**TRANSCRIPT**

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Vanessa: Hello. How are you? Good. I'm Vanessa, and I want to welcome you to our presentation today. I'm from the Division of Medicare Benefit Coordination, which was formerly known as Medicare Secondary Payer. We have with us today over 100 plus years of experience in this area. And we hope that the presentation that you see today will enhance and help you with what you have to do when you go back to your offices.

One thing that I wanted to discuss is that we are aware that some of you may be having a problem with your flat file submissions for ECRS Web or for ECRS. And we're going to address that and go over that a little bit. For those of you who aren't aware of it, you may become aware of it once you go back to your office.

So, we're going to have Alberta Smythe. Let me introduce my team. We have Bill Ford, Alberta Smythe, they're from the Coordination of Benefit contractor. We have here Harry Smith, Gordon Hicks, Patricia or Pat Ambrose from Neil Hoosier and Associates. We also have Jeanine Centori on the front row, Neil Hoosier and Associates. Jeanine is from CMS as well. Jeanine, can you stand, Neil? And we also have Lori Gambetti from ViPS. Okay, so we're going to have Alberta to give you a brief overview before we go into the presentation of what we may- what we're experiencing now with the flat file. I mean Bill Ford. Why do I keep giving it to Alberta? Okay, I've been reminded. There may be a survey on your seats. There's probably three of them or four of them. One of them is for if you currently use ECRS Web. We want you to complete that for us so you can give us some feedback and let us know if we're meeting your needs. The second evaluation form is for the seminar today to give us also some feedback and let us know how we can do this a little better the next time. And is it three or four? Just three. Okay, and the last survey is from--for the conference. Okay, so I'm going to hand it over to Bill Ford. Thank you.

Bill: Good afternoon everyone. I'm Bill Ford. I'm the EDI Manager for GHI, the coordination of benefits contractor for CMS. I'm only going to briefly be up here talking about something you all may have seen recently. There's been a change to the flat file submission for the headers. There's a new field called Submitter Type. Many of you probably haven't gotten the new file layouts. When you get them, you'll notice there's a submitter type in the 23rd bite of the header. And the submitter type is one field, and it's a "C" or a "D" where you can indicate whether you're looking- you're a Part C plan or a Part D plan. If you're both, then you could use "C" in that field. What's been happening lately, and some of you probably noticed this, you're receiving errors, an HE06 error. That's a new error, meaning that the submitter type is missing. But if you haven't got the new file layouts, you wouldn't know that. And we do apologize for not getting those file layouts to you. If you need the file layouts, you could email either myself or Alberta, and we will get them to you. That was really all I wanted to talk about was the HE06 error. We know it's a problem. We know it's an issue. We're working on fixing this and getting you the flat files. And we'll be here to field question and answers at the end. Thank you.

Vanessa: Okay, if you guys have any questions about this, I ask you to write them down. We'll have Q&A at the end of the presentation, and you can present your questions about that then. Right now I'm going to hand it over to Harry Gamble, who's going to begin with our ECRS overview.

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Harry:  Good afternoon.  I'm Harry Gamble, formerly known as Harry Smith.  This presentation is an overview, although I got to admit it's a pretty long- there's probably 44 slides.  I may go through some of them rather quickly.  I think that you're probably--some of you are using the ECRS Web system now, but this is just to kind of give you a little bit of overview of what that system is about.

The first slide, ECRS Web, prior to Web, of course, everybody had to do--you know, you could submit two ways, either on the online CICS version of ECRS or a flat file.  So now, with the implementation of ECRS Web, you have what we hope is a more user-friendly Web-based interface that's available 24/7.  I think the hours, we're not nearly that for the prior versions but this ECRS Web is available 24/7.

The new interface provides for the electronic submission and tracking of requests to add, change, and delete MSP Occurrence records and other health insurance records. Change the slide.  I knew I'd forget to do that.  And you will have the--even in the batch mode, you will have the ability to view the individual requests.

Okay, and of course right now and continuing with ECRS Web, there are three types of transactions, the MSP Inquiry, CWL Assistance Requests, and the Prescription Drug--that should say "Prescription Drug Coverage Inquiry."  So, that hasn't changed.  And, of course, the MSP inquiry, I think you're probably all familiar with that, that's to basically create a new MSP record.  Where you have somebody that you haven't gotten- hasn't yet been identified on your submissions from CMS but you know their MSP, that's a way for you to change CMS's records and add that MSP record.

The CWF Assistance Request, and I know a lot of you folks probably aren't that familiar with that term CWF, I mean, because you're MBD users.  But anyway, the CWF request is not to put on a new record; it's to change or update a record that's already there or to delete them.  There again, that's one of the old transactions, but it's certainly available under ECRS Web.

And, of course, the third transaction is the Prescription Drug Coverage Inquiry.  And that's kind of the equivalent of the MSP inquiry except, you know, it's for drug records.  And it gives you the ability not only to put an MSP record on but also a supplemental record for Part D.

You'll need to access the ECRS Web.  There's a couple of steps.  And if you'll note that self-registration Website there, that's' very important.  That's how you get authorized to have access to the IACS System at CMS.  You'll need an IACS ID and password.  You self-register through the Website that's there on the slide.

And this next step is to obtain an ECRS access code.  And to do the, you call either Alberta Smythe, and her telephone number there is correct, or Bill ford.  And his number should be (646) 458, so that number on the slide is wrong.

Okay, so once you got the IACS user ID and password and them validated, the system will display the ECRS federal systems log and warning page.  And of course, you have to agree to what that says.  And you have to enter your contractor number and ECRS access code.  As of April, if the contractor number begins with an "R" or and "H," which I think all your contractor number do, and it's followed by four digits – and that's just--your plan ID, I think, is your contractor number – the system will redisplay the contractor lookup page and require the user to select these submitter type of Part C or Part D.  And, as Vanessa was talking about, that's the piece on the header record of the flat file that you were not properly informed of, and that's why you're getting that error.  So that's a requirement to enter that submitter type.  And you know, that was put in there to give ECRS's Web users a mechanism to distinguish between their requests, whether it's coming from a Part C plan or a Part D.

Okay, the next thing as your going through this that you'll see is the main menu.  Upon successful log-in, the system will present the ECRS main menu screen.  This is the home page for the ECRS application.  The navigation menu at the top of each page gives the user access to various parts of the ECRS Web to facilitate using the application.  "Home" will return to the main menu page.  "CMS" will link to the CMS Website. "Help" will display information about ECRS menu options and "Contact" will display information about contacting the COBC.  "About" will display information about ECRS. "Sign out" will log the user out of the ECRS application.  That's pretty self-explanatory stuff.  I don't know why I'm talking about it.

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Okay, on the right side bar, the "Change Contractor" link will allow the user to return to the contractor lookup page to change the contractor number and the ECRS access code. The "Quick Help" link will provide users with access to display helpful information for completing the current page. The contractor information will be pre-filled with the information entered in the contractor lookup page. And the name is the name of the contractor associated with the contractor number or regional office, or if it's a CMS user, the CMS ID. But these fields will be pre-filled with the person who logged on.

