (bin) for your Part D coverage, then no, there is no need to notify COB of that change.

Vanessa Jackson: OK.

Our next question is, ECRS online requires a valid other health insurance effective date for PDI inquiry or CWF request. If not available, the training indicates that a default value should be entered as 1/1/2006. Batch processing file layout requirements state that if a date is unknown, the submitter should submit zeros in the effective date field.

The question is, what is CMS's expectations for plans to obtain the effective date considering some input processes, for example, the Medicare model application enrollment form, aren't equipped to capture the date.

If plan sponsors are unable to obtain the member's effective date for their OHI coverage, is there a default value that should be submitted?

Bill Ford: As far as the default date of 1/1/06, that really isn't accurate. There should not be a default date as far as an effective date. Because if you're submitting a prescription drug inquiry and you default to 1/1/06, that's the date that that record is going to post. And that's an inaccurate record.

You should make every effort to try to obtain that effective date.

Also, on the prescription drug inquiry screen, the effective date is a required field. So zeros would not work if you're using a PDI layout. However, if you're using the assistance request, then the effective date is not a required field. You can default to zeros. And you could, I guess, ask us to try to obtain that effective date.

However, you should make every effort to really get that effective date.

(Male): The danger is that you would, could potentially have other sources in and providing the actual date, which in this case our system would treat that as another coverage. And so, you go back and try to term the record that you send in originally and it's not going to term because somebody else has a record with the actual effective date out there. So it'll effect your record, then the record you submitted would be termed but there would still be claims being denied for MSP because the record that was submitted by someone else with the accurate date is still out there. So, that's …

(Male): And this also is how you end up with multiple …

(Male): Yes,.

(Male): … records for the same person.

Vanessa Jackson: OK. Thank you.

Plans are required to submit an (EMI), and OHI, any OHI information made available as part of the enrollment approval process upon initial enrollment to CMS. Our understanding is that this information is not provided to, by CMS to GHI. Plans also send this information in a separate transaction to GHI.

The question is, is the other health insurance information loaded to MBD via the transaction 61 process? And if so, will plans receive that posted information back through the COBC file? What is the time (lag) from CMS approval to COBC file creation and transmission to plan? Should plans wait until the COBC file is received prior to sending the information to GHI? Keeping in mind that the 30-day TAT must be met.

(Female): No. We don't know …

(Male): GHI …

(Female): … what a 61.

(Male): Yes.

(Female): So that'd be …

(Female): From the plan.

(Male): Yes. I mean, the information that we post comes from the plan, so the ECRS transaction.

(Female): Right.

(Female): Correct.

(Male): It doesn't come through anything goes MBD. We only receive the Part D enrollment information from MBD. We don't receive other health insurance information via MBD.

(Female): OK. I also want to add the. OK. We'll keep moving on.

(Female): And I don't know …

(Female): Yes. I'm not…where the pad is. I don't know.

(Female): It sounds like it's something they're doing already.

Vanessa Jackson: OK.

What is CMS's expectation of plans to validate COB information at time of enrollment prior to submission to GHI?

(Female): Our requirement is that you would capture what was referred to as credible information. That is enough information to basically coast reasonably, a reasonably complete record of, to provide it to, via ECRS, to COBC.

So, if on enrollment you have an enrollment application that has a question do you have other coverage. And the beneficiary checks yes. Then it would be incumbent upon the plan to pursue that yes information. And get, again, sufficient information to post a reasonable record without, you know, with the minimum amount of follow up by COBC.

Vanessa Jackson: OK. Great.

What is the turnaround time from when plans receive a CM15 on PDI and CM50 on CWF response files to when the information is updated and visible in MDE (mark).

(Female): If you receive a, well I believe it's the same deal for CM15, but I know if you receive a CM50 that means that your record has been updated. And we have already received a response back from CWS or MBD that the update was expected. So, when you receive that CM50, that information should be in CWS and/or MBD.

Vanessa Jackson: OK.

Part of the same set of questions. Since the current CWS file layout does not allow entry of all four Rx data fields, CWS layout only allows for group and PCN, fields are not a part of GHI's matching key criteria. Will GHI understand a plan sponsor's request if the plan submits the new group and PCN and the designated fields on the CWS layout with action code of DI.

Since (ben) and ID are not included on the CWS layout, it is our understanding that updates to these fields are to be noted with the current data element written in the comments area only, under action code of DI. Should plans be using the comments field for submission of all four Rx data then PCN group ID field updates and not populate the group and PCB in their respective fields?

(Female): If you're asking us to change it, if you have the correct (ben) PCN, then you can populate it in those fields and use the action code II. If you're asking us to obtain that information and populate the record with that information, then you would use the DI to develop for insurance information. And again, I would use the comments to say please obtain the Rx (ben) PCN for this record.

Vanessa Jackson: OK.

Plans are receiving CMS COB files in which a less bracket is populated in the (hickans) field for RRB members. It is our understanding that CMS wants to no longer transmit these records formats to plan sponsors. However, we are still receiving them in the daily COBC files. If it is the intention of CMS to send the RRB records, will CMS convert these (hickans) into a valid CMS formatted (hickans)?

(Female): That's MBD.

(Female): Yes.

(Female): Yes.

