

TRANSCRIPT
TOWN HALL TELECONFERENCE

**SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
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DATE OF CALL: December 18, 2013

**SUGGESTED AUDIENCE: Group Health Plan Responsible Reporting
Entities – Question and Answer Session.**

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CENTERS FOR MEDICARE & MEDICAID SERVICES

**Moderator: John Albert
December 18, 2013
1:00 p.m. ET**

Operator: Good afternoon. My name is (Brianna) and I will be your conference operator today. At this time, I would like to welcome everyone to the Section 11 – sorry – Section 11 GHP Town Hall Conference Call. All lines have been placed on mute to prevent any background noise.

After the speakers' 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'd like to withdraw your question, press the pound key. Thank you.

John Albert, you may begin your conference.

John Albert: Thank you, operator. Good afternoon, everyone. And, for the record, today is Wednesday, December 18, 2013 and this is the Section 111 GHP town hall teleconference.

As I state at the beginning of every one of these calls, on occasion, we may say things that contradict the user guide or other official documents on the Section 111 Web site. Again, where there is a contradiction in the materials on what we – in the materials with what we say on the call that the user guide and other materials do take precedent over anything we say on this call.

Today, I'll be providing an introduction and then, Mr. (Jim Brady) and Jeremy Farquhar will be providing introductions to the BCRC and then we'll go into a Q&A session. As always, we ask that people provide their name and the company they're with and that, because of time constraints, that they please limit themselves to one question and one follow up so other people in the queue can get their questions answered.

I want to remind everyone to please continue to submit your policy and technical guidance questions to the resource mailbox. These are used to develop our presentations for these calls and to update the guidance on the Section 111 Web site.

If you have more general operational technical questions, please try your EDI rep first rather than use the resource mailbox. If, for some reason, you can't get what you need from your EDI rep, there is also the escalation process in the user guide. We've noted an increase in some routine questions that our EDI representatives are more than qualified to handle. We want to make sure that you get those questions answered as quickly as possible.

In November 1999, CMS award the Coordination of Benefits contract to consolidate activities related to the collection and management of other health insurance coverage information. In October 2006, we established the MSP Recovery Contract or MSPRC to consolidate MSP debt collection activities.

Previously, all these activities have been handled by each of the Medicare claims processing contractors on their own. With the consolidation of MSP data collection and recovery activities as a result of the many benefits to the Medicare program, CMS realized that further benefits could be realized by further restructuring its MSP contractor operation.

As you may have heard on the previous call, CMS is restructuring its Coordination of Benefits in Medicare secondary payer recovery activities into a new contracting structure. This action will provide improved customer service to stakeholders, consolidated and streamlined data collection and recovery operations and value-added efficiencies and enhanced resource utilization for all involved.

CMS has already transitioned all group health plan recovery activity to a commercial repayment center effective May 13, 2013 and we had Webinars and all to introduce them to the public, so some of you may be familiar with them already.

The purpose of today's call is to formally introduce you to the new recently-awarded Benefit Coordination and Recovery Center or BCRC. The new Benefit Coordination and Recovery Center will assume all operational activities of the COBC and will perform recovery case work for non-group health plan liability, no fault and workers' compensation insurance. As I mentioned before, GHP recovery was transitioned to the commercial repayment center on May 13, 2013.

Group Health Incorporated, who is the prime contractor for both the COB contract and the MSPRC contract is the prime contractor for the new Benefit Coordination Recovery Center contracts. The Benefit Coordination and Recovery Center is currently performing activities to transition into its new role. CMS expects transition to be complete with a go-live in early February.

A specific go-live date and additional information will be provided at later dates either cms.gov and other (outlets). Now, I'd like to turn the call over to (Jim Brady), the project director for the new Benefit Coordination Recovery Center, who would tell you more about what to expect with the new contractor. (Jim)?

(Jim Brady): Thank you, John. Good afternoon, everybody. My name is (Jim Brady) and, as John said, I am the project director for the Benefit Coordination and Recovery Center, the BCRC. And the BCRC will be performing the Coordination of Benefits activities for group health plans and taking over from the COB contractor today of doing the same function.

The important thing to remember is that as the incumbent on the current contract, one of our primary objectives is to ensure that the transition is as seamless as possible to our customers. To that end, for the Section 111 reporters, the following will remain the same.

Current reporting requirements and processes will remain unchanged. The Web sites and systems currently used by the responsible reporting entities, the RREs, yourselves, will remain unchanged and the EDI hotline number that you probably have on speed dial and the associated escalation process in the user guide will remain unchanged.

