2015 Medicare Advantage and Prescription Drug Plan Spring Conference & Webcast Transcript

Update Enrollment Information Session

Our next session today is a panel of speakers who will provide us with an understand of the changes to enrollment and eligibility, from the Medicare Enrollment and Appeals group, we have Jim Canavan, Cindy Falconi and Pattie Halpenstein.

Hi everyone. Today, we'll focus on four separate topics. First, changes to involuntary disenrollment requirements for individuals outside the plan service area, because of incarceration. Then changes to eligibility for enrollment based on lawful presence. Changes to the Good Cause process. And lastly, explanation of critical factors for individuals eligible for both Medicare and the Marketplace.

First, we'll discuss the changes for out of area due to incarceration. On May 23, 2014, CMS published regulations that clarify the requirements for involuntary disenrollments due to incarceration. We adjusted the definition of service area for cost plans to specifically note that individuals confined to incarceration facilities are outside the plan service area. We amended the involuntary disenrollment requirements to include that plans must disenroll individuals incarcerated upon notification of such status by CMS.

This is because these individuals are confirmed to be outside the plan service area based on data CMS receives from the Social Security Administration. This change eliminates the period for which a plan can maintain enrollment while determining if the individual is outside the service area, which is six months for Medicare Advantage, 12 months for Part D, and 90 days for cost plans.

These changes apply to all Medicare Advantage plans, cost plans, and Part D plans. And because the individual is confirmed as outside the plan service area, due to their incarceration, they're ineligible to enroll in any of these plans.

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The process the plans follow to determine an individual's incarceration, and ultimately, if they reside outside the plan service area, is changing. First, I'll describe the current process which is in place now. When CMS obtains incarceration data, a transaction reply code, TRC 155, is generated and sent to the plan. The TRC 155 is a notification of potential out-of-area status due to possible incarceration. The plan is then required to research and confirm the individual's permanent residence, whether they're incarcerated or not, and if currently incarcerated, the start date of incarceration, if available. This must happen within the timeframes for permitting an out-of-area individual to remain enrolled in the plan. Again, for Medicare Advantage, that's six months, Part D 12 months, and cost plans, 90 days.

If the plan confirms the individual is currently incarcerated, they're required to involuntarily disenroll the individual based on the incarceration start date, if they have it, or the first of the next month after the plan obtains the incarceration confirmation. The plan submits the disenrollment to CMS and sends the required notice, following the existing requirements and regulation for residing outside the plan service area.

With the regulation changes, the process is changing. For cases where CMS receives confirmation of incarceration from SSA, CMS will indicate in our systems that the individual is no longer eligible to enroll in or remain enrolled in the plan, because they're outside the plan service area. The information will be available in the beneficiary eligibility query, BEQ, or the MARx user interface, for plans to verify eligibility for enrollment as part of the normal enrollment processing. If an individual is a current member, CMS will initiate the involuntary disenrollment transaction, and we'll talk more about that in a few minutes.

The difference in this process that CMS, rather than the plan, now has the burden of confirming incarceration status for most cases. Once an individual is determined ineligible, and is showing as show in the BEQ or the MARx user interface, plans are required to deny enrollment requests for an individual with confirmed incarceration. And then, of course, notify the individual of the denial, following existing enrollment guidance policies.

Should an enrollment transaction be submitted for an incarcerated individual, CMS will reject these enrollment, due to the individual's ineligibility, and as we mentioned before, if CMS receives confirmed incarceration data for a plan's current member, that person would no longer be eligible to remain enrolled in the plan, and CMS would effectuate the involuntary disenrollment.

There remains some plan responsibility in this new process. In cases where the plan learns of an individual's possible incarceration from a source other than CMS, like a family member, state prison, et cetera, the plan much follow the current process of researching and confirming the incarceration, before any enrollment can take place. Plans must determine this within the timeframes for permitting an out-of-area individual to remain enrolled in the plan, and submit the disenrollment transactions to CMS following the current guidance policies.

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Let's talk a little more about CMS-initiated disenrollments. CMS will notify plans with the new and specific transaction reply code. For this situation, that's shared through the daily transaction reply report. The involuntary disenrollment will be effective the first of the month following the start date of the confirmed incarceration.

For example, on May 15, CMS receives incarceration data confirming that incarceration began on April 10. The disenrollment effective date would be May 1, which is the first of the month they became incarcerated. Once the plan receives the disenrollment TRC, it must send the disenrollment notice to the member, following the timeframes for loss of eligibility due to not residing within the plan's service area. CMS is working on the enrollment guidance, and it will include a model notice specific to this situation.

