TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: JUNE 15, 2011

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

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: John Albert
June 15, 2011
1:00 p.m. ET

Operator: Good morning. My name is (Stephanie), and I will be your conference operator today. At this time, I would like to welcome everyone to the MNSEA 111 GHP Conference Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you 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 morning or afternoon, depending on where you're calling from. My name is John Albert with Centers for Medicare and Medicaid Services. And again, for the record, this is the Group House Plan teleconference for the implementation of section 111 of the Mandatory Insurer Reporting Provision of the 2007 MMSEA Act (et cetera).

Today also is Wednesday, June 15. Forgive me. I'm a little slow this morning. It's June 15. And also, for the record, as we always state, while we try to accurately state and repeat what are in the official user instructions at the Mandatory Insurer Reporting Web site, occasionally we do contradict the materials. Where that may occur, the written materials at the Web site always take precedence over anything that we say here on the call.

As is with these calls in the past, we'll go through a couple of presentations, and then we'll open it up to some Q&A with everyone. We ask that folks limit their questions to one primary question and one follow-up, and then jump back in the queue so that other folks on the line can get a chance to get their questions answered. Participation today is a little lighter than average, probably judging by the fact that it's now getting into the summer season. So

you should have plenty of opportunity to jump back in and ask more questions if you need to. And also, when introducing yourselves, you'll be asked for your name and the company you represent.

With that, I will turn it over to Ms. (Pat Ameris) (inaudible) presentation on some of the new materials, et cetera, and then Mr. Bill Decker will have a few things to say, and it'll come back to me, and I have a couple of brief things I want to mention as well.

So (Pat)?

(Pat Ameris): OK, thanks, John. First of all, some posting to the CMS Mandatory Insurer Reporting Web site. Since our last call, which was on March 21, on the GHP page, the main GHP page, of version 3.2 of the GHP user guide for section 111 dated April 20, 2011 has been posted. As always, section one indicates the changes that were made to this version since the prior version of version 3.1 that was.

On the GHP Transcript page, you'll see the transcript from our March 23, 2011 call. On the GHP Alert page, you will see the alert discussing the TIN reference response file and address validation that will be implemented in October 2011. This alert was reposted with a revised date of May 17, 2011. So note that we did make some changes, and the changes to that alert are listed right at the beginning of the revised version.

Also on the GHP Alert page, you will see an alert providing some information about a new unsolicited response file program. That alert is dated March 28, 2011. I'll have some more information about that in a minute.

And then on the MMSEA 111 Alert page, there is a notification about the upcoming changes to upgrade to version 5010 for the X12 270, 271 query files and the corresponding HIPAA elability wrapper …

John Albert: Eligibility.

(Pat Ameris): Eligibility wrapper. I knew it was somewhere in there. Also known as the ACW or the (Hughes) software, the upgrades to that that will be taking place.

So please make sure that you've reviewed that information, and there is corresponding information in the version 3.2 of the user guide as well. By the way, we'll have a companion guide for those using their own X12 translators, a new companion guide for the 5010 version of the X12 270 and 271 used for section 111 query purposes. That will be posted on or about July 1, 2011.

As always, we continue to keep the computer based training modules, or CBTs, updated with current information and publishing new courses on new topics. So very soon, we'll have a course or two published related to the MSP hierarchy changes that were implemented in April 2011. Information on hierarchy is, of course, in version 3.2 of the user guide. The CBTs have been updated to reflect version 3.2 of the user guide as well, and we're working on some additional courses related to the TIN reference response file and address validation going in October and the unsolicited response process.

So keep your eyes out if you have not registered for the CBTs and you're interested, they're available free of charge. You go to the www.cms.gov/mandatoryinsrep Web site. That's the section 111 – CMS' section 111 Mandatory Insurer Reporting Web site. On the left-hand side, there's a series of tabs, and there is one related to computer-based training, or CBT. Click on that. It'll take you to a page that explains how to sign up for the computer-based training. Once you're signed up and a registered user at the CBTs, you'll be notified anytime a new course related to GHP is posted out there or an updated link.

Next, as I mentioned, we did implement MSP hierarchy changes back in April 2011. We have some feedback from our data validation team that takes a look at files after they've been submitted, doing exactly what their title indicates, validating data and making sure that folks are reporting properly, et cetera. We are seeing some (RREs) that are getting the SPH 0 error on updates that appear to be attempting to add a termination date to a record that already got updated by a COBC customer service representative, or CSR, with a termination date. And this is working according to – you know working as expected. I just wanted to mention, though, that on the MSP response file, we are sending back the MSP effective and MSP termination dates even when

you're getting an (FP) disposition code with the (FP) 8.0 error. So you don't necessarily need to override to apply your change every time.

Make sure you're interrogating that response record. And if all you were trying to do is post a termination date, and that same termination date is already out there on the MSP occurrence and being returned on your response file in the MSP termination date, then you're good to go. You do not need to take any further action to override it or call the COB call center or anything of that nature.

So we're trying to give you more information on the response file records, and if, like I said, all you were trying to do was post the termination date and it's already there, you're good to go. That would be true with the SPH 1 error as well. You're not actually able to override that error, but if you needed to make a change that you were prevented from making due to the hierarchy rules, and we see (inaudible) SPH 1, your only alternative there is to make a phone call to the COB call centers indicated in the user guide.

OK, the unsolicited response, this is the new process to notify responsible reporting entities or RREs of changes made to the MSP data by other sources. We have posted an alert that provides high-level information regarding this process. A user guide addendum, a separate addendum will be published, and CBTs, computer-based training modules, will be published. These are pending internal review, but should be out there early in the July 2011 timeframe. As this is an option file that an RRE may receive on a monthly basis, you opt into receiving this file on the COB secure Web site. It's not yet available to all RREs.

The pilot started in April 2011, and we've decided to extend that pilot through the month of August to get some more feedback since it's a monthly file and we've just transmitted, I think, one and maybe, I think, maybe two unsolicited response files to our pilot testers – or they're not really – this is production data, but to our pilots. We haven't gotten a lot of feedback yet, frankly. So before we allow other RREs to opt in, we thought we'd extend the pilot and continue looking at the results and making sure that it's functioning the way that we want it to. So it will be opened up and available to all RREs as of

September 6, 2011. So RREs interested in the unsolicited alert, unsolicited response file process may opt in on the COB secure Web site starting September 6.

And is that all we wanted to say, or John, do you …

John Albert: Well, yes, this is John. Again, we have – so we had the pilot going on for a while, but in the interest of you know more fully testing for volume in particular, we're looking for some additional pilot testers. We've reached out to some, but basically haven't received as much response as we would like. So I just wanted to put it out there on the call to those participating that if they are interested in pilot testing or becoming part of the pilot tests, that they can contact their EDI rep. In fact, I just want to announce that Bill Ford and Jeremy Farquhar are actually – from the COB contract are actually on this call of speakers that have dialed in. You know we've sent out some requests, and again, we're looking in particular for entities that have larger volumes of claims.

But of course, you know anyone who would like to volunteer, so we would obviously consider. It is ultimately up to the COB contractor if we get enough you know interest to pick who they would you know choose to – or you know choose the pilots to actually do it. But again, I can't stress enough that this is a very valuable tool that we've been talking about doing long before section 111 under the old voluntary process. It's a way for you to identify that there are other sources of data that you probably work with, particularly employers and beneficiaries who may be providing information that is different than you're providing, and it allows you to you know do outreach to your partners as well to make sure that you know the data coming in is as accurate as possible.

So we strongly advise that, even though this is a voluntary process, that people take advantage of this unique tool because, you know for example, as an insurer, if you're having trouble getting termination dates from a particular employer, and you're finding out that (inaudible) response, you may find out that a particular – and that entity exists, and you can you know do your own outreach to them as well to make sure that you're getting timely data from them as well. So again, anyone who is interested in pilot testing can contact

their EDI rep and – you know, then again, in September, this will be opened up to all officially.

So I don't know, Bill or Jeremy, if you had anything to add or not? If not, don't worry about it, so.