Okay, now we're going to go to create a request or inquiry. Authorized ECRS Web users can submit a request to, like I say, either change or put a new record on. Of course, you electronically transmit these records one at a time, and they're uploaded to a batch file. I'm sorry- oh I thought I did. But there's other pages in here that I hadn't put in. Okay, so the request or an inquiry, you do them one at a time using the online data entry, or through the Web you can upload multiple transactions in a batch file. So, the fact that it's a Web application doesn't mean you have to do the stuff one-by-one. You can still upload a file though the Web rather than doing it through the prior methods with NDM and the mailbox at CMS. That's still available, but you can upload that same file via the Web application now.

And I've gotten a little out of order here, let me--okay, to create a request or inquiry, click on the desired link under the Create Requests or Inquiries category and it will page through each data entry page and complete all the known and required data fields and submit the transaction. And this stuff is certainly discussed in more detail in the ECRS Web manual. And that's what you really need. You know, don't try and use my slides to actually use the system. This is supposed to be an overview, although I will admit it's a little more detailed than an overview might normally be. So, don't use this. It's okay to listen to this, but use the manual to actually do it.

ECRS processing. After a request has been submitted, the transaction is automatically stored at the COB system. The batch process reads the transactions and processes them. COB communicates status of the request using the status and reason codes. Status and reason codes are updated as the transaction moves through the system. Users should check the status and reason codes to determine the results of processing. For example, if the status is in process it indicates the transaction is going through the process of being edited by COBC. This narrative corresponds to status code IP. The reason is under development. This indicates a transaction is under development. There's information that COBC needed that didn't come in, and they're developing for it. And this narrative corresponds to reason code 03. And there again, all this stuff is all pretty plainly stated in the ECRS Web manual.

Okay, a little bit of discussion on the inquiry request. If everything is there and it all makes sense, these transactions can go right straight through and be automatically created. The transaction to update CMS's records can automatically be created by the system but that won't always happen. COBC's systems verify that the record does not match or duplicate an existing record. If it does match an existing MSP or OHI Occurrence, a new Occurrence will not be established. And the user is notified that the inquiry duplicated an existing Occurrence. So it's not absolutely automatic. Sometimes you don't get what you want. Okay, if the request for an inquiry does not duplicate an existing MSP Occurrence and contains all the mandatory CWF HUSP fields, the cobs will, their system will create the electronic HUSP record and that updates CWF within 48 hours. When the HUSP record is transmitted, a confirmation letter is sent to the beneficiary telling him that his record has been changed or record's been added. And the status and reason on the inquiry will change to "in process." If CWF errors the transaction out as part of its edit routines, COBC is notified of those errors and COBC staff will correct the errors and resubmit the HUSP records. When all the records have been resolved, the new MSP Occurrence will appear on Medicare's records. And you'll see that on your download from CMS. At this point, the status and reason will change to "Complete" so you'll know that your record took. And there is a note here, and I kind of mentioned it before, that if all the mandatory fields to create the record aren't there, COBC will do development. And that sometimes, depending on who they develop to for the information and the amount of cooperation they get, can take up to 100 days to complete. So sometimes things don't happen as quickly as you'd like them to, and that's the reason.

For inquiry requests for prescription drug coverage, there again they need to include all the mandatory prescription drug fields and make sure that it's not a duplicate of an existing record. Then it gets sent on to MBD. And MBD is what generates your COB file to you. It's probably worth mentioning that the mandatory fields for the prescription drug coverage inquiry include the HIC number, beneficiary information like date of birth, sex, and name, the person code supplemental drug type, Effective Date and the Rx information, the Rx BIN. And if all these fields are not present, the

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transaction will be rejected. And the kind of clink in the system here is that if COBC does not do development on prescription drug inquiry requests. So, if you don't send all the necessary information, the record is not going to get out there. They're not going to develop for it.

For assistance requests, and remember that's the change, that's not the "Add a record," that's the "Change an Existing Record," that processing is a little different at COBC. It actually is processed, you know, it's handled by COBC personnel. They actually look at each one of these transactions, so just because it's complete doesn't mean it sails right straight through, not touched by human hands. So, they don't automatically apply the requested change. Sometimes the information isn't sufficient to make the change. Sometimes there's a discrepancy. They've got the same information from somebody else, and they have to make a decision as to who they're going to- whose information they're going to take and apply to the system. Sometimes there's missing information. They're doing development and they don't get any response to the development letter. So that's another instance where they're not going to make the change.

And if the requested change is not made, CWF's analyst there at GHI will add comments explaining why the action was not taken. Users should check your COB response file on the ECRS CWF assistance summary page to view the comments. If the COBC staff analysts determine the CWF Assistance Request is complete, that is, they don't need any other information to fill in the mandatory fields, they'll update the MSP Occurrence or prescription drug Occurrence as applicable. Once the record is updated, the status and reason will be changed to "completed," the record updated for MSP Occurrence records or complete update and the update is sent to MBD.

And I, you know, COB doesn't update. They don't send you your COB file. I guess you all know that, but you know they update CMS's MBD record and an extract of that is what is written off and sent to you via MARX as your COB file. So they're not sent. COB is not sending you the file. They're just updating a record and the extract is cut from that record.

Another feature of the system is to- you have the ability to search for transactions that were previously submitted. You can search for a previously entered CWF Assistance Request, MSP inquiry or prescription drug inquiry with the system. From the main menu, click on the link for the transaction type you wish to locate, and this option allows users to view, update, or delete records under certain circumstances. The ability to search for a record is based on any combination of the following criteria: contractor number, which is your plan number; health insurance claim number; document control number; status; reason; Social Security number; user ID; and origin date range. So this feature will allow users to view the status and reason for a request.

There are also some reports available though the online or through the ECRS Web application. The main menu allows users to access reports. And really there's basically two reports here: the Contractor Workload Tracking Report, which provides users with statistics on the number of CWF Assistance Requests, MSP inquiries and prescription drug inquiries that their contractor site submitted during a user-specified time period. There's another report that's the CMS Workload Tracking Option. You might see that option there, but that's only available to COBC and CMS. So, you really only have that one report, but I think it's a pretty good report if you want to go back and see what you sent, where it is, and what's happening with it.

The last option of the main menu is titled "Files." Users who have been given permission from the COBC EDI Department to upload and download files can use this option to upload multiple requests in a batch file via ECRS Web. So this is kind of analogous to the other batch process that's will alive but that you send to the CMS mailbox or send via Connect Direct. You can send that same file via the Web portal now. The Upload File link opens the ECRS upload file Web page, where a user can browse, select, and upload files stored on their system. And this is where I think that the little glitch that we talked about, in that header record for that file, there's that new field that says whether you're a Part C or Part D. And I don't think that you probably have all the information that you previously needed to do that.

Okay, and this slide is about batch submission outside of ECRS Web. And I don't know that I need to go into that. I mean, those of you who have been doing that, you know, probably know how to do it by now. It's, you know, just using FTP and sending to the GenTran mailbox at CMS or Connect Direct via NDM from an AT&T reseller. So, I think you probably all know how to do that if you have chosen that option.

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In the beginning, the first step we talked about was obtaining an IX ID. And there I believe that there is a computer-based training module that tells you how do to this, is that correct? Rather than--I'm not sure how many slides I have here about doing that - several – rather than me going through these, you know, in minute detail, you probably should take the CBT. That's going to, you know, be a lot more- that will help you a lot more than me going through this. Just understand that you have to go through there and get that set up before you can access the Web. It's the necessary first step. And I would suggest that you take that CBT.