Regarding new enrollments, CMS will indicate if an individual is currently incarcerated, and thus ineligible for enrollment. As mentioned before, the plan is required to check out systems for eligibility and deny those ineligible based on the incarceration data noted; however, if an enrollment transaction is submitted and the individual's data in CMS's record shows ineligibility due to incarceration, CMS will reject or deny the enrollment.

CMS will send a new specific transaction reply code for this rejected enrollment, due to the person's ineligibility. Plans should use the incarceration data to determine eligibility based on the effective date of the enrollment. CMS will accept enrollment transactions if the effective date of the enrollment starts after the incarceration ending.

For example, on June 20, an individual submits an enrollment request with an effective date of July 1. The CMS data shows that the individual has an incarceration ending June 1, so it would be accepted.

We also want to note, that in very limited circumstances, CMS may receive data that indicates both a start and stop date of the incarceration. In such cases, if the individual was enrolled in a plan or plans for the entire period of the incarceration, CMS will involuntarily disenroll based on the start date, and reenroll back into the plan, based on the incarceration end date. If the individual has switched plans while incarcerated, the individual will be disenrolled from the first plan, and reenrolled in the current plan.

This will remove enrollment for the period of time for which the individual was ineligible for enrollment in the plan or plans, due to out-of-area incarceration. More information regarding these rare enrollment transactions will be included in the detailed notice for system changes prior to implementation.

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We're working to make all the systems changes necessary to implement this new process. As mentioned in the advanced announcement of the August 2015 software release sent via HPMS on April 13, 2015, CMS will implement the system changes to establish the structural framework to populate the incarceration data. Incarceration data fields, such as MARx screens and the BEQ will be displayed as blanks, until the full implementation is in effect. At this time, plans will not receive the new TRCs. We encourage plans to make changes to their internal systems in anticipation of receiving this data. More information about the TRCs will be released on the detailed announcement for the August release.

While CMS doesn't know the exact date for when we will be receiving the data and using the new process, once the data is available, we'll be moving quickly to start sending these transactions. In the meantime, plans shall continue processing incarceration data following current policy guidelines. CMS will continue to send TRC 155, the incarceration notification received, until further notice.

Thank you, and now I'll pass it on to Patty to talk about lawful presence.

Okay, good afternoon. I'm actually going to be covering both lawful presence and Good Cause, and of course, we're going to go ahead and start with lawful presence.

So first and foremost, with respect to lawful presence, the law doesn't allow for individuals who are unlawfully present in the United States to receive federal public benefits, which of course includes Medicare. To that end, we established regulations on February 12, 2015, and in that, we established that you have to be a US citizen or lawfully present in the United States in order to be eligible for enrollment in Medicare Advantage, cost, and Part D plans.

In addition, this regulation also allows us to involuntarily disenroll individuals, if they lack the lawful presence status. Meaning, if you're unlawful and you're currently in a plan, you would be involuntarily disenrolled, because you're ineligible for enrollment. And I just want to point out that this impacts all plan types in MARx.

So since this is not a data element that is currently reviewed by plans for eligibility, I just want to talk a little bit about the current process. Generally, SSA receives data from the Department of Homeland Security, and they do checks, and make sure that the individual is actually eligible to be receiving benefits, both Social Security and Medicare.

As part of their review process, if an individual is found, or they believe is unlawfully present, they will actually provide due process, where they will give the individual advance notification and opportunity to actually come in or provide the documentation, or whatever it might, so that they can establish lawful presence. If they are, in fact, unlawful, and they go through that due process period, then Social Security will go ahead and indicate the unlawful presence status on the record, and then that person would no longer be eligible for Social Security benefits, and of course, Medicare benefits. And the person is notified of that.

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At that point, then, of course, that information comes over to Medicare, you know us at CMS, and we basically, at that point, for fee-for-service claims, because of the law, we will deny any claims submitted for services, while the person is unlawfully present. Currently, right now, we don't have that in place to stop enrollment into Medicare Advantage, Part D, or cost plans, and that's what the regulation has adjusted. It really provides alignment with our two sides of our program, to ensure that we're appropriately paying for services for eligible individuals, or vice versa, not paying for people that are ineligible for them.

So now, we're going to talk a little bit about what's different. Obviously, I've gone through what the eligibility requirements are. US citizenship or lawful presence, but more importantly, this is not anything that the plans have to determine on their own. CMS is going to be providing that information, as we're notified of the unlawful presence status. And we're going to be indicating that information in the beneficiary eligibility query, or the MARx user interface.