(Pat Ameris): OK. Next topic is the TIN reference response file and address validation. As I mentioned earlier on the call, these changes are going live October 1, 2011. The response file and the new address validation requirements for the TIN reference files are documented in version 3.2 of the GHP user guide that's out on – posted out on the Web site now. There's also an alert with the same information, the file layout requirements and error codes and the like. The alert, please review the updated alert. There is some additional information there that – just to make sure that you have the most current. I think all of this – the information in the alert is actually in the user guide, but this would kind of bring it more to the forefront for you.

What is not in the user guide is the fact that we will not be processing any TIN reference or MSP input files the last week of September. That's September 22 through the 30th. So if you have that week as your files – normal quarterly file submission date for third quarter, we will ask that you not send your third quarter file that week and instead send it under the old rules the week before, or if you choose you may send it the week after, send it a week late, but it will be processed under the new rule.

So take that into consideration when you're deciding what to do. But we basically need to finish processing existing or files that we've already received under the so-called old rules and get the system prepared to turn over and start processing under the new rules as of October 1. So check out that information in the alert related to that.

The other thing I wanted to point out is that there's little applications out on the United States Postal Service Web site that allow you to check addresses, and in fact, will reformat your address and return your address in – using the USPS standard abbreviations. And it will also check to make sure that the

address that you're providing is deliverable, that it is you know actually a point or a place where the U.S. Postal Service can deliver mail.

And those same kinds of checks are going into the section 111 processing in October. So you could actually pre-validate your addresses for the TIN reference file using that USPS Web site link that I listed in the alert. It really is – originally, that link is intended to help you derive a (zip) plus 4. But it turns out that it also is validating – doing delivery point validation and the like. So it's just a suggestion, not a requirement. But it might save you some headaches come October.

Let's see. Now, again, as a reminder, we are upgrading to the 5010 version of the ANSI X12 270, 271. This will reflect very minor changes. It's not really going to change the way that we use the 270, 271 for section 111 queries, but we're required to do it since all of CMS and Medicare are upgrading to that version. Again, the alert has been posted on the MMSEA 111 Alert page. Companion guides will be published by July 1. The (Hughes) software, updated (Hughes) software will be available for both test and production as of October 1. RREs month use the 5010 version of the X12 by January 2012 and must upgrade to the new version of the (Hughes) by January 2012.

The format for the files going in and out of the (Q) software for this new version will be the same as for version 2.0.0. But if you're using the (Q) version 1.2.0, the older one, that's no longer valid. Oh, that will no longer be accepted, and you really should be upgrading to version 2 now and then the new version of the (Q) in October.

Some changes that have been made or are being made to the COB secure Web site. This is www.section111.cms.hhs.gov, dot gov. The beneficiary lookup is a function that's already available off the RRE listing. However, it does not provide as much information as the query response file or the basis application, and we're correcting that in the October release. So as of October 2, you will see the reason for entitlement and also get a display of the ESRD and the Part D data. Part D will be displayed if you're an expanded reporter. ESRD and reason for entitlement will be displayed for all RREs. So that

improvement is being made and will be available to all RREs as of October 2 on the COB secure Web site.

In the July 2011 timeframe, we're adding a new function off the RRE listing that allows you to download a table of your associated RRE IDs and export it to, say, Excel or some other spreadsheet application. So it's probably more beneficial for reporting agents that may have a lot of RRE IDs associated with their log-in ID. But it could apply to some RREs as well who are using more than one RRE ID. So that'll be a function that's available off the RRE listing.

And then, sorry to jump around here, but in October, we're adding a change to allow an account designee to remove their access to an RRE ID if they so choose. What we're finding is that an RRE's account manager may add, say, a reporting agent, a person who is a reporting agent for them, and then subsequently they change reporting agents. And so that account designee no longer needs access. Now, the account manager is supposed to go in and clean that up and remove the account designee's access, but it's not always happening in a timely fashion, and we've had requests from some reporting agents to be able to remove themselves so that they no longer have access with that ID, particularly to the secure FTP mailboxes and the like.

And we actually like that idea because it does improve our security. And so an account designee will be able to actually remove their access to an RRE ID. They will not be able to add access to an RRE ID. They will not be able to obtain access to an RRE ID unless they get the account manager to add them. So only the account manager can add you, but you as an account designee can remove yourself if you so desire.

As always, on every call, I remind you to please submit your specific technical questions to your EDI representative first. Specific technical issues related to your file submissions can't always be addressed effectively if they are sent just to the CMS resource mailbox or elsewhere, or even at – during these town halls, although we do welcome your questions. And as John said, we have Jeremy Farquhar and Bill Ford on the phone available to assist you. But for very specific questions that relate to just one RRE, we ask that you contact your EDI representative and then follow the escalation procedures that

are documented in section 12.2 of the GHP user guide if necessary. So that's – I'll move on from that.

Yes, we did have some questions that were submitted to the CMS section 111 mailbox, the section 111 e-mail address. If you're looking for that e-mail address, that can be found on the mandatory insurer reporting Web site that I mentioned earlier. It's on the what's new page right at the top.

OK, the first question that I am going to address, I'm trying to stick to the more technical questions, here is one about a TPA who will be reporting on the behalf of some employers. They're planning to report HRA data, and they were asking, when they're submitting data for these HRA plans, these HRA GHPs, can one file be submitted for multiple employers, or does a file need to be sent for each employer. The answer to that hopefully you can find in the user guide.

It depends on who the RRE is. If the TPA is the RRE, one file per RRE may be submitted, and within that file for the RRE, multiple records beneath or for the each employer HRA may be submitted within that file. On the other hand, if it's actually the employer who is the RRE, and this other entity that is actually submitting the records is not the RRE but just a reporting agent, they must send separate files. So it really depends on who the RRE is.

You'll see a TIN, two different tax identification numbers on the MSP input file. One is for the insurer or TPA who is the RRE, and the other is for the employer, if different. And also, on the TIN reference files you must submit records that correspond to the insurer slash TPA TIN and the employer, and you can submit multiple employer records on that TIN reference file, obviously.

So I encourage you to review the user guide, particularly the sections related to registration and the section 7111 related to who is an RRE, and hopefully that'll help you answer your questions. If you haven't registered yet and you need help from the EDI department, there's a – in the user guide, there's a main number to that EDI department that you can contact directly, and someone will get back to you.

This question, and I know these are kind of basic questions, but I'm assuming we have some you know people who are still getting geared up, particularly related to HRA reporting. So bear with me. This question went on to ask about can you confirm if we are only to send records of individuals who are on Medicare or anyone over the age of 45? You're only required to send records on your MSP input file for active covered individuals who are Medicare beneficiaries. Now, there is two reporting methods. One uses that age threshold, where you report all active covered individuals, and those are – there's a very specific definition for active covered individuals in the user guide. So you may use that age threshold. On the other hand, you may use what we refer to as the finder file method.

So see section 712 of the user guide, where you would query your active covered individuals first, find out which ones can be matched to Medicare beneficiaries and then report only the active covered individuals that are Medicare beneficiaries on your MSP input file. There's also computer-based training modules that I mentioned earlier that explain these reporting options and this methodology in detail that I think you would find helpful.

The last part of this question was, because we are so small, can we just send an Excel file? And the answer is no. We only accept files as defined in the user guide. We can't take an Excel spreadsheet for this information at this time. Now, that's not to say that you internally couldn't create an Excel template and produce a – the necessary flat text file and submit that, but that's up to you to perform that, take that step.

OK, another question that was just asking about registration, how do I – how do I go about getting instructions on how to set up my reporting structure, my register for an RRE ID and get started on reporting? So again, first off, go out to the CMS Web site, www.cms.gov/mandatoryinsret, the mandatory insurer reporting page of the CMS.gov Web site. There, you need to go to the GHP page and download the user guide.

