

**TRANSCRIPT
TOWN HALL TELECONFERENCE**

**SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
ACT OF 2007
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DATE OF CALL: March 23, 2011

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
March 23, 2011
1:00 p.m. ET

Operator: At this time, I would like to welcome everyone to the MMSEA 111 GHP conference call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad and if you would like to withdraw your question press the pound key.

Thank you, Mr. John Albert, you may begin your conference.

John Albert: Thank you, operator. Good afternoon, everyone. For the record, today is Wednesday, March 23rd, 2011, and this call is the section 11 GHP or Group Health Plan Teleconference. As we do on all these calls we have some presentations and we will follow up with a question-and-answer session that will last until just around 3 o'clock Eastern Time or two hours from now.

Again, for the record we need to emphasize that on occasion, we do contradict the written materials and the user guides and alerts, absence former release of such written requirements on the section 11 Web site. Those written documents are still the official policy guidance et cetera, until those documents on the web are updated. And again, where there is that contradiction, usually we do follow up you know on some of these calls and new issues and that might result in some additional updates or new materials but until those materials are out on the web, they are not official policy until then.

We have a presentation by Ms. Pat Ambrose followed by Bill Decker and a very brief statement from myself and we'll get right into the Q&A session. We do remind everyone to please limit your questions to one and one follow up and then jump back into the – at end of the queue to allow other

participants time to answer – or get their questions answered. We are taking both policy as well as technical calls or questions on this. And if we can't answer them today because we are short a few people, we will try to get back with more formal answers through other means.

We continue to encourage folks to submit their written questions, suggestions, what not, to the resource mailbox. We go through those for every one of these call that information is extremely useful to us and having that documentation helps us help you.

Also, again, if you're experiencing anymore technical issues, please go through EDI Rep to report any problems issues and what not. I can't stress enough too that if you do have a particular concern, please provide examples that the EDI Rep can take and use to research your particular issue to see if there is, in fact, a problem or a need or what not.

Again, we need to have specific information to be able to identify any potential problem which includes you know examples of particular records and things like that so the more specific the better.

With that, I will turn it over to Pat and we can get started.

Pat Ambrose: OK, thank you, John. I have some announcements and some material to cover and we'll address some of the technical questions that were submitted to the Section 111 resource mailbox since our last call in September. Please note that alerts have been posted to the GHP page of the mandatory insure reporting CMS Web site for Section 111. That's www.cms.gov/mandatoryinsrep. On the left-hand side of the page just as a reminder there is a link for various pages related to Section 111 and one of those is the GHP alert page. There is an alert out there dated February 28th. Employer and Insurer EPA 10 submission that just provides some additional information about submitting 10, more or less, as a reminder.

Note that the use of pseudo-TINs or Fake TINs for employers is no longer allowed. Right now you were getting compliance flags for that, but you will experience or receive errors for submission of that shortly. I'll give more

information on that in a moment. February 11th, 2011 there is an alert related to the beneficiary lookup on the COB secure Web site, a new function that's available to users of the COB secure Web site to do or perform an online query to obtain the Medicare status determine whether a covered individual is a Medicare beneficiary or not.

There is also an alert about hierarchy MSP or Medicare Secondary tier hierarchy rules that are being implemented on April 1st, 2011. That alert is dated November 19th, 2010. I'll provide some more information about that. There is also an alert dated November 18th, 2011 – I'm mean, 2010 – November 18th, 2010, entitled TIN reference file address validation information. Please review that alert if you haven't already done so.

And then finally since the last call on October 12th, 2010 there is an alert regarding the error code SP 50. Remember that we have computer-based training modules, see the CBT page link on the left-hand side of those mandatory insure reporting Web site for information on how to register for the computer-based training or CBTs and also there you will find curriculum documents available for download so you can review what courses are available. Note that we are working on a CBT for the hierarchy changes that are going in in April. That has not yet been released yet, though.

So as I mentioned, April 1st, 2011 we will implement what is known MSP hierarchy changes. Please see the alert that I referenced above. This information has not yet been added to the user guide but we are working on that. It involves IREs receiving some new error codes based on your ability to update MSP occurrences using transactions from your section 111 files. These error codes are FPH0, FPH1 and FPH2. RREs have the ability to overwrite the FPH0 using the new overwrite code sealed on the MSP input file detailed record and submitting a value with HB standing for Hierarchy Bypass.

You must first receive the FPH0 error then you may subsequently after you've validated that your transaction needs to be processed in your next file submission, you can submit that record that was rejected with the FPH0 with the override code, in order to override that error and get your transaction

posted. The alert also provides information on what you can do if you are prevented from making a change. For example the MSP occurrence has been locked by the COBC and you receive the FPH1 error back. In order for you to apply a change, you'll have to the COBC call center in order to discuss making that change.

Your EDI representatives are available to help you with these hierarchy changes and if you have any technical questions, so be sure to do so once you've reviewed the information in the alert.

We are implementing a new process called unsolicited responses. This is a process to notify RREs of changes made to their MSP data by other sources, by other entities. There's an alert to announce this new process that are pending. It has not yet been published, but that should be published very soon. This is an optional file that you may receive on a monthly basis with notifications in that file of changes that were made to MSP occurrences that you have a vested interest in.

We are actually implementing a pilot for the unsolicited response process in April 2011 and after that successful conclusion of that pilot process. We will implement this option for all GHP RREs starting July 1st, 2011. You will opt into the program, opt into unsolicited response on the COB secure Web site and then there might be some you know setup that needs to be done, but then you will start receiving the unsolicited response files on a monthly basis subsequent to opting in.

Again, it is an optional feature, but we think that it'll be very beneficial for RREs and help us better coordinate benefits going forward. As of October 1st, 2011 we are implementing a new TIN-referenced response file and some additional TIN-referenced address validation. We had previously announced that the TIN-referenced response file would be implemented in July, but we are – in order to give RREs enough time to react to this change, we are delaying that implementation to October 1st, 2011.