So the plan's task, then, is when an enrollment request comes in, as part of the normal processing where you check for eligibility, entitlement, that type of thing, is to also look at this factor. If the individual is unlawfully present, they're in fact, then, ineligible for enrollment, and that enrollment request would need to be denied.

However, if an enrollment request gets submitted, CMS will be rejecting that enrollment, because the person is ineligible. And we will be providing that denial rejection with a specific transaction reply code that provided on the daily transaction reply report.

To talk a little bit more about the involuntary disenrollments, CMS will be effectuating those. Again, that's not something the plan would be submitting a transaction for. We will go ahead and do that, based on the data that we're receiving. And again, there will be a very specific transaction reply code put forth on the daily transaction reply report for this particular scenario. The effective date for the involuntary disenrollment is the first of the month following the month CMS is notified, or that we're notifying the plans.

So for example, if we receive data saying on May 15, an individual is unlawfully present, we're going to be passing that over. Usually our involuntary disenrollments that are automated are going to occur very quickly, and the disenrollment effective date, I believe, would be, and I'm sorry, I forgot the original date I said, so June 15, we get the data, the effective date would be July 1.

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Now talking just a little bit about the requirements following the disenrollment. Because Social Security is sending a notice indicating that the individual is ineligible to receive Medicare benefits for their unlawful presence status, the regulation does not include a requirement to send a disenrollment notice; however, we strongly encourage that you do so, simply because we're not sure that the individual would actually make the connection that having coverage in your plan is still connected with them getting the letter from Social Security, saying they're not eligible for Medicare benefits. So we do strongly encourage that. We believe it would also help lessen potential calls to your plan, or things of that nature, for people that aren't sure what's happening with them.

A couple items to also point out is that, as we said before, no plan will be determining lawful presence status. That's something that CMS will be passing along. So therefore, as part of the enrollment process, it's inappropriate to ask for citizenship or lawful presence status, or obtain any proof about this. In addition, if we are involuntarily disenrolling an individual because they're ineligible, and an individual comes in and says, wait, wait, here's my proof, there's nothing that can be done to stop that. You can't continue to you know, stop the involuntary disenrollment, or even to request a reinstatement for this purpose.

Generally this impact to beneficiaries, when they're disenrolled, is that they'll revert to fee-for-service, and then of course, because of their unlawful presence status, their claims will be denied, while they're unlawfully present. If they come back and say, wait, my status isn't right, this is wrong, their only recourse is to go to the Social Security Administration and establish the correct documentation, so that they will be determined to be lawfully present in the United States.

Once an individual establishes or regains lawful presence, then of course, Social Security will update its information. They will pass it over to us. We will change the information in our systems to then allow for fee-for-service claims to be paid, or allow for enrollment into Medicare Advantage, cost, or Part D plans. And the individual will be given an SEP. You know, they'll have that special enrollment period, so that they can actually choose to enroll into a plan.

And the last point is that, while the individual is ineligible for enrollment, the months that they're unlawfully present or ineligible to enroll in a Part D plan, those months will not count against them when you calculate the Part D late enrollment penalty.

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As far as next steps, CMS is in the process of making systems changes, which, because this is a new eligibility requirement, or a little more extensive than perhaps establishing a new code, or what it might be. So we are in the process of completing those systems changes, and we will be notifying plans through the normal process, the advance notification of software release, and the detailed notification of software release. In addition, we're developing the guidance to outline exactly what the rules are surrounding all of this, as well as indicating adjustments to the model notices for the denial and the rejection for enrollment, as well as the involuntary disenrollment, and we're working to have the guidance complete in July.

So now, I'm going to move on to Good Cause, and we do have some changes that were made in regulation that we finalized in February, but I want to first start with the basics of Good Cause. So an individual can only request Good Cause if they've been disenrolled for non-payment of either plan premiums or Part D-IRMAA. They're the only, you know, the only situations in which someone can ask for Good Cause, and that request needs to be made within 60 calendar days of that disenrollment effective date.

In addition, once a determination is made, if it's a favorable determination, meaning the person met Good Cause, the individual has to pay all of the owed amounts within three months of the disenrollment effective date, and if the determination is unfavorable, and there's no indication of plan error, the individual remains disenrolled, and that decision cannot be appealed.

