MMSEA Section 111
MSP Mandatory Reporting

GHP User Guide

Version 7.9

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Chapter 1: Summary of Version 7.9 Updates

The following updates have been made in Version 7.9 of the MMSEA Section 111 GHP User Guide:

Verbiage has been added to clarify that a member's most current Medicare ID will be provided when a match is found (Appendix A, Appendix B, Appendix C, Appendix H).

To improve efficiency, files that have been in MSP HOLD (TIN) error status or Severe Error status will automatically be deleted after 50 days (Sections 8.3.1, 9.5.1, and 9.5.2).

The "as of" date has been removed since implementation of the additional insurer names (Appendix D).

Chapter 2: Introduction

This guide provides information and instructions for the Medicare Secondary Payer (MSP) Group Health Plan (GHP) reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173). An overview of Section 111 related legislation, MSP rules, and the GHP reporting process is followed by detailed instructions and process requirements. Complete explanations of entities that are required to report and how this reporting will be implemented are included in this guide. File specifications are located in appendices to this guide for easy reference.

This guide also provides information and instruction for mandatory reporting requirements for Medicare beneficiaries who have prescription drug coverage under GHP arrangements. Section 4002 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act ("the SUPPORT Act") mandates the reporting of primary prescription drug coverage information, in addition to the existing Section 111 reporting requirements. All GHPs that offer primary prescription drug coverage are required to report this coverage for each calendar quarter.

This guide is for use by all Section 111 GHP Responsible Reporting Entities (RREs).

Please note that CMS is implementing the Section 111 requirements in phases. As time passes and we gain experience with Section 111 reporting, the data exchange requirements will continue to be refined and new processes added when necessary. CMS will issue revised versions of the Section 111 GHP User Guide from time to time. Please check the CMS Section 111 Mandatory Insurer Reporting for Group Health Plans Web pages often at https://go.cms.gov/mirghp for the latest version of the user guide and for other important information. The GHP User Guide can be found at the following link: GHP User Guide.

To be notified via email of updates to the GHP or any CMS.gov webpage, enter your email address in the "Get email updates" section at the bottom of any CMS.gov webpage, and choose which topics for which you want updates. When new information regarding those topics is available, you will be notified. These announcements will also be posted to the GHP **What's New** page. Additional information related to Section 111 can be found on the login page of the Section 111 Coordination of Benefits Secure Website (COBSW) at https://www.cob.cms.hhs.gov/Section111/.

Note: Frequently, CMS will publish new information in the form of an alert which is then incorporated in subsequent versions of the user guide. Information in published Section 111 alerts supersedes information published in the user guide. To obtain the most up to date information and requirements related to Section 111 reporting, be sure to review not only the user guide but any pertinent alerts published subsequent to the current version of the user guide.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that RREs may use to send CMS policy-related questions regarding the MSP reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. RREs are requested to send only policy-related questions to the Section 111 Resource Mailbox.

If you have a technical question, or if you are unable to contact your Electronic Data Interchange (EDI) Representative, for any reason, call the EDI Hotline at (646) 458-6740. If you have not registered to become an RRE, please contact the Benefits Coordination & Recovery Center (BCRC) directly at 1-855-798-2627.

Chapter 3: MMSEA Section 111 Overview

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111) adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Implementation dates were January 1, 2009, for GHP arrangement information and July 1, 2009, for information concerning liability insurance, no-fault insurance and workers' compensation.

The provisions for GHP arrangements found at 42 U.S.C. 1395y(b)(7):

- Add reporting rules; do not eliminate any existing statutory provisions or regulations.
- Include penalties for noncompliance.
- Contain provisions for the Secretary to share information on Part A entitlement and enrollment under Part B.
- Include who must report: "an entity serving as an insurer or third-party administrator for a group health plan…and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary."
- Include what must be reported: data elements determined by the Secretary.
- Specify that reporting must be done in a form and manner, including frequency, specified by the Secretary. GHP reporting will be done on a quarterly basis in an electronic format.

The Medicare program may collect primary payer information from other sources, but Section 1862(b)(7) of the Act imposed unique reporting requirements on specific entities to report data to CMS. Such data must also be reported to CMS in the manner and form specified by the Secretary regardless of whether another party may have reported the same or similar data to CMS or another Federal agency or entity, or even if the RRE itself reported similar information to CMS through another process (unless otherwise specified by CMS, such as in the event of a settlement).

Note: You must use the statutory language at 42 U.S.C. 1395y(b)(7) together with the "Definitions and Reporting Responsibilities" document published in conjunction with the Paperwork Reduction Act Federal Register Notice for Section 111 to determine if you are a "responsible reporting entity" for purposes of the Section 111 mandatory GHP reporting requirements. See Appendix E and Appendix F.

Chapter 4: Medicare Entitlement, Eligibility, and Enrollment

This section provides a general overview of Medicare entitlement, eligibility, and enrollment. Please refer to https://www.cms.gov for more information on this topic.

Medicare is a health insurance program for:

- People aged 65 or older,
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (ESRD) (i.e., permanent kidney failure requiring dialysis or a kidney transplant).

4.1 Medicare Coverage

Medicare includes the following:

Part A Hospital Insurance—Most people receive premium-free Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance, or HI) helps cover inpatient care in hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance—Most people pay a monthly premium for Part B. Medicare Part B (Supplemental Medical Insurance, or SMI) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part C Medicare Advantage Plan Coverage—Medicare Advantage Plans are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans.” These plans are an alternative to the fee-for-service Part A and Part B coverage and often provide extra coverage for services such as vision or dental care.

Part D Prescription Drug Coverage—As of January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Private companies provide the coverage. Beneficiaries choose the drug plan they wish to enroll in, and most will pay a monthly premium.

Throughout, Medicare has various coverage and payment rules which determine whether or not a particular item or service will be covered and reimbursed.

Section 111 states that CMS will share Medicare Part A entitlement and Part B enrollment information with GHP responsible reporting entities (RREs). As of July 2019, CMS started sharing Part D enrollment information with RREs that report primary prescription drug coverage. In your response files you will get information about beneficiary eligibility and enrollment.

4.2 Eligibility vs. Enrollment

The distinction between an individual's benefit **eligibility** and benefit **enrollment** can be confusing. While it sometimes appears that the two terms are used interchangeably, for CMS they have very different and distinct meanings.

Once an individual is a Medicare beneficiary, that person is then **eligible to participate** in Medicare's benefit programs, including Part D. Usually, the Medicare beneficiary can choose to participate, and if the beneficiary does, the first day the beneficiary's participation is effective is **the date of enrollment** in the benefit program. For example, individuals who have aged into Medicare Part A are then eligible to enroll in Medicare Parts B and D, if they so choose. Once an application for enrollment is accepted, the beneficiary's effective date of enrollment is established.

In summary, an eligible Medicare beneficiary may participate in Medicare program benefits beginning on the beneficiary's date of enrollment in the benefit program. For beneficiaries who choose to participate in the Part B and D programs, the date of enrollment is, usually, the first day of the following month.

Chapter 5: MSP Overview for GHP

The following paragraphs provide only a very high-level overview of the MSP provisions. Employers, insurers, third-party administrators, group health plans, and other group health plan sponsors are always responsible for understanding when they are providing coverage primary to Medicare, and for paying appropriately. See 42 U.S.C. 1395y(b), and 42 C.F.R. Part 411, for the applicable statutory and regulatory provisions, and CMS manuals and Web pages for further detail. There are also computer-based training (CBT) modules available for Section 111 RREs that cover basic MSP topics. See Chapter 19 to learn how to enroll in these courses free of charge.

Some people who have Medicare also have group health coverage. Often, employer-provided group health coverage must pay before Medicare does. In that case, Medicare is the secondary payer. Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans' benefits. Since 1980, new laws have made Medicare the secondary payer for several additional categories of people. The additional categories of people for whom Medicare is the secondary payer are described below.

5.1 Medicare Secondary Payer

Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first.

The terms "Medicare supplement" and "Medicare secondary payer" are sometimes confused. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program. Private "Medigap" insurance and Medicare secondary payer law and regulations are not the same.

Federal Medicare law takes precedence over conflicting State law and private contracts. Thus, for the categories of people described below, Medicare is secondary payer regardless of state law or plan provisions.

5.2 Who Does MSP Affect?

Medicare is now secondary payer to some group health plans (GHPs) or large group health plans (LGHPs) for services provided to the following groups of Medicare beneficiaries:

- The "working aged,"
- People with permanent kidney failure, and
- Certain disabled people.

5.2.1 Working Aged

The "working aged" are employed people age 65 or over and people age 65 or over with employed spouses of any age who have GHP coverage because of their or their spouse's current

employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship.

Medicare is secondary payer to GHPs for the "working aged" where either:

- a single employer of 20 or more full and/or part-time employees is the sponsor of the GHP or contributor to the GHP, or
- two or more employers are sponsors or contributors to a multi-employer/multiple employer plan, and at least one of them has 20 or more full and/or part-time employees.

When determining the "20 or more threshold," employers (i.e., individual or wholly-owned entities) with more than one company must follow the IRS aggregation rules. The relevant IRS codes can be found in 26 U.S.C. sections 52(a), 52(b), 414 (n) (2).

There is one exception to the employer size rule for beneficiaries entitled due to age: A multi-employer/multiple employer GHP may request to exempt specific working aged people enrolled through an employer with fewer than 20 full and/or part-time employees. If CMS approves the request, Medicare will become primary payer for specifically identified working aged people enrolled through a specifically identified employer with fewer than 20 full or part-time employees. The GHP must be able to document its request and/or CMS approval of its request to exempt such individuals. See the Small Employer Exception Section 8.5 for more information.

5.2.2 People with Permanent Kidney Failure

Medicare is the secondary payer to GHPs during a 30-month coordination period for beneficiaries who have permanent kidney failure (End Stage Renal Disease or ESRD), and who have coverage under a GHP on any basis (current employment status is not required as the basis for coverage). The coordination of benefits period applies regardless of the number of full and/or part-time individuals employed by an employer and regardless of whether or not the employer belongs to a multi-employer/multiple employer GHP.

5.2.3 Disabled People

Medicare is the secondary payer for people under age 65 who have Medicare because of disability and who are covered under a Large Group Health Plan (LGHP) based on the individual's (or a family member's) current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship. A LGHP provides health benefits to employees, former employees, the employer, business associates of the employer, or their families, where the employer has 100 or more full and/or part-time employees. Where an employer of any size is part of a multi-employer/multiple employer GHP, Medicare is secondary for individuals who have Medicare because of a disability if one or more of the employers in the GHP has 100 or more full and/or part-time employees.

5.3 Making MSP Work

The entities under contract to pay Medicare claims ("Medicare contractors") are responsible for denying claims for primary benefits when Medicare is secondary payer. In making claims processing decisions, the Medicare contractors use information on the claim form and in CMS data systems in order to avoid making primary payments in error. Where CMS' systems indicate an MSP occurrence, Medicare will deny payment. In such cases, Medicare will not pay the claim as a primary payer and will return it to the claimant with instructions to bill the proper party.

Sometimes, after a Medicare claim is paid, CMS receives new information that indicates Medicare made a primary payment by mistake. Based on this new information, CMS takes action to recover the mistaken Medicare payment. CMS uses its Commercial Repayment Center (CRC) which is responsible for all of the functions and workloads related to GHP MSP recovery with the exception of provider, physician, or other supplier recovery activities or actions. The CRC issues a demand letter for repayment to any or all the parties obligated to repay Medicare (the employer, insurer, third party administrator, plan, or other plan sponsor.) If the CRC does not receive repayment or a valid documented defense in response, it will refer the debt to the Department of the Treasury for the Treasury Offset Program and other cross-servicing activities pursuant to the Debt Collection Improvement Act of 1996. **CMS may also refer debts to the Department of Justice for legal action if it determines that the required payment or a properly documented defense has not been provided.** The law authorizes the Federal government to collect double damages from any party that is responsible for resolving the matter, but which fails to do so.

5.4 Role of the Medicare Benefits Coordination & Recovery Center

The purposes of the Coordination of Benefits (COB) program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The CMS Benefits Coordination & Recovery Center (BCRC) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The BCRC does not process claims, nor does it handle any mistaken payment recoveries or claims-specific inquiries. Instead, the BCRC updates the Medicare systems and databases used in the claims payment and recovery processes. The BCRC has been directed by CMS to implement the MSP requirements of the MMSEA Section 111 legislation as part of its responsibilities to collect information in order for CMS to coordinate benefits for Medicare beneficiaries.

5.5 Where to Find MSP Regulations

The sections of the Social Security Act known as the Medicare Secondary Payer (MSP) provisions were originally enacted in the early 1980s and have been amended several times, including by the MMSEA Section 111 mandatory reporting requirements. See section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b). See 42 CFR Part 411 for the applicable regulations. Medicare has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965.

Additionally, the SUPPORT Act, which was signed into law on October 24, 2018, requires mandatory reporting of primary prescription drug coverage through the Section 111 process. See also H.R. 6, Public Law No: 115-271 for details regarding the SUPPORT Act.

Chapter 6: The GHP Reporting Process

6.1 Overview

The purpose of the Section 111 GHP reporting process is to enable CMS to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 authorizes CMS and Section 111 GHP responsible reporting entities (RREs) to electronically exchange health insurance benefit entitlement information. The actual data exchange process takes place between the RREs and the CMS Benefits Coordination & Recovery Center (the BCRC). The BCRC manages the technical aspects of the Section 111 data exchange process for all Section 111 RREs.

On a quarterly basis, a responsible reporting entity must submit group health plan (GHP) entitlement information about employees and dependents to the BCRC. In exchange, the BCRC will provide the RRE with Medicare entitlement information for those individuals in a GHP that can be identified as Medicare beneficiaries. This mutual data exchange helps to assure that claims will be paid by the appropriate organization at first billing. RREs also have the option of submitting primary prescription drug coverage information, which will become required for quarters after January 1, 2020.

The Section 111 GHP reporting process includes an option to exchange supplemental prescription drug coverage information to coordinate benefits related to Medicare Part D. CMS also allows RREs that are also participating in the Retiree Drug Subsidy (RDS) program or are reporting to RDS on behalf of a plan sponsor to use the Section 111 GHP reporting process to submit subsidy enrollment (retiree) files to the RDS Center.

Section 111 RREs are required to register with the BCRC and fully test the GHP data reporting exchange before submitting production files. You will be assigned a production file submission timeframe during which you are to submit your files on a quarterly basis. Once you are in a production mode, you will submit your initial file containing GHP coverage information for all individuals meeting the definition of an Active Covered Individual, or Active Covered Individuals identified as Medicare beneficiaries through the query process. Subsequent quarterly file submissions are to contain only new or changed coverage information using add, delete and update transactions. These requirements are explained in later sections of this user guide.

The data exchanged through the Section 111 GHP reporting process is arranged in multiple files with different record layouts. A responsible reporting entity (RRE) electronically transmits a data file to the BCRC. The BCRC processes the data in this **input file** by first editing the incoming data. Other insurance information for Medicare beneficiaries derived from the input file is posted on the Medicare Common Working File (CWF) and the Medicare Beneficiary Database (MBD) by the BCRC for use by other Medicare contractors for claims processing and recovery efforts. When this processing is completed or the prescribed time for response file generation has elapsed, the BCRC electronically transmits a **response file** back to the responsible reporting entity. The response file will include information on any errors found, disposition codes that indicate the results of processing, and Medicare entitlement/enrollment information as prescribed by the particular file format.

In ordinary circumstances it will always be an input file that will generate a response file.

6.2 GHP Reporting Options

Pursuant to Section 111, the Secretary of Health and Human Services (HHS) has determined that GHP RREs are to provide CMS with information regarding hospital and medical GHP coverage they make available to Medicare beneficiaries. As required by the SUPPORT Act, GHPs are required to submit primary prescription drug coverage information using the Section 111 reporting process. Section 111 also provides for CMS to share information regarding a beneficiary's Medicare Part A (hospital) entitlement, Part B (medical), and Part C (Medicare Advantage), and Part D (prescription drug) coverage in return. There are two reporting options available—Basic and Expanded—in the Section 111 GHP reporting process.

The **Basic Reporting Option** reflects the minimum requirements you must adhere to in order to comply with Section 111. The Basic Reporting Option allows you to submit hospital and medical coverage as well as primary prescription drug coverage information. RREs that offer primary prescription drug coverage are required to report this coverage.

The **Expanded Reporting Option** includes the minimum requirements for Section 111 plus the exchange of secondary or supplemental prescription drug coverage information. You will then receive response files with entitlement and enrollment information for Medicare Parts A, B, C, and D.

The following sections explain each option in further detail. Complete explanations of the file types listed follow in later sections of this guide.

6.2.1 Basic Reporting Option

The Basic Reporting Option represents the minimum requirements you must adhere to for compliance with the Section 111 requirements. The Basic Reporting Option includes submission of the Medicare Secondary Payer (MSP) Input File for hospital and medical coverage of Active Covered Individuals and, optionally, the Query Only Input File, in the form of an ANSI X12 270/271 Entitlement Query file, along with the corresponding response files. In response, the BCRC will return Medicare Parts A, B, C, and D eligibility information and Parts A, B, and C enrollment information. In addition to your hospital and medical reporting, you can also submit primary prescription drug coverage. If you do submit primary prescription drug coverage information, you will also receive Medicare Part D enrollment information.

Table 6-1: MMSEA Section 111 Basic GHP Reporting Option Files

File Type	Description
GHP MSP Input File	This is the data set transmitted from a MMSEA Section 111 responsible reporting entity (RRE) to the BCRC that is used to report information regarding Active Covered Individuals whose GHP coverage may be primary to Medicare.
GHP MSP Response File	This is the data set transmitted from the BCRC to the MMSEA Section 111 RRE after the information supplied in the RRE's MSP Input File has been processed.
TIN Reference File	The TIN Reference File consists of a listing of each business entity's Federal tax identification number (TIN) and the business mailing address that is linked to that particular TIN.
TIN Reference Response File	This is the data set transmitted from the BCRC to the RRE after the information supplied in the RRE's TIN Reference File has been processed.

File Type	Description
Query Only Input File	This is a query file used to obtain Medicare Part A entitlement and Parts B and C enrollment information of potential Medicare beneficiaries.
Query Only Response File	After the BCRC has processed the Query Only Input File it will return the Query Only Response File with Medicare Parts A, B, C, and D eligibility information and Parts A, B, C, and D enrollment information (Part D enrollment will be (or is) returned for primary prescription drug coverage) for individuals identified as Medicare beneficiaries.

6.2.2 Expanded Reporting Option

The Expanded Reporting Option is similar to the former insurer VDSA/VDEA process. It includes submission of the MSP Input File for primary medical, hospital and prescription drug coverage for Active Covered Individuals, the Non-MSP Input File with supplemental prescription drug coverage records, optional Retiree Drug Subsidy (RDS) reporting and entitlement/enrollment query capability, and the optional Query Only Input File, in the form of an ANSI X12 270/271 Entitlement Query transaction set. The BCRC will provide response files with entitlement/enrollment information for Medicare Parts A, B, C, and D with this option.

The Expanded Reporting Option represents the minimum you must adhere to for compliance to the Section 111 requirements plus the exchange of supplemental or secondary prescription drug coverage information. If you choose the Expanded Reporting Option, you must provide supplemental drug coverage records or RDS retiree file records on the Non-MSP Input File.

If you maintain a Coordination of Benefits Agreement (COBA) with CMS for the purposes of receiving claims paid by Medicare for secondary payment by your plan, then you may submit supplemental prescription drug information using the COBA Drug Coverage Eligibility (E02) records and remain compliant with the requirements of the Section 111 Expanded Reporting Option. Note that we ask for this information during the Section 111 registration process. The BCRC will track your COBA submissions accordingly.

Table 6-2: MMSEA Section 111 Expanded GHP Reporting Option Files

File Type	Description
GHP MSP Input File	This is the data set transmitted from a MMSEA Section 111 responsible reporting entity (RRE) to the BCRC that is used to report information regarding Active Covered Individuals whose GHP coverage may be primary to Medicare.
GHP MSP Response File	This is the data set transmitted from the BCRC to the MMSEA Section 111 RRE after the information supplied in the RRE's MSP Input File has been processed.
TIN Reference File	The TIN Reference File consists of a listing of each business entity's Federal tax identification number (TIN) and the business mailing address that is linked to that TIN.
TIN Reference Response File	This is the data set transmitted from the BCRC to the RRE after the information supplied in the RRE's TIN Reference File has been processed.
GHP Non-MSP Input File	This is the data set transmitted from a MMSEA Section 111 RRE to the BCRC that is used to report information regarding the drug insurance coverage information of Inactive (e.g., not employed, retired) Covered Individuals.

File Type	Description
GHP Non-MSP Response File	This is the data set transmitted from the BCRC to the MMSEA Section 111 RRE after the information supplied in the Non-MSP Input File has been processed.
Query Only Input File	This is a query file used to obtain Medicare Part A entitlement and Parts B and C enrollment information of potential Medicare beneficiaries.
Query Only Response File	After the BCRC has processed the Query Only Input File it will return the Query Only Response File with Medicare Parts A, B, C, and D coverage information (Part D enrollment will be (or is) returned for primary prescription drug coverage) for individuals identified as Medicare beneficiaries.

Chapter 7: GHP Mandatory Reporting Requirements

7.1 Who Must Report: Responsible Reporting Entities

A GHP organization that must report under Section 111 is defined as "an entity serving as an insurer or third-party administrator for a group health plan…and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary." These organizations are referred to as Section 111 GHP responsible reporting entities, or RREs. **Note**: You must use the definitions given in Appendix F when determining whether you are a responsible reporting entity under this provision.

The SUPPORT Act mandates the reporting of primary prescription drug coverage by GHP RREs. The entity considered to be the RRE for the purpose of reporting primary prescription drug coverage will depend upon how the employer or other plan sponsor facilitates its prescription drug coverage benefit. The RRE for the primary prescription drug coverage reporting is the entity that has the direct relationship with the employer or other plan sponsor regarding the provision of this benefit.

The group health plan arrangements of multi-national organizations, foreign nations, American Indians and Alaskan Native Tribes that may cover Medicare beneficiaries are subject to the MSP provisions and must be reported accordingly.

7.2 Use of Agents

Note: See the discussion of "agents" with respect to GHP reporting in Appendix F.

GHP RREs may use agents to submit data on their behalf. An agent is a data services company, consulting company, or the like that can create and submit Section 111 files to the BCRC on behalf of the RRE. Information on the use of agents is required as part of the Section 111 registration process. The RRE remains solely responsible and accountable for adhering to the requirements of the Section 111 program and for the accuracy of data submitted.

7.3 Whose Information Must I Report?

7.3.1 Active Covered Individuals

Section 111 GHP RREs are required to report information for Medicare beneficiaries, who have GHP coverage which is primary to Medicare and Medicare is the secondary payer, on the MSP Input File. Since an RRE may not know whether a covered individual is a Medicare beneficiary, CMS is providing two approaches for RREs to determine whom to report for Section 111. The first involves reporting on individuals defined as "Active Covered Individuals." The second involves using a "finder file" to query on an individual's Medicare entitlement and enrollment to determine whether an individual should be included in the MSP Input File. The finder file method is described in Section 7.3.2.

Note: Under no circumstances should these two reporting options be construed as requiring RREs to report on individuals who are not Medicare beneficiaries. Instead, these two options, properly executed, allow RREs to identify and report on all individuals who have Medicare and for whom Medicare is the secondary payer of benefits, as required by the Section 111 legislation.

The definition of an Active Covered Individual is set forth below. Active Covered Individuals are to be reported on the RRE's Section 111 MSP Input File. In many cases, the GHP coverage being reported will be primary to Medicare. When an RRE uses this reporting method, the BCRC will determine whether the Active Covered Individual is a Medicare beneficiary based upon the information submitted and whether the GHP coverage reported is primary to Medicare. The results of that determination are provided back to the RRE on the MSP Response File. The phrase "current employment status" in the definition below refers to the subscriber's employment status. This includes employees who may be in a temporary disability status. It does NOT include a subscriber who is a retiree covered by an employer's retirement plan. Note that the part of the definition related to individuals with ESRD does not depend on the current employment status of the subscriber. However, except in certain circumstances where the retiree has ESRD, individuals covered by a retiree plan would never be considered Active Covered Individuals and should NOT be reported to CMS as Active Covered Individuals on the MSP File. Please refer to the MSP Overview for GHP (Chapter 5) for further information on MSP rules.

For purposes of reporting, an Active Covered Individual is defined as someone who may be Medicare eligible and currently is employed, or the spouse or other family member of a worker who is covered by the employed individual's GHP and who may be eligible for Medicare and for whom Medicare would be a secondary payer for these individuals. On the MSP Input File, CMS is requiring an RRE using the Active Covered Individual definition to report for Section 111 to include all of the individuals covered by the GHP for whom, if they had Medicare, Medicare would be a secondary payer of their GHP benefits. The BCRC will determine if the Active Covered Individual is a Medicare beneficiary based upon the information submitted and whether the GHP coverage overlaps Medicare coverage. The results of this determination are then provided to the submitter on the returned MSP Response File.

For purposes of Section 111 reporting, Active Covered Individuals are further defined to include:

- All individuals covered in a GHP age **45 through 64** who have coverage based on their **own or a family member's** current employment status.
- All individuals covered in a GHP age **65 and older** who have coverage based upon their **own or a spouse's** current employment status.
- All individuals covered in a GHP who have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status and regardless of their age.
- All individuals covered in a GHP who are under age 45, are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status. **When reporting individuals under age 45 in the MSP Input File, you must submit their Medicare ID, which can be the Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI).**

Note: The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.

With one exception, coverage through COBRA is not considered GHP coverage. Therefore, an individual covered by a COBRA plan is not considered an Active Covered Individual and should not be reported on the MSP Input File. The exception involves active dialysis treatment or kidney transplant. If the COBRA covered individual is receiving dialysis or has had a kidney transplant, the individual is considered an Active Covered Individual for reporting purposes.

Additional Notes on Active Covered Individuals:

- If an employer has less than 20 full and/or part-time employees as defined in 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170, and the employer is not part of a multi-employer/multiple employer GHP, then the covered individuals under that plan do not have to be reported under Section 111 unless a covered individual is receiving dialysis or has had a kidney transplant (ESRD).
- The fact that an employer has less than 20 full and/or part-time employees is **NOT** a basis for excluding such employees from the Section 111 GHP reporting process if the employer is part of a multi-employer/multiple employer GHP. Please also refer to the section of this user guide discussing the Small Employer Exception (Section 8.5) and Appendix G.
- The size of the employer is not relevant with respect to reporting for individuals who have been receiving kidney dialysis or have received a kidney transplant (ESRD).
- The MSP provisions for the disabled apply to all employers in a multi-employer/multiple employer GHP if one or more of the employers has 100 or more full and/or part-time employees as defined in 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170.
- See Appendix G for more information on the calculation of employer size and how that affects MSP and reporting of Active Covered Individuals.
- Regarding reporting individuals under the age threshold who are "known to be entitled to Medicare," CMS expects that the RRE "knows" that an individual is entitled to Medicare when they have a Medicare ID (HICN or MBI) on record, or the RRE is paying primary or secondary to Medicare for a covered individual that has GHP coverage due to the subscriber's current employment status. In this case, the RRE "knows" that the individual is entitled to Medicare and should submit a record for this person with the Medicare ID on the MSP Input File. This means that the RRE should check their internal enrollment, "other insurance" or coordination of benefits files or claims payment records for these circumstances. However, it does not imply that the RRE should send an MSP Input record or query record for every covered individual under the age threshold to determine Medicare entitlement if the RRE has no reason to believe these individuals are entitled to Medicare.
- GHP RREs who submit quarterly HEW Query Files, in the MSP Input Files, do not need to submit individuals ages **45 through 64** who receive Disposition Code 51 in their Query Response File. Continue to submit those individuals in the HEW Query File. When they receive a Disposition Code 01, begin reporting MSP coverage.

Examples of Active Covered Individuals:

- A subscriber, age 55, is an employee of a company that has had more than 19 employees for the last several years. The subscriber's spouse, age 46, is also covered by the plan. In this case, both the subscriber and their spouse are Active Covered Individuals due to age. Coverage information should be submitted on the MSP Input file for each on separate reporting records.
- A subscriber, age 44, is an employee of a company that has had more than 19 employees for the last several years. The subscriber's spouse, age 56, and their son, age 10, are also covered by the plan. In this case, only the spouse qualifies as an Active Covered Individual since the spouse is over the age threshold. Only the spouse's GHP coverage information should be submitted on the MSP Input File.

- A subscriber, age 44, is an employee of a company with any number of employees. The subscriber's son, age 10, is also covered by the plan. The son is known to have ESRD and be entitled to Medicare. In this case, the son is an Active Covered Individual, but the subscriber is not. GHP coverage information for the son should be submitted on the MSP Input File. **Since the son is under 45, his Medicare ID (HICN or MBI) must be included.**
- A subscriber is a retiree and the subscriber and their spouse are covered by the GHP through the subscriber's retirement plan. Neither is known to have ESRD. Neither is considered an Active Covered Individual since the subscriber is not currently employed. No information should be sent on these individuals on the MSP Input File.
- A subscriber is an employee of a company that has had more than 19 employees for the last several years and the subscriber and their spouse are both 67. The subscriber's spouse is not covered by the GHP. Only the subscriber is an Active Covered Individual since their spouse is not covered by the plan. Only information on the subscriber will be sent on the MSP Input File.
- A subscriber, age 66, is an employee of a company that has had less than 20 employees for the last several years. The subscriber is not known to have ESRD and not known to be a Medicare beneficiary. The employer is NOT part of a multi-employer GHP. Even though the subscriber fits the definition of an Active Covered Individual, since the employer has less than 20 employees and is not part of a multi-employer GHP, this individual does not have to be reported on the MSP Input File. Alternatively, a record for the subscriber could be submitted but the BCRC will determine that the coverage is not primary to Medicare due to the employer's size.

7.3.2 Finder File Approach

A second approach that can be used to determine which individuals to report is the "finder file." This approach involves the RRE first sending a query file of Active Covered Individuals through which the BCRC would identify any Medicare beneficiaries based on the information submitted and return these positive identifications to the RRE. The RRE would then submit MSP Input File records for those identified Medicare beneficiaries who have coverage based on their own or a family member's current employment status or those known to have ESRD and for whom Medicare should be the secondary payer of benefits.

If you choose to use the "finder file" approach, query records must be submitted via the Query Only Input File (Basic or Expanded Reporting Option) or as N records on your Non-MSP Input File (Expanded Reporting Option only). Requirements for these file submissions are provided in Chapter 10. Note that a Non-MSP Input File cannot be submitted with only N records. The query file must be submitted in a timely fashion such that you are able to meet the requirements for quarterly file submission of your MSP Input File during your assigned file submission timeframe. Query records must be submitted using accurate information for the data elements the BCRC uses as matching criteria for individuals (Medicare ID [HICN or MBI] or Social Security Number [SSN], name, date of birth, and gender). Query files will only be accepted once per calendar quarter. See Chapter 10 for more information on the query process. All other requirements for the MSP Input File must be adhered to including reporting applicable individuals with new or changed coverage with each quarterly submission.

7.3.3 Inactive Covered Individuals

Inactive Covered Individuals are to be reported on your Non-MSP Input File and can be submitted on your Query Only Input Files. In most cases for these individuals, the GHP coverage you provide will be secondary to Medicare and Medicare will be the primary payer.

Inactive Covered Individuals are people who are currently not employed (most are carried as retired), and a spouse and (or) other dependents, enrolled in your GHP who cannot be classified as Active Covered Individuals. Do **NOT** submit Inactive Covered Individuals on your MSP Input File.

7.4 File Format

All data files submitted for Section 111 must be fixed width, flat files. All records in the file must be the same length as specified in the file layouts. All data fields on the files are of a specified length and should be filled with the proper characters to match those lengths. No field delimiters, such as commas between fields, are to be used. Detailed record and field specifications are found in the appendices of this guide.

7.4.1 Header, Detail, and Trailer Records

Each input file format contains at least three record types. The file begins with a header record. Header records identify the type of file being submitted and will contain your Section 111 RRE ID. You will receive your RRE ID on your profile report after your registration for Section 111 is processed. Detail records represent coverage information or query requests for individual people. Each file always ends with a trailer record that marks the end of the file and contains summary information including counts of the detail records for validation purposes. Each header record must have a corresponding trailer record. Each trailer record must contain the proper count of detail records. **Do not include the header and trailer records in these counts.** If the trailer record contains invalid counts, your file will be rejected.

7.5 Data Formatting Standards

7.5.1 Conventions for Describing Data Values

The following table defines the formatting standard for each data type found in the Section 111 files, both input and response. **These standards apply unless otherwise noted in specific file layouts.**

Table 7-1: Formatting Standards

Data/Field Type	Formatting Standard	Examples
Numeric	Zero through 9 (0–9) Padded with leading zeroes	Numeric (5): “12345” Numeric (5): “00045”
Alpha	A through Z Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case.	Alpha (12): “TEST EXAMPLE” Alpha (12): “EXAMPLE “

Data/Field Type	Formatting Standard	Examples
Alphanumeric	A through Z (all alpha) 0 through 9 (all numeric) Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case.	Alphanum (8): “AB55823D” Alphanum (8): “MM221 “
Text	A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space ( ) Dash (-) Period (.) Single quote (‘) Colon (:) Semicolon (;) Number (#) Forward slash (/) At sign (@) Left justified Non-populated bytes padded with spaces Alphabetic characters sent in lower case will be converted and returned in upper case.	Text (8): “AB55823D” Text (8): “XX299Y “ Text (18): “ADDRESS@DOMAIN.COM” Text (12): “ 800-555-1234” Text (12): “#34 “
Date/Numeric Date	All dates are in the format of century, year, month and day supplied as CCYYMMDD. Default input value is all zeros for open-ended dates, such as a termination date that has not yet been established or determined. Date fields on response files may be returned with a valid date or default values of all zeros or all spaces if not applicable.	“20110419” Open ended date: “00000000”
Filler	Populate with spaces	n/a
Internal Use	Populate with spaces	n/a

7.6 Section 111 Registration

7.6.1 Overview

The registration process requires responsible reporting entities (RREs) to provide notification to the BCRC of their intent to report data to comply with the requirements of Section 111 of the MMSEA. Registration **by the responsible reporting entity** is required and must be completed before testing between the RRE (or its agent) and the BCRC can begin. Through the registration process, the BCRC will obtain the information needed to:

- Validate information provided by the RRE registrant.
- Assign Section 111 Reporter IDs or Responsible Reporting Entity Identification Numbers (RRE IDs) to each RRE.
- Develop a Section 111 reporting profile for each entity including estimates of the volume and type of data to be exchanged for planning purposes.
- Assign a production live date and ongoing file submission timeframe for MSP Input Files to each entity.
- Establish the necessary file transfer mechanisms.
- Assign an Electronic Data Interchange (EDI) Representative to each entity to assist with ongoing communication and data exchange.
- Assign login IDs to individual users associated with each RRE ID account.

New Section 111 GHP RREs will register on the Section 111 COB Secure Website (COBSW) using an interactive Web portal designed for this purpose. The registration process will remain available in the future for new RREs to register and for existing RREs that need to change their reporting structure.

The Section 111 COBSW website URL is https://www.cob.cms.hhs.gov/Section111/.

Once you click on the "I Accept" link and accept the terms of the Login Warning, the homepage will display. Information on the New Registration and Account Setup processes can be found under the "How To" menu option. **A login ID is not needed to access this menu option**. Click on the menu option and a drop-down list will appear. Then click on the item desired in the list. In particular, please read the documents found under "How to Get Started" and "How to Invite Account Designees." Once you have begun the registration process on the Section 111 COBSW, you will have access to "Help" information on each page displayed. By clicking on the link for the Help page, a new window will open with instructions and information needed to complete the page you are working on. Once you have finished the New Registration and Account Setup steps and obtain a login ID for the Section 111 COBSW, you may log into the application using the login fields displayed on the right side of the homepage. After login, a detailed Section 111 COBSW User Guide is available under the "Reference Materials" menu option. You must be logged into the application to gain access to the user guide.

Note: Entities that are RREs for purposes of the Section 111 GHP reporting are not required to register if they will have nothing to report. For example, a TPA that administers and pays claims only for certain stand-alone or "carve-out" GHP coverage that does not overlap Medicare coverage (dental, behavioral health, etc.), may not have anything to report. However, if a TPA is contracted directly with the plan sponsor to provide prescription drug coverage, the TPA is considered the RRE and will have to register. RREs that do not register initially because they currently have no expectation of having GHP coverage to report, **must** register in time to allow a

full quarter for testing if they have future situations where they have a reasonable expectation of having to report.

7.6.2 Registration and Account Setup Process

Section 111 registration and account setup is a five-step process.

Step 1: Identify an Authorized Representative, Account Manager, and other COBSW Users

Each RRE must assign or name an Authorized Representative. This is the individual in the RRE organization who has the legal authority to bind the organization to a contract and the terms of MMSEA Section 111 requirements and processing. This is normally a person at the executive level of the organization. The Authorized Representative has ultimate accountability for the RRE's compliance with Section 111 reporting requirements. Please refer to the Data Use Agreement in Chapter 16 and make sure the person you name as your Authorized Representative has the authority to sign this agreement.

The Authorized Representative:

- Cannot be a user of the Section 111 COBSW for any RRE ID.
- Cannot be an agent of the RRE.
- May perform the initial registration on the COBSW, but will not be provided with a login ID.
- Will designate the Account Manager.
- Must approve the account setup, by physically signing the profile report, which includes the Data Use Agreement, and returning it to the BCRC.
- Will be the recipient of BCRC notifications related to non-compliance with Section 111 reporting requirements.

Each RRE must assign or name an Account Manager. Each RRE ID can have only one Account Manager. This is the individual who controls the administration of an RRE's account and manages the overall reporting process. The Account Manager may choose to manage the entire account and data file exchange or may invite other company employees or data processing agents to assist.

The Account Manager:

- Must register on the COBSW, obtain a login ID and complete the account setup tasks.
- Can be an Account Manager associated with another RRE ID if they receive the authorized PIN from the BCRC mailing. This can occur when a reporting entity has multiple RRE IDs under which they will report separate MSP Input Files or when the entity chooses to name an agent as its Account Manager.
- Can invite other users to register on the COBSW and function as Account Designees.
- Can manage the RRE's profile including selection of a file transfer method.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use their login ID and password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can review file transmission history.

- Can review file-processing status and file statistics.
- Can remove an Account Designee's association to an RRE ID account.
- Can change account contact information (e.g., address, phone, etc.)
- Can change their personal information.
- Cannot be an Authorized Representative for any RRE ID or an Account Designee for the same RRE ID.

At the RRE's discretion, the Account Manager may designate other individuals, known as Account Designees, to register as users of the COBSW associated with the RRE's account. Account Designees assist the Account Manager with the reporting process. Account Designees may be RRE employees or agents.

The Account Designee:

- Must register on the COBSW and obtain a login ID.
- Can be associated with multiple RRE accounts, but only by an Account Manager invitation for each RRE ID.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use their login ID and password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can review file transmission history.
- Can review file-processing statuses and file statistics.
- Can change their personal information.
- Cannot be an Authorized Representative for any RRE ID or the Account Manager for the same RRE ID.
- Cannot invite other users to the account.
- Cannot update RRE account information.

Note: Each user of the Section 111 application on the COBSW will have only one login ID and password. With that login ID and password, you may be associated with multiple RRE IDs (RRE accounts). With one login ID, you may be an Account Manager for one RRE ID and an Account Designee for another. In other words, the role you play on the COBSW is by RRE ID.

Step 2: Determine Reporting Structure

Before beginning the registration process, an RRE must also determine how the RRE will submit its Section 111 files to the BCRC and how many Section 111 Reporter IDs (RRE IDs) will be needed. Only one MSP Input File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, GHP enrollment system structures, data processing systems, data centers and agents that may be used for file submission, you may want to submit more than one MSP Input File to the BCRC on a quarterly basis and therefore need more than one RRE ID in order to do so.

For example, if an RRE will use one agent to submit one set of GHP coverage information and another agent to submit another set of GHP coverage information, the RRE must register on the COBSW twice to obtain two RRE IDs that will be used by each agent respectively. You may name the same Authorized Representative and Account Manager for both accounts, or use different individuals. Likewise, if you have two or more subsidiary companies that handle GHPs

for different regions of the country (or different lines of business) using different enrollment/claims systems and you will not combine the MSP Input Files for Section 111 reporting, you must register for each claim file submission to obtain separate RRE IDs in order to submit multiple MSP Input Files in one quarter.

You may not set up a separate RRE ID for submission of the Query Only File or Non-MSP Input File only. You must submit MSP Input Files for every RRE ID you establish.

You must complete the New Registration and Account Setup steps on the Section 111 COBSW for **each** RRE ID you want, so careful consideration must be given to the number of RRE IDs you request. Once logged into the Section 111 COBSW, most functions are performed by each RRE ID. Your Account Manager must invite and identify Account Designees that will need access to multiple accounts by RRE ID. File transmission and viewing the results of file processing is done by RRE ID. So, to ease the management of reporting, account maintenance and user access, we suggest that fewer RRE IDs are better than many. The registration process will remain available indefinitely. You may request one or more additional RRE IDs in the future if changes in your business operations require changes in your data reporting requirements. If you register and obtain an RRE ID that you later determine you will not need, contact your EDI Representative to have it disabled.

You are not required to obtain an RRE ID for each subsidiary separately, but you must do so if separate input files will be submitted for each or if each/any subsidiary is handling its own reporting. Alternatively, the parent organization may register, obtain one RRE ID and report for all applicable subsidiaries under that RRE ID.

Claims processing TPAs are often the RRE. Please refer to the definition of an RRE in Section 7.1. A GHP TPA RRE is **not** required to register and obtain separate RRE IDs for each client's GHP data. If you process all your clients' GHP data in one system and can submit one combined file, you need only one RRE ID for the GHP TPA. One MSP Input File can be submitted per quarter. The individual GHPs will be defined using the Employer/Plan Sponsor TINs submitted on the GHP TPA's MSP Input File.

If you register for multiple RRE IDs:

- You can use the same TIN for each or different TINs for each. No matching is done between the TINs supplied at registration and the TINs supplied on your input files.
- You can name the same Authorized Representative for each or a different Authorized Representative for each.
- You can name the same Account Manager for each or a different Account Manager for each.

The system randomly assigns EDI Representatives to RRE IDs. If you register for multiple RRE IDs and want them all assigned to one EDI Representative, then contact one of the assigned EDI Representatives and request a reassignment of all RRE IDs to one EDI Representative.

Step 3: RRE Registration on the COBSW – New Registration

A company representative for the RRE must go to the Section 111 COBSW URL (https://www.cob.cms.hhs.gov/Section111/), click on the "New Registration" button, complete and submit the registration for the RRE. This step must be completed by the RRE, not an agent for the RRE. It must be performed for each RRE ID needed for Section 111 reporting.

The application will ask that you submit:

- A Federal Tax Identification Number (TIN) for the RRE
- Company name and address
- Company Authorized Representative contact information (name, job title, address, email address, phone)
- National Association of Insurance Commissioners (NAIC) company code, if applicable
- Reporter Type (Select GHP)
- Optional Subsidiary company information to be included in the file submission for the registration (names, TINs, NAIC company codes for the subsidiaries)
- If your organization does not have NAIC company codes, you may default these fields to zeros

It is critical that you provide contact information for your Authorized Representative in this step regardless of who is actually performing this task on the Section 111 COBSW. The Authorized Representative cannot be a user of the Section 111 COBSW for any RRE ID. If you need to change your Authorized Representative after completing this step, you must contact your assigned EDI Representative.

When a registration application is submitted, the information provided will be validated by the BCRC. Once this is completed, the BCRC will send a letter via the US Postal Service to the named Authorized Representative with a personal identification number (PIN) and the BCRC-assigned RRE ID (Section 111 Reporter ID) associated with the registration. Your Authorized Representative should receive the PIN letter within 10 business days after the New Registration step is completed.

The Authorized Representative must give this PIN and RRE ID to their Account Manager to use to complete the Account Setup step on the Section 111 COBSW.

Each time this step is completed, a new RRE ID is generated by the system. If you need more than one RRE ID for Section 111 reporting, this step must be repeated for each. If you erroneously completed this step for more RRE IDs than needed, please contact the EDI Department to have the RRE IDs that you will not be using deleted.

Note: Information for subsidiaries is optional. CMS encourages you to supply this information. Doing so will assist us in our efforts to help ensure that you are in compliance with the Section 111 reporting requirements. Further, we may require this information at a later date during subsequent recovery efforts. However, all TINs supplied for subsidiaries under one RRE ID must be unique. In other words, all TINs for the RRE ID and subsidiaries listed in the New Registration step must be different within one specific RRE ID. If your subsidiaries do not have different TINs, then do not list them on the corporate structure page of the New Registration step on the COBSW. You can use the same TIN for multiple, different RRE IDs. TINs just need to be unique within the same RRE ID. For example, if you are one entity with one TIN registering five different RRE IDs, you can use the same TIN for all five distinct RRE IDs. The subsidiary information on the corporate structure page is not required. If you have trouble with data entry on this page, you may simply click the Continue button to bypass it.

Step 4: RRE Account Setup on the COBSW – Account Manager

In order to perform the RRE Account Setup tasks, the RRE's Account Manager must go to the Section 111 COBSW website (https://www.cob.cms.hhs.gov/Section111/) with the PIN and RRE ID and click the "Account Setup" button.