And I guess we're going to talk about later how they register for CBTs. Are you folks all familiar with registering for the suite of CBTs that are available for a lot of this stuff?

Can you show, by rise of hands, how many have used the CBTs? Okay.

Okay, we think they're good. I don't know what you folks think, but I think that maybe you'll get a chance on your survey to give us some input on that. But rather than me go through these slides, I urge you to take that CBT. And I think it will give you better information than I could. I'm sorry.

We'll provide that if they don't- it should be in here. It's in there, the link to-

We'll make sure you have that link before we leave here, just in case you don't have it. So I'm going to page through these. And, you know, I think some of you are probably--you know, already have your IX ID and stuff so that you don't need this. But for those that don't, like I say, take that CBT. It's a very good guide.

Excuse me, I hate to--how many have their IX access already? Can you show me by raise of hands how many have it? Okay, that's good, that's good, okay. Thank you.

Was it-- I mean it's pretty straightforward getting it, isn't it? I'm going to take that as a "yes." And these are the steps that, you know, you go through to change your profile and all that stuff, which I'm going to skip.

Okay, so since this was meant to be an overview and not an excruciatingly detailed analysis of the system, I'm pretty well done. Just I think that you'll find it much better than the system that came before it, probably not perfect, but I think that you'll think that it is at least a step in the right direction. And, as I mentioned before, there is a whole curriculum of CBTs to assist you in using the ECRS Web and, in fact, understanding the fundamentals of all this MSP stuff. I think that, you know, if you don't pretty much know this stuff, that those- they don't take that long and I think you would find them useful. And I guess we're here to strongly recommend that you complete the appropriate CBTs for stuff that we talked about here.

And in case you don't know how to get to that, here it is right here. To register for that curriculum - and there is a whole suite of courses there, a whole curriculum really – send an email to techi@nhassociates.net, give your company name, company description, your name, your phone number, and your email address, and an email notification will be returned to you to say that you're registered. Okay, now I think that we're going to hold questions to the end, so I'm sure you have some but we'll try and entertain those all at the end. Okay, you're done with me for now.

Vanessa: Thank you, Harry. Again, you know, I can't emphasize enough the importance of using the CBTs. We have CBTs on everything. I mean anything that you may have in question to Medicare secondary payer, you can find the CBT on that site, Tech Associates. It's a plethora of information out there for you to help you. Well, we're going to keep proceeding, and we have Gordon Hicks from Neil Hoosier and Associates who's going to provide our next presentation. Thank you.

Gordon: Thanks and good afternoon. Just one more thing. I'll also try to sell these computer-based training programs. The one selling point I want to make is they're free. You know, it doesn't cost you anything, that as many people at your sites can enroll in those classes as they want. Again, I would encourage start at the beginning, taking all the courses. You will learn a lot. The courses probably average anywhere from 10 to probably 20 minutes at the longest. So again, you know, we really encourage you to enroll in those courses and share that address with your coworkers so that they also can take advantage of the courses.

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Okay, I want to share some background information as to reason the topic of maintaining Medicare Secondary Payer and Other Health Insurance Occurrences were selected for this session. Over the past several months the coordination of benefits contractor has been examining and tracking incoming CWF Assistance Requests. While the overall quality of these requests has been fairly good, there are areas, if improved upon, that will result in the COBC being able to provide better service to you and to your members.

This session will address the various aspects of MSP and OHI Occurrences and how the CWF Assistance Request is used to maintain these Occurrences. The topics addressed and examples presented are ones that were identified by the COBC as ones that will do the most to improve the overall quality and timelines of CWF Assistance Request processing.

The MSP Occurrence is a unique record that reflects a period of time when a beneficiary has, or had, other health insurance that is primary to Medicare. The beneficiary may have more than one MSP Occurrence. The key data fields that uniquely identify an MSP Occurrence are the beneficiary's HICN, Health Insurance Claim Number; the MSP Effective Date or start date of coverage that is primary to Medicare; the insurance coverage type; the Patient Relationship Code; and the MSP type.

Plans are required to establish and maintain MSP Occurrences for their members when the health coverage an employer provides is during the same period of time as the member's enrolment in Medicare. The employer coverage is primary to Medicare during this time period when certain requirements are met. The MSP Occurrence is established and maintained on CWF.

The OHI Occurrence is also a unique record that reflects a period of time when a beneficiary has, or had, other prescription coverage that is primary or supplemental to Medicare. The OHI Occurrence is established on the Medicare Beneficiary Database. Plans are required to establish and maintain OHI Occurrences for members when the other primary or supplemental prescription coverage is during the same period of time as the member's enrollment in Medicare Part D.

Occurrence records have effective and termination dates. For the MSP Occurrence, the Effective Date is the beneficiary's Medicare Effective Date or the date he, or she, becomes covered under other insurance that is primary to Medicare, whichever date is later. For the OHI Occurrence, if the other prescription coverage is supplemental to Medicare, the OHI Effective Date is the later of the beneficiary's Effective Date under Medicare Part D or the Effective Date of the supplemental prescription coverage.

The Termination Date for the MSP or OHI Occurrence that is primary to Medicare is the date the other insurance ceases being primary or the date the other coverage terminates. If the OHI Occurrence is supplemental to Medicare, the Termination Date is the date the other prescription coverage terminates. If the beneficiary has Medicare and primary GHP coverage, the MSP Occurrence will have an open-ended date, that is, no Termination Date. The Termination Date for an active primary or supplemental prescription coverage Occurrence will also be open-ended.

It is vital that MSP Occurrences and OHI Occurrences be both timely and accurate. Occurrences that are set up late, not maintained or are inaccurate may result in Medicare claims not being processed properly. Both the beneficiary level MSP payment adjustment and the TrOOP calculation may be impacted as well.

The CWF Assistance Request is the means used by plans to update or delete existing MSP and OHI Occurrences. Before submitting a CWF Assistance Request, plans should first check ECRS Web to see if an earlier assistance request already exists. The COBC regularly receives duplicate CWF Assistance Requests.

When a CWF Assistance Request is submitted, it is important to identify the correct Occurrence to be updated or deleted. Since a Medicare beneficiary may have multiple MSP or OHI Occurrence records, plans must ensure that the COBC knows which Occurrence to update or to delete. Plans identify which MSP Occurrence needs to be updated or deleted by entering the appropriate auxiliary record number on the CWF Assistance Request. When submitting a CWF Assistance

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Request or an OHI Occurrence, the plan must identify the correct OHI Occurrence to be updated or deleted by inserting key identifiers in narrative comments on the CWF Assistance Request.

As an example, the plan may submit comments that say, "Please update supplemental prescription drug record. Effective date is 12/1/2008, Record type is SUP, Insurer Name is Beta Insurance, Add Termination Date November 30th 2010 to this record. This narrative allows the COBC to identify the correct OHI Occurrence to update and tells the COBC superficially what update to make.

Now, when I finish this presentation, this we realize is a pain for everybody to do. When I finish this presentation, Harry is going to get up again and tell you about a future enhancement to the system that will do away with quite a few of the hoops that you have to jump through on the prescription drug side.