The changes that will occur include a new consolidated customer service phone number, as well as some new post office box, mailing addresses for federal correspondents. Over the next few weeks, you will be hearing more about changes to the addresses and the toll free numbers, however, please keep in mind that, for a period of time, mail and phone calls will be forwarded from the old numbers to the new and from the old post office boxes to the new so we'll be able to provide uninterrupted service.

For the most current information on the transition activities, visit the Coordination of Benefits and Recovery page on cms.gov. And, with that, I will pass it off to Jeremy Farquhar to give you an update on the news-related Section 111 GHP reporting.

Jeremy Farquhar: OK. Thanks, (Jim). First off, for those who may not already be aware, another update to the GHP user guide has been published since our last town hall call. The current version is 4.2 dated 9/30/2013, but not much has changed since the prior version published back in July. The only updates were to the U.S.PS links contained in Sections 7.2.2.2 and 7.2.6.3.

The new version is available for download via the CMS GHP mandatory insurer reporting site at <http://go.cms.gov/mirghp>. That's go.cms.gov/mirghp.

Next, before getting into some – excuse me – next, before getting into some resource mailbox questions, I just like to take a couple of minutes to once again remind everyone of the optional unsolicited MSP response file process. COBC collects coverage data from numerous sources. That being the case, there will be occasions where records submitted via Section 111 may be updated with information coming from somewhere other than a Section 111 file submission.

Prior to the implementation of the unsolicited response process, the Section 111 RRE would have had no way of knowing if changes were made to the data which they had previously reported. Now, an RRE has the option to receive the unsolicited response file which will tell them if a record which they have submitted has been updated or deleted.

The unsolicited response files are generated monthly on the second Sunday of the month. The file will contain a response for each record updated or deleted by another source during the timeframe since the generation of the last unsolicited file. Each response record will contain all of the data elements as they presently reflect on Medicare's database.

In addition to this, the response will indicate the type of entity from which the information had been received and, when available, the name of the updating entity along with the general reason for the update.

Maintaining the data provider via the unsolicited response file in conjunction with the data from the standard MSP response file will provide the RRE with the clearest picture of exactly what coverage data Medicare has on file for their insurer group at the present.

Situations where update is being received by alternate sources may appear to be in conflict with their own data, the unsolicited response will help the RRE determine where the conflicting information is originating from. Although not required to do so, RREs are encouraged to use this information to investigate and rectify discrepancies with beneficiaries and employer groups.

Another significant benefit of the unsolicited MSP response file is that for any record on which the RRE receives an unsolicited response, the RRE may send a hierarchy override code on their subsequent quarterly MSP file without first having received hierarchy reject code on a prior MSP (inaudible) file. However, before doing so, the RRE should research to ensure that their information is accurate in instances where there appears to be conflicts.

An RRE that does not participate in the unsolicited response process would first have to submit an update on their quarterly submission, wait for a response with a hierarchy reject and then submit an update with a hierarchy override on their next quarterly file.

Participation in the unsolicited response process would allow for the RRE to rectify any possible discrepancies much more expediently as opposed to having to wait an entire additional quarter to do so. For further information

regarding the unsolicited MSP response file process, please refer to Section 7.2.10 and Appendix H within the current GHP user guides.

OK. Moving on, there are a couple of questions from the resource mailbox which I'd like to address. The first is in regard to entitlement data returned via our query-only response files. The RRE had commented that the query response file presently returns Part A, B and C entitlement information. They went on to indicate that it would be very helpful for them if the query response files also contain Part D enrollment information and they asked if CMS had any future plans to add that information to these files.

The answer to that question is no. But it is possible to obtain Part D enrollment information when inquiring entitlement if your RRE is an expanded reporter. If you're set up as an expanded reporter and are using a non-MSP file format to submit either supplemental drug coverage or RDS data, then, you can also use that same non-MSP to query rather than utilizing the query-only file format.

The responses to the N record type non-MSP queries include Part D enrollment information. The premise is basically that if you're an expanded reporter providing us with drug data, then, we'll offer you Part D enrollment information in return. If an RRE is opted for the basic reporting option and are not providing drug data, then, they are limited to the use of the query-only file and Part D enrollment information will not be provided. If you are currently a basic reporter but would like to become an expanded reporter in order to begin submitting drug data in addition to your hospital medical coverage, then, please contact your assigned EDI rep and they should be able to assist you in making that change.