The Account Manager will:

- Enter the RRE ID and associated PIN.
- Enter personal information including name, job title, address, phone and email address.
- Create a login ID for the COBSW.
- Enter account information related to expected volume of data to be exchanged under this RRE ID (estimated number of covered individuals and estimated number of covered individuals aged 45 and over).
- Enter reporting agent name, address, contact email and TIN if applicable.
- Select a file transmission method.
- Provide dataset naming information needed if the Connect:Direct transmission method is selected (Section 14.1). **You must have destination dataset names available if the Connect:Direct method is selected, or this step cannot be completed and all the other data you provided will be lost.**

Once the Account Manager has successfully obtained a COBSW login ID, that person may log into the application and invite Account Designees to register for login IDs. In addition, after completing Account Setup for their first RRE ID, since only one login ID is required per user, the Account Manager will bypass the steps for creating another login ID and password when setting up subsequent RRE IDs.

The Account Setup step **must** be completed by your Account Manager. In this step, the Account Manager will obtain a login ID and must personally agree to the terms of the User Agreement. If you need to change your Account Manager after completing this step, contact your assigned EDI Representative.

This step must be repeated for each RRE ID.

Step 5: Return Signed RRE Profile Report – Authorized Representative

Once Account Setup has been completed on the COBSW (including file transmission details for Connect:Direct if that method is selected) and processed by the BCRC, a profile report will be sent to the RRE's Authorized Representative and Account Manager via email. You should receive your profile report within 10 business days after completing the Account Setup step on the COBSW.

The profile report contains:

- A summary of the information you provided during New Registration and Account Setup.
- Important information you will need for your data file transmission.
- Your RRE ID that you will need to include on all files transmitted to the BCRC.
- Your assigned production live date and ongoing quarterly file submission timeframe for the MSP Input File.
- Contact information for your EDI Representative who will support you through testing, implementation and subsequent production reporting.

The RRE's Authorized Representative must review, sign and return the profile report to the BCRC. Once your profile report has been marked as received by the BCRC, you may begin testing your Section 111 files. The BCRC will send an email to your Authorized Representative and Account Manager indicating that testing can begin.

The status of your RRE ID will be updated by the system as each step of the registration process is completed. Once the BCRC receives your signed profile report, your RRE ID will be placed in a "testing" status. Once testing is completed (see Chapter 13), your RRE ID will be placed in a "production" status. RRE IDs are expected to move to a production status within 180 days after initiation of the registration process (completion of the New Registration step).

Profile reports are regenerated and emailed to the RRE's Authorized Representative and Account Manager on an annual basis, based on the receipt date of the last signed profile report. The RRE's Authorized Representative must review, sign and return the profile report to the BCRC within 30 days of receipt to confirm or update account information and active reporting status for the RRE ID. Failure to return the signed profile report may result in deactivation of the RRE ID.

7.6.3 Changes to RRE Registration and Reporting

This section provides information regarding steps RREs must take if changes occur after initial Section 111 registration is completed.

7.6.3.1 Abandoned RRE IDs

If you erroneously registered for an RRE ID that you no longer need or have abandoned due to starting the registration process over, and you will not use the RRE ID for Section 111 file submission, please contact your assigned EDI Representative to have that RRE ID deleted. Unused RRE IDs may trigger automated warning notifications and follow-up by the BCRC to the associated Authorized Representative and/or Account Manager. Delete requests should only be made for RRE IDs that have never been used for production file submission.

7.6.3.2 Ceasing and Transitioning Reporting

If you have been reporting production Section 111 files under an RRE ID but will cease reporting under it in the future due to changes in your reporting structure, changes to what entity is the RRE, ceasing business operations or other reasons, then please contact your assigned EDI Representative. Inform your EDI Representative of circumstances affecting the change. Since the RRE ID was used for production reporting, it will not be deleted. You and your EDI Representative will create a transition plan and your EDI Representative will change the status of your RRE ID to an "discontinued" status after your last production file has been processed. Once the status is changed, information for the RRE ID will remain in the BCRC Section 111 system. However, production file submissions will no longer be accepted or expected. This change in RRE ID status will prevent the automatic generation of the Late File Submission emails and subsequent follow-up contact by the BCRC to your Authorized Representative and Account Manager related to Section 111 reporting compliance.

The transition of reporting responsibility from one RRE to another is the responsibility of the RREs involved. The BCRC cannot supply a file of previously submitted and accepted records for use in the transition by the new or former RRE or their reporting agents. For example, if a GHP transitions to a new claims-processing TPA, it is likely that the new TPA will become the RRE for Section 111 reporting. The new TPA may register for a new RRE ID or report the GHP coverage under one of its existing RRE IDs. The new TPA RRE may update and delete records previously submitted by the former TPA RRE under a different RRE ID as long as the key fields for the MSP occurrences match. The RRE IDs do not need to match. The former RRE must **NOT** delete previously submitted and accepted records. If the coverage previously reported has ended, then update transactions should be sent with applicable Termination Dates. The new RRE may send add transactions for new coverage information or update transactions to change

existing records with new information such as the new Insurer/TPA TIN. See Section 8.7 for more information on submitting add and update transactions.

If an RRE is changing reporting agents, the new agent should continue to submit files under the RRE's existing RRE ID(s). Again, the BCRC cannot supply a file of previously submitted and accepted records for the RRE IDs. It is the RRE's responsibility to coordinate the transition of reporting from the former agent to the new agent. Individuals from the new reporting agent should be given access to the RRE ID on the Section 111 COBSW. This can be done by the Account Manager for the RRE ID by using the Designee Maintenance action off the RRE Listing page and inviting these individuals as Account Designees. The new agent may then use their COBSW login ID for access to the RRE ID on the COBSW as well as for the HTTPS and SFTP file transmission methods. The Account Manager should remove any Account Designees associated with the former agent from their RRE ID account on the COBSW.

If you have questions regarding your specific circumstances related to ceasing or transitioning reporting, please contact your EDI Representative.

7.6.3.3 Changing RRE Information

After registration is completed on the Section 111 COBSW, your Account Manager may update certain information related to the RRE profile. After logging on to the COBSW (https://www.cob.cms.hhs.gov/Section111/), Account Managers may use the RRE Information action off the RRE Listing page to update the RRE name, address and telephone information. Changes to other information such as reporting agent, file transmission method or TIN associated with the RRE ID must be requested through your EDI Representative. You must also contact your EDI Representative to change your Authorized Representative or Account Manager to a different individual.

Note that all users of the COBSW may update their own personal information associated with their login ID, such as email address or phone number, after logging on to the site.

7.7 MSP File Submission Timeframes

An RRE is to submit the MSP Input File on a quarterly basis during its assigned file submission timeframe. You will receive your file submission timeframe assignment on your profile report which is sent after the BCRC has processed your Section 111 registration. It also is displayed on the RRE Listing page after logging on to the Section 111 COBSW. Each 3-month calendar quarter of the year has been divided into 12 submission periods as shown in the chart below. For example, if you have been assigned to Group 7, you will submit your MSP Input and associated TIN Reference File between the 15th and 21st day of the second month of each calendar year quarter; February 15th and February 21st for the first quarter, May 15th and May 21st for the second quarter, August 15th and August 21st for the third quarter and November 15th and November 21st for the fourth quarter of each year.

Note: Your MSP Input File receipt date will be set by the BCRC system when the batch cycle runs. The BCRC batch cycle runs nightly Monday-Friday, except holidays. RREs must send their files as close to the first day of their submission timeframe as possible in order to have the file receipt date fall within their submission timeframe. For example, if you submit a file on a Saturday, the BCRC system will not mark the receipt date until the BCRC batch cycle runs on Monday night. In addition, if the batch cycle runs past midnight, your file receipt date might not be set until Tuesday. The seven-day submission window is provided to account for this delay between file transmission and receipt date determination. It is not intended to allow you more

time to submit your file. You should be ready to transmit your files to the BCRC on the first day of your submission timeframe to be compliant with Section 111 reporting requirements (Table 7-2).

TIN Reference Files may be sent as often as needed at any time during a calendar quarter. Many RREs choose to submit a TIN Reference File with every MSP Input File submission. Since information from the TIN Reference File is needed for successful processing of the MSP Input File, your TIN Reference File must be submitted and successfully processed before or at the same time as your MSP Input File.

There is no submission timeframe associated with Query Only or Non-MSP Input Files. You may start sending the Query Only Input File on a quarterly basis and the Non-MSP Input File as frequently as monthly, after your production live date, on any day of the month.

Table 7-2: Quarterly MSP Input File Submission Timeframes

Dates	1st Month	2nd Month	3rd Month
01 – 07	Group 1	Group 5	Group 9
08 – 14	Group 2	Group 6	Group 10
15 – 21	Group 3	Group 7	Group 11
22 – 28	Group 4	Group 8	Group 12

7.8 Civil Monetary Penalties

To enhance enforcement of the MSP provisions, the reporting provisions also include authority for CMS to impose Civil Money Penalties (CMPs) against RREs that fail to comply with the reporting requirements. GHP RREs that fail to comply with these reporting requirements are subject to a CMP of $1,000 as adjusted for inflation (refer to 42 CFR § 102.3 for current CMP amount), for each calendar day of noncompliance. CMS has recently published regulations about the imposition of penalties related to noncompliance with reporting obligations, which can be found at 42 CFR §§ 402.1(c)(21)-(22). These regulations are effective as of December 11, 2023, and will be applied to RREs starting October 11, 2024.

To drive compliance with the required reporting, CMS will select a randomized sample of 250 new MSP occurrences each quarter and audit these occurrences to determine whether RREs have complied with the reporting requirements for each of these occurrences. An RRE is deemed compliant where the RRE reported the MSP occurrence no later than 365 days after the RRE assumed primary payment responsibility or primary payment responsibility was otherwise demonstrated by a settlement, judgment, award, or other payment. In other words, RREs must report within one year of the GHP coverage effective date, the date of incident when Ongoing Responsibility for Medicals (ORM) is assumed by an NGHP RRE, or the NGHP Total Payment Obligation to Claimant (TPOC) date, or other operative dates when appropriate (for example, the beneficiary's entitlement date if the beneficiary became entitled after the GHP coverage started.

The occurrences to be audited will include both Section 111 submissions and records from sources outside of the Section 111 reporting process, to ensure that CMS does not miss those situations where an RRE has entirely failed to report the occurrence. RREs will only be informed when there is a potential instance of non-compliance.

RREs will be notified of potential non-compliance by CMS and afforded the opportunity to present information that demonstrates that the RRE was actually compliant. Such information will vary depending upon the situation, but may **not** include those situations where the RRE submitted records that CMS was unable to process due to the RRE's file and record errors.

Should CMS move forward with a potential CMP, a notice of proposed penalty will be issued. RREs should take note that the imposition of CMPs and appeals processes are separate and distinct from the initial determination and appeal rights for MSP debts. Should the RRE fail to request a hearing in response to the proposed penalty, or fail to successfully dispute the proposed penalty in the hearing, the penalty will be imposed.

Chapter 8: MSP Input File Requirements

8.1 Overview

The MSP Input File is the data set transmitted from a Section 111 GHP responsible reporting entity to CMS that is used to report information regarding Active Covered Individuals who are Medicare beneficiaries. Please review Sections 7.3.1 and 7.3.2 for information on the reporting using the definition of Active Covered Individuals and the finder file approach. If using the definition of Active Covered Individuals to report, you must include information about all Active Covered Individuals who are at least 45 years of age and older. You must also include information on Active Covered Individuals you know or should know to be Medicare beneficiaries and those being treated for End Stage Renal Disease (ESRD). Some of the individuals on this file will obviously not be Medicare beneficiaries but CMS has determined that by using this age threshold, information for the majority of Medicare beneficiaries will be captured. If you are using the finder file method, you must report on all Active Covered Individuals identified as Medicare beneficiaries through the query process.

CMS uses the information in the MSP Input File to determine GHP coverage for Medicare beneficiaries that is primary to Medicare, data which is then used for proper claims payment. If your hospital/medical coverage for a Medicare beneficiary covered by Parts A and/or B during the same time period is primary to Medicare, the BCRC sets up what is known as an **"MSP occurrence"** on the Medicare Common Working File (CWF). In the case of prescription drug coverage primary to Medicare for a Medicare beneficiary covered by Part D during the same time period, the drug coverage occurrence is established on the Medicare Beneficiary Database (MBD). MSP and drug coverage occurrences have start and end dates based on the beneficiary's Medicare entitlement and Part D enrollment respectively and your coverage dates. Both MSP and drug coverage occurrences will have an open-end date if both your coverage and Medicare coverage are active. An end date is applied when either the GHP or Medicare coverage ends. The BCRC collects other health insurance information for Medicare beneficiaries from many sources so an MSP occurrence established from your data may get changed as a result of information received from other sources at times. Hierarchy rules the BCRC applies when processing data from different sources are described in Section 9.9.

This file format requires you to initially send an "add" record for the first report of coverage for an Active Covered Individual. If that record is accepted by CMS as reflecting MSP (coverage primary to Medicare) then you only need to apply any changes to that information in "update" or "delete" records going forward. If the record is not accepted due to errors, you must correct it and resend. If the record is not accepted due the individual not being a Medicare beneficiary, then you must continue to send **current** information for the individual as an add record on all subsequent submissions until the record is either accepted, the individual is no longer an Active Covered Individual or your GHP coverage is terminated. Alternatively, you may monitor the Medicare status of the individual using the query process and resend the associated MSP record when Medicare entitlement is established or re-established.

An MSP Response File will be sent back to you by the BCRC for each MSP Input File you send. This is the data set transmitted from BCRC to the GHP RRE after the information supplied on the MSP Input File has been processed. It consists of the same data elements in the Input File,

with updates applied by the BCRC based on Medicare's information for that individual, disposition and error codes which let you know what we did with the record, as well as applicable Medicare entitlement and enrollment information.

MSP Input, TIN Reference, MSP Response and TIN Reference Response Files and data element specifications can be found in Appendix A.

All Section 111 GHP RREs, regardless of the reporting option chosen, must submit MSP Input Files on a quarterly basis.

Note: On the MSP Input File, RREs are only to report individuals who have GHP coverage based on their own or a family member's current employment status or those known to have ESRD. **It is important that you do not submit information for those covered by a retirement plan, where Medicare is the primary payer, on this file.**

8.2 TIN Reference File

CMS uses IRS-assigned Tax Identification Numbers or TINs to identify insurers, TPAs and employers. The TIN is the same as the Federal Employer ID Number, the FEIN or EIN. The TIN Reference File is submitted with or prior to the MSP Input File so that Insurer and Employer name and address information does not have to be repeated on every MSP Input Record. **The mailing address associated with each TIN on the TIN Reference File should be the address to which health care insurance coordination of benefits issues, claims payment issues and recovery demands should be directed.**

The TIN Reference File may be submitted within your MSP Input File as a logically separated file within the same physical file, or as a completely separate physical file. It has its own header and trailer records. It must be sent prior to or at the same time as your first MSP Input File.

The TIN Reference File is to be submitted with a record for each insurer and employer TIN reported in Fields 21 and 22 of your MSP Input File. This includes all associated insurer TINs submitted and a record for each employer group or other plan sponsor TIN used. If the RRE is a TPA, then the TIN Reference File will contain records for all of its TPA TINs used on the MSP Input File in Field 22 as well as records for each of its client employer groups or other plan sponsors that are reported in Field 21 of the MSP Input File. Any insurer/TPA or employer TIN submitted on an MSP Input record must be included in the TIN Reference File in order for the MSP Input record to process. **Every TIN submitted in Field 21 or 22 on the MSP Input File must have an associated record submitted for it on the TIN Reference File.**

The TIN Reference File must contain only one record per unique TIN and TIN Indicator combination. In most cases, a TIN has only one associated TIN Indicator (Field 8 of the TIN Reference File). The valid values include 'I' for an insurer/TPA TIN, 'E' for an employer TIN, 'S' for other plan sponsor TIN (e.g., a union or health and welfare fund), 'F' for a Federal Employer TIN, and 'Z' for a TIN that reflects a foreign employer without a valid TIN. In the case of an RRE that is a self-insured employer that administers its own plan, the same TIN may represent the insurer and employer. In this situation, two TIN Reference File records for the self-insured/self-administered employer plan TIN should be submitted, one with a TIN Indicator of 'I' and the other with a TIN Indicator of 'E', 'S', or 'F' depending on the type of plan sponsor.

Note: Each Insurer/TPA TIN submitted in Field 22 of MSP Input File Detail Records must have a matching TIN Reference File Detail Record with a TIN Indicator of 'I'. Each Employer TIN submitted in Field 21 of MSP Input File Detail Records must have a matching TIN Reference File Detail Record with a TIN Indicator of 'E', 'S', 'F', or 'Z'. Failure to submit corresponding

TIN Reference File Records with appropriate TIN Indicators for Insurer/TPA and Employer TINs will result in errors on MSP Response File records.

A submitted TIN Reference File will generate a corresponding TIN Response File. Errors on TIN Reference File records will result in the rejection of subsequently processed MSP Input File Detail Records that have matching TINs (Section 8.3). The TIN Reference File layout and field descriptions can be found after the MSP Input File layout in Appendix A.

Note: You do not need to send a TIN Reference File with every MSP Input File submission. After the initial TIN Reference File is processed, you only need to resend it if you have changes or additions to make. Only new or changed TIN records need to be included on subsequent submissions. However, many RREs choose to submit a full TIN Reference File with each MSP Input File submission. All TINs will be verified so it is imperative that accurate information be provided in the file.

8.2.1 Formatting Employer TIN Records

Employer TIN – TIN Indicator 'E'

Under typical circumstances, TIN Reference File Detail Records submitted for employer TINs will have an 'E' in the TIN Indicator. However, there are several special cases concerning the reporting of employer TINs described below.

Other Plan Sponsor TIN – TIN Indicator 'S'

A plan sponsor TIN must be used in place of individual employer TINs in the case of all multiple employer/multi-employer plans. RREs are not to report the individual employer TINs in the case of a multiple employer/multi-employer plan, but instead report the overall plan sponsor TIN (e.g., workers' union or trade group). The plan sponsor TIN should be entered in Field 21, Employer TIN, on each applicable MSP Input File Detail Record for Active Covered Individuals covered by the multiple employer/multi-employer plan. A corresponding TIN Reference File Detail Record should be submitted with a value of 'S' in the TIN Indicator (Field 8), and the plan sponsor's TIN, name and address provided in Fields 1-7.

Note: The Commercial Repayment Center (CRC) directs GHP recovery demands to the entity identified by the Employer TIN (Field 21). Therefore, in the case of a multiple employer/multi-employer plan, the plan sponsor is responsible for responding to Medicare for related recovery demands.

Federal Employer TIN – TIN Indicator 'F'

Employer TIN records submitted on the TIN Reference File that are associated with Federal employer entities should be submitted with a value of 'F' in the TIN Indicator (Field 8).

Note: If the Federal Employer is the Office of Personnel Management, please ensure that the correct TIN is submitted in Field 21 (Employer TIN) on the MSP Input File Detail Record so that the correct entity is established as the primary debtor.

Foreign Employer TIN – TIN Indicator 'Z'

In certain rare circumstances, an RRE may be required to report records which reflect coverage of an Active Covered Individual provided by a foreign employer that does not have an IRS-assigned TIN. For example, the RRE may be a healthcare insurer based in the US, the Active Covered Individual a US citizen entitled to Medicare who works for an employer in Canada (may or may not reside in the US), and the Canadian employer sponsors healthcare coverage for

the employee through the US-based insurer RRE under which the covered individual may be covered for healthcare services provided in the US. The Canadian employer might not have a TIN and might not have an address in the US.

In circumstances like these, the RRE must create a fake or "pseudo-TIN" for the foreign employer and submit that in Field 21 of the applicable MSP Input File Detail Records. A pseudo-TIN is a 9-digit number made up by the RRE to represent an employer in lieu of a valid employer TIN. Pseudo-TINs must be unique within RRE ID. A TIN Reference File Detail Record must also be submitted for the foreign employer with the pseudo-TIN in Field 1 and a value of 'Z' in the TIN Indicator (Field 8). If the employer does not have an address in the US, then use the Foreign Employer Address Fields described below.

Foreign Employer Address Fields

To accommodate reporting of foreign employers with no US address, a set of address fields is provided on the TIN Reference File Detail Record, the Foreign Employer Address Lines 1-4 (Fields 15-18). Since there are numerous differences in the format of international addresses, these text fields are 32 bytes each and the RRE may provide the address using these fields in a "free form" manner of their choosing as long as at least the first address line Field 15 is supplied. Components of the address (e.g., street, city) should be separated by spaces.

The Foreign Employer Address Line fields may only be used on TIN Reference File Detail Records with a TIN Indicator of 'E', 'S', or 'Z'. A value of 'FC' must be submitted in the State Code Field 6 of the record to indicate that a foreign address is being supplied in Fields 15-18. When the State Code in Field 6 is equal to 'FC', then some non-blank values must be supplied in Foreign Employer Address Line 1 (Field 15) and spaces must be submitted in Fields 3, 4, 5 and 7.

8.2.2 Formatting Insurer/TPA TIN Records

Insurer/TPA Addresses

Most often only one address is needed for a given Insurer/TPA TIN. However, an RRE can have more than one TIN. For example, an insurer or TPA may have claims operations defined for various regions of the country. Because they are separate business operations, each could have its own TIN, and each TIN may be associated with a distinct business mailing address. This mailing address will help CMS and others to direct correspondence to the most appropriate contact for the GHP RRE. If the RRE has more than one TIN, you may choose to report all records under one primary Insurer/TPA TIN or use different TINs on different records with different addresses as you see fit.

The Insurer/TPA name and address provided in Fields 2-7 of the TIN Reference File will be used for contact regarding claims payment, coordination of benefit issues, and to send a courtesy copy of the recovery demand package to the RRE if applicable. This address is posted to MSP occurrences on CWF and made available to providers and suppliers who erroneously submit claims to Medicare as the primary payer instead of secondary.

If the RRE wishes to provide a different address for the recovery demand information, then Fields 9-14 (Insurer/TPA Demand Mailing Name and Address) may be used. These fields are optional. If left blank, then CMS will only use Fields 2-7 to contact the RRE. If Fields 9-14 are supplied, then Fields 2-7 will be used to contact the RRE for claim payment and coordination of benefits issues and Fields 9-14 will be used by the CRC to contact the RRE regarding recovery demand issues. Fields 2-7 are always required. Fields 9-14 are optional but may only be supplied

on TIN Reference File Detail Records where the TIN Indicator is 'I'. Fields 9-14 may not be used on employer TIN Reference File Detail Records. Only one address is allowed per unique employer TIN.

Again, the use of the Insurer/TPA Recovery Demand Mailing Name and Address is optional. If not used, then leave the fields blank on all TIN Reference File Records.

Changing TINs or TIN Addresses

If an RRE wishes to change the name and/or address associated with an Insurer/TPA or Employer TIN, then **two** actions must be taken. First, a new TIN Reference File must be submitted with the new address supplied on the applicable TIN Reference File Detail Record. Second, all the MSP Input File Detail Records previously submitted with the associated TIN that received an "01" disposition code must be resubmitted as update transactions in order to associate the new address with the TIN on the MSP occurrence. This will ensure that the new address is posted to the MSP occurrence and passed to other Medicare contractors for claims processing. These updates are to be made with your regular quarterly file submission unless otherwise instructed by your EDI Representative.

Note: The most recent name and address submitted on a TIN Reference File Detail Record will always be used for communications related to recovery demand activity, even if the RRE did not resubmit related MSP Input File Detail Records with the TIN record update.

8.3 TIN Validation

The following outlines the field matching criteria for TINs:

- An employer/other plan sponsor TIN in Field 21 of the MSP Input File Detail Record must match a TIN on a current or previously submitted TIN Reference File record. The TIN Reference File record must have a TIN Indicator of 'E', 'F', 'S', or 'Z'.
- An insurer/TPA TIN in Field 22 of the MSP Input File Detail Record must match a TIN on a current or previously submitted TIN Reference File record. The TIN Reference File record must have a TIN Indicator of 'I'.
- All employer and insurer/TPA TINs submitted must be valid IRS-assigned tax IDs (except for foreign employer pseudo-TINs). Only the TIN will be used in this validation. The name and address do not have to match the name and address associated with the TIN by the IRS.
- No validation is done on RRE-assigned pseudo-TINs submitted for foreign employers (TIN Indicator of 'Z') other than to check for a 9-digit number.

8.3.1 Basic TIN Reference File Field Validation

The BCRC will process TIN Reference Files submitted with MSP Input Files first. RREs may also submit a TIN Reference File without submission of an MSP Input File and the system will proceed with processing the TIN file in the next scheduled batch cycle. There is no file submission timeframe associated with a separately submitted TIN Reference File. Additionally:

- Basic field validations will be performed according to the field descriptions in the TIN Reference File layouts in Appendix A.
- Each insurer/TPA and employer TIN will be validated to ensure it is a valid IRS-assigned tax ID. Only the TIN will be used in this validation. The name and address do not have to match the name and address associated with the TIN by the IRS.

- If an error is found on an input TIN Reference File Detail Record during the basic field validation step, the TIN record will be rejected and returned on the TIN Reference Response File with a 'TN' disposition code and error codes specific to the errors, as identified in Appendix D.
- As with other Section 111 file processing, certain severe errors will be generated and notifications returned to RREs via email alerts for TIN Reference Files. These include severe errors for missing header or trailer records, incorrectly formatted header and trailer records, an invalid record count on the trailer, and empty files. Files with a severe error status will automatically be deleted after 50 days.

  In the event of a severe error, RREs must contact their assigned EDI Representative and resubmit a corrected TIN Reference File as instructed.

8.3.2 TIN Address Validation

RREs are encouraged to pre-validate employer and insurer/TPA addresses using postal software or online tools available on the USPS website pages such as https://tools.usps.com/go/ZipLookupAction!input.action. This can prevent address validation issues that hinder processing.

TIN Reference File records that pass the basic field validation edits will be further processed by the BCRC using a postal software tool. This tool will be used to validate and improve the deliverability of mailing addresses. To this end:

- Non-foreign addresses will be reformatted into the standardized format as recommended by the U. S. Postal Service (USPS), so that they can be matched against a database of valid, deliverable addresses. This will involve changes like correcting misspellings, changing the order of the individual components of the primary address line, and applying standard postal abbreviations such as RD for "Road."
- After the address is standardized, it will be matched to the postal database. This matching will include Delivery Point Validation (DPV). If an address is matched to one that is considered an undeliverable address, such as a vacant lot, the address will not be considered valid.
- When a match to a deliverable address is confirmed, the address is considered a valid address.
- The general return codes from the postal software will be translated into more descriptive error codes that will indicate why the address failed to be validated in this step. These errors include TN18–TN29 as shown in Appendix D.

Address validation will also be applied to the following addresses on TIN Reference input file records that have passed all the basic field validations:

- Insurer/TPA Address in TIN Reference File Fields 3–7 where the TIN Indicator equals 'I'.
- Insurer/TPA Demand Address in TIN Reference File Fields 10-14 where the TIN Indicator equals 'I'.
- Employer Address in TIN Reference File Fields 3–7 where the TIN Indicator equals 'E,' 'F,' 'S,' or 'Z' and the State code in Field 6 is not equal to 'FC'.

Foreign Employer Addresses, submitted on TIN records with a TIN Indicator of 'E,' 'S,' or 'Z,' where the State code in Field 6 equals 'FC,' will not be validated in this step. Only the basic field validations will apply to the Foreign Employer Address.

If an insurer/TPA TIN Reference File Detail Record (TIN Indicator of 'I') has both an insurer/TPA "claims office" address in Fields 3-7 and an insurer/TPA demand address in Fields 10-14, both addresses will be matched to the postal database, even if the first fails, so that all address errors can be identified and returned to the RRE on the corresponding TIN Reference Response File Detail Record.

8.3.3 TIN Reference Response File

TIN Reference Response Files will start with a header record, followed by detail records for each submitted TIN Reference File Detail Record, and end with a trailer record containing a detail record count. Each record is a fixed length of 650 bytes. The file layout is shown in Appendix A.

The TIN Reference Response File Detail Record will contain the submitted TIN, a disposition (TIN Disp) code, ten error code fields, the submitted insurer/TPA/employer mailing address, applied mailing address, submitted insurer demand address, applied insurer demand address, submitted TIN indicator, submitted foreign employer address, and indicators to show whether the system applied changes to the mailing or insurer demand address fields.

If a TIN Reference File Detail Record **fails** the TIN and/or TIN address validation, it will be rejected, and a corresponding TIN Reference Response File Detail Record returned with:

- A value of 'TN' in the TIN Disp Code (Field 29)
- Associated errors in the TIN Error Code 1-10 (Fields 30–39)
- TIN Reference File name and addresses in the corresponding submitted name and address fields (Fields 2–7, 14–19, 25–28)
- Spaces in the applied addresses (Fields 8–12, 20–24)
- TIN Indicator provided in the input record in the Submitted TIN Indicator (Field 13)
- Spaces in the Mailing Address Change Flag (Field 40) and Demand Address Change Flag (Field 41)

If your address fails validation with USPS, you must visit your local USPS office to correct this issue. Please make the correction immediately, as TN errors delay records posting.

If a TIN Reference File Detail Record **passes** the TIN and TIN address validation, it will be accepted, and a TIN Reference Response File Detail Record returned with:

- A value of '01' in the TIN Disp Code (Field 29)
- Spaces in the TIN Error Code 1-10 (Fields 30–39)
- TIN Reference File name and addresses in the corresponding submitted name and address fields (Fields 2–7, 14–19, 25–28)
- TIN Indicator provided in the input record in the Submitted TIN Indicator (Field 13)
- Addresses the BCRC will use for subsequent processing in the corresponding applied addresses (Fields 8–12, 20–24)
- If the applied address for the insurer/TPA or employer (Fields 8–12) is different from the submitted address (Fields 3–7), the Mailing Address Change Flag (Field 40) will be set to 'Y.' If they are the same, Field 40 will be set to 'N.'

- If the applied Insurer/TPA Demand Address (Fields 20–24) is different from the Submitted Insurer/TPA and Demand Address (Fields 15–19) the Demand Address Change Flag (Field 41) will be set to 'Y.' If they are the same, Field 41 will be set to 'N.' If there was a TIN Reference File Detail Record previously submitted that matches the TIN and TIN Indicator of the new TIN Reference File Detail Record being processed, the new record will overlay the prior record on the COB database and the new record will be used for subsequent MSP Input File processing, regardless of the TIN Disp Code returned. New TIN records in error can replace previously existing TIN records that were determined to be valid.

  Note: Errors on TIN Reference File records will result in rejection of subsequently processed MSP Input File Detail Records with matching insurer/TPA or employer TINs. TIN records returned with errors must be corrected and resubmitted in order for the corresponding MSP records to process correctly.

TIN Reference Response Files will be created for both test and production TIN Reference File submissions. Email notifications will be sent to the Account Manager for the RRE ID when a response file has been transmitted or is available for download.

RREs are encouraged, but not required, to update their internal systems with the applied address fields returned.

8.3.4 Processing TINs on the MSP Input File

The Insurer/TPA TIN (MSP Input Field 22) and Employer TIN (MSP Input Field 21) will be matched to the COB database table of valid, **accepted** TIN Reference File records submitted by the RRE.

If a match is found: the TIN information will be used in creation of MSP occurrences and subsequent Medicare claims processing and recovery processing at the CRC.

If a match is not found to a valid TIN record: the MSP Input File Detail Record will be **rejected** and returned on the MSP Response File with an 'SP' disposition code and an error code indicating that a valid TIN record could not be found. These errors will be specific to insurer/TPA TIN (SPT1) and employer TIN (SPT0) but will not provide information as to why the TIN record was rejected. **RREs will have to refer to the errors returned on their TIN Reference Response Files** to determine what caused the matching TIN record to be rejected. It will be necessary for an RRE to resubmit corrected TIN Reference File records, along with resubmitting the corresponding MSP Input File Detail Records that were rejected, in their next file submission or as instructed by their EDI Representative.

RREs are encouraged to pre-validate employer and insurer/TPA addresses using postal software or online tools available on the USPS website pages such as https://tools.usps.com/go/ZipLookupAction!input.action. RREs should use standard abbreviations and adhere to USPS standards. The address validation enhancements effective in the BCRC Section 111 system will 'scrub' addresses submitted on the TIN Reference File using USPS standards, but it is recommended that RREs attempt to adhere to these standards as well to improve results. If your address fails validation with USPS, you must visit your local USPS office to correct this issue. Please make the correction immediately, as TN errors delay MSP posting.

8.4 Record Matching Criteria

8.4.1 Individuals

To determine whether an individual is a Medicare beneficiary, the BCRC must match your data to Medicare's. This matching can be done using either an individual's Medicare ID (HICN or MBI) or by using an individual's SSN. The Medicare ID is preferred and once the Medicare ID is returned on a response file, the RRE is required to use it on all subsequent transactions. To determine whether an individual is a Medicare beneficiary you must send either a Medicare ID or an SSN as part of the individual's record in the MSP Input File or the Query Only Input File. For matching an individual to determine if they are a Medicare beneficiary, the BCRC uses Medicare ID or SSN.

Note: The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.

- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender (Sex)

First the BCRC must find an exact match on the Medicare ID or SSN. Then at least three out of the four remaining criteria must be matched exactly. If a match is found, you will always be returned the beneficiary's most current Medicare ID (HICN or MBI) to use going forward on all update and delete transactions. You must store this Medicare ID on your internal files and are required to use it on future transactions.

Note that MSP Input File Detail Records submitted for individuals under age 45 must include the Medicare ID for that individual. See the description for error code SP99 in Appendix D. No matching will be done on an MSP Input File Detail Record, for an individual under age 45, if the Medicare ID is not submitted. However, Query Input File Detail Records may be submitted with only the individual's SSN, regardless of their age, and the system will proceed with the matching process and return a Medicare ID on the Query Response File Detail Record if a match is found.

Also note that if an RRE submits both the SSN and Medicare ID on an MSP Input File Detail Record or a query record, the system will only use the Medicare ID for matching purposes and the SSN will be ignored. The system will attempt to match the Medicare ID to any previously assigned Medicare ID for the individual, since Medicare IDs can change or be reassigned by the Social Security Administration, but if no match is found using the Medicare ID it will not then make a second attempt to match using the SSN provided. If submitting query files using the SSN, partial SSNs are accepted for matching using the last five digits (Appendix B).

8.4.2 MSP Occurrences

MSP occurrences created and stored by the BCRC for Medicare claims processing are keyed by:

- Medicare ID (HICN or MBI)
- MSP Effective Date
- Insurance Coverage Type (hospital, medical, drug, etc.)
- Patient Relationship Code (self, spouse, dependent, etc.)
- MSP Type (reason coverage is primary – working aged, ESRD, disability, etc.)

The BCRC will use these criteria for subsequent update and delete transactions you send. You should save the MSP Effective Date returned to you on the response files in your internal files so it can be used for claims processing.

The Insurance Coverage Type is what you provide on your MSP Input File. The MSP Type is generated by the BCRC and depends on the reason the beneficiary is entitled to Medicare and why the GHP coverage is primary. You must send the Medicare ID that the BCRC sends back on the MSP Response File on all subsequent MSP Input File update and delete transactions.

Note: Since Medicare often determines entitlement/eligibility in advance, MSP Effective Dates returned may be future dated.

8.5 MSP Rules for Small Employer Exception (SEE)

If an employer, having fewer than 20 full and/or part-time employees, sponsors or contributes to a single-employer GHP, the MSP rules applicable to individuals entitled to Medicare based on age do not apply to such individuals. However, if such an employer participates in a multiple employer or multi-employer GHP and at least one participating employer has at least 20 full and/or part-time employees, these MSP rules apply to all individuals entitled to Medicare based on age, including those associated with the employer having fewer than 20 employees. The law provides that a multi-employer GHP may be granted an exception with respect to certain individuals entitled to Medicare based on age and who are covered as a named insured or spouse (covered individual) of an employer with fewer than 20 full and/or part-time employees.

For an MSP SEE to exist, the multi-employer GHP must request, and the CMS BCRC must approve, the exception to the Working-Aged MSP rules. An approved exception will apply only with respect to the specifically named and approved beneficiaries associated with a specifically named employer participant in a specifically identified multi-employer plan. **This exception applies only to individuals entitled to Medicare on the basis of age.** All approvals are prospective. To request Medicare approval of a SEE, the multi-employer GHP must submit a written request, with all required supporting documents, to the CMS' BCRC stating that the plan seeks to elect Medicare as the primary payer for identified beneficiaries who are associated with identified employers that participate in the specific multi-employer plan.

For the purposes of requesting the SEE, the term multi-employer GHP means any trust, plan, association, or any other arrangement made by one or more employers to contribute, sponsor, directly provide health benefits, or facilitate directly or indirectly the acquisition of health insurance by an employer member. (If such facilitation exists, the employer is considered to be a participant in a multi-employer GHP even if it has separate contract with an insurer.) However, the GHP can, by agreement or otherwise, delegate the responsibility for requesting the SEE to the insurer.

8.5.1 Multi-Employer GHPs & Medicare Entitlement Based Upon Disability or ESRD

If an employer participates in a multi-employer GHP and at least one participating employer has at least 100 full and/or part-time employees, the MSP rules apply to all individuals entitled to Medicare based on disability, including those associated with the employer having fewer than 100 full and/or part-time employees.

There are no exclusions to the MSP rules based upon employer size where Medicare entitlement is based upon ESRD/permanent kidney failure.

8.5.2 GHP RRE Section 111 Reporting Regarding SEEs

The multi-employer GHP or insurer must submit the SEE request for each applicable covered individual and employer to the BCRC. If the BCRC approves the request, the start and end dates for the SEE are recorded in the BCRC database by covered individual (Medicare ID [HICN or MBI]) and employer (EIN) along with the associated start and end dates for the SEE.

If reporting on an Active Covered Individual for whom a SEE has been granted, place the individual's Medicare ID in MSP Input File Field 32, Small Employer Exception Medicare ID. If the BCRC can match this to its records, then the insurance effective date from the submitted MSP Input File record will be compared to the SEE start and end dates.

Note: The BCRC will not check its database for a SEE unless the RRE submits the individual's Medicare ID in the SEE Medicare ID field. If that field is not populated, the record will not be compared to the database of approved SEE periods and instead be treated as though no SEE has been approved for that individual and employer.

- If the insurance coverage period is entirely within the SEE start and end dates, no working-aged MSP occurrence will be created, and the coverage will not be considered primary to Medicare. A disposition code of 'BY' (bypassed) and a SEE Response Code (Field 81) of 'SA' (SEE Accepted) will be returned on the MSP Response File.
- If the insurance effective date is prior to the SEE start date, an MSP occurrence will be generated if the individual was covered by Medicare for that period. The MSP Effective Date will be set as the insurance effective date submitted on the MSP Input File. The MSP Termination Date will be 1 calendar day prior to the SEE start date. The appropriate disposition code for the updated record and a SEE Response Code of 'SP' (SEE Partial) will be returned on the MSP Response File record.
- If the insurance effective date is within the SEE effective period and the insurance end date is after the close of the SEE effective period, the MSP Effective Date will be set to 1 calendar day after the SEE termination date. The appropriate disposition code for the updated record and a SEE Response Code of 'SP' (SEE Partial) will be returned on the MSP Response File record.
- If an MSP occurrence is created because the insurance coverage period is outside of the SEE effective period, the appropriate disposition code for the updated record and a SEE Response Code of 'SN' (SEE Not Applicable) will be returned on the MSP Response File record.

If a SEE match is not found, an MSP occurrence will be generated if applicable. A SEE Response of 'SN' (SEE Not Applicable) will be returned to the submitter indicating that the SEE Medicare ID was not found. This will give the submitter the opportunity to advise the multi-employer plan that CMS has no record of an approved SEE. The plan may then, if it wishes to do so, request a SEE.

It is the RRE's responsibility to correct records that result in MSP occurrences that overlap a SEE effective period. This could happen if the RRE failed to submit the SEE Medicare ID (Field 32) on the MSP Input File Detail Record or if the SEE was approved subsequent to the MSP Input File submission with a retroactive SEE start date. To correct the record, the RRE must submit a delete transaction that matches the previously submitted and accepted add transaction (response returned with an '01' disposition code) followed by an add transaction with the SEE Medicare ID supplied in Field 32 for reconsideration of MSP by the BCRC.

Please refer to the Small Employer Exception page at https://www.cms.gov/medicare/coordination-benefits-recovery/employer-services/small-employer-exception on the CMS website for more information on applying for a SEE.

8.6 Initial MSP Input File Submission

To begin reporting for Section 111, you must create and send a file that contains information for all Active Covered Individuals (or Active Covered Individuals who are identified to be Medicare beneficiaries through the query process) and who are currently enrolled in your plan. Information must be supplied for individuals who had active coverage at that time even if it has since been terminated. Information must be supplied for individuals even if their coverage has since been

terminated. Information must also be supplied for individuals who are currently enrolled at the time of the report.

At least one record is to be supplied for each individual who qualifies as an Active Covered Individual, including the subscriber, the subscriber's spouse, and every other dependent that fits the definition of an Active Covered Individual. If an individual had multiple periods of coverage during this timeframe, multiple records must be submitted with the applicable Effective and Termination (end) Dates (Fields 10 and 11). The Effective Date should reflect when the coverage was initially effective even if that occurred prior to your initial plan. However, the *MSP Effective Date* field will accept dates up to three months from the current date. This field can be in the future for currently entitled beneficiaries (i.e., enrolled in Medicare), or for beneficiaries who will be entitled starting up to three months in the future.

If the coverage is current and open at the time of the report, the record should reflect an open-ended coverage by putting zeroes in the Termination Date (Field 11). Termination Dates should only be supplied when the actual coverage reported has ended. (**Note:** The date submitted in the Coverage Termination Date (Field 11) should be the last day that the Active Covered Individual is covered through a GHP due to current employment (with the exception of situations involving ESRD). Please see Section 8.7.1.1, **How to Report a Coverage Termination Date for Active Covered Individuals**, for additional information. Yearly renewals of the same coverage are not to be reported as separate records. If the coverage remains the same from year to year, a new record does not need to be reported since the previous report should have had an open-ended Termination Date.

Your initial MSP Input File will obviously be larger than your subsequent update files since it will contain the entire population of your Active Covered Individuals for whom you must report. All records on your initial file will be "add" records and have a value of zero ('0') in the Transaction Type (Field 7).

When you register for Section 111 reporting, you will be assigned a production live date and a 7-day window for your quarterly file submission. The production live date is the first day of your first quarterly submission timeframe and your initial MSP Input File must be received inside that 7-day window.

You must submit a TIN Reference File prior to or with your initial MSP Input File submission.

8.7 Quarterly Update MSP Input File Submissions

Each subsequent quarter after your initial MSP Input File submission, you must send an update MSP Input File to reflect any changes from the last submission, including new enrollees (subscribers and dependents) who are Active Covered Individuals, existing subscribers and dependents who are now Active Covered Individuals, changes to previously submitted records, corrections to previously submitted records, and updates to report on a coverage termination date.

Note that you may not have reported on an individual in your plan(s) previously since they were not an Active Covered Individual at that time. Each quarter you must check to see if they now fit that definition (i.e., have reached the age threshold, diagnosed with ESRD, been identified as a Medicare beneficiary though the query process, etc.) and send them on your quarterly update file.

If you are reporting any new TINs on your MSP Input File, submit a TIN Reference File with records for each new TIN with your update MSP Input File submission.

If you have nothing to report for a given quarter, you may either submit an "empty file" with a header record, no detail records and a trailer record with a zero-record count or submit no file at all. Empty files are not required. If an empty file is submitted, you will not receive an MSP Response File.

8.7.1 Add, Delete, and Update Transactions

Add Transactions

An "add" record or transaction is defined with a '0' (zero) in the Transaction Type (Field 7). An add is a new record of coverage information that the BCRC has not posted to the Medicare CWF or MBD as an MSP occurrence. Records accepted and added as an MSP occurrence to the CWF or MBD receive a '01' disposition code in your MSP Response File you receive back from the BCRC. An add transaction could be a record never sent before or a record that was sent before but not accepted due to errors or the individual not being a Medicare beneficiary during the GHP coverage period at the time of processing.

Example: Mr. John X. Smith has not yet been included on an MSP Input File. Although he had health insurance as a covered benefit through his employer, Mr. Smith was not yet 45 years of age. Mr. Smith reaches age 45. Consequently, in the next quarterly update MSP Input File, a record for Mr. Smith is sent as an add transaction if he was still covered under the plan after age 45. Note that as an alternative, the RRE may submit a query record for Mr. Smith and determine whether to include him on the MSP Input File based on whether his information was matched to a Medicare beneficiary or not.

Example: Information about Mr. John Jones, an Active Covered Individual, was included on a previous MSP Input File as an add transaction, but the record did not include enough of Mr. Jones' required personal identification data elements. The BCRC could not determine whether the name and SSN submitted belonged to a Medicare beneficiary, and so this attempt to add Mr. Jones was rejected. With the next quarterly update MSP Input File, an add transaction is sent with complete personal identification data elements for Mr. John Jones. The record now includes enough information for the BCRC to confirm that he is a beneficiary and is accepted.

Note: If rejected again, the record must continue to be sent as an add transaction (or re-queried using the finder file method) until you receive a response file from the BCRC indicating the individual is a Medicare beneficiary and an MSP occurrence was posted, until the individual no longer satisfies the definition of an Active Covered Individual, or until the individual is no longer covered by the plan.