And then, of course, there – take a look at all of the other tabs on that Web site related to GHP, the alerts and so forth. Next, for specific information then on the registration, take a look at section 716, and section 11 in particular, to help

you with registration and your use of the COB secure Web site. So we have documentation on the CMS Web site on the mandatory insurer reporting page, and then the Web site that you actually go to perform the registration and view, possibly upload files and view statistics about your files and so forth is the section 111 COB secure Web site. The URL for that is www.section111.cms.hhs.gov. After you accept the log-in warning, you don't have to log in. You'll see the log-in page display. Across the top of that log-in page is our menu options, and one of those is the How To menu option, and there's one about how to register and so on. It also provides information.

Lastly, as I mentioned before, you may call the COB EDI department, and I'll give the main number now. That's 646-458-6740. That's in the user guide as well.

So again, I'm sorry for those of you who are more familiar with the reporting process, but I kind of wanted to give out some information there to a few people that are just getting started.

The next question was talking about the – an issue that the RRE finds themselves in and where they are resubmitting the same transaction over and over again. They weren't exactly clear to me as to which transaction they meant, whether it was the MSP input file detail record or whether it was the query. Now, you are responsible for checking the Medicare status of an active covered individual in the GHPs that you're reporting on, basically following that definition of active covered individuals in the user guide and using in particular the age threshold. You don't have to resubmit an MSP record over and over again that you're receiving a 51 disposition code back on, indicating that that person can't be matched to a Medicare beneficiary. But you do need to check your Medicare status by other means, and that most likely would be using the section 111 query file.

So if you're using – and so I would recommend, in this case, that the RRE use the finder file method that's described in the user guide in section 712 and also take a look at the corresponding CBT. You most certainly may then use the dates that are returned on the query response to decide whether the GHP coverage overlaps Medicare entitlement and determine whether you should

then submit that individual on your MSP input file. That's the whole point of returning those dates to you. So hopefully, that provides you some information.

John Albert: I mean some people asked the question you know why is it that, if we send someone to you, that we have to keep constantly querying? Why can't you just tell us when the person attains Medicare entitlement status, and then we'll send you an MSP record. And the problem is that we are prohibited under the Privacy Act from sharing information with entities that we can't confirm at the time whether or not you still have a relationship with that individual.

So as an example, you send us John Smith, and he's aged, what, 56 years old. And he never you know achieves Medicare status because of ESRD disability until he's age 65. At age 65, we still have no way of knowing whether you still are insuring John Smith. So we would prohibited from sending you confirmation at that later date that that person now has attained Medicare entitlement and you can report them.

So unfortunately, with the way – well, I guess I'll say fortunately for those who care about privacy like we do and lots of other people in their work as well as personal lives, you have to continue to basically ping our database with your queries and/or MSP reports at the time to see if, in fact, you – that person is a beneficiary. So that's why it's done that way.

(Pat Ameris): OK. Thanks, John.

The next question, or this same question went on to ask about when their – how to handle the situation when you're receiving two response file records for one input record in the case of split entitlement and were returning two periods of MSP coverage and the difficulty then that the RRE is experiencing maintaining that. So there's some information on this in the user guide. Again, it's covered in the CBTs.

For a period of split entitlement where we have returned to MSP periods, in many cases, you may continue to just send the GHP coverage dates if you need to make an update. It's only when – and this is described in the user guide when you have to go back and possibly delete a record and we need to

make sure that that both MSP occurrences are deleted. But you know we create and maintain MSP records. Periods of time when Medicare is secondary to the GHP, and the GHP is primary, you're encouraged to do the same in your system. That's why we're passing back the MSP effective and termination dates, so that you know the order of payment or the primacy of payment. And MSP occurrences, in part, are maintained by the reason for entitlement.

So that's why we're suspending back this information the way that we are. Just like this GHP is not happy about having to maintain the split periods, you know we don't really have an interest in maintaining the entire time of your GHP coverage. We only are interested when your GHP coverage is primary to Medicare. So I'd encourage you on the topic of splits to review the user guide, review the CBTs and then have a conversation with your EDI representative to see how maybe you can streamline your maintenance of that information.

Next, questions came in about the new TIN reference response file. The first question – again, this is the TIN reference response file will be implemented in October 2011. The first question was, "What will be the turnaround time for the – for receiving the TIN reference response file once it is submitted in production?" And we estimate approximately three business days for return of a TIN reference response file, which, by the way, is being sent separately from your MSP response file.

When can we start testing the new TIN input and response file process? And you may start on that Monday following our October release, which is October 3, 2011. The question also went on to ask how long it will take to receive a TIN reference response file in the test environment. And that's also approximately three business days. So both production and test.

And then the questioner went on to ask, "Do I need to coordinate testing with my EDI representative," and not really, no. Just like with other test files, you can submit that test file at any point after the October release goes in, and the system will process that file automatically. Of course, your EDI rep is available for assistance at any time.

Next question was about the compliance flag codes for TIN validation and TIN reference address validation that were implemented in January 2011. These compliance flags that are actually being replaced with TIN reference file error codes come October. The question was, "Did this actually go into production? (DRE) is not receiving any and is wondering if there is a problem." Well, it's a good thing that you're not receiving them, meaning that you're passing the basic validation step. Obviously, we're not running that against the delivery point and then the USPS standards for the address. But if you feel like you should have gotten a compliance flag and you're not getting it, if you don't think that the system is applying the logic of documents in the user guide, as always, please report that to your EDI representative, and they will assist you.

Lastly, this question went on to ask about a slight change in wording that was added to the user guide in Appendix D related to disposition code 51. At the – in part of the description for 51, it now says to resubmit the record on the next file submission as necessary. That was really not an implication of a change in requirements, but maybe just clarification or, to be more accurate, more or less semantics. It basically – there's information in the user guide about when you must resubmit either a query or a MSP record.

When you receive a 51 disposition code, there was – there was not intent there to change those requirements. Make sure that when you receive a 51 disposition code that you have actually submitted accurate data for the beneficiary. You know we're not telling you whether a person is or isn't a Medicare beneficiary. We are telling you whether the data that you sent has matched our file of Medicare beneficiary data, whether we can match the information that you sent to that of a Medicare beneficiary. So our matching and the disposition – the return of the disposition code is only as good as the data that you've sent us.

So I think that – hopefully that answers that question. And with that, John, I'm finished.

Bill Decker: Yes, hi. This is Bill Decker. I have some too. Anyway, excuse me, my – I have a – trouble in my throat, I guess.

The – (Pat) has answered most of the questions that we got in between the last GHP call and this one. And in fact, between the last GHP call and this one, we did answer offline a couple of the specific questions that we got in. Some of the HRA questions that (Pat) didn't actually answer we had addressed offline with particular RREs, and we've covered that information. (Pat's) – The general information that (Pat) gave about HRE reporting applies to everyone, and we really don't need to get into the sort of the very specific situations that some of the HRAs had.

I do have a couple of other comments to make, though. The first is, we got a question/comment from a GHP reporter that tells us they provide vision benefits to their employees to contracted donors and want to know about how to report those.

Male: That's practice providers.

Bill Decker: Contracted providers, right.

Male: At least the donors.

Bill Decker: Oh, no, they wouldn't be donors. We basically don't cover vision benefits. So if there are vision benefits being provided to an individual, first, is the individual a Medicare beneficiary, because that's the only type of individual reporting to us. And secondly, since Medicare doesn't cover the vast majority of vision care benefits, they probably would not be reported.

(Bill Zevornia): However, if they – you had provided – if they're providing a service for which Medicare does provide coverage to RDUs via MSP rules as a primary.

Bill Decker: Right. One of those coverage's that – that was (Bill Zevornia), by the way. One of those coverage's that does – that Medicare does pay for is one set of eye glasses after cataract surgery, for example. There are some specific instances where Medicare will make a payment for a benefit, but they're not

particularly common, and the vast majority of vision care services Medicare is not a payer.

Another question we got was, from an – I – a school fringe benefits consortium asking about what are their (repercations) for an employee who refuses to provide Social Security numbers and thus can't be reported? We've covered this before. We'll – I'll just mention it again. You need to ask the potentially covered individual if – to give you the information that's necessary for you to be – to enable you to report to us. And for us, that information is bottom line a Medicare ID number or Medicare HICN with other information. If you don't have a Medicare number, you can give us an SSN, which we will then take, and with some other information, attempt to match it to our databases to see if the individual is a beneficiary or not.