And the next question came from an RRE seeking information on Medicare primacy in relation to individual insurance policies. They'd indicated that they reviewed the information on the Section 111 site, but could not find anything on this topic.

OK. So individual policies are not covered on the Section 111 Web site because individual policies are never primary to Medicare and are not to be

reported via Section 111. The information we are collecting via Section 111 is for employer group health plans where coverage is based on active employment.

There is no MSP when a beneficiary is only under coverage besides their Medicare as an individual policy, so please don't submit that data on your Section 111 file. That will cause problems. And with that, I'll turn it back over to John.

John Albert: OK. Thanks, Jeremy. I guess, operator, now, we're ready to go into the Q&A session, so if folks have questions now is the time.

Operator: As a reminder, if you would like to ask a question, please press star one on your telephone keypad. If you would also like to withdraw your question, press the pound key. Your first question comes from the line of Catherine Kiefer with PreferredOne. Your line is open.

Catherine Kiefer: Hi. With the Affordable Care Act coming into play and reporting for Medicare, we recently had – I'm from Minnesota – we recently had a conference call where the state said for processing the Affordable Care Act that they were not going to require social security numbers. They got inundated with concerns from insurers saying we have to have that in order to process Medicare.

The other piece that we are not getting at this time that I know of is the number of employees for small groups signing up to use that as their insurance for their employees. Have you had any conversation with the people that drafted or are administering the Affordable Care Act to indicate what you need to process Medicare secondary payer? That's the end of my question.

(Bill Decker): This is (Bill Decker), also with CMS. On the business of small – of small – on the subject of small businesses and the ACA, the Affordable Care Act, as you may – as it may occur to you, for MSP purposes of small business is any business with less than 20 employees. And, in such case, Medicare is ordinarily primary for those employees. For the ACA...

Catherine Kiefer: I understand that.

(Bill Decker): For the ACA...

Catherine Kiefer: However...

(Bill Decker): For the ACA, a small business can be up to 50 employees.

Catherine Kiefer: Right.

(Bill Decker): And if it's over 20 – and if it's over 20 employees, a small business with group health plan insurance that is offering towards employees is required to report to us under the Medicare secondary payer provisions. We have had a number of conversations over the past year with the folks in CMS who are putting together the rules and regulations for the Affordable Care Act on this issue.

The other part of CMS that is an agency known as (Sasayo) is aware of the fact that some small businesses offering product under the ACA; another SHOP provision, Small Business Health Options Provision; are going to have to report to us. It is up to the ACA and up to us here and the Medicare secondary payer area, to be sure that these employers understand that and know that if they've never done this before, they will have to be reporting to us.

Quite honestly, I thought an employer has – already has, say, 40 or 50 employees and has group health plan insurance coverage that will be reporting to us now or at least they should be because that's what the rules are.

The SHOP option is essentially set up for new entrants into the employer based coverage arena. Those new entrants may not, in fact, understand that if they have 20 or more employees and still qualify for the SHOP option under the ACA that they're going to have to be reporting under the Medicare secondary payer reporting option – requirements, rather.

So to answer that part of your two-pronged question, we here in CMS, every part of the agency that is aware and that is involved with the SHOP option and

with the measure and secondary payer option know that there are going to be some employers in the SHOP area that don't – probably don't understand that they're going to have to start reporting under Section 111.

On the other hand, it is actually the insurer's responsibility to do that reporting, not the employer's. So it is the insurers that are going to end up being the ones who are going to have to understand that if they are providing coverage to a SHOP-based small business health-options based new employer that they are going to have to be – that is, the insurer, is going to have to be reporting the coverage.

So I hope that covers your – that range. If you have any other subtext questions to that, you can ask me right now. I'll see if I can answer them for you.

Catherine Kiefer: I think that'll do it for right now. Thank you.

(Bill Decker): OK. What was your first – the first half of your question about the social security number?

Catherine Kiefer: Well, we had a conference call with the state of Minnesota and during that portion of it, the state said that they were not going to require social security numbers to sign up for – in the State of Minnesota it's called MNsure. They were inundated with calls and e-mails and everything from insurers saying, "Absolutely not. We must have that in order to report to Medicare."

And, since then, they have put in the – in order to sign up for MNsure, they are now requiring social security numbers. I was using that as an example in order to see if it was going to change regarding the size of the employer group.

(Bill Decker): I don't think the requirements to collect SSNs or a state law that says they don't need to be collected would have any effect on reporting under Section 111 GHP reporting. (We do – we have) our requirements remain unchanged.