Update Transactions

An "update" record or transaction is defined with a '2' in the Transaction Type (Field 7). An update transaction is sent when you need to change information on a record previously accepted and added as an MSP occurrence to the Medicare CWF or MBD by the BCRC for which you received a '01' disposition code in your MSP Response File. An update is only to be used if the record was previously accepted with a '01' disposition code. If a record with coverage that needs to be reported has not yet been accepted with a '01' disposition code, it must be submitted as an add transaction. Please see the information on disposition codes in Section 9.1.

To successfully update a previously added record, the BCRC must be able to match on the key fields of the MSP occurrence. See Record Matching Criteria in Section 8.4. The BCRC will use this criterion for update and delete transactions you send. You must save the Medicare ID (HICN

or MBI) returned to you on the response files in your internal file so it can be used in subsequent update and delete transactions. Report the actual GHP effective date for the individual. The BCRC will make the necessary calculations to match to the GHP effective date to the effective date of the corresponding MSP occurrence.

Example: In January, an add transaction was sent for an Active Covered Individual identified as a Medicare beneficiary, and an MSP occurrence was created and posted for the individual by the BCRC. Subsequently, the individual stopped working and retired. The beneficiary's last day of employment was July 15th. On the next quarterly update MSP Input File, an update transaction is sent with July 15th in the termination date (i.e., the last day of current employment). The BCRC updates the MSP occurrence previously posted with this termination date which will result in an indication that Medicare is the primary payer subsequent to July 15th. Note that an update record is sent to report the termination date, not a delete record.

Delete Transactions

A "delete" record or transaction is defined with a '1' in the Transaction Type (Field 7). A delete transaction is sent to remove an erroneous MSP occurrence previously posted to the CWF or MBD by the BCRC. Records accepted and added as an MSP occurrence to the CWF or MBD receive a '01' disposition code in your MSP Response File you receive back from the BCRC. If your add transaction did not result in a '01' disposition code, there's no need to delete it even if it was previously sent in error.

To successfully delete a previously added record, the BCRC must match on the key fields of the MSP occurrence. See Record Matching Criteria in Section 8.4. The BCRC will use this criterion for update and delete transactions you send. You must save the Medicare ID (HICN or MBI) returned to you on the response files in your internal system and use it in subsequent update and delete transactions to assure a match. Aside from the transaction type and possibly the Medicare ID (if it wasn't supplied on the original add record), a delete transaction should be submitted with the same values in other fields that were submitted on the original.

Example: A record was previously sent to the BCRC and an MSP occurrence posted indicating that a GHP was a primary payer based on the individual's current employment status. Subsequently, it is discovered that the individual was not employed and that Medicare should have been the primary payer. The original record was sent and posted in error. A delete transaction is sent on the next quarterly update MSP Input File and the BCRC removes the MSP occurrence from the CWF or MBD.

Note: Delete transaction only need to be submitted for records that resulted in a '01' disposition code on a previous corresponding response file record. If the record was not returned with a '01' then an MSP occurrence was not created and there is nothing to delete from Medicare's files. In addition, deletes are only to be used to remove an MSP occurrence created in error. Please review the following information concerning reporting Termination Dates, correcting and changing information carefully.

8.7.1.1 How to Report a Coverage Termination Date for Active Covered Individuals

The Coverage Termination Date is the last day that the Active Covered Individual is covered through a GHP due to current employment (with the exception of situations involving ESRD). Even though GHP coverage may continue past their last day of employment, (e.g., the covered individual stops working mid-month but retains coverage until the end of the month), the

submitted coverage termination date should be the last day that the Active Covered Individual was employed). Medicare becomes primary payer once current employment ends.

Example #1:

Covered individual retires on June 10, 2013 but retains GHP coverage until June 30, 2013. The RRE must submit the last day of current employment (June 10, 2013) in the Coverage Termination Date (Field 11). **Do not submit the day after the last date the beneficiary was covered by the GHP (July 1, 2013) in the Coverage Termination Date.** Medicare becomes primary on June 11, 2013.

Example #2

Covered individual is entitled to Medicare because of ESRD and is still in the 30-month coordination period when they stop working on April 15, 2013. They have retained their GHP coverage until April 30, 2013. Since this individual is entitled to Medicare because of ESRD **and** is still in the 30-month ESRD coordination period, the RRE must submit the last date of GHP coverage (April 30, 2013) in the Coverage Termination Date (Field 11) and not the last date of current employment (April 15, 2013). Medicare becomes primary payer on May 1, 2013 because the GHP coverage ceased on April 30, 2013.

When coverage for an Active Covered Individual previously sent and accepted by the BCRC ends, you must send an update record with the Termination Date (Field 11). The BCRC will update the MSP occurrence Termination Date and Medicare will become the primary payer after that date. **Do not send a delete transaction** in these cases. A delete transaction will remove the MSP occurrence entirely, as though Medicare was always supposed to be the primary payer, and claims will be paid erroneously.

8.7.1.2 Correcting MSP Occurrence Key Information – When to Send a Delete or Add

If you need to correct one of the key matching fields used for MSP occurrences (Medicare ID/SSN, Effective Date, Insurance Coverage Type (with an exception; see Note 1 below), or Relationship to Policyholder) or other information used to determine MSP (Employer Size, Employee Status), you need to follow a special process to make this update. First, a delete transaction must be sent in your file to remove the previously added record. The delete transaction should then be followed by an add transaction in the same file to add the record back, if applicable, with the corrected information. This process will completely replace the previously added MSP occurrence with the correct information.

This instruction applies to situations where incorrect information was sent on a previous record for the following fields and the record was accepted and returned with an ’01’ disposition code meaning that an MSP occurrence was created:

- Medicare ID/SSN – Fields 1 or 9 (the wrong person was submitted)
- Effective Date – Field 10
- Coverage Type – Field 8 (except changing ‘A’ to ‘W’; see Note 1 below)
- Relationship Code – Field 12
- Employer Size – Field 16
- Employee Status – Field 20

If **incorrect** information was submitted for any of these fields and an MSP occurrence was created, then it is the RRE’s responsibility to first remove the MSP occurrence and then resend

the record with corrected information on a new add record in order for the BCRC to make a new MSP determination. If the new information regarding the individual's coverage results in him/her not meeting the criteria to be considered an Active Covered Individual, then only a delete record needs to be sent to remove the erroneous MSP occurrence. No add record is required if the person is not now considered an Active Covered Individual.

Note 1: If you are correcting the coverage type from 'A' to 'W', please submit only an update record.

Note 2: RREs only need to correct the Medicare ID/SSN in cases where an incorrect person was submitted and accepted on the input record. Medicare IDs (HICNs or MBIs) may be changed by the Social Security Administration at times, but the BCRC is able to crosswalk the old Medicare ID to the new Medicare ID. Therefore, in those instances where the correct person was previously submitted and the Medicare ID changes for that person at a later date, the RRE does not need to correct the record. In fact, updates may continue to be sent under the original Medicare ID/SSN submitted. The BCRC will always return the most current Medicare ID on response records and RREs are encouraged to update their systems with that information and use it on subsequent record transmissions.

Note 3: If a record was previously submitted and accepted with only a SSN, and the RRE obtains the Medicare ID on the response file, the RRE should not send a "Delete" and "Add" to update the beneficiary's information with the Medicare ID. The record has already been stored under both the SSN and Medicare ID by the BCRC. Subsequent transactions for the record must be submitted with the Medicare ID.

Example 1: A record was previously sent with March 1 as the coverage effective date. The BCRC returned a disposition code of '01' for the record on the response file and indicated that the MSP Effective Date on the posted record is March 1. Subsequently it is determined that the Active Covered Individual's GHP coverage effective date was actually April 1. A delete transaction is sent in the next quarterly MSP Input File with March 1 in the effective date. In the same file, but following the delete transaction, an add transaction is sent with April 1 as the effective date. The BCRC removes the MSP occurrence with the March 1 effective date and adds the correct MSP occurrence with an April 1 effective date.

Example 2: A record was previously sent with an Employer Size of '2' to indicate that the employer had 100 or more employees. The BCRC returned a disposition code of '01' for the record on the response file and posted an MSP occurrence at CWF. Subsequently it is discovered by the RRE that the Employer Size should have been submitted with a value of '1' since the employer had less than 100 employees in the previous calendar year but more than 19. A delete transaction is sent in the next quarterly MSP Input File with the Employer Size of '2'. In the same file, but following the delete transaction, an add transaction is sent with an Employer Size of '1'. The BCRC removes the MSP occurrence previously created and makes a new determination of MSP based on the corrected Employer Size submitted. The disposition code returned will depend on the new MSP determination which is based on MSP regulations and the information submitted on the new add record.

8.7.1.3 Changing Information Used to Determine MSP– When to Send an Update and Add

The following fields are used, in part, by the BCRC in determining whether Medicare is secondary to an RRE's GHP coverage for an individual:

- Coverage Type – Field 8 (except changing 'A' to 'W'; see Note 1 in Section 8.7.1.2)
- Relationship Code – Field 12
- Employer Size – Field 16
- Employee Status – Field 20

If the information for any of these fields **changes** after an MSP occurrence has been created, do the following:

- Submit an **update** transaction with the old values and a termination date reflecting the last day the information was true.
- Submit an add transaction with the new data values with an effective date equal to the date the changed value became effective (the day after the termination date in the update record previously described.)

If the changed information regarding the individual's coverage results in the beneficiary not meeting the criteria to be considered an Active Covered Individual since the date the change occurred, then only an update record needs to be sent to terminate the MSP occurrence. If the beneficiary expands or reduces their insurance coverage, first terminate the record by providing an end date and then send an add record with the updated coverage (see next example). No add record is required if the person is not considered an Active Covered Individual subsequent to the change.

Example: An add transaction was sent indicating that the Coverage Type was Hospital and Medical (a value of 'A' in Field 8). The Effective Date submitted was January 1 and the Termination Date was open-ended. The record was accepted and the BCRC created an MSP occurrence and returned a disposition code of '01'. Effective June 1, the coverage for the individual changed to Hospital Only. In the next quarterly file submission, an update transaction should be sent with a Coverage Type value of 'A', Effective Date of January 1 and a Termination Date of May 31. In the same update file, an add transaction should be sent with an Effective Date of June 1, an open-ended Termination Date and a Coverage Type of 'J' reflecting the new Hospital Only coverage.

Note that this situation differs from the previous discussion of deleting the original record and adding a new record. In this case the original record was correct, but the information changed subsequent to the MSP occurrence being posted by the BCRC. If information changes for fields other than those listed here and MSP occurrence key fields listed previously, you may simply submit one update transaction with the new information in the applicable field.

Note: For more information regarding calculating and reporting changes to employer size, please see Appendix G.

8.7.1.4 Initial Reporting When Employer Size Reaches 20 and Employer is Not Part of a Multi-Employer/Multiple Employer Plan

As stated previously, if an employer has less than 20 full and/or part-time employees as defined in 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170, and the employer is not part of a multi-employer/multiple employer GHP, then the covered individuals under that plan do not have to be reported under Section 111 unless a covered individual is receiving dialysis or has had a kidney transplant (ESRD). However, records for all Active Covered Individuals in these plans may be submitted with the proper value in the Employer Size (Field 16). If reported and the BCRC determines that MSP does not exist, then an SPES error code will be returned, as explained in Section 9.2.1.

If coverage was **not** previously reported for any individuals due to the employer size being less than 20 employees, and subsequently the number of employees increases to 20 or more, the affected covered individuals must be reported on add records if they meet the other requirements to be included on the MSP Input File. When these add records are submitted, you must use the **later** of the effective date of the new employer size or the individual's GHP coverage effective date in Field 10 (Effective Date) of the MSP Input File Detail record rather than simply the effective date of the individual's GHP coverage. This will ensure that the BCRC creates an MSP occurrence starting at the date that Medicare becomes the secondary payer.

See Appendix G for more information on Employer Size.

8.8 Quarterly Update Event Table

The following table provides a summary of the events to be considered when creating a quarterly update MSP Input File for ongoing Section 111 reporting. It is to be used by RREs and their agents to determine when and how to send records on a quarterly MSP Input File after the initial MSP Input file has been successfully processed. RRE Actions reflect MSP Input File record submissions to be included in the next quarterly submission after the event occurs. Please see the MSP Input File requirements in other sections of this guide and record layouts in Appendix D for the requirements for each specific field on the record as this table describes the record submission only in general terms. The phrase "previously reported and accepted" means that an MSP Input Detail record was previously submitted and the BCRC sent back a disposition code of '01' on the corresponding MSP Response File record. A complete explanation of the disposition codes returned can be found in Section 9.1 and in Appendix D.

Table 8-1: Quarterly Update Event Table

Event	RRE Action
Initial Report of New GHP Coverage • New enrollee (subscriber/dependent) • New Active Covered Individual/Medicare Beneficiary	**Send Add Record:** • '0' (add) in the Transaction Type (Field 7) • All other fields as specified in Appendix A • Refer to all other requirements for MSP Input File reporting
Termination of GHP Coverage • MSP record with an open-ended termination date previously reported and accepted by the BCRC • GHP for the Medicare beneficiary ends	**Send Update Record:** • '2' (update) in the Transaction Type • Date GHP Coverage ended in Termination Date (Field 11). Submit the last day that the Active Covered Individual is covered through the GHP due to current employment (with the exception of situations involving ESRD). • All other fields as previously reported on the initial add record as specified in Appendix A

Event	RRE Action

Key Field or Field Used in MSP Determination
Correction – Delete/Add
• MSP record was previously reported and accepted
• Incorrect key field/MSP field information was originally submitted. One or more of the following fields was **corrected** after the initial MSP record was submitted and accepted:
  • Medicare ID (Field 1) or SSN (Field 9) – an incorrect person was originally identified
  • Effective Date (Field 10)
  • Coverage Type (Field 8) (**except** correcting 'A' to 'W'; send Update record only for this)
  • Relationship Code (Field 12)
  • Employer Size (Field 16)
  • Employee Status (Field 20)
	Send a Delete followed by an Add in the same file
	Send Delete Record:
	• '1' (delete) in the Transaction Type
	• All other fields with matching values sent on the original record
	Send Add Record:
	• '0' (add) in the Transaction Type
	• Corrected/updated information for all other fields

Changed MSP Information – Update/Add
• MSP record was previously reported and accepted
• One or more of the following fields used to determine MSP was subsequently **changed** after the initial MSP record was submitted and accepted:
  • Coverage Type (Field 8)
  • Relationship Code (Field 12)
  • Employer Size (Field 16)
  • Employee Status (Field 20)
	Send an Update followed by an Add
	Send Update Record:
	• '2' (update) in the Transaction Type
	• Last date the information was true in Termination Date (Field 11)
	• All other fields with matching values sent on the original record
	Send Add Record:
	• '0' (add) in the Transaction Type
	• Effective Date **of the changed information** in the Effective Date (Field 10). This should be the day after the Termination Date supplied on the update record.
	• Updated information for all fields

Other Changed Information (other than Key Field or information used to determine MSP) • MSP record was previously reported and accepted • One or more of the fields on the MSP Input Detail Record has changed other than the key fields and those used to determine MSP as specified above	**Send Update Record:** • '2' (update) in the Transaction Type • Values that match the original accepted record in key fields and other information used to determine MSP • Changed values for affected fields
Delete/Cancel Prior Record Submission • MSP record was previously reported and accepted • Record was submitted in error – it should not have been sent due to an RRE system problem or other issue	**Send Delete Record:** • '1' (delete) in the Transaction Type • All other fields with matching values sent on the original record

Event	RRE Action
Record Rejected with Errors • Submitted MSP record returned with an 'SP' disposition code in the corresponding response file record (not accepted, rejected by the BCRC due to errors)	**Correct errors:** • Send record with previously submitted Transaction Type (Add, Update, or Delete)
Record in Process at BCRC • Submitted MSP record returned with a '50', '52', '53', '61', 'AB', or 'CI' disposition code in the corresponding response file record (still being processed by the BCRC)	Resubmit same record
Ongoing Monitoring of Active Covered Individuals • MSP record previously submitted and rejected by the BCRC with a '51' disposition code • GHP coverage for the individual continues • Individual meets definition of Active Covered Individual	**Send Add Record:** • '0' (add) in the Transaction Type • Send record with current information according to specifications in Appendix A OR • Monitor using the query function (finder file) and send add once identified as Medicare beneficiary
Change in TIN Name or Address • MSP record was previously reported and accepted • Name or address information changes for the Employer or Insurer TIN submitted in Field 21 or 22	**Send updated TIN Reference File:** • Send updated TIN Reference File for affected TINs with updated name and/or address fields **Send Update Records for all matching MSP Input File Records:** • '2' (update) in the Transaction Type • All other fields with matching values sent on the original record. This will associate the new name/address with the MSP occurrence.
Request Small Employer Exception (SEE) for Previously Posted MSP Occurrence • MSP record was previously reported and accepted. No SEE Medicare ID (Field 32) submitted. • RRE subsequently determines that an approved SEE applies to the previously reported GHP coverage period.	**Send Delete Record:** • '1' (delete) in the Transaction Type • All other fields with matching values sent on the original record. Do not include SEE Medicare ID (HICN or MBI) on the delete record. **Send Add Record:** • '0' (add) in the Transaction Type • Current information for all fields. Include SEE Medicare ID (Field 32).

8.9 Helpful Reminders MSP Input Files

The following list includes some helpful reminders for RREs to consider when submitting MSP Input Files.

- Do not include GHP coverage related to a retirement plan on your MSP Input File, when coverage for the Active Covered Individual is not due to the current employment status of the subscriber/employee, unless the reported individual is likely to be entitled to Medicare due to ESRD.
- Always make sure the Employee Status (Field 20) reflects the correct employment status of the **subscriber/employee** when you are reporting GHP coverage for the subscriber or a dependent. Field 20 applies to the subscriber/employee who is not always the Active Covered Individual or beneficiary for which coverage is being reported.
- You must include the Medicare ID (HICN or MBI) for individuals under age 45 on MSP Input File Detail Records. The Medicare ID can be obtained directly from the beneficiary or by making use of the Query Only Input/Response File or the Beneficiary Lookup feature on the Section 111 COBSW.
- If an Active Covered Individual has a combination of hospital, medical, and prescription drug coverage under the GHP, make use of one of the comprehensive Coverage Type codes (Field 8) such as A, W, or 4. A beneficiary should never have two MSP occurrences, for the same time period, for the same type of coverage, or under the same GHP insurer. Do not submit separate, multiple records for hospital and medical coverage (e.g., Coverage Type J and K) unless the hospital and medical coverage are under separate GHPs with different insurers. If coverage for the beneficiary changes (e.g., from comprehensive hospital/medical to hospital only or medical only) submit an update record with a termination date for the previous coverage record and an add record that reflects the new Coverage Type with the associated effective date of that change.
- Delete transactions should only be submitted to 1) remove an entire record that was created in error or 2) **correct** a key field as specified in the Event Table.
- Make sure that Termination Dates reflect the last day of the coverage reported rather than the day after. Effective and Termination Dates are to reflect a coverage period “through and including” the reported dates not “up to but less than” the Termination Date. For example, if coverage ends at the end of the month of October, then report October 31 in the Termination Date, not November 1.
- RREs are encouraged to pre-validate employer and insurer/TPA addresses using postal software or online tools available on the USPS website pages, such as: https://tools.usps.com/go/ZipLookupAction!input.action. Please address errors immediately, as TN errors delay records posting.
- When submitting new or updated information on TIN Reference Records, be sure to also submit updates for MSP records previously submitted and accepted that have the matching insurer or employer TINs on the MSP Input File. In order to associate new TIN name and address information to an existing MSP occurrence, you must not only submit the TIN Reference File record but also resubmit the associated MSP Input File record.

8.10 MSP Input File Detailed Requirements

- MSP Input Files must contain properly formatted header, detail and trailer records as defined in Appendix A.
- MSP Input Files must be submitted on a quarterly basis, four times a year, unless an RRE has nothing to report for a particular quarter.
- Files must be submitted within your assigned, 7-day submission period each quarter.

  The receipt date of your file will be set to the date the BCRC batch system processes it. The BCRC runs batch processes nightly Monday–Friday excluding holidays. As batch processing may cross midnight, the receipt date may not be defined until the day after transmission by the Section 111 RRE. Files submitted on weekends will be held and not processed until the Monday night batch cycle. If your receipt date falls after your 7-day submission timeframe, your file will be processed but will be marked as late on subsequent compliance reports.
- New Section 111 RREs are to complete registration on the COBSW at least one quarter in advance of having production data to report for Section 111 in order to allow for adequate time to test the file submission process prior to the start of production file reporting.

8.10.1 MSP Initial Input Files

RREs' initial MSP Input File submissions must report on all Active Covered Individuals or Active Covered Individuals identified as Medicare beneficiaries through the query process, who had open coverage under you GHPs and regardless of the assigned date for a particular RRE's first submission.

However, if the GHP coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, you may submit that information on your next quarterly file (the following quarterly file submission period). This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. Records not received on time will be processed but marked as late and used for subsequent compliance tracking.

See special instructions for HRA reporting (Section 8.11).

A TIN Reference File must be submitted prior to or with the Initial MSP Input File, containing records for each TIN submitted in Fields 21 and 22 of the MSP Input File.

8.10.2 MSP Subsequent Quarterly Input Files

Subsequent MSP Input Files do not need to be accompanied by a TIN Reference File unless there are changes to TIN information previously submitted or new TINs have been added. Additionally:

- All TINs (or EINs) on the MSP Input File records must have a valid corresponding TIN record on the TIN Reference File.
- Subsequent quarterly update files must include records for any Active Covered Individual (or an Active Covered Individual identified as a Medicare beneficiary through the query process) that you have added to your plan since the last file submission.

  However, if the coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly

file. This grace period allows you time to process the new enrollee information internally prior to submission for Section 111.

For example, if an Active Covered Individual's GHP coverage effective date is May 1, 2019, and your file submission period for the second quarter of 2019 is June 1-7, 2019, then you may delay reporting that individual until your third quarter file submission during September 1-7, 2019. However, if the individual's GHP coverage effective date is April 1, 2019, then you must include this individual on your second quarter file submission during June 1-7, 2019. Records not received in time will be processed but marked as late and used for subsequent compliance tracking.

- Subsequent quarterly update files must include updates to any previously submitted record that has changed since the last submission.
- Quarterly update files must contain resubmission of any records found in error on the previous file (Disposition Code of SP) with corrections made. See Processing Response Files (Chapter 9) for more information.
- Quarterly update files must contain resubmission of any records that received the Disposition Codes 'ID' or '51' on the previous response file, if the individual is still covered and is an Active Covered Individual (or an Active Covered Individual identified as a Medicare beneficiary through the query process), with corrections applied as needed. See Processing Response Files in Chapter 9.

8.10.2.1 About Submitting Full-File Replacements

RREs are **NOT** to submit full-file replacements for the MSP Input File each quarter. You must process your MSP Response File per the instructions in this user guide. You must submit add, update and delete transactions according to the instructions in this user guide. RREs that continue to submit full-file replacements or send the same records repeatedly, regardless of the disposition codes returned on the MSP Response File or regardless of whether the individual meets the definition of an Active Covered Individual, are considered non-compliant with Section 111 Mandatory Reporting Requirements. Full file replacements are acceptable for submission of the TIN Reference File.

If you have no new information to supply on a quarterly update file, you may submit an "empty" MSP Input File with a header record, no detail records, and a trailer record that indicates a zero-detail record count. RREs are not required to submit empty files if they have nothing to report for a particular quarter. Empty files will be accepted but are not required. Response Files are not returned for empty file submissions.

Email notifications will be sent to the Account Manager assigned to the RRE ID after a file has been received, and when a response file has been transmitted or is available for download.

8.10.2.2 Requirements for Using Document Control Numbers

Each detail record on the MSP Input File must contain a unique Document Control Number (DCN) generated by the RRE. This DCN is required so that response records can be matched and issues with files more easily identified and resolved. It can be any format of the RREs choosing as long as it is not more than 15 text characters as defined in the record layout. The DCN only needs to be unique within the current file being submitted. Records may be submitted with the same DCN in subsequent file submissions as long as they are unique within the file submitted.

8.10.2.3 Proper Reporting of Employer Size

Employer size (the number of full or part-time employees, not the number of covered lives under a particular GHP) is critical to determining primary vs. secondary payment responsibility. RREs must report all Active Covered Individuals for all employers who are part of a multiple/multi-employer GHP regardless of the number of full or part time employees for a particular employer. RREs must have employer size information for all of the employers in a multiple/multi-employer GHP. Employer size must be reported on each MSP Input File record in Field 16. If the employer is part of a multi-employer plan, this field should reflect the size of the **largest** employer in the plan. Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on the calculation of employer size. Additional information can be found at https://www.cms.gov/manuals/downloads/msp105c01.pdf. All Medicare manuals can be found at https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms. The MSP Manual is publication 100-05. See Appendix G for more information on calculating employer size.

Employer size must be based on the size of the entire company or corporation, not just the subsidiary. When calculating the number of employees, RREs should use the total number of employees in an organizational structure (parent, subsidiaries and siblings) rather than just the number of employees in the particular subsidiary being reported on. Subsidiaries of foreign companies must count the number of employees of the organization worldwide. Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on this calculation. Additional information can be found at https://www.cms.gov/manuals/downloads/msp105c01.pdf. All Medicare manuals can be found at https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms on the internet. The MSP Manual is publication 100-05.

8.11 About FSAs, HSAs, and HRAs

A Flexible Spending Account (FSA) product is not considered to be GHP coverage for MSP purposes. RREs are not required to include FSA programs in Section 111 reporting.

A Health Savings Account (HSA) is typically associated with a high deductible GHP product. Under current law, Medicare beneficiaries may not make further contributions to the savings portion of an HSA, although they retain access to previous contributions, both their own and those made by an employer. The CMS will not consider HSAs to be reportable under Section 111 as long as Medicare beneficiaries may not make a current year contribution to an HSA or did not make a contribution during the time the beneficiary was a Medicare beneficiary.

A Health Reimbursement Arrangement (HRA) is a GHP arrangement and is subject to the MSP reporting provisions. HRAs include Individual Coverage HRAs (ICHRAs). ICHRAs can be used to pay both premiums and medical claims. All HRAs, including ICHRAs, Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs), and excepted benefit HRAs, are subject to the applicable MSP provisions regardless of whether or not they have an end-of-year carry-over or roll-over feature. An HRA **is funded 100% by an employer**. Additionally:

- HRA coverage should be reported in the RRE's regular quarterly MSP Input File which is submitted during the file submission timeframe assigned to the applicable RRE ID.
- Only HRA coverage that reflects an annual benefit value of $5,000 or more that is available to a specific Medicare beneficiary to pay medical claims is to be reported. HRAs with an annual benefit amount of less than $5,000 that is available to the specific Medicare beneficiary to pay medical claims are exempt from reporting. Amounts rolled

over from the previous plan year's coverage must be included when calculating the current year's annual benefit value. **Note:** The new $5,000 Annual Benefit Reporting Threshold applies to all new or renewing HRA coverage which became effective on or after October 3, 2011. RREs reporting existing coverage will continue to do so at the present threshold ($1,000) until the employer's HRA benefit period is renewed.

- Termination Dates are to be submitted when the covered individual loses or cancels coverage, or when the annual benefit value to pay medical claims is exhausted and no additional funds will be added to the HRA for the remainder of the HRA's current benefit coverage term.

  Note: Notice of the termination is to be provided to the BCRC by including it in the RRE's next regularly scheduled MSP Input File submission. The RRE may also call the BCRC Call Center, at 1-855-798-2627 (TTY/TDD: 1-855-797-2627), with notice of the termination.

- Once the GHP HRA benefit period is renewed, the RRE must submit a new add record on the MSP Input File for each Medicare beneficiary that is an Active Covered Individual and whose HRA annual benefit is $5,000 or greater to pay medical claims. The Effective Date (Field 10) should reflect the start date of the new coverage period.
- If reportable HRA coverage continues year to year, then the record may be reported with an open-ended Termination Date as is done with non-HRA GHP coverage reporting. A Termination Date should not be reported unless the HRA coverage is not continued or not renewed in the subsequent year.
- HRA coverage is to be reported using the values of 'R' or 'Z' in Coverage Type (Field 8) in the MSP Input File Detail Records.

  Note: If the HRA covers hospital, medical, and prescription drugs, an RRE will need to submit two separate MSP input records for an individual: one for Coverage Type 'R' and the other using Coverage Type 'Z.'

- HRA coverage is reported in addition to other applicable GHP coverage. Consequently, an RRE may need to submit multiple MSP Input File Detail records for an individual, one for the HRA using Coverage Type 'R,' a second for HRA using Coverage Type 'Z' (if the HRA also covers prescription drugs), and a record for the "standard" GHP coverage using the applicable value for that in the Coverage Type field.

Routine dental services, dentures, acupuncture, chiropractic services, cosmetic surgery, routine hearing examinations and hearing aids are not covered benefits in the Medicare program. Medicare does cover inpatient hospital services required in dental services. Routine vision care is also not a covered Medicare benefit, although Medicare does cover periodic eye exams to check for the presence of diabetic retinopathy and will pay for one pair of glasses after one particular type of cataract surgery. When offered as stand-alone products or "carve-outs," dental, acupuncture, chiropractic services, routine hearing exams, hearing aids and vision care GHP coverage are not to be included in Section 111 reporting. However, RREs are responsible for being aware of situations where services are covered by Medicare and pay primary to Medicare for all beneficiaries who have such stand-alone coverage when appropriate.

Behavioral/mental healthcare services are generally not covered benefits in the Medicare program. When offered as stand-alone products or "carve-outs", behavioral and/or mental healthcare GHP coverage is not to be included in Section 111 reporting. However, RREs are responsible for being aware of situations where healthcare services are covered by Medicare and

pay primary to Medicare for all beneficiaries who have such stand-alone coverage when appropriate.

Information concerning an individual's coverage under TRICARE or a Medicare Advantage plan (Part C) should not be included on the MSP Input File. TRICARE coverage is always secondary to Medicare, Medicare is the primary payer. Medicare Advantage is a form of Medicare coverage, so it does not apply to MSP determinations.

CMS recommends that RREs send a covered individual's Medicare ID (HICN or MBI) on MSP Input File records whenever it is available. The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries. It is CMS' identifier for Medicare beneficiaries and is the preferred data element for matching purposes. RREs are encouraged to obtain Medicare IDs from Medicare beneficiaries they cover for initial reporting. RREs must use the Medicare IDs passed back to them by the BCRC on response files on all subsequent transactions for the beneficiary.

Note: If you submitted a record initially using a HICN and it was accepted, and then updated it to an MBI, then use the MBI with future updates.

Special Note for Religious Orders: Members of religious orders who have taken a vow of poverty **may be** exempt from the MSP provisions. **This exemption is only applicable for work being performed as an employee of the religious order and where the religious order is providing the GHP coverage. If GHP coverage is provided by any entity other than the order (e.g., a school in which the member teaches or a hospital in which the member works) the exemption does not apply.** RREs are not to report GHP coverage on the MSP Input File when the coverage is provided by the religious order for individuals who have taken a vow of poverty and the coverage meets the conditions of this exemption. For further information on religious order exemptions, refer to the Medicare MSP regulations as cited in Section 5.5.

Chapter 9: Processing MSP Response Files

For every non-empty MSP Input File, you send to the BCRC for Section 111 reporting that is successfully transmitted without severe errors, the BCRC will send you a response file in return. The MSP Response File specifications are in Appendix A. The response file will be transmitted back to you within 45 days of receipt of your input file, in the same manner you used to send your input file. The response file contains a header record, followed by detail records for each record you submitted on your input file, followed by a trailer record that contains a count of the detail records supplied. This count does not include the header and trailer records. In some cases you may receive more than one detail record for the input records you sent, but ordinarily it will be a one for one exchange. The response file detail records consist of the same data elements in the input file you sent, with updated Medicare information applied by the BCRC, the disposition and error codes which let you know what the BCRC did with the record, as well as new information, such as Medicare entitlement and enrollment data, regarding the covered individuals themselves.

You must develop processing to react to the response file. Your response file for a given quarterly report must be processed before submission of your subsequent quarterly MSP Input File. Disposition, SP and Rx error codes, TIN Reference error codes are documented in Appendix D.

9.1 Disposition Codes

Every MSP Input File record will receive a disposition code on the corresponding response file record, and you must take the following actions:

- Records marked in error with an 'SP' disposition code must be corrected as specified in the error code description in Appendix D and resent on your next quarterly submission. Note that most errors require a correction on the part of the RRE but certain others do not.
- If a record was rejected with a disposition code of '51', which indicates the Active Covered Individual could not be matched to a Medicare beneficiary, you must continue to resend **current information** for this individual in subsequent quarterly file submissions until it is accepted, your coverage for this individual is terminated, or the individual no longer meets the definition of an Active Covered Individual (e.g., employment ends, retirement, etc.). Alternatively, you may use the query process to monitor the Medicare status of the individual and resubmit the MSP Input File Record only after determining the individual is covered by Medicare and remains an Active Covered Individual.
- A disposition code of '51' will also be returned if neither a valid Medicare ID (HICN or MBI) nor SSN is submitted on the input record. You must obtain a valid Medicare ID or SSN for the Active Covered Individual and resubmit the record on your next quarterly file submission.
- Records accepted with a '01' disposition code have been added by the BCRC as coverage primary to Medicare in the form of an MSP occurrence on the Medicare CWF or MBD and will be used in Medicare claims processing to make sure Medicare pays secondary.

The following fields may contain **updated** information from the BCRC based on Medicare's information and should be used to update your internal files:

- Medicare ID
- Active Covered Individual/Beneficiary Name
- Date of Birth
- Gender

Note: You must store the Medicare ID returned on the response file in your internal system and are required to use it on future transactions.

In addition, records returned with a '01' disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- MSP Effective and Termination Dates:

  These are the start and end dates for the period of time your coverage overlaps Medicare coverage, your coverage is primary to Medicare and should pay first.

  Note that in some cases, the MSP Effective Date may reflect a future date based on an established Medicare entitlement date in the future. The *MSP Effective Date* field will accept dates up to three months from the current date. This field can be in the future for currently entitled beneficiaries (i.e., enrolled in Medicare), or for beneficiaries who will be entitled starting up to three months in the future.

- Medicare Part A, B, C, and D Coverage Dates:

  Part D enrollment information will be returned to those who report primary prescription drug coverage.

- End Stage Renal Disease (ESRD) information.

Records that are rejected with any other disposition code must be resubmitted on your next quarterly update file. As a rule, you should check these records for accuracy, update the information previously sent, as applicable, and resubmit.

Note that since the age threshold for Active Covered Individuals is 45 but most people are not entitled to Medicare until they are 65, you will receive a significant number of records back with disposition '51' each quarter. This is a completely acceptable situation, and you should continue to send current information for these individuals with each quarterly submission until you receive a '01' disposition code, the GHP coverage is terminated, or the individuals no longer fit the definition of Active Covered Individuals.

9.2 SP Error Codes

In Appendix D, all possible SP error codes are listed for reference. In the table, each error code is marked as "RRE Responsible" or "BCRC Responsible". There are some errors that an RRE cannot fix, such as those related to conflicting data on internal Medicare databases.

Since the BCRC must send records to other Medicare databases to post the MSP occurrences, errors beyond your control can occur. Usually, the BCRC corrects these errors before creating and sending your response file. At times though, due to the requirement to send a response file back to an RRE within 45 days, a response file might be sent back to you before these errors can be properly addressed. Thus, on rare occasions you may see such an error on your response file,

accompanied by an SP disposition code. When this occurs, correct any other errors that are your responsibility and resend the record on your next quarterly submission.

9.2.1 Considering the SPES Error Code

On the MSP Input File, you are asked to submit a code in Field 16, Employer Size, to reflect the size of the employer sponsoring the GHP associated with each Active Covered Individual. A value of zero indicates the employer has less than 20 employees; a value of 1 indicates 20 to 99 employees and a value of 2 indicates the employer has 100 or more employees. This is not a simple count of current employees. Refer to Appendix G for more information on how to calculate the values for Employer Size.

The BCRC uses the value provided in the Employer Size field when determining whether the GHP coverage is primary to Medicare and thus establishing MSP occurrences. In some cases, an MSP occurrence is not created. For example, if an employer has less than 100 employees and the beneficiary is entitled to Medicare due to disability, Medicare will be the primary payer in any case and an MSP occurrence will not be created. (**Note:** If the employer is part of a multi-/multiple employer plan, Medicare is secondary if any employer in the plan has 100 or more employees.) When the BCRC determines that Medicare is the primary payer for the GHP coverage reported, it will return a disposition code of SP and put 'SPES' in one of the SP error code fields on the corresponding response file record.

Usually when processing an 'SP' disposition code, you are to correct all errors and resubmit a record in your next quarterly response file. The SPES error code requires special handling and is an exception to this general rule.

When you receive an SPES error on a response file record, check that the employer size submitted was correct, update it if the employer size was submitted incorrectly, and continue to resend the record on all subsequent quarterly file submissions until the individual is no longer covered by your plan or a '01' disposition code is returned. Since the employer size may not change, you may continue to receive a response record back with an SP disposition and SPES error code for these situations. However, you should continue to send these records in case the reason for the beneficiary's entitlement to Medicare changes (i.e., from disability to age) which may affect the MSP determination. As an alternative, the query process could be used to monitor the Medicare status of these individuals and resend the MSP Input File Detail Record as appropriate.

9.2.2 Considering Non-Overlapping GHP and Medicare Coverage

If the Active Covered Individual you submit on an MSP Input File add record is not found to be a Medicare Beneficiary, you will receive a disposition code '51' back on your response file. However, if the individual is a Medicare beneficiary but your GHP coverage does not overlap Medicare coverage because it ended prior to Medicare enrollment, no MSP occurrence will be built. For example, the GHP coverage may be from 1/1/2012 to 3/31/2012 and Medicare coverage begins on 4/1/2012. In this particular situation, you will receive a disposition code of SP with a SP error code of SP32 or SP62 indicating you sent an invalid termination date or an SP75 indicating that the beneficiary did not have Medicare Part A entitlement during your GHP coverage period. Of course, you cannot change the dates of your GHP coverage arbitrarily to "fix" this error. On an add record, you may ignore the error, and if the individual is no longer considered to be an Active Covered Individual because the individual is no longer covered by your plan, discontinue sending a record for that person on subsequent quarterly file submissions.

If the individual is still an Active Covered Individual, you must continue to send the record on subsequent files or monitor that person's Medicare status via the query process.

An SP32 error will also be returned when you submit an update record to post a termination date to a previously accepted open-ended record and the termination date on the update is prior to the beneficiary's date of Medicare entitlement. For example, this circumstance may occur if an employer is late in reporting a termination date to the insurer RRE. In this case, since the GHP coverage ended prior to Medicare entitlement, Medicare is primary, and no MSP occurrence should exist for the GHP coverage. In order to remove the MSP occurrence, send a delete transaction with the same effective date and zeroes in the termination date.

In all other cases, if you receive a SP32 or SP62 error, then you most likely submitted an actual invalid date that needs to be corrected, and the record must then be resubmitted. Please see the description of SP error codes in Appendix D.

9.2.3 Considering the SP99 Error Code

If an RRE submits an MSP Input File Detail record for a covered individual under age 45 without supplying a Medicare ID (HICN or MBI) on that record, then the record will be rejected with an 'SP' disposition code and an 'SP99' error code. The BCRC will not attempt to match this record to Medicare beneficiary information. A record submission of this kind will not protect an RRE from the risk of non-compliance with Section 111 reporting requirements as the BCRC will not retain a record of this submission since it is considered to be submitted in error. If an RRE needs to submit GHP coverage information for a **Medicare beneficiary under age 45**, the RRE must first obtain the Medicare ID for the beneficiary. This can be done by obtaining the information directly from the Medicare beneficiary.

To view and download the "Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers)" alert, go to the **Downloads** section of the GHP web page at: https://go.cms.gov/mirghp.

As an alternative, the RRE may submit a query record for this individual. If the information is matched to a Medicare beneficiary, the query response record will be returned with the current Medicare ID for the beneficiary, which then can be used to properly submit the applicable MSP Input File Detail Record. Reporting of individuals under the age threshold is only necessary for Active Covered Individuals under age 45 known to be Medicare beneficiaries, **not** all covered individuals under the age threshold. The Beneficiary Lookup feature on the Section 111 COBSW may also be used to submit an online query of Medicare status (see Section 15.1.2).

9.3 Rx Disposition and Rx Error Codes

Prescription drug information can be sent as part of a combined coverage record with hospital and/or medical coverage (Input Field 8 Coverage Types W, X, Y, 4, 5, 6) or as a separate coverage record for drug-only (Input Field 8 Coverage Types U, V, and Z). Records that contain information for both hospital/medical coverage and prescription drug coverage will receive one response record. The status of the hospital/medical coverage period will be provided in the disposition code field (Response Field 8) and the status of the drug coverage period will be provided in the Rx disposition code field (Response Field 69). If the input record contains drug coverage information only, then the disposition code in Field 8 may be spaces and the disposition of the drug coverage record will be in Response Field 69. This is because MSP occurrences for

hospital/medical coverage are stored on a different Medicare system database (CWF) than the drug coverage occurrences for prescription drug coverage (MBD).

The matching criteria for a drug coverage occurrence that is primary to Medicare Part D are:

- Medicare ID (HICN or MBI)
- MSP Effective Date (later of GHP drug coverage effective date or Part D Enrollment Date)
- Patient Relationship Code (self, spouse, dependent, etc.)
- Section 111 RRE ID (supplied on your header record)
- Insurance Coverage Type (Comprehensive hospital/medical/drug, Drug Only Network Drug, etc.)

The BCRC matches on these fields when processing update and delete transactions for drug coverage records.

The Rx Disposition Code (Response Field 69) provides you information regarding what was done with the prescription drug information you sent. The Rx Error Codes (Response Fields 71-74) are specific to the prescription drug coverage data elements on the MSP Input File including Rx Insured ID (Field 24) Rx Group (Field 25), Rx PCN (Field 26), Rx BIN (Field 27), Toll-Free Number (Field 28) and Person Code (Field 29). Drug records may also have errors for the non-drug-specific fields in the regular error codes found in Response Fields 40-43.

To process a response record for an input record that contains only hospital/medical information (Coverage Types A, J, K, and R), you must examine:

- The disposition code in response field 8
- The error codes in response fields 40-43

To process a response record for an input record that contains drug and hospital and/or medical information (Coverage Types W, X, Y, 4, 5, and 6), you must examine:

- The disposition code in response field 8
- The error codes in response fields 40-43
- The Rx disposition code in response field 69
- The Rx error codes in response fields 71-74

To process a response record for an input record that contains only drug information (Coverage Type U, V and Z), you must examine:

- The error codes in response fields 40-43
- The Rx disposition code in response field 69
- The Rx error codes in response fields 71-74

Every MSP Input File record containing drug coverage information will receive an Rx disposition code on the corresponding response file record and you must take the following actions:

- Drug records marked in error with an ‘SP’ Rx disposition code must be corrected and resent on your next quarterly submission.
- If a drug record was rejected with a Rx disposition code of ‘ID’ or ‘51’ which indicate the Active Covered Individual could not be matched to a Medicare Beneficiary, you must check the information you sent for accuracy and then continue to send **current**

information for the individual until it is accepted or this individual is no longer an Active Covered Individual.

- Drug records accepted with a '01' Rx disposition code have been added by the BCRC as drug coverage primary to Medicare in the form of an MSP occurrence on the Medicare MBD and will be used in Medicare claims processing to make sure Medicare pays secondary. The following fields may contain updated information from the BCRC and could be used to update your internal files:
  - Medicare ID (HICN or MBI)
  - Active Covered Individual/Beneficiary Name
  - Date of Birth
  - Gender

Note: You must store the Medicare ID returned on the response file in your internal system and are required to use it on future transactions.

In addition, drug records returned with a '01' Rx disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- MSP Effective and Termination Dates – start and end dates for the period of time your coverage is primary to Medicare and should pay first.
- Medicare Part A, B, C, and D Coverage Dates – Part D enrollment information will be returned to those who report primary prescription drug coverage.
- End Stage Renal Disease (ESRD) information

Records that are rejected with an Rx disposition code other than those listed above must be resubmitted on your next quarterly update file. As a rule, you should check these records for accuracy, update the information previously sent as applicable, and resubmit.

Note: Section 111 RREs that receive RX 07 error codes when submitting drug records for beneficiaries who have not yet enrolled in a Medicare Part D plan can resubmit records that received this error on your first file submission of the next calendar year or monitor the individual's Medicare Part D enrollment status by logging in to the Section 111 COBSW portal and using the Beneficiary Lookup Tool.

Please make note that there are Special Enrollment Periods (SEPs) that can make a Medicare beneficiary qualify for Part D. It is the RRE's responsibility to ensure correct reporting.

9.3.1 Considering the RX19 Error Code

On the MSP Input File, you are asked to submit a code in Field 10 (Effective Date) to reflect the start date of the covered individual's GHP Coverage and submit a code in Field 11 (Termination Date) to reflect the end date of the covered individual's GHP Coverage. If an RRE submits an MSP Input File Detail record (add or update transaction) for any drug coverage type (U, V, W, X, Y, Z, 4, 5, or 6) with an effective date or termination date that falls within or overlaps an existing drug record's effective date or termination date, the record will be rejected with disposition code "SP" and Rx error "RX19 – Overlapping Rx Coverage" on the response file.

If the drug coverage is continuous, you do not need to periodically submit records with updated coverage dates if these dates already fall within the same period for the beneficiary. For example, if the coverage is from 01/01/24 to 12/31/24 and an RRE submits an add or update transaction

with coverage that begins 02/01/24 and ends 12/31/24 or the termination date is left open-ended, the record will be rejected with the SP disposition code and RX19 error.