There will be an alert posted to the section 111 Web site by April 1st, 2011. This alert will include the file layout for the TIN-referenced response file, the

requirements related to that file, error codes that may be returned on that and any – you know all related information that you need in order to process the new TIN reference response file and react to the additional address validation that we will be performing on your TIN records.

Errors with your TIN records then will be returned. The error codes will be returned on the TIN-reference response file. We will convert the existing TIN and TIN address compliance flags to actual error codes on the TIN reference response file and the whole purpose really behind this is to provide you with better information about why TIN records are rejected.

Right now on your MSP response file records, you might receive a more generic error such as SP25 related to an invalid insurer name, but it doesn't really tell you why we rejected the TIN record and why we, in essence, couldn't match your MSP. We could not match the insure CPA 10 or the Employer 10 on your MSP record to a valid TIN record.

So this whole process will provide you with more specific information on your TIN reference response file. As part of this change we are also implementing at the COBC postal software that will perform delivery point validation of addresses and sine scrubbing of address. Delivery point validation involved checking to make sure that the address submitted is considered deliverable by the United States Postal Services. For example, if the address is for a vacant lot for which there is no facility there, that address will be considered invalid and you'll start receiving error codes as a result of that.

The TIN records will either be accepted or rejected and the TIN reference response file will provide you with a disposition code very similar to the MSP response file. TIN records that are rejected will receive a TN disposition code. If they're accepted, they will receive a 01 disposition code. We will also return on the TIN reference response file the address information that you submitted – obviously, we're returning the TIN that you submitted as well – and then we will also return applied address fields and flags that indicate whether we actually not only accepted your submitted address, but scrubbed it using postal software. This is more or less FYI. You can tape a scrubbed

address and use that in your internal system, but it will also notify you that this is the applied address that we are passing on to other Medicare contractors for use and demand recovery and claims processing.

The applied addresses will be posted on the common working file, also known as CWF, and pass to the Medicare Secondary Payer recovery contractor, the MSPRC that will then use that – those addresses on any recovery demand notifications that you receive.

MSP records, when the MSP input file is processed, MSP records that match rejected TIN records will actually be rejected. They are not rejected now – you receive compliance flags – but as of this change in October 2011 MSP records will start – that match to rejected TIN records will start being rejected with new error codes on the MSP response file. These error codes will be FPT0 and FPT1.

Again, if that MSP record, both the insured TPA 10 and the Employer TIN submitted in the MSP detail record fields 21 and 22 must match to a valid TIN record. If they don't, you will receive one of those two new errors back. RREs will use the TIN reference response files to determine what was wrong with their TIN record.

What we are strongly recommending advising RREs is that you all submit full TIN reference files after the October 1st date either with your MSP input file or before you submit your MSP input file, in order to have your TIN records completely reprocessed and in order for you to receive then information back on the new TIN reference response file indicating whether the TIN record was accepted and what the applied address we will use is going forward or if your TIN record was rejected, you'll receive that specific error with what was incorrect.

Now many of these errors match the compliance flags that are currently in place, so we'll essentially be converting the compliance flags to error codes and then adding some additional error codes related to that address validation using the postal software including the delivery point validation I mentioned.

So it's in your best interest to review the compliance flags you are receiving back on your MSP records now related to TIN validation and TIN address validation and correct your TIN records on your TIN reference response file now, get that cleaned up before the October release and then, come October 1st, try to submit your TIN reference file early and get your TIN records cleaned up if you haven't already done so prior to submission of your MSP input file for the fourth quarter 2011.

Now I realize that some of you have submission timeframes very early in the quarter and may have no choice but to submit your new TIN reference file with your MSP input file, your EDI representatives will work with you to resubmit files as needed.

So another thing that I want to make clear is that the TIN reference file may be submitted along with the MSP input file as an all-in-one physical file, but the TIN reference file is logically separated with the header and trailer records. But you may also submit a TIN reference file, frankly, at any time exclusively all by itself. If you submit an MSP file off schedule you may receive a threshold error for that and obviously you can't submit more than one MSP input file in a quarter unless instructed to do so by your EDI representative.

But a TIN reference file maybe submitted multiple times and really at any time during the quarter. So again, I encourage you to be prepared to resubmit a TIN reference file early in the fourth quarter and clean up any errors that you have in order for a cleaner submission of your required MSP input file. Another reminder is that the special GHP recording extension for dependants expired at the end of 2010 please review 7.2.8 of the user guide. This extension was intended to give RREs more time to report dependents whose coverage started before January 1st 2009 to give RREs more time to collect information necessary to report that covered individual with a either a HIC number an HICN or their SSN as needed or required.

So at any rate, all RREs should now be reporting dependants that are considered active covered individuals on their MSP input file. The GHP user guide updates are still in process. No significant changes are being made to

the user guide that has not already been published or won't very soon be published in the form of an alert. So you may start with user guide version 3.1 that's published, apply the various alerts that have been posted out to the CMS Section 111 Web site and you have current information. So in other words, even though the update to the GHP user guide is delayed, there will be no surprises, when you do see the new version.

I'd like to say we are making every effort to get it out there as soon as possible and I would think that we should be able to post it by May 1st, 2011. I do apologize for the delay. Another announcement of new information is that we must upgrade to the 5010 version of the ANSI X12 270/271 that is used for the query input file. I'm working on an alert for this information. This should involve very minor changes. It won't in essence change the way that we use the X12 270/271, but there will be some minor changes.

Companion guides will be published by July 1st, 2011 for those people or those RREs that are using their own X12 translator. The HIPAA – help me out here, the HIPAA Eligibility Wrapper or the HEW also pronounced the HEW software, will have a new version of that available by October 1st, 2011.

You will be able to submit 5010 versions starting on October 2011 and then RREs will be required to upgrade and use the 5010 version by January 1st, 2012. So you'll have your companion guide by July 1. You'll have your updated HEW software by October 1 and we need everyone converted over to using the 5010 version of either your own X12 translator or the HEW software by January 1st, 2012. Again, an alert will be posted with this information and the companion guides that you need will be available by July 1. Note that as of January 1st, 2012 that means that the existing versions of the HEW software will no longer be operational or functional or usable, so you will need to replace your existing HEW software with the new version by January 1st, 2012.