If the employee will not give you the SSN after repeated attempts, you can ask the employee to sign a form, which we call model language. You keep that on file. You, the insurer, that are doing – is doing the reporting. You keep that on file in your office, and thus, you have a record of the attempt to comply with the section 111 reporting. We have covered that territory before, but for anybody who was out there and hasn't heard that, that's what you need to do. We have model language on the Web site. You access that. You attempt to collect the information. If the information cannot be collected, or the individual will not comply with your request, you simply keep a copy of the request.

John Albert: And you know in terms of that model language that Bill – this is John Albert – mentioned, I mean that we would, again, strongly recommend to use as a last resort and an attempt to collect the minimum information necessary for reporting purposes for the GHP. That is available on the GHP tab, and it's dated as a download August 18, 2009. So that's where that exists. But again, we would ask you to use that as a last resort when attempting to collect the health insurance claim number, HICN, and/or SSN, and of course, name, date of birth, gender of the person, which is a primary – the primary data elements used by us to match to a Medicare beneficiary on our database.

Bill Decker: If you send us information about someone you're interested in knowing whether they're covered or not and is it adequate for us to check, and we find that they're a Medicare beneficiary, we tell you that they are on our database as a Medicare beneficiary. If we do not match, we tell you that we did not match. We don't tell you anything else.

That's a – and that's – I'm finished now, John. Thank you very much.

John Albert: OK. And this is John, and I have a couple of things that wanted to remind folks, that in – when certain RREs have submitted files, they've made a mistake by submitting retirees on the MSP file, or essentially people who should not be reported as MSP, and it is very important that you notify your EDI rep as soon as possible once you determine that that is, in fact, the case.

We've had some RREs you know from the very beginning even today that have mistakenly spent you know large numbers of retirees on their file and basically – which could result in inaccurate MSP records being built on our system, and therefore claims being denied for payment where Medicare is, in fact, the primary payer. Don't wait until the next quarter to submit the information. You need to get on – get on the phone with your EDI rep, and they will work with you to do an off-cycle delete file to remove those from our system as quickly as possible. So again, if you realize you made a mistake, the first thing to do is to call your EDI rep, and they will work with you to fix the problem as soon as possible.

I also wanted to use this as an opportunity to pitch the computer-based training modules. A lot of people have taken advantage of them. A lot of people have not. We know that they are useful because, in general, the folks that have been taking them seem to have a lot better understanding of the process from start to finish. So again …

Bill Decker: Give the course it's high marks.

John Albert: Yes, give the course it's high marks. So again, if you are struggling with any particular part of this process, please look at the CBTs and pick some of them. They are you know self-service process and that you can go at your own pace and things like that, which a lot of people find useful, so.

Bill Decker: And they're free.

John Albert: And they're free, yes. Yes. And in terms of – I noticed that our Web site, we have no more calls scheduled after this, but we are working on scheduling future calls. It was a – it was a funding issue, but we do have some money to do some calls. We just haven't scheduled any yet. But there will be more calls in the future.

Other than that, I think that …

Bill Decker: Try to make them at convenient times.

John Albert: Yes, so other than that, operator, I guess we can go straight into Q&A.

Operator: Certainly. At this time, if you would like to ask a question, please press star, then the number one on your telephone keypad. We ask that you limit your questions to one primary question and one follow-up question. Thank you. We will now pause for just a moment to compile the Q&A roster. Your first question comes from the line of Melissa Murphy from United Healthcare New Jersey. Your line is open.

Melissa Murphy: Hello, everyone. I actually have two questions, unfortunately. First is, we have four HRA vendors associated with the United Health Group. Two of them provide HRA coverage for United medical members, but two provide HRA coverage to non-United medical members. The two that are not associated with United Healthcare medical are struggling with how they determine who gets sent on the MSP file, because they don't have access to any information regarding who is considered primary or secondary.

John Albert: Who gets sent on a – for an HRA RRE? Are they – Melissa, you're saying that they're not United HRA RREs, right?

Melissa Murphy: No, they're – they are …

John Albert: They're freestanding – they're freestanding RREs?

Melissa Murphy: They part of United, but the corresponding medical coverage is not with United. It's with another carrier. But the HRA is with United.

John Albert: OK, any HRA would be working with the employer to find out who is to be reported. That's sort of who they're going to have to know.

Melissa Murphy: But isn't it the GHP's role to determine who is primary and secondary?

(Pat Ameris): No. No …

Melissa Murphy: How would the employer know?

(Pat Ameris): You need to go to the user guide and read the definition of an active covered individual.

Melissa Murphy: I know it well.

(Pat Ameris): OK, and so you need information about is this person covered due to active employment. You need to know their age, name, gender and …

Male: Sex.

(Pat Ameris): Right.

Melissa Murphy: So the expectation is that the HRA vendor, whether they have a you know brother or sister medical coverage in their – in their company, it's their job to find out – to determine Medicare primary, because they know who to send on (MSC) …

(Pat Ameris): As – all right, it is – it is their job to report according to the requirements in the user guide, their job to …

Melissa Murphy: It's …

(Pat Ameris): … their job to obtain the necessary information. Now, when you send that information accurately, it's actually the COB and CMS that determine whether the coverage being reported is primary to Medicare or not. But it's very

important that you submit that record accurately, for example, and for submitting for active-covered individuals as defined in the user guide.

And you know we'll – you can use the query process to find out whether they're a Medicare beneficiary or not and only report those Medicare beneficiaries that are active covered individuals. But we actually, when we receive the MSP input file record, make the determination of whether the GHP coverage is primary to Medicare or not. And I mean HRA coverage or you know standard GHP coverage.

Melissa Murphy: Right.

(Pat Ameris): We make the determination, create the MSP occurrence with MSP effective and termination dates, if applicable, and send that back to you on the response file.

John Albert: But the – so the question, though, that you're asking is about the HRA getting the basic information – you know they need to get that from the employer, though. I mean like the employer size, for example. I mean the HRA would have to get that in order to bill that file, that individual record to send to CMS. Is that the kind of information you're talking about?

Melissa Murphy: Yes, that's exactly what I'm talking about, yes. And regarding MSP making that determination and establishing the MSP occurrence, that's correct. However, if we don't do our due diligence and send you what we perceive to be the correct members, we have a quarter of a year's time when the record could be incorrect, or we have to create a delete file.

(Pat Ameris): Right. I'm not suggestion that you shouldn't pay attention to the MSP rules, by any means. But you know you can see by the data that we're collecting – as John mentioned, employer size, and we talked about you know coverage under active employment or not and the age of the individual and so on. You know that all factors in.

Melissa Murphy: OK.

(Pat Ameris): But the final MSP determination – but yes, I mean I guess the answer to your question is that this RRE needs to obtain this information from the employer who is offering this HRA coverage to the …

Melissa Murphy: Well, we are the RRE. They're just one of the entities that report under our RRE.

(Pat Ameris): Oh, OK.

Male: Are they funneling the data to you to be reported under your RRE number?

Melissa Murphy: The HRA vendor is part of our enterprise. It's part of our organization, and we report all business segments in our organization one file.

(Pat Ameris): OK.

Melissa Murphy: I do have a follow-up question somewhat related, and that has to do with the timing of the query file. As I understand it, today an employer can submit a VDSA file on a monthly basis. However, we as the GHP, who are mandated to submit MSP, are limited to a quarterly submission on a query file. Is there any possibility of increasing the frequency to allow us to get changes and new adds on a more frequent basis?

(Pat Ameris): Right now, the only option is for section 111 RREs to submit query files on a quarterly basis. You do have the BASIS, B-A-S-I-S, application, and the beneficiary lookup functionality available for you know entering one-by-one queries online. But right now, that's all that's available to section 111 RREs is that quarterly query. I mean I guess we can take a note that you're looking for being able to query more frequently, but right now it's quarterly.

Melissa Murphy: Yes, quarterly gaps does create claim issues. And I guess my concern was that employers who aren't charged with claim payment have a more frequent option than the GHP.