Note: Prescription drug information sent as part of a combined coverage record with hospital and/or medical coverage (Coverage Types W, X, Y, 4, 5, or 6) will only be rejected for the drug portion of the record if it has overlapping drug coverage dates. Overlapping coverage will result in an RX20 error for RREs who are not the original reporter, which will trigger a warning but not a rejection of the record, allowing submissions and thus increasing likelihood of timely submission.

9.4 Part D Eligibility and Enrollment Data

The MSP Response Files contain five related fields that can have information about current Medicare Part D eligibility and enrollment. Fields 57, 58, and 59 contain information for those reporting under the Expanded Reporting Option. These fields contain information for those reporting primary prescription drug coverage under the Basic Reporting Option. Those fields will be left blank on MSP Response File records for those not reporting primary prescription drug coverage under the Basic Reporting Option.

Part D Eligibility Start Date (Field 60). This is the first date a Medicare beneficiary can enroll in Part D. It is almost always the effective date of coverage for the beneficiary's Part A or Part B participation. Information in this data field **does not** show that a beneficiary has enrolled in Part D.

Part D Eligibility Stop Date (Field 61). This is the date that a Medicare beneficiary's right to enroll in Part D has ended, for any reason.

Current Medicare Part D Plan Contractor Number (Field 57). This identifies the beneficiary's current Part D Plan contractor number.

Current Medicare Part D Enrollment Date (Field 58). This is the effective date of a Medicare beneficiary's most recent enrollment in Part D. It is the current first date the beneficiary can receive Part D benefit coverage.

Current Medicare Part D Plan Termination Date (Field 59). This is the last date a Medicare beneficiary can receive Part D benefit coverage from the beneficiary's current Part D plan. After this date the beneficiary is no longer enrolled and can no longer receive benefit coverage from the (most recent former) Part D plan.

MSP Response File Fields 58 and 59 tell you whether a beneficiary has actually chosen Part D coverage, and the period of time the current benefit coverage is in force. For Section 111 RREs, these two fields are the most immediate indicators of Part D coverage.

9.5 MSP Input File Threshold and Severe Errors

9.5.1 Threshold Errors

After completion of data quality edits, the BCRC will check your MSP Input File to ensure it does not exceed any threshold restrictions. Threshold checks are performed to identify a file that may be in error. In some cases, there could be a reasonable explanation. The file threshold checks include:

- More than 5% of the total records are delete transactions.
- More than 13% of the individuals reported are 79 years old or older.

- 20% or more of the total records failed with a disposition code of SP due to errors.
- More than one MSP Input File was submitted during your defined quarter.

A file that exceeds the threshold checks will be suspended from further processing until the suspension is overridden by your EDI Representative. An email will be sent to your Account Manager to inform him/her of this suspension. You must contact your assigned EDI Representative to discuss and resolve file threshold errors. Your file may be released for processing or, if sent in error, deleted by your EDI Representative in which case you may need to send a corrected file as instructed by your EDI Representative.

Notes: The age threshold check is intended to identify a possible situation where an RRE mistakenly included individuals covered by retirement plans, and not Active Covered Individuals whose GHP coverage should be primary, to Medicare on the MSP Input File. This is one of the most common reporting problems and results in mistaken claim denials for Medicare beneficiaries and requires the RRE to submit delete records to remove erroneous MSP occurrences. RREs that report a large volume of data for many employer GHPs may want to run a similar age threshold check internally for each employer GHP separately since a large volume of data will mask a problem at the plan level on a file submitted to the BCRC.

A file is placed into MSP HOLD (TIN) when a previous TIN file goes into Severe Error status. EDI will continue to hold the MSP file until a corrected TIN file is submitted or until the Account Manager requests release. If no response is received, the file will be deleted after 50 days.

The following table provides some additional information for each threshold error an RRE may receive. However, RREs must always contact their EDI Representative in the case of a threshold error.

Table 9-1: Threshold Errors

Threshold Error	Explanation/Correction
5% or more of records are delete transactions	Examine use of the delete function. Do not submit deletes when GHP coverage ends. Submit updates with termination dates instead. Only submit deletes to remove erroneous records previously accepted with a '01' disposition code. Very small files may suspend for very few delete records. If the delete transaction was used correctly, your EDI Representative will release the file for normal processing.
20% or more of records failed record level edits	Error messages will display in the threshold email. Contact your EDI Representative to discuss most common errors found. Your EDI Representative will provide further instruction. Very small files may suspend for very few records in error. In that case, your EDI Representative may release the file for processing.
Multiple files submitted. Exceeds allowed submission frequency.	Only one MSP Input File may be submitted per calendar **quarter**. Only one Query Only File may be submitted **per quarter**. Only one Non-MSP Input File with N/D records may be submitted per **month**.
File submitted prior to assigned submission period	Files received up to 14 days prior to the start of the RRE's assigned file submission timeframe will be considered early and placed in a hold status. Once the file submission timeframe arrives, the file will be automatically released for processing. If this file should be processed immediately, contact your EDI Representative.

Threshold Error	Explanation/Correction
Another file in process for/still processing from prior submission period	A file of the same type submitted previously is still processing. This prior file must complete processing before the new file can be released by your EDI Representative.
Late submission of file	File receipt date is after the current submission period. No file correction is needed. Files must be submitted in time to prevent this error. Contact your EDI Representative to have the file released for processing as appropriate.
Large number of aged beneficiaries	13% or more of the individuals submitted on the file are age 79 or older. This may indicate that the RRE included individuals covered by retirement plans rather than limiting the submission to Active Covered Individuals (including those over the age threshold covered by current employment and those diagnosed with ESRD). Review the records submitted for those over age 65 on the file and verify that they are truly covered by their own or their spouse's current employment. Advise your EDI Representative accordingly. If the file contained erroneous records, your EDI Representative will delete it and you will send a corrected file.
File held via watch list	Your RRE ID has been put on a watch list by the BCRC due to past issues with erroneous file submissions. Contact your EDI Representative to resolve.

9.5.2 Severe Errors

Files detected with severe errors will also suspend from processing. An email will be sent to the Account Manager for the RRE ID regarding the severe error found. You must contact your EDI Representative to discuss the situation. The EDI Representative will then delete the file and provide you with instructions as to when to send a corrected file. Files that have been in severe error status for more than 50 days will automatically be deleted. Severe errors include:

- Missing or improperly formatted header or trailer records
- Record counts that do not match those actually submitted

The following table provides some additional information for each severe error an RRE may receive. However, RREs must always contact their EDI Representative in the case of a severe error.

Table 9-2: Severe Errors

Severe Error	Explanation/Correction
File has invalid RECFM/Record Format	Files must be submitted in a fixed-block format with all records of the same fixed length.
File has invalid LRECL/records with invalid record lengths	The record length of each record on the file must match that specified in the record layouts in the appendices. All unused fields must be set to default values and filler at the end of the record must be filled with spaces to the end of the record length.
File empty	A file with no header, detail and trailer records was transmitted to the BCRC. Transmission may have failed or there was a problem at the RRE with the creation of the file. If you have nothing to report for a quarter, you may submit a header record, no detail records and a trailer record with a zero-record count.
Header record was missing	Header record starting with the characters ‘H0’ was not present prior to encountering a detail or trailer record. Do not submit detail records with Medicare IDs (Health Insurance Claim Numbers [HICNs] or Medicare Beneficiary Identifiers [MBIs]) starting with ‘H0’ or ‘T0’ as these are not valid and might be confused with header and trailer records.
Header record does not match filename or Header record RRE ID does not match mailbox RRE ID	The RRE ID on the file header record does not match the RRE ID under which it was uploaded. The file was uploaded via HTTPS under the wrong RRE ID or sent to the wrong SFTP mailbox.
Header record not formatted properly	Refer to the file layouts in the appendices for proper header record formats. In particular, the header indicator and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as CCYYMMDD.
Trailer record missing	No trailer record was found at the end of the file or prior to the system encountering another header record beginning with ‘H0’. Do not submit detail records with Medicare IDs starting with ‘H0’ or ‘T0’ as these are not valid and might be confused with header and trailer records.

Severe Error	Explanation/Correction
Trailer record not formatted properly	Refer to the file layouts in the appendices for proper trailer record formats. In particular, the trailer indicator and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as CCYYMMDD, and the record count must be numeric with leading zeroes as appropriate.
Trailer record does not match header record	The RRE ID and/or file submission dates on the header and trailer records are not the same.
Trailer record count does not match count of records in file	The trailer record count should only include the number of detail records on the file. Do not include the header and trailer records in this count.
Test file with more than 100 records	Test files must be limited to 100 detail records or less. Resubmit a new test file with fewer records.
Production file reporter status not equal to P	A production file was received for an RRE ID that is not in a production status. Make sure your profile report has been signed by your Authorized Representative and returned to the BCRC. Verify testing requirements have been met. If so, contact your EDI Representative to request that your RRE ID be changed to a production status.
Reporter in discontinued/inactive status	A test or production file was received but your RRE ID has been deactivated. File submitted in error. Check to see that the proper RRE ID was used and that the file was sent to the proper RRE ID mailbox/dataset. If this RRE ID is still in use, ask your EDI Representative to correct the status of your RRE ID.

9.6 Late Submission Indicator

The MSP Response File contains a Late Submission Indicators that provides information on issues related to reporting compliance. This indicator is different from an error code. Unlike an error code, a record will **not** be rejected if the Late Submission Indicator is set. Instead, the record is processed, and an MSP occurrence posted if applicable. However, the BCRC will set the indicator, track this information, and include it on compliance reports. The indicator provides the RRE notice that the submitted record was not in compliance with Section 111 reporting requirements. You must apply corrections to your internal system or data used for Section 111 reporting and ensure that records are submitted in time.

The Late Submission Indicator in Field 82 indicates that the submitted record was not sent in time. It is set to a value of 'Y' when the later date of either the effective date of the covered individual's GHP coverage (Field 10 on the incoming MSP Input File) is more than 45 calendar days prior to the start of the RRE's prior quarter submission timeframe or the Part A add date from MBD is greater than 135 calendar days before the start date of the RRE's file submission period. If the coverage effective date is within 45 days prior to the start of your 7-day file submission timeframe, then you may submit that information on your next quarterly file. This grace period allows you time to process the new enrollee information internally prior to submission for Section 111. Another way to look at it is that any record received on a quarterly file submission will be marked as late if the later of the effective date or the Part A add date is more than 135 days older than the start date of that same file submission period.

For example, suppose your second quarter file submission timeframe is June 1-7 and your third quarter file submission timeframe is September 1-7. The start date of your second quarter file submission is then June 1 and the start date of your third quarter file submission is September 1. A record with a GHP effective date of April 1 MUST be submitted on your second quarter file submission since April 1 is more than 45 days older than June 1. If it is received in your third quarter file submission in September (or later), it will be considered late, and the corresponding response record will have a 'Y' in the Late Submission Indicator field. However, a record with a GHP effective date of May 1, if received in your third quarter file submission, will not be marked as late since it is not more than 45 days older than June 1. The record with an effective date of May 1 may be submitted with your second quarter file submission in June if you have the information available in your system at that time. If not submitted in June, it MUST be submitted in your third quarter file submission in September. Note that the BCRC will account for an individual's age in this determination. If the individual was not over the age threshold for reporting on April 1 in the previous example, the Late Submission Indicator will not be set.

9.7 Split Entitlement Indicator – Multiple Response Records

Medicare entitlement and enrollment can begin, end and then begin again depending on many factors, which can result in a beneficiary having multiple periods of Medicare coverage. In addition, the reason for Medicare entitlement can change due to a disabled beneficiary turning age 65. Due to these multiple periods of coverage and reasons for entitlement, the BCRC may create more than one MSP occurrence for a period of coverage under your plan. When this situation occurs, you will receive more than one MSP Response File record for the one Input File record submitted. Each response record will have a different MSP Effective and Termination Date depending on the periods of Medicare coverage. Your GHP coverage is primary during the MSP Effective and Termination Dates and during any periods where there is no Medicare coverage. Each Response File record will contain a 'Y' in the Split Entitlement Indicator (Response Field 44). Each record will contain your original DCN supplied on the input file record so you can match them to the original record submitted.

To maintain previously reported GHP coverage which was returned with multiple response records with Split Entitlement Indicators of 'Y', in most cases you **could** continue to send any applicable updates and deletes to previously accepted records by transmitting one record with the original GHP effective date. The system will take that record, look at the beneficiary's entitlement, and in the case of split (or dual) entitlement, split the update or delete transaction and apply it to the two MSP records accordingly.

For example, suppose an MSP Input File Detail Record is sent for GHP coverage effective 1/1/2010 and an open-ended termination date (00/00/0000). The beneficiary was originally entitled to Medicare due to disability on 1/1/2009 and then became entitled due to age on 7/1/2010. Two MSP Response records will be returned with a '01' disposition code and 'Y' in the Split Entitlement Indicator. The first response record shows an MSP occurrence under the disability entitlement with an effective date of 1/1/2010 and a termination date of 6/30/2010. The second shows an MSP occurrence with an effective date of 7/1/2010 and an open-ended termination date under the aged entitlement. The "split date" is 7/1/2010. If you now send an update or delete record with the same key fields as you originally sent including the effective date of 1/1/2010, the system will apply the update or delete to both records. Suppose you send an update to submit a termination date for the GHP coverage for 9/30/2010. Since the first record is already terminated prior to 9/30/2010, the 9/30/2010 date would only get applied to the second record.

However, there is a circumstance where this will not work. It is only when a GHP termination date is submitted that is **PRIOR** to the "split date." The system splits the incoming transaction first and then applies the split records to MSP occurrences it has or creates MSP occurrences if applicable. If a record is sent that has a termination date prior to the split date, then it won't be split. This results in the update transaction only being applied to the first record. In order for this to happen in the example above, you would have to submit an update record with an effective date of 1/1/2010 and a termination date prior to 7/1/2010. That termination date would only be applied to the first record and the second record would remain open which is not what you want to happen since the GHP coverage ended. The result would be an open-ended MSP occurrence 7/1/2010 – 00/00/0000. Medicare would erroneously deny claims submitted as primary with dates of service 7/1/2010 and subsequent until this MSP occurrence is deleted. Even though this doesn't occur very often RREs should maintain the split records in their systems in order to properly maintain the MSP occurrences.

To correctly maintain MSP information and avoid the situation described above, the RRE would need to take the MSP Effective and MSP Termination Dates returned on the split response records, maintain those in its system and send updates and deletes using those dates. In other words, using this example, maintain two separate records one for 1/1/2010 – 6/30/2010 and the other for 7/1/2010 – 00/00/0000. However, there is no reason to maintain the first MSP occurrence which was terminated on 6/30/2010 unless you reported it erroneously and it needs to be deleted or the GHP coverage actually ends prior to 6/30/2010. In that case, an update would be sent to terminate the first record and a delete would be sent to remove the MSP occurrence of 7/1/2010 – 00/00/0000. For any other coverage changes, just the second record with an MSP Effective Date of 7/1/2010 will need to be maintained ongoing.

9.8 MSP End Stage Renal Disease (ESRD)

To allow Section 111 reporting entities to better coordinate benefits for Medicare beneficiaries with End Stage Renal Disease (ESRD), the BCRC will provide ESRD data fields on your MSP Response File. These fields are the ESRD Coordination Period Start and End Dates, the First (oldest) Dialysis Date, the Self-Training Date, the most recent Kidney Transplant Date, and the most recent Kidney Transplant Failure Date. Please refer to MSP Response File Fields 75-80 in the file specifications in Appendix A.

For an individual with ESRD there is an initial 30-month coordination of benefits period where the patient's GHP coverage may be primary to Medicare. Subsequent to that 30-month period, Medicare becomes the primary payer regardless of the patient's other GHP coverage. There are conditions that must be met in order for a patient to receive Medicare benefits and coverage for an ESRD diagnosis. Refer to https://www.cms.gov/training-education/open-door-forums/end-stage-renal-disease-clinical-laboratories-esrd/general https://www.cms.gov/medicare/enrollment-renewal/health-plans/original-part-a-b and https://www.cms.gov/medicare/coordination-benefits-recovery/overview/end-stage-renal-disease-esrd for more information related to the coordination of benefits with Medicare for ESRD. This topic is also covered in the computer-based training curriculum made available to RREs as described in Chapter 19.

Note that the MSP Effective Date on the MSP Response File may be adjusted to coincide with the start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare.

9.9 Hierarchy Requirements

9.9.1 Background

The BCRC is charged with collecting information to identify other health insurance that Medicare beneficiaries have that is primary to Medicare coverage. This other insurance information is posted by the BCRC in the form of MSP occurrences on the Medicare Common Working File (CWF) and Medicare Beneficiary Database (MBD). It is then used in the Medicare claims payment process to prevent mistaken payment of Medicare benefits and for subsequent recovery where mistaken payments were made prior to the identification of the other primary health insurance.

To obtain comprehensive other insurance information and post it to CWF in a timely fashion to prevent mistaken Medicare payments, the BCRC utilizes various methods of data collection mandated Section 111 reporting, voluntary data sharing agreements, and telephone calls to the Beneficiary Call Center (1-800-Medicare) and the BCRC Call Center. While each of these methods has proven effective, CMS has found that historically, some sources are more reliable than others and collection from different entities resulted in conflicting information or "flip-flopping" of certain fields that make up an MSP occurrence. This in turn resulted in reduced data integrity, inaccurate Medicare claim payment and recovery issues. Most often, the conflicting information was related to the MSP Termination Date. To resolve this issue, the BCRC implemented a hierarchy of sources to determine which source's update should take precedent.

When the Part D program was implemented, the BCRC initially used a COB Identifier field (uniquely identified the source) to prevent the "flip flopping" of updates; however, this resulted in duplicate drug coverage occurrences. With the April 2023 release, hierarchy requirements like those for MSP were implemented to address the problems with duplicate prescription drug records. Both hierarchies are discussed in this section.

9.9.2 MSP Hierarchy Requirements

CMS has ranked all of the possible sources of an update/delete request from the highest level (first) to the lowest level (fifth). When an update or delete transaction is received that matches an existing MSP occurrence, the source of that information and its associated hierarchy ranking will be compared to the source and hierarchy ranking of the existing occurrence. The following table illustrates the hierarchy rank associated to each source. When an update/delete transaction is received, the BCRC will compare the source of the incoming transaction to the source of the existing transaction. The decision to apply the update or delete will be based on the hierarchy ranking of each source. If the hierarchy ranking of the source on the incoming transaction is greater than or equal to the hierarchy ranking of the source on the existing transaction, the update/delete transaction will be allowed. If the hierarchy ranking of the source on the incoming transaction is lower than the hierarchy ranking of the source on the existing transaction, the update/delete transaction will NOT be allowed.

The hierarchy requirements for MSP occurrences and prescription drug records are described in this section.

Table 9-3: MSP Hierarchy Requirements

Hierarchy Ranking	Source of Update/Delete Request
First	BCRC Analyst (11100) **Note**: The BCRC Analyst will have the authority to **manually lock** an MSP occurrence from any subsequent changes except those made by the BCRC.
Second	• BCRC Call Center/BCRC CSR (11110) • Beneficiary Call Center (1-800-Medicare) (11140) • CRC GHP Recovery (11139) • CRC ORM Recovery (11142)
Third	• Section 111 GHP RREs (11121) • Section 111 NGHP RREs (11122) • Medicare Advantage (MA)/(Part C Plan) (11143)
Fourth	• Employer Voluntary Data Sharing Agreements (VDSAs) (11105) • Employer response to IRS/SSA/CMS Data Match Questionnaire
Fifth	• Medicare Administrative Contractors (MACs) • Other Medicare Contractors • All others

9.9.3 Processing Records Using Hierarchy Requirements

Using the hierarchy requirements, when an update or delete transaction is received, the BCRC will:

- Attempt to match the incoming update or delete transaction to an existing MSP occurrence.
- Reject the record if there is no match.
- If there is a match, it will compare the hierarchy ranking of the entity submitting the current (incoming) transaction to the hierarchy ranking of the entity that last added, updated, or deleted the matching MSP occurrence.
- Apply the following rules to the existing MSP occurrence:
  - Allow the update/delete if the hierarchy ranking of the source of the request is greater or equal to the hierarchy ranking of the entity that last added or changed the occurrence.
  - Disallow the update/delete if the hierarchy ranking of the source of the request is lower than the hierarchy ranking of the entity that last added or changed the occurrence. (These update/delete transactions will be rejected.)

The examples that follow (also depicted in the following table) demonstrate how an update/delete transaction will be handled by the BCRC:

- If the current source of an update/delete transaction (e.g., a BCRC CSR or the CRC in Tier 2) is a higher-ranking source than the previous source of the add/update/delete (e.g., an RRE in Tier 3), the update/delete will be allowed.
- If the current source of an update/delete transaction (e.g., a Medicare Advantage Plan in Tier 3) is in the same ranking Tier as the previous source of the add/update/delete (e.g., an RRE in Tier 3), the update/delete will be allowed.

- If the current source of update/delete transaction (e.g., an RRE in Tier 3) is in a lower ranking Tier than the previous source of the add/update/delete (e.g., a BCRC CSR or the CRC in Tier 2), the update/delete will NOT be allowed.

Table 9-4: Hierarchy Requirements Examples

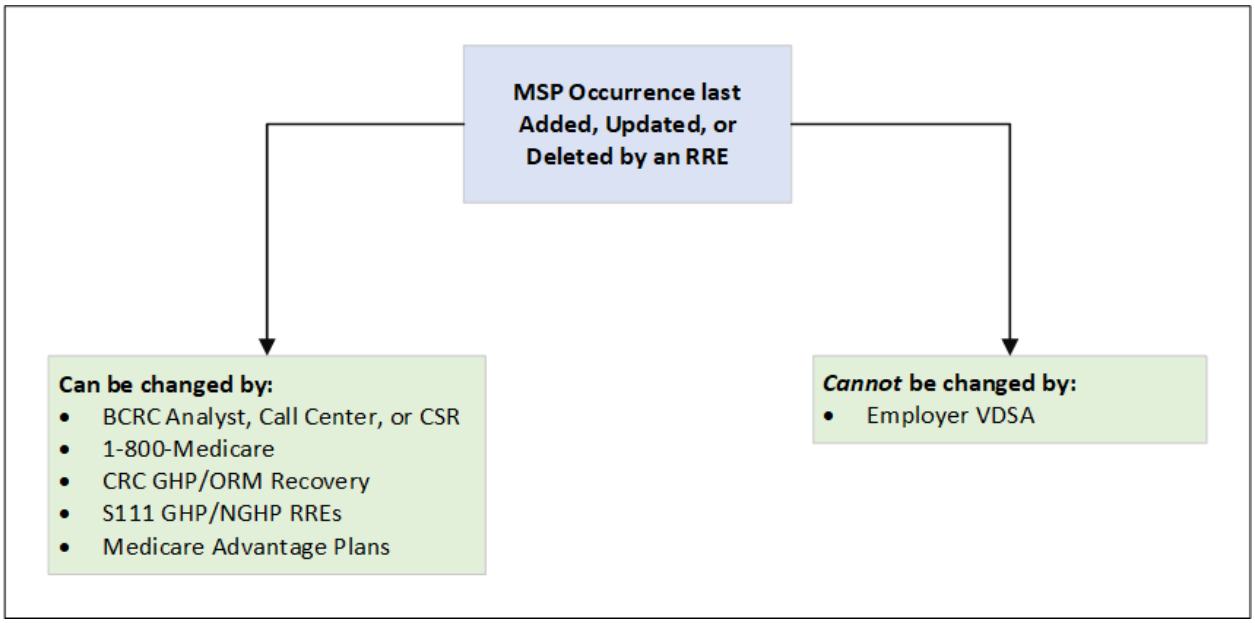
Current Source (Tier Level) of Update/Delete Transaction	Previous Source (Tier Level) of Add/Update/Delete Transaction	Change Permissible
BCRC CSR or CRC (Tier 2)	Section 111 GHP RRE (Tier 3)	Yes
Medicare Advantage Plan/Part C Plan (Tier 3)	Section 111 GHP RRE (Tier 3)	Yes
Section 111 GHP RRE (Tier 3)	BCRC CSR or CRC (Tier 2)	No

9.9.4 Effect of Hierarchy Requirements on RRE Submissions

Even with MSP hierarchy requirements in place, MSP occurrences established by RREs can be updated or deleted by other RREs, the BCRC Call Center, a BCRC Analyst, the Beneficiary Call Center (i.e., 1-800-633-4227), or a Medicare Advantage (MA) Plan.

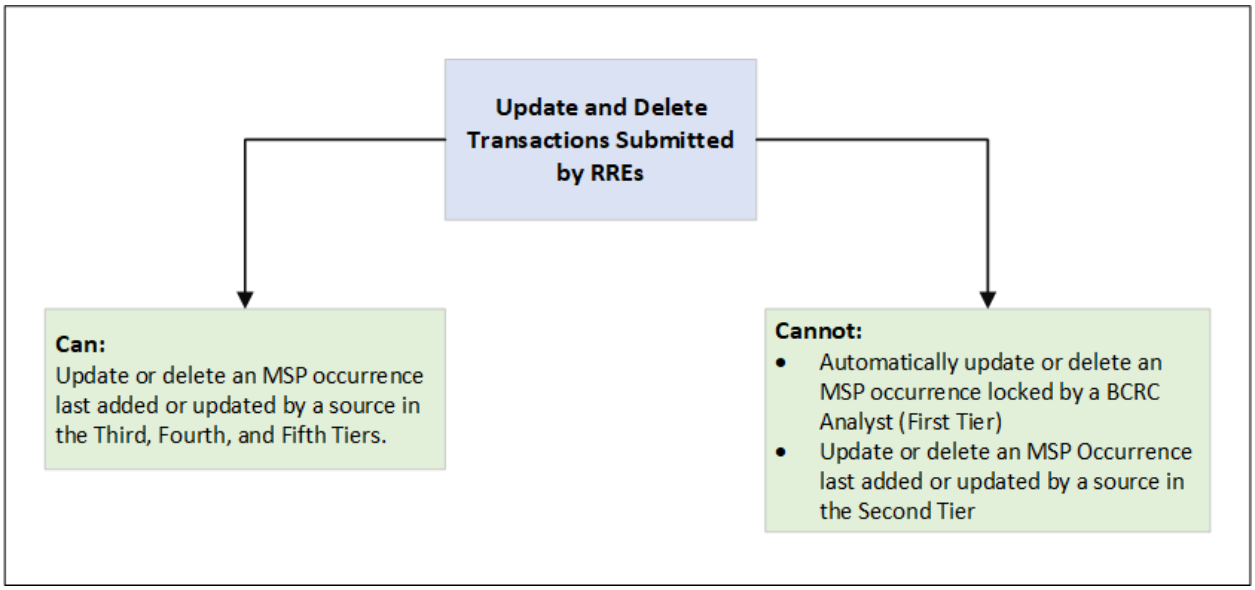
The following figure shows which entities can/cannot change an MSP occurrence that was last added, updated, or deleted by an RRE.

Figure 9-1: MSP Occurrence Add, Update, and Delete Permissions



The MSP hierarchy requirements also affect the RREs ability to make updates or deletes to records. The following figure shows the precedence of an update or delete transaction submitted by an RRE to a previously submitted record.

Figure 9-2: MSP Occurrence Update & Delete Permissions



When an RRE attempts to update or delete an MSP occurrence that was last added or updated by a higher-ranking source, the record will be rejected. The error returned on the MSP Response File will depend on whether or not the MSP occurrence is locked. As noted in Table 9-3, the BCRC Analyst will have the authority to **manually lock** an MSP occurrence from any subsequent changes except those made by the BCRC. Records rejected due to hierarchy requirements will include the following errors:

SPH0 (ending in the numeral zero) – Transaction attempted to update/delete an MSP occurrence last updated by a higher-ranking source. MSP occurrence is **not locked**.

SPH1 – Transaction attempted to update/delete an MSP occurrence **locked** by the BCRC. No update or delete accepted via Section 111 reporting.

9.9.5 Hierarchy Override Code

The Override Code, Field 33, on the MSP Input File Detail Record, allows an RRE (Third Tier) to apply an update or delete to an unlocked MSP or primary dug coverage occurrence that was last updated by a source/entity ranked higher than the RRE in terms of the MSP hierarchy requirements. **Note:** The Override Code, Field 28, on the Non-MSP Input File Detail Record is used for supplemental drug coverage occurrences.

After receipt of the SPH0 error, you must:

- Review submitted information and determine if the update/delete must be applied:
- If you determine that the update/delete must be applied, then submit the transaction again in your next quarterly file submission with a value of HB (Hierarchy Bypass) in the Override Code (Field 33) of the MSP Input File Detail Record.
- If you determine that the update/delete does not need to be applied, which may be the case if your information is out of date (e.g., the employee/subscriber retired), then update the information in your internal system and take no further action.

After receipt of the SPH1 error:

- You are advised to contact the associated employer/other plan sponsor to verify the accuracy of the submitted data.

- Do **NOT** attempt to resubmit this record. The only way to apply the update/delete is by contacting the BCRC.
- If changes are necessary, contact the BCRC Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired.
- If you determine that the update/delete does not need to be applied, then update the information in your internal system and take no further action.

Note: You are advised to retain a record of SPH0 and SPH1 errors received as documentation of failed Section 111 data submission attempts.

9.9.6 Prescription Drug Hierarchy Requirements

The hierarchy rules for Part D primary and supplemental drug records are described in Table 9-5.

If the MSP record is accepted based on hierarchy rules, hierarchy rules are also applied to the drug record.

Table 9-5: Primary and Supplemental Drug Record Hierarchy Requirements

Hierarchy Ranking	Source of Update/Delete Request
First	BCRC Analyst (11100) **Note**: The BCRC Analyst will have the authority to **manually lock** a drug occurrence from any subsequent changes except those made by the BCRC.
Second	• BCRC Call Center/BCRC CSR (11110) • SPD/PDC Questionnaires (11110) • Beneficiary Call Center (1-800-Medicare) (11140) – Primary only
Third	• Section 111 GHP RREs (11121) • Part C/D Plans – PDP Medicare Advantage (MAPD) automated PDARs/ARs (11143) • Part D Plan – PDP automated PDARs/ARs (11143) • COBA Contractor (11120) (not Supplemental Type 1 Medicaid) – Supplemental only
Fourth	• PDIs (11109) • WCMSA Contractor (11119) – Primary only • Contractor ID (11106) (not Supplemental Type 2 Tricare) – Supplemental only • All Other Contractor IDs
Fifth	• VDSAs (11105)

9.10 Unsolicited MSP Response File

9.10.1 Overview

The Unsolicited MSP Response File notifies GHP RREs whenever another entity changes or deletes an MSP occurrence (includes combination MSP/drug coverage and drug coverage-only records) previously submitted by them. GHP RREs can voluntarily elect to participate and receive this file. Once an RRE elects to receive the Unsolicited MSP Response File, the BCRC

will track the MSP occurrences for which the RRE has submitted MSP Input File records that were accepted with a '01' disposition code. Whenever one of these MSP occurrences is changed by an entity other than the participating RRE over the last month, a record is written to the RRE's Unsolicited MSP Response File. The BCRC then transmits the Unsolicited MSP Response File to the RRE once per month. The Unsolicited MSP Response File contains information for the RRE to identify the MSP occurrence and information regarding the modifications that were subsequently applied (e.g., source and reason for the change).

9.10.2 Benefits

This prompt notification of changes and identification of the source of changes assists participating RREs in many ways:

- By electing to use and verify the information in the Unsolicited MSP Response File, a **participating RRE** can submit an update transaction on their MSP Input File using the Hierarchy Override Code (HB) **before receiving the SPH0** error. RREs that do not participate and use the override code to update a S111 GHP record without first receiving the SPH0 error will continue to receive the SPH2 error, but the record will reject with an SP disposition code (see Section 9.2 for more information). **Note:** An SPH0 error will be received if an RRE submits an update/delete transaction for an MSP occurrence or drug coverage record that was last updated by a higher-ranking source.
- Allow for more precise confirmation or investigation of GHP coverage and its relevance to MSP determinations. Knowing the source of the change and reason for the update/delete request will assist the RRE in confirming the validity of a reported modification, and of the data in its own system The RRE can use this information to verify the accuracy of the update/delete request with the source that submitted the change to ensure compliance with Section 111 reporting.
- Provide information that may be useful in the RRE's business relationships with their employer/other plan sponsor customers to help rectify discrepancies.
- Improve both the accuracy of data reporting and its compliance with the Section 111 reporting requirements. Once verified, the RRE can use this information to update their internal systems if their data is incorrect or submit an override record if their data is correct.
- Improve the overall accuracy of MSP information used and stored by Medicare, RREs, and employers.

9.10.3 RRE Enrollment and Termination

9.10.3.1 Enrollment

RREs electing to receive Unsolicited MSP Response Files must sign up for this process on the Section 111 COBSW at https://www.cob.cms.hhs.gov/Section111/.

New RREs: Newly registering RREs that would like to receive the Unsolicited MSP Response File will select this option during the registration process on the Section 111 COBSW. During Account Setup, the Account Manager must select "Yes" for the "Would you like to receive Unsolicited Alerts" question on the Company Information page.

Existing RREs: If the RRE has already completed their registration for Section 111, the Account Manager must login to the Section 111 COBSW and select the "RRE Information"

action on the RRE Listing page. The Account Manager must then edit the RRE's information and change the "Receive Unsolicited Alerts" option to "Yes."

Please see the Section 111 COBSW User Guide for more detailed information on the RRE Listing page. Your EDI Representative can also help as needed.

9.10.3.2 Termination

To discontinue receiving the Unsolicited MSP Response File, the Account Manager must again login to the Section 111 COBSW and change the "Receive Unsolicited Alerts" option to "No" using the "RRE Information" action. Once an RRE opts out of this process, they will no longer receive the Unsolicited MSP Response File. Partial files will not be created (i.e., if an RRE discontinues this process prior to the monthly Unsolicited MSP Response File generation, they will not receive any file that month).

9.10.4 Interested Party Table

Once an RRE has elected to receive the Unsolicited MSP Response File, the participating RRE is identified as an "Interested Party" (i.e., the RRE ID now has an "interest" in receiving alerts when MSP or drug coverage records submitted by them are changed by another entity).

For those RREs that have elected to receive the Unsolicited MSP Response File, the BCRC creates and maintains entries in what is referred to as the "Interested Party table". The Interested Party table will contain information related to the MSP occurrences or drug coverage records for which a participating RRE might be interested in receiving notifications.

The initial Interested Party table entries are created by the BCRC on the first Sunday after the RRE's Account Manager has enrolled in this process. The BCRC searches through the last 12 months of MSP Response Files that were transmitted back to the participating RRE. It identifies all new or changed MSP occurrences or drug coverage records that received a '01' disposition code. For each, most recent, unique record identified, the BCRC creates a record in the Interested Party table. These records indicate which MSP occurrences or drug coverage records the participating RRE has an interest in.

The BCRC then continues to maintain entries in this table for the RRE. Whenever the participating RRE submits an add, update, or delete transaction that receives a '01' disposition code, the Interested Party Table is updated accordingly:

- **Update Records** are applied as updates to the Interested Party table. The most recent Document Control Number (DCN) submitted by the participating RRE is stored on the Interested Party table so that it can be returned on Unsolicited MSP Response File Detail Records.
- **Delete Records** remove the entries from the Interested Party table. It is assumed that once the record is deleted by the participating RRE, they no longer have an interest in the record. The BCRC will not produce any subsequent Unsolicited MSP Response Records for deleted records.
- **Add Records** are added to the Interested Party table as new occurrences the RRE is interested in.

Whenever one of these MSP occurrences or drug coverage records is changed (or deleted) by an entity other than the participating RRE over the last month, a record is written to the RRE's Unsolicited MSP Response File.

9.10.5 File Creation and Transmission

The Unsolicited MSP Response File includes a Header Record designated by a value of "USOL" in Field 3, followed by Detail Records for each notification, followed by a Trailer Record. The Trailer Record contains a count of the total number of notification records included in the submission. This count does not include the Header and Trailer Records. Note: The Unsolicited MSP Response File layout is documented in Appendix H.

If no Unsolicited MSP Response File Records (notifications) are created for an RRE during the course of a month for a participating RRE, an "empty" Unsolicited MSP Response File will be transmitted to the RRE. This file will include a Header Record, no Detail Records, and a Trailer Record with a value of all zeros in the File Record Count (Field 5).

Unsolicited MSP Response Files are created and transmitted to participating Section 111 GHP RREs on the second Sunday of each month. RREs must have signed up on the Section 111 COBSW at least 9 days in advance of the file creation date in order to receive an Unsolicited MSP Response File for that month. If an RRE does not enroll in the process at least 9 days prior to the second Sunday of the month, the RRE's file transmission will commence the following month. This file will **NOT** be created for test file transmissions.

Unsolicited MSP Response Files will be transmitted the same way MSP Response Files are sent to the participating RRE. For example, if the MSP Response Files are delivered via Secure File Transfer Protocol (SFTP), the Unsolicited MSP Response Files will be transmitted via SFTP.

- Connect:Direct—RREs using the Connect:Direct file transmission method must contact their EDI Representative to set up the necessary parameters including the destination dataset name to be used by the BCRC. Without this information, transmission of the Unsolicited MSP Response File will fail.
- SFTP—For RREs using SFTP, the Unsolicited MSP Response File will be placed in the same mailbox that the MSP Response File is delivered: /RREID/response/prod/msp.
- HTTPS—For RREs using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS), the Unsolicited MSP Response File will be available for download from the RRE's Section 111 COBSW File Listing page.

Note: For SFTP & HTTPS submitters, the BCRC will name Unsolicited MSP Response Files according to the following convention:

PCOB.BA.MR.GHPUNS.RESP.Dccyymmdd.Thhmmsscc.TXTwhere'Dccyymmdd' is 'D' followed by a date as century/year/month/day and 'Thhmmsscc' is 'T' followed by a time as hours/minutes/seconds/centiseconds. The date and timestamp used in the response file names are generated by the BCRC when it creates the response file.

9.10.6 Unsolicited MSP Response File Records

Unsolicited Response File Records **reflect** changes (updates and deletes) made to MSP or drug coverage-only records listed in the participating RRE's Interested Party Table that were submitted by an entity other than the RRE over the last month. **Note:** If more than one change is made by another entity to a particular MSP occurrence or drug coverage record during a month, only one Unsolicited MSP Response Detail Record will be created reflecting the most recent change applied.

Unsolicited Response File Records **include:**

- Key matching fields for the MSP occurrence (including the last DCN submitted by the participating RRE);
- Current values for other fields associated with the MSP occurrence (i.e., if an MSP occurrence was updated multiple times during the monthly timeframe, only information from the last change made will be sent); and,
- Most recent Medicare beneficiary entitlement and enrollment information (although changes to this information will not cause an Unsolicited MSP Response Record to be created).
- Rx drug coverage information

Unsolicited Response File Records include changes made to MSP occurrences reflecting hospital and medical coverage and changes applied to prescription drug coverage occurrences. RREs that offer primary prescription drug coverage and select the unsolicited alerts option on the S111 portal will receive information for drug-only or drug/MSP coverage types, based on what coverages they report. **Note:** RREs that submit drug records and that have already opted in to receive the alerts need not take any further action to receive drug records on their response file.

Some fields of interest on the Unsolicited MSP Response File include the following. Please see Appendix H for a complete list of the valid values.

- Field 9 (Last Transaction Type) identifies the last action performed on the MSP occurrence by an entity other than the participating RRE. A value of '0' means the other entity updated the MSP occurrence. A value of '1' means the other entity deleted the MSP occurrence.
- Fields 10-32 contain the current MSP information for the occurrence.
- Field 33 (Modifier Type) & Field 34 (Modifier Name) contain information related to the updating source. Field 33 indicates the type of entity that applied the modification to the MSP occurrence. Field 34 identifies the name of the source of the modification (if available).
- Field 35 (Change Reason Code) indicates why the occurrence was modified (if known). If a reason for change cannot be determined, or if blank is returned.
- Field 36 (Last Update Applied Date). This field identifies the date the BCRC last changed the occurrence.
- Fields 37-41 and 50-54 identify the following prescription drug information: Current Medicare Part D Plan Contractor Number, Current Medicare Part D Plan Enrollment Date, Current Medicare Part D Plan Termination Date, Part D Eligibility Start Date, Part D Eligibility Stop Date, and Rx Insured ID, Rx Group Number, Rx PCN, and Rx BIN.

Table 9-6: Modifier Type Code and Modifier Name

Modifier Type Code (Field 33)	Value in Modifier Name if available (Field 34)	Description
CBN	Beneficiary Name	Change made by a BCRC CSR/Analyst due to information received from a Medicare beneficiary
CEM	Employer/Other Plan Sponsor Name	Change made by a BCRC CSR/Analyst due to information received from an employer or other plan sponsor
CIN	Insurer Name	Change made by a BCRC CSR/Analyst due to information received outside the Section 111 reporting process from an insurer or TPA
PRV	From a provider	Change made by a BCRC CSR/Analyst due to information received from provider
ECR	Contractor number 11139, 11141, 11142 or 11143. If the change was made due to Group Health Plan Recovery, the Modifier Name will contain the value 11139. If the change was made due to Non-Group Health Plan Non-ORM Recovery, the Modifier Name will contain the value 11141. If the change was made due to Non-Group Health Plan ORM Recovery, the Modifier Name will contain the value 11142. If the change was made due to a Part C/Medicare Advantage Plan request, the Modifier Name will contain the value 11143.	Change was made due to information received from another Medicare contractor
RRE	Name of the RRE	Systematic change applied due to a transaction submitted by an RRE other than the participating RRE
COB	BCRC	Other change made by the BCRC
BCR	BCR-BCRC Contractor	Other changes made by the BCRC
DSA	Name of the Voluntary Data Sharing Agreement (VDSA) entity	Systematic change applied by the BCRC employer/other plan sponsor VDSA process
800	1-800-MEDICARE	Change made by a 1-800-MEDICARE CSR due to information received from a Medicare beneficiary

Table 9-7: Change Reason Description

Change Reason (Field 35)	Description
AO	Added occurrence
ES	Employer size change
CE	Change in employment status
CT	Change termination date
DO	Delete occurance
II	Insurance information change
EI	Employer information change
EC	Entitlement change
SP	SP error correction
Blank	System generated, reason unknown

9.10.7 Using the Unsolicited MSP Response File

The Unsolicited MSP Response File provides notification to an RRE regarding changes or deletes made by another entity to MSP or drug coverage occurrences previously submitted by them. Although RREs are not required to develop processing to react to the Unsolicited MSP Response File, RREs should use the information it provides to investigate the coverage information further, work with beneficiaries and employers to rectify discrepancies, and update their internal systems as deemed appropriate.

If the RRE confirms that a change made by another entity was accurate, the RRE should apply the changed information, such as retirement or employment termination dates, to its internal system and use this information as applicable for subsequent Section 111 reporting and claim processing. However, if the RRE determines that a change made by another entity was inaccurate, they must take steps to correct the error on their next MSP Input File or follow up with the BCRC Call Center as appropriate. By effectively using the Unsolicited MSP Response File to maintain accurate records, the RRE can help avoid the risk of non-compliance with Section 111 reporting requirements.

9.10.8 Hierarchy Override Code Usage

9.10.8.1 RREs Participating in the Unsolicited MSP Response File

RREs that participate in the Unsolicited MSP Response File process do not need to wait to receive an SPH0 error on an MSP Input File Detail Record before being able to submit the HB Override Code (Section 9.9.5). RREs may submit the Override Code on an MSP Input File Detail Record after receipt of an Unsolicited MSP Response File Record. By opting to use the Unsolicited MSP Response File, an RRE can streamline the hierarchy override process and apply the necessary change in one quarterly MSP Input File submission.

Note: RREs that do not participate in the process and use the override code to update a S111 GHP record without first receiving the SPH0 error will continue to receive the SPH2 error, but the record will reject with an SP disposition code.

Please note that RREs should NOT automatically attempt to override any records without first validating that their information is correct.

Override Code example

An RRE participating in the Unsolicited MSP Response File process submitted an MSP Input File Add Record for GHP coverage provided to a Medicare beneficiary. The record was accepted by the BCRC and the RRE received a '01' disposition code on its response file indicating that an MSP occurrence was created. This record was added to the RRE's Interested Party Table (Section 9.10.4). Subsequently, the beneficiary called the BCRC Call Center and stated that he or she did not have the GHP coverage reflected in the MSP occurrence. In this case, the MSP occurrence had to be deleted since Medicare should be the primary payer. A BCRC CSR manually deleted the MSP occurrence and applied the Modifier Type Code of 'CBN' (Change made by a BCRC CSR/Analyst due to information received from a Medicare beneficiary).

Since the change (i.e., the delete) to this occurrence was made by an entity other than the participating RRE (change was made by the BCRC CSR), a notification for this deletion was sent to the participating RRE on their next Unsolicited MSP Response File. When the RRE received their Unsolicited MSP Response File, they researched this situation, contacted the beneficiary and were able to confirm that this deletion was incorrect. Since the change (deletion) was made by a BCRC CSR which is ranked higher than the RRE in the MSP hierarchy requirements, the RRE will need to override the CSR's change in order to add this record back. Since the RRE received an Unsolicited MSP Response notification, it may utilize the override code without first getting the SPH0 error.