As always, please submit your specific technical question to your EDI representative first. Specific technical issues related to your file submission can't be addressed effectively as they are sent only to the CMS resource

mailbox. You will get a much faster response to your specific technical issues if you contact your EDI Rep and follow the escalation procedures in the user guide, if necessary. So again, I just encourage you to make sure that you're staying in contact with your EDI Rep and following up with them.

I have a few questions here, mostly technically in nature, that I'm going to answer. These are questions that were submitted by RREs to the CMS Section 111 resource mailbox. If you're interested in obtaining the e-mail address for this resource mailbox, go to the Section 111 Web site that I mentioned before – the www.cms.gov/mandatoryinsrep and click on the what's new link on the left-hand side at the top of the What's New page you'll see the e-mail address published there.

The first question was asking a very basic question about the MSP input file, due dependants, over age 45 need to be recorded if they are not a Medicare beneficiary and the same rules apply to dependants as they do to subscribers. If they are an active covered individual, technically you only need to report Medicare beneficiaries on your MSP input file. You have two options available to you to determine whether an individual is a Medicare beneficiary; you can use the query finder file method and determine their Medicare status, first. And then if they are a Medicare beneficiary, submit them on your MSP input file. If they are an active covered individual, remember that there's a definition in the user guide for that and that definition relates to, in some cases, to the employment status of the subscriber.

And the other methodology is to use the reporting threshold, the age thresholds and report all active covered individuals over age 45 on your MSP input file and the first thing that we do is determine Medicare status of that individual first and then go on to determine if MSP exists. So at any rate, dependants are included in that definition of an active covered individual.

The question went on to ask about what effective date they should submit. This is, in particular, an HRA that might have a plan effective date of 10/1/2010, but the – a particular covered individual in the plan did not – the effective date of their individual coverage did not start until 12/1/2010. They are asking what effective date to report and they should report the effective

date of that actual beneficiary or covered individual being the later date from their plan year since they were not covered as of 10/1. So hopefully, that clarifies that question.

This question also went onto to ask about the TIN reference file and asking if a group has no known Medicare beneficiaries, but they have a 20 or more group size, should we put the company on the TIN file. There are a couple of things that I need to clarify. First of all, when it comes to the size we're talking about the employer size, and the number of employees. It's not the size of the group or the GHP that is applicable to that employer size calculation.

So I encourage you to review appendix I in the GHP user guide that provides extensive information on calculating the employer size and the various rules related to that. At any rate, though, if you are reporting records on your MSP input file for the TIN in question, then you should include the TIN on your TIN reference file; in fact, you must.

On the other hand, if you may or not be reporting MSP records under a particular employer TIN then you do – you may submit the employer TIN on your TIN reference file, even if you don't have any MSP records, as of yet, to report. So in other words, you can report all your applicable TINs on the TIN reference file. What's most important is that you do include the ones that are associated with the MSP input record.

Another question went on to ask about two cases of defining a particular person as an active covered individual. I'll read the scenarios. Jane is the dependent of her son and is covered by her son's GHP. Her son is currently employed, Jane is 63 years old. Is she an active covered individual? And yes, according to the definition of an active covered individual in the user guide. Now we don't just use that information when making a determination of MSP. A determination of MSP does depend on other factors, such as the relationship of that individual to the subscriber and also the reason that Jane might be entitled to Medicare, whether she is entitled to disability or ESRD or age.

The question went on to ask: If Jane is 78 years old, is she an active covered individual under the same circumstances? And again yes, she is. So hopefully, we've cleared that. And the same factors apply. Be sure to submit the correct patient relationship code, the correct employee status and we'll determine the reason for entitlement and make the MSP determination from there.

Another question went on to ask: If there are any issues with sending members on the MSP input file with future termination dates? For example, an MSP input file is sent on November 22nd, 2010 and there is a member whose termination date is 12/31/2010. Take a look at the description for error code SP32 for working age beneficiaries, termination date cannot be greater than the current date plus six months. So in other words, you may submit a future termination date, if that termination date is positively determined. I mean, I encourage you not to guess. In fact, you are not to guess at the termination date. But if it's confirmed and definite, you may submit a future dated termination date, but it cannot be – essentially, it cannot be six months in advance.

There is other rules related to that specific to the entitlement reason for that individual. But the safest this thing to do is not to submit a termination date that's more than six months in advance, since you may not know the reason for entitlement prior to that.

Another question went on to ask about the MSP hierarchy changes and this question asks: If we received a response back and the record, the MSP occurrence, is locked and I receive error code FPH1. After we've verified – the RREs have verified their information and they determine that this change does need to be made, but they are prevented from doing so by the hierarchy rules and the FPH1 error, what should they do? Can they contact the COBC or resend a record? If you receive the FPH1 you will not be able to update that record via your Section 111 file. You cannot resend a record, you'll get the same FPH1 back.

The alert out on the Web site instructs you if this change does need to be applied and you're confident of that that you can call the COBC call center.

And the COBC will update that record manually. You will – initially, when you call the call center, you'll get a customer service representative, a CSR. Because the record is locked, your request will have to be transferred to a higher authority at the COBC, a COBC analyst, who will take care of setting your information and making that change as necessary.

The next question related also to MSP hierarchy: How will the COBC rectify the situation with all parties involved with a locked record? They are asking that if the COBC then does subsequently make a change to a locked record, what is the process to notify the various parties involved, maybe the insurer, the employer, the beneficiary whoever maybe involved in that situation. The COBC doesn't really unlock a record when they apply a change. The record remains locked and they will apply whatever changes they determine to be appropriate. Notes will be made on that MSP occurrence or related to that MSP occurrence for future audit and future reference purposes.

There is the possibility that if the RREs signs up later for the unsolicited response that they will get an alert record in their unsolicited response file notifying them of that change. So – otherwise, there's no other mechanism to inform the parties involved. Records don't get locked on a regular basis. It really is a more extreme case and you know where certain information has been flip-flopping back and forth and a beneficiary is you know really in a bad situation of not having their claims paid correctly or the MSPRC has already started the demand for the situation and determine that change is needed to be made to that MSP occurrence and the record needs to be essentially frozen. So those are the kind of you know rare circumstances that a record gets locked for.