There was – there has been, I will admit, some confusion among some states about whether – what data elements that they would require under their

programs. Unfortunately, or fortunately, the (impending) Part 1's perspective, the social security number is essentially a drop-dead requirement for reporting for group health plan insurers, also for NGHP insurers although this is not an NGHP call. And, as everyone knows, that is the basis for the Medicare health insurance claim here with the Medicare HIC.

At this point, those requirements for reporting either SSNs and the private sector or the Medicare HIC and in our perspective, are still in place and haven't changed. Thus, if a state like Minnesota was saying, "Well, we're not going to collect them." That could be a problem for reporting at the federal level under the Section 111 rules or within the state or the private sector insurers that have to deal with the new sign ups in a – in a state-based program.

We tried to make that very clear to the insurance industry in a series of efforts last year, in fact, and to the state governments in a separate series of an issue that was last year in (Sasayo) that there were certain data elements that had to be collected. There were other states that were considering not collecting SSNs.

I'm surprised that that message didn't get out to Minnesota since they're one of the states that we worked very closely with over the period of implementation of the ACA. That's probably more information than you wanted, but it's a – I hope an explanation for anybody who's out there about that issue at this point.

Catherine Kiefer: Thank you very much, (Bill). Have a great day.

Operator: Your next question comes from the line of David Pittman with Zenith American Solutions. Your line is open.

David Pittman: This is David Pittman. My question is about the reporting of the relationship to a spouse who's of the same gender as the participant. What is the correct code to use when reporting same-sex spouses?

(Bill Decker): The coding under Section 111 reporting for a covered individual who has a spouse has not changed. There is no change in any requirement under Section

111 currently to report and how spousal coverage is reported. Or, again, it's a – it's a function of the insurer that is doing the reporting and the insurers are expected to correctly identify and report spousal coverage when it is appropriate to do so.

The issue of whether or not a particular same-sex spouse is eligible for that coverage is somewhat complicated yet. In many states, it is not an issue; in some states, it remains an issue; and particularly in states where same-sex marriage is not recognized at the state level. It is an issue at the level in those states and it is an issue for us in one way.

We, in CMS, run the Medicare program which is joined at the hip to the social security program. Most of – most of you know Medicare beneficiaries come into Medicare through the Social Security System. And the social security program has not yet clarified how it will – itself, the Social Security System – will treat same-sex married spouses in states where they are living if the state does not itself recognize same-sex marriage.

There is an issue at the Social Security System level at the – at that level that affects us. We can't make a unilateral change of any sort in our current policy until we get guidance from the social security program and that guidance from social security is going to have to be signed off on by the Department of Justice. That's the process that seems to be taking a little bit longer than everybody thought it should, but it's still a process that binds us to our current requirements and our current reporting schemes.

David Pittman: OK. Thank you.

Operator: Once again, if you'd like to ask a question, it's star one on your telephone keypad. Your next question comes from the line of Lindsay McBeth with Discovery Benefits. Your line is open.

Lindsay McBeth: Thank you. I have a question in regards to health reimbursement arrangements and MSP reporting. Is anything changing in the requirement of that since, now, HRA is going to be integrated with the health plan?

(Bill Decker): No is the simple answer. Our reporting under Section 111 for HRAs remains exactly the same as it was. Our cut-off limits are exactly the same. Everything that is in the GHP user guide about HR reporting is exactly the same.

The difference in (inaudible), the – some insurance sold under the – under the (inaudible) of the ACA do permit a health reimbursement component to group health plan coverage. But at this point, we don't think that's going to be a particular issue for because it is basically structured under the ACA so that the individuals who are covered don't actually handle the HRA money. That's handled by the insurer.

It's – it has some peculiarities to it, but right now, we don't believe that there is – it's going to have much of an impact at all on HRA reporting except that it turns out that every insurer in the country decides to offer HRAs are embedded, that's the term that we use. We probably won't see any more HRA reporting, so other than that, there is no change.

Lindsay McBeth: OK. Thank you.

Operator: And there are no further questions in queue. I'll turn the call back over to the presenters.

John Albert: OK. Since it is so early, I'll offer one more time. Going once – anyone else dialing in? No?

Operator: There are no questions.

John Albert: OK. All right. Well, everyone, that was a pretty quick call. It seems like the ACA was the driving discussion here which is kind of expected, but anyway, I'd like to thank everyone for their participation and stay tuned to cms.gov and other outlets for more information concerning the rollout of the new Benefit Coordination and Recovery Contracts and, with that, good day. Thanks.

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

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