9.10.8.2 RREs Not Participating in the Unsolicited MSP Response File

Non-participating RREs can only submit the Override Code in their next quarterly submission if they:

- First receive the SPH0 error, and
- Verify that the override is appropriate and necessary.

RREs not participating in the Unsolicited MSP Response program cannot use the Override Code (Section 9.9.5) until they first receive an SPH0 error (i.e., attempt to update/delete an MSP occurrence last updated by a higher-ranking source) on an MSP Input File Detail Record. If the Override Code is submitted on an MSP Input File Detail Record without first receiving the SPH0 error, the SPH2 error (transaction attempted to override the SPH0 error without prior notification) will be returned with an SP disposition code instead of a 50 disposition code.

RREs not participating in the Unsolicited MSP Response program may have to potentially submit two quarterly MSP Input Files (taking approximately six months to apply their change) if their first attempt to submit an update or delete rejects with an SPH0 error. The first submission would be when they attempted to update/delete an MSP occurrence, but the record rejected with an SPH0. The second submission would be on their next quarterly MSP Input File using the Override Code for the record previously rejected with the SPH0 error.

Note: This process could actually take longer than two submissions, or more than six months to rectify, depending on the length of time needed to verify the change.

Since RREs are ultimately responsible for ensuring that their MSP records are submitted with accurate information, they should take advantage of and enroll in the Unsolicited MSP Response File process.

Chapter 10: Query Only Input File Requirements

10.1 Overview

The Query Only Input File is a dataset transmitted from a GHP Section 111 responsible reporting entity under the Basic and Expanded Reporting Options to request information regarding Medicare status and Medicare Part A entitlement and Parts B and C enrollment of individuals covered by the GHP. You may submit query records for any individual covered by your GHP.

Note: GHP RREs who submit quarterly HEW Query Files, in the MSP Input Files, do not need to submit individuals ages **45 through 64** who receive Disposition Code 51 in their Query Response File. Continue to submit those individuals in the HEW Query File. When they receive a Disposition Code 01, begin reporting MSP coverage.

If you are using the "finder file" approach for reporting individuals on your MSP Input File, you may use the results of the query process to determine which Active Covered Individuals are Medicare beneficiaries and must be reported on the MSP Input File. In addition, you may use the Medicare coverage dates in your GHP claims processing system when determining whether to pay primary or secondary to Medicare. In most cases for Inactive Covered Individuals, if the individual is a Medicare beneficiary, then Medicare will be the primary payer.

Query Only Input File records must be submitted with the Medicare ID (HICN or MBI) or SSN, name, date of birth and gender of the covered individual. The query process is to be used only for Section 111 reporting purposes. Please review the Data Use Agreement in Chapter 16 for restrictions on the use of data exchanged for Section 111.

To determine whether a submitted covered individual is a Medicare beneficiary, the BCRC must match your data to Medicare's. This matching can be done using either an individual's Medicare ID or by using an individual's SSN. If submitting an SSN in a query, you may submit a partial, using the last five digits for matching, or full SSN (Appendix B).

For matching an individual to determine if they are a Medicare beneficiary the BCRC uses:

- Medicare ID or SSN
- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender

First the BCRC must find an exact match on the Medicare ID or SSN. For exact matching, partial SSNs may be submitted on queries using the last five digits (Appendix B). Then at least three out of the four remaining criteria must be matched exactly. If a match is found, you will always be returned the current Medicare ID for the individual on the corresponding response record. You must store this Medicare ID on your internal files and use it on future transactions. This is CMS' official identifier for the beneficiary. The BCRC will also supply updated values for the first initial, first 6 characters of the last name, date of birth and gender in the applicable fields of the Query Only Response File records based on the information stored for that beneficiary on Medicare's files. The SSN returned on the response record will always be the

SSN submitted on the query input record by the RRE. Other than the Medicare ID, the updated fields returned on the response record are simply for informational purposes.

Note that if an RRE submits a value of '0' for an unknown gender for an individual, the BCRC will change this value to a '1' for matching purposes and return that changed value of '1' on the response record regardless of a match.

Also note that if an RRE submits both the SSN and Medicare ID on a query record, the system will only use the Medicare ID for matching purposes and the SSN will be ignored. The system will attempt to match the Medicare ID to any previously assigned Medicare ID for the individual, since Medicare IDs can change or be reassigned by SSA, but if no match is found using the Medicare ID it will not then attempt to match using the SSN provided.

After the BCRC has processed the Query Only Input File it will return the Query Only Response File with a determination as to whether the queried individual can be identified as a Medicare beneficiary based upon the information submitted. The Query Only Response File records contain a Disposition Code. A value of '01' indicates that the individual submitted on the input record is/was a Medicare beneficiary and the record will contain the updated Medicare ID, name fields, DOB and gender according to Medicare's information along with Medicare entitlement and enrollment dates. The BCRC will never return an updated or corrected SSN on the Query Only Response File. You must store the Medicare ID returned on the query response in your internal system and are required to use it on future transactions. A value of '51' indicates that the information supplied on the query record could not be matched to a Medicare beneficiary.

The Query Only Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set. You may use your own translator software, or the HIPAA Eligibility Wrapper (HEW) software (provided by the BCRC) to submit a Query Only Input File and process the Query Only Response File. To use the HEW software, you first will create an input file according to the specifications in Appendix B. This flat file is then used as input to the HEW software. You will install and run the HEW software at your processing site. The HEW software produces the X12 270 eligibility query file format which you then transmit to the BCRC. The BCRC will send back your response file in the X12 271. You will feed that into the HEW software to produce the Query Only Response File according to the specifications in Appendix B. This flat file containing Medicare entitlement and enrollment information for the individuals found to be Medicare beneficiaries can then be used in your internal systems to determine which individuals must be reported on the MSP Input File and to assist with coordination of benefits in your claims processing. Note that the Query Only Response File that is output from the HEW software does not contain any header or trailer records.

Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the Windows version of the HEW software after logging on to the Section 111 COBSW at https://www.cob.cms.hhs.gov/Section111/. You may request a copy of both the mainframe and Windows versions from your EDI Representative or by contacting the EDI Department at 646-458-6740.

Query Only Input and Response File specifications for the flat files that are the input and output of the HEW software can be found in Appendix B.

If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query Only File and process the X12 271 response, download the 270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for Mandatory Reporting GHP

Entities document at the bottom of the cms.gov web site. This document includes the X12 270/271 mapping required for Section 111.

10.2 Query Only Input File Detailed Requirements

Query Only Files must be transmitted in the HIPAA-compliant ANSI X12 270/271 transaction set. They may be submitted up to once per calendar quarter. Calendar quarters are defined as January–March, April–June, July–September, and October–December for the Query Only File submissions. For example, a Query Only Input File may be submitted in March and again in April of the same year since March is in the first calendar quarter and April in the second. However, if a Query Only Input File is submitted in April, another file cannot be submitted in June of the same year, since April and June are both in the second calendar quarter. These files do not have to be submitted during a specific submission timeframe, or on a specific day, but cannot exceed the allowed frequency.

Additional details:

- Medicare Part A, Part B, Part C, and Part D coverage information will be supplied on the Query Only Response File (Part D if the submitter provides primary prescription drug coverage).
- Query Only Response Files will be returned to you within 14 days.
- The following edits will be applied to the Query Only Input File. Any failure of these edits will result in the file being placed in a severe error status. You will receive an email notification and are to contact your EDI Representative to address the identified errors. Files failing for these errors must be corrected before they can be processed.
  - File does not contain a header record
  - Header record does not contain a valid Section 111 RRE ID
  - File does not contain a trailer record.
- The HEW Query Only Response Files have NO header and trailer records.

Email notifications will be sent to the Account Manager for the RRE ID after the file has been received and when a response file has been transmitted or is available for download.

Two RRE-defined, optional document control number (DCN) fields are available for use on the X12 270/271 and the latest version of the HEW Query Only Input/Response Files. The DCN fields are alphanumeric, may contain spaces, numbers, letters, and special characters as defined for a text field type, are left justified and unused bytes must be space-filled. The BCRC will always return query response records with whatever value the RRE submitted in these DCNs so that the RRE may use them to match response records to input records.

10.3 HEW Software Processing Environment Requirements

The HEW software is available in mainframe and Windows PC/Server versions. It will not run on an AS400, Linux or UNIX platform. Network communication ports are not part of the HEW application. The HEW only converts incoming files. Telecommunications must be done separately.

The Windows PC/Server version will execute on any Microsoft operating system of NT or better (2000, 2003, XP, etc.) and requires at least a Pentium II with 64 MB of memory. APIs (application program interfaces) are not made available for the Windows version. However, effective with Version 2.0.0 released in January 2010, the Windows PC/Server version of the

HEW may be invoked using a command line interface. Instructions on how to invoke the HEW software from an automated process can be found in documentation that is contained in the software package download.

10.4 Query Files and HEW Software Requirements

The BCRC will only accept test and production query files submitted using Version 5010A1 (and the latest HEW software version) of the ASC X12 270/271.

- A copy of the latest PC/server HEW software is available for download on the Section 111 COBSW at https://www.cob.cms.hhs.gov/Section111/. (**Note:** You must log into the application to download.)
- RREs using the mainframe version of the HEW may request a copy of the latest HEW version from their EDI Representative.
- Query files submitted under Version 4010A1 (or created using HEW Versions 1.2.0 and 2.0.0) will be rejected with a severe error and not processed.

Chapter 11: Non-MSP Input File Requirements

11.1 Overview

This is the data set transmitted from a GHP Responsible Reporting Entity (RRE) under the Expanded Reporting Option to the BCRC that is used to report information regarding the prescription drug insurance coverage information of your Inactive Covered Individuals. These are people who are not currently employed by the GHP Plan Sponsor (most are carried as retired), a spouse, and other dependents, that are enrolled in a GHP but cannot be classified as Active Covered Individuals. The Non-MSP Input File is used to report drug coverage information that is secondary or supplemental to Medicare Part D. Information related to End Stage Renal Disease (ESRD) is also provided back on the Non-MSP Response File. You may use this information in your claims processing to determine the primary payer. In most cases for Inactive Covered Individuals, if the individual is a Medicare beneficiary, then Medicare will be the primary payer. The Non-MSP Input File can also be used to query CMS about potential beneficiary Medicare Parts A, B, C, and D coverage. Finally, this file may also be used as a way to submit retiree files to the Retiree Drug Subsidy (RDS) Center on behalf of Plan Sponsors claiming the Retiree Drug Subsidy.

CMS uses the information in the Non-MSP File to determine GHP coverage that is secondary to Medicare Part D for Medicare beneficiaries, which is then used for proper claims payment and the calculation of the beneficiary's True Out of Pocket (TrOOP) drug costs. If the individual reported is a Medicare beneficiary enrolled in Part D and it is determined that your prescription drug coverage is secondary or supplemental to Medicare Part D, the BCRC sets up a supplemental Part D record on the Medicare Beneficiary Database (MBD). Part D supplemental records have start and end dates based on the later of the beneficiary's enrollment in Part D and your coverage start date. A supplemental Part D record will have an open-ended date if both your coverage and Medicare coverage are active. An end date is applied when either your or Medicare's coverage ends.

This file format requires you to initially send an "add" record for the initial report on supplemental prescription drug coverage for an Inactive Covered Individual or an RDS retiree file record. If that record is accepted by the BCRC then you only need to apply any changes to that information in "update" or "delete" records going forward. If the record is not accepted due to errors, you must correct it and resend. If the record is not accepted due to the individual not being a Medicare beneficiary or not being enrolled in Part D during the reported drug coverage period, then you must continue to send it as an add record on all subsequent submissions until the record is either accepted or your coverage is terminated.

A Non-MSP Response File will be transmitted from the BCRC back to you after the information supplied in your Non-MSP Input File has been processed. It consists of the same data elements in the Non-MSP Input File, with updates applied by the BCRC based on Medicare's information, disposition and edit codes which let you know what we did with the record, as well as applicable Medicare entitlement and enrollment information.

This Non-MSP Response File format is also used to send you unsolicited response files originating from the RDS Center if you are opting to report RDS retiree files through Section 111 reporting. These transmissions from the RDS Center will notify you that significant data you previously submitted has changed. Unsolicited RDS responses are designated by the "RDSU" file type in Field 3 in the header and are discussed in Section 12.9.4.

Non-MSP Input and Response File and data field specifications can be found in Appendix C. Each field description includes an explanation on how to use the field for the different record (action) types.

11.2 Action Types

Each record on the Non-MSP Input File contains an Action Type in Field 20 to indicate what the record represents.

11.2.1 N – Query Records

Action Type "N" is known as a Non-Reporting Record and is used to query Medicare entitlement and enrollment information. The corresponding record in the Non-MSP Response File will contain the Medicare entitlement and enrollment information requested for the individual. N records may be submitted for any covered individual. They are not limited to Inactive Covered Individuals.

11.2.2 D – Supplemental Prescription Drug Coverage Records

Action Type "D" is known as a Drug Reporting Record and is used to submit prescription drug coverage that is secondary or supplemental to Medicare Part D for Inactive Covered Individuals. The corresponding record in the Non-MSP Response File will contain the Medicare entitlement and enrollment information requested for the individual as well as information about whether the supplemental drug record was accepted and posted by the BCRC on the MBD.

11.2.3 S – RDS Retiree File Records

Action Type "S" is known as a Subsidy Reporting Record and is used to submit retiree file information to the RDS Center. The corresponding record in the Non-MSP Response File will contain information from the RDS Center indicating whether the retiree was accepted for the subsidy program as well as Medicare entitlement and enrollment information for the individual.

Note: If you are **not** submitting retiree file information to the RDS Center on behalf of a Plan Sponsor participating in the Part D Retiree Drug Subsidy Program, then you may disregard any further information regarding S records.

11.3 Record Matching Criteria

11.3.1 Individuals

To determine whether an individual is a Medicare beneficiary, the BCRC must match your data to Medicare's. This matching can be done using either an individual's Medicare ID (HICN or MBI) or by using an individual's SSN. The Medicare ID is preferred. You must send either a Medicare ID or an SSN as part of the individual's record in the Non-MSP Input File. For matching an individual to determine if they are Medicare beneficiary the BCRC uses:

- Medicare ID or SSN
- First initial of the first name
- First 6 characters of the last name
- Date of birth (DOB)
- Gender (Sex)

First the BCRC must find an exact match on the Medicare ID or SSN. Then at least three out of the four remaining criteria must be matched exactly. If a match is found, you will always be returned the beneficiary's most current Medicare ID (HICN or MBI) to use going forward on all update and delete transactions. You must store the Medicare ID returned on the Non-MSP Response file in your internal system and are required to use it on future transactions.

Note that if an RRE submits both the SSN and Medicare ID on a Non-MSP Input File Detail Record, the system will only use the Medicare ID for matching purposes and the SSN will be ignored. The system will attempt to match the Medicare ID to any previously assigned Medicare ID for the individual, since Medicare IDs can change or be reassigned by SSA, but if no match is found using the Medicare ID it will not then attempt to match using the SSN provided.

11.3.2 Supplemental Prescription Drug Records

Supplemental drug coverage records created and stored by the BCRC for Medicare claims processing are keyed by:

- Medicare ID (HICN or MBI)
- Supplemental Coverage Effective Date
- Coverage Type (network drug only, comprehensive hospital/medical/drug, etc.)
- Patient Relationship Code (self, spouse, dependent, etc.) and
- Section 111 RRE ID

The BCRC will use this criterion for subsequent update and delete transactions you send. You are required to send the Medicare ID that the BCRC sends back to you on the response file on all subsequent update and delete transactions.

For information regarding how to submit prescription drug records for beneficiaries with HRAs that cover medical, hospital, and prescription drugs, see Section 8.11).

11.4 Initial Non-MSP Input File Submission

To begin non-MSP reporting of supplemental drug coverage for Section 111, you must create and send a file of D records that contains information for all Inactive Covered Individuals who are currently enrolled in your plan. Information must be supplied for individuals who had open coverage at that time even if it has since been terminated. Information must be supplied for individuals even if their coverage has since been terminated. Information must also be supplied for individuals who are currently enrolled at the time of the report.

One D record is to be supplied for each individual who qualifies as an Inactive Covered Individual including the subscriber, the subscriber's spouse, and every other dependent that fits the definition of an Inactive Covered Individual. If an individual had multiple periods of coverage during this timeframe, multiple records must be submitted with the applicable effective and termination (end) dates (Fields 10 and 11). The effective date should reflect when the coverage was initially effective even if that occurred prior to January 1, 2009. If the coverage is

current and open at the time of the report, the record should reflect an open-ended coverage by putting zeroes in the Termination Date (Field 11). **Termination dates should only be sent when the actual coverage reported has ended. Yearly renewals of the same coverage are not to be reported as separate records. If the coverage remains the same from year to year, a new record does not need to be reported since the previous report should have had an open-ended termination date.**

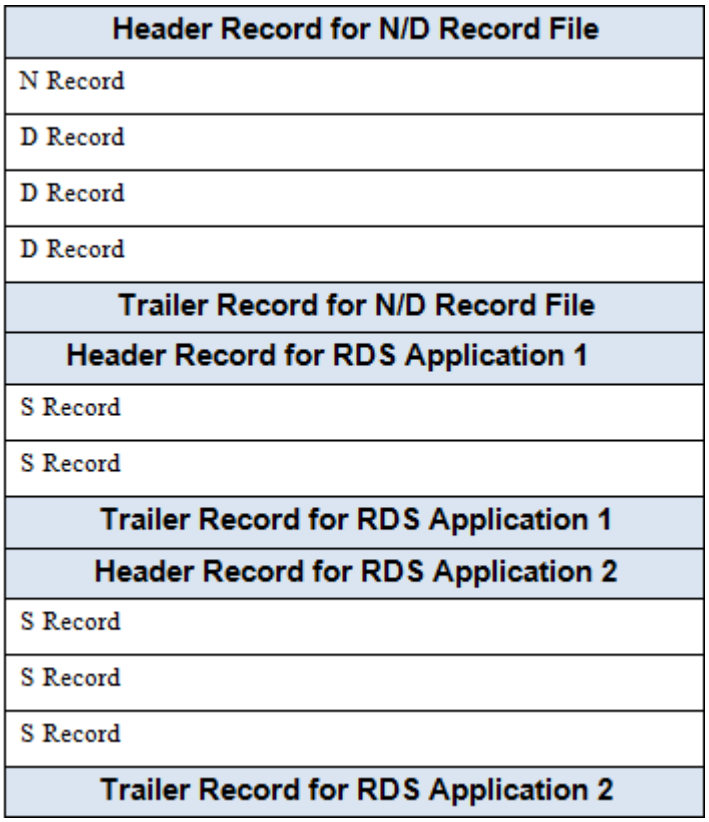
Your initial Non-MSP Input File will obviously be larger than your subsequent update files since it will contain D records for the entire population of your Inactive Covered Individuals for whom you must report. All records on your initial file will be "add" records and have a value of zero ('0') in the Transaction Type (Field 21).

Your initial Non-MSP Input File may contain N query records for Inactive Covered Individuals for whom you wish to obtain Medicare coverage information.

You may submit your initial Non-MSP Input File at any time during the first quarter you go live with production data as long as testing has been successfully completed.

N and D records can be mixed together on one "logical" file between the same header and trailer records. S records must be submitted on their own logical file with their own header and trailers. S records cannot be mixed in the same logical file as N/D records. RREs may send in retiree files for multiple plan sponsors (employers) for multiple RDS applications. The RDS application number goes on the header record of the Non-MSP Input File. So, if you are submitting retiree files for multiple plan sponsors, you must put the S records associated with each application number in separate logical files separated by the corresponding header and trailer records. All of these logical files can either be submitted separately or be concatenated together and submitted in one "physical" file as shown in MMSEA Section 111 Basic GHP Reporting Option Files (Section 6.2). However, only one logical Non-MSP Input File with N/D records will be accepted per month. Multiple Non-MSP Files with S records will be accepted and are to be sent on the frequency required by the RDS Center. If you are not using the Non-MSP File to submit RDS retiree files, then one Non-MSP File can be submitted per month with a mixture of N and D records.

Figure 11-1: Non-MSP File Structure



11.5 Update Non-MSP Input File Submissions

An update Non-MSP Input File reflects any changes from the last submission including new enrollees (subscribers and dependents) that are now Inactive Covered Individuals with drug coverage under your plan, changes to previously submitted drug or subsidy records, corrections to previously submitted records, updates to report on a coverage termination date, and new query records. Update files containing N and D records may be submitted on a monthly or quarterly basis. No specific submission timeframe is assigned for Non-MSP Input Files. The only restrictions are that N and D records must be submitted on one input file and files with N and D records cannot be sent more often than once per calendar month.

RDS retiree files submitted via S records should be sent in separate Non-MSP Files with their own header and trailer records reflecting the associated RDS Application Number. Multiple Non-MSP Files with S records will be accepted and are to be sent according to the frequency required by the RDS Center.

Your Non-MSP Input update file may contain N query records for Inactive Covered Individuals for whom you wish to obtain Medicare coverage information.

11.5.1 Add, Delete, Update Transactions

Add, update and delete records are identified by a value in the Transaction Type (Field 21) on your Non-MSP Input File. **They do not apply to N query records**. These transactions are processed on Non-MSP Input Files in very much the same manner as described previously for the MSP Input Files.

Add Transactions

An "add" record or transaction is defined with a '0' (zero) in the Transaction Type (Field 21). An add is a new record of coverage information that the BCRC has not posted to the Medicare Beneficiary Database (MBD). D records accepted and added as supplemental drug coverage to the MBD receive a '01' D/N disposition code (Field 48) in your Non-MSP Response File you receive back from the BCRC. An add transaction could be a record never sent before or a record that was sent before but not accepted due to errors or the individual not being a Medicare beneficiary at the time of processing.

Update Transactions

An "update" record or transaction is defined with a '2' in the Transaction Type (Field 21). An update transaction is sent when you need to correct information on a record previously accepted and added as a supplemental drug record to MBD for which you received a '01' disposition code in your Non-MSP Response File.

To successfully update a previously added record, you must match on the key fields of the supplemental drug or subsidy record. Please refer to the Record Matching Criteria, Section 11.3. The BCRC will use this criterion for update and delete transactions you send. You must save the Medicare ID (HICN or MBI) returned to you on the response files in your internal system and use it on subsequent update and delete transactions.

Delete Transactions

A "delete" record or transaction is defined with a '1' in the Transaction Type (Field 21). Deletes are used to remove erroneous records. A delete transaction is sent to remove a supplemental drug or subsidy record previously posted to the MBD from an add transaction that was created in error. If your add transaction did not result in a '01' disposition code, there's no need to delete it even if it was previously sent in error.

To successfully delete a previously added record, the BCRC must match on the key fields of the supplemental drug or subsidy record. Please refer to the Record Matching Criteria, Section 11.3. The BCRC will use this criterion for update and delete transactions you send. You must save and use the Medicare ID returned to you on the response files in your internal system and use it on subsequent update and delete transactions.

11.5.1.1 How to Report a Coverage Termination Date for Inactive Covered Individuals

If your coverage for an Inactive Covered Individual previously sent and accepted ends, you must send an update record with the Termination Date (Field 11). For Inactive Covered Individuals, the submitted Termination Date should be the date the individual's GHP coverage ends. Please see the following example: The BCRC will update the supplemental drug or subsidy record termination date**. Do not send a delete transaction** in these cases as that will remove the record entirely as though the coverage never existed and result in potential erroneous claims payment.

11.5.1.2 Correcting Supplemental Drug Record Key Information—When to Send a Delete and Add to Make Corrections

If you need to **correct** one of the key matching fields used for supplemental drug records, you need to follow a special process to make this update. First, a delete transaction must be sent in your file to remove the previously added record. The delete transaction should then be followed by an add transaction in the same file to add the record back with the corrected information.

Note 1: If you are correcting the insurance coverage type from 'A' to 'W', please send only an update transaction.

Note 2: RREs only need to correct the Medicare ID/SSN in cases where an incorrect person was submitted and accepted on the input record. Medicare IDs may be changed by the Social Security Administration at times, but the BCRC is able to crosswalk the old Medicare ID to the new Medicare ID. Therefore, in those instances where the correct person was previously submitted and the Medicare ID changes for that person at a later date, the RRE does not need to correct the record. In fact, updates may continue to be sent under the original Medicare ID submitted. The BCRC will always return the most current Medicare ID on response records and RREs are encouraged to update their systems with that information and use it on subsequent record transmissions.

Note 3: If a record was previously submitted and accepted with only a SSN, and the RRE obtains the Medicare ID on the response file, the RRE should not send a "Delete" and "Add" to update the beneficiary's information with the Medicare ID. The record has already been stored under both the SSN and Medicare ID by the BCRC. Subsequent transactions for the record must be submitted with the Medicare ID.

11.5.1.3 Changing Coverage Information on a Supplemental Drug Record

If coverage information **changes** on a subsequent date after a supplement drug record has been posted by the BCRC, then:

- Submit an update transaction with the old values and a termination date reflecting the last day the information was true.
- Submit an add transaction with an effective date equal to the date the changed value became effective (the day after the termination date in the update record previously described).

For Non-MSP reporting purposes, changed coverage information referenced above includes:

- Coverage Type
- Relationship Code
- Rx BIN
- Rx PCN
- Rx Group Number
- GHP Number
- Individual Policy Number
- Rx Insured ID Number

11.6 Detailed Non-MSP Input File Requirements

Non-MSP Input Files must contain properly formatted header, detail and trailer records as defined in Appendix C. Only Section 111 responsible reporting entities that registered for the Expanded Reporting Option may submit Non-MSP Input Files. Additionally:

- Non-MSP Input Files may be submitted on a monthly or quarterly basis.
- Non-MSP Input Files must be received on at least a quarterly basis in order to be considered compliant with the requirements for the Expanded Reporting Option unless you are submitting supplemental drug coverage on E02 under a COBA.

- A Non-MSP Input File must contain at least one D or S record. It may not be used exclusively for querying about Medicare coverage with N records only.
- A single Non-MSP Input File may contain D and N records. S records are to be submitted on separate files.
- A Non-MSP response file for N and D records will be generated within 14 calendar days after the day of release into the system for processing. A response file will be generated when all records have been processed or after 14 calendar days. If all records have not been applied, a disposition code will be returned indicating what records should be resent.
- Non-MSP Response Files for S records will be returned after the BCRC has received a response from the RDS Center.

11.6.1 Processing Initial and Subsequent Non-MSP Input Files

The initial Non-MSP Input File should contain D records for all Inactive Covered Individuals who previously had open prescription drug coverage under your plan, even if it has since been terminated, and who currently have active prescription drug coverage under your plan as of the date of submission.

The subsequent, update files should include D records for any Inactive Covered Individual you have added to your plan since the last file submission. Additionally:

- Subsequent update files must include updates to any previously submitted D and S records that have changed since the last submission.
- Update files must contain resubmission of any records found in error on the previous file (Disposition Codes SP) with corrections made. See Processing MSP Response Files (Chapter 9) for more information.
- Update files must contain resubmission of any records that received Disposition Codes ‘ID’ or ‘51’ on the previous file submission response, with corrections applied as needed.

Email notifications will be sent to the Account Manager for the RRE ID when the file has been received and when a response file has been transmitted or is available for download.

CMS recommends that RREs send a covered individual’s Medicare ID (HICN or MBI) on Non-MSP Input File records whenever it is available. The Medicare ID is the preferred data element for matching purposes. RREs are encouraged to obtain Medicare IDs from Medicare beneficiaries they cover and must use the Medicare IDs passed back to them by the BCRC on response files.

Chapter 12: Processing Non-MSP Response Files

For every Non-MSP Input File you send to the BCRC for Section 111 reporting, the BCRC will send you a response file in return. See Appendix C for the Non-MSP Response File specifications. The response file will be transmitted back to you in the same manner that you sent your input file. Response files for Non-MSP Files submitted with N and D records will be returned within 14 days of receipt of your input file. (See the later section of this guide on response files for Non-MSP Files with RDS retiree S records.) The response file contains a header record, followed by detail records for each record you submitted on your input file, followed by a trailer record that contains a count of the detail records supplied. This count does not include the header and trailer records. In some cases, which will be explained in later sections, you may receive more than one detail response record for the input record you sent, but usually it will be one for one. The response file detail records consist of the same data elements in the input file you sent, with corrections applied by the BCRC, the disposition and error codes which let you know what the BCRC did with the input record, as well as Medicare Part A, B, C, and D coverage information.

You must develop processing to react to the response file. Disposition and error codes are shown in Appendix D.

12.1 Part D Eligibility and Enrollment Data

In addition to information on Medicare Part A, B and C coverage, in the Non-MSP Response Files there are five related fields that can have information about current Medicare Part D eligibility and enrollment.

Part D Eligibility Start Date (Field 35). This will be the first date a Medicare beneficiary can enroll in Part D. It is almost always the effective date of coverage for the beneficiary's Part A or Part B participation. Information in this data field **does not** show that a beneficiary has enrolled in Part D.

Part D Eligibility Stop Date (Field 36). This is the date that a Medicare beneficiary's right to enroll in Part D has ended, for any reason.

Current Medicare Part D Plan Contractor Number (Field 41). This identifies the beneficiary's current Part D Plan contractor number.

Current Medicare Part D Enrollment Date (Field 42). This is the effective date of a Medicare beneficiary's most recent enrollment in Part D. It is the current first date the beneficiary can receive Part D benefit coverage.

Current Medicare Part D Plan Termination Date (Field 43). This is the last date a Medicare beneficiary can receive Part D benefit coverage from the beneficiary's current Part D plan. After this date the beneficiary is no longer enrolled and can no longer receive benefit coverage from the (most recent former) Part D plan.

Non-MSP Response File Fields 42 and 43 tell you whether a beneficiary has actually chosen Part D coverage, and the period of time the current benefit coverage is in force. For Section 111 RREs, these two fields are the most immediate indicators of Part D coverage for Inactive Covered Individuals.

12.2 Processing "D" Response Records

Every Non-MSP Input File D record will receive a disposition code in the D/N Disposition Code (Field 48) on the corresponding response file record and you must take the following actions:

- Records marked in error with an 'SP' D/N disposition code must be corrected and resent on your next submission. Error codes are provided in Fields 44 – 47 on the Non-MSP Response File record. An explanation of the error codes is in Appendix D.
- If a record was rejected with a D/N disposition code of 'ID' or '51', which indicates the Inactive Covered Individual could not be matched to a Medicare beneficiary, you must continue to resend **current information** for the individual in subsequent file submissions until it is accepted, your coverage for this individual is terminated, or the individual no longer meets the definition of an Inactive Covered Individual (e.g., returns to work).
- A D/N disposition code of '51' will also be returned if neither a Medicare ID (HICN or MBI) nor SSN was submitted on the input record. You must obtain a valid Medicare ID or SSN for the individual and resubmit the record in your next file submission.
- Records accepted with a '01' D/N disposition code have been added by the BCRC as drug coverage supplemental to Medicare on the MBD and will be used in Medicare Part D claims processing. The following fields may contain updated information from the BCRC based on Medicare data and could be used to update your internal files:
  - Medicare ID (HICN or MBI)
  - Inactive Covered Individual/Beneficiary Name
  - Date of Birth
  - Gender

Note: You must store the Medicare ID returned on the Non-MSP Response File in your internal system and are required to use it on future transactions.

In addition, records returned with a '01' disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- Supplemental Drug Record Effective and Termination Dates – start and end dates for the period of time your drug coverage is secondary to Medicare Part D and Medicare should pay first.
- Reason for Medicare entitlement
- Beneficiary Date of Death
- Medicare Part A, B, C, and D Coverage Dates
- End Stage Renal Disease (ESRD) information

12.3 Processing "N" Response Records

Every Non-MSP Input File N record will receive a disposition code in the D/N Disposition Code (Field 48) on the corresponding response file record and you must take the following actions:

- Records marked in error with an 'SP' D/N disposition code must be corrected and resent on your next submission. SP and Rx Error codes are provided in Fields 44–47 on the Non-MSP Response File record. An explanation of the error codes is in Appendix D.
- If a record was rejected with a D/N disposition code of 'ID' or '51', which indicates the Inactive Covered Individual could not be matched to a Medicare beneficiary, you must check the information you sent for accuracy and then resend as appropriate.
- Records accepted with a '01' D/N disposition code have been matched by the BCRC to a Medicare beneficiary and the beneficiary's Medicare coverage information has been provided on the response record. The following fields may contain updated information from the BCRC based on Medicare data and could be used to update your internal files:
  - Medicare ID (HICN or MBI)
  - Inactive Covered Individual/Beneficiary Name
  - Date of Birth
  - Gender

Note: You must store the Medicare ID returned on the response file in your internal system and are required to use it on future transactions.

N records returned with a '01' disposition code will contain the following information which you may use in your claims processing for coordination of benefits and proper claim processing:

- Reason for Medicare entitlement
- Beneficiary Date of Death
- Medicare Part A, B, C, and D Coverage Dates
- End Stage Renal Disease (ESRD) information

12.4 Processing "S" Response Records

Please refer to the RDS Retiree File Submission process in Section 12.9.

12.5 Non-MSP Input File Threshold and Severe Errors

12.5.1 Threshold Errors

After completion of data quality edits, the BCRC will check your Non-MSP Input File to ensure it **does not exceed** any threshold restrictions. Threshold checks are performed to identify a file that may be in error. In some cases, there could be a reasonable explanation. The file threshold checks include:

- More than 5% of the total D records are delete transactions.
- More than one Non-MSP Input File with N/D records was submitted during a one-month period of time.
- No D or S records are included in the file. You may not send a Non-MSP Input File with only N query records. The Non-MSP Input File must contain supplemental drug coverage records. If you only have a need to query for Medicare entitlement, then the Query Only File format must be used.

A file that exceeds the threshold checks will be suspended from further processing until the suspension is overridden by your EDI Representative. An email will be sent to the Account Manager for the RRE ID to inform him/her of this suspension. You must contact your EDI

Representative to discuss and resolve file threshold errors. Your file may be released for processing or, if sent in error, deleted by your EDI Representative in which case you may resend a corrected file as instructed by your EDI Representative.

Table 12-1: Threshold Errors

Threshold Error	Explanation/Correction
5% or more of records are delete transactions	Examine use of the delete function. Do not submit deletes when GHP coverage ends. Submit updates with termination dates instead. Only submit deletes to remove erroneous records previously accepted with a '01' disposition code. Very small files may suspend for very few delete records. If the delete transaction was used correctly, your EDI Representative will release the file for normal processing.
20% or more of records failed record level edits	Error messages will display in the threshold email. Contact your EDI Representative to discuss most common errors found. Your EDI Representative will provide further instruction. Very small files may suspend for very few records in error. In that case, your EDI Representative may release the file for processing.
Multiple files submitted. Exceeds allowed submission frequency.	Only one Non-MSP Input File with N/D records may be submitted per **month.**
No Supplemental Drug or RDS Subsidy records included with file	Non-MSP Input Files cannot be submitted with only 'N' query records. The Non-MSP Input File cannot be used solely for querying.
Another file in process for/still processing from prior submission period	A file of the same type submitted previously is still processing. This prior file must complete processing before the new file can be released by your EDI Representative.
File held via watch list	Your RRE ID has been put on a watch list by the BCRC due to past issues with erroneous file submissions. Contact your EDI Representative to resolve.

12.5.2 Severe Errors

Files detected with severe errors will also suspend from processing. An email will be sent to the Account Manager for the RRE ID regarding the severe error found. You must contact your EDI Representative to discuss the situation. The EDI Representative will then delete the file and provide you with instructions as to when to send a corrected file. Severe errors include:

- Missing or improperly formatted header or trailer records
- Record counts that do not match those actually submitted

Table 12-2: Severe Errors

Severe Error	Explanation/Correction
File has invalid RECFM/Record Format	Files must be submitted in a fixed-block format with all records of the same fixed length.
File has invalid LRECL/records with invalid record lengths	The record length of each record on the file must match that specified in the record layouts in the appendices. All unused fields must be set to default values and filler at the end of the record must be filled with spaces to the end of the record length.
File empty	A file with no header, detail and trailer records was transmitted to the BCRC. Transmission may have failed or there was a problem at the RRE with the creation of the file. If you have nothing to report for a quarter, you may submit a header record, no detail records and a trailer record with a zero-record count.
Header record was missing	Header record starting with the characters 'H0' was not present prior to encountering a detail or trailer record. Do not submit detail records with Medicare IDs (Health Insurance Claim Numbers [HICNs] or Medicare Beneficiary Identifiers [MBIs]) starting with 'H0' or 'T0' as these are not valid and might be confused with header and trailer records. **Note:** The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.
Header record does not match filename –or- Header record RRE ID does not match mailbox RRE ID	The RRE ID on the file header record does not match the RRE ID under which it was uploaded. The file was uploaded via HTTPS under the wrong RRE ID or sent to the wrong SFTP mailbox.
Header record not formatted properly	Refer to the file layouts in the appendices for proper header record formats. In particular, the header indicator and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as CCYYMMDD.
Trailer record missing	No trailer record was found at the end of the file or prior to the system encountering another header record beginning with 'H0'. Do not submit detail records with Medicare IDs starting with 'H0' or 'T0' as these are not valid and might be confused with header and trailer records.
Trailer record not formatted properly	Refer to the file layouts in the appendices for proper trailer record formats. In particular, the trailer indicator and file type must be valid, RRE ID must be numeric with leading zeroes as appropriate, date fields must contain a valid date and be formatted as CCYYMMDD, and the record count must be numeric with leading zeroes as appropriate.
Trailer record does not match header record	The RRE ID and/or file submission dates on the header and trailer records are not the same.
Trailer record count does not match count of records in file	The trailer record count should only include the number of detail records on the file. Do not include the header and trailer records in this count.

Severe Error	Explanation/Correction
Non-MSP: Detail record action code not valid for header record file type	Action type on a Non-MSP Input File Detail Record is invalid. Detail record action types must be equal to D, S, or N.
Test file with more than 100 records	Test files must be limited to 100 detail records or less. Resubmit a new test file with fewer records.
Production file reporter status not equal to P	A production file was received for an RRE ID that is not in a production status. Make sure your profile report has been signed by your Authorized Representative and returned to the BCRC. Verify testing requirements have been met. If so, contact your EDI Representative to request that your RRE ID be changed to a production status.
Reporter in discontinued/inactive status	A test or production file was received but your RRE ID has been deactivated. File submitted in error. Check to see that the proper RRE ID was used and that the file was sent to the proper RRE ID mailbox/dataset. If this RRE ID is still in use, ask your EDI Representative to correct the status of your RRE ID.

12.6 Non-MSP Input File RX19 Error Code

On the Non-MSP Input File, you are asked to submit a code in Field 10 (Effective Date) to reflect the start date of the covered individual's GHP Coverage and submit a code in Field 11 (Termination Date) to reflect the end date of the covered individual's GHP Coverage. If an RRE submits a Non-MSP Input File Detail record (add or update transaction) for any drug coverage type (U, V, W, X, Y, Z, 4, 5, or 6) with an effective date or termination date that falls within or overlaps an existing drug record's effective date or termination date, the record will be rejected with D/N disposition code "SP" and Rx error "RX19 – Overlapping Rx Coverage" on the response file.

If the drug coverage is continuous, you do not need to periodically submit records with updated coverage dates if these dates already fall within the same period for the beneficiary. For example, if the coverage is from 01/01/24 to 12/31/24 and an RRE submits an add or update transaction with coverage that begins 02/01/24 and ends 12/31/24 or the termination date is left open-ended, the record will be rejected with the SP D/N disposition code and RX19 error.

Note: The RX19 error code only applies to submissions reported by the same RRE. Prescription drug information sent as part of a combined coverage record with hospital and/or medical coverage (Coverage Types W, X, Y, 4, 5, or 6) will only be rejected for the drug portion of the record if it has overlapping drug coverage dates. Overlapping coverage will result in an RX20 error for RREs who are not the original reporter, which will trigger a warning but not a rejection of the record, allowing submissions and thus increasing likelihood of timely submission.

12.7 Non-MSP End Stage Renal Disease (ESRD)

To allow Section 111 RREs to better coordinate benefits for Medicare beneficiaries related to End Stage Renal Disease (ESRD), the BCRC will provide ESRD data fields on your Non-MSP Response File for Inactive Covered Individuals. These fields are the ESRD Coverage Period Effective and Termination Dates, the First (oldest) Dialysis Date, the Self-Training Date, the

most recent Kidney Transplant Date, and the most recent Kidney Transplant Failure Date. Please refer to fields 55-60 in the Non-MSP Response File specifications in Appendix C.

For an individual with ESRD there is a 30-month coordination of benefits period for ESRD where the patient's GHP coverage may be primary to Medicare. Subsequent to that 30-month period, Medicare becomes the primary payer regardless of the patient's other GHP coverage. There are conditions that must be met in order for a patient to receive Medicare benefits and coverage for an ESRD diagnosis. Refer to https://www.cms.gov/training-education/open-door-forums/end-stage-renal-disease-clinical-laboratories-esrd/general https://www.cms.gov/medicare/enrollment-renewal/health-plans/original-part-a-b and https://www.cms.gov/medicare/coordination-benefits-recovery/overview/end-stage-renal-disease-esrd for more information related to the coordination of benefits with Medicare for ESRD. This topic is also covered in the computer-based training curriculum made available to RREs as described in Chapter 13.

12.8 True-Out-of-Pocket (TrOOP) Facilitation RxBIN and PCN Codes

Section 111 responsible reporting entities that choose the Expanded Reporting Option and provide supplemental prescription drug coverage to Inactive Covered Individuals will need to obtain TrOOP Facilitation RxBIN or PCN codes to route claims through the Part D Transaction Facilitator (i.e., the TrOOP Facilitator). The TrOOP Facilitation RxBIN or PCN codes are routing numbers used to flag claims for coverage supplemental to Medicare Part D that will be paid by Section 111 reporters or their agents. As it is being routed to the pharmacy, the TrOOP Facilitation RxBIN or PCN will enable the TrOOP Facilitation Contractor to identify a Part D supplemental claim, capture it, and transmit the supplemental paid claim amount to the appropriate Part D Plan to support the Plan's TrOOP calculation responsibilities. To route these claims through the TrOOP Facilitation Contractor, you may use a separate and unique RxBIN by itself or a unique PCN in addition to your existing RxBIN.

The organization that issues the original RxBIN is the American National Standards Institute, or ANSI. ANSI can be contacted through its web address: https://www.ansi.org.

A different organization, the National Council for Prescription Drug Programs (NCPDP) issues the Processor Control Number, or PCN. For TrOOP routing you can use a new or additional PCN in lieu of an additional RxBIN. The NCPDP can be contacted through its web address: https://www.ncpdp.org.

12.9 RDS Retiree File Submission

This section only applies to you if you plan to submit retiree files to the Part D Retiree Drug Subsidy (RDS) Center on behalf of a Plan Sponsor (usually an employer) through your Section 111 reporting process. If you have no plan to do that, you may ignore the information in this section.

You may use Section 111 reporting as an alternative method of providing retiree drug subsidy enrollment files to the RDS Center. After enrollment with the RDS program, a Plan Sponsor can use Section 111 for its necessary data transfer and management of retiree files with the RDS Center. Plan Sponsors wishing to receive the Part D Retiree Drug Subsidy for retiree drug coverage must submit an initial application to the RDS Center, a requirement this is separate from the Section 111 process. For more information and complete requirements related to the retiree drug subsidy please visit: https://rds.cms.hhs.gov/. The RDS User Guide can be found under the User Guides menu option on this website.

As part of the application process, the Plan Sponsor must send an initial enrollment file of all retirees and dependents for whom they wish to claim the subsidy. The initial retiree file will be followed by regularly scheduled update files containing adds, updates and deletes.

Section 111 responsible reporting entities submitting retiree files for RDS may opt to do so using records with the 'S' Action Type in the Non-MSP Input File format. 'S' records require essentially the same data elements required for 'D' records. Non-MSP Input Files containing S records must contain the RDS Application Number, a data element the RDS Center will assign to a Plan Sponsor at the start of the RDS application process, in the associated header record for the file. Since the RDS Application Number is part of the non-MSP header record, you may submit multiple Non-MSP files for each RDS Application Number on the frequency prescribed by the RDS Center. These multiple files can be submitted separately or within the same physical file, as long as the files are separated by the appropriate header and trailer records as shown in Figure 12-1.

Do not put N and D records on a Non-MSP File containing S records.

Figure 12-1: Non-MSP File Structure for RDS Retiree Files

Header Record for RDS Application 1
S Record
S Record
S Record
S Record
Trailer Record for RDS Application 1
Header Record for RDS Application 2
S Record
S Record
Trailer Record for RDS Application 2
Header Record for RDS Application 3
S Record
S Record
S Record
Trailer Record for RDS Application 3

The BCRC essentially acts as a pass through and will send S records directly to the RDS Center for processing. The RDS Center will determine whether the covered individuals included on S records are eligible for the subsidy (Part D eligible, but not enrolled in Part D). On the response records, the RDS Center will indicate whether a covered individual was accepted (eligible to be included as part of the plan sponsor's subsidy population) or rejected, by putting a 'Y' or 'N' in the RDS Determination Indicator (Field 54). If the covered individual is not accepted for the subsidy, or the record is in error, corresponding reason/error codes will be posted in the RDS Reason Code (Field 53). The BCRC will populate the S response record with Medicare Part A,

B, C, and D coverage information as applicable. The BCRC will then return the S records to the Section 111 reporter on a Non-MSP Response File.