Plans must also ensure that CWF Assistance Request includes all known and required data elements as specified in the ECRS Web user guide. It is critical that the correct action is entered and that the description entered in the "Comments" fields consistent for the action. If an incorrect action, or if the comments contradict that action, it is likely that the desired outcome for the CWF Assistance Request will not be achieved. An example of a CWF Assistance Request that is not consistent would be one where the request contains an action of 'ED', change effective date, but the comments state to add a Termination Date. Clearly, the action conflicts with comments, creating a dilemma for the COBC.

I want to review some of the most common actions that are used. Action 'TD' requests that a Termination Date be added to an MSP or OHI Occurrence. Action 'TD' shouldn't be used when the existing Occurrence does not yet have a termination date, in other words it's open-ended. Do not use Action 'TD' if the beneficiary never had the coverage identified by the Occurrence. Action DO, which stands for Delete Occurrence, would be appropriate because the Occurrence obviously should be deleted.

Action 'CT' requests that an existing Termination Date be changed. Action 'CT' should only be used when the existing Occurrence already has a Termination Date but the current Termination Date is incorrect. To not use Action 'CT' if the beneficiary never had the coverage identified by the Occurrence. Again, Action 'DO' is appropriate in that circumstance.

Action 'ED' requests a change to an Effective Date on an Occurrence. Action 'ED' should be used when the Effective Date on the existing Occurrence is incorrect. Note that the Effective Date can never be earlier than the Medicare enrollment date.

Action 'DO' requests that an existing Occurrence be deleted. Action 'DO' should only be used – and please, if you're going learn one action code, learn this one – Action 'DO' should only be used to remove an Occurrence that has been determined to be invalid, that is or for example the spouse who was a Medicare beneficiary was never covered on her husband's group health plan. That is an invalid record, since she never had the group health plan coverage. If there was such an Occurrence, you would want to send a "Delete Transaction" to have that record deleted.

Action 'DO' should not be used to delete and MSP or OHI Occurrence when coverage for the Medicare beneficiary ends or terminates, for example when the beneficiary retires or drops the other coverage. If the beneficiary retires or drops the other coverage, a CWF Assistance should be submitted with Action 'TD' to add the Termination Date to the Occurrence.

Action 'DO' should not be used to delete a primary MSP or OHI Occurrence when an employer changes its insurer. Action 'TD' should be submitted on a CWF Assistance Request to terminate the Occurrence. In addition, a new Occurrence should be established for the new insurer using the MSP inquiry or prescription coverage inquiry is applicable.

An issue that the COBC has noted is one that we refer to as a flip-flop of an Occurrence. A primary MSP Occurrence is established as the result, let's say, of insurers reporting that they are the primary payer. The MSP Occurrence is later investigated by a health plan, the health plan discovers their member does not have the gap coverage that the insurer reported and therefore sends a CWF Assistance Request to have the MSP Occurrence deleted. The MSP Occurrence is later re-established by the insurer, thus creating the flip-flop situation.

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We've investigated a number of these flip-flop situations, and what we have found is in some cases the insurer is not being informed by the employer or the beneficiary that retirement occurred or that the coverage ended. In other cases, information received by the health plan is incorrect. Their member really does have the employer insurance. We also encountered some cases where the member's coverage under the group health plan did end but a delete request was submitted by the health plan, not a request to have a terminate date added.

There's not a lot a health plan can do to resolve the first two issues on the slide. The third issue, however, can be resolved by the health plan if, when they learn from their member that he, or she, does not have group health plan coverage, they need to inquire if the member had the coverage but it has since terminated. If it's terminated, the health plan should obtain the Termination Date and submit a CWF Assistance Request using Action 'TD' to have the Occurrence terminated.

After a CWF Assistance Request is submitted and processed by the COBC, plans should review the COB's response. The plan should review the current status and reason associated with the CWF Assistance Request and review any comments the COBC has supplied. If the COBC does not take the action requested, they will provide an explanation.

We're going to go over some examples of how CWF Assistance Requests should be used. Let's say there's an open-ended MSP Occurrence for a health plan member. On February 28th, 2011, the individual retired. The health plan must submit a CWF Assistance Request. The CWF Assistance Request must identify the correct MSP Occurrence to update if more than one exists. Action 'TD' to add a Termination Date should be submitted, and the Termination Date field should be populated with 2/28/2011. To ensure the existing Occurrence is updated correctly, use the "Comments" field to further clarify the request.

In this example, we will assume an open-ended supplemental drug plan Occurrence exists. The drug plan sponsor is notified that the supplemental plan was dropped on 2/28/2011. The drug plan sponsor must submit a CWF Assistance Request to have a Termination Date applied to the Occurrence. And again, this is where you've got to jump through hoops to do it today, but Harry's going to be talking about an enhancement to the system that hopefully we'll be adding in the not too distant future to make this process easier. The reason that it's harder on the drug plan side is that the programming of the CWF Assistance Request was not designed to address prescription coverage Occurrences. Thus, drug plan sponsors must use some dummy MSP codes to bypass system edits that would otherwise prevent the CWF Assistance Request from transmitted to the COBC. However, and you'll hear me probably say this a couple of times, if the actual value for one or more of these dummy codes is known, it should still be entered.

Dummy MSP codes that may be entered in the CWF Assistance Request are listed on this slide. Again, I want to stress that if the actual value of one or more of these dummy codes is known, it should be entered. In the example that we started on the previous slide, we need to submit a CWF Assistance Request to terminate a supplemental drug plan Occurrence. The drug plan sponsor that submits the CWF Assistance Request should substitute Action 'TD' for dummy code DD.

This slide summarizes the steps to be taken by the drug plan sponsor to submit a CWF Assistance Request. First, they must identify the correct OHI Occurrence to update if more than one Occurrence exists. The drug plan sponsor will submit Action 'TD' to add a Termination Date to the Occurrence. The Termination Date field on the CWF Assistance Request will be populated with 2/28/2011. The drug plan sponsor will add comments that identify the occurrence to update if more than one exists and explain that the COBC should add a Termination Date of 2/28/2011 because the supplemental plan was dropped.

In this example, let's say there's an MSP Occurrence with an Effective Date of November 1, 2006, and a Termination Date of 6/15/2010. A health plan receives information that the correct Effective Date is 12/1/2006, and the correct Termination Date is May 15th, 2010. The health plan must submit a CWF Assistance Request. The CWF Assistance Request must identify the correct MSP occurrence to update if more than one exists. Action 'ED' to change an Effective Date and Action 'CT' to change a termination date should be submitted. You're doing two actions on one CWF Assistance Request. The Effective Date and Termination Date fields should be populated with the dates 12/1/2006 and

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5/15/2010, respectively. Comments should be added that are consistent with the change Effective Date and change Termination Date actions.

Here's a similar example involving an OHI Supplemental Occurrence that needs its Effective Date and Termination Date changed. As stated before, dummy MSP codes must be used to bypass system edits. The steps to be taken by the drug plan sponsor to submit the CWF Assistance Request for this example include identify the correct OHI Occurrence to be updated, submit Actions 'ED' and 'CT.' Submit the Effective Date as 12/1/2006 and submit the Termination Date as 5/15/2010.

Additionally, the drug plan sponsor should utilize the "Comments" section of the CWF Assistance Request to inform the COBC of the correct OHI Occurrence to update, the updates that are needed, and the reasons for the updates.