Vanessa Jackson: That's an MBD question. We'll have to research it and get back with you on this one.

OK. Thank you.

We have approximately 25 enrollees that have their MA or PDP coverage. Oh I'm sorry. Forgive me. I'm back tracking. I forgot a question.

It is our understanding that GHI's Consortia group works requests on a first in first out basis. In situations where multiple requests are active for a single beneficiary, how does GHI ensure that first in first out method when requests can be worked by different Consortia team members? Is it possible that a delete request could be applied sooner than a previously submitted update request? If an SPAP sends a new add to GHI and a Part D sponsor based on a survey response sends an update with less complete information, which submitters record is posted within MBD?

Alberta Smythe: OK. First, the CWS analysts or the Consortia group, they work the CWS requests. If an SPAP or a Part D sponsor is sending a record, that's a whole different process.

As far as the CWS request to update records, we do process them first in first out. However, if there are multiple records for one (hikan) number, the

Consortia rep that is assigned that (hikan) number will receive all the requests. So they will process all the requests for that (hikan) number.

Vanessa Jackson: OK. Thank you, Alberta.

We have approximately 25 enrollees that have their MA or PDP coverage with Sterling listed as primary to Sterling. This is invalid data and I will be submitting for deletion. However, what would the transaction source code be?

Bill Ford: You could populate the trans source code with survey, S-R-V-Y. And then just include in the comments field that these are your own members and that they should be deleted.

Vanessa Jackson: Thank you, Bill.

Next question. It is my understanding that TRICARE services are for life. If the member states that they do not have this other coverage, are we to accept the members response and update the MSP occurrence?

(Male): First of all, TRICARE is never primary to Medicare. So that's the, that's the one thing I wanted to make sure of is that Tri Care is always the pair of last resort, essentially. Down there with Medicaid …

(Female): Medicaid.

(Male): … and all that. So, Medicare is always primary to TRICARE.

In terms of they're stating they do not have this coverage – we still have a data exchange with TRICARE, right? Yes. I mean, most of the TRICARE data that we have on our system comes from TRICARE themselves. We have a data, a regular ongoing data exchange with them.

So I, you know, they can attempt to point it out but if we see that TRICARE sent us the record then we will most likely not touch that record because they, being a voluntary data share partner, only certain entities can cause updates to those records. So, if they disputed that entity may need to go to TRICARE themselves to dispute whether that coverage fits or not. So.

Bill Ford: But if you have a TRICARE as primary, you should …

(Male): (Inaudible).

(Female): (Inaudible).

(Female): Yes.

(Male): (Inaudible) definitely (inaudible) because TRICARE is never a primary. It's never a primary (inaudible).

Vanessa Jackson: Thank you.

What, the next question is, what are we to do with members that are dis-enrolled from plan yet come in the COB file with an open occurrence? Member has been dis-enrolled for a few years and this is the first time that we received notification of an MSP occurrence.

(Female): And again, it depends on when they say dis-enrolled from plan, are they saying they're dis-enrolled from the primary plan that's on that MSP record? Or dis-enrolled from their plan?

If you're saying they're dis-enrolled from that primary group health plan, then you would submit that request to us to term it with the date that they dis-enrolled, assuming that it was a retirement date.

Vanessa Jackson: OK. Thank you.

(Female): And if it's not, if it's the same question we had earlier (then I'd pursue it).

(Female): Right.

(Female): I got you either way.

Vanessa Jackson: What exactly does the validity indicator I stand for?

(Female): A validity indictor I is a record that is created by our fee for service Medicare contractors. If they have information that there is a possible MSP situation,

they can create what we call validity I records. That I record is sent to CWS. And once it goes to CWS and alert is sent to COB. COB receives that I alert and develops to obtain, to make, to validate the information on that record.

Once COB has validated, the record will be changed from an I to a Y validity. Or deleted, if it's termed that information is invalid.

Vanessa Jackson: How are supplemental records updated?

Bill Ford: Via the assistance request.

Vanessa Jackson: What if the plan cannot obtain all of the information required to update the record? Can updates be sent with whatever information we have?

(Female): Well, why would you be trying to update a record if you can't determine if it's valid or not? I'm a little confused by this question.

Vanessa Jackson: OK.

(Male): You want to say, do not send the information if you're not sure of it to being with. Because the, it will do nothing but cause (leg) work for everyone.

(Female): No. And again, it goes to the fact that what we're looking for is credible information. Which you need …

(Female): Exactly.

(Female): … complete. Or reasonably complete.

(Female): Exactly.

(Male): Yes.

Vanessa Jackson: OK.

To date we have received three interim files that we are currently working for end of week completion. We're also receiving daily files from COB files from CMS. What is the difference – is this a duplicate?

(Female): Yes.

Vanessa Jackson: What is the difference between the two other – I'm sorry. Is it a duplicate?

(Female): Yes. It …

Vanessa Jackson: Oh. OK. We're going to move forward. This is a duplicate question. We've answered that prior. And, OK. Great.

Are liability insurance considered valid MSP occurrences? If not, why are they identified in both MSP and COB files? Do plans need to notify COBC via ECRS that these liability coverages are invalid?

(Female): (I'm sorry. We lost you).