Male: There are a variety of other people – other entities, let me put it that way, to be more precise – that report to us under data sharing agreements that have other schedules that are not the same as the section 111 reporting schedule because

their data – our data requirements are different or their data requirements are different or they were older systems or any variety of reasons. We would like to have section 111 reporters reporting to us on a scheduled and in a manner that is most efficient for both you guys and for us, and that's what we're working for.

Melissa Murphy: Thank you very much.

Operator: Your next question comes from the line of (William Survey) from Harvard Pilgrim Healthcare. Your line is open.

(William Survey): Thank you. Again, this is (Bill Survey) with Harvard Program Healthcare. One of the questions that you had submitted from us that you had spoken to, I was a little confused and want some clarification. This was regarding the TIN input file and the TIN response file. I believe I heard your answer be that testing can start October 3. It can't start prior to the go-live date?

(Pat Ameris): No, it can't.

(William Survey): OK.

Male: The go-live – the go-live date is not just for you to submit. It's also for us to have our technical systems fully operational.

(William Survey): I was – I was falsely, incorrectly making the assumption you'd have test systems with it available beforehand. That was my misunderstanding.

(Pat Ameris): Yes, I mean it's basically all going live at the same time. And so if you have – if you have a later submission, file submission period, you can send and test TIN reference files and you know make sure that it's processing accurately and then be prepared for your October – I mean your fourth quarter submission in production.

(William Survey): Yes, I'm sitting here with my …

(Pat Ameris): And then …

(William Survey): Sorry. Go ahead.

(Pat Ameris): Well, and I suggest try going out to the USPS Web site to you know manually test your addresses and make sure you're cleaning up your – any compliance flags that you might be getting on the addresses right now. The basic format of the TIN reference file that you're inputting is not changing so much as them having to deal with, though, a different response file in processing – or deal with a response file and processing mat. So – but yes, it – the testing and the production are essentially go live at the same time.

(William Survey): I understand. Thank you for the clarification.

Operator: Your next question comes from the line of (Cheryl Horner) from Unite Here Health. Your line is open.

(Armand Webber): Hi. I have a question on the – sorry, my name is (Armand Webber) with Unite Here Health. I had a question on the SPH 0 errors. I got a handful of these on my most recent – on my most recent file. It sounded like earlier that you said if we received the H0 error, that it was – it was a mismatch on the dates, and they transaction went through and we didn't need to do anything else. My understanding, from reading the alert, was that we needed to verify the dates and then resubmit the file with an override code. Can you just clarify that?

(Pat Ameris): Yes. I'm sorry, I must have confused you earlier. What the SPH 0 means is that some other entity that's higher than you in the – higher – the ranking, the tiered ranking has changed the record since they updated that record last. And so then your update came in, and we initially are not going to allow your update. We haven't – we have not actually compared what change was made to what change you're trying to make. That is up to you. What I was trying to say was, before you just automatically think that you need to override, take a look at the response record, because nine times out of 10, what's happening with these records is a termination data is being added.

So bear with me with an example. You might have submitted the GHP coverage initially, and we created an open-ended MSP occurrence, no termination date. Then the beneficiary – and maybe this was for a beneficiary who is working and covered by active employment, and they retire. On their

date of retirement, they – because you're on a quarterly reporting process, you might not have made that update yet.

But the beneficiary might be interested in getting their Medicare claims paid correctly, and they will call the COB call center or 1-800 Medicare and describe their circumstance and say that they retired on X date, and the customer service representative from 1-800 Medicare or the COBC applies the termination date to the MSP occurrence. Then your quarterly reporting comes around and you submit the same termination dates, reflect their retirement date. In that circumstance, because the CSR is at a higher level than the section 111 RRE, you'll initially get the SPH 0.

Now, if all you were doing was reporting, say, June 15, 2011 as the retirement date, and the response record with the SPH 0 comes back to you with an MSP termination of June 15, 2011, then you can see from that that the change that you were trying to apply has already been made, and you don't need to make another update with an override because that data and the fact that the record is terminated is already there. That's the point – the point that I was trying to make if that. Does that help clear it up?

(Armand Webber): Yes, that makes sense. I understand now.

(Pat Ameris): OK, now, if you disagree with that date or you believe the record should remain open-ended or something of that nature, you know you need to validate the data, and then you may submit that change with an override code to force your change through on your next quarterly file.

(Armand Webber): OK, I understand.

(Pat Ameris): Great.

(Armand Webber): And then my second question is, we are a multi-employer (inaudible) fund. So I have only submitted one TIN file ever, and it has our own tax ID and our own – a single record with our tax ID and our address on it. Now, on October, I'm assuming I'll just have to resubmit that single TIN record with our own – with the same information on it. Is that correct?

(Pat Ameris): Yes. Yes, take the addresses that you put on your TIN file, you know if somebody gets a chance, and manually type them into that USPS Web site that I was talking about, their zip plus four application, just to check and make sure that you have them formatted and that they're considered you know deliverable. But yes, that's pretty much all it will take is a resubmission of your same TIN reference file.

(Armand Webber): OK, very good.

(Pat Ameris): Great.

(Armand Webber): Thank you.

Operator: Your next question comes from the line of (Fran Frolish) from Horizon Blue Cross Blue Shield of New Jersey. Your line is open.

(Fran Frolish): Thank you. This is (Fran Frolish) from Horizon Blue Cross Blue Shield of New Jersey. On the MSP input file, in field 17 is the group policy number. And that number is only required when the coverage type is ZZ 4, 5, and 6. And that group policy number will be returned on the MSP file. We would like to report this group policy number for every record we create. Can we do that?

John Albert: Yes, it's only required for certain, but you may report it, and we will take it in and use it.

(Fran Frolish): OK, so we don't really need to limit ourselves to reporting it for those five coverage types?

(Pat Ameris): Yes.

John Albert: Correct.

(Fran Frolish): That's great. Thank you.

Operator: Your next question comes from the line of Mari Williams from Kaiser. Your line is open.

Mari Williams: Hi. This is Mari Williams from Kaiser Permanente, and one of my colleagues submitted a question, but I didn't hear it answered. So I wanted to ask it. Hundreds of employers' TINs have been marked invalid, and we believe that they're actually valid. We understand the TIN override process, but this depends on our employer group customers' cooperation in providing IRS 147C documentation to us, which is going to take some time to gather. So if we're unable to override an invalid TIN that is truly valid, or if we're unable to locate a valid IRS assigned TIN for an employer group by October, can we still submit records with invalid or pseudo TINs in our …

(Pat Ameris): No.

Mari Williams: … file?

(Pat Ameris): No.

John Albert: No, it'll be …

(Pat Ameris): It's going to reject – the TIN file will – the TIN file record will reject, and any associated MSP records that bumps up against it. So you really have to get valid TINs now, and you really should have done that already. You should not be submitting pseudo TINs any longer anyway. Maybe Jeremy and Bill Ford, who are on the call, in order to – what – I guess the question I have is what information are you asking from an RRE in order to update the system to mark an employer TIN as valid?

Jeremy Farquhar: Well, we're not terribly specific about what the actual documentation might be. We'll pretty much accept any type of IRS document that is actually not filled out by the RRE themselves, you know a pre-populated document, or it could even be something from a local or state government agency, something that's pre-populated by that agency that has both the name and the TIN of the entity, and then we'll take that as verification.

Although, if you're getting hundreds of them, and you feel that you're all valid TINs, perhaps you could – you could give us some examples and we can look into that. This is Jeremy Farquhar, by the way. And if you'd like to send me an e-mail, you can do so. My e-mail is jfarquhar@ehmedicare.com.

Mari Williams: Thank you.

Jeremy Farquhar: And I'll – sure.

(Pat Ameris): Jeremy's e-mail, as the EDI department's supervisor, is in the user guide as well.

Mari Williams: OK, thank you.

(Pat Ameris): Thanks, Jeremy.

Jeremy Farquhar: Sure.

Operator: Your next question comes from the line of Tami Jones from Emmanuel Baptist Church. Your line is open.