12.9.1 Splits – Multiple S Response Records

Because periods of eligibility can be interrupted, or a retiree is not eligible for the subsidy for the entire year, you may get more than one S response record for a given submitted S record for a beneficiary/retiree. If this is the case, the RDS Split Indicator (Field 52) will be set to 'Y' and the RDS Start and End Dates in Fields 50-51 will reflect the split periods on each of the response records. Each response record will contain your original DCN (document control number) in the response Field 21. Each response record will contain the RDS Determination and Reason Codes that apply to the date span specified. For example, if the S record was sent to claim the subsidy for 1/1/2009 through 12/31/2009 but the retiree is not entitled to Medicare until 4/1/2009, one response record will include RDS Start and End Dates for 01/01/2009 through 03/31/2009 with a RDS Determination Indicator of N and a RDS Reason Code of 11 (person is not yet eligible for Medicare). The second response record will have dates 04/01/2009 through 12/31/2009 covering the remainder of the plan year with an RDS Determination Indicator of 'Y' and a blank RDS Reason Code.

12.9.2 RDS Determination and Reason Codes

When the original GHP data sharing process was first expanded to include RDS reporting capabilities, the BCRC converted the RDS-specific Determination and Reason Codes to the existing data sharing process Disposition and SP Error Codes that appear in Field 29 (S Disposition Code) and Fields 44-47 (Error Codes) of the Non-MSP Response File. RDS has since added new RDS Reason Codes that could not be cross-walked to the existing codes, which are now the Section 111 Disposition Codes. Therefore, the Non-MSP Response record layout now includes the **actual** RDS Reason Code in Field 53 and the RDS Determination Indicator in Field 54 in addition to the cross-walked fields. Field 53 and 54 contain the same codes you would receive if you submitted the RDS retiree files directly to the RDS Center and not through the Section 111 process.

You should use Fields 53 and 54 for your S record response processing. For questions about the RDS codes please contact the RDS Center directly or visit https://rds.cms.hhs.gov/. The RDS User Guide can be found under the User Guides menu option on this website. The RDS User Guide contains complete and most current information regarding RDS Determination and Reason Codes.

12.9.3 Converting an "S" Record to a "D" Record

Prior to transmitting the Non-MSP Response File back to you, when the BCRC receives S record responses from the RDS Center, it will screen those responses for covered individuals who do not qualify to be counted in the Plan Sponsor's drug subsidy because they are enrolled in Part D. These individuals will then be considered to have other drug coverage supplemental to their Part D coverage. Accordingly, using the information you sent on the S record, the BCRC will add a supplemental drug coverage record to the MBD (as it would with a standard D record). You will receive one response record with a D in the Action Type Field 24 and S in the Original Action Type Field 23. The RDS Determination and Reason Codes in Fields 53 and 54 will indicate why the record was rejected for the subsidy, Field 29 will have the BCRC Disposition Code for the S record, and the D/N Disposition in Field 48 will indicate the results of posting the record as a supplemental drug record. The response record will contain your original DCN (document

control number) in Field 21. You will be expected to submit updates and/or deletes to maintain this supplemental drug record going forward on your subsequent Non-MSP Input Files with D record action types.

12.9.4 Unsolicited RDS Response Files or Records

The Non-MSP Response File format is also used to send you **unsolicited** response files originating from the RDS Center. These transmissions from the RDS Center will notify you that significant data you previously submitted, that may affect the Plan Sponsor's ability to claim the subsidy for an individual, has changed. For example, the retiree may have enrolled in Part D making them ineligible for the subsidy from the Part D enrollment date going forward.

Unsolicited RDS responses are designated by the "RDSU" file type in Field 3 in the header of the Non-MSP Response File and will be sent separately from the regular Non-MSP Response Files ('NMSR' in Header Field 3). The following table lists the RDS Reason Codes you may receive in Field 53 on an unsolicited response file record. The RDS Start and End Dates in Field 50-51 may also have been adjusted. In addition, the RDS Determination Indicator may show a changed value of 'N' instead of 'Y' for Reason Codes 10, 11, and 12. The Plan Sponsor must adjust the periods for claiming the subsidy for affected individuals using this information or resend the original records for proper subsidy determination. Please refer to the RDS User Guide found under the User Guides menu option on https://rds.cms.hhs.gov/ for more information.

Table 12-3: RDS Reason Codes Returned on Unsolicited Response File Record

RDS Reason Code	Description
10	**Enrolled in Part D**. The retiree cannot be covered under the RDS program because the retiree is/was enrolled in Medicare Part D during the coverage period provided by the Plan sponsor.
11	**Not eligible for Medicare**. The retiree cannot be covered under the RDS program because the retired is/was not enrolled/entitled to Medicare during the coverage period provided by the Plan sponsor.
12	**Beneficiary is deceased.**
204	**Beneficiary attempted to enroll in Part D and received an initial rejection.** The retiree tried to enroll in Medicare Part D when (s)he was already covered under the RDS program and as a result this initial attempt to enroll in Part D was denied. The Plan Sponsor may counsel the beneficiary that they have equal or better prescription drug coverage through the RDS program. The Plan Sponsor will not be able to claim the subsidy for the beneficiary if the retiree overrides the denial and enrolls in Part D.
21	**New Medicare information has been received – resend record.** After an initial rejection of the retiree's record, the RDS Center has now been notified of a change in the retiree's Medicare enrollment/entitlement status. The Plan sponsor should resubmit the retiree data on its next monthly update to determine if the retiree is now eligible for RDS program coverage.

Chapter 13: Testing the Section 111 Reporting Process

13.1 Overview of the Testing Process

RREs must pass a testing process prior to sending production files for Section 111. The testing process will ensure that the RRE has developed an adequate system internally to capture and report data to the BCRC as well as process the corresponding response files. A series of test files will be submitted to the BCRC in order to verify that the RRE can transmit files successfully in the correct format, accept and process response files, and properly submit add, update, and delete records. If the RRE is using an agent to test, the agent must submit and pass the testing process on behalf of the RRE. Testing must be completed for each RRE ID registered.

RREs will submit test files in the same manner as the method they choose for submitting production files (HTTPS, SFTP or Connect:Direct). All RREs will be able to monitor the status of the testing process on the COBSW no matter which method is chosen.

Note: When using the HTTPS file transmission method, only files with the file extension of .txt are allowed for uploading. Any other file type will generate an Invalid File error message.

Your EDI Representative will be your main point of contact to assist you throughout the testing process.

13.2 General Testing Requirements

- RREs must complete the registration and account setup process on the Section 111 COBSW and return the signed profile report to the BCRC before testing may begin. A signed profile report must be returned for each RRE ID registered.
- Testing must be completed for each RRE ID registered.
- The RRE must transmit test files to the BCRC in the same transmission method as that chosen for production files.
- The BCRC will maintain a test environment that contains a mirror image of the COB Beneficiary Master Database containing all beneficiary information the BCRC has in production and programs that will mimic the way the files would be processed in production, with the exception of actually updating other Medicare systems and databases.
- RREs will send actual information for covered individuals on test files in order to test realistic situations. However, no production Medicare databases or systems will be updated from test file submissions.
- Test files must be limited to no more than 100 records. Test files with more than 100 detail records will be rejected and not processed.
- The system will apply the same file error threshold checks to test files as those applied to production files.
- RREs choosing to transmit files via SFTP will receive a test submission mailbox/directory separate from their production submission mailbox/directory on the Section 111 SFTP server. RREs choosing to transmit files via HTTPS will do so using

the "Upload File" action on the RRE Listing page after logging on to the Section 111 COBSW application. The Upload File action requires you to indicate whether you are submitting a test or production file and the system will place the file automatically in the proper directory for you. RREs choosing Connect:Direct will send test files to a different destination dataset name than production files.

- The BCRC will return a test response file within one week of submission of a test input file.
- The BCRC will track the progress made with test files, display results on the Section 111 COBSW and put the RRE ID in a "production" status after the testing requirements have been successfully completed. The RRE may continue to test with additional test file submissions after being placed in a production status.
- The results of MSP Input File testing will trigger the transition of an RRE from a testing status to a production status. However, testing of the Non-MSP and Query Only Files is highly recommended.
- Once an RRE has moved to a production status, any subsequent test files received will continue to be processed by the BCRC and results will be displayed on the COBSW. Test response files will be produced and transmitted. In other words, RREs may continue to submit test files after the RRE ID has changed to a production status and even after production files have been submitted. This will allow RREs to test subsequent changes to their internal reporting process without disruption to production reporting.
- Testing progress and completion dates will be tracked and reported in the system by the BCRC. The COBSW will provide a Testing Results page to show the status of test file processing. Information regarding the attainment of test requirements will be available there for review. All users associated with the RRE ID account on the COBSW will be able to monitor the status of the testing process on the COBSW. If testing is not completed by an RRE by the production file submission date, an email notification will be sent to the Authorized Representative and Account Manager. RRE ID accounts that have been in a "testing" status for more than 30 calendar days will receive a warning email indicating that the account may be at risk of non-compliance with the Section 111 Mandatory Reporting requirement. This is for informational purposes only. Please be sure that your EDI Representative is kept informed of your testing progress and any issues that you have encountered.
- If you run the risk of not completing testing in time to submit required information on your initial MSP Input File, please notify your EDI Representative immediately. Even after the RRE ID has been put in a production status, you may continue to send test files for any file type as you deem necessary.
- If an RRE ID is not yet in a production status, production files submitted for any file type will be rejected.
- Once the MSP Input File test requirements have been met for the RRE ID and your EDI Representative has moved the RRE ID to a production status, an email will be sent to the RRE's Authorized Representative and Account Manager to notify them of the change in status and that production files may now be submitted.

13.3 MSP Input File Testing

A test TIN Reference File must be submitted prior to or with your test MSP Input Files. RREs are advised to submit and complete successful processing of test TIN Reference Files prior to

attempting submission of MSP Input Files as the TIN information is required for successful processing of MSP Input Files.

GHP RREs selecting either the Basic or Expanded Reporting Option must submit at least the following test MSP Input Files:

- A TIN Reference File with information for each TIN submitted on the MSP Input File.
- One initial MSP Input File with at least 25 add records.
- A second MSP Input File with at least 5 updates and 5 deletes for previously submitted and accepted records. This file is submitted after the first response file returned by the BCRC is processed.

GHP RREs selecting either the Basic or Expanded Reporting Option must process at least two test MSP Response Files sent back by the BCRC.

GHP RREs selecting either the Basic or Expanded Reporting Option must successfully perform the following to pass the testing process. These records must receive a '01' disposition code on corresponding response file records:

- Post at least 25 new cases with add records in **one** file submission.
- Complete at least 5 updates to previously posted records in **one** file submission.
- Complete at least 5 deletes to previously posted records in **one** file submission.

Note: Additional test files must be submitted until these requirements are met and as advised by your EDI Representative.

13.4 Non-MSP Input File Testing

RREs must pass the testing requirements for processing MSP Files in order to attain a "production" status for each RRE ID. Once the RRE ID is set to a production status, production files of any type may be submitted. However, the BCRC strongly recommends that GHP RREs selecting the Expanded Reporting Option submit at least the following additional test files:

- One Non-MSP Input File with at least 25 supplemental drug coverage add transactions (D records) and 5 query records (N records).
- A second Non-MSP file with at least 5 updates and 5 deletes to previously submitted drug coverage records.

The BCRC recommends that GHP RREs selecting the Expanded Reporting Option successfully perform the following before submitting production Non-MSP Input Files. These records must receive a '01' disposition code on corresponding response file records in order to be considered successful transactions:

- Post at least 25 new drug coverage cases with add records in **one** file submission.
- Complete at least 5 updates to previously posted drug coverage records in **one** file submission.
- Complete at least 5 deletes to previously posted drug coverage records in **one** file submission.

Additional test files may be submitted as deemed necessary by the RRE.

13.5 Query Only File Testing

RREs must pass the testing requirements for processing MSP Files in order to attain a "production" status for each RRE ID. Once the RRE ID is set to a production status, production files of any type may be submitted. However, the BCRC strongly recommends that GHP RREs using the query process test before submitting production Query Only Input Files. As described previously, you may use the HEW software to produce your test Query Only Input Files and process your test Query Only Response Files or use your own X12 translator software to create and exchange the ASC X12 270/271 transaction set.

After processing the test Query Only Input File, the BCRC will provide you a test Query Only Response File identifying those covered individuals that are entitled to Medicare and those individuals not matched to a Medicare beneficiary as prescribed by the file record layouts in Appendix B (if using the HEW software) or as documented in the Section 111 X12 270/271 companion guide. After you are satisfied with the results of the testing, you may begin submitting regular production Query Only Input Files on a monthly basis as long as the RRE ID is in a production status based on MSP Input File testing results.

Testing for the query process may be completed before, during or after your testing of the MSP Input File. Testing for the query process may be completed after the RRE has been set to a production status. Testing the MSP Input File should be your highest priority.

RREs should submit at least the following test files:

- One Query Only Input File with at least five detail records.
- Additional Query Only Input Files as needed to validate the use of the query process by the RRE.

RREs will process at least the following test response files sent back by the BCRC:

- One (1) corresponding Query Only Response File.
- Additional response files as needed/requested.

The BCRC will return test Query Only Response Files within one week of submission of the test Query Only Input File.

13.6 Steps to Register, Test, and Submit Production Files

In summary, the following are the high-level steps you need to follow to set up your reporting process for Section 111:

Complete your registration and account setup (including file transmission information) on the Section 111 COB Secure Website (COBSW) at https://www.cob.cms.hhs.gov/Section111/ on the internet. Register users for the COBSW. You will receive your profile report via email indicating your registration was accepted by the BCRC. Then:

1. Verify, sign and return your profile report to the BCRC.
2. Complete your file transmission setup.

   If you choose SFTP/HTTPS on the COBSW, the system will automatically create the necessary mailbox/directories. If you choose Connect:Direct, contact your EDI Representative for information on how to establish a connection to the BCRC via the CMS Extranet and CMSNet, and create transmission jobs and datasets.

3. Review file specifications, develop software to produce Section 111 files, and schedule your internal quarterly submission process.
4. Test your file transmission method with the BCRC.
5. Test each Section 111 file type you will be submitting with the BCRC.
   - Basic Reporting Option Submitters – MSP, TIN Reference and optional Query Only Files.
   - Expanded Reporting Option Submitters – MSP, TIN Reference, Non-MSP, and optional Query Only Files.
6. Submit your initial TIN Reference File and MSP Input File with all Active Covered Individuals by your assigned production live date.

   If you are an Expanded Reporting Option submitter, submit your initial Non-MSP File with all Inactive Covered Individuals after your assigned production live date.
7. Submit your Query Only File as needed but no more than quarterly ongoing.
8. Submit your quarterly MSP Input File ongoing during your assigned submission periods.
9. Submit your monthly or quarterly Non-MSP Input File ongoing.
10. Monitor file processing and statistics on the COBSW on a regular basis.
11. Monitor emails transmitted to your Account Manager and Authorized Representative ongoing (see Chapter 17).

Contact your EDI Representative to resolve any technical reporting questions and issues and remember to update passwords used for the COBSW and SFTP on a regular basis (at least every 60 days.)

Profile reports will be regenerated and emailed to the RRE's Authorized Representative and Account Manager on an annual basis, based on the receipt date of the last signed profile report. The RRE's Authorized Representative must review, sign, and return the profile report to the BCRC within 30 days of receipt to confirm or update account information and active reporting status for the RRE ID. Failure to return the signed profile report may result in deactivation of the RRE ID.

Chapter 14: Electronic Data Exchange

14.1 File Transmission Methods

There are three separate methods of data transmission that Section 111 responsible reporting entities may utilize. As part of your account setup on the COBSW for Section 111, you will indicate the method you will use and submit the applicable transmission information. Each file type (MSP, Non-MSP, and Query Only) can be set up with the same file transmission method or you may select a different file transmission method for each. However, the method selected for the file type will be used to transmit the corresponding response file back to the RRE by the BCRC.

Generally speaking, if you expect to be transmitting files with more than 24,000 records on a regular basis, it is suggested that you use either the Connect:Direct or SFTP methods described below. HTTPS is more suitable for use with smaller files due to the time it may take to upload and download files during an active user session on the Section 111 COBSW using that method.

14.1.1 Connect:Direct (NDM via CMS EFT)

RREs with a very large transmission volume may wish to consider using Connect:Direct (formerly known as Network Data Mover or NDM) via the CMS Electronic File Transfer (CMS EFT) protocol, which then connects to the CMS Extranet Network and CMS' private CMSNet network hosted by Verizon Business Network Services. Please contact the EDI Department at (646) 458-6740 or your EDI Representative for information on how to establish this connectivity.

During COBSW account setup, you will select the Connect:Direct option and provide the dataset names you want the BCRC to use when sending back response files. You must then contact your EDI Representative to complete the setup. After your registration has been processed and connectivity established, the BCRC will email a profile report to confirm your Section 111 destination dataset names to which you will send your input files. If you have already registered for Section 111 under another file transmission method and wish to change to Connect:Direct, contact your EDI Representative.

The dataset naming convention you will use to transmit files to the BCRC under this method is:

Production or Test Files (Submission)

MSP Input/TIN Reference Files: P#/T#EFT.ON.MRMSP.Rxxxxxxx.Dyymmdd.Thhmmsst

Non-MSP Files: P#/T#EFT.ON.MRNMSP.Rxxxxxxx.Dyymmdd.Thhmmsst

Query Only Files: P#/T#EFT.ON.MRQRY.Rxxxxxxx.Dyymmdd.Thhmmsst

Response Files (sent to the RRE) (Submission)

MSP GHP Files: HLQ.Rxxxxxx.GHPMSP.Dyymmdd.Thhmmsst

Non-MSP Files: HLQ.Rxxxxxx.NONMSP.Dyymmdd.Thhmmsst

Claim TIN Reference Files: HLQ.Rxxxxxx.TIN.Dyymmdd.Thhmmsst

Query Files: HLQ.Rxxxxxx.QRY.Dyymmdd.Thhmmsst

Unsolicited: HLQ.Rxxxxxx.UNS.Dyymmdd.Thhmmsst

Notes:

- P#/T# = Production or test
- HLQ = Customer-defined high-level qualifier, one for production and one for test
- **X**nnnn = Assigned Exchange ID that uniquely identifies the recipient for CMS EFT routing
- **D**yymmdd.**T**hhmmsst = Current date and time
- **R**xxxxxxx = RRE ID padded with zeros (i.e., R0080043)

Your Account Manager must provide the following information **for each file type** during Section 111 COBSW account setup:

- Test and production destination dataset names to which you want the BCRC to send your response files
- Optional special instructions such as file triggers you want the BCRC to use.

Note: Your Account Manager must have the destination dataset name information listed above on hand when completing account setup on the COBSW. If this information cannot be provided, the account setup step cannot be completed, other account information entered during that step will not be saved and your Account Manager will have to return to perform account setup from the beginning at a later time.

14.1.2 Secure File Transfer Protocol (SFTP)

RREs that select the SFTP method will transmit files over the Internet to and from the BCRC for Section 111 using directories (mailboxes) created on the BCRC Section111 SFTP server. Separate directories are set up for each RRE ID. Subdirectories are set up for test input, production input, test response files and production response files. The mailboxes are automatically created when your Account Manager selects SFTP as the file transmission method during COBSW account setup.

A login ID and password are required for the SFTP file transmission method. Any login ID/password assigned to a user of the Section 111 application on the COBSW associated with the RRE account may be used. During initial account setup on the COBSW, the RRE's Account Manager will create a login ID and password (or use their previously defined login ID when performing setup for multiple RRE IDs). The Account Manager may then log in to the site and invite other users to be become Account Designees associated with the RRE. Each Account Designee will obtain their own login ID and password. These same login IDs and passwords are to be used for SFTP transmission. Each user of the COBSW will have one login ID and password. That same login ID and password can be used for multiple RRE SFTP transmissions. For example, an agent may be an Account Manager or Account Designee for many RREs. That agent may use their one COBSW login ID and password to transmit files for all RRE clients via SFTP. The agent may also use this login ID to log in to the COBSW application and monitor file processing.

Note: Passwords for the COBSW must be changed every 60 days. You must sign on to the Section 111 Application on the COBSW to change your password. Failure to maintain a current password will result in an unsuccessful SFTP file transfer. The BCRC recommends that you login to the COBSW and perform the Change Password function once a month to avoid password expiration.

For this transmission method, CMS has extensive experience using the Sterling Connect:Enterprise Secure Client. The cost to you to acquire this software is nominal. However, you may use other software, if it is SSH v2 capable.

Here is the information you will need to configure your SFTP software to transmit Section 111 files:

Table 14-1: SFTP Software Configuration

Type of Server	Standard SSH Server
Host or IP Address of Server	sftp.section111.cms.hhs.gov
Port Number of Server	10022
User Credentials (ID and Password)	Individual COBSW login ID and password assigned to an Account Manager or Account Designee associated with the RRE ID account

Each RRE mailbox will be defined with the following directory/subdirectories (where RREID is the 9-digit Section 111 Reporter ID or RRE ID.) Subdirectory names are in lower case. These are the directories to which you will send files for upload to the COBSW and from which you will pull files for download. The BCRC will not actually transmit response files back to the RRE or its agent. You must pull/download response files from the COBSW.

Input Files (upload):

RREID/submission/test
RREID/submission/prod

Response Files (download):

RREID/response/test/msp
RREID/response/test/non-msp
RREID/response/test/query-only
RREID/response/test/non-msp-rds
RREID/response/prod/msp
RREID/response/prod/non-msp
RREID/response/prod/query-only
RREID/response/prod/non-msp-rds

In summary, the SFTP file directory is structured as:

- RRE ID
  - submission
  - test
  - prod
  - response
  - test
    - msp
    - non-msp
    - query-only
    - non-msp-rds

- prod
  - msp
  - non-msp
  - query-only
  - non-msp-rds

Note: TIN Reference Response Files (effective October 1, 2011) are placed in the "msp" folder.

Using your SFTP client or other software (e.g., command line interface), you will sign on to the Section 111 SFTP server, provide your credentials, navigate through the RRE ID directories and subdirectories to which you have access and then upload or download the applicable file(s).

To navigate to an RRE ID directory, take the following steps:

1. Connect to the Section 111 SFTP server using the host name/IP address and port provided above.
2. Sign on with your Section 111 COBSW login ID and password.

   If your login ID is associated with more than one RRE ID, you will be presented with the directories for each RRE ID to which the login ID is associated on the COBSW.
3. Navigate (change directories) to the RRE ID for which you will be uploading or downloading. If your login ID is only associated with one RRE ID, skip this step.

   Within the RRE ID directory, you will find submission and response directories. Navigate (change directories) to the submission directory to upload input files or to the response directory to download response files.

Upload

1. From the submission directory, navigate (change directories) to either the test or prod directory as applicable to the file you are uploading.
2. From the test or prod directory, proceed to upload your file. There is no specific file naming convention needed. The BCRC will determine the file type from the file contents and test/prod directory to which it's uploaded.

Download

1. From the response directory, navigate (change directories) to either the test or prod directory as applicable for the response file you wish to download.
2. From the test or prod directory, you will be presented with the response file directories to choose from (msp, non-msp, query-only, and non-msp-rds). Select or navigate to the applicable subdirectory for the response file you wish to download.
3. From the selected subdirectory, proceed to download the response file.

   The response file naming convention used is shown below and contains a date and timestamp. If you are automating your SFTP, you may wish to set up your software to pull response files subsequent to a certain date parameter or do a comparison of the files present in the directory to the files you previously downloaded so that you only pull new response files added by the BCRC since your last access. Response files remain on the Section 111 SFTP server for 60 days.

The BCRC will name response files according to the following convention and place them in the corresponding subdirectories for download by the RRE or its agent:

MSP: PCOB.BA.MR.GHPMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
TIN: PCOB.BA.MR.GHPTIN.RESP.Dccyymmdd.Thhmmssmm.TXT
Non-MSP:PCOB.BA.MR.GHPNMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
Query: PCOB.BA.MR.GHPQRY.RESP.Dccyymmdd.Thhmmssmm.TXT
RDS: PCOB.BA.MR.GHPRDS.RESP.Dccyymmdd.Thhmmssmm.TXT
Unsolicited Resp: PCOB.BA.MR.GHPUNS.RESP.Dccyymmdd.Thhmmssmm.TXT

Where 'Dccyymmdd' is 'D' followed by a date as century/year/month/day and 'Thhmmssmm' is 'T' followed by a time as hours/minutes/seconds/centiseconds.

Response files will remain available for downloading for 60 days. Response files can be downloaded more than once as needed. COBSW users cannot delete response files from the COBSW SFTP server. The BCRC will remove these files automatically after 60 days.

Files submitted via SFTP to the COBSW should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

14.1.3 Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

Files uploaded via HTTPS are sent over the Internet to the Section 111 COB Secure Website (COBSW). This is done using the Section 111 COBSW application. There is no additional cost or software associated with using this method as long as a standard Internet browser is used. However, because this method requires a user to be logged in to the COBSW with an active session, use of HTTPS is only recommended for entities with a relatively small amount of data to submit (less than 24,000 records on a regular basis).

During account setup on the COBSW, your Account Manager can select this method for file transfer. The account setup process is described in a previous section of the guide. The RRE's Account Manager obtains a COBSW login ID and password during the account setup process. After that, the Account Manager can sign onto the COBSW and invite other users to obtain login IDs and be associated with the RRE's account as Account Designees. All users associated with the RRE's account will have the ability to upload input files and download response files.

COBSW users associated with the RRE's account will logon to the Section 111 application on the COBSW at https://www.cob.cms.hhs.gov/Section111/ and use the application interface to upload and download files. Instructions are provided in the Section 111 COBSW User Guide available on the site and associated Help pages. Users must maintain an active session on the Section 111 application on the COBSW when uploading or downloading files via the HTTPS file transfer method.

Note: When using the HTTPS file transmission method, only files with the file extension of .txt are allowed for uploading. Any other file type will generate an Invalid File error message.

Files uploaded successfully to the COBSW are not subsequently accessible by users of the COBSW. A user cannot not view or delete a file once uploaded. If a file is uploaded in error, you should contact your EDI Representative for assistance.

Response files will remain available for downloading for two calendar quarters (180 days). Response files can be downloaded more than once as needed. COBSW users cannot delete response files from the COBSW. The BCRC will remove these files automatically after 60 days.

There is no specific naming convention needed when uploading input files.

The BCRC will name response files according to the following convention. A list of files available for download will be presented to users of the COBSW when selecting the download option in the Section 111 COBSW application.

MSP: PCOB.BA.MR.GHPMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
TIN: PCOB.BA.MR.GHPTIN.RESP.Dccyymmdd.Thhmmssmm.TXT
Non-MSP: PCOB.BA.MR.GHPNMSP.RESP.Dccyymmdd.Thhmmssmm.TXT
Query: PCOB.BA.MR.GHPQRY.RESP.Dccyymmdd.Thhmmssmm.TXT
RDS: PCOB.BA.MR.GHPRDS.RESP.Dccyymmdd.Thhmmssmm.TXT
Unsolicited Resp: PCOB.BA.MR.GHPUNS.RESP.Dccyymmdd.Thhmmssmm.TXT

Where ‘Dccyymmdd’ is ‘D’ followed by a date as century/year/month/day and ‘Thhmmssmm’ is ‘T’ followed by a time as hours/minutes/seconds/centiseconds.

Files submitted via HTTPS to the COBSW should utilize an ASCII format. Fields within the records are length delimited and all records are fixed length.

Chapter 15: Querying for Medicare Coverage Information

To coordinate benefits and determine primary and secondary payers for health care services, CMS will share Medicare coverage information for Medicare beneficiaries with Section 111 GHP responsible reporting entities. While you must report coverage information for all Active Covered Individuals who are Medicare beneficiaries under Section 111, you may also be interested to know the Medicare status for your other covered individuals. In most cases, when an individual is currently employed (or is a dependent of a currently employed individual) but is also covered by Medicare, your GHP coverage will be primary to Medicare. However, when the subscriber retires, if the individual is covered by Medicare, then Medicare becomes the primary payer. It is in our mutual best interest to have claims paid by the correct payer early rather than later. To assist you, you may want to set up a process to query for Medicare coverage on each of your retirees and/or their dependents until primary Medicare coverage is confirmed.

The distinction between an individual's benefit **eligibility** and benefit **enrollment** can be confusing. While it sometimes appears that the two terms are used interchangeably, for CMS they have very different and distinct meanings.

Once an individual is a Medicare beneficiary, he or she is then **eligible to participate** in Medicare's benefit programs, including Part D. Usually, the Medicare beneficiary can choose to participate, and if he or she does, the first day the beneficiary's participation is effective is **the date of enrollment** in the benefit program. For example, individuals who have aged into Medicare Part A are then eligible to enroll in Medicare Parts B and D, if they so choose. Once an application for enrollment is accepted, the beneficiary's effective date of enrollment is determined.

In summary, an eligible Medicare beneficiary may participate in Medicare program benefits beginning on the beneficiary's date of enrollment in the benefit program. For beneficiaries who choose to participate in the Part B and D programs, the date of enrollment is, usually, the first day of the following month.

15.1 How to Obtain Medicare Coverage Information

15.1.1 File Transmission

If you report for Section 111 under the Basic Reporting Option, you will receive Medicare Parts A, B, and C coverage information back on your MSP Response File for Active Covered Individuals and Query Only Response File for Active and Inactive Covered Individuals. You will also receive Part D eligibility information back on the MSP Response File for Active Covered Individuals. If you report Medicare Part D primary prescription drug coverage, you will also receive Medicare Part D enrollment information.

If you report for Section 111 under the Expanded Reporting Option, you will receive Medicare Parts A, B, C, and D coverage information back on your MSP Response File for Active Covered Individuals and Non-MSP Response File for Inactive Covered Individuals. Expanded reporters may also submit the Query Only File to get Parts A, B, C, and D coverage information back on any covered individual (Part D if the submitter provides primary prescription drug coverage).

Please refer to the response file layouts in the appendices for the complete set of fields returned with each response file.

15.1.2 Beneficiary Lookup on the Section 111 COBSW

When a Section 111 responsible reporting entity has an immediate need to access Medicare entitlement information, the Beneficiary Lookup feature on the Section 111 COBSW permits you to make a limited number of on-line queries to CMS to find out if an individual is eligible for or enrolled in Medicare.

GHP RREs that are in a production status will have the Beneficiary Lookup action available on the RRE Listing page after logging on to the Section 111 COBSW (https://www.cob.cms.hhs.gov/Section111/). Refer to Section 7.6 and Chapter 17 for information on how to obtain a Section 111 COBSW login ID. The Beneficiary Lookup will utilize the same matching criteria and methodology as used for the Query Only Input File and the MSP Input File.

To use the Beneficiary Lookup action:

1. Log on to the Section 111 COBSW

   The *RRE Listing* page appears.
2. Click on the Actions drop-down box for the RRE ID under which you wish to query.
3. Select the Beneficiary Lookup action from the list and click **Go**.

   The Beneficiary Lookup page appears.
4. On the Beneficiary Lookup page, enter the following required information:
   - Medicare ID (HICN or MBI) or SSN

     Note: The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.
   - Covered Individual First Name
   - Covered Individual Last Name
   - Covered Individual Date of Birth
   - Covered Individual Gender
5. Click **Next**.

   The system will attempt to match the information submitted to a Medicare beneficiary.

   If a match is found, the Beneficiary Lookup Response page will display with Medicare entitlement and enrollment information.

   If the information entered cannot be matched to a Medicare beneficiary, the Beneficiary Not Found page will display.

Important Considerations:

- RREs are limited to 500 query requests per RRE ID per calendar month using the Beneficiary Lookup on the COBSW. Each month the system will display a count of the remaining queries left and will reset this count up to 500 on the first day of each succeeding calendar month. Each query submitted using the Beneficiary Lookup will count toward this limit of 500 per month, regardless of whether or not a match was found.
- Use of the Beneficiary Lookup action is limited to the purposes prescribed by the Section 111 Data Use Agreement as documented in Chapter 16 and agreed to by the RRE's Authorized Representative on the signed Profile Report as well as by each user of the Section 111 COBSW.
- The Beneficiary Lookup action will only be available for RRE IDs in a production status.
- All users associated to the RRE ID (Account Manager and Account Designees) will be able to use the Beneficiary Lookup function.
- Use of the Beneficiary Lookup action is **optional**. It will be offered under all GHP RRE IDs. No special application or sign-up is required.
- RREs using the Beneficiary Lookup action may continue to submit the Query Only Input File, as documented in the user guide. If you selected the Basic Reporting Option for Section 111, you will be provided with Medicare Parts A, B, and C coverage information and Part D eligibility dates. If you report primary prescription drug coverage, you will also receive Part D coverage information. Expanded Reporting Option submitters will continue to receive Parts A, B, C, and D coverage information.

Chapter 16: Data Use Agreement

As part of the Section 111 registration process, the Authorized Representative for each Section 111 RRE will be asked to sign a copy of the following Data Use Agreement. It will be included on the profile report sent to the Authorized Representative after Section 111 COBSW registration and account setup. The Authorized Representative must sign and return the last page of the profile report to the BCRC. In addition, all users must agree to similar language each time they log on to the Section 111 application of the COBSW. Data exchanged for Section 111 is to be used solely for the purposes of coordinating health care benefits for Medicare beneficiaries between Medicare and Section 111 RREs that provide other health insurance coverage. Measures must be taken by all involved parties to secure all data exchanged and ensure it is used properly.

SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I, the undersigned Authorized Representative of the Responsible Reporting Entity (RRE) defined above, certify that the information contained in this Registration is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395kk(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity and its duly authorized agent for this Section 111 reporting, if any, shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the only entities authorized to have access to the data are CMS, the RRE or its authorized agent for Mandatory Reporting. RREs must ensure that agents reporting on behalf of multiple RREs will segregate data reported on behalf of each unique RRE to limit access to only the RRE and CMS and the agent. Further, RREs must ensure that access by the agent is limited to instances where it is acting solely on behalf of the unique RRE on whose behalf the data was obtained. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the RRE and its duly authorized agent, if any, is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and RRE employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

Chapter 17: Section 111 COB Secure Website (COBSW)

17.1 Overview

The BCRC maintains an application on the Section 111 COB Secure Website (COBSW) to support Section 111 reporting. All Section 111 GHP RREs must register and set up accounts on the Section 111 COBSW. The COBSW URL is https://www.cob.cms.hhs.gov/Section111/.

On the COBSW, Section 111 reporters can:

- Complete the registration and account setup process. All information is collected through an interactive Web application.
- Obtain login IDs and assign users for Section 111 COBSW accounts.
- Exchange files via HTTPS or SFTP directly with the BCRC.
- View and update Section 111 reporting account profile information such as contacts and company information.
- View the status of current file processing such as when a file was marked as received and whether a response file has been created.
- View statistics related to previous file submission and processing.
- View statistics related to compliance with Section 111 reporting requirements such as whether files and records have been submitted on a timely basis.
- Utilize an online query function, the Beneficiary Lookup, to determine the Medicare status of a covered individual.
- Submit requests to EDI Representatives for RRE IDs.

17.2 Using the Section 111 Application: Sources of Help

To access the Section 111 COBSW, go to https://www.cob.cms.hhs.gov/Section111/ using your Internet browser. Once you click on the "I Accept" link and accept the terms of the login Warning, the homepage will display.

Information on the New Registration, Account Setup, and other processes can be found under the **"How To" menu option** at the top of the homepage. **A login ID is not needed to access this menu option**. Click on the menu option and a drop-down list will appear. Then click on the item desired in the list.

All pages of the Section 111 COBSW application provide access to **"Quick Help"** information. Click on the link for Quick Help and a new window will open with instructions and information needed to complete the page you are working on.

Once you have obtained a login ID for the Section 111 COBSW, you may log into the application using the login fields displayed on the right side of the homepage. After login, a detailed **Section 111 COBSW User Guide** is available under the "Reference Materials" menu option at the top of the page. You must be logged into the application to gain access to the COBSW User Guide.

Computer-Based Training (CBT) modules for the Section 111 application on the COBSW are available free of charge to RREs and their agents. See Chapter 19 for information on how to register for the CBT courses.

17.3 About Login IDs

Each person using the Section 111 COBSW must obtain their own login ID and password. Your personal login ID may be used for access to multiple RRE IDs. Your login ID will also be used to transmit files via SFTP (see Section 14.1). You can play one of two roles under an RRE ID with your single login ID—Account Manager or Account Designee. Authorized Representatives **cannot** be users of the COBSW (see Section 7.6).

To obtain a login ID, you must either perform the Account Setup step of the registration process for the RRE ID on the COBSW and become the **Account Manager** or be invited by an already established Account Manager to be associated to the RRE ID as an **Account Designee**. Refer to the information in Section 7.6 on the registration process and the "How Tos" referenced above for more information on obtaining login IDs during the registration process.

If your organization has completed the registration process and you need a login ID for the COBSW, contact your Account Manager and request that he or she add you as an Account Designee. You will receive an email invitation to come to the site and set up your login ID and password. Likewise, if you are a reporting agent and need access to a customer's COBSW account to assist with the reporting process, contact the RRE's Account Manager to be invited as an Account Designee.

Each RRE must assign or name an Account Manager. The Account Manager may be an employee of the RRE or a reporting agent. Each RRE ID can have only one Account Manager. This is the individual who controls the administration of an RRE's account and manages the overall reporting process. The Account Manager may choose to manage the entire account and data file exchange or may invite other company employees or data processing agents to assist.

The Account Manager:

- Must register on the COBSW using the PIN for the RRE ID (see Section 7.6.2), obtain a login ID and complete the account setup tasks.
- Can be an Account Manager associated with another RRE ID if they receive the authorized PIN from the BCRC mailing. This can occur when a reporting entity has multiple RRE IDs under which they will report separate MSP Input Files or when the entity chooses to name an agent as its Account Manager.
- Can invite other users to register on the COBSW as Account Designees for an RRE ID.
- Can manage the RRE's profile including selection of a file transfer method.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use their login ID and password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can review file transmission history.
- Can review file-processing status and file statistics.
- Can remove an Account Designee's association to an RRE ID account.
- Can change account contact information (e.g., address, phone, etc.)

- Can change their personal information.
- Cannot be an Authorized Representative for any RRE ID.

At the RRE's discretion, the Account Manager may designate other individuals, known as Account Designees, to register as users of the COBSW associated with the RRE's account. Account Designees assist the Account Manager with the reporting process. Account Designees may be RRE employees or agents.

The Account Designee:

- Must register on the COBSW and obtain a login ID.
- Can be associated with multiple RRE accounts, but only by an Account Manager invitation for each RRE ID.
- Can upload and download files to the COBSW if the RRE has specified HTTPS as the file transfer method.
- Can use their login ID and password to transmit files if the RRE has specified SFTP as the file transfer method.
- Can review file transmission history.
- Can review file-processing statuses and file statistics.
- Can change their personal information.
- Cannot be an Authorized Representative for any RRE ID.
- Cannot invite other users to the account.
- Cannot update RRE account information.

Note: Each user of the Section 111 application on the COBSW will have only one login ID and password. With that login ID and password, you may be associated with multiple RRE IDs (RRE accounts). With one login ID, you may be an Account Manager for one RRE ID and an Account Designee for another. In other words, the role you play on the COBSW is by RRE ID.

17.4 System-Generated Emails

The following table lists the emails that are generated by the system to the Authorized Representative, Account Manager, and/or Account Designees for the RRE ID. Emails will be sent from COBVA@mail.cms.hhs.gov. Please do not reply to this email address as replies are not monitored by the BCRC. If additional information or action is needed, please contact your EDI Representative directly.

Table 17-1: System-Generated Emails

Email Notification	Recipient	Purpose
Profile Report	Authorized Representative, Account Manager	Sent after Account Setup step is complete on the COBSW. Includes attachment with profile report. The profile report must be signed by the RRE's Authorized Representative and returned to the BCRC.

Email Notification	Recipient	Purpose
Non-Receipt of Signed Profile Report	Authorized Representative, Account Manager	Generated 30 days after the Profile Report email if a signed copy of the profile report has not been received at the BCRC. The Authorized Representative for the RRE ID must sign and return the profile report. If another copy is needed, contact your EDI Representative.
Successful File Receipt	Account Manager	Sent after an input file has been successfully received but not yet processed at the BCRC. Informational only. No action required. Subsequent emails will be sent regarding the results of actual file processing.
Late File Submission	Authorized Representative, Account Manager	Sent 7 days after the end of the file submission period if no MSP Input File was received for the RRE ID. Send the file immediately and contact your EDI Representative.
Threshold Error	Account Manager	Sent when an input file has been suspended for a threshold error. Contact your EDI Representative to resolve.
Severe Error	Account Manager	Sent when an input file has been suspended for a severe error. Contact your EDI Representative to resolve.
Deleted File	Account Manager	Sent when an input file in Threshold Error, Severe Error, or TIN Error status is automatically deleted. The RRE can then take appropriate action or follow up as needed.
Ready for Testing	Account Manager	Account setup is complete and the signed profile report has been received at the BCRC. The RRE may begin testing.
Non-Attainment of Production Status	Authorized Representative, Account Manager	RRE ID has been in a testing status for more than 30 days. Informational only. Be sure your EDI Representative is aware of your testing progress.
Ready for Production	Account Manager	Testing requirements have been met and production files will now be accepted for the RRE ID.
Successful File Processed	Account Manager	The BCRC has completed processing on an input file and the response file is available.
Account Designee Invitation	Account Designee	Sent to an Account Designee after the Account Manager for the RRE ID adds the Account Designee to the RRE ID on the COBSW. If the Account Designee is a new user, the email will contain an URL with a secure token link for the user to follow to obtain a login ID for the COBSW.

Email Notification	Recipient	Purpose
Personal Information Changed	User Affected (Account Manager or Account Designee)	Generated after a user changes their personal information on the COBSW. Informational only.
Password Reset	User Affected (Account Manager or Account Designee)	Generated when a user's password is reset on the COBSW.
Login ID Request	User Affected (Account Manager or Account Designee)	Generated after a user completes the "Forgot Login ID" function on the COBSW.
Recertification of Profile Report Information	Authorized Representative Account Manager	Generated annually on anniversary of upload of signed profile report or prior recertification date.
Non-Submission Notification	Account Representative Account Manager	Generated when a GHP RRE fails to submit their scheduled quarterly GHP MSP Input File.

17.5 Best Practices

CMS advises all Section 111 COBSW users to implement the following best practices:

- Keep the personal computer Operating System and Internet Browser software (e.g., Chrome, Edge, or Firefox) at the most current patch level.
- Install and use the latest versions of anti-virus/spyware software to continuously protect personal computers.
- Use desktop firewall software on personal computers and ensure that file sharing is disabled.
- Never use a public computer (library, internet café, etc.) to login to CMS resources.

Chapter 18: Customer Service and Reporting Assistance

Please be sure to visit the Section 111 page on the CMS Website https://go.cms.gov/mirghp frequently for updated information on Section 111 reporting requirements including updates to this guide. To be notified via email of updates to the GHP or any CMS.gov webpage, enter your email address in the "Get email updates" section at the bottom of any CMS.gov webpage, and choose which topics for which you want updates. When new information regarding those topics is available, you will be notified.

The Section 111 Resource Mailbox, at PL110-173SEC111-comments@cms.hhs.gov, is a vehicle that RREs may use to send CMS policy-related questions regarding the MSP reporting requirements included in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and the SUPPORT Act. You are requested to send only policy-related questions to the Section 111 Resource Mailbox.

If you have a technical question, or if you are unable to contact your EDI Representative, for any reason, call the EDI Hotline at (646) 458-6740.

Please note that emails from CMS or the BCRC may come from @cms.hhs.gov and @bcrcgdit.com addresses. Please update your spam filter software to allow receipt of these email addresses.

18.1 EDI Representative

After you register for Section 111 reporting, you will be assigned an EDI Representative to be your main contact for Section 111 file transmission and technical reporting issues. Contact information for your EDI Representative will be provided on your profile report.

If you have not registered to become an RRE, or have not been assigned an EDI Representative, please contact the BCRC directly at 1-855-798-2627.

18.2 Contact Protocol for the Section 111 Data Exchange

In all complex electronic data management programs, there is the potential for an occasional breakdown in information exchange. **If you have a program or technical problem involving your Section 111 data exchange, the first person to contact is your own EDI Representative at the BCRC.** Your EDI Representative should always be sought out first to help you find solutions for any questions, issues or problems you have.

If you have not yet been assigned an EDI Representative, please call the EDI Department at 646-458-6740 for assistance.

Escalation Process

The BCRC places great importance in providing exceptional service to its customers. To that end, we have developed the following escalation process to ensure our customers' needs are met:

- If your Section 111 EDI Representative does not respond to your inquiry or issue within **two business** days, you may contact the EDI Director, Angel Pagan, at 646-458-2121. Mr. Pagan's email is apagan@bcrcgdit.com.

- If the EDI Director does not respond to your inquiry or issue within **one business day**, you may contact the BCRC Project Director, Jim Brady, who has overall responsibility for the EDI Department and technical aspects of the Section 111 reporting process. Mr. Brady can be reached at 646-458-6682. His email address is JBrady@bcrcgdit.com. Please contact Mr. Brady only after attempting to resolve your issue following the escalation protocol provided above.

Chapter 19: Training and Education

Various forms of training and educational materials are available to help you with Section 111 in addition to this guide.