Vanessa Jackson: OK. So, I'm still on number 20. But I'm at the third part of number 20. You don't have that one.

(Female): OK. Read it.

Vanessa Jackson: OK. Bear with us for a minute. We're updating. I'm going to repeat the question again.

Are liability, are liability insurance, for example life, motor vehicle, etcetera, considered valid MSP occurrences? If not, why are they identified in both MSP and COB files? Do plans need to notify COBC via ECRS that these liability coverages are invalid?

(Female): And I think we addressed this as well. This, again, is talking about the non-group health plan records. So, we'll be getting back to them …

Vanessa Jackson: OK.

(Female): … with more information on that.

Vanessa Jackson: Great. OK.

John Albert: Liability records are valid records then they're established because of, you know, a settlement or whatever that occurred. A lot of times the liability may

have a one-day effective date. But in terms of it somehow being reported as something similar to like a GHP though, I mean, that's not the case.

But that's all, again, handled through the initial COB development. Followed by the work done by the MSP RC to further validate and resolve any potential liability, workers comp, whatever case is out there.

Vanessa Jackson: OK. Thank you, (John).

OK. The scenario here is GHI has clarified that a research request development for missing policy numbers, contact information and insurer names are not initiated. GHI will only develop a research request for terminations then PCN and Rx group. This creates an issue as the daily COB files received from CMS does not contain the insurers name or policy numbers that are required fields when attempting to develop missing information in ECRS.

Plan sponsors are unable to validate coverage with other insurance companies without this information. Question. If GHI is not required to provide other insurance name and policy numbers, what is CMS's expectation in regards to processing a Medicare Part C and D claim? If the issue cannot be resolved in the development process, should the claim be contested for the EOB from the primary insurance?

Alternatively, would CMS expect the plan sponsor to pay the claim as primary despite GHI's information that Medicare is secondary?

(Female): And I can only speak on, as far as MSP records, Medicare (our) secondary payer records, they are required to have an insurance name. And they will not be in CWF without one. It is one of the mandatory fields.

So I'm assuming that you're speaking about drug records. And with drug records, and Bill can expand on this, the majority of our partners are required to give us that information. I believe except for the Part D plans. They're the only ones whose records end up posting based on what they submitted.

So if you submitted to us a drug record without the insurance information, it will post. And that's why you're seeing those records without the insurance information.

Vanessa Jackson: OK. Thank you.

Deb Larwood: Let me, let me just add …

(Female): (Hold that).

Deb Larwood: … like this is a good situation to, you know, report what you've, what's there in the annual COB notification. Ask the beneficiary to provide the additional information if they have it. And work with them to get it. You know, direct them to provide the information, particularly for Rx information. For example, also their other insurance cards so that you have credible information to report to the COBC via ECRS so we can get a complete record.

Or, if you find out that that coverage is not valid at all, and that's part of the reason why it's incomplete, we can get it off of the COB file. (Inaudible).

Vanessa Jackson: OK. Thank you, (Deb).

Our next question is, when our plan receives correct COB information the plan system is flagged to ensure the member has continual access to their benefits. It may be necessary for the plan to submit updated data to GHI via the ECRS system. Is there a process plans should be following to protect the member's eligibility upon receiving an updated file from CMS? Since the updated file does not clearly communicate to the plan that the requested update was approved, disapproved, or is still pending.

(Female): And I assume if you're speaking about the submissions to ECRS, again, you do receive a response for every record that you submitted to ECRS. Either via flat file or via online.

So I guess we would need some clarification on this question.

Vanessa Jackson: OK.

Our next question is, our plan has submitted delete transactions which are now over three months old and have not received a response. Should our plan continue to resubmit a question for deletion or will these reject as a duplicate since ECRS still shows it in process?

(Female): If you have requests that are over three months old, you should be contacting your Consortia. Give them an example and they will let you know what the status of your record is.

Vanessa Jackson: This may be a duplicate also. What will GHI research and will not research when submitting into ECRS?

(Female): We did that one. That was a duplicate.

Vanessa Jackson: OK.

When submitting a DO action, since this is an automated process, is there any need to enter notes in the comments field?

(Female): Again, DO action is automated for MSP records. It is not automated for drug records. So, it's always helpful to submit comments.

Vanessa Jackson: What is the difference between EIN and employee number? On COB file we receive a column that says employee ID in what field, employee ID. And what field would this go into?

(Female): On the file that you receive the employee ID would go into the employee number. If you're looking for the employer EIN, that is found in the insurance group field. It's not labeled EIN, it's labeled insurance group. And that would be the employer's EIN for those records where the originating contractor is 11102 or 77777. And those are the only records that require that employer EIN or/and employee ID.

OK.

(Male): (Inaudible).

Vanessa Jackson: I'm sorry. The next question is, if we get more than one occurrence or different effective dates on a record we want deleted, do we have to send separate transactions since the process is automated.

(Male): Yes. It's not automation.

(Female): Right. The drug records, it's not automated. But even with drug records, if there's multiple drug records, again, submit one request with your comments.

Vanessa Jackson: OK.

Next question, does CMS want separate response files to each contract? Assuming yes, should record count in the trailer record include counting the header and trailer records?

(Male): No.

Vanessa Jackson: OK.