Again, this question did go on asking about the TIN reference response file layout and as I mentioned we'll have an alert posted by April 1st for that.

The next question was related to the beneficiary look-up and there are some differences between what you were able to do with the BASIS, BASIS application which was a dial-up application and what you're able to do with the COB secure Web site beneficiary lookup. For one thing, there is a

difference between the number of transactions allowed per month in BASIS. I believe the transactions allowed were 200 and we've reduced that to 100.

If you run into a jam where you've reached your transaction threshold for the beneficiary lookup in a particular month, contact your EDI representative and discuss it. They can bump up that transaction count for you for a particular month. It shouldn't really be necessary. If you're performing more than a 100 queries per month, I would think that a more efficient method would be to use your quarterly query file. But at any rate, you may speak to your EDI representative about that situation.

We also have recognized that we're not displaying back all the same information on the beneficiary lookup that we provided back on BASIS. And we have a change request out there to rectify that situation and display back as much information, particularly the reason for entitlement, back on the beneficiary lookup. So I apologize for that oversight and we're taking care of that.

Next question – questions related to various things. First, about the changes related to the hierarchy MSP hierarchy will CMS will be providing a test process or window of time when RREs can submit test files related to the new MSP input layout? You may submit – start submitting test files using that hierarchy overwrite code as of April 1st, using the normal testing methodology, even though you're in production status, you may submit test files, but there is no testing timeframe or process that is planned related to that. But you may certainly send the test files.

Next question has to do with: Will CMS provide details for why a record is not being accepted and what the discrepancy details are when sending back the FPH0 record? We will be sending back some of the applied information on the MSP inference in the applied field. So, for example, if the RRE has submitted the occurrence, the MSP information with an open-ended termination date and later we get a phone call from the beneficiary stating that they have retired and the COBC applies a termination date to that record, you will receive that termination date back on your MSP response file along with the FPH0. And also if you opt into the unsolicited response process available

starting in July, you would get some more information on those types of updates.

But it's not going to be real specific as to what changed or why you received that. But you should get enough information back on – in the applied field. I think you know 90 percent of the time, it is the termination date that's been applied and you'll be able to get notification of that.

This question went on to ask about the FPH1. Actually, that's pretty much been asked and answered. Reason for a record being locked – I did discuss those earlier and another question came up about will you get the new FPH0 H1 and H2 error? How did they relate in terms of the SPES error code?

Essentially, you'll get the SPES related to employer – that's related to employer size. You might get that error or you will get that error back and the H0, H1 and H2 error codes won't apply because we're not creating an MSP occurrence, so you can expect to get you know basic edits back. If we've determined that either the record you've submitted is in error or MSP doesn't apply, then we're obviously not going to move on and into the logic for the hierarchy updates so.

John Albert: But first, we check to see if the record is clean and (inaudible) and see if there is another record out there that it bumps again in hierarchy and then make that decision, so you would again get those error codes first.

Pat Ambrose: Right. Thank you, John, for that clarification. And lastly, a question was asked about the upgrade to the 270/271, the 5010 version for that. And as I mentioned earlier, yes, we will be making those updates and information is pending.

So with that, I believe, I am turning it to over Bill Decker for some additional announcements. Thank you

Bill Decker: Thank you very much, Pat. Hi, everybody. My name is Bill Decker and I'm with CMS. I'm going to take a couple other questions that were so not technical in nature, and these are principally questions that have to do with

HRA or Health Reimbursement Arrangement reporting and with the collection and use of social security numbers.

We did get a few more of those in here, the social security number questions and I'll go through those. I know you take them as they come up, so we will be sort of going back and forth between an HRA question and a social security question. And the first one is an HRA question. It came in from an employer that says that they have an HRA. And during some period of coverage time, the employee has received a deposit of \$750 into his HRA. And sometime after that, the employee pays some claims and gets some more money. The two deposits equal \$1000. And for this particularly reporting period, the employer wants to know if the HRA needs to be reported, because during this particular reporting period the HRA's coverage value is a \$1000 which is the threshold limit.

And if it's a \$1000 or more, the HRA needs to be reported. The answer to that question is that it should be reported, if it's within the – if the coverage period was never termed. If the coverage was termed at some point and then reestablished for that employee, then you're not going to count the new addition. But if the coverage in the coverage period exceeds the \$1000 threshold, then it should be reported. And (inaudible) same question. It starts off with: I am writing on behalf of the Self-Insured Multi-employer group health plan. The plan is currently reporting SSNs to CMS. It is not clear about whether it has additional reporting responsibilities beginning in January. Based on this question, we think that this is an NGHP question, not a GHP question, and we are not going to address that particular question at this point.

An HRA question: Our clients is at TPA for an HRA arrangement with an employer with a separate insurance plan. Is our client responsible – is our client the responsible reporting entity for this HRA? The answer is yes, because the other insurer reports this information, even though the other insurance plan is entirely separate from the HRA. The answer is yes, it could, but is still – the TPA for the HRA is responsible for the reporting.

he other insurer, the GHP insurer, could be an agent for the TPA, that would work. But it's the TPA's responsibility to do the reporting. How that reporting gets to CMS, it can be made through an arrangement with any other insurer or any other agent, for that matter.

Another SSN question: Please explain why we get a hit back on all our SSN records submitted in our query files? The answer to that question is that we don't know. It could be that everybody you sent us is, in fact, a Medicare beneficiary. It could be that there's a glitch in the system. It could be a whole range of issues. I have to know pretty much what you mean by the word "all" in that question.

Pat Ambrose: And if I could jump in Bill for a minute, if you have particular situations where you don't receive back the expected response on your query file or you believe that the query response is erroneous, you need to provide that information directly to your EDI representative in a secure fashion and allow us to research it that way. So that's the best vehicle for getting that researched. There is no known you know major problem with the query process, so we don't want to set you up to think you know. And as Bill said, we really need to know more information from this question in order to find out what the situation is. So contact your EDI representative, figure out a way to transmit the information securely and we'll research it from there.