- The GHP Section 111 CMS Web page at https://go.cms.gov/mirghp contains links to all CMS publications regarding the MSP Mandatory Reporting Requirements under Section 111 of the MMSEA of 2007 for GHPs. To be notified via email of updates to the GHP or any CMS.gov webpage, enter your email address in the "Get email updates" section at the bottom of any CMS.gov webpage, and choose which topics for which you want updates. When new information regarding those topics is available, you will be notified.
- During implementation of the Section 111 reporting, CMS is conducting a series of teleconferences to provide information regarding Section 111 reporting requirements. The schedule for these calls is posted (and updated as new calls are scheduled) on the GHP Alerts page of the CMS website at https://go.cms.gov/mirghp.
- CMS has made available a curriculum of computer-based training (CBT) courses to Section 111 GHP RREs and agents. These courses provide in-depth training on Section 111 reporting requirements, file transmission, file formats, file processing, the Section 111 COBSW, and general MSP topics. These courses are all available on the GHP Training Material page of the CMS website at https://www.cms.gov/medicare/coordination-benefits-recovery/mandatory-insurer-reporting-group-health-plans/training-manual.

Note: The Section 111 User Guides and instructions do not and are not intended to cover all aspects of the MSP program. Although these materials may provide high level overviews of MSP in general, any individual/entity which has responsibility as a primary payer to Medicare is responsible for their obligations under the law. The statutory provisions for MSP can be found at 42 U.S.C. 1395y(b); the applicable regulations can be found at 42 C.F.R. Part 411. Supplemental guidance regarding the MSP provisions can also be found at:

- https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer and
- https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms. The MSP manual is publication 100-05.

Appendix A MSP File Specifications

Section 111 GHP MSP Input File

MSP Input File Header Record

Table A-1: Section 111 GHP MSP Input File Header – 425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-numeric	**Must be: 'H0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Alpha	**Must be 'MSPI'** – MSP Input File.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD **Required.**
5.	Filler	402	24-425	Alpha-Numeric	Unused Field – **fill with spaces**.

MSP Input File Detail Record

Table A-2: Section 111 GHP MSP Input File Detail Record—425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Medicare ID	12	1-12	Alpha-Numeric	Active Covered Individual's/Beneficiary's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]). **Note:** This is also known as the Medicare Number to CMS' Medicare beneficiaries. **Required if SSN not provided.** **Required if the Active Covered Individual is under 45 years of age and is eligible for Medicare due to ESRD or a disability.** Populate with spaces if unavailable.
2.	Beneficiary Surname	6	13-18	Text	Active Covered Individual's/Beneficiary's Last Name – **Required**. Report the last name as it appears on the individual's SSN or Medicare Card.
3.	Beneficiary First Initial	1	19-19	Text	Beneficiary's First Initial – **Required**. Report the initial as it appears on the individual's SSN or Medicare Card.
4.	Beneficiary Date of Birth	8	20-27	Date	Beneficiary's DOB (CCYYMMDD) – **Required**.
5.	Beneficiary Sex Code	1	28-28	Numeric	Beneficiary's Sex – **Required**. Valid Values: 0 = Unknown 1 = Male 2 = Female
6.	DCN	15	29-43	Text	Document Control Number; assigned by the Section 111 GHP RRE. **Required.** Each record within the current file must have a unique DCN.

Field	Name	Size	Displacement	Data Type	Description
7.	Transaction Type	1	44-44	Numeric	Type of Transaction – **Required.** Valid Values: '0' = Add record '1' = Delete record '2' = Update/Change record
8.	Coverage Type	1	45-45	Alpha-Numeric	Type of Insurance – **Required**. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug Only (non-network Rx) 'W' = Comprehensive Coverage – Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Prescription Drug Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage – Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) 'R' = Health Reimbursement Arrangement (HRA) **Note:** If an HRA covers hospital, medical, and prescription drugs, submit two separate records: one for Coverage Type 'R' and the other for 'Z.'
9.	Beneficiary Social Security Number	9	46-54	Alpha-numeric	Active Covered Individual's/Beneficiary's SSN – **Required if Medicare ID (HICN or MBI) not provided.** This field accepts the last 5 digits of the SSN. Fill with four leading blank spaces. Populate with 9 spaces or all zeros if unavailable.

Field	Name	Size	Displacement	Data Type	Description
10.	Effective Date	8	55-62	Date	Start Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). **Notes:** This field accepts dates up to three months in the future from the current date, as follows: For currently entitled beneficiaries (i.e., enrolled in Medicare), or for beneficiaries who will be entitled starting up to three months in the future. For beneficiaries who are currently enrolled in Part D, or for beneficiaries who will be enrolled starting up to three months in the future. When records (prescription drug or otherwise) are submitted as updates, the submitted Effective Date will be used for the matching criteria, When non-drug records (all coverage types) are submitted as updates with an Effective Date prior to the Entitlement Date, matching will be done using either the record Effective Date or the submitted Effective Date. Please see Section 9.3.1 for information on errors for incoming records that overlap existing drug coverage periods. **Required**.

Field	Name	Size	Displacement	Data Type	Description
11.	Termination Date	8	63-70	Date	End Date of Covered Individual's GHP Coverage. (CCYYMMDD) **Note**: Submit the last day that the Active Covered Individual is covered through a GHP due to current employment status (with the exception of situations involving ESRD). Please see Section 8.7.1.1. **How to Report a Coverage Termination Date for Active Covered Individuals** for additional information and examples. Please see Section 9.3.1 for information on errors for incoming records that overlap existing drug coverage periods. **Required**. ***Use all zeros if open-ended.**
12.	Relationship Code	2	71-72	Numeric	Covered Individual's Relationship to Policy Holder – **Required**. Valid values: '01' = Self; Covered Individual is Policy Holder or Subscriber '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Family Member
13.	Policy Holder's First Name	9	73-81	Text	Employee or Subscriber's First name – **Required.**
14.	Policy Holder's Last Name	16	82-97	Text	Employee or Subscriber's Last Name – **Required**.

Field	Name	Size	Displacement	Data Type	Description
15.	Policy Holder's SSN	9	98-106	Alpha-numeric	Subscriber/Employee SSN RREs must submit **at least** Field 15 – **OR** – the Individual Policy Number (Field 18). Both fields may be submitted, but RREs are encouraged to use Field 18 instead of Field 15 if possible. Field 18 should reflect the unique identifier the RRE uses for the individual being reported on the record which in most cases is the identification number shown on the individual's insurance card. The value supplied in these fields will be placed on any related recovery demand notifications for the RRE to use to identify the GHP coverage for the individual reported on the record.
16.	Employer Size	1	107	Numeric	Valid Values: '0' = 1 to 19 employees* '1' = 20 to 99 employees* '2' = 100 or more employees *Employer Size Rule for Multi-Employer Plans: If the employer is part of a multi-employer plan, this field should reflect the size of the **largest** employer in the plan. Enter '1' if employer has fewer than 20 full or part-time employees but is part of a multi-employer plan (a group of plans) and another employer in that group has 20 or more employees. Enter '2' if employer has fewer than 100 full or part-time employees but is part of a multi-employer plan where another employer in that group has 100 or more employees. Refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 and Appendix H for details on this calculation. **Required**.

Field	Name	Size	Displacement	Data Type	Description
17.	Group Policy Number	20	108-127	Text	Policy Number assigned by GHP Payer. If no group number exists, as in the case of a self-insured RRE, this field may be set to any valid text value as a default. For use when Coverage Type is V, Z, 4, 5, and 6.
18.	Individual Policy Number	17	128-144	Text	GHP's unique individual identifier for the Active Covered Individual (beneficiary) reported on this record. Number that appears on the individual's insurance card. It may reflect a unique identifier used by the RRE for the individual or the subscriber/member/employee's unique identifier. For self-insured RRE's, covered person's member ID or other unique ID used to identify individuals covered by the plan. **The Policy Holder's SSN (Field 15) OR Individual Policy Number (Field 18) is required.** Both fields may be submitted, but RREs are encouraged to use Field 18 instead of Field 15 if possible. Field 18 should reflect the unique identifier the RRE uses for the individual being reported on the record which in most cases is the identification number shown on the individual's insurance card. The value supplied in these fields will be placed on any related recovery demand notifications for the RRE to use to identify the GHP coverage for the individual reported on the record.
19.	Employee Coverage Election	1	145	Numeric	Who the Policy Covers – **Optional.** '1' = Policyholder/Subscriber Only. '2' = Policyholder/Subscriber & Family (also use this value if the coverage reflects Policyholder/Subscriber & Spouse only). '3' = Policyholder/Subscriber & Dependents, but not Spouse.

Field	Name	Size	Displacement	Data Type	Description
20.	Employee Status	1	146	Numeric	'1' = Active/Currently Employed during GHP effective period reported. '2' = Not Active/Not Currently Employed during GHP effective period reported. Since only Active Covered Individuals are to be submitted on the MSP Input File, a value of '2' will only be used when reporting individuals with ESRD who are not covered due to current employment status. Otherwise, this indicator should always be '1'. See Section 7.3.1 regarding Active Covered Individuals. **Required**.
21.	Employer TIN	9	147-155	Numeric	Employer Tax Identification Number (EIN) – **Required**. A matching record must be (or have been) submitted on the TIN Reference File. For multiple employer/multi-employer plans submit the plan sponsor TIN rather than the actual employer TIN.
22.	Insurer/TPA TIN	9	156-164	Numeric	Insurer/TPA Tax Identification Number for the RRE – **Required**. A matching record must be (or have been) submitted on the TIN Reference File. If the RRE is a TPA, report the TIN of the TPA entity. If the RRE is a self-insured employer/plan sponsor entity, then the TIN of the self-insured employer/plan sponsor RRE is to be used.
23.	National Health Plan	10	165-174	Filler	National Health Plan Identifier – (Future Use). **Fill with spaces.**
24.	Rx Insured ID Number	20	175-194	Text	Insured's Identification Number for prescription drug coverage. **Required for Coverage Types U, W, X, & Y.** **Cannot be blank or all zeros.**
25.	Rx Group Number	15	195-209	Text	Group Number for prescription drug coverage. Provide if Rx Group values assigned; otherwise, leave blank.

Field	Name	Size	Displacement	Data Type	Description
26.	Rx PCN	10	210-219	Text	Rx Processor Control Number. **Must provide if available.** **Cannot have special characters, except for a non-leading dash, and no leading space.**
27.	Rx BIN Number	6	220-225	Numeric	Benefit Identification Number for Rx processing. **Required for Coverage Types U, W, X, & Y.** **Must be a 6-digit number.** **Cannot be all the same number.**
28.	Rx Toll Free Number	18	226- 243	Text plus "(" and ")"	Prescription Drug/Pharmacy Benefit Information Toll Free Number.
29.	Person Code	3	244-246	Text	Person Code the plan uses to identify specific individuals on a policy. The values are established by the insurer. May also known as a Dependent Code.
30.	Reserved	10	247-256	Alpha-Numeric	Reserved for BCRC use. **Fill with spaces only.**
31.	Reserved	5	257-261	Alpha-Numeric	Reserved for BCRC use. **Fill with spaces only.**
32.	Small Employer Exception Medicare ID	12	262-273	Alpha-Numeric	Beneficiary's Medicare ID (HICN or MBI) if exception has been approved for a small employer. Fill with spaces if there is no approval.
33.	Override Code	2	274-275	Alpha-Numeric	Code used to override specific hierarchy error codes. Valid Values: HB = Hierarchy bypass. Use to override error code SPH0. HB can be used to update or delete a prescription drug record with a higher-ranking source if the record has not been locked by the BCRC. Spaces = Not Applicable
34.	Filler	150	276-425	Alpha-numeric	Unused Field. **Fill with spaces only.**

MSP Input File Trailer Record

Table A-3: Section 111 GHP MSP Input File Trailer Record—425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	**Must be: 'T0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Alpha	**Must be 'MSPI'** – MSP Input File.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD **Required.**
5.	Record Count	9	24-32	Numeric	Number of Active Covered Individual records in this file. **Do not include the Header and Trailer Records in this Record Count.** **Required.**
6.	Filler	393	33-425	Alpha-Numeric	Unused Field – **fill with spaces.**

Section 111 GHP MSP TIN Reference File

TIN Reference Input File Header Record

Table A-4: Section 111 GHP MSP TIN Reference Input File Header Record—425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	**Must be: 'H0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Alpha	**Must be: 'REFR'** – TIN Reference File. **Required.**
4.	File Date	8	16-23	Numeric Date	CCYYMMDD **Required.**
5.	Filler	402	24-425	Alpha Numeric	Unused Field – **fill with spaces**.

TIN Reference Input File Detail Record

Table A-5: Section 111 GHP MSP TIN Reference Input File Detail Record—425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	TIN	9	1-9	Numeric	Tax identification number, EIN or FEIN of the entity (insurer, TPA, employer), or cross-reference number to TIN field in the MSP Input File Detail Records (Fields 21 and 22). Must be unique – only one record per TIN/TIN Indicator combination will be processed and saved by the BCRC. If multiple records for the same TIN/TIN Indicator are submitted on the TIN Reference File, only the information for the last record will be used. Corresponds to either Field 21 or 22 of the MSP Input File Detail Record. Each TIN used in Fields 21 and 22 of MSP Input File Detail Records must have a corresponding TIN Reference File Detail Record. The value in the TIN indicator (Field 8) identifies what type of TIN is being submitted on this record. **Required.**
2.	Name	32	10-41	Text	Name of the entity. Will be used with the Mailing Address Fields 3-7. **Required.**

Field	Name	Size	Displacement	Data Type	Description
3.	Address Line 1	32	42-73	Text	Address Line 1. The mailing address associated with each TIN should be the address to which health care insurance coordination of benefits issues should be directed. This mailing address will help CMS and others to direct correspondence to the most appropriate contact at the GHP responsible reporting entity, employer, or plan sponsor. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. If the TIN Indicator (Field 8) = 'I', then this address may be used by providers and suppliers to redirect claim submissions. If the TIN Indicator (Field 8) is 'E', 'S', or 'Z' reflecting an employer TIN record, and no US address is available, fill with spaces and put 'FC' in the State (Field 6) and provide the Foreign Employer Address starting in Field 15. **Required.**
4.	Address Line 2	32	74-105	Text	Address Line 2. If the TIN Indicator = 'I', then this address may be used by providers and suppliers to redirect claim submissions. If the TIN Indicator (Field 8) is 'E', 'S', or 'Z' reflecting an employer TIN record, and no US address is available, fill with spaces and put 'FC' in the State (Field 6) and provide the Foreign Employer Address starting in Field 15.

Field	Name	Size	Displacement	Data Type	Description
5.	City	15	106-120	Text	City. If the TIN Indicator = 'I', then this address may be used by providers and suppliers to redirect claim submissions. If the TIN Indicator (Field 8) is 'E', 'S', or 'Z' reflecting an employer TIN record, and no US address is available, fill with spaces and put 'FC' in the State (Field 6) and provide the Foreign Employer Address starting in Field 15. **Required.**
6.	State	2	121-122	Alpha	State – Must be a valid USPS state abbreviation or 'FC'. See https://pe.usps.gov/text/pub28/28apb.htm. If the TIN Indicator = 'I', then this address may be used by providers and suppliers to redirect claim submissions. If the TIN Indicator (Field 8) is 'E', 'S', or 'Z' reflecting an employer TIN record, and no US address is available, fill with 'FC' and provide the Foreign Employer Address starting in Field 15. **Required.**
7.	Zip Code	9	123-131	Alpha-Numeric	ZIP Code. If the TIN Indicator = 'I', then this address may be used by providers and suppliers to redirect claim submissions. If the TIN Indicator (Field 8) is 'E', 'S', or 'Z' reflecting an employer TIN record, and no US address is available, fill with spaces and put 'FC' in the State (Field 6) and provide the Foreign Employer Address starting in Field 15. **First 5 positions required. Use all spaces for remaing positions if unknown. Do not use zeros.**

Field	Name	Size	Displacement	Data Type	Description
8.	TIN Indicator	1	132	Alpha	Used to indicate whether the TIN is for an insurer/TPA or employer. Values: E = The TIN field contains a valid TIN (EIN) for an Employer. I = The TIN field contains a valid TIN for an Insurer/TPA. S = The TIN field contains a valid TIN for the plan sponsor of a multiple employer/multi-employer plan. F = The TIN field contains a valid TIN for a Federal employer. Z = The TIN field reflects a foreign employer that has no valid TIN. The TIN field contains a pseudo-TIN for the foreign employer. **Required.**
9.	Insurer/TPA Demand Mailing Name	32	133-164	Text	Name to be used on insurer/TPA's courtesy copy of demand packages sent for recovery purposes if different from where claims should be forwarded. If not supplied then Fields 2-7 will be used on recovery demand packages. Use only if TIN Indicator (Field 8) = 'I'. **The Demand Name and Address fields are optional but if any are supplied, then Demand Name, Demand Address Line 1, Demand City, Demand State and Demand ZIP are required.** **Optional.**
10.	Insurer/TPA Demand Address Line 1	32	165-196	Text	Address line 1 to be used on insurer/TPA's courtesy copy of demand packages sent for recovery purposes if different from where claims should be forwarded. If not supplied then Fields 2-7 will be used on demand packages. Street number and street name should be placed on one address line field while other information such as suite number, attention to, etc. should be placed on the other. Use only if TIN Indicator (Field 8) = 'I'. **Optional.**

Field	Name	Size	Displacement	Data Type	Description
11.	Insurer/TPA Demand Address Line 2	32	197-228	Text	Address line 2 to be used on insurer/TPA's courtesy copy of demand packages sent for recovery purposes if different from where claims should be forwarded. If not supplied then Fields 2-7 will be used on demand packages. Use only if TIN Indicator (Field 8) = 'I'. **Optional.**
12.	Insurer/TPA Demand Mailing City	15	229-243	Text	City to be used on insurer/TPA's courtesy copy of demand packages sent for recovery purposes if different from where claims should be forwarded. If not supplied then Fields 2-7 will be used on demand packages. Use only if TIN Indicator (Field 8) = 'I'. **Optional.**
13.	Insurer/TPA Demand Mailing State	2	244-245	Alpha	State to be used on insurer/TPA's courtesy copy of demand packages sent for recovery purposes if different from where claims should be forwarded. If not supplied then Fields 2-7 will be used on demand packages. Use only if TIN Indicator (Field 8) = 'I'. **Optional.**
14.	Insurer/TPA Demand Mailing Zip	9	246-254	Alpha-numeric	USPS ZIP Code to be used on insurer/TPA's courtesy copy of demand packages sent for recovery purposes if different from where claims should be forwarded. If not supplied then Fields 2-7 will be used on demand packages. Use only if TIN Indicator (Field 8) = 'I'. Use all spaces if unknown. Do not use zeros. **Optional.**
15.	Foreign Employer Address Line 1	32	255-286	Text	First line of mailing address of a foreign employer. Use only if TIN Indicator (Field 8) = 'E', 'S', or 'Z' and employer has no US address. **Required if State (Field 6) = 'FC'.**

Field	Name	Size	Displacement	Data Type	Description
16.	Foreign Employer Address Line 2	32	287-318	Text	Second line of mailing address of a foreign employer. Use only if TIN Indicator (Field 8) = 'E', 'S', or 'Z' and employer has no US address. **Optional.**
17.	Foreign Employer Address Line 3	32	319-350	Text	Third line of mailing address of a foreign employer. Use only if TIN Indicator (Field 8) = 'E', 'S', or 'Z' and employer has no US address. **Optional.**
18.	Foreign Employer Address Line 4	32	351-382	Text	Fourth line of mailing address of a foreign employer. Use only if TIN Indicator (Field 8) = 'E', 'S', or 'Z' and employer has no US address. **Optional.**
19.	Filler	43	383-425	Text	Future use – **Fill with spaces.**

TIN Reference Input File Trailer Record

Table A-6: Section 111 GHP MSP TIN Reference Input File Trailer Record—425 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	**Must be: 'T0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Alpha	Must be: **'REFR'** – TIN Reference File.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD **Required.**
5.	Record Count	9	24-32	Numeric	Number of TIN records in this file. Do not include the Header and Trailer Records in the Record Count. **Required.**
6.	Filler	393	33-425	Alpha-Numeric	Unused Field – **fill with spaces**.

Section 111 GHP MSP Response File

MSP Response File Header Record

Table A-7: Section 111 GHP MSP Response File Header Record—800 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alphanumeric	**Must be: 'H0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. Corresponds to the RRE ID submitted on the MSP Input File.
3.	File Type	4	12-15	Alpha	'MSPR' – MSP Response File.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD BCRC supplied.
5.	Filler	777	24-800	Alphanumeric	Unused Field. Space filled.

MSP Response File Detail Record

Table A-8: Section 111 GHP MSP Response File Detail Record—800 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Filler	4	1-4	Alphanumeric	For BCRC internal use.
2.	Medicare ID	12	5-16	Alphanumeric	Most current Medicare Beneficiary Identifier (MBI) or most current Medicare ID (Health Insurance Claim Number [HICN]). If the information submitted on the input record was matched to a Medicare beneficiary, this field will contain the most current MBI for the beneficiary. **Note:** This is also known as the Medicare Number to CMS' Medicare beneficiaries. Store this MBI in your system for future updates and deletes. If no match is found, the position will be filled with spaces.
3.	Beneficiary Surname	6	17-22	Text	Beneficiary's Last Name. Field will contain either the first 6 characters of the name supplied or the **corrected** name from BCRC database.
4.	Beneficiary First Initial	1	23	Text	Beneficiary's First Initial. Field will contain either the value supplied or the **corrected** value from BCRC database.
5.	Beneficiary Date of Birth	8	24-31	Numeric Date	Beneficiary's DOB (CCYYMMDD). Field will contain either the value supplied or the **corrected** value from BCRC database.
6.	Beneficiary Sex Code	1	32	Alphanumeric	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Field will contain either the value supplied or the **corrected** value from BCRC database.

Field	Name	Size	Displacement	Data Type	Description
7.	BCRC DCN	15	33-47	Alphanumeric	Document Control Number assigned by the BCRC. BCRC supplied.
8.	Disposition Code	2	48-49	Alphanumeric	Response Disposition Code from BCRC (via the Medicare CWF). See GHP Disposition Code Table for values.
9.	Transaction Type	1	50	Alphanumeric	Type of Transaction: '0' = Add Record '1' = Delete record '2' = Update record Transaction Type applied by BCRC.
10.	Reason for Medicare Entitlement	1	51	Alphanumeric	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Value returned if individual is entitled. BCRC supplied.

Field	Name	Size	Displacement	Data Type	Description
11.	Coverage Type (insurer type/policy type)	1	52	Alphanumeric	Type of Insurance: Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug Only (non-network Rx) 'W' = Comprehensive Coverage –Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Prescription Drug Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage –Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) Field will contain value supplied on input. 'R' = Health Reimbursement Arrangement (HRA)
12.	Insurer Name	32	53-84	Text	Insurer name. Field will contain value supplied on TIN Reference File.
13.	Insurer Address 1	32	85-116	Text	Insurer's Address Line 1. Field will contain value supplied on TIN Reference File.
14.	Insurer Address 2	32	117-148	Text	Insurer's Address Line 2. Field will contain value supplied on TIN Reference File.
15.	Insurer City	15	149-163	Text	Insurer's City. Field will contain value supplied on TIN Reference File.

Field	Name	Size	Displacement	Data Type	Description
16.	Insurer State	2	164-165	Alpha	Insurer's State. Field will contain value supplied on TIN Reference File.
17.	Insurer Zip Code	9	166-174	Alphanumeric	Insurer's ZIP Code. Field will contain value supplied on TIN Reference File.
18.	Beneficiary SSN	9	175-183	Alphanumeric	Beneficiary's SSN. Field will contain the value supplied by the RRE on the input record.
19.	MSP Effective Date	8	184-191	Numeric Date	Start date of Beneficiary's Primary GHP Coverage (CCYYMMDD). Effective date of the MSP occurrence posted on the Medicare CWF or MBD. Medicare is the secondary payer between the MSP Effective Date and MSP Termination Date. This field may be set to a future date based on MSP Input File rules. BCRC supplied.
20.	MSP Termination Date	8	192-199	Numeric Date	End date of Beneficiary's Primary GHP Coverage (CCYYMMDD). End date of the MSP occurrence posted on the Medicare CWF or MBD. *All zeros if open-ended. Medicare is the secondary payer between the MSP Effective Date and MSP Termination Date. BCRC supplied.
21.	Relationship Code	2	200-201	Alphanumeric	Covered Individual's Relationship to Active Employee: '01' = Covered Individual is Active Employee '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Family Member Default is '01'

Field	Name	Size	Displacement	Data Type	Description
22.	Policy Holder's First Name	9	202-210	Text	Active Employee's First Name. Field will contain value supplied on input.
23.	Policy Holder's Last Name	16	211-226	Text	Active Employee's Last Name. Field will contain value supplied on input.
24.	Policy Holder's SSN	12	227-238	Alphanumeric	Subscriber/Employee SSN. (9 digits, left justified.) Field will contain value supplied on input.
25.	Employer's Name	32	239-270	Text	Employer Providing Coverage. Field will contain the value supplied on the TIN Reference File.
26.	Employer's Address Line 1	32	271-302	Text	Employer's Street Address, line 1. Field will contain value supplied on TIN Reference File.
27.	Employer's Address Line 2	32	303-334	Text	Employer's Street Address, line 2. Field will contain value supplied on TIN Reference File.
28.	Employer's City	15	335-349	Text	Employer's City. Field will contain value supplied on TIN Reference File.
29.	Employer's State	2	350-351	Alpha	Employer's State Code. Field will contain value supplied on TIN Reference File.
30.	Employer's Zip Code	9	352-360	Alphanumeric	Employer's ZIP Code. Field will contain value supplied on TIN Reference File.
31.	Group Policy Number	20	361-380	Text	Group Policy Number. Field will contain value supplied on input.
32.	Individual Policy Number	17	381-397	Text	Individual's Policy Number. Field will contain value supplied on input.

Field	Name	Size	Displacement	Data Type	Description
33.	Last Query Date	8	398-405	Numeric Date	Last Date the BCRC sent a record for this MSP occurrence to the CWF (Common Working File) (CCYYMMDD). BCRC supplied.
34.	Current Disposition Code	2	406-407	Alphanumeric	Result from Most Current CWF Transmission (same as Field #8). BCRC supplied.
35.	Current Disposition Date	8	408-415	Numeric Date	Date of Most Current CWF Transmission (CCYYMMDD). BCRC supplied.
36.	Previous Disposition Code	2	416-417	Alphanumeric	Result from Previous CWF Transmission. BCRC supplied.
37.	Previous Disposition Date	8	418-425	Numeric Date	Date of Previous CWF Transmission (CCYYMMDD). BCRC supplied.
38.	First Disposition Code	2	426-427	Alphanumeric	Result from First CWF Transmission. BCRC supplied.
39.	First Disposition Date	8	428-435	Numeric Date	Date of First CWF Transmission (CCYYMMDD). BCRC supplied.
40.	Error Code 1	4	436-439	Alphanumeric	SP Error Code 1 See SP Error Code Table for values. BCRC or CWF supplied.
41.	Error Code 2	4	440-443	Alphanumeric	SP Error Code 2 See SP Error Code Table for values. BCRC or CWF supplied.
42.	Error Code 3	4	444-447	Alphanumeric	SP Error Code 3 See SP Error Code Table for values. BCRC or CWF supplied.
43.	Error Code 4	4	448-451	Alphanumeric	SP Error Code 4 See SP Error Code Table for values. BCRC or CWF supplied.

Field	Name	Size	Displacement	Data Type	Description
44.	Split Entitlement Indicator	1	452	Alpha	Entitlement Split Indicator: 'Y' = yes 'N' or blank = no BCRC supplied.
45.	Original Reason for Medicare Entitlement	1	453	Alphanumeric	Original Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled BCRC supplied.
46.	Original Coverage Effective Date	8	454-461	Numeric Date	The original GHP coverage effective date sent. This gets populated if a SP31 error occurs (CCYYMMDD). Field will be the value supplied on input.
47.	Original Coverage Termination Date*	8	462-469	Numeric Date	The original GHP coverage termination date sent. This gets populated if an SP32 error occurs (CCYYMMDD). Field will be the value supplied on input. *All zeros if open-ended.
48.	RRE Assigned DCN	15	470-484	Text	The Document Control Number assigned by the Section 111 GHP responsible reporting entity. It is moved here so we can provide our own unique BCRC DCN in Field 7. Field will be the value supplied on input.
49.	Current Medicare Part A Effective Date	8	485-492	Numeric Date	Effective Date of Medicare Part A Coverage (CCYYMMDD). BCRC supplied.
50.	Current Medicare Part A Termination Date*	8	493-500	Numeric Date	Termination Date of Medicare Part A Coverage (CCYYMMDD). BCRC supplied. * All zeros if open-ended.
51.	Current Medicare Part B Effective Date	8	501-508	Numeric Date	Effective Date of Medicare Part B Coverage (CCYYMMDD). BCRC supplied.

Field	Name	Size	Displacement	Data Type	Description
52.	Current Medicare Part B Termination Date*	8	509-516	Numeric Date	Termination Date of Medicare Part B Coverage (CCYYMMDD). BCRC supplied. * All zeros if open-ended.
53.	Medicare Beneficiary Date of Death	8	517-524	Numeric Date	Medicare Beneficiary Date of Death (CCYYMMDD). BCRC supplied.
54.	Current Medicare Part C Plan Contractor Number	5	525-529	Alphanumeric	Contractor Number of the current Medicare Part C Plan in which the beneficiary is enrolled. BCRC supplied.
55.	Current Medicare Part C Plan Enrollment Date	8	530-537	Numeric Date	Effective Date of coverage provided by current Medicare Part C Plan (CCYYMMDD). BCRC supplied.
56.	Current Medicare Part C Plan Termination Date*	8	538-545	Numeric Date	Termination Date of coverage provided by current Medicare Part C Plan (CCYYMMDD). BCRC supplied. * All zeros if open-ended (i.e., if coverage is not terminated).
57.	Current Medicare Part D Plan Contractor Number	5	546-550	Alphanumeric	Contractor Number of the Medicare Part D Plan BCRC supplied. Provided to Expanded and Basic reporters who indicate they offer primary prescription drug coverage on their S111 profile.
58.	Current Part D Plan Enrollment Date	8	551-558	Numeric Date	Effective Date of coverage provided by Medicare Part D Plan (CCYYMMDD). BCRC supplied. Provided to Expanded and Basic reporters who indicate they offer primary prescription drug coverage on their S111 profile.

Field	Name	Size	Displacement	Data Type	Description
59.	Current Medicare Part D Plan Termination Date*	8	559-566	Numeric Date	Termination Date of coverage Medicare Part D Plan (CCYYMMDD). BCRC supplied. * All zeros if open-ended (i.e., if coverage is not terminated). Provided to Expanded and Basic reporters who indicate they offer primary prescription drug coverage on their S111 profile.
60.	Part D Eligibility Start Date	8	567-574	Numeric Date	Earliest date that Beneficiary is eligible to receive Part D Benefits – Refer to Field 58 for Part D Plan Enrollment Date (CCYYMMDD). BCRC supplied.
61.	Part D Eligibility Stop Date*	8	575-582	Numeric Date	Date the Beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 59 for Part D Plan Termination Date (CCYYMMDD). BCRC supplied. * All zeros if open-ended.
62.	National Health Plan ID	10	583-592	Alphanumeric	National Health Plan Identifier. (Future requirement.) Field will contain value supplied on input.
63.	Rx Insured ID number	20	593-612	Text	Insured's Identification Number. Field will contain value supplied on input.
64.	Rx Group Number	15	613-627	Text	Group Number. Field will contain value supplied on input.
65.	Rx PCN	10	628-637	Text	Processor Control Number. Field will contain value supplied on input.
66.	Rx BIN Number	6	638-643	Text	Benefit Identification Number for Rx processing. Field will contain value supplied on input.
67.	Rx 800 Number	18	644-661	Text plus "(" and ")"	Pharmacy benefit information Toll Free Number. Field will contain value supplied on input.

Field	Name	Size	Displacement	Data Type	Description
68.	Person Code	3	662-664	Text	Person Code. Field will contain value supplied on input.
69.	Rx Disposition Code	2	665-666	Alphanumeric	Response Rx Disposition Code from BCRC Medicare Beneficiary Database or MBD. Refer to GHP Disposition Codes for values. Code supplied by the BCRC.
70.	Rx Disposition Date	8	667-674	Numeric Date	Date Rx Disposition Code was generated (CCYYMMDD). Code supplied by the BCRC.
71.	Rx Error Code 1	4	675-678	Alphanumeric	Rx Error Code 1. Refer to GHP Rx Error Codes or Section 111 GHP SP Error codes for values. BCRC supplied.
72.	Rx Error Code 2	4	679-682	Alphanumeric	Rx Error Code 2. Refer to GHP Rx Error Codes or Section 111 GHP SP Error codes for values. BCRC supplied.
73.	Rx Error Code 3	4	683-686	Alphanumeric	Rx Error Code 3. Refer to GHP Rx Error Codes or Section 111 GHP SP Error codes for values. BCRC supplied.
74.	Rx Error Code 4	4	687-690	Alphanumeric	Rx Error Code 4. Refer to GHP Rx Error Codes or Section 111 GHP SP Error codes for values. BCRC supplied.
75.	ESRD Coordination Period Start Date	8	691-698	Numeric Date	The start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of End Stage Renal Disease (CCYYMMDD). BCRC supplied.

Field	Name	Size	Displacement	Data Type	Description
76.	ESRD Coordination Period End Date	8	699-706	Numeric Date	The ending date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of ESRD. A corresponding GHP coverage will no longer be considered an MSP record after the 30-month coordination period is terminated (CCYYMMDD). BCRC supplied.
77.	First Dialysis Date	8	707-714	Numeric Date	A date that indicates when the ESRD Dialysis first started (CCYYMMDD). Value will be zero if not applicable. BCRC supplied.
78.	ESRD Self-Training Date	8	715-722	Numeric Date	A date that indicates when the beneficiary participated in ESRD Self-Care Training (CCYYMMDD). Value will be zero if not applicable. BCRC supplied.
79.	Transplant Date – Most Recent	8	723-730	Numeric Date	A date that indicates when a Kidney Transplant Operation occurred (CCYYMMDD). Value will be zero if not applicable. BCRC supplied.
80.	Transplant Failure Date – Most Recent	8	731-738	Numeric Date	A date that indicates when a Kidney Transplant failed. Last occurrence will be reported (CCYYMMDD). BCRC supplied.
81.	SEE Response Code	2	739-740	Alphanumeric	Small Employer Exception (SEE) Response Code. (Spaces): Not applicable. SEE Medicare ID not provided SA – SEE Medicare ID accepted SN – SEE Medicare ID not accepted SP – SEE Medicare ID partially accepted (SEE Medicare ID period does not cover entire MSP period) BCRC supplied.

Field	Name	Size	Displacement	Data Type	Description
82.	Late Submission Indicator	1	741-741	Alphanumeric	Value of 'Y' indicates that the submitted record was not received in time. See Section 9.6. BCRC supplied.
83.	Warning Flag 1	2	742-743	Alphanumeric	Future Use – not used at this time. Space filled.
84.	Warning Flag 2	2	744-745	Alphanumeric	Future Use – not used at this time. Space filled.
85.	Warning Flag 3	2	746-747	Alphanumeric	Future Use – not used at this time. Space filled.
86.	Warning Flag 4	2	748-749	Alphanumeric	Future Use – not used at this time. Space filled.
87.	Warning Flag 5	2	750-751	Alphanumeric	Future Use – not used at this time. Space filled.
88.	Warning Flag 6	2	752-753	Alphanumeric	Future Use – not used at this time. Space filled.
89.	Warning Flag 7	2	754-755	Alphanumeric	Future Use – not used at this time. Space filled.
90.	Warning Flag 8	2	756-757	Alphanumeric	Future Use – not used at this time. Space filled.
91.	Warning Flag 9	2	758-759	Alphanumeric	Future Use – not used at this time. Space filled.
92.	Warning Flag 10	2	760-761	Alphanumeric	Future Use – not used at this time. Space filled.
93.	Filler	39	762-800	Alphanumeric	Unused field. Space filled.

MSP Response File Trailer Record

Table A-9: Section 111 GHP MSP Response File Trailer Record—800 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alphanumeric	Will contain a value of 'T0'. BCRC supplied.
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by BCRC. Corresponds to the RRE ID submitted on the MSP Input File. BCRC supplied.
3.	File Type	4	12-15	Alpha	'MSPR' – MSP Response File. BCRC supplied.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD BCRC supplied.
5.	Record Count	9	24-32	Numeric	Number of response records contained in this file. Does not include the header and trailer records in the count. BCRC supplied.
6.	Filler	768	33-800	Alphanumeric	Unused field. Space filled.

Section 111 GHP TIN Reference Response File

TIN Reference Response File Header Record

Table A-10: Section 111 GHP MSP TIN Reference Response File Header Record—650 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alphanumeric	Contains a value of 'H0'
2.	Section 111 RRE ID	9	3-11	Numeric	ID number assigned by the BCRC.
3.	File Type	4	12-15	Alpha	'TGRP' – TIN Reference Response File.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD
5.	Filler	627	24-650	Alphanumeric	Filled with spaces.

TIN Reference Response File Detail Record

Table A-11: Section 111 GHP MSP TIN Reference Response File Detail Record—650 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Submitted TIN	9	1-9	Numeric	Submitted tax identification number of the entity.
2.	Submitted Name	32	10-41	Text	Submitted name of the entity. This field (and others that follow) will contain the submitted Insurer/TPA information if TIN indicator equals I. It will contain Employer information if TIN indicator equals E, S, F or Z.
3.	Submitted Address Line 1	32	42-73	Text	Submitted Address Line 1 as provided on input record.
4.	Submitted Address Line 2	32	74-105	Text	Submitted Address Line 2 as provided on input record.
5.	Submitted City	15	106-120	Text	Submitted City as provided on input record.
6.	Submitted State	2	121-122	Alpha	Submitted State as provided on input record.
7.	Submitted Zip Code	9	123-131	Alpha-Numeric	Submitted ZIP Code as provided on input record.
8.	Applied Address 1	32	132-163	Text	Address Line 1, after address validation completed, which will be used by Medicare for subsequent processing. Mailing Address Change Flag (Field 40) will equal Y if the applied address in Fields 8 – 12 is different from the submitted address (Fields 3-7) and N if it is the same as the submitted address. Will contain spaces if the TIN record was rejected. The field will also contain spaces if the submitted State code contained 'FC' indicating the address is foreign.
9.	Applied Address 2	32	164-195	Text	Address Line 2 after address validation completed. See description for Field 8.
10.	Applied City	13	196-208	Text	City after address validation completed. See description for Field 8.
11.	Applied State	2	209-210	Alpha	State after address validation completed. See description for Field 8.

Field	Name	Size	Displacement	Data Type	Description
12.	Applied Zip Code	9	211-219	Alpha-numeric	ZIP Code after address validation completed. See description for Field 8.
13	Submitted TIN Indicator	1	220-220	Alpha	Submitted TIN Indicator as provided on the input record.
14.	Submitted Insurer/TPA Demand Mailing Name	32	221-252	Text	Insurer/TPA Demand Mailing Name as provided on the input record.
15.	Submitted Insurer/TPA Demand Address Line 1	32	253-284	Text	Insurer/TPA Demand Address Line 1 as provided on input record.
16.	Submitted Insurer/TPA Demand Address Line 2	32	285-316	Text	Insurer/TPA Demand Address Line 2 as provided on input record.
17.	Submitted Insurer/TPA Demand Mailing City	15	317-331	Text	Insurer/TPA Demand Mailing City as provided on input record.
18.	Submitted Insurer/TPA Demand Mailing State	2	332-333	Alpha	Insurer/TPA Demand Mailing State as provided on input record.
19.	Submitted Insurer/TPA Demand Mailing Zip	9	334-342	Alpha-Numeric	Insurer/TPA Demand Mailing ZIP as provided on input record.
20.	Applied Insurer/TPA Demand Address Line 1	32	343-374	Text	Insurer/TPA Demand Address Line 1, after address validation completed, which will be used by Medicare for subsequent processing. Demand Address Change Flag (Field 41) will equal Y if the applied address in Fields 20 – 24 is different from the submitted address (Fields 15 – 19) and N if it is the same as the submitted address. Will contain spaces if the TIN record was rejected.
21.	Applied Insurer/TPA Demand Address Line 2	32	375-406	Text	Insurer/TPA Demand Address Line 2 after address validation completed. See description for Field 20.

Field	Name	Size	Displacement	Data Type	Description
22.	Applied Insurer/TPA Demand Mailing City	13	407-419	Text	Insurer/TPA Demand Mailing City after address validation completed. See description for Field 20.
23.	Applied Insurer/TPA Demand Mailing State	2	420-421	Alpha	Insurer/TPA Demand Mailing State after address validation completed. See description for Field 20.
24.	Applied Insurer/TPA Demand Mailing Zip	9	422-430	Alpha-numeric	Insurer/TPA Demand Mailing ZIP after address validation completed. See description for Field 20.
25.	Submitted Foreign Employer Address Line 1	32	431-462	Text	Foreign Employer Address Line 1 as provided on input record.
26.	Submitted Foreign Employer Address Line 2	32	463-494	Text	Foreign Employer Address Line 2 as provided on input record.
27.	Submitted Foreign Employer Address Line 3	32	495-526	Text	Foreign Employer Address Line 3 as provided on input record.
28.	Submitted Foreign Employer Address Line 4	32	527-558	Alpha	Foreign Employer Address Line 4 as provided on input record.
29.	TIN Disp Code	2	559-560	Alpha	Code to indicate validation processing results of the submitted TIN Reference File Detail Record: ‘01’ – TIN Record accepted ‘TN’ – TIN Record rejected
30.	TIN Error Code 1	4	561-564	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
31.	TIN Error Code 2	4	565-568	Alpha-numeric	Code indicating an error was found in the on the input record. Refer to the TN Error Code Table.
32.	TIN Error Code 3	4	569-572	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
33.	TIN Error Code 4	4	573-576	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.

Field	Name	Size	Displacement	Data Type	Description
34.	TIN Error Code 5	4	577-580	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
35.	TIN Error Code 6	4	581-584	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
36.	TIN Error Code 7	4	585-588	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
37.	TIN Error Code 8	4	589-592	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
38.	TIN Error Code 9	4	593-596	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
39.	TIN Error Code 10	4	597-600	Alpha-numeric	Code indicating an error was found on the input record. Refer to the TN Error Code Table.
40	Mailing Address Change Flag	1	601-601	Alpha-numeric	Code indicating whether Submitted Address (Fields 3-7) differs from the Applied Address (Fields 8 -12). Values: Y – address changed N – address did not change Space – record could not be validated
41.	Demand Address Change Flag	1	602-602	Alpha-numeric	Code indicating whether Submitted Insurer/TPA Demand Mailing (Fields 15 – 19) differs from the Applied Insurer/TPA Demand Mailing Address (Fields 20 – 24). Values: Y – address changed N – address did not change Space – record could not be validated.
42.	Filler	48	603-650	Alpha-numeric	Filled with spaces.

TIN Reference Response File Trailer Record

Table A-12: Section 111 GHP MSP TIN Reference File Trailer Record—800 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alphanumeric	Contains a value of 'T0'.
2.	Section 111 RRE ID	9	3-11	Numeric	ID number assigned by the BCRC.
3.	File Type	4	12-15	Alpha	'TGRP' – TIN Reference Response file.
4.	File Date	8	16-23	Numeric Date	CCYYMMDD
5.	Record Count	9	24-32	Numeric	Number of TIN Reference Response File Detail Records in this file. Does not include the Header and Trailer Records in the Record Count.
6.	Filler	618	33-650	Alphanumeric	Filled with spaces.

Appendix B Query Only HEW File Specifications

Section 111 Query Only Input File (ANSI X12 270/271 Entitlement Query HEW Flat File Format)

Note: These file layouts are for use with the HIPAA Eligibility Wrapper (HEW) software supplied by the BCRC to process the ASC X12 270/271.

Mainframe and Windows PC/Server-based versions of the HEW software are available. You may download the latest Windows version of the HEW software after logging on to the Section 111 COBSW at https://www.cob.cms.hhs.gov/Section111/.You may request a copy of both the mainframe and Windows versions from your EDI Representative or by contacting the EDI Department at 646-458-6740.

Note: When using the HEW software, RREs should select the "S111/VDSA" processing format for the Section 111 output file. See Appendix I for detailed steps on how to install and configure the HEW software.

If you choose to use your own ANSI X12 translator to create the ANSI X12 270 files for the Section 111 Query Only File and process the X12 271 response, download the 270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for Mandatory Reporting GHP Entities document located at the bottom of the cms.gov website. This document includes the X12 270/271 mapping required for Section 111.

HEW Query Only Input File Header Record—Version 5.0.0

Table B-1: Section 111 HEW Query Only Input File Header Record—200 bytes

Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Must be: 'H0'. **Required.**
2.	Section 111 RRE ID (RRE ID)	9	3-11	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Must be 'IACT'. **Required.**
4.	File Date	8	16-23	Date RRE created or transmitted the file. (CCYYMMDD). **Required.**
5.	Filler	177	24-200	Unused Field. Fill with spaces.