I do want to make note of one item on plan error, and that is sometimes, someone will come in and ask for Good Cause, but their reason, or whatever it might be, may come out that perhaps they did make payment. You know, they're alleging that a payment wasn't applied, or whatever it might be. Those would not be Good Cause, those would follow along the plan error process, where the plan potentially is trying to find out if there was an error and resolving it, as part of the normal course of business.

So the current process that we follow today for Good Cause is, once an individual is disenrolled for non-payment of premiums, plan premiums or Part D-IRMAA, they're referred to call 1-800-MEDICARE, and we receive those requests through that locale, or through the CMS regional office. At that point, we determine the eligibility. We triage it, to see if they're actually eligible to request Good Cause, meaning, did you ask within the 60 days. And then we make the determination, and of course, then the plan will go ahead, collect the money, and if paid in full, will submit the reinstatement transaction over to the retroactive processing contractor.

So what will be different? Basically, the portion of receiving the request by CMS, CMS triaging it and making the determination, that's the piece that's going to be switching over and becoming the plan's responsibility. The notices that go out for non-payment of plan premiums will include the plans for the number, instead of referring to 1-800-MEDICARE. The plan will receive those requests, and go ahead and triage it all the way through the process.

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Now, I want to talk a little bit about the triage, because generally, it's going to be the same thing that CMS is doing now. Again, the request has to be made within 60 calendar days of the disenrollment effective date, and during that triage, there are two other piece to this. The first piece is that the individual needs to make an attestation of an unexpected or uncontrollable circumstance that occurred during the grace period. Generally that's – it's an emergency, it's going to generally follow what we already have outlined in guidance today. And they also need to make an attestation of their ability to pay all the past-due amounts within three months of the disenrollment effective date.

And I want to clarify here that the individual only has to pay the amounts owed as of the disenrollment effective date. We used to have a policy where you have to pay the plus three months, but that's no longer. You just have to pay the amount owed as of the disenrollment effective date.

So I do want to talk a little bit about Part D-IRMAA. If an individual is disenrolled for plan premiums, and there's any indication of Part D-IRMAA, you can ignore. It's irrelevant for your purposes. If an individual is disenrolled for plan premiums, you only have to worry about them paying the plan premiums back, provided they get a favorable determination for their Good Cause request.

If the individual is disenrolled for non-payment of Part D-IRMAA, that process is not changing at all. Those disenrollment notices will continue to refer people to 1-800-MEDICARE, we'll continue to receive them, make the determinations, and then notify the plan, using the CTM as the communication mechanism in which to provide a determination, so that you all can send out the notice to say here's how much you owe us, and here's when it's due. And then, if paid timely, reporting that back to CMS, so we can go ahead and make sure the D-IRMAA has been paid, and continue to close out that case.

I want to talk a little bit about some of the notable items. These tend to come up fairly often, but if an individual has an authorized representative, someone that pays the premiums on their behalf, and the individual is disenrolled for non-payment of plan premiums, then the circumstance and everything related to Good Cause has to be applied to the person paying the premiums. So for example, you have a member whose son is paying premiums for his father, and is disenrolled for non-payment of premiums. When it comes to reviewing that circumstance, it's the payer's circumstance that you're reviewing and making the determination on, not the member's, because the member wasn't paying the premiums.

Another point is that plans can provide access to services upon receipt of full plan premium payment, but that's only if they're disenrolled for non-payment of plan premiums. If disenrolled for Part D-IRMAA, then you have to wait to get notification from CMS of either the reinstatement, or contact from a CMS regional office, saying it's okay to turn back on services; we've received our payment, and the reinstatement is coming very shortly.

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And I think one of the biggest items for good cause is that, generally, we expect that an individual who goes through this process isn't going to go through it again. It's usually for emergency, unexpected, uncontrollable reasons, and hopefully, they're not putting themselves either into that situation, or you know, they just generally, it's not going to happen again. So we do encourage anyone that's in the good cause process, we encourage plans to please educate them on the automated payment options that may be available, so that generally the individual really doesn't get into this situation again.

In addition, plans do have five extra days beyond the three-month period for the individual to pay, in order to make sure the payment clears the bank. That doesn't mean the individual has five extra days to pay; it means that when you get it, you have time to make sure the money's going to come through before you turn back on benefits, or submit the reinstatement transaction request to the RPC.

And again, just as a reminder for plan premium cases, please submit your reinstatement requests to the retroactive processing contractor, and not to CMS RO, unless it's D-IRMAA, and then you would kick back the CTM, so that you could communicate back with us.

