The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Group Health Plan (GHP) Reporting Reminders Webinar

May 7, 2020

Presentation Overview

- SUPPORT Act Reminder
- Responsible Reporting Entity (RRE)
- Reporting Reminders
- Resources

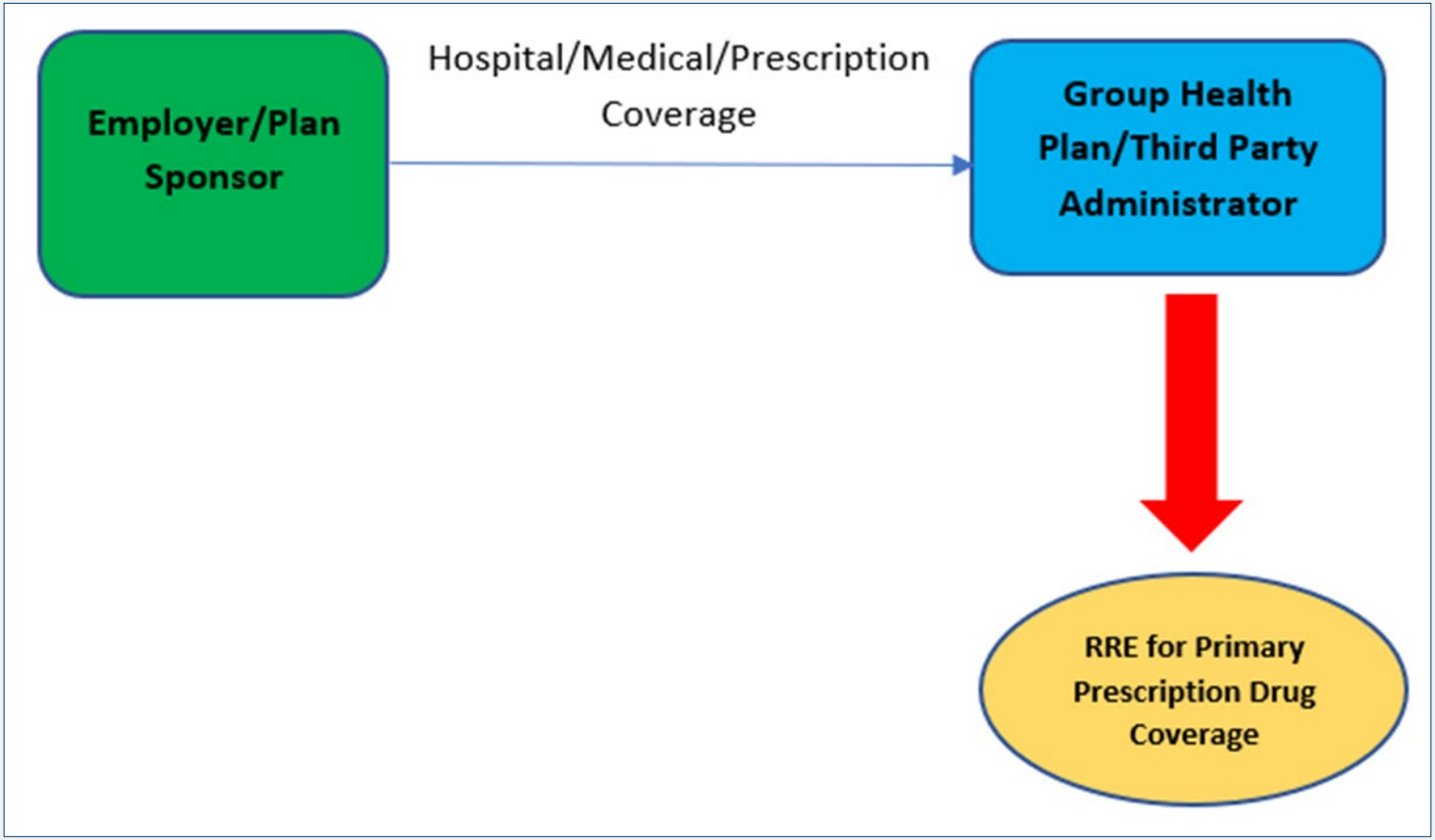
SUPPORT Act Reminders

- Section 4002 of the SUPPORT Act applies to Section 111 GHP reporting of primary prescription drug coverage.
- The SUPPORT Act mandates the reporting of primary prescription drug coverage by GHP RREs.
- The Act went into effect January 1, 2020.