(Male): Well, one thing to keep in mind. We see a lot of this actually on the record counts. So I'm glad it came up.

On the record count, it's a nine byte field. And a lot of plans gets TE06 errors because they will just count their records. And say there's 10 records. They'll put in 10. And they'll get a tE06 error. And a TE error means the whole file failed. It never got tasked with the header or trailer.

So, always use leading zeros. So if you're giving us 10 records, you would give us seven leading zeros and then the number 1-0.

Vanessa Jackson: OK.

Given the rule for MSP term data as described in the flat file documentation, if we determine there's a different term date for this member's primary insurance, there's no way of passing the information to GHI. We are told to put zeros in MSP term date. Is that correct?

(Female): No. And if you determine that the termination date on the record is incorrect and it should be a different date, then you should be submitting a CWS with a transaction code of CT to change termination date.

The one thing we are seeing though that if you determine the termination date is prior to the effective date, in that case that means that record is invalid and you should be submitting a DO transaction where a termination date would not be required. And a DO is to delete that invalid record.

So you're not going to be allowed to put a termination date that's earlier than the effective date.

Vanessa Jackson: Thank you.

Next question. Since our Rx COB information coming back from members is very rarely complete, what information should be entered into ECRS if not all the requested data is returned?

(Female): And this would depend on what action you're trying to take. If you're trying to update, delete or change a record. If you look at the flat file format, there's – it'll give you certain, what's required for certain action codes, transaction codes.

Bill Ford: Yes. And if it's to add a record, again, there are required fields that have to be populated. So, just look for all those required fields.

But again, it's important to try to get us as much information as possible.

Vanessa Jackson: OK. Thank you, Bill.

If a member simply returns only the name of the other Rx COB coverage and this creates a 52 error in ECRS, what should the health plan do with this information? Just ignore the name and not enter it at all?

Bill Ford: Yes. I'm not sure of the 52 error by, I'm thinking the person who wrote this is thinking about the PE52 error. But thePE52 is for Rx group. But the Rx group is not a required field. So if you're getting a PE52 it could be you're not populating the Rx group with spaces.

Because every field has to be accounted for. So if you don't have the Rx group, you should populate that with spaces. And you wouldn't get a PE52 error.

Vanessa Jackson: OK.

Bill Ford: However, this goes back to the other issue. If all you're getting is the name, you really should try to get additional information.

Vanessa Jackson: OK. So I guess that covers (inaudible).

OK. If we try to pull, tried to pull up the information on a member identified in the Rx COB files they can never be pulled up in ECRS. Do we not have the correct access assigned to be able to view other Rx COB coverage on our members? We can only view individuals where we have entered something into ECRS.

(Female): That's right.

(Female): And that's correct. ECRS will only show you information that your plan has entered.

Vanessa Jackson: Next question. In regard to the 2010 liability letter surveys, when members respond with a no answer to having any other liability insurance does the plan need to go into ECRS and enter anything to submit to CMS?

(Female): No.

Vanessa Jackson: No.

Next question. Based on the results we are seeing with our validation process for the MSP process we are seeing less than 5 percent accuracy rate with the files CMS is sending. Which means over 90 percent of the data CMS is sending us is inaccurately showing Medicare as secondary.

What is CMS's plan and timeline to clean up the date coming on the files and lessen the impact this has on retroactive reimbursements?

(Female): Part (inaudible).

(Male): Part C.

Vanessa Jackson: It is a Part C question.

(Female): (Inaudible).

Vanessa Jackson: And again, whatever questions we aren't able to answer here on this forum, we will provide the answer in written format on the transcript.

Does CMS – the next one is too? Does CMS require duplicative outreach to the member if they're MSP status has already been investigated and verified? It just has not dropped from the CMS monthly report due to increased volumes and a possible delay in processing.

(Female): That's a C question.

Vanessa Jackson: That's a C question. Do you have that one?

(Female): Yes.

Vanessa Jackson: Oh, you have that. OK.

OK. Let's mark that as a Part C question.

Next one. After submission if we are not seeing members drop from the MSP file due to increased volumes and/or a possible delay in processing of the ECRS file, do we need to continue to send this membership on the ECRS file? Or do we only send new adds?

(Female): You should only be sending new adds. I mean, it's important too that you check your response files and see that you got a response to that member. If you did not get a response to that member then you can indicate it before you can reach out to your Consortia.

But if you got a response then you have to make sure the response matches what you're seeing in your file.

Vanessa Jackson: Next question. Can CMS provide an explanation of how to populate the MSP inquiry layout to indicate that Medicare is not secondary? We have discussed this with the CMS contractor, but would like to ensure that we are doing it correctly, what we are doing is correct.

Bill Ford: You wouldn't use the MSP inquiry layout if Medicare is not secondary. You would use the assistance request to have that primary record deleted or termed or whatever. But if it's the wrong layout, then you got to use that assistance request.

(Female): Yes.

(Female): So just refer to the CWS layout and that's what you would submit to update that record to show that Medicare is primary.

Vanessa Jackson: OK.

Next, the last, no it's not, next to the last question because we want to allow time for questions. While not specific to the ECRS flat file I have two questions concerning a new and old CMS file.