Bill Decker: Thank you, Pat. Moving on, we have a question about this concern, moving if on correctly here. Yes: Our SSN is legally required for dependant's enrollment on Group Health benefit policies. That's not a question for us, actually; that would be question for someone else.

But our answer is: Not that we know of. There isn't anything on the Section 111 law that requires a collection of SSNs by employers, for example, or the collection of SSNs by insurers. So that came from a – actually a government entity, a federal government entity and we're not – we really can't answer it.

The question about SSNs, though, is always that in Section 111 reporting there is no requirement that SSNs be collected by employers or insurers for

the purposes of the reporting. And my colleague Bill Zavoina who is here today, might want expand on that a little.

Bill Zavoina: You need to report either the HIC number or the SSN of someone who is a Medicare beneficiary.

Bill Decker: Of someone who is a Medicare beneficiary that's right.

Bill Zavoina: Or you can list your social security numbers of your active covered individual and we'll determine if they're a beneficiary.

Bill Decker: But that is for determination of eligibility. In that case, it's not actually for the actual reporting. Our gold standard for reporting, as always, is the Medicare ID number, the Medicare HICN. That's what we actually do require. We actually don't require and the law doesn't require the collection or submission of SSNs. You need to tell us about Medicare beneficiaries. It may be useful to report their SSNs, but that's useful, is as far we'll go with that.

An HRA question: As part of the Medicare – as part of the Section 111 law How do I act as a responsible reporting entity for an eligible HRA plan? If you believe you should be in the RRE and reporting on HRA, you need to go to the Section 111 Web site, go to the GHP tab, go to the user guide, look at the alerts and follow the instruction there to report. And it's not a complicated process – it seems complicated – but actually, getting signed up and reporting is not as complicated as it may look at first blush. And it is not something we can walk you through here on this call.

Pat Ambrose: I think Bill when I read that question I wondered if the individual was thinking that they had a choice as to who the RRE is or they could, in a sense, sign up. In the user guide, there's a clear definition of who must report, who is the RRE. That is dictated by CMS policy, not by the choice of various individuals involved.

Male: Right, thank you Pat.

Another HRA question: I work for an employer instituting an HRA beginning 10/1/10. Now with the HRA, we individually select a health insurance carrier

and the employer pays us a pretax portion of the premium and we make up the rest. And it goes on to describe a typical HRA arrangement. Does my employer need to report as an RRE, under Section 111, with a HRA setup like this? And the answer to that question is, no, because your employer, unless it's self-funded and self-insured entirely and not using an insurer or GPA for its coverage, would not be reporting under Section 111 at all. Insurer's report under Section 111, employers only report if they are, in fact, an insurer. I think that's the simplest way to put that.

Bill Zavoina: However, bear in mind, that even though you've purchased an HR – an individual policy with funds from the, HRA it is considered a group health plan under our rules and that individual policy must be primary to Medicare.

Male: That's correct Bill, thank you. Thank you for putting that out. That is true and that's one of the reasons why we report HRA.

Another question here we got which is not related to either HRAs or SSNs actually, we were just informed about these new reporting requirements. I don't know if we are required to report, though. We have Group Health Plan insurance. We're a small employer, do we report? Again, it's the same answer as the other one. The insurer reports. If reporting is required, the insurer will report, not the employer.

An SSN question which starts off this way: MMSEA, that's the Medicare and Medicaid SCHIP Extension Act, which is where Section 111 comes from, require a self-insured health insurance plans to provide social security numbers to CMS. And then it goes on. Actually that premise is not true, it does not require self-insured health insurance plans to provide social security numbers. It requires people to report about Medicare beneficiary.

Bill Zavoina: HICN.

Male: Right, there is HICN.

Moving on to – the last one is an HRA question. (Inaudible) in the GHP user guide is big. I wonder if the \$1000 exemption cutoff applies for a planned

coverage or per individual coverage and then it asks for a couple – and then it gives a couple of examples. Our answer to this is that reporting is at the employee's HRA benefit level, not at the individual level.

Bill Zavoina: In other words, if the employee and the spouse and dependent children are all able to tap into the HRA and it's a \$1000 contribution, it gets reported.

Male: Right. And that's all the questions that I am going to address. And so, John, I'll turn it back over to you.

John Albert: OK, thanks.

Male: Thank you.

John Albert: Thanks Bill – both Bills. One quick thing that was passed on to me right before this call was that we're seeing instances of entities providing information in the name field of the TIN reference file, in particular for the demand address portion of the TIN reference file.

Now people are using, for example, series of numbers or random characters or basically you know letters and/or random that really don't make any sense. I realize that the name can be either a company or a person and that sometimes there are company names that you know are – A1 or something like that. But again, we've seen enough of these that we want to remind folks to please make sure that if they have a valid name and/or entity for that field so please use it, because again, that is used as the mailing address for any recovery action sought by CMS's Medicare Secondary Payer recovery contractor.

So again, please, I just remind everyone to check those fields and imagine that people are just putting characters in there because they don't necessarily have the name. But again, that is going to possibly result in misrouted mail, et cetera, or just not getting there – so to the right person or entity. So again, that's all I had.

And with that, operator, we can go into questions and answers

Operator: At this time, I would like to remind everyone, in order to ask a question, press the star and the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. And your first question comes from the line of Alicia Hernandez from ABPA. Your line is now open. Ms. Hernandez your line is now open.

Alicia Hernandez: I have no question, thank you.

Operator: Your next question comes from the line of Barbara Cullison from SunGard. Your line is now open.

Barbara Cullison: I also thought I had canceled mine. I'm sorry I have no question – mine was answered.

Operator: Your next question comes from the line of (Scott Shelton) from EBSRMS CO you line is now open.

(Scott Shelton): Hi, my question is regarding the HRA accounts and the \$1000 annual benefit threshold and whether or not rollover from previous plan years should be included when determining that \$1000 threshold?