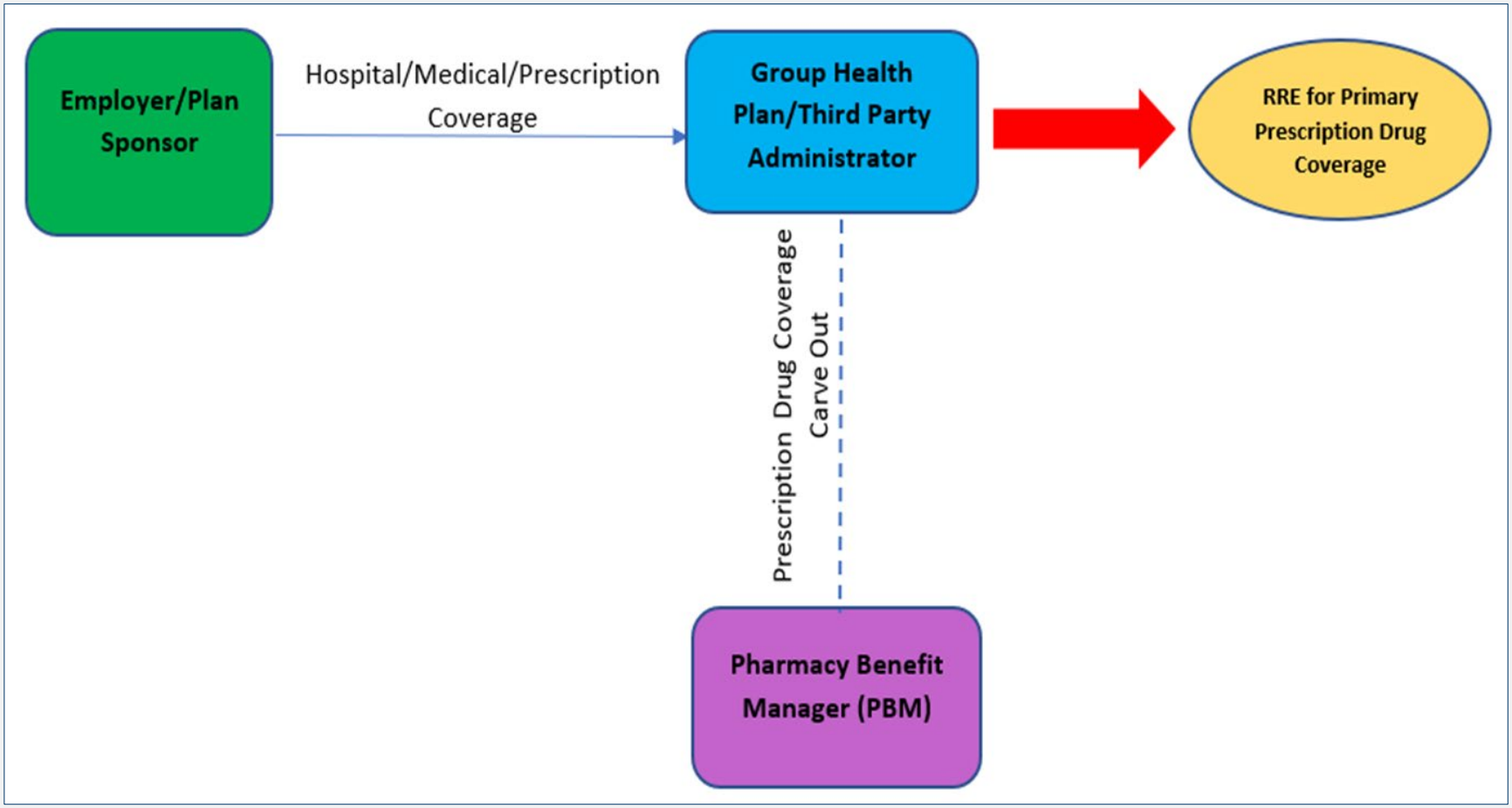
Who is the RRE?

- Who is considered the RRE will depend on how the Employer/Plan Sponsor structures its contracts for hospital, medical, and prescription drug coverage.
- The RRE for the primary prescription drug coverage reporting is the entity that has the direct relationship with the Employer/Plan Sponsor regarding this coverage offering.
- The RRE is responsible for reporting the primary prescription drug coverage information as required under the SUPPORT Act.