Will the (mark) COB file continue to be delivered to plans? Or does the new MSP COB AD file replace it? If the (mark) COB and the MSP COB MA files indicate conflicting data, does one file supersede the other?

Deb Larwood: I think this is what we answered a little bit before. And that is, some of these are, the fact that a coverage is different between C and D. So you're going to have differences between files, between those files. As well as, as what was also mentioned with timing is different.

Vanessa Jackson: OK. Thank you, (Deb).

Our last question is, return duplicate ECRS request used with CMS status. We received this response on records we have only sent to ECRS one time. I am not sure how these are considered duplicate requests unless another plan

has submitted information on the member. How do we know that our request was processed?

(Female): And again, I'm assuming that you got the CM53. And you can only get the CM53 if there are multiple requests. If you want you can either send myself some examples of where you think you only, where you're saying you only submitted one record. Or you can contact your Consortia and give them some examples. And they'll be happy to go over it with you.

Vanessa Jackson: OK.

Incoming requests conflict with information on file. How do we process this response? Does this mean that our request will or will not be processed? In these cases we submitted ECRS forms with updated information or requests to delete based on the research performed by the plan.

Or does this mean that something we submitted, like the MSP effective date or patient relationship code does not match the information we received on the file from CMS?

(Female): If you received a CM83 conflicting information, that means based on what you submitted we cannot determine what action you would like us to take. So, that is closed and you would need to resubmit it with either adding comments as to exactly what action you would like taken.

Vanessa Jackson: OK. Thank you. That concludes our pre-submitted questions.

At this time, (Sarah), we would like to open up the lines for questions please.

Operator: At this time I would like to remind everyone in order to ask a question please press star then the number one on your telephone keypad.

Your first question comes from the line of (Michelle Ford) from Medicare First.

You line is open.

(Michelle Ford): Hello. I wanted to know if you can explain how to resolve PE10?

(Male): One zero?

(Michelle Ford): Yes. PE10.

Vanessa Jackson: We can barely hear you. Is this (Michelle)?

(Michelle Ford): Yes.

Vanessa Jackson: Can you speak up a little bit for us? Thank you.

(Michelle Ford): I wanted to find out how we can resolve PE10 responses.

(Male): PE10 is incorrect beneficiary social security number.

Vanessa Jackson: Can you hear us, (Michelle)?

(Michelle Ford): Yes. OK. Thank you.

(Male): The PE10 is the – is an invalid beneficiary social security number.

(Female): So then you …

(Male): So, you have to either provide us with the (hikan) or the social security number. So, if you have the (hikan), the social security number becomes irrelevant and you shouldn't get a PE10. As long as you have the (hikan) you can just space fill the social security number.

Otherwise if you have no (hikan) and you're giving us an invalid social security number, you'll get a PE10. And the only way to get that fixed is to get the corrected SSN or the (hikan).

(Michelle Ford): OK. Great. Thank you.

Vanessa Jackson: Thank you.

Operator: Your next question comes from the line of (Angie Garcia) from Blue Shield of California.

Your line is now open.

(Howard Chang): Hello. This is (Howard Chang).

Question I have has to do with whether the MSP file will have records deleted from it. But we were told originally that that file, (which is) OHI file, always is a cumulative file. But I think we've seen in some of the files we're received that records have been deleted from the one we got the previous month.

So I'm trying to get some clarification on that, on if that's actually the intent or not.

(Male): No. That seems like a Part C question.

(Female): It is.

(Male): But, I know the MSP file is a snapshot at that time. So it's not an ongoing file. It's a snapshot of what's in CWF at that particular time. So if it's June 11, that's what CWF looked like on June 11.

(Howard Change): OK. Thank you.

Vanessa Jackson: You're welcome.

Operator: Your next question comes from the line of (Carol Bendle).

Your line is open.

(Carol Bendle): Hi. I'm calling to ask during a recent conversation with GHI regarding the errors on our file it was determined that we had not received the new user guide that was released in April. We would like to know how this was distributed and what will the standard process be for this to be (using) updated versions of this user manual moving forward.

(Male): I don't know how we distribute it moving forward. But I mean, if you don't have it, anybody who doesn't have it, shoot me an e-mail and I'll certainly get it out to you right away.

(Carol Bendle): I think the problem was it was already out and we were not aware that it had even been distributed to any of the plans.

(Female): Right.

(Carol Bendle): I mean, was it sent our via e-mail? How was the original updated guide released?

(Male): Well, I know it was additionally released years ago. And it was sent out via a welcome package.

(Carol Bendle): Correct. Correct. And then there was a release in April. And we were totally unaware of that. So we're just asking if there happens to be an updated guide released after this what is the standard process?

(Female): Currently we have a process that we use for the fee for service plans. And it's something that we may need to look at for changes for the Part C and Part D plans.

(Carol Bendle): Right. What apparently happened is we did send a flat file in but we were unaware of the updates. So of course, it errored out. So we're just trying to prevent that from happening in the future.

(Female): OK. We thank you very much. We appreciate that.

(Female): Yes.

(Female): And we will definitely go back and look into doing something that anytime there is a change, the guide will be distributed to all Part C and Part D plans.

(Female): Yes. And …

(Carol Bendle): Thank you.