And last but not least, it's important to remember that with Good Cause, the individual must pay the full amount owed within the three months of the disenrollment effective date, in order to be reinstated. We can't accept partial payments, can't do payment plans, it's got to be the full amount. And then the only other thing we have is, if it's a D-IRMAA case, and you have received full payment, or it's at the very end of the three-month period and you didn't receive payment, to please notify CMS within five days of that receipt, so we can go ahead and close the case.

With that, I'm going to turn it over to my colleague, Jim Canavan, to talk about Medicare and the Marketplace. Thank you.

Good afternoon. So there's a growing number of Marketplace plans out there, and a growing number of Medicare beneficiaries every day, and we get a lot of questions about how those two intersect, so we're going to discuss that this afternoon.

Let's start with a little level set of the knowledge here, just to make sure everybody knows, everybody's on the same page. These are some of the abbreviations we'll be using today. If you're not familiar with Marketplace plans, APTC, that's one of the big ones you're going to want to recognize. If you're familiar with low-income subsidy on the Medicare side, APTC is very similar to the premium reduction that low-income subsidy individuals have on their Part D plans.

Similarly, CSR, second from the bottom there, cost sharing reduction, is similar to the copay adjustments that low-income subsidy individuals have on their Part D plans. COB, coordination of benefits, I'm sure you'll all familiar with that. Minimum essential coverage, that's what's required by law to avoid penalties at tax time.

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Medicare secondary payer comes into play during coordination of benefits between Medicare and Marketplace plans, on some occasions. QHP, that's how, if you're familiar with Medicare, but not with the Marketplace, QHP is how we refer to plans on the Marketplace side of things. The qualified health plan. And SHOP is basically a QHP that is also a group health plan, and SHOP plans are based on active employments.

So, what if you have Medicare, and then you decide you want a Marketplace plan? Well, the law prohibits the sale of a QHP to someone who you know to have Medicare. Even if they only have Part A, or they have Part B, and have declined premium Part A, it's still – you still can't sell them a QHP. Part A by itself is considered minimum essential coverage; Part B is not. So people often say, well, if I only have Part B, how come I still can't get a Marketplace plan? Well, it's not a matter of whether it's minimum essential coverage, it's that it's duplicative coverage. That's what the statute prevents, is duplicative coverage.

If a Medicare beneficiary has a SHOP coverage available, however, they can get that. It's sort of like having a group health plan while you have Medicare, and that's when Medicare secondary payer comes into play. And generally, that's someone who is entitled to Part A, but has chosen not to enroll in Part B, because they're still actively covered by a current employer.

So these people often ask us, well, can I drop my Medicare and then pick up a Marketplace plan? Well, you can, if you have Part B and premium Part A, you can disenroll, or if you only have Part B. If you have free Part A, however, you have to withdraw your application entirely, your application for retiree disability benefits. Then you have to pay back all of those benefits that you've received, including Medicare's costs for services that you've received to that point. And if you're withdrawing your retiree application, you have to do so within the first year of receiving your Social Security benefits.

For most people, this isn't really cost-effective, especially in the long run, but certainly each individual needs to consider their own circumstances when making this sort of decision. So if the person does withdraw from Medicare, they have to keep in mind that if they want to get Medicare again later, they can only do so at certain times of the year, such as during the general enrollment period, and because, when you enroll during the general enrollment period, January 1 to March 31, your coverage is effective July 1, you may end up with a gap in coverage, and end up with late enrollment penalties. And keep in mind that the penalty for Part B is a lifetime penalty.

Now say someone with a Marketplace plan gets Medicare. So they start off with a marketplace plan, and then become eligible for Medicare in some way, and then they enroll. If they have APTC, or cost sharing, they're going to lose that as soon as their Part A starts, and there's also no coordination of benefits between Medicare and the Marketplace, unless your marketplace plan is a SHOP plan, in which case, Medicare secondary payer again comes into play. If you have a Marketplace and Medicare, Medicare is primary, and we'll pay first; however, it is the individual's responsibility to seek payment from the other coverage, in this case, the QHP.

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So one of the questions we get asked by QHP issuers is, can't we just terminate these people with Medicare? Can't we just terminate them from our plan? And no, no they can't. You can't just terminate someone, just because they have Medicare. Either the enrollee has to request termination, and then follow the normal procedure for terminating Marketplace coverage, which I believe is 14 days, at least prospectively, or they can terminate for any of the other involuntary reasons that are available through QHP, such as if the person refuses to pay their premiums, but then again, they have to meet all of the requirements for that, as well.