Tami Jones: Thank you. This is Tami Jones from Emmanuel Baptist Church. And we are – I apologize if you already addressed this. I had an appointment I couldn't change. I didn't know about this conference call until this morning, and so I was about 30 minutes late coming into the call. But we are a church, and we do not offer Group Health plans for our employees. We offer a HRA amount that's given each month, and then that's to pay for those that have Group Health insurance premiums or copays or vis and dental, and it's not an amount that it's so large that it even usually pays for all of those things.

We did our first reporting in April, and now we have an employee who has Medicare, and she's being denied Medicare, saying the HRA is her primary. And so she's being treated like she doesn't have insurance. They're requiring or asking her to pay for any treatment that she might need ahead you know before she has the procedure.

And now the medical providers are sending the church – we're not an insurance company, we're just a church. We're just employing this individual. They're sending us documents with medical codes that don't even have amounts on them that we're supposed to process, and what – now they're telling – I called those providers and have asked for them you know – or to explain the situation, and they're saying, well, we have to process these forms

with the medical codes that they're getting so that they can generate a statement.

But you know we're not equipped to do that. And so you know we're just trying to figure out how now to care for this employee and how she can get the treatment she needs, and you know how do we report to Medicare to say that HRA is out of money, but then the next money she's going to get money for the previous month. So it's this ongoing vortex that we're – we don't know how to – you know how to process. And she's called Medicare, I've called Medicare. Nobody seems to be able to give us any kind of answers.

Bill Decker: Yes, this is Bill Decker. First of all, we're aware of the general problem that you're having. I'll get to that in a second. But let me ask you this ahead of time. The – what is the annual value of the HRAs that you give to your employees?

Tami Jones: Forty-eight hundred. They get 400 a month.

Bill Decker: Four hundred dollars a month, 4800 bucks a years.

Tami Jones: Yes.

Bill Decker: And they will typically exceed the monthly value of the HRA. There'll be nothing left in it to pay a medical bill?

Tami Jones: Well, like this individual that I'm talking about that turned 65 last fall and now is on Medicare, her – but before she went just on Medicare, her Blue Cross Blue Shield premium was $593 a month. So in previous months, you know before she went onto Medicare, it didn't even pay all of her health insurance policy.

We – what we've done is we've just given each individual this money and then said, OK, you do with it – you know if you want Group Health – or not Group Health insurance, but individual insurance policy, then we'll reimburse you those premium costs, or a few of our employees have decided to not even get insurance. They just are trying to use it to pay out-of-pocket expenses as they

come or vision or dental that aren't covered by their – you know by a policy anyway.

And so – like for this individual now that's on Medicare, she has Medicare, she has another supplemental because Medicare doesn't pay for everything. So her supplemental is $260 a month. So she would have 140 a month that would help pay you know additional costs what – you know whatever she would have that Medicare and the supplemental doesn't pay or any dental or vision that's not covered by either policy.

But now she's getting denied from Medicare. Then the supplemental is denying it because it's – only covers what Medicare covers. So none of the insurance policies that she should be covered under are covering her, and they're sending the bills to us. Well, we're a church. We're not any kind of insurance. You know we're just – we were just going to pay for out-of-pocket – out-of-pocket expenses that were not covered by those insurances, or vision or dental, which are not covered by Medicare anyway.

Bill Decker: You've got a complex problem here. We're going to take it a couple of little pieces. First of all, you're not the only HRA provider that's in this same situation. We've become aware of it in the last couple of months. What's happening is the providers are supposed to know that if they – if there's no primary GHP coverage left anymore, they're supposed to bill Medicare as a secondary payer, and apparently they're not doing that, which is a problem that we can fix.

But there are some other issues here too, and one of them is the supplemental insurance issue that you just raised. And (Bill Zevornia), who's also here with us today, I'd like to have him address that for you.

(Bill Zevornia): The HRA is a Group Health plan. I'm assuming you have at least 20 employees?

Tami Jones: We don't have 20 full-time employees, but we do have …

(Bill Zevornia): Do you have 20 employees …

Tami Jones: Yes.

(Bill Zevornia): … full and/or part-time?

Tami Jones: Yes.

(Bill Zevornia): Yes. Therefore, you're subject to the MSP rules. The MSP rules say that any coverage that you provide that pays for health benefits, directly or indirectly, you must be primary to Medicare. You're providing the funds that are paying the premium for this – for this Blue Cross plan you mentioned. It is illegal – it makes your plan nonconforming to have that policy a supplement to Medicare. It must be primary to Medicare. You can't use that HRA to circumvent your obligations under the MSP laws.

Tami Jones: I'm not – I'm not trying to. What …

(Bill Zevornia): Well, that's what you're doing by saying that there's going to be a supplemental coverage. Any coverage that's provided through the HRA needs to be primary coverage to Medicare.

Male: For working aged.

(Bill Zevornia): For working aged, which you indicated this person is.

Tami Jones: Right. What I'm saying is, once Medicare is denying this claim, then the providers are sending us bills that don't even have amounts on them of what to do. They're documents with medical codes, and I'm not trying to say – what I'm – what I'm – look, the question I need answered is, how do we process this, and you know – like let's say she has a $450 bill that comes due in June, and she gets $400. So we pay 400 of it, but 50 of it doesn't get paid. In – because we – she – because her HRA doesn't have enough money to pay that claim for that thing in June.

But then the first of July, she gets $400 more for the bill – for June, because it's for the month before. Then she has $400 again, but there's 50 that didn't get paid. What happens to that $50? You know then the provider's saying, well, we're not going to bill that to Medicare, because you just have to – she

just has to pay the whole claim. Well, Medicare should be – should be secondary, but it's – she's not getting treated that way.

(Bill Zevornia): No, Medicare – you're missing the point. The plan – the plan must be primary to Medicare. You say she's got a Medicare supplement. Under the rules, the arrangements between the employer – that's you – and the insurer, through the Group Health plan – that's the HRA, the insurer is the Blue Cross plan – are responsible for full charges. Otherwise, you have a nonconforming Group Health plan.

Male: And then once that – those charges are paid appropriately, the provider will then bill Medicare for secondary …

(Bill Zevornia): … to bill Medicare because charges have been paid.

Male: Well, if all charges are the same. But it's the charges …

(Pat Ameris): Once they've exhausted the benefits of the primary insurer, then …

(Bill Zevornia): Well, they did not provide proper primary insurance. We say that the arrangements between the employer, the Group Health plan, which is the HRA, and the insurer, which is the Medicare supplement, are responsible for full charges. And then it basically boils down to that it's the employer's responsibility because they did not set up a conforming Group Health plan.

Tami Jones: How is – I'm not following how our HRA is not a conforming health plan.

(Bill Zevornia): If it's – (because we're) buying – it is funneling money to a Medicare supplement rather than to a Medicare primary plan.

Bill Decker: Based on – this is all based on your description of what your plan is. Can we contact you on …

Tami Jones: So what you're …

John Albert: Can we contact you off line, because this is really going beyond scope of this call, and we have people that need to get their questions answered. Would

you be willing to provide us with your contact information, either here or through an e-mail through the resource mailbox under that subject?

Bill Decker: Yes, you have a very complex problem that we can't really address …

Tami Jones: Well, and can you just clarify this then is what – let me just say this, so if I'm doing something wrong, I don't want to keep doing it. Are you saying that by reimbursing her for her supplemental plan through her HRA that I'm not supposed to do that?

Male: Yes.

Tami Jones: OK. How can we …

John Albert: Well, again, we need to talk about this off-line, because if – we need your contact information because we have 150 people on the call who are here to get section 111 questions answered, and this is clearly outside the scope. So if you want to provide your name and contact information, either here or on the phone or through the resource mailbox.

Bill Decker: It would be better through the resource mailbox.

John Albert: Yes, please do so, and will get someone out to help you.

Bill Decker: On the section 111 Web site, you'll see a section 111 mailbox address. Send a message to that address, and will get back in touch with you after this call

Tami Jones: All right, thank you.

Bill Decker: Sure.

John Albert: All right, thank you.