(Female): … provide your e-mail address again.

Bill Ford: wford@bhmedicare.com.

(Female): Thank you.

(Carol Bendle): Thank you.

Operator: Your next question comes from the line of (Angel Mizak) from (Himark).

Your line is open.

(Dave Fernabo): Hi. This is (Dave Fernabo).

I had a question. It was touched on about the Part D COB notification for this year. Are plans expected to notify the members of all COB coverages, including all the MSP types. Whether it's A, B or G. Or the other more accident related ones. And does that also include all the supplemental type codes? Including TRICARE and the other codes?

(Female): Yes. That's our intent is to provide them with everything so that they can confirm that what we have currently on our COB file for them is correct. And give them the option of making any corrections that are appropriate. And at least they are aware of how we're going to be adjudicating claims and processing their benefits. Because you'll be taking that other coverage into consideration.

(Dave Fernabo): If we have say 10 to 15 occurrences, maybe we have multiple TRICARE records, should we present the member with all those records? Or try to filter it?

(Female): Really that depends. I mean, you can provide them everything that's on the record. Or, and you're just, you know, basically just say this is what's there. And, you know, we recognize that there are multiple occurrences. And perhaps this will require some correction. And you getting in touch with TRICARE to make it right.

(Dave Fernabo): OK. And my …

(Female): Or, you can say there are multiple occurrences of TRICARE. Is this accurate? In which case they'll get back to you and then you'll have to have a subsequent conversation with them about how to fix it.

(Dave Fernabo): OK. And my last question. We're just trying to do a systematic process since we have a number of members. If we are surveying about TRICARE and we have a (pace) coverage, which is specific to Pennsylvania, there are direct feeds to the COBC from those plans. If we submit any kind of updates and they wont' actually be updated since there's a better source? Is it worth surveying? For those coverages? I mean, I guess you said yes. But I just want to double check.

(Female): I don't think we're following you. Are you saying because the, if the information comes from a source. And you send us a request to update it, that we wont' honor your request because of the source?

(Dave Fernabo): Yes. Its sort of the true source and the primary source and the member's telling us something different. Is there a hierarchy of what's considered the truth of the COB?

(Male): We're actually meeting currently to talk about hierarchies.

(Female): Yes.

(Male): So that is something we are addressing going forward.

(Dave Fernabo): OK.

(Male): In time, we look at a lot of things historically in terms of the most accurate source of data. And there are certain instances where we don't typically accept an update to it, again, like the case of some of the data exchanges that we do. You know, typically only they can update that information. Or …

(Dave Fernabo): Yes. Exactly.

(Male): … sources essentially. I mean, obviously, they're all processes are designed to (safely glue) that request up the food chain, so to speak, to the folks at the COBC who basically have to do a hands on audit of the particular records.

But, I mean, there are some hierarchies. And there may be more later on. But again, they will always have exceptions to them as well. And processes are in

place now as they will be in the future that if someone truly is adamant that that record could get kicked out for a manual review.

(Dave Fernabo): OK. Yes. Thank you.

(Female): Thank you.

Operator: Your next question comes from the line (Aderin Orvitt) from CVS Caremark.

Your line is open.

(Aderin Orvitt): Hello, everyone. I just wanted to follow up on our question regarding utilizing a default value for the coverage effective date. I understand that the training materials are out of date and a default date of 1/01/2006 is not valid. However, since the effective date is a required field for submission and the tools used to capture that information from members is incomplete, for example, the CMS model enrollment form.

Technically all new enrollments would then be deemed incomplete based upon that requirement. So based upon the responses from the call, our plans are to require this information. So in situations where we cannot get a hold of a member after multiple attempts to try and acquire this effective date, is it acceptable to default the OHI coverage effective date to the members Med D effective date?

Or do we submit the CWF request to validate the effective date?

Alberta Smythe: This is Alberta. And we won't develop for the effective date. On the PDI, the effective date is a required field. I can't, I mean CMS would have to tell you if that's OK for you to default to the Part D entitlement date. But we, to submit a PDI you have to have the effective date.

(Aderin Orvitt): OK. And I guess, are the folks on the call that could address that question? Because I thought what I, what I heard is there was an option to submit that for effective date development if it was unable to obtain it.

(Male): Not for supplemental coverage. (Inaudible).

(Aderin Orvitt): Not for supplemental?

(Male): Would we develop a primary, Alberta?

Alberta Smythe: If they use the MSP, yes.

(Male): MSP. Yes.

(Female): (Inaudible).

(Aderin Orvitt): So, in situations then for supplemental coverages that a member may provide. And I'm talking new lines of coverage where a member would fill out the enrollment form first. And they had supplemental coverage. What's the expectation then of plans to do, are we to hold that record indefinitely until an effective date could be obtained? If we're unable to get a hold of a member after multiple attempts? Or is it something where some information regarding this coverage would be better than nothing. You know, and should be submitted?

(Female): Could you bear with us one moment? We're having a side bar.

(Aderin Orvitt): Yes. Thank you.

(Female): Thank you.

Deb Larwood: We're back. And this is Deb Larwood. I would say that probably the best approach is to continue to work to develop the effective date. And when you get it, report it. The worst thing that can happen is that we'll get and we'll have to do some retroactive work to make sure that the other payer pays their portions. And that will really probably be the (beni's) responsibility.