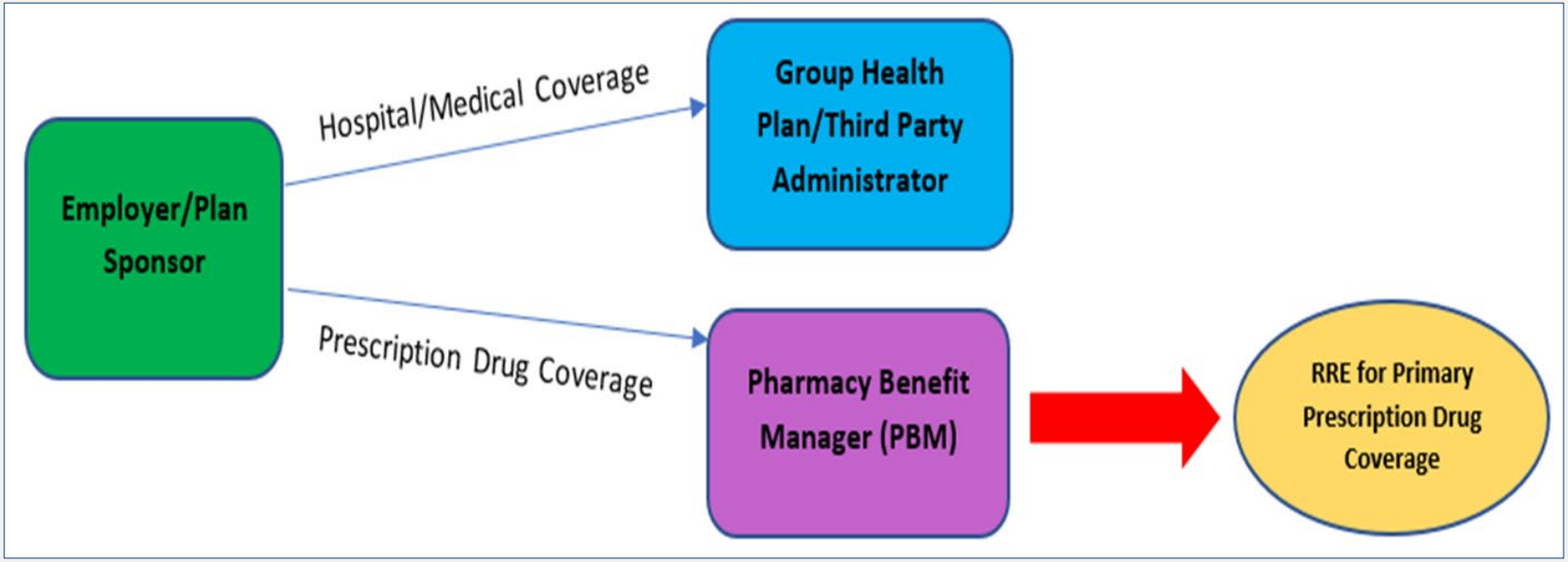
GHP/TPA Comprehensive Coverage



GHP/TPA Comprehensive Coverage with Rx Coverage Carve Out



PBM Contract for Rx with Employer/Plan Sponsor



Tax Identification Number (TIN) Reference File Reminders

- The TIN Reference File should be submitted before or with the MSP Input File.
- The Employer TIN is the Employer/Plan Sponsor TIN, and it must match an Employer TIN submitted on a TIN Reference File Record.
- The Insurer/TPA TIN is the RRE's TIN, and it must match an Insurer TIN submitted on a TIN Reference File Record.
- In the TIN Reference File, make sure to define all Employer/Plan Sponsor and Insurer/GHP TINs that will be referenced on the MSP Input File.

MSP Input File Reminders

- If an RRE offers comprehensive coverage but has only been reporting on the hospital and medical coverage, then an updated record with the correct comprehensive coverage type should be submitted with the same start date, which will overlay any existing record(s).
- Only primary Rx coverage that is active as of January 1, 2020 should be reported.
- The Effective Date reported should be the actual start date of the individual's Rx coverage which could be prior to January 1, 2020.

MSP Input File Reminders Cont.

- Do not report retiree coverage on the MSP Input File, only report coverage based on active employment.
- Only submit plain text ANSI files.
- Pay close attention to required fields.