Operator: Your next question comes from the line of (Heather Wells) from Discovery Benefits. Your line is open.

(Heather Wells): Good afternoon. Again, my name is (Heather Wells) with Discovery Benefits. We are responsible reporting entity for HRA plans, and we have ran into a

couple of instance, where, just like previous caller described, individuals have exhausted their HRA benefits, and they are now being denied for Medicare claims. The difference is, we are not paying Medicare supplementary insurance premiums.

John Albert: We appreciate that. Listen, we're aware of these issues. A lot of – a lot of it comes down to needing to reeducate our providers.

Male: Properly close bills.

John Albert: Yes. Yes. So we are aware of this issue and are working with our provider outreach and education group here within CMS to get communication out to them because we've heard lots of examples of you know of providers not handling this the way they should. HRAs have always been GHP coverage, but they aren't necessarily following proper billing procedures, et cetera. So we are aware of this. And are working hard to make sure those providers are doing what they're supposed to do when it comes to billing.

(Heather Wells): And I understand that. And we are referring those individuals to their local Medicare offices right now, as advised by our EDA representative. My question is, when we report those on the MSP occurrences, should we be reporting the start date of the HRA coverage as the first date that their benefit met or exceeded $1,000, or should we be using the original HRA start date as long as the HRA plan has a potential to meet or exceed $1,000 in benefits?

John Albert: Number two.

(Heather Wells): OK, the original. So even in a case where the individual has a $300 annual benefit but they could, through rollovers, meet or exceed $1,000 eventually, we should report them as soon as they …

Male: Yes.

(Pat Ameris): Not could, have exceeded.

(Heather Wells): Have – oh, OK.

(Bill Zevornia): … even if the benefit is over $1,000, consider it $1,000.

Bill Decker: Right, if you've got a – if you're just starting to report HRA coverage now, and the HRA coverage is going to be for $1,000 or more on an annual basis, then it must be reported. If you're – if you've got an HRA that has $300 in it now, and it may exceed $1,000 in the future, then you don't need to report it now. You just need to report it once it – you'll have to reported in the next cycle once it exceeds $1,000.

(Pat Ameris): And effective, the plan here, where it exceeds 1,000 for that annual.

Bill Decker: Right. Right.

(Heather Wells): OK

Bill Decker: Any HRA on an annual basis, that doesn't make that thousand dollar threshold does not need to be reported, by the way.

(Heather Wells): OK. So we'll have to refine our tracking to make sure that we are tracking that specific plan year, where they exceed $1,000.

So let me ask a follow-up question, then. So let's say, with my example, of the $300 benefit participant, let's say in the third quarter of the year, that individual now exceeds $1,000. Would we then report the date of that the benefit exceeded $1,000, or the original plan year start date of …

Male: The plan year, start date.

(Bill Zevornia): … plan year start date, it seems to me that you just said that October of this year, that your plan year started January 1, it's going to exceed the $1,000. So you're contributing at least $1,000 during the claim year.

(Heather Wells): Well, but we may not know that we're contributing that much until later in the year, is my …

(Bill Zevornia): Is there a potential to contribute the $1,000?

(Heather Wells): There is in potential, but there was a potential as soon as the individual started.

(Bill Zevornia): OK. So how are you – how are you making your contributions?

(Heather Wells): Well, it depends on our employer. We are a third-party administrator for these employers. So it depends on their set up how they design the contributions in their scheduling.

(Bill Zevornia): OK. So if they designed it so that they're $1,000 a year or more, you've got to report it at the start of the year.

(Heather Wells): Yes, and we are doing that, but the issue comes into play when the employer allows rollover dollars from year to year.

(Bill Zevornia): OK, then – that's what Bill mentioned when he said that – if, let's suppose you're only contributing $500 year, and one year, the guy was healthy and didn't require any care, and the next year he got it up to $1,000 in January, then you report it.

(Heather Wells): OK. Thank you.

Bill Decker: Yes, the general response there is this. An HRA is Group Health plan insurance. Consider it as you would any regular Group Health plan insurance coverage. You're going to start a benefit year at a certain date for employee. If the value of the HRA in that benefit year is going – is either $1,000 or more than $1,000, it needs to be reported at the beginning of the benefit year, regardless of how much money is spent, regardless of whether or not any money that is left over in it at the end of the first benefit year is rolled over into the second benefit year.

That's the general rule that we have always had for HRA reporting. Again, if it's under $1,000, you don't need to report it at all, as long as during any benefit year, it stays under $1,000 per benefit year. It's the idea of the benefit year is the same as the idea for any GHP insurance.

And now let's move on to the next question. Thanks.

Operator: Your next question comes from the line of Jamie Johnson from Eflexgroup. Your line is open.

Jamie Johnson: Yes, hi. This is Jamie Johnson with Eflexgroup. I was calling to basically – pretty much related to the two previous callers about HRA. I think I got some of my questions answered. But my question that remains is, if an HRA benefit is exhausted, how then is that communicated to Medicare that that primary HRA has been exhausted?

Male: It's communicated initially to the provider, which submitted the bill to the HRA. The provider who's ways to provider codes to claim, because he submits it to Medicare so that Medicare knows the benefit is exhausted for a period of time.

Jamie Johnson: OK. And that – the examples we've had so far, the providers are submitting the bills directly to the employers – to the participant. They're not coming to us. We're a third-party administrator. We're not a carrier. We don't have the tools to code claims and all that. So I'm not sure how we would report that back to the provider other than being able to provide a statement to the employee, which then they could pass on to the provider. Is that kind of – would that work?

John Albert: I guess the question I have, is what address information are you're submitting on the section 111 file, because that's the information that's used.

Male: By the provider.

John Albert: Yes, that they can use. Unless they're getting information from the beneficiary that contradicts that.

Jamie Johnson: Well, I'm …

John Albert: And like I said, as I mentioned before, we know that there are issues with provider billing and how they're doing it, and they're not doing it correctly. I know that in one example, where claims are routinely rejected, is that their provider, for example, is finding out that the particular benefit year is exhausted, and they are mistakenly billing Medicare for primary payment, when, in fact they should still be billing Medicare for secondary payment, but of course reflecting on that bill, that the primary provider paid zero.

Male: If benefits were exhausted (inaudible) at every post.

John Albert: Yes And that can happen in a regular GHP plan as well as an HRA, so. And they know that, and so that's why, again, we're seeing this as a provider education issue.

Jamie Johnson: OK. OK, thank you.

Bill Decker: OK, we're going to go off-line, just for a second.

John Albert: Hang on just for a second before you ask.

Bill Decker: All right, we're back operator. I guess we can go onto the next question.

John Albert: Yes, we didn't actually address the question that was just asked us, but the answer is still that the provider should be billing correctly, and if the provider is sending a bill to an HRA administrator because the HRA is no longer able to pay for the individual covered bill – individual covered charges, the HRA administrator could go back to the provider and say, "I'm sorry, this is not our responsibility. You need to contact Medicare or the – or the employer."

Bill Decker: Because depending – it depends on you know with HRAs, I mean like some of them are monthly annuities, some are yearly, some are incident until the money runs out or whatever. But I mean the provider needs to bill the primary payer first under the MSP statute. And that's what they're doing. And again, the provider doesn't know what benefit is available, because, again, every HRA is different and everyone runs out of money or has money reestablished at different times. But again, HRA coverage is GHP coverage. And in a case of the MSP statute, it is to be billed for primary payment and then Medicare for secondary payment.

John Albert: Yes, we are in the process of telling all that to all of our millions of providers. But to all of our thousands of insurers, it's useful to know that you need to maybe talk to some of these providers to make sure that they're billing correctly if you find that they're not.

Bill Decker: I mean all I can say is that for whatever reason, you know section 111 brought to light a requirement that has been here long before section 111, and that is there is an MSP statute. And these claims should be billed, in the case of MSPs, that they need to be billed to the proper primary payer first and then to Medicare.