Male: Yes, that \$1000 – in fact the beginning of the new coverage period, the HRA is valued at \$1000 or more.

Bill Zavoina: Or will be during the period.

Male: Or it will be during the period of coverage, then it needs to be reported and that's if you're – you need to take into consideration what we mean by at the beginning of the new coverage period.

(Scott Shelton): OK, I just want to be clear on that because that's exactly what we were advised in the June 24th teleconference, I believe it was. Yes, our EDI representative had recently advised us otherwise that rollover should not be counted in determining that – whether or not they are at that \$1000 threshold.

(Pat Ambrose): We'll follow up and make sure that that information is conveyed to the EDI department if there's any confusion there.

Male: OK, great.

(Scott Shelton): Thank you.

Operator: And your next question comes from the line of Geraldine Hawkins from Way Insurance. Your line is now open.

(Rick): Hi, this is Rick. I had the question. On the online query, as you noted earlier, there is some missing information. So as to get that information, we called the MCCOB New York line, but they also have a disclaimer saying that excessive use will warrant further investigation. Is that going to be waived, while we need to get this data that's no longer available on the online?

Pat Ambrose: We need to put you on hold for a second.

That is true that through the call center the 1-800 line there is the ability to also if you are an appropriate entity to also query for entitlement information and excessive use there. We have had some – well, you know I refer to as abusers, of that process in the past. Really, what I'd like to encourage you to do is to use the query input and response file process to obtain this information.

(Rick): That's not effective because we can only do it only once a quarter and we got people on the phone with questions and we need to get the data to answer those questions. And we – it could be two months after the last query file and still a month away before we can submit another one.

Pat Ambrose: I guess I'm confused as to – you know the query is for determining it's for your use in Section 111 reporting. So if you're using it for other purposes, you need to take a look at the data use agreement and that sort of thing. I'm not quite clear on where you're going with that question and maybe I need to turn it back to John and Bill to answer. But again, the query is for the purpose of determining whether you need to include an individual on your MSP input file and you know we have determined that since the MSP input file is due once a quarter that's getting – clearing once a quarter should be adequate. So I don't know what else to say.

Bill Zavoina: What sort of questions are these people asking you about that you would need to query?

(Rick): Well, we've had a customer or a member question what is this documentation I got about part D? They didn't even know they had part D and we didn't have any information, so we had to look it up. And again, we don't even – can't now get the contractor number that's assigned them to part D apparently.

Bill Zavoina: Who is this that is asking you about Part B?

Male: D.

Bill Zavoina: Oh D, I thought he said B. I'm sorry.

(Rick): D, as in dog.

Bill Zavoina: All right.

(Rick): It was a member. They got some literature in the mail saying that they had part D and didn't know what that was and they called us.

Pat Ambrose: Shouldn't you refer that beneficiary to the 1-800 Medicare line? I think that would be appropriate place for them to start to get their question answered, rather than going to their commercial group health carrier? I mean –

Male: Yes, I mean.

John Albert: This beneficiary should be either contacting 1-800 Medicare or the COBC directly, preferably the 1-800 Medicare. I mean, that's what they're there for.

Pat Ambrose: So possibly, in that circumstance, you need to develop a script or a process, internal procedure, to refer the beneficiary to the appropriate Medicare helpline. And but – at any rate, we you know duly noted about the information on the online beneficiary lookups. You know as I said, we are working to put the same information – return the same information then with any look up that we did on BASIS.

(Rick): Like part D is missing and.

Pat Ambrose: Yes.

(Rick): (Inaudible) isn't missing.

Pat Ambrose: Yes.

(Rick): But those are the questions that we then have to call that number to get.

Pat Ambrose: Yes. And again, you know as a possible change to your internal procedures would be to refer the beneficiary to 1-800 Medicare.

Bill Zavoina: I'm assuming the beneficiary did not get that information through the Section 111.

(Rick): I have no idea. I don't know where ...

Pat Ambrose: I don't know how they could.

Bill Zavoina: They may have gotten something from some other stores that had nothing to do with Section 111 and called you, but that doesn't mean you use Section 111 processes to answer those questions.

(Rick): OK. Yes. The other thing that I wanted to comment on is the alert. When we look at those because there wasn't enough detail to put together work packages for programming, our assumption is that alerts are just kind of heads up and that the user guide is the official documentation where you're going to have all the specifics to do your programming. Is that correct?

Pat Ambrose: No, that's incorrect. Alerts are supplements to the user guide. And if you don't feel there's enough information for you to proceed with your coding, you should be asking us now

(Rick): Which I did.

Pat Ambrose: OK.

(Rick): Where is the file layout for that MSP response file or the TIN response file?

Pat Ambrose: It will be published in an alert by April 1st.

(Rick): Right.

Pat Ambrose: And that file is not being implemented until October 1st.

(Rick): Right, but the alert come out in November. So I went back to my EDI rep.

Pat Ambrose: Now, actually, I'm sorry. I'm going to stop you there and say that the alert that was posted in November was about TIN information and TIN validation information, as it exist today. And it did mentioned that we were adding this response file and that more information would be provided which we are working very diligently on to get published. So I think you will have – I mean, I think the alert is at least 15 pages long. It includes a detailed file layout. I you know had a big hand in writing it and I wrote it with the idea in mind that if I had to code the – what information would I need. So stay tuned. It will only be a matter of you know a couple of weeks now.

John Albert: Yes. I mean, our primary goal is always to get any kind of new information that includes like a modification to a process out at least six months in advance of it going live. There are may, on occasion, be exceptions to that because sometimes they are other drivers beyond our control that might mandate a sooner turnaround, for whatever reason, but again the goal is to the final requirements out to everyone six months prior at a minimum, so.

Male: The notice – the six month notice was met for this particular process. The actual process itself will be up on the Web site around the beginning of April.

(Rick): Have you ever considered expanding that six-month notice. Because a lot of times for corporate America six month is not enough lead time for us to get IT resources available?