Type Code Reminders

Type Codes:

For reporting comprehensive coverage:

‘W’ = Comprehensive Coverage – Hosp/Med/Drug (network Rx)
“R” = Health Reimbursement Arrangement (HRA)
‘X’ = Hospital and Drug (network Rx)
‘Y’ = Medical and Drug (network Rx)
‘4’ = Comprehensive Coverage – Hosp/Med/Drug (non-network Rx)
‘5’ = Hospital and Drug (non-network Rx)
‘6’ = Medical and Drug (non-network Rx)

For reporting only primary prescription drug coverage:

‘Z’ = Prescription Drug Health Reimbursement Account (non-network Rx)
‘U’ = Drug Only (network Rx)
‘V’ = Drug Only (non-network Rx)

MSP Response File Reminders

- For MSP Input File records that are Medicare non-matches in your MSP Response File (disposition code 51), continue to send on future MSP Files until those members become Medicare beneficiaries, or until they are no longer covered.
- Review your Response Files, analyze the Disposition Codes and Errors, and make corrections in your subsequent file submissions.

Disposition Code Reminders

- Disposition Codes related to Rx coverage submission: Records that contain information for both hospital/medical coverage and prescription drug coverage will receive one response record.
- The status of the hospital/medical coverage period will be provided in the disposition code field (Response Field 8) and the status of the drug coverage period will be provided in the Rx disposition code field (Response Field 69).
- If the input record contains drug coverage information only, then the disposition code in Field 8 will be spaces and the disposition of the drug coverage record will be in Response Field 69.

Error Code Reminders

- Error Codes returned related to Rx coverage submission: The Rx Error Codes (Response Fields 71-74) are specific to the prescription drug coverage data elements on the MSP Input File including the Rx Insured ID (Field 24) Rx Group (Field 25), Rx PCN (Field 26), Rx BIN (Field 27), Toll-Free Number (Field 28) and Person Code (Field 29).
- Drug records may also have errors for the non-drug-specific fields in the regular error codes found in Response Fields 40-43.

Resources

- The EDI Department is available for assistance at (646) 458-6740.
- For additional information, please also see the following resources:

  Previous SUPPORT Act Webinars
  SUPPORT Act FAQs
  GHP User Guide
  GHP Training Material
  Section 111 Mailbox

Questions & Answers

Title: The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Slide 1: Presentation Overview

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which we will refer to as the SUPPORT Act for the duration of this webinar, was enacted in response to growing concerns about opioid abuse in the U.S.

In this webinar we want to remind everyone about what the SUPPORT Act is, how it impacts GHP reporting, offer scenarios for identifying the RRE and go over some reporting tips and reminders.

Slide 2: SUPPORT Act Reminders

While most of you are aware, by now, of the meaning of The SUPPORT Act, we just wanted to take a moment to again talk about how Section 4002 of The SUPPORT Act impacts Section 111 GHP reporting.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under GHP arrangements. Section 4002 of the SUPPORT Act added the mandate of reporting primary prescription drug coverage information to the existing Section 111 reporting requirements.

This means that all GHPs that offer primary prescription drug coverage are now required to report coverage for calendar quarters beginning on or after January 1, 2020. For example, if a submission is scheduled for May 23, 2020, it will need to include primary prescription drug coverage that is in effect/active for Medicare beneficiaries on that MSP Input File submission. Note that this includes Health Reimbursement Arrangements (HRAs) that meet the current reporting threshold requirement.

Slide 3: Who is the RRE?

The key piece to understanding how the SUPPORT Act reporting changes impact GHPs is in understanding who must report the primary prescription drug coverage as the RRE. We wanted to take a few minutes to again walk through how to identify who the RRE is when reporting primary prescription drug coverage.

The entity considered to be the RRE for the purpose of reporting primary prescription drug coverage will depend on how the Employer/Plan Sponsor structures its contracts for hospital, medical, and prescription drug coverage. The RRE for the primary prescription drug coverage reporting is the entity that has the direct relationship with the Employer/Plan Sponsor regarding this coverage offering.

It should not be assumed that the RRE will be the entity that has direct responsibility of processing and paying the prescription drug claims.

Let’s walk through some examples to help us better break down how the reporting responsibility changes based on different contract arrangements.

Slide 3: GHP/TPA Comprehensive Coverage

Our first example is the most straight forward.