And you know, we – as we hear more about this, of course, from our perspective we will do what we can to do – to facilitate you know outreach to folks. Again, this is very useful to us you know, but clearly there are some folks out there, be it providers or whoever, that you know don't necessarily understand all the processes. But again, under the statute, the HRA coverage's are primary to Medicare. And that has nothing to do with section 111. That's just the way it is. And so we will take this under advisement and move forward with hopefully materials across CMS and out there to educate everyone in terms of their responsibility.

John Albert: And as we get information that we can share with you, we will post it on the section 111 Web site in the form of alerts and other announcements.

Bill Decker: Yes. Definitely.

Male: All right.

John Albert: OK operator, thank you. We can move on now, please.

Operator: Your next question comes from the line of Donna Thrasher from Innovative Employee Benefits. Your line is open.

Donna Thrasher: Thank you. I think you're pretty much on target answering our questions. We're an HRA third-party administrator, having the same issues. And from what I'm hearing from you, that it's a provider education issue as far as our planned payments being primary. So what are we to do in the meantime, when the claims are being denied and they're not coming our way? Medicare's denying the claim, the provider doesn't send us the bill, and our insured's are upset.

John Albert: Yes, I – you know, I don't want to, like, you know, give you official guidance in terms of some of these issues that really are a little bit beyond our full scope of knowledge in terms of the processes. But you know in the meantime, you know anyone can remind the provider that you know the HRA in this situation should be billed and that you know documentation on the – on the response needs to indicate you know what the payment was and that that provider should be told the bill Medicare for secondary payment after you know you've responded to their bill.

Like I said, I know one of the common things that's occurring is that providers are just assuming because the benefit is exhausted, that there is no longer an MSP record, which is just not true. I know that's a very common thing. And again, for folks that are you know dealing with that issue, it certainly can't hurt to remind that provider, hey, there is a valid MSP record out there. You need to submit to Medicare for secondary payments.

Bill Decker: And like (Bill Zevornia) was saying, I mean they're supposed code that claim correctly. But that's not something that this group right here can necessarily cause to occur. We have to work with our folks, which we're doing, in CMS that you know basically you know run that show, so to speak. I mean Medicare's a big business, as you know, so.

John Albert: The answer to your immediate question, what should we do in the meantime is go back to the provider. Tell them that Medicare's probably secondary and they should bill Medicare that way.

Donna Thrasher: And so that there's no way – that you're saying that there's no real way that we, as the TPA – the HRA TPA, can file an EOB, say, directly with Medicare, on what we …

John Albert: That's correct.

Donna Thrasher: There's no way to do that, is what you're saying.

John Albert: Yes, that's correct.

Donna Thrasher: OK, well, that's what we will looking for, and obviously that's why we can't find it, because it doesn't exist, the procedures.

Male: Yes.

Donna Thrasher: OK. Thank you.

Operator: Your next question comes from the line of (Lisa Logard) from Jaeger & Flynn Associates. Your line is open.

(Lisa Logard): We are a third-party administrator, like many of the most recent callers, and what I wanted to share with anybody who's on the line just some ideas about what we have done. I'm sorry this is outside of the reporting scope out of section 111, but for those of us who are swimming in this everyday and trying to help out these Medicare beneficiaries, it's becoming an overwhelming task.

We've provided ID cards and given them to our beneficiaries and told them give this to all of their providers and show it to them and give them these handouts that say, "Don't bill Medicare. Please don't bill Medicare." And we'd just take scores of calls everyday and handle each one as best we can.

When I had originally asked to be put in the queue, I had wanted just to voice a request that when you do have that off line conversation or if you pass that on to whatever entity should have that off line conversation with the woman who was calling in from the church, we would very much like to be part of that same call. And hopefully …

John Albert: OK, that would be fine. Yes, again, send a – your contact information to the resource mailbox on the Web site.

(Lisa Logard): OK.

Bill Decker: Yes, and actually, in terms of you know like the best practices, I mean this – that's – I mean I thank you for you know those suggestions, because that's the kind of stuff that you know, again, you know once we work with the you know provider education group here in CMS, I mean you know they may

want resources of you know people that would be willing to offer their feedback as well directly.

So if you wouldn't mind documenting that on the – you know in your note to the resource mailbox, that would be very useful. You know like I said, we're always looking to partner with different organizations to make this work as smoothly as possible. And we're very interested in you know that kind of constructive input.

(Lisa Logard): We'd be happy to. And for anybody who's out there, again, who's struggling with this type of information, if you want to look even myself up on Linked In, (Lisa Logard) at (Jagrines) & Associates, we could start conversations and develop best practices with each other for firms all across the nation.

John Albert: Thank you.

Operator: Your next question comes from the line of (Bridget Bowman) from SJH Agency, Inc. Your line is open.

(Steve): Hi. This is (Steve) from SJH Agency. We do some CPA work here. And we find a situation where we've got an employer who just has an HRA, and they're set up to reimburse employees once the employee sends a claim in for all kinds of things, not just what might be normally in the – of the major medical plans.

But the point is, is there – I don't think they're equipped to send checks to providers. Theirs is a reimbursement plan for employees have incurred out-of-pocket expenses. So we're having a little difficulty instructing the client what to do. Perhaps we should tell them that they have to pay the provider and not wait until the employee's out of pocket and reimburse them.

John Albert: Yes, I don't – I mean I don't want to – I don't want to waste your time in terms of – I mean this is – this is a conversation that we're – really, we can't provide those kind of answers to. We're just not equipped with the knowledge of that entire process and what needs to be done. So again, we're going to – we working with that provider education group to …

Bill Decker: Whatever the situation is, if that's insurance coverage, it's GHP, and that needs to be reported to us under the terms of the section 111 reporting process by somebody, whoever is administering that program, regardless of how it's structured.

Male: But I mean we've – we have received you know very similar comments to yours, and you know are going to be discussing that with them, for sure. But we're not involved in claims payments at all. That is COB, the scope of the COB contract other than claims crossover, and these are all areas that are kind of outside of our sphere of influence, in that sense. So we have to take this information to that particular component you know and have them officially addressed to providers directly. Again, we …

(Steve): Is that something that we can …

Male: … thank everyone for that information, because you know we knew that we were going to get these kind of questions, because we knew ahead of time you know kind of what the process was for certain types of entities like this and have been documenting that and attempt to bring that up as the purposes of reporting. It is GHP, and it's reportable.

So this – I mean the good that comes out of this is that I'm hoping that you know once this all you know bubbles up and you know this can be addressed, then in the future we won't have these issues, I mean which is sometimes these reporting requirements have the effective ceiling identifying weaknesses in the current process.

John Albert: And it may be useful for everybody on the call to try to keep in mind the section 111 reporting is reporting about coverage. It's not reporting about payment. It's not reporting about billing. It's reporting only about the fact that there is coverage being provided to a Medicare beneficiary.

(Steve): And I understand.

John Albert: Right.

(Steve): I'm just looking for a direction anywhere we can get it.

Male: No, I totally understand it. Like I said, this has been made a priority for a couple of people in this unit and to try to get that information out and get people straightened up. So because we know that – we know, like I said, for example, there are issues with the providers and with – and we – and we have the authority to make them do what they should do, so.

(Steve): Thank you.

Operator: I'm showing no further questions at this time.

John Albert: Are there any questions about the actual reporting? That's what we'd like to hear, especially with – especially the fact that we do have a couple of resources from the COB contractor on the call. So we'll give it 10 more seconds for any reporting issues. Going once, going twice. No one else, operator?

Operator: There are still no questions in the queue.

John Albert: (Inaudible). All right, well, we'd like to thank everyone. This was a good conversation. Again, in terms of comments regarding HRA issues, or even like we said, beyond the section 111, you know that's – anyone who (inaudible) for the next couple of weeks regarding particular issues surrounding claims, processing payment, whatever, we can take that information and compile that and get that to the folks who CMS who need to see it. We thank everyone for the very thorough input on this.

Stay tuned for the section 111, the Mandatory Insurer Reporting Web page for any future calls. Like I said, there are none currently posted, but we do have plans on establishing at least one more call before the end of the fiscal year. And then we'll start again come October 1.

Other than that, thank you very much. And if, operator, you could come back in after releasing everyone.

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