In this example, assume there is an open-ended MSP Occurrence with Alpha Insurance listed as the insurer. Information is received by the health plan that documents the employer switched to Beta Insurance on 2/1/2011. To address this circumstance, the health plan must submit both a CWF Assistance Request and an MSP inquiry.

The CWF Assistance Request must identify the correct Occurrence to be updated. Action 'TD' will be submitted and the Termination Date field will be populated with 1/31/2011, the last date of coverage under Alpha Insurance. Comments should be added that are consistent with these actions. The health plan should also submit an MSP Inquiry with an Effective Date of February 1st, 2011. The insurer on the MSP inquiry will be Beta Insurance. The Termination Date on that record will be open-ended because the beneficiary still has Beta Insurance. Health plans must not use Action 'DO' to request deletion of the Occurrence containing Alpha Insurance, nor should Action 'II' – change insurer information – be submitted. Addition of a Termination Date and submission of an MSP inquiry are the appropriate steps to take.

In this last example, assume there was an open-ended primary prescription drug plan Occurrence. The drug plan sponsor is notified by the employer that offers the primary plan that the drug plan sponsor's member was never covered by the primary plan. The drug plan sponsor will need to submit a CWF Assistance Request to have the invalid Occurrence deleted. As with the other examples, the drug plan sponsor must use dummy MSP codes to bypass system edits to allow the CWF Assistance Requests to be sent to the COBC when the real values are not known. If the drug plan sponsor knows the correct value to submit for any of the dummy MSP codes, the correct value should be used.

When submitting the CWF Assistance Request, the drug plan sponsor must identify the correct OHI occurrence to be deleted. Action 'DO' should be submitted to have the invalid primary prescription Occurrence deleted. Comments should include a reason as to why the occurrence is invalid.

And that concludes my presentation, and we're going to hold off on questions. I'm going to turn it back over to--yeah?

Turn it back over to Harry.

Harry: Thank you, Gordon. I'm not going to take up too much more of your time. We've kind of hinted at this several times. There's a hole in the system today. You know, there's the MSP inquiry to put an MSP record on. There's this CWF Assistance Request to change a record that's already on. There's the prescription drug inquiry to put a drug record on, but there's really no handy way to change a drug record. And that's kind of because in the beginning that Part D was kind of integrated into the existing system, and nobody I guess had the vision to see the need for a separate transaction to change prescription drug records, especially supplemental drug records. So that's what this new enhancement is all about. You know, the current system just doesn't adequately support a way to change a drug record. And the not so distant future that we talked about is October of this year. That's when the next ECRS release will happen.

And, as I just already kind of hinted at, the current process accepts three types of transactions. It really needs to accept four, and that fourth transaction is really what the enhancement is all about. It's going to give the user the ability to make modifications to existing drug transactions without having to go put in all these dummy codes. There will be codes for the real stuff there. And so there will be no unnecessary information that has to be entered just to pass system edits; you won't have to do any of that anymore.

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And so this stuff is still kind of in the planning but the main menu is just going to have a fourth selection there for a drug assistance request that's just a fourth option. And like I said, only drug coverage data will be required on that, and it will specifically be used to update either supplemental drug coverage or coverage that's primary to Part D. And it's essentially going to give you the ability to change any field that was sent in via the prescription drug inquiry transaction.

There's going to be new action codes for the OHI records. We have this list here now. I'm not sure that it's completely exhaustive, but certainly these actions are all the common ones they it will at least include. And, you know, I don't know if you folks will be able to suggest additional codes for common changes. Please, in the question and answer period, please feel free to give us those if you see something that's missing here.

So this is the enhancement that's been needed for quite a while and is scheduled to happen in October. I guess I would ask you now, you know, since you're the users of the system, are there other obvious additional enhancements that you see that need to happen and that we haven't thought of yet? Does anybody want to venture an additional enhancement? Maybe you haven't had time to think about that, but yeah.

Panelist: Reporting at the member level or it's just the summary?

Harry: Reporting at the memory level- member level. Okay, Yeah and probably the rest of you can't hear what she's saying and need to. Can you start that over from the beginning in the mike?

Audience Member: Sure, absolutely. I would stand up but my foot's asleep, sorry. Hi, I'm Amy Partridge from UPNC Health Plan. The one thing that we feel would be very beneficial when we're using the ECRS Web portal to submit one member at a time to either update or change an existing record, to my knowledge the only way to track those submissions is to go back into each member individually to identify whether they were accepted or rejected. And it would be very helpful to have some type of a reporting output by member so that we could identify more quickly and it would streamline the process to say, "Okay, you made 100 updates yesterday or two days ago. 80 of them have been completed and here are the 20 rejections."

Panelist: Okay. Go ahead. Currently, the flat file process is- currently, the flat file process, that's the way the response is submitted. You can, if you submit a file of like 500, you will get a response based on each time we update any of those 500. So if today you submitted 500 and tomorrow we completed 100, you're going to get a response file of the 100 that are completed. Unfortunately, we do not supply that for the ones that are manually entered. You do have to go in the system. You know, we can look at that, but I don't know if that's something we'll be able to do.

Amy: Thank you.

Vanessa: Yeah, okay all right. And there may be other suggestions in that there's time at the end or you can come up to one of us afterwards and talk about it, but I don't want to cheat Pat out of her time.

Pat Ambrose is going to give us a little overview of hierarchy. As in Gordon's presentation you may have noticed that it said referenced flip-flopping of records, and we've had that to be an issue. We have insurers not talking with providers. And you know, so as a result, we have flip-flop in our records. Records are deleted, reopened, deleted again, and reopened. So it creates a problem. So we had a work group to get together at CMS and we developed a hierarchy. And Pat is going to give us a little overview of that so that you can better understand the process. Thank you, Pat.

Pat: Thank you, Vanessa. She did half of my presentation. No, I'm just kidding. So, as Vanessa said and Gordon mentioned earlier, we do have this issue of records flip-flopping or particular fields on MSP Occurrences flip-flopping, the Termination Date being added and then a subsequent process removing it. So I'm here to just provide a very brief overview of the new rules that the COBC and CMS have recently implemented in the COB system and COB operational procedures when we're applying updates and deletes to existing MSP Occurrences. These new rules actually only apply to Group Health Plan, or GAP MSP occurrences. And they were implemented and incorporated into the system and operational procedures on April 1st, 2011.

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So, a little bit more background as to why we did this. As you know, the COBC collects information related to Medicare secondary payer information from multiple different sources. So we receive information on the Medicare beneficiary's Initial Enrolment Questionnaire, or IEQ. We receive information from an employer questionnaire that's related to an IRS/SSA/CMS data match process. We receive information that's mandated reporting done by insurers and TPAs due to Section 111 of the Medicare, Medicaid, and S chip extension Act of 2007. You might have heard this referred to as MMSEA or just Section 111. That began come time ago in 2009. So, we are collecting MSP information from all group health plans, insurers or TPAs, as the case may be. We also still collect information from employers through a voluntary data sharing agreement and then, of course, from Medicare contactors so like the Max, D Max, MAP D plans. And then final, and probably not last, but another major source of information is from the 1-800-Medicare call center and the COBC call center.

So at times this information that we're receiving from different sources conflicts and, in fact, is completely contradictory. And that does result in flip-flopping of fields and from MSP Occurrences from being deleted and then added back by other processes. So obviously it reduces our data integrity and ends up with inaccurate Medicare claim payment, recovery issues, and issues for the MAPD plans, of course.