In this example we can see that the Employer/Plan Sponsor is contracting directly with the Group Health Plan or Third-Party Administrator (TPA) for hospital, medical and/or prescription drug coverage. The GHP in this example is processing and paying the claims directly and will be considered the RRE and, as such, will be responsible for reporting the primary prescription drug coverage information.

Slide 5: GHP/TPA Comprehensive Coverage with Rx Coverage Carve Out

In this second example the Employer/Plan Sponsor is still contracting with the GHP for hospital, medical and prescription drug coverage. The difference in this example is that you can see that the GHP has chosen to carve out the processing and payment of the primary prescription drug claims to a Pharmacy Benefit Manager (PBM).

However, because the GHP has the direct contract with the Employer/Plan Sponsor for that prescription drug coverage, it doesn't matter whether the GHP administers the prescription drug coverage directly or carves out the prescription drug coverage to a PBM, it will still be considered the RRE and will have reporting responsibility for the primary prescription drug coverage information.

Slide 6: PBM Contract for Rx with Employer/Plan Sponsor

In our last example the Employer/Plan Sponsor has contracted with the GHP for medical and/or hospital coverage only. The Employer/Plan Sponsor has then independently contracted with another third party, such as a PBM, to administer the prescription drug coverage.

In this case, because the contract for the prescription drug coverage is between the Employer/Plan Sponsor and the PBM directly, the PBM is considered the RRE and has the responsibility for reporting the primary prescription drug coverage information.

I hope that these examples have helped to better clarify who is considered the RRE under the SUPPORT Act for the reporting of primary prescription drug coverage.

Slide 7: Tax Identification Number (TIN) Reference File Reminders

Now that we have talked about the SUPPORT Act in general and how to identify the RRE for reporting purposes, we want to also offer some reporting reminders. While many of you are very familiar with Section 111 reporting, we do understand that there are some new RREs participating in this process for the first time. We hope that going through some of the key components of the Section 111 process and reiterating other resources available will be helpful.

Let's begin by talking about the TIN Reference File.

CMS uses IRS-assigned Tax Identification Numbers or TINs to identify insurers, TPAs, and employers. The TIN is the same as the Federal Employer ID Number, the FEIN, or EIN. The TIN Reference File is submitted with or prior to the MSP Input File so that Insurer and Employer name and address information does not have to be repeated on every MSP Input Record. Please note that the TIN Reference File only needs to be submitted if there is a change (but it can be submitted each time).

The Employer TIN is the Employer/Plan Sponsor TIN, and it must match an Employer TIN submitted on a TIN Reference File Record. The Insurer/TPA TIN is the RRE's TIN, and it must match an Insurer TIN submitted on a TIN Reference File Record.

For the TIN Reference File, also be sure to define all Employer and Insurer TINs that will be referenced in the MSP Input File.

Slide 8: MSP Input File Reminders

So now that we have talked more about the TIN refence file we need to discuss some important reminders about the MSP Input File. The MSP Input File is the data set transmitted from a Section 111 GHP responsible reporting entity to CMS that is used to report information regarding Active Covered Individuals who are Medicare beneficiaries.

If an RRE offers comprehensive coverage of hospital, medical, and prescription drugs but has only been reporting on the hospital and medical coverage, an Update record with the updated coverage code should be submitted with the same start date, which will overlay any existing record(s).

Only primary Rx coverage that is active as of January 1, 2020 should be reported. However, the Effective Date reported should be the actual start date of the individual's Rx coverage which could be prior to January 1, 2020. For example if Mr. Smith has active prescription coverage on January 1, 2020 but the effective date of that coverage was September 1, 2018 then the date reported should be his original effective date of September 1, 2018.

Slide 9: MSP Input File Reminders (Cont.)

It is also important to remember that coverage provided to retirees is not reportable and should not be included in the MSP Input File. For further information about the definition of Active Covered Individuals, please refer to section 7.1.2 of the Section 111 GHP User Guide.

You should also only submit using plain text ANSI files. (Do not submit Unix, Excel spreadsheets, MS Word, or WordPad files as they are not acceptable formats.)

It is critical that all required fields are accurately populated. A full list of all the required fields and their descriptions can be found in the GHP User Guide, Appendix A.

Slide 10: Type Code Reminders

Because we continue to receive questions about which coverage type code to use on the MSP Input File, when you begin to report primary prescription drug coverage, we thought it was worth mentioning the coverage type codes.