And then, you know, you'd have to make the adjustments to, you know, (troop) depending on the (troop) eligibility of the other payer. But, you know, the thing is I think you've got the opportunity to let the beneficiary know that it's to their advantage that they get the supplemental payer information on the COB file. So that the other payer can be, a claim can be submitted to them at point of sale.

And the beneficiary then actually gets point of sale advantage of their other coverage. I mean, if they're paying for coverage that isn't being tapped at point of sale, then they're paying more out of pocket than they would have to pay ordinarily. So, you know, I think you've got, you've got a way to encourage them to provide the information.

(Aderin Orvitt): OK. And thanks, (Deb) for providing that. So just one more thing regarding this then. As far as turn around times of submission of data into the COBC, GHI, etcetera. Then these situations would fall outside of that 30-day rule as far as when it was provided to the plan versus when it was actually submitted into the COBC. Correct?

Deb Larwood: Yes. I mean, I think that arguably you're going to want to have, you know, for audit purposes, you would want to have a procedure in place that says, you know, under normal circumstances you know provides COBC with the information within 30 days unless of course it requires development on your part. In which case, you know, it may take longer but you'll do it, you know, promptly and …

(Aderin Orvitt): Agreed. OK.

Deb Larwood: … so that, you know, things work out.

(Aderin Orvitt): OK. Thanks. Thanks, (Deb). And I guess one final thing out there regarding this question. I do have one additional one is that is there any plans or intent on possibly going back and looking at the tools, the Med D enrollment form, Medicare, gov etcetera to add these additional fields here as far as requirements to those forms. So that when members do enroll initially with this new information that they are at least asked up front, if they know it, to provide it.

Deb Larwood: So, I don't, I don't know of, but that's something we can certainly (inaudible) for. I don't know what's being done with regards to that.

(Aderin Orvitt): OK. Is that something that we can get some follow up on then if …

Deb Larwood: Certainly.

(Aderin Orvitt): OK. And then lastly. My second question …

Vanessa Jackson: In the interest of being fair, we have a lot of other people that are waiting for questions that are, we only have like maybe seven minutes. And we've answered almost, to like four or five of your questions. So we want to remain fair. So if it's three OK, but we really need to move forward.

(Aderin Orvitt): Yes. It's real quick. It was just in a follow up to CMS's expectations on plans to validate the COB information at time of enrollment. So it's in the same vein. The question is, is that it was referred to as that reasonable information would need to be obtained. And I was just wondering what the definition of reasonable information is as far as the data elements.

(Female): Well, not reasonable, credible.

(Aderin Orvitt): Credible.

(Female): And credible is defined in the new regulation that just went out in April.

(Aderin Orvitt): OK. All right. Thank you for the time. Appreciate it.

(Female): Thank you.

Operator: Your next question comes from the line of (Sarah Peterson) from (Fallon Community Health).

Your line is open.

(Sarah Peterson): Hi. Yes. So the June 2007 ECRS Part D plan batch requirements doc sent that has all the file layouts. Is that what was updated in April 2010?

Bill Ford: Yes.

(Sarah Peterson): OK. And (inaudible) for that.

And then where can will we be able to find the transcript for this, today's call. Where will that be posted?

Vanessa Jackson: We have not decided yet. But as soon as we do we'll let you know either through e-mail or through the call that you have on Wednesday. Is that OK?

(Female): Yes.

Vanessa Jackson: OK. We will get the information to you as to where it will be placed.

(Sarah Peterson): OK. Thank you very much.

Vanessa Jackson: Thank you, (Sarah).

Operator: Your next question comes from the line of (Neil Weiss) from Touchstone Health.

Your line is open.

(Neil Weiss): Hi. Thanks. For the monthly COBC file, I just wanted, I understand that it's a snapshot each month. Does that snapshot represent all members that are, that have active COB occurrences?

(Male): That's what it should represent, yes.

(Female): And again, (Neil), that's our understanding of what that file is. But again, we do not create that file.

(Male): And remember there's nobody here from the Part C side …

(Female): Yes.

(Male): … to address these questions. So.

(Neil Weiss): OK. So then I don't know if you'll help me with this one then. Then if the, if we get the file an the MSP date, effective date has all zeros in it, or the MSP type is C or W, which I don't see it on the layout. Are we, if I have to send these records back, am I going to, I have to send them back with what was provided? So if it's all zeros, provide back all zeros and the Z and the W for MSP type?

Alberta Smythe: There wouldn't be an MSP record without an effective date. And again, a D is a no fault if that, you're talking about MSP types. A D is a no fault and a W is a workers comp set aside.

(Male): Hi, Alberta. This is (inaudible). We're actually getting Z on, as in zebra.

Alberta Smythe: Z are invalid records. You don't need to do anything with those records.

(Male): OH. OK. Great. Great.

(Male): Anything else?

Alberta Smythe: That's why they have they zeros. They're all invalid. So you can just ignore those.

(Male): OK.

(Male): So if we get a record that has an MSP effective date of all zeros, I guess we're going to assume that maybe they don't have COB?

Alberta Smythe: Correct. That's the only thing you got for that member. That's correct.