So, what we created were what we're referring to as GHP/MSP hierarchy rules to address these issues. And again, as I said, these were implemented April 1st, 2011, and the rules only apply when we're updating or deleting GHP/MSP Occurrences.

So, what we've done is created a ranking for the information that we receive basically from these different sources. These sources are ranked in tiers. For example, the first tier, or the highest authority for updating an MSP occurrence, is the COBC itself, and in particular the analysts that work on CWF change requests and the like. These analysts are actually able to lock MSP Occurrences from subsequent change in certain circumstances. In the second tier is the COBC call center, CSRs assisting people who telephone with change requests. The MSP RC 1-800 and the 1-800 call center. Next down in the third tier of the ranking is Section 111 reporting by insurers and TPAs and MAPD plans submitting information through ECRS. Beneath them is employer information received through the voluntary data sharing and data match questionnaires, and then subsequently all other sources of information.

So again, the intended effect of these hierarchy rules is to reduce the flip-flopping. It won't eliminate it completely, but at least to reduce it and improve our data integrity, and also importantly, just as importantly, to encourage and improve communication between all the stakeholders involved in MSP. So, that includes the beneficiary insurers, employers, Medicare contractors, the MAPD plans, and providers.

Now specifically, the effect of these rules on MAPD plans and your submission of MSP information should not be that significant. You will continue, of course, to submit your ECRS inquiries and assistance requests as usual. Make sure that you provide the appropriate documentation and data along with those requests, as Gordon was describing. In particular is the addition of this new field, the Submitter Type. So please make use of that new ECRS Part C indicator, or the Submitter Type, to make sure that your assistance request is ranked in the proper tier or the proper order. We want to make sure that we handle your change requests with the appropriate- in the appropriate category, appropriate ranking. And we're doing that in part by use of that Submitter Type that you provide either on your ECRS batch files or ECRS Web.

I also wanted to remind you to be sure to submit your ECRS Assistance Requests to change an existing MSP Occurrence and not submit an inquiry for that purpose. Gordon covered this in his presentation, but we do see a lot of erroneous, so to speak, inquiries in ECRS or coming in through ECRS as opposed to an Assistance Request to make a change to an Occurrence.

And then, as always, if the change you requested through an ECRS Assistance Request is rejected by the COBC, then contact your COB consortia contact and be prepared to provide supporting documentation. So that's no different than it is today.

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And lastly, I just want to say that this was a very brief overview of these hierarchy rules. And CMS will be providing additional outreach to MAPD plans to providers and other entities that are affected by these hierarchy rules in the near future. So, that's all I've got. Thank you.

Vanessa: Thank you, thank you Pat. I want to remind you that the surveys that you have on your seat, if you could complete them after the Q&A because we're going to go into Q&A next. But if you complete the surveys once you go out we have a free CD for you. You can give it there and, you know, once you go out the door you give your completed surveys, evaluations, and then we can give you the CD. We'd like to open this up but I'm going to hand it over to Jill so we can answer some questions.

Jill: All right, one more time, all you have to do is raise your hand. All we have to do is hand you a microphone. Ready? Got one already right here in the middle. Just give them a minute. Let's try one more time.

[Audience Question]: Hello? Hi, I'm [Audience Member's Name Withheld] from [Organization Name Withheld], and I just had a follow-up question to the MSP hierarchy. So, are you saying, based on this hierarchy structure that you've defined, if a PDP submits MSP information and, for example, you get a VDSA file behind it that contradicts it, will the PDP information remain the correct information?

[Audience Member's Name Withheld]: That will work. [inaudible]

Panelist: Oh okay, I'm sorry, I didn't realize it was. Yes, that is correct. If a change comes in behind your update, your last update, essentially what we're doing is comparing what source or entity last updated or added the record or deleted it in fact to the incoming source. So, if the MAPD plan had updated it and using that Part C indicator and the employer VDSA comes in behind it, the employer VDSA record would be rejected and not overlay. On the other hand, Section 111 is at the same ranking. And a Section 111 record could make that update. So, although I don't know if there would necessary be an overlap.

[Audience Member's Name Withheld]: Okay and just another follow-up, where in this hierarchy would employers that are using the retiree drug subsidy fall?

Panelist: Well, that's really related to supplemental drug records. And the hierarchy rules only relate to primary coverage. So I'm not sure if I can answer that any more. I'm not sure that I can answer that.

Panelist: You know what, what's your name?

[Audience Member's Name Withheld]: [Audience Member's Name Withheld]..

Panelist: [Audience Member's Name Withheld], I'm going to get back to you on that, because as far as the RDS, I'm not quite sure how. I would think it would be an all/other ranking but I'm not sure about the RDS piece. So I'd have to, if you want to give me your email, I'll follow up with you on that. Uh-huh, you're welcome.

Jill: We have another question, go ahead.

[Audience Question]: Hi, [Audience Member's Name Withheld] from [Organization Name Withheld]. I had two questions please. The first is, does the inclusion of comments on the Assistant Request reduce the probability of an automated response? That's my first question.

Panelist: For the MAPD plans there's two types of automated responses, two types of automated actions. That's the 'TD' and the 'DO.' So, as long as you give us the mandatory fields, even if you have comments, we are going to attempt to automate that as long as it doesn't violate hierarchy. We will automate that. If it violates hierarchy, it will go into a work queue and be processed by a CWF analyst, and then they will evaluate the comments.

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[Audience Member's Name Withheld]: Thank you.  My second question is on this is related to the new flat file change.  And again on the Assistance Request, if you have an MAPD member and you need to make an update, we would submit that.  We wouldn't submit two requests to 'C' entity, we would just submit a 'C' is that what I heard you say early on in the presentation?

Panelist:  That would be correct.  You'd just submit one update.

[Audience Member's Name Withheld]:  One update with the 'C' as the submitter type.  Thank you very much.

Jill:  Do we have another question?  Okay right here.

[Audience Question]: Hi, my name is [Audience Member's Name Withheld]. I'm from [Organization Name Withheld].  I have three quick questions to you.  With respect to Part D plans, if the COBC file receipt is lagging what the real-time update for a member is, where's the best place to look to try to get a real-time view if there are updates that were submitted that we did not make, meaning we're expecting that a group health plan is submitting some updates?  Where can we see the best real-time view?

Panelist:  MBD.

[Audience Member's Name Withheld]:  You would think MBD should give you the best place to see where the update took.

Panelist:  And do you have any-- Bill, do you have any idea what kind of a lag we could see?  Because we get information where we're expecting a group health plan to correct an incorrect submission.  In the example I'm talking about, we're a PDP plan, a medical provider has incorrectly submitted a huge volume of OHI updates that are hitting Part D, but they really only cover medical, so that's kind of part of the flip-flop kind of scenarios.  And we've been working with them for, gosh, over a year.  And we're still waiting to get that update on the COBC.  We keep hearing that they submitted the deletes.  We just don't see it, you know, and we're into our second year of the annual OHI confirmation, you know,.

[Audience Question]: Yeah, we have a nightly batch B with MBD so as quickly as we update CWF, which is 24 to 48 hours, it should apply the same update to MBD.