The available coverage type codes listed here include those for comprehensive coverage; that is, coverage that includes hospital and/or medical and primary prescription drug. For comprehensive coverage use W, X, Y, 4, 5 or 6.

If only primary prescription drug coverage is being reported then the codes Z, U, or V should be used. Note that HRAs that meet the current threshold reporting requirement that can be used for hospital and/or medical and prescription drugs should report using the "R" code.

HRAs that meet the current threshold reporting requirement but can only be used for prescription drugs should report using the "Z" code.

You'll also notice coverage types separating Network and Non-network. So as a reminder network coverage is coverage where claims are routed electronically, and you have BIN/PCN numbers. Non-network would be for manual claims only where there are no BIN/PCN numbers.

Slide 11: MSP Response File Reminders

Now we would like to talk about the MSP Response File. For every non-empty MSP Input File that you send to the BCRC for Section 111 reporting that is successfully transmitted without severe errors, the BCRC will send you a response file in return. There are some important things to pay attention to when reviewing your MSP Response File.

For MSP Records that are Medicare non-matches in your MSP Response File, as identified by disposition code 51, continue to send those records in future MSP Input Files until those members become Medicare beneficiaries, or until they are no longer covered.

You will need to carefully review your MSP Response File, and analyze the Disposition Codes and Errors, in order to make corrections in your subsequent file submissions.

Slide 12: Disposition Code Reminders

Let's talk in more detail about dealing with the disposition codes and error codes, which should help you better analyze the MSP Response File.

A disposition code (examples: 01, 02, 03, DP, SP, 50, 51, TN), which can be returned on the MSP Response File, indicate a status or required action regarding the submission record.

Disposition Codes related to Rx coverage submission: Records that contain information for both hospital/medical coverage and prescription drug coverage will receive one response record.

The status of the hospital/medical coverage period will be provided in the disposition code field (Response Field 8) and the status of the drug coverage period will be provided in the Rx disposition code field (Response Field 69).

If the input record contains drug coverage information only, then the disposition code in Field 8 will be spaces and the disposition of the drug coverage record will be in Response Field 69.

Slide 13: Error Code Reminders

An error code (examples: CB01, CC01, TN01), which can be returned on a TIN Reference Response File, indicates specific incorrect information in the submission record. The codes describe in which file the error occurred, the nature or type of error, and the field where the error occurred.

For the purposes of this call we want to point out the codes that you should be aware of specific to prescription drug coverage. However, a full list of the codes and their definitions are available in the GHP User Guide.

The Rx Error Codes (Response Fields 71-74) are specific to the prescription drug coverage data elements on the MSP Input File including the Rx Insured ID (Field 24) Rx Group (Field 25), Rx PCN (Field 26), Rx BIN (Field 27), Toll-Free Number (Field 28) and Person Code (Field 29).

Note that drug records may also have errors for the non-drug-specific fields in the regular error codes found in Response Fields 40-43.

Slide 14: Resources

Lastly, today we want to remind everyone of the various resources that are available to you.

The EDI Department is available for assistance at 646-458-6740.

You can always reference the GHP User Guide as well as training materials which are available on CMS.gov. And if you haven't already, you can also sign up to receive notifications on CMS.gov from the Section 111 GHP pages. You can do this using the "Sign Up" box at the bottom of any CMS.gov page and selecting which pages you want to receive updates on. That will allow you to receive notices when materials are updated, or new information is posted.

Finally, you may always submit reporting questions to the Section 111 mailbox.

Slide 15: Questions & Answers

We hope that you found the information helpful. That concludes our presentation and we will now begin the question and answer portion of the webinar.

Acronyms

ANSI	American National Standards Institute
BCRC	Benefits Coordination & Recovery Center
BIN	Bank Identification Number
CMS	Centers for Medicare & Medicaid Services
COBSW	Coordination of Benefits Secure Website
EDI	Electronic Data Interchange
FEIN	Federal Employer ID Number
GHP	Group Health Plan
HRA	Health Reimbursement Arrangement
MMSEA	Medicare, Medicaid, and SCHIP Extension Act
MSP	Medicare Secondary Payer
PBM	Pharmacy Benefit Manager
PCN	Processor Control Number
PIN	Personal Identification Number
RRE	Responsible Reporting Entity
SUPPORT	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment
TIN	Tax Identification Number
TPA	Third Party Administrator