(Male): OK. Its just odd because they keep appearing every month.

(Male): They will.

(Male): They will.

Alberta Smythe: The Z records, yes.

(Male): OK.

(Male): OK.

(Female): Thank you.

(Male): OK. Thanks, Alberta.

Alberta Smythe: You're welcome.

Operator: Your next question comes from the line of (Erica Thompson) from HealthNet.

Your line is open.

(Erica Thompson): Hi. I just wanted to verify what will GHI research and will not research when submitting into ECRS assistance request.

(Female): It depends, are you, it depends on what you're asking, what your action code is.

(Erica Thompson): It's a DI and we're asking to supply maybe missing policy numbers or insurance information. We've tried to make outreach and we can't get a hold of the member. Or the member hasn't responded to our letters. So we're kind of stuck.

(Female): And I assume you're talking about a supplemental drug record. And again, if it's a supplemental drug record, we'll develop for the Rx (bin), PCN and policy number.

(Erica Thompson): Yes. They're for drug records. Would you develop for the missing insurer's name for the drug record?

(Female): No. If we're developing for the other information and we happen to receive back the insurance name, then of course we will update the record with that information.

(Erica Thompson): OK.

(Female): And the development letter that we do send for the PC, for the (bin), PCN, it does ask for the insurer's name. So hopefully they'll send it. We try to get them to give us back all of the information so that we can, you know, update and the record be complete.

But, if you just send a request to develop for the insurer name, we will not honor that request.

(Erica Thompson): But you will honor for missing policy numbers?

(Female): I'm sorry. Not policy numbers, Rx (bin) and PCNs.

(Erica Thompson): OK. Just for the (four X) data.

(Female): Yes.

(Erica Thompson): Not for the missing policy numbers or the insurers name?

(Female): Yes.

(Erica Thompson): OK. Thank you.

(Female): Policy number is not a mandatory field.

(Female): Thank you.

Operator: Your next question comes from the line of (Angie Garcia) from Blue Shield of California.

(Howard Chang): Yes. This is Howard Chang again. On the COB file there's a field called sequence number. And I was wondering if the combination of (hick) number, the file creation date, and the sequence number is sufficient to identify a record uniquely on the COB file?

(Female): And I believe that's a sequence number is what we call the aux in the CWF files. So if the aux number is different, yes.

(Howard Chang): OK. Would that aux number be the same for the same record if it appears in the following, in the subsequent month?

(Female): It's possible, yes. The aux number may never change.

(Howard Chang): May never change. That means there's a possibility it could change?

(Female): Very rarely. So I would say that, yes, that aux number will always be the same.

(Howard Chang): OK. Because I'm trying to identify the fields on a (inaudible) record that will make it a unique key that I can use. So if anybody has any other suggestion on what fields I might use to accomplish that.

(Female): Well, and I guess, again, if you have that sequence number, that would be unique to that record. You will not have a record with the same sequence number.

(Howard Chang): OK.

(Female): OK.

(Howard Chang): The second question, the second part of that question was, the next file, the next month file, would I be able to rely on that same sequence number to identify that same record for the following month?

(Female): Yes.

(Howard Chang): OK.

(Female): And are you talking about the daily MSP file or COB file? Or are talking about the monthly.

(Howard Chang): No this is the COB file. Not the MSP file.

(Female): OK.

(Howard Chang): So the answer to that is yes, right?

(Female): Yes.

(Howard Chang): OK. Thank you.

(Female): You're welcome.

Vanessa Jackson: Operator? (Sarah)?

Operator: Yes.

Vanessa Jackson: We – that was, that was, let's just take one more call. One more question. And then we're going to do a wrap up.

Operator: Your next question comes from the line of (Susan Tisher) from HealthPlan.

Your line is open.

(Susan Tisher): Good afternoon. We're still establishing processes on how to get into ECRS. To submit the transactions. We've made several telephone calls but we're not really getting responses back. And I'm wondering, is there anyone specific who can assist us?

Bill Ford: Send me an e-mail at wford@ehmedicare.com.

(Susan Tisher): OK.

Bill Ford. You'll have much more success getting me via e-mail.

(Susan Tisher): All right. Then that's what we'll do. Thank you very much.

Vanessa Jackson: Thank you.

Again, we'd like to thank you for joining the call. We realize that we may not have been able to get to everyone's questions. But we encourage you to use the CBTs for the drug plan sponsors curriculum. And also utilize your Consortia rep.

I think we have some wrap up, Alberta.

Alberta Smythe: Just one thing, I just want to remind the plans. A lot of you were set up years ago when we first started receiving the Part D data. And some of you are new to the whole ECRS process. We just want to say that when you're going through the setup process, it's important even the plans that are already set up, that if there's any changes that you notify us.

It's also important that if you send a test file and then you received your response, to not send a production file until you have notified us so that we

can ensure that you're setup is complete. And that your response files are going to, your production response files are going to the right place.

Bill, did you want to add anything?

Vanessa Jackson: OK. Again, we thank you for participating on the call. And hopefully this has helped to clear up a lot of questions that you may have had and improving the ECRS process.

Thank you so very much. And have a great afternoon.

Operator: And this concludes today's conference call. You may now disconnect.

END