John Albert: Yes, we're very aware of that and have delayed many things many times because of that. You know lot of it comes down to the complexity of the process. And then of course because this is still an evolving process, you know there's also the need as well that the issue with the TIN has been pretty

significant for a while. It's something that we've been looking at for a long time and we apologize if that timeframe is rather short. But again, we do think about that. We recognize that oftentimes stuff is done on a fiscal yearly basis, you know and we recognize it just like you know we do, we have to line up the resources with enough lead time so.

(Rick): That's all I have, thank you.

John Albert: All right, thank you.

Operator: And your next question comes from the line of (Sheila Bur) from Blue Cross Blue Shield. Your line is now open.

(Sheila Bur): Hi. The first question is related to the – being able to lookup as the gentleman was just speaking. I understand that you've submitted the request for the change, but while the change is also (inaudible) kind of in addition to what he was saying, are we still going to have the ability to go into BASIS to get the information for the (bene) since the (bene) lookup does not contain everything we need?

Pat Ambrose: I believe BASIS is still available, but I have to check on that. I don't know whether your login ID has been expired for BASIS or not. So I would recommend that what you do is follow up with your EDI representative. I'll get an answer and make sure the EDI reps know the answer to that. I'm sorry, I just don't know off the top of my head the status of BASIS.

(Sheila Bur): OK. And generally, how long do we think it will take for that change control to be where – well, do we have any idea of how long we will ...

Pat Ambrose: I don't. I'm afraid I don't have the date for that, off the top of my head either, and I don't have any documentation with me.

(Sheila Bur): OK. OK.

John Albert: It will not be immediate, I can tell you that much. And I think we're going to be actually be phasing the data in over two separate releases in terms of – the

primary goal is to get the reason for entitlement out there, followed by the other information, but that might be at a later date.

Pat Ambrose: well, as we work around, we certainly can take under consideration keeping BASIS available for users – the existing users.

(Sheila Bur): All right. That's what I was basically trying to understand. That may help us a little. And subsequently to that, as we were just – as he was discussing with you know I apologize because I don't know his name – but the reason that we may have to access the (bene) lookup so often for our plan what we're experiencing is we've exchanged a member on the 6.1.11 we have a response.

For example, entitlement comes back ESRD and you provide the dates of dialysis and et cetera. However, internally from a previous date exchange, we may already have some information online that shows something different; there's a conflict. And then in addition to that we do get a (bene) call or a claim got held because of the conflict. So for our purpose we utilize the (bene) lookup and BASIS to resolve most of the conflicts between the Section 111 process as well as any other information we received from the (bene).

We are doing the queries and lookups, but then (inaudible) in itself there's conflicts. I have a couple of examples that we have seen where we have just exchanged a Section 111 file. I got a file back, for example, last week. If I go into BASIS right now, the eligibility information; entitlement and effective dates are different.

And if I call the COBC, they also have given us different information. So we're experiencing it to that level which is causing a higher volume of calls and especially if it's ESRD, it automatically sends you to a representative. So you don't have the IVR capability. I understand the thresholds and the accounts related to how our usage is been tracked is related to the number of times we get to a representative versus the IVR.

So age and disability entitlements we can get through IVR. But when you get into ESRD and when we get into the conflicts between what's coming back on our Section 111 file versus what we're seeing today in BASIS, there's no

other option, but to talk to a representative. So that's kind of an additional example. Like the gentlemen was saying, certain condition is forcing us to get the representatives because of the conflicts in its own data.

John Albert: Could you hang for a minute please? We're going to put everybody on hold just for a sec?

(Sheila Bur): Sure.

John Albert: Hey, we're back. I mean, there are valid reasons for some of those changes to occur. And so, the one you were mentioning especially in the case of ESRD beneficiary. But then again, at the same time, if there are discrepancies, we do want to know about them as well. So I mean we can't answer definitively that, oh, there's a problem or not a problem. We need, again, for you all to point this out to your EDI rep and have them take a research – a look at that and see what's going on. But so far, I mean, we don't hear too many problems with the data. I mean, it all depends on when you query and what the reasons for entitlement is as of that period.

Pat Ambrose: And you're only going to get – if I understand, Bill, correctly the current reason for entitlement and related information. I mean, you still get the ESRD coordination dates, but Bill, you might have a better.

Male: If someone started out at (ESRD) and then become entitled on the basis of age or disability, you're going to get back age or disability as the basis of entitlement. If someone – if age and ESRD or disability and ESRD eligibility were to concur, you're still only going to get back disability or age. You don't get back multiple basis of entitlements. So you just have to keep that in mind when you're getting these kinds of questions.

(Sheila Bur): Exactly, but I think what we are experiencing and we are aware of that part, but what happening is we may receive age and disability back on the file but you still provide the ESRD date.

Male: Correct, because there is – that's correct, because even though there is – even though it is being listed as their current basis of eligibility, the ESRD coordination period is still in effect.

(Sheila Bur): OK, that's where there's conflict.

Male: Right.

(Sheila Bur): Because there – so what you are saying is that, although we see the ESRD date on the file and the entitlement is currently age and disability, we should set a order of liability and use the (inaudible) rules for age and disability and not ESRD?

Male: No. No.

(Sheila Bur): No, so use ESRD because ...

Male: That's why I said – remember, the rules for ESRD are pretty simply.

(Sheila Bur): Right.

Male: If somebody – if Medicare was not the proper primary payer immediately prior to the date of eligibility for ESRD, then a coordination period applies, period, end of discussion. So even though someone may have (inaudible) December 1st, 2010 become eligible on the basis of ESRD and on January 1st, become eligible on the basis of age and they're retired, the ESRD coordination period is going to apply for the full 30 months. If they are still working and otherwise the working age rules would apply, the working age rules would not apply, but the ESRD coordination of benefit rules with the 30-month coordination period would apply. You can see all of this explained in the online manuals on the CMS Web site.

Pat Ambrose: We also had ...