HEW Query Only Input File Detail Record—Version 5.0.0

Table B-2: Section 111 HEW Query Only Input File Detail Record—200 bytes

Field	Name	Size	Displacement	Description
1.	Medicare ID	12	1-12	Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) **Note:** This is also known as the Medicare Number to CMS' Medicare beneficiaries. **Required if SSN not provided.**
2.	Last Name	6	13-18	First 6 characters of the last name of Covered Individual. Provide the last name as it appears on the individual's SSN or Medicare Card. **Required.**
3.	First Initial	1	19-19	First Initial of Covered Individual. Provide the first initial as it appears on the individual's SSN or Medicare Card. **Required.**
4.	DOB	8	20-27	Covered Individual's Date of Birth (CCYYMMDD). **Required.**
5.	Sex Code	1	28-28	Covered Individual's Gender: 0 = Unknown* 1 = Male 2 = Female **Required.** *If a value of '0' is submitted, the BCRC will change it to '1' for matching purposes.
6.	SSN	9	29-37	Social Security Number of the Covered Individual. **Note:** When submitting an SSN, this field may contain either the last five digits or the full nine digits of the SSN. If a partial SSN is submitted, space fill the first four characters followed by the last five digits of the SSN. **Required if Medicare ID not provided.** **If SSN not provided, fill with zeros.**
7.	RRE DCN 1	30	38-67	Primary identifier assigned to record by RRE for tracking. Will be returned on the corresponding response record.
8.	RRE DCN 2	30	68-97	Secondary identifier assigned to record by RRE for tracking. Will be returned on the corresponding response record.
9.	Filler	103	98-200	Unused field. Fill with spaces.

HEW Query Only Input File Trailer Record – Version 5.0.0

Table B-3: Section 111 HEW Query Only Input File Trailer Record—200 bytes

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Must be: 'T0'
2.	Section 111 Reporter ID (RRE ID)	9	3-11	'000000001', '000000002', etc. ID number assigned by the BCRC. Must match RRE ID used on the header record. **Required**.
3.	File Type	4	12-15	Must be 'IACT'. **Required**.
4.	File Date	8	16-23	Date RRE created or transmitted the file. Must match the date used on the header record. (CCYYMMDD). **Required**.
5.	Record Count	9	24-32	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count. **Required**.
6.	Filler	168	33-200	Unused Field. Fill with spaces.

HEW Query Only Response File Record – Version 5.0.0

Note: The HEW Query Only Response File does not have a header or trailer record.

Table B-4: Section 111 HEW Query Only Response File Record—300 bytes

Field	Name	Size	Displacement	Description
1.	Medicare ID	12	1-12	Most current Medicare Beneficiary Identifier (MBI) or most current Medicare ID (Health Insurance Claim Number [HICN]). BCRC-supplied if individual was matched to a Medicare beneficiary. Store this identifier in your internal system and use it on all subsequent transactions. **Note:** This is also known as the Medicare Number to CMS' Medicare beneficiaries. If no match is found, the position will be filled with spaces.
2.	Last Name	6	13-18	First 6 characters of the last name of Covered Individual. BCRC supplied if individual was matched to a Medicare beneficiary.
3.	First Initial	1	19-19	First Initial of Covered Individual. BCRC supplied if individual was matched to a Medicare beneficiary.
4.	DOB	8	20-27	Covered Individual's Date of Birth (CCYYMMDD). BCRC supplied if individual was matched to a Medicare beneficiary.
5.	Sex Code	1	28-28	Covered Individual's Gender: 1 = Male* 2 = Female BCRC supplied if individual was matched to a Medicare beneficiary. *If '0' was submitted on the input record then the BCRC will change this value to '1' regardless of a match.
6.	SSN	9	29-37	Social Security Number of the Covered Individual as submitted on the input record.
7.	Entitlement Reason (Medicare reason)	1	38	Reason for Medicare Entitlement: A = Aged B = ESRD G = Disabled BCRC supplied.
8.	Current Medicare Part A Effective Date	8	39-46	Effective Date of Medicare Part A Coverage (CCYYMMDD). BCRC supplied.

Field	Name	Size	Displacement	Description
9.	Current Medicare Part A Termination Date*	8	47-54	Termination Date of Medicare Part A Coverage (CCYYMMDD). * Blank if ongoing. BCRC supplied.
10.	Current Medicare Part B Effective Date	8	55-62	Effective Date of Medicare Part B Coverage (CCYYMMDD). BCRC supplied.
11.	Current Medicare Part B Termination Date*	8	63-70	Termination Date of Medicare Part B Coverage (CCYYMMDD). *Blank if ongoing. BCRC supplied.
12.	Medicare Beneficiary Date of Death	8	71-78	Beneficiary Date of Death (CCYYMMDD). BCRC supplied.
13.	Current Medicare Part C Plan Contractor Number	5	79-83	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. BCRC supplied.
14.	Current Medicare Part C Plan Enrollment Date	8	84-91	Effective Date of coverage provided by the beneficiary's current Medicare Part C Plan (CCYYMMDD). BCRC supplied.
15.	Current Medicare Part C Plan Termination Date*	8	92-99	Termination Date of the coverage provided by the beneficiary's current Medicare Part C Plan (CCYYMMDD). *Blank if ongoing. BCRC supplied.
16.	Disposition Code	2	100-101	01 = Record Accepted. Individual was matched to a Medicare beneficiary. 51 = Individual was not matched to a Medicare beneficiary. BCRC supplied.
17.	CMS Document Control Number	15	102-116	BCRC generated record tracking number. BCRC supplied.
18.	RRE DCN 1	30	117-146	Primary identifier assigned to record by RRE for tracking as submitted on the input record.
19.	RRE DCN 2	30	147-176	Secondary identifier assigned to record by RRE for tracking as submitted on the input record.
20.	Most Recent Medicare Part D Plan Contract Number	5	177-181	Most recent Contractor Number of the Part D Plan in which the beneficiary is enrolled. Alpha-Numeric

Field	Name	Size	Displacement	Description
21.	Most Recent Medicare Part D Plan Enrollment Date	8	182-189	Most recent Effective Date of coverage provided by the beneficiary's Medicare Part D Plan. Numeric Date (CCYYMMDD)
22.	Most Recent Medicare Part D Plan Termination Date	8	190-197	Most recent Termination Date of the coverage provided by the beneficiary's Medicare Part D Plan. Numeric Date (CCYYMMDD)
23.	Filler	103	198-300	Future Use

Appendix C Non-MSP File Specifications

Section 111 GHP Non-MSP Input File – Expanded Reporting Option Only

Non-MSP Input File Header Record

Table C-1: Section 111 GHP Non-MSP Input File Header Record—300 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	**Must be: 'H0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Alpha	**Must be: 'NMSI'** – Non-MSP Input File.
4.	File Date	8	16-23	Numeric	CCYYMMDD **Required.**
5.	RDS Application Number	10	24-33	Alpha-Numeric	Retiree Drug Subsidy ID number that is associated with a particular RDS application. Assigned by the RDS Center. When populated, this field should contain 10 digits (0-9), right justified with leading positions zero filled. This application number will change each year when a new application is submitted. **Required for files containing Action Type S (S Records). Fill with spaces for files containing Action Types D and N (D/N Records).**
6.	Filler	267	34-300	Filler	Unused Field.

Non-MSP Input File Detail Record

Table C-2: Section 111 GHP Non-MSP Input File Detail Record—300 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Beneficiary Social Security Number	9	1-9	Numeric	Inactive Covered Individual's Social Security Number. **Required if Medicare ID field (below) not populated.** This field accepts the last 5 digits of the SSN. Fill with four leading blank spaces. Fill with spaces if SSN is not available.
2.	Medicare ID	12	10-21	Alpha-Numeric	Inactive Covered Individual's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) **Note:** This is also known as the Medicare Number to CMS' Medicare beneficiaries. **Required if SSN field (above) not populated.** Populate with spaces if not available.
3.	Covered Individual's Surname	6	22-27	Text	Inactive Covered Individual's Last Name – **Required**. Report the last name as it appears on the individual's SSN or Medicare Card.
4.	Covered Individual's First Initial	1	28-28	Alpha	Inactive Covered Individual's First Initial – **Required.** Report first initial as it appears on the individual's SSN or Medicare Card.
5.	Covered Individual's Middle Initial	1	29-29	Alpha	Inactive Covered Individual's Middle Initial – Optional.
6.	Covered Individual's Date of Birth	8	30-37	Numeric Date	Inactive Covered Individual's DOB (CCYYMMDD). **Required.**
7.	Covered Individual's Sex Code	1	38-38	Numeric	Inactive Covered Individual's Sex Valid values: 0 = Unknown 1 = Male 2 = Female **Required.**

Field	Name	Size	Displacement	Data Type	Description
8.	Group Health Plan (GHP) Number	20	39-58	Text	GHP Number assigned by Payer for Action Type D, or, **Unique Benefit Option Identifier**, as defined by the RDS Center, assigned by Payer for Action Type S. For more information on formatting S records, refer to the RDS User Guide on https://rds.cms.hhs.gov under the User Guides menu option. For use with Action Types D and S. **Required for Action Type S when Coverage Type is V, Z, 4, 5 or 6.**
9.	Individual Policy Number	17	59-75	Text	Unique Identifier assigned by the payer to identify the covered individual. For use with Action Types D and S. **Required for Action Type D when Coverage Type is V, Z, 4, 5, and 6.**
10.	Effective Date	8	76-83	Numeric Date	Start Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). **Required for Action Types D and S.** **Note:** Please see Section 12.6 for information on errors for incoming records that overlap existing drug coverage periods.
11.	Termination Date**	8	84-91	Numeric Date	End Date of Covered Individual's GHP Coverage by Insurer (CCYYMMDD). For use with Action Types D and S. **Required for Action Type S.** **All zeros if open-ended. **Note:** Please see Section 12.6 for information on errors for incoming records that overlap existing drug coverage periods.
12.	National Health Plan	10	92-101	Filler	National Health Plan Identifier. (**Future Use**.)
13.	Rx Insured ID Number	20	102-121	Text	Insured's Rx Identification Number. **Required for Action Type D and S when Coverage Type = U, W, X, or Y.** **Cannot be blank or all zeros.**

Field	Name	Size	Displacement	Data Type	Description
14.	Rx Group Number	15	122-136	Text	Rx Group Health Plan Number assigned by Payer for Action Type D, or, **Unique Benefit Option Identifier**, as defined by the RDS Center, and assigned by Payer for Action Type S. Provide if Rx Group values assigned; otherwise, leave blank. For more information on formatting S records, refer to the RDS User Guide on https://rds.cms.hhs.gov.
15.	Rx PCN	10	137-146	Text	Rx Processor Control Number for Medicare Beneficiaries. For use with Action Type D and S when Coverage Type = U, W, X, or Y. **Must provide if available.** **Cannot have special characters, except for a non-leading dash, and no leading space.**
16.	Rx BIN Number	6	147-152	Numeric	Benefit Identification Number for Rx processing – Medicare Beneficiaries. **Required for Action Type D and S when Coverage Type = U, W, X, or Y.** **Must be a 6-digit number and cannot be all the same number.**
17.	Rx Toll Free Number	18	153-170	Text plus "(" and ")"	Toll Free Number Pharmacist can use to contact Rx Insurer. For use with Action Types D and S.
18.	Relationship Code	2	171-172	Numeric	Covered Individual's Relation to Policy Holder: Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Or spaces. **Required for Action Types D and S.**

Field	Name	Size	Displacement	Data Type	Description
19.	DCN	15	173-187	Text	Document Control Number; assigned by the Section 111 GHP RRE. **Required.** Each record within the current file must have a unique DCN.
20.	Action Type	1	188	Alpha	Type of Record: Valid values: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record **Required.**
21.	Transaction Type	1	189	Alpha-Numeric	Type of Transaction: Valid values: '0' = Add record '1' = Delete record '2' = Update record Fill with space for Action Type N. **Required for Action Types D or S.**
22.	Coverage Type	1	190	Alpha-Numeric	Type of Coverage: • 'U' – Drug Only—network Rx • 'V' – Drug Only—non-network Rx • 'W' – Comprehensive Coverage—Hosp/Med/Drug—network Rx • 'X' – Hospital and Drug—network Rx • 'Y' – Medical and Drug—network Rx • 'Z' – Health Reimbursement Arrangement—non-network Rx • '4' – Comprehensive Coverage—Hosp/Med/Drug—non-network Rx • '5' – Hospital and Drug—non-network Rx • '6' – Medical and Drug—non-network Rx **Required for Action Types D or S.**

Field	Name	Size	Displacement	Data Type	Description
23.	Person Code	3	191-193	Text	Person Code the plan uses to identify specific individuals on a policy. For use with Action Types D and S.
24.	Reserved	10	194-203	Internal use	Reserved for COB internal use. **Fill with spaces only.**
25.	Reserved	5	204-208	Internal use	Reserved for BCRC internal use. **Fill with spaces only.**
26.	Reserved	1	209	Internal use	Reserved for BCRC internal use. **Fill with spaces only.**
27.	Insurer Name	32	210-241	Text	Name of Insurance company providing Prescription Drug coverage. For use with Action Types D and S. **Required for Action Type D effective 10/1/2018.** **Required for Action Type S effective 4/1/2020.**
28.	Override Code	2	242-243	Alpha-Numeric	Code used to override specific hierarchy error codes. Valid Values: HB = Hierarchy bypass. HB can be used to update or delete an MSP or prescription drug record with a higher-ranking source if the record has not been locked by the BCRC Primary or supplemental drug occurrences. Spaces = Not Applicable
29.	Filler	57	244-300	Filler	Unused field.

Non-MSP Input File Trailer Record

Table C-3: Section 111 GHP Non-MSP Input File Trailer Record—300 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	**Must be: 'T0'**
2.	Section 111 RRE ID	9	3-11	Numeric	'000000001', '000000002', etc. ID number assigned by the BCRC. **Required.**
3.	File Type	4	12-15	Alpha	**Must be: 'NMSI'** – Non-MSP Input File.
4.	File Date	8	16-23	Numeric	CCYYMMDD **Required.**
5.	S Record Count	9	24-32	Numeric	Number of Action Type 'S' records on file. **Required.**
6.	D Record Count	9	33-41	Numeric	Number of Action Type 'D' records on file. **Required.**
7.	N Record Count	9	42-50	Numeric	Number of Action Type 'N' records on file. **Required.**
8.	Total Record Count	9	51-59	Numeric	Number of detail records in this file. Do not include the Header and Trailer Records in the Record Count. **Required.**
9.	Filler	240	60-300	Filler	Unused Field.

Section 111 GHP Non-MSP Response File

Non-MSP Response File Header Record

Table C-4: Section 111 GHP Non-MSP Response File Header Record—500 bytes

Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Must be: 'H0'
2.	Section 111 RRE ID	9	3-11	'000000001', '000000002', etc. ID number assigned by the BCRC. Corresponds to the RRE ID submitted on the Non-MSP Input File.
3.	File Type	4	12-15	'NMSR' – Non-MSP Response file. 'RDSU' – Unsolicited RDS Response File.
4.	File Date	8	16-23	CCYYMMDD COB supplied.
5.	RDS Application Number	10	24-33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application. This application number will change each year when a new application is submitted. Field will contain value supplied on input.
6.	Filler	467	34-500	Unused Field. Space filled.

Non-MSP Response File Detail Record

Table C-5: Section 111 GHP Non-MSP Response File Detail Record—500 bytes

Field	Name	Size	Displacement	Description
1.	Filler	4	1-4	BCRC use.
2.	SSN	9	5-13	Beneficiary's SSN. Included for Action Types D, S, and N. Field will contain the value supplied on input record.
3.	Medicare ID	12	14-25	Most current Medicare Beneficiary Identifier (MBI) or most current Beneficiary's Medicare ID (Health Insurance Claim Number [HICN]). Included for Action Types D, S, and N. If the information submitted on the input record was matched to a Medicare beneficiary, this field will contain the most current MBI for the beneficiary. Store this MBI in your system for future updates and deletes. **Note:** This is also known as the Medicare Number to CMS' Medicare beneficiaries. If no match is found, the position will be filled with spaces.
4.	Covered Individual's Surname	6	26-31	Beneficiary's Last Name. Included for Action Types D, S, and N. Field will contain either the name supplied or a **corrected** name from BCRC database.
5.	Beneficiary First Initial	1	32	Beneficiary's First Initial. Included for Action Types D, S, and N. Field will contain either the value supplied or a **corrected** value from BCRC database.
6.	Beneficiary Middle Initial	1	33	Beneficiary's Middle Initial. Included for Action Types D, S, and N. Field will contain the value supplied.
7.	Beneficiary Date of Birth	8	34-41	Beneficiary's DOB (CCYYMMDD). Included for Action Types D, S, and N. Field will contain either the value supplied or a **corrected** value from BCRC database.
8.	Beneficiary Sex Code	1	42	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Included for Action Types D, S, and N. Field will contain either the value supplied or a **corrected** value from COB database.

Field	Name	Size	Displacement	Description
9.	Group Health Plan Number	20	43-62	GHP Number assigned by Payer for Action Type D, or, **Unique Benefit Option Identifier**, as defined by the RDS Center, and assigned by Payer for Action Type S. Included for Action Types D and S. Field will contain the value supplied on input.
10.	Individual Policy Number	17	63-79	Policy Number. Included for Action Types D and S. Field will contain the value supplied on input.
11.	Effective Date	8	80-87	Start Date of Beneficiary's Supplemental Drug Insurance Coverage (CCYYMMDD). Included for Action Types D and S. Field will contain the effective date applied to the supplemental drug coverage record.
12.	Termination Date	8	88-95	End Date of Beneficiary's Supplemental Drug Insurance Coverage (CCYYMMDD). **All zeros if open-ended or non-applicable. Included for Action Types D and S. Field will contain the term date applied to the supplemental drug coverage record.
13.	National Health Plan ID	10	96-105	National Health Plan Identifier. For Action Types D and S. (**Future Use**).
14.	Rx Insured ID Number	20	106-125	Insured's Rx Identification Number. Included for Action Types D and S. Field will contain the value supplied on input.
15.	Rx Group Number	15	126-140	Rx Group Health Plan Number assigned by payer for Action Type D or **Unique Benefit Option Identifier** assigned by payer for Action Type S. Included for Action Types D and S. Field will contain the value supplied on input.
16.	Rx PCN	10	141-150	Rx Processor Control Number. Included for Action Types D and S. Field will contain the value supplied on input.
17.	Rx BIN Number	6	151-156	Benefit Identification Number for Rx processing. Included for Action Types D and S. Field will contain the value supplied on input.
18.	Rx Toll Free Number	18	157-174	Pharmacy benefit Toll Free Number. Included for Action Types D and S. Field will contain the value supplied on input.
19.	Person Code	3	175-177	Person Code the Plan uses to identify specific individuals on a policy. Included for Action Types D and S. Defaults to '001' for D records if not provided on input.

Field	Name	Size	Displacement	Description
20.	Relationship Code	2	178-179	Beneficiary's Relationship to active employee: '01' = Beneficiary is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '20' – Domestic Partner '04' = Other Included for Action Types D and S. Field will contain the value supplied on input.
21.	RRE Assigned DCN	15	180-194	The Document Control Number assigned by the Section 111 GHP RRE. Included for Action Types D, S, and N. Field will contain the value supplied on input.
22.	BCRC DCN	15	195-209	BCRC Document Control Number. Included for Action Types D, S, and N. Field will contain the DCN created for this record by the BCRC.
23.	Original Action Type	1	210	Type of Record: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for Action Types D, S, and N. Field will contain value supplied on input.
24.	Action Type	1	211	Type of Record applied by BCRC (BCRC may change an S action to a D if RDS rejects the record due to Part D enrollment): 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for Action Types D, S and N. BCRC supplied value.
25.	Transaction Type	1	212	Type of Transaction: '0' = Add record '1' = Delete record '2' = Update record Included for Action Types D and S. Field will contain value supplied on input.

Field	Name	Size	Displacement	Description
26.	Coverage Type	1	213	Type of Coverage: 'U' = Drug Only—network Rx 'V' = Drug Only—non-network Rx 'W' = Comprehensive Coverage—Hosp/Med/Drug—network Rx 'X' = Hospital and Drug—network Rx 'Y' = Medical and Drug—network Rx 'Z' = Health Reimbursement Arrangement—non-network Rx '4' = Comprehensive Coverage—Hosp/Med/Drug—non-network Rx '5' = Hospital and Drug—non-network Rx '6' = Medical and Drug—non-network Rx Included for Action Types D and S. Field will contain the value supplied on input.
27.	Filler	1	214	Unused Field.
28.	Reason for Medicare Entitlement	1	215	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Included for Action Types D and N. BCRC-supplied value.

Field	Name	Size	Displacement	Description
29.	Disposition Code	2	216-217	Cross-walked result from RDS processing to BCRC disposition codes. Included for records submitted with 'S' Action Type. RDS-supplied value converted to Section 111 GHP specific S Disposition Code. Values: 01 = Subsidy record accepted. 02 = Application pending or in process at RDS (BCRC internal use). 03 = Rejected—Beneficiary record not found. 04 = Rejected—Beneficiary already enrolled in Part D. 05 = Rejected—Beneficiary not Medicare entitled. 06 = Rejected—Subsidy record rejected for errors. 07 = Rejected—Associated RDS application was rejected. 08 = Rejected—Beneficiary deceased. 09 = Rejected—Missing header/trailer record (for RDS interface only). 10 = Beneficiary has attempted to enroll in Part D. Communicate with the beneficiary about their intentions regarding the subsidy coverage. 11 = Resubmit previously rejected record (re: unsolicited response input). Refer to Field 53 (RDS Reason Code) and Field 54 (RDS Determination Indicator) for actual codes supplied by the RDS Center.
30.	S Disposition Date	8	218-225	Date S Disposition determined (CCYYMMDD). Included for records with an original S Action Type. RDS Center supplied value.
31.	Current Medicare Part A Effective Date	8	226-233	Effective Date of Medicare Part A Coverage (CCYYMMDD). Included for all Action Types. BCRC supplied value.
32.	Current Medicare Part A Termination Date*	8	234-241	Termination Date of Medicare Part A Coverage (CCYYMMDD). Included for all Action Types. BCRC supplied value. * All zeros if open-ended or not applicable.
33.	Current Medicare Part B Effective Date	8	242-249	Effective Date of Medicare Part B Coverage (CCYYMMDD). Included for all Action Types. BCRC supplied value.

Field	Name	Size	Displacement	Description
34.	Current Medicare Part B Termination Date*	8	250-257	Termination Date of Medicare Part B Coverage (CCYYMMDD). Included for all Action Types. BCRC supplied value. * All zeros if open-ended or not applicable.
35.	Part D Eligibility Start Date	8	258-265	Earliest date that beneficiary is eligible to enroll in Part D – Refer to Field 42 for the Part D Plan Enrollment Date (CCYYMMDD). Included for all Action Types. BCRC supplied value.
36.	Part D Eligibility Stop Date*	8	266-273	Date the beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 43 for the Part D Plan Termination Date (CCYYMMDD). Included for all Action Types. BCRC supplied value. * All zeros if open-ended or not applicable.
37.	Medicare Beneficiary Date of Death*	8	274-281	Medicare Beneficiary Date of Death (CCYYMMDD). Included for all Action Types. BCRC supplied value. * All zeros if not applicable.
38.	Current Medicare Part C Plan Contractor Number	5	282-286	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. Included for all Action Types. BCRC supplied value.
39.	Current Medicare Part C Plan Enrollment Date	8	287-294	Effective Date of coverage provided by the Beneficiary's current Medicare Part C Plan (CCYYMMDD). Included for all Action Types. BCRC supplied value.
40.	Current Medicare Part C Plan Termination Date*	8	295-302	Termination Date of the coverage provided by the Beneficiary's current Medicare Part C Plan (CCYYMMDD). Included for all Action Types. BCRC supplied value. * All zeros if open-ended or not applicable.
41.	Current Medicare Part D Plan Contractor Number	5	303-307	Contractor Number of the Medicare Part D Plan. Included for all Action Types. BCRC supplied value.
42.	Current Medicare Part D Plan Enrollment Date	8	308-315	Effective Date of coverage provided by the Medicare Part D Plan (CCYYMMDD). Included for all Action Types. BCRC supplied value.

Field	Name	Size	Displacement	Description
43.	Current Medicare Part D Plan Termination Date*	8	316-323	Termination Date of coverage provided by the Medicare Part D Plan (CCYYMMDD). Included for all Action Types. BCRC supplied value. * All zeros if open-ended or not applicable.
44.	Error Code 1	4	324-327	Error Code 1 – May contain SP or Rx error codes from BCRC or RDS processing if applicable. See SP and Rx Error Code Tables for values. BCRC supplied value for D/N records. RDS supplied value for S records.
45.	Error Code 2	4	328-331	Error Code 2 – May contain SP or Rx error codes from BCRC or RDS processing if applicable. See SP and Rx Error Code Tables for values. BCRC supplied value for D/N records. RDS supplied value for S records.
46.	Error Code 3	4	332-335	Error Code 3 – May contain SP or Rx error codes from BCRC or RDS processing if applicable. See SP and Rx Error Code Tables for values. BCRC supplied value for D/N records. RDS supplied value for S records.
47.	Error Code 4	4	336-339	Error Code 4 – May contain SP or Rx error codes from BCRC or RDS processing if applicable. See SP and Rx Error Code Tables for values. BCRC supplied value for D/N records. RDS supplied value for S records.
48.	D/N Disposition Code	2	340-341	Result from processing of an Action Type D or N record. This will also be used to provide a disposition for D records converted from S records – in such case, the S Disposition Code and Date (Fields 29 and 30) will also be populated. See GHP Disposition Code Table for values. Code supplied by the BCRC.
49.	D/N Disposition Date	8	342-349	Processing date associated with the D/N Disposition Code (CCYYMMDD). Supplied by the BCRC.
50.	RDS Start Date	8	350-357	Start date for the RDS subsidy period (CCYYMMDD). RDS-supplied value.
51.	RDS End Date	8	358-365	End date for RDS subsidy period (CCYYMMDD). RDS-supplied value.
52.	RDS Split Indicator	1	366	Indicates multiple subsidy periods within the plan year. Expect multiple records. Values: 'Y' if applicable. Space if not applicable. RDS-supplied value.

Field	Name	Size	Displacement	Description
53.	RDS Reason Code*	2	367-368	Spaces = Accepted 01=Application deadline missed 02=Invalid Application Number 03=Invalid Last Name 04=Invalid First Name 05=Invalid Date of Birth 06=Invalid Gender 07=Invalid Coverage Effective Date 08= Invalid Coverage Termination Date 09= Invalid Benefit Option Identifier (Rx Group Number) 10= Enrolled in Part D 11= Not eligible for Medicare 12= Beneficiary is deceased 13= Invalid Medicare ID (HICN or MBI) or SSN 14=Termination Date less than Effective Date 15= Missing Trailer Record 16= Not a valid Medicare beneficiary 17= No coverage period exists for delete transaction 18= Invalid Action Type 19= Invalid Relationship Code 20= Beneficiary attempted to enroll in Part D and received an initial rejection. 21= New Medicare information has been received – resend record. *RDS Center-supplied codes. The RDS User Guide can be found on https://rds.cms.hhs.gov under the User Guides menu option. The RDS User Guide contains the most current and complete information regarding RDS Determination and Reason Codes.
54.	RDS Determination Indicator	1	369	Y = Yes, the retiree qualifies for the RDS subsidy. N = No, the retiree does not qualify for the RDS subsidy. **This indicator may be blank on records in unsolicited RDS response files.** RDS supplied value.
55.	ESRD Coverage Period Effective Date	8	370-377	The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End Stage Renal Disease (CCYYMMDD). Last coverage period will be reported if multiple coverage periods exist. Supplied by the BCRC.
56.	ESRD Coverage Period Term Date	8	378-385	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions (CCYYMMDD). Last coverage period will be reported if multiple coverage periods exist. Supplied by the BCRC.

Field	Name	Size	Displacement	Description
57.	First Dialysis Date	8	386-393	A date that indicates when the beneficiary first started ESRD Dialysis (CCYYMMDD). Supplied by the BCRC.
58.	ESRD Self-Training Date	8	394-401	A date that indicates when the beneficiary participated in ESRD Self Care Training (CCYYMMDD). Supplied by the BCRC.
59.	Transplant Date – Most Recent	8	402-409	A date that indicates when a Kidney Transplant Operation Occurred (CCYYMMDD). Last occurrence will be reported. Supplied by the BCRC.
60.	Transplant Failure Date – Most Recent	8	410-417	A date that indicates when a Kidney Transplant failed (CCYYMMDD). Last occurrence will be reported. Supplied by the BCRC.
61	Override Code	2	418-419	Code used to override specific hierarchy error codes. Valid Values: HB = Hierarchy bypass. Spaces = Not Applicable
62.	Filler	83	420-500	Unused Field. Filled with spaces.

Non-MSP Response File Trailer Record

Table C-6: Section 111 GHP Non-MSP Response File Trailer Record—500 bytes

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Must be: 'T0'
2.	Section 111 RRE ID	9	3-11	'000000001', '000000002', etc. ID number assigned by the BCRC. Corresponds to the RRE ID submitted on the Non-MSP Input File and the Response File Header Record.
3.	File Type	4	12-15	'NMSR' – Non-MSP Response File. 'RDSU' – Unsolicited RDS Response File. Field will contain value supplied on input.
4.	File Date	8	16-23	CCYYMMDD COB supplied.
5.	Record Count	9	24-32	Number of detail records in this file. **Header and trailer records are not included in this count.** BCRC Supplied.
6.	Filler	468	33-500	Unused Field. Space filled.

Appendix D Disposition, Error, and Compliance Codes

Section 111 GHP Disposition Codes

Table D-1: Section 111 GHP Disposition Codes

Disposition Codes	Description
01	MSP and Non-MSP Response Files: Record accepted by the Medicare Common Working File (CWF) or the Medicare Beneficiary Database (MBD) as an "Add," "Update," or "Delete" record. An MSP occurrence, primary or supplemental drug record was added, updated, or deleted. Query Only Response File: The individual was found to be a Medicare beneficiary and the response record contains Medicare entitlement and enrollment information. TIN Reference Response File: TIN Record accepted.
SP	Transaction error: Record was found to be in error and rejected. Record returned with at least one SP or Rx error (specific SP and Rx errors are described below). Record must be corrected and resubmitted on the next file submission unless otherwise specified in the error description.
50	Record still being processed by CMS. Internal CMS use only**; resubmit record on next file submission.**
51	Individual was not found to be (could not be matched with) a Medicare beneficiary; that is, the individual does not have Medicare Part A entitlement. Record will not be recycled. (**Note:** Individuals may be Medicare beneficiaries but have Medicare Part B coverage only. The MSP provision does not apply to Medicare beneficiaries who only have Medicare Part B coverage.) The RRE should verify individual' status based on information in its files and **resubmit record on next file submission, as necessary.** RREs will also receive this disposition code for the following: • If neither the Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) nor SSN is submitted on the input record. In this case the RRE must obtain a valid Medicare ID or SSN and resubmit the record on the next file submission. • If the coverage dates fall completely outside the Medicare entitlement period, or if the record was submitted prior to the effective date of the individual's Medicare entitlement. In this case the RRE should continue to resend the record until the record is either accepted, the individual is no longer an Active Covered Individual, or their GHP coverage is terminated. Alternatively, the RRE may monitor the Medicare status of the individual using the query process and resend the associated MSP record when Medicare entitlement is established or re-established. • If the coverage was terminated prior to the effective date of the individual's Medicare entitlement. In this case, since the individual is no longer considered to be an Active Covered Individual due to GHP coverage termination, the RRE does not need to resend the record unless the GHP coverage is reactivated later.

Disposition Codes	Description
51 (continued)	• If the individual submitted on a drug record does not have Medicare Part D, this disposition will be received in the Rx Disposition Code field (response field 69). The RRE should verify the individual's status based on information in its files and resubmit the record on their next file submission, as necessary. **Note:** The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.
52	Record still being processed by CMS. Internal CMS use only; **resubmit record on next file submission.**
53	Record in alpha match at CMS. Internal CMS use only; **resubmit record on next file submission.**
61	Cross-Reference Data Base Problem. Internal CMS use only**; resubmit record on next file submission.**
AB	CWF problem that can only be resolved by CWF Technician. Internal CMS use only; **resubmit record on next file submission.**
CI	Processing Error. Internal CMS use only; **resubmit record on next file submission.**
ID	Drug Record Processing Error. Internal CMS use only; **resubmit record on next file submission.**
BY	Bypass. Record was bypassed. SEE Medicare ID (HICN or MBI) was submitted by RRE and accepted; Do not resubmit the record unless the SEE expires, GHP coverage continues, and the beneficiary meets the definition of an Active Covered Individual. Refer to Section 8.5 for more information on the Small Employer Exception. RREs will also receive this disposition code if the employee's status is shown to be inactive ('2' in Field 20 of MSP Input File Detail Record) and the individual was found to be entitled to Medicare due to age or disability (not ESRD). This beneficiary is not an Active Covered Individual since he or she is not entitled due to ESRD and not covered due to current employment of the subscriber. Medicare is not secondary to the GHP coverage. Do not resubmit the record. Additionally, RREs will receive this disposition code if they submit a GHP ESRD record with effective dates outside the 30-month coordination period.
TN	TIN Reference File Detail Record rejected due to errors. Only returned on TIN Reference Response File. Record returned with at least one TN edit (specific TN error codes are described below). Record must be corrected and resubmitted on the next file submission.

Section 111 GHP SP Error Codes

Note: SP errors may be returned on the MSP Response File and the Non-MSP Response File. However, not all SP errors apply to Non-MSP records. If you have any questions on how to resolve a specific error, please contact your EDI Representative.

Table D-2: Section 111 GHP SP Error Codes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP11	Invalid MSP Transaction Record Type. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP12	Invalid Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) (Mandatory). Field must contain alpha and numeric characters. Do not include dashes/hyphens. You received this error because an invalid character was found in this field. **Note:** The Medicare ID is also known as the Medicare Number to CMS' Medicare beneficiaries.	No	Yes
SP13	Invalid Beneficiary/Individual Surname (Mandatory). Field must contain alpha characters. Field cannot begin with a space or contain all spaces. Field cannot contain numeric characters.	No	Yes
SP14	Invalid Beneficiary/Individual First Name Initial (Mandatory). Field must contain alpha characters. First position cannot be blank or a space, a numeric character, or a punctuation mark.	No	Yes
SP15	Invalid Beneficiary/Individual Date of Birth (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and day = 30, the record will reject.	No	Yes
SP16	Invalid Beneficiary/Individual Sex Code (Mandatory). Field must contain numeric character. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown 1 = Male 2 = Female	No	Yes
SP17	Invalid Contractor Number (Mandatory). **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP18	Invalid Document Control Number (DCN) submitted by the BCRC to CWF. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP19	Invalid Transaction Type (Mandatory). This error results from what is provided in the type of record transaction field. Field must contain a numeric character. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record	No	Yes
SP20	Invalid Validity Indicator. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP21	Invalid MSP Code. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP22	Invalid Diagnosis Code. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP23	Invalid Remarks Code. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP24	Invalid Coverage Type. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug Only (non-network Rx) 'W' = Comprehensive Coverage – Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Prescription Drug Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage – Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) 'R' = Health Reimbursement Arrangement (HRA)	No	Yes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP25	Invalid or no insurer name supplied. On the Non-MSP Input Detail Record, when the submitted Action Type (Field 20) is 'D' (Drug Reporting record) or 'S' (Subsidy reporting record), RREs must submit the Insurer Name (Field 27). Field 27 cannot be blank or contain **only** numeric characters and spaces. Field 27 cannot be equal to COBC, COORDINATION OF BENEFITS CONTRACTOR, COORDINATION OF BENEFITS CONTRAC, SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, UNK, MISC, NA, NO, NO FAULT, NO-FAULT, BC, BX, BS, XX, BCBS, BCBX, BLUE CROSS, BLUE SHIELD, COB, HCFA, VA, VA BENEFITS, VETERANS AFFAIRS, VA COVERAGE, VETERANS ADMINISTRATION, US DEPT OF VETERANS AFFAIRS, ADAP, SPAP, PAP, QSP, ASSISTANCE PROGRAM, QUALIFIED STATE PROGRAM, TRICARE, MEDICAID, or MEDICARE. Valid values: alphabetic, numeric, space, comma, & - ' . @ # / : ;. (Effective 10/1/2018 for 'D' records; effective 4/1/2020 for 'S' records.) If an attempt is made to convert an 'S' (Subsidy) record to a 'D' record and the insurer name is missing or invalid, the SP25 error will be received.	No	Yes
SP30	Invalid or no insurer policy number supplied. On the MSP Input Detail Record, RREs must submit either the Policy Holder's SSN (Field 15) – **OR** – Individual Policy Number (Field 18). RREs are encouraged to use Field 18 instead of Field 15 if possible. Field 18 should reflect the unique identifier the RRE uses for the individual being reported on the record which in most cases is the identification number shown on the individual's insurance card. The value supplied in these fields will be placed on any related recovery demand notifications for the RRE to use to identify the GHP coverage for the individual reported on the record.	No	Yes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP31	Invalid Effective Date (Mandatory). Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. The date must be in the following format: CCYYMMDD. Number of days must correspond with the particular month. For example, the date 20110230 is not acceptable (February does not have a day 30). Effective date must be less than or equal to the current date and cannot be a future date. For example, today is 20030312 and an RRE submits a record with an effective date of 30000901. Since this is a future date, the RRE will receive an SP31.	No	Yes
SP32	Invalid Termination Date (Mandatory). Field must contain numeric characters. The date must be in the following format: CCYYMMDD. Number of days must correspond with the particular month. For example, the date 20110230 is not acceptable (February cannot have 30 days). Plan termination date cannot be earlier than the effective date or beneficiary's eligibility start date. If there is no termination date (coverage is still active), you must use zeros (not spaces) in this field. For Working-Aged beneficiaries, the termination date cannot be greater than the current date plus 6 months. For Disability beneficiaries, the termination date cannot be greater than the first day the beneficiary turned 65. Will accept future date for ESRD up to 30 months.	No	Yes
SP33	Invalid Relationship Code (Mandatory). Field must contain numeric characters. Field cannot be blank or contain alpha characters. Acceptable numeric values are as follows: 01 = Self; Covered Individual is Policy Holder or Subscriber 02 = Spouse or Common Law Spouse 03 = Child* 04 = Other 20 = Domestic Partner *Applies only for children covered under the ESRD provision or disabled adult children covered under the disability provision.	No	Yes
SP34	Invalid Policy Holder/Subscriber First Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ;. If field is not used, field must contain spaces.	No	Yes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP35	Invalid Policy Holder/Subscriber Last Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ;. If field is not used, field must contain spaces.	No	Yes
SP36	Invalid Policy Holder SSN. If supplied, must be numeric. If not used, default to spaces or all zeros. On MSP Input Detail Record, either Field 15 (Policy Holder's SSN) or Field 18 (Individual Policy Number) is required.	No	Yes
SP37	Invalid Source Code. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP38	Invalid Employee Information Data Code. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP44	Invalid Insurance Group Policy Number. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;.	No	Yes
SP45	Invalid Individual Policy Number. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;.	No	Yes
SP46	Invalid Pre-Paid Health Plan Date. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP47	Delete transaction does not match to an existing MSP occurrence. Beneficiary MSP Indicator not on for delete transaction. An attempt was made to delete an MSP record where there is no MSP indicator on the beneficiary Medicare record. According to CMS records Medicare has always been the primary payer. No MSP occurrences exist for this beneficiary.	No	Yes
SP48	Delete transaction does not match to an existing MSP occurrence. Matching criteria on the delete transaction may be incorrect, original add transaction may not have been accepted with a '01' disposition code, or the matching MSP occurrence may have been deleted prior to the processing of this transaction. Correct matching criteria and resend as needed. If submitted matching criteria was correct, no further action is necessary.	No	Yes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP49	Delete transaction does not match to an existing MSP occurrence. MSP auxiliary occurrence not found for delete data transaction. Where there is an existing MSP period, the incoming record must match on certain criteria so the system can differentiate among various periods of MSP on the beneficiary's Medicare file. These criteria are patient relationship, MSP effective date, MSP type, and coverage type. An SP 49 is received when an RRE attempts to delete an occurrence that is not on CWF, or one for which there is no "match" on CWF, or you send in a delete transaction for a record that has been previously deleted by the RRE or another entity and the record no longer exists. Matching criteria on the delete transaction may be incorrect, original add transaction may not have been accepted with a '01' disposition code, or MSP occurrence may have been deleted prior to the processing of this transaction. Correct matching criteria and resend as needed. If submitted matching criteria was correct, no further action is necessary.	No	Yes
SP50	Invalid function for update or delete. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP51	MSP auxiliary record has 17 occurrences, and none can be replaced. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP52	Invalid Relationship Code/MSP Code combination. MSP determinations depend in part on the reason for the beneficiary's entitlement and the relationship of the beneficiary to the subscriber. The MSP Code (MSP Type based on reason for entitlement) must correspond with valid Relationship Codes as cited below. MSP Code/ Relationship Codes A = Working Aged 01 = Beneficiary 02 = Spouse G = Disabled 01 = Beneficiary 02 = Spouse 03 = Child 04 = Other 20 = Domestic Partner B = ESRD 01 = Beneficiary 02 = Spouse 03 = Child 04 = Other 20 = Domestic Partner For example, this error may occur when the covered individual submitted is a Medicare beneficiary entitled due to age but their relationship to the subscriber of the GHP (employee) is not self (01) and not spouse (02). Under these circumstances, the record was not submitted in error. Instead, it means that Medicare is not secondary and the BCRC did not create an MSP occurrence. In this case, the RRE cannot fix this error but may continue to send the record until the individual is no longer considered to be an Active Covered Individual. Alternatively, the **RRE does not need to resend the record unless the individual's coverage information (i.e., relationship to the subscriber) changes.**	No	Yes
SP53	MSP Code 'G' or 'B' overlaps another Code 'A', 'G', or 'B'. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP54	MSP Code 'A' or 'G' has an effective date that is in conflict with the calculated date the beneficiary reaches 65 years old. For MSP Code 'A', the effective date must not be less than the date at age 65. For MSP Code 'G', the effective date must not be greater than the date at age 65. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP55	MSP Effective Date is less than the earliest beneficiary Part A or Part B entitlement date. MSP can only occur after the beneficiary becomes entitled to Medicare Part A or Medicare Part B. An MSP Effective Date that is an invalid date will also cause SP 55 error. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP56	MSP pre-paid health plan date must equal or be greater than the MSP Effective Date or less than MSP Termination Date. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP57	Termination Date greater than 6 months before date of accretion. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP58	Invalid Coverage Type, MSP Code, and validity indicator combination. Mapped coverage type must equal 'J', 'K', or 'A'. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP59	Invalid insurer type and validity indicator combination. RREs should not receive this edit. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP60	Other coverage type for same period on file. RRE submits a 'J' or 'K' coverage type, but Medicare's CWF shows 'A' coverage type for the same period of MSP. **No correction necessary—verify submitted information and resubmit records with this error on your next file submission.**	Yes	No
SP61	Other coverage type for same period on file. RRE submits an 'A' coverage type, but Medicare's CWF shows 'J' or 'K' coverage type for the same period of MSP. **No correction necessary—verify submitted information and resubmit records with this error on your next file submission.**	Yes	No

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP62	Incoming termination date is less than MSP Effective Date. MSP Termination Date provided must be greater than the MSP Effective Date. The RRE sent a Termination Date prior to the MSP Effective Date. This edit occurs when an RRE fails to note CMS' modification of the RRE's MSP Effective Date to correspond with the commencement of the Medicare entitlement date. The RRE should go back to its previous response file and identify the correct MSP Effective Date for this record. If the Termination Date is earlier than the MSP Effective Date on the previous response file, this indicates that there was no MSP and the RRE should send a transaction to delete the record.	No	Yes
SP66	MSP Effective Date is greater than the Effective Date on matching occurrence on Auxiliary file. SP 66 occurs when the Effective Date on the maintenance record is greater than the Effective Date on the Auxiliary record to be updated, and Effective Date plus 30 is greater than "+30." **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP67	Not Used.	Yes	No
SP72	Invalid transaction attempted. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP73	Invalid Termination Date/Delete Transaction attempted. Internal CMS use only. **No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP74	Invalid—cannot update 'I' record**. No correction necessary—resubmit records with this error on your next file submission.**	Yes	No
SP75	Invalid transaction. Beneficiary does not have Medicare Part A benefits for the time period identified in the RRE's update file. If there is no Part A entitlement, there is no MSP. **No correction necessary—resubmit records with this error on your next file submission or monitor the individual's Medicare status using the query file.**	No	Yes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SP91	Invalid Employer Size (Mandatory). Field must contain a numeric character. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: '0' = 1 to 19 employees '1' = 20 to 99 employees '2' = 100 or more employees	No	Yes
SP99	Medicare ID (HICN or MBI) required if individual is less than 45 years of age. In order to submit an MSP Input File Detail Record for an individual under age 45, the RRE must first obtain the Medicare ID from the beneficiary or by using the query process. No matching will be done by the system on a record for an individual under age 45 unless the Medicare ID is submitted. RREs cannot submit an MSP Input File Detail Record with only the SSN for an individual under age 45. The system will not attempt to match such a record to a Medicare beneficiary and will not return the Medicare ID if found. Instead, the record will be rejected with the SP99 error.	No	Yes
SPES	Due to the employer size, an MSP occurrence is not created. Check that the employer size submitted was correct and continue to resend the record on all subsequent quarterly file submissions until a '01' disposition code is received, or the individual is no longer covered by your plan. Since the employer size may not change, you may continue to receive a response record back with an 'SP' disposition code for these situations.	No	Yes
SPH0	Transaction attempted to update/delete an MSP or primary or supplemental drug occurrence last updated by a higher-ranking source. MSP or primary or supplemental drug occurrence is not locked, and the RRE may submit an Override Code on the record in its next quarterly file submission. RREs must validate their information prior to resubmission to make sure the override is appropriate. Primary or supplemental drug occurrences.	No	Yes

SP Error Code	Description	BCRC Responsible	RRE Responsible
SPH