End-stage renal disease, of course, is a big factor in coordinating between Medicare and the Marketplace. Partly because treatments, of course, are so expensive, and also because it's its own animal when it comes to becoming eligible for Medicare. If someone does become diagnosed with ESRD, they are not required to get Medicare, it is entirely voluntary. If they have no Part A and no Part B, if they choose to decline Medicare, they can enroll in a QHP. ESRD itself is not a disqualification for having APTC or CSR as well, so if a person does pick up a Marketplace plan, and they meet the eligibility requirements for those two programs, they can receive them.

One more thing. If a person has Medicare due to ESRD, and decides they want a Marketplace plan instead, again, they would have to withdraw their application, pay back all of the costs that Medicare has already paid, and then later, if they choose to enroll later, they'll be subject to late enrollment penalties. This is again, probably not cost-effective in the long run, but individual circumstances may vary.

So this is, well, it's a little blurry, but this is a screen shot of where we keep our master FAQ document for how Medicare and the Marketplace intersect. This is a live document, meaning that we do update it, and you should see the date on the document itself as when it was last updated. We ask that if you do go to this page, and I guess I should tell you how to get there. It's on CMS.gov, and when you're on CMS.gov, you'll see the yellow Medicare tab in the upper left corner. You click on that, scroll down to enrollments and eligibility, and it is the bottom link under enrollments and eligibility. It will take you right to this page, and if you click on the download, you can see, under downloads, it will take you right to the document itself.

If you're going to link to this, if you're going to bookmark it, we ask that you bookmark this page, and the reason for that is, if you bookmark the document itself, if we update the document, you've probably linked to an obsolete document at that point. And if you go to your bookmark, it will bring up the old version; it won't bring up the new version. And not only that, but we may put updates in the text of the web page, as well.

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So we have resources available for all of the topics we've talked about today. Normally, we recommend that you contact your account manager with any questions you may have, and certainly anybody at central office, if we receive a question, we're more than happy to try and answer your question. However, we do have processes in place for tracking questions that we get, so that we can notice any trends, notice any weaknesses where we need to increase our communications, so we ask that you go through your account managers.

As you can see, in the middle bullet there, that's the link that leads to the screenshot that I showed you. That would be that page right there, and the bottom link that you're looking at there, that's the link to the regulation for incarceration that Cindy mentioned earlier.

The top link here, that's the link to the Good Cause and lawful presence regulations that Patty was talking about. And the two links below that are, I'm sure you're familiar with those, those are the links to the Medicare Advantage, cost plan, and Part D plan enrollment guidances. And keep an eye on those pages, because we're hoping to post drafts very soon, of our updates.

And here is the – it's basically a link to how SSA determines the income-related monthly adjustment amount for both Part B and Part D, and below that are HPMS memos that we've released that address certain topics we've discussed today. And with that, I'm going to turn it back to Stacy, so she can moderate some questions.

Great. We do have some time for questions, and I see that we have somebody in-house, so go ahead with your question, please.

Hi, Scott Levine, Affinity Health Plan. On the QHP disenrollment, we've instructed – New York State administers the Marketplace, and they've instructed us to disenroll for QHP members who become eligible for Medicare. Do you have any thoughts on that?

That's -- I would certainly defer to our colleagues who manage the Marketplace, but from what we've heard, state-based Marketplaces are in many ways their own animal, and do have their own regulations however.

Okay, do you suggest that we refer that to CMS for further investigation, or is that something we really don't need to worry about?

I'm sure you have colleagues with our counterparts – I'm sure you have contacts with our colleagues in CCIO, the Center for Communication on Insurance Oversight, pardon me.

Okay. Fair enough. And then just one other quick question on incarcerated beneficiary. If CMS receives the retrospective notification, there's notification that someone is incarcerated a number of months ago, will the disenrollment also be retroactive?

Yes.

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Okay, thank you.

Any other questions from our in-house audience? No? Okay, well I do have a question here that was sent in from our viewing audience, and the question is regarding incarceration. When will the final specific transaction reply codes and requirements be provided by CMS for the August software release?

So CMS will provide the specifics of the system edits through HPMS following our normal processes for announcing system changes. Plans should have received the advance announcement in August 2015 for the software release, and that outlined the system changes that will be made in August, and indicated that the implementation of this process by plans is delayed. So as soon as we know, you will know.

Okay. Well, believe it or not, this brings us to the end of our session, and we are out of time for additional questions, so thank you for the questions that were sent in, and that you posed for our presenters today. I would like to thank Cindy and Jim and Patty for taking time to share their expertise with us today.

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