(Sheila Bur): And maybe we can share this offline because I thoroughly understand that and walked through some examples with our EDR Rep, and what we were told was that if we receive our response files back on (inaudible) and we are seeing ESRD dates, however the entitlement that's being returned is age and disability, we were told that we were supposed to set the order based on ESRD. But when I go into BASIS or the member queries or we call COBC,

we're told the person's current entitlement is age and there should not be ESRD applied. That's what I'm – that's the conflict.

Male: That information is not necessarily correct. What someone is doing, depending on who you're talking to, is simply looking up to basis of eligibility on CWF and they're only seeing the one file. They're not going to check in the other files that would be (inaudible).

Pat Ambrose: So we can take as an action item to you know go back to the COBC call center and see if some additional training or changes to procedures are necessary there. I also encourage you – I mean, you might not need it but for others on the call who might be as confused as I'm about ESRD and MSP rules related – we do have some computer-based training modules related to MSP topics that are out there and available. You can sign up for the same way as you do the Section 111 CBTs. And I know that there is information about ESRD coordination period and MSP and that sort of thing in those CBTs too.

(Sheila Bur): Right. I think what is missing is that on the Section 111 side, we do not expect to have the entitlement not match the date; that's the key. If I'm giving on the entitlement of age or disability, it should be just be that; not the fact that my current entitlement is showing age and disability, but the ESRD coordination is still happening. So it's the dual entitlement issue that's not being addressed in the Section 111 file (inaudible). We exchange two million records a quarter, so I got maybe 8,000 members that's impacted. I'm not talking about a few scenarios. This is a bigger issue that we've been trying to work with our EDI Rep and we cannot get resolution.

So my comment would be we're thoroughly educated on what ESRD is and how to set periods. What we're asking is in the circumstances when this person is now entitled to age and disability, the ESRD is still play, we need some way of identifying that for the automation that's in place that's bring in our data and sets the appropriate order of liability.

Male: Well, you can look at – giving you the dialysis information, generally you can use the dialysis information along with the rules to determine what the ESRD coordination period would be.

(Sheila Bur): OK.

Male: I don't think given the way the system is set up with the basis of eligibility quoted into CWF, I don't think that they're going to be able to tell you prior basis of eligibility without an awful lot of work and an awful lot of reprogramming.

John Albert: Let us take this back offline and take a look at it.

Pat Ambrose: Yes, I mean if we can provide more clear information back on the response files, we'll certainly attempt to do that.

(Sheila Bur): OK, thank you.

Operator: And your next question comes from the line of (Scott Shelton) from (EBS RMSCO). Your line is now open.

(Scott Shelton): Yes. I just had a question and then a concern about actually deleting some retirees that were reported in error. We have been advised by our – and basically the proper process to go about that – we have been advised by our EDI representative if it was a small number of retirees, less than 100 to contact the COBC call center which we did because we only had a small number. And the COBC call center has told us that we couldn't do that. So I mean we just – we sent that back to our EDI representative to look into and still at this point haven't received confirmation.

Pat Ambrose: What is your RRE Id?

(Scott Shelton): 37832.

Pat Ambrose: 37832. We'll have somebody follow up and find out you know what the best process is and get back to you on that and also follow up as to you know the referral to the call center versus whether that's an appropriate referral or not.

Male: And hang on just a second. We're going to go offline, just quickly here.

(Scott Shelton): OK.

Female: You asked an off-liner?

(Scott Shelton): I know. That question was posed at least a week ago or almost a week ago now. (Inaudible) someone at least be aware of that question and (inaudible).

Operator: Your next question comes from the line of (Deborah Eck) from (Palmco)

(Deborah Eck): Yes, thank you. I'm really – most recent MSP file we had an error SP52. We're reporting two domestic partners and it appears that we reported them as disabled, using – I'm sorry – using a code 20 to denote domestic partner. It's reported back on the response file in field 10 as been aged. And so the question there is no domestic partner under working age. And so should we really be reporting these to begin with?

Male: Domestic partners are not considered spouses, under current law, for the purpose that working age provision. There are considered family members under the disability provision. So as a basis of entitlement of the policyholder. That's the key, the policyholder is age, then you should – there should not be a dependant who is a domestic partner. However, if the policyholder is eligible for Medicare on the basis of disability and has a domestic partner who may be aged, that domestic partner is a family member of the policyholder who is eligible on the basis on disability and you would (record) them.

People here – it looks like they have a headache.

Male: Did you understand the explanation?

(Deborah Eck): No.

Male: I mean, well really the safe thing to do is if you have somebody you know is the beneficiary, you provide us with the employer size and that person's information and we make the determination based on the reason for

entitlement that we have whether or not there's MSP. In that case, we determine there's no MSP, because it sounds like they were ...

Male: The policyholder was ...

Male: ... was what?

Male: ... disabled.

Male: Yes, yes.

(Deborah Eck): We received an error that specifically said you are reporting this person wrong, based on an invalid patient relationship code, so you know this is truly a domestic partner. So patient is entitled to Medicare.

Pat Ambrose: The description on that – the description of the error code in the user guide is somewhat incorrect in the sense that what it really means is that MSP doesn't apply. You know I'm not suggesting that the patient relationship reported was wrong. It's just that MSP doesn't apply in this circumstance. So I'll take it as an action to update the wording in that user guide. But you know what is really being conveyed to you is that MSP doesn't apply in this circumstance and you really don't need to take up further action.

(Deborah Eck): Very good, thank you.

Operator: And again, if you'd like to ask a question please press star one on your telephone keypad. And there are no further questions in queue. I'll turn the call back over to the presenters.

John Albert: OK. Well, that was little faster than we expected. Does anyone else have anything they wanted to add?

OK. This is John Albert again. I'd like to thank everyone for their participation. We had some good questions. We will go back on some of the things we promised to follow up and hopefully report out on those at the next call which is June 15th. Again, from CMS, we'd like to thank everyone for their participation. Please continue to submit your questions to the resource

mailbox. And again, for more specific questions concerning examples, provide those examples to your EDI departments. If you're not getting what you need from them, please follow the escalation clause that's in the user guide in terms of referring your question up to higher levels within the coordination of benefits contract. And with that, I'd like to thank everyone and good afternoon.

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

END