Panelist:  Okay. Yeah, I know on your COB file you got to mark sometimes, you don't see the updates there for quite a while.  And that, I don't know why.

[Audience Question]: Okay, okay.  And my last question, have you seen examples where beneficiaries, probably confused, are incorrectly reporting their Part D coverage as OHI?

Panelist:  Yes.  So, we've seen examples come back on our COBC where the BIN, the PCN and the member number-- Is yours.  They're the same as the Part D coverage.  And right now, we're just including them as part of our annual campaign.  But it's very inefficient, ineffective, and probably confusing for somebody who made this mistake the first time, you know, who got themselves enrolled in Part D, reported their Part D coverage as OHI.  Now we're going through the annual confirmation and this is coverage that really needs to go off the system.  We need to have an educated beneficiary.  I just was looking to see if there's any advice on that.

Panelist:  Well, we've seen that several times.  I've also seen it where Part D plans have submitted their Part D information as the OHI.  You know, in the early days, which was 1/1/2006, we saw a lot of that because it was very confusing.  I think we're seeing less and less of that now.  So I think it's getting better but it's there.  Yes, it still happens.

[Audience Member's Name Withheld]:  And I guess is the advice call the members, talk, talk to them and get that incorrect coverage deleted?

Panelist:  Right, have them call the call center to get rid of it, yeah.

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[Audience Member's Name Withheld]:  Thank you.

Panelist:  You know, and just the same, you may need to do some outreach.

[Audience Member's Name Withheld]:  Yes.

Panelist:  You know, to the beneficiaries to clarify the usage.

[Audience Member's Name Withheld]:  Exactly.

Panelist:  So, that's one thing I have to take back to a CPC.

[Audience Member's Name Withheld]:  Great, thank you.

Panelist:  You can also, your Part D plan can also make that update via ECRS.

[Audience Member's Name Withheld]:  Right, right, okay, thank you.

Jill:  David, we have a question right down here.

[Audience Question]: I'm from [Organization Name Withheld], not [Organization Name Withheld], it is a group health plan but I think the problem is is that I'm a vested- have a vested interest in the COB but I don't do COB, I'm not the PBM, but there seems to be a great disconnect between the file that comes from CMS and what gets transmitted to the PBM and the disconnects between the COB.  So, what I'm really asking is, where do I get the training so that I understand how all these pieces need to interconnect so we can make recommendations internally and to our PBM to make it all work cohesively?  Because right now it's just garbage.  It's that simple.  So who do I reach out to at CMS to help me understand and then turn around and project that back through our health plan?

Panelist:  Well, since I'm thinking that maybe do you have a contact at the CPC on the CPC?

[Audience Member's Name Withheld]:  I do not personally.

Panelist:  Okay, because I can't really provide you with any recommendation, but if you give me your email. I will look up and see who can help you.  I'm thinking maybe someone in the CPC could help you with that.

[Audience Member's Name Withheld]:  Okay I'll do that, thank you.

Jill:  Do we have any more questions?  Yes, we do right here, okay.

[Audience Question]: Hi, [Audience Member's Name Withheld] with [Organization Name Withheld].  The question I have is, okay we're following the process, we're submitting the Delete transactions.  Once the incorrect COB instance is removed, we do see that on the MMR the payment is now adjusted on a forward-going basis.  But the retrospective money has not showed up yet.  How long will it be before that payment shows up in the plan?

Vanessa: I don't think there's anybody up here that can answer that.  That's a CPC.

Panelist:  Yeah, no, that's a CPC issue.  Yeah, thank you, Harry.

Vanessa:  That's a reimbursement issue. I'm sorry, we don't-- you would have to contact, you know, contact someone at the CPC in order to get that question answered.  I'm sorry.

Jill:  Jackie, we have another question.

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[Audience Question]: [Audience Member's Name Withheld] from [Organization Name Withheld], and I've got--I'm taking off my Part D that right now because we are a Part D plan as an employer plan. But on our commercial side, our active side, we actually have plans that are non-creditable. They're high deductible health plans. And so some of our active members do go out and purchase Part D. And so am I understanding that that Part D coverage isn't being recorded? Because we're sending them as active on our 111. But they do have Part D as a secondary carrier. So, should they be reporting that? I mean, would that get wiped out? Is that kind of- maybe I misunderstand what you were trying to say. But to me, that would still go in the hierarchy because they would have that secondary coverage. They have the right to purchase Part D so they don't have to pay the LEP.

Panelist: That information should still be reported, yes.

Panelist: It would depend on who are you saying is their primary coverage?

[Audience Member's Name Withheld]: It would be our employer plan. They just have a high deductible health plan that's non-creditable and in order to avoid the LEP they have to have Part D coverage or credible coverage. So if they're going and buying an individual Part D plan which would pay secondary to their active coverage, if there wasn't any coverage or they were in their deductible phase of their high deductible health plan.

Panelist: The active coverage is what should be reported.

[Audience Member's Name Withheld]: It is going on our 111 report, but the Part D plan is also required to submit it because they have these individuals but they're you know, they're entitled to Part D and pay for it so they don't have to pay LEP the rest of their life. That's a real situation, and we've had some confusion because the Part D plans that these individuals have enrolled through 1-800- Medicare or Medicare.gov, or wherever they enroll through an agent is being recorded. But we are also sending it on our 111. And I think what you said is the 111 would show active, but I just want to make sure that Part D plan isn't getting wiped out, because we have had a lot of calls where there's a lot of confusion, because they are putting their other Part D coverage, you know, the NRECA coverage, down and vice-versa. They put down, okay I now have XYZ Part D plan but we know they're active. So we know we're primary but they do have this other Part D. So that's a real hierarchy issue that is very real for beneficiaries out there. And we wouldn't want that secondary coverage to get wiped out in the COB hierarchy, because they are entitled to that so they don't have a LEP. So, I just want to make that comment.

Panelist: Part D plans, Part D plans don't report their Part D coverage to the COBC. They report their other coverages. So nothing they would report to us would wipe out your coverage because-

[Audience Member's Name Withheld]: Okay, good. I just- there seems to be some confusion, and I don't know where that information is coming back to the Part D plan and how that's flowing. Maybe because they're uploading into Medicare, but I would hope the 111 would trump the Part D coverage if you had that in your report. So just want to comment.

Jill: We have a question over here.

[Audience Question]: Hello, I'm [Audience Member's Name Withheld for [Organization Name Withheld], and I have a couple of questions. What is the percentage of commercial carriers that actually submit in the Section 111? Do all the commercial carriers have to submit?

Panelist: Yes, actually. The Responsible Reporting Entities, or RREs for Section 111 are either for the group health plan, are either the insurer or a claims-paying TPA. In some cases, a self-insured, self-administered employer or multi-employer plan might be the RRE and have to report. But they all are required to report their coverage for active covered individuals who are Medicare beneficiaries on their Section 111 files.

[Audience Member's Name Withheld]: Okay.

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Panelist: And, to add to that, it's not just group health plan reporting under Section 111. There are also reporting liability insurers, workers compensation and no-fault at also reporting as well.

[Audience Member's Name Withheld]: Oh good, thank you.

Panelist: Oh and one other thing I want to add to Pat's is that we rely heavily on that Section 111 insurers data. That's why we placed it so high in the hierarchy.

[Audience Member's Name Withheld]: Okay, thank you. And the monthly reports that come over, the monthly files that come over, we get a lot of old information like some of the files from the start date could be like five years old. Is there any way they could clean up the files and make it more current, or will we always have the lag times? Because sometimes we're working files that are like five years back or so, and then we have to do some cleanup.

Panelist: Well, when we collect MSP information, we do try to get the initial start date of the GHP coverage, the primary coverage in question, and post that information. It's not only used by the MAPD plans, but it might be used by the MSP RC for their recovery purposes. So, you know, we are, for Section 111 we ask them to go back to January 1st, 2009 and report coverage going forward. But some of the other processes, in particular the employer data match, might be collecting some older year's plan year information. So, you know, we're pretty much charged with putting all MSP we know about out there mainly because of possible, potential recovery. You know, the older information is going out because of potential recovery use. So, you know, we don't at the COBC actually control the transfer of data from MBD and the MARX system to the MAPDs.

[Audience Member's Name Withheld]: My last two questions, is there a backlog at the COBC and is there any more initiatives for 2011 or 2012 for the MSPs?

Panelist: Could you repeat that, I'm sorry.

[Audience Member's Name Withheld]: Is there a backlog at the COBC, and is there going to be any more significant changes in the MSCP process for 2011 or through 2012.

Panelist: In the MSP RC process you're talking about?

[Audience Member's Name Withheld]: Yes, the MSPs process for 2011, 2012.

Panelist: I don't think she's talking about the recovery content. [crosstalk]

Panelist: You're talking about recovery contracts?

[Audience Member's Name Withheld]: Yes.

Panelist: Oh, I know that we're making strides towards some improvements with the MSP RC. To date, I cannot tell you exactly what is in place, but we are always continuously trying to improve the processes on that end as well.

[Audience Member's Name Withheld]: Okay and any backlog at COBC or we're current?

Panelist: It's small, you want to- it's a small backlog with the Assistance Requests.

Panelist: Yes, there is a backlog with the assist- manually processed Assistance Requests.

[Audience Member's Name Withheld]: Okay, thank you very much.

Jill: And we have a question?

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Panelist:  And we are working to improve it to get it down and get it out.

[Audience Question]: I'm [Audience Member's Name Withheld] from the [Organization Name Withheld].  I want to give a shout out to Bill Ford.

Panelist: Hey, [Audience Member's Name Withheld]..

[Audience Member's Name Withheld]:  Thanks for helping everybody across the country this year on COB.  I've got a few questions and a couple of comments.  First of all in the IAQ, that's really the origin of a lot of this COB information.  And I agree it was pretty confusing because a lot of members put their current insurance coverage on there, so when they age in, we already have an MSP issue that's incorrect.  There's also a lot of old data on the common working file.  Wouldn't it be nice if the IAQ actually went on a member basis, enlist with all their current insurance?  And they could say "No, no, no" and help them get the information that's effective on the day they age into Medicare.  That's one comment.  So our second one and for our IX information.

Panelist: I'm sorry, could you repeat that comment about the IAP again?

[Audience Member's Name Withheld]:  Yeah, see what happens-

Panelist: I can't hear, you know.

[Audience Member's Name Withheld]:  What often happens with a member that's aging into Medicare, they get the IAQ and it says, "Are you insured?"  And they list their current insurance.  And then they retire and that current insurance ends.

Panelist:  Right.

[Audience Member's Name Withheld]:  So somehow from the IAQ that information that information that they put down gets into the COBC and the common working.  And it shows an MSP Occurrence on his first day of Medicare eligibility; that's not correct.

Panelist:  Well we always post the first date of Medicare eligibility as the MSP effective date because anything prior to that; there's no COB as far as Medicare's concerned. But are you saying that by the time they actually retire, that coverage is no longer active?

Panelist: Right.

Panelist:  It becomes retiree coverage.  Right, it becomes retiree coverage, yes, right.

[Audience Member's Name Withheld]:  Right, so that's- my second comment is on four Rx information, four X information is very important for health plans and PBMs downstream to make sure to get the Part D claims.  But four Rx is not required on most COBC transactions.  So, one of my requests is to require as much four Rx data as you can up front.  That will help us all on the back end.

Panelist: It will be in the October update.

[Audience Member's Name Withheld]:  Okay, my third one – sorry – NGHP, which is also MSP, but there's a whole lot of NGHP information that you can see on that COBC file we get and on the MSP file.  And so NGHP is workers comp, third-party liability, that sort of thing.  As I understand it, we're supposed to or plans are supposed to present  a case, document a case for this MSP occurrence and send on a manual basis to the COBC to it accept it.  That goes to the MSP RC and eventually this loop.  But I don't think that is very clear how to make that happen.

Panelist:  For the non-GHP, like how to update a non-GHP record?

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[Audience Member's Name Withheld]:  [inaudible]

Panelist: They got to reach out to MSPs.

[Audience Member's Name Withheld]:  We got old workers comp, we got liability.  And it shows up under COBC files, so you have it.  You got to do something with it.

Panelist: You do.

Panelist: There's no real easy way to correct it.

[Audience Member's Name Withheld]:  I know.  And you have to go through the MSP RC for that.  But the MSP RC says you got to send it to COB first, and then the COB.

Panelist:  We're working on that, we're working on that, because that process does need to be more defined and clarified.  So we are working on that.  We are aware that it exists and we are working to improve that process as well.

Jill:  We have one more question.  Go ahead.

[Audience Question]: Hi, this is [Audience Member's Name Withheld] from [Organization Name Withheld], and first of all, thanks a lot to making- providing the ACRs.  That platform is really nice.  The question I have is like now, we have our files upload and download facility of a level in ECR as well.  So, once we upload the file, the CWF Assistance Request file, the response files, we will be able to download through the same Web ECRS Web portal?  And the other thing is like what will be the archival periods of those files?  I mean those files are like intent on mailbox.  It's usually like 30 days after that you cannot download those files.  So it will be like staying there on Web platform, or you will remove those?

Panelist: There is a time limit, isn't there Lori?  There's a time limit for search but not for the download?  Yeah, so the files should stay there for you to download more than 30 days. Now you know, to get access to upload and download you need to request that.  It doesn't just come automatically.  You actually have to send an email, there's a three person limit to who can upload and download per contact number.  So if you need upload or download authority, you need to send me an email so we can get you that access.

Panelist: Give him your email address.

Panelist: If anybody needs my email address, it's WFord – W-F-O-R-D at ehmedicare.com.

[Audience Member's Name Withheld]:  And the other question I have is, like, once we get the response, once we get the response files, so like she mentioned that we have- we get like 50 transactions cleared out today, we'll get the response file next day.  And so we'll get those response files in pieces.  Same way where like we are getting from [inaudible] mailbox and the file layout will be the same that we are getting from [inaudible]

Panelist: Yes, it's all the same.

Panelist: And before we leave, I just want to expand on the earlier question.  I had time to think about it.  For the person who said that they're going in to check individually, you know, in ECRS Web there is, as Harry spoke about earlier, there is a search feature.  So if you really wanted to see what requests we updated per day, you could go in and you could put either just yesterday's day and it will bring up whatever.  And you can put the status code and it will tell you.  If you want to see what we close, you can put the CM status code and just put the date, and it will show you all your requests, all the requests that you submitted that were closed on that particular day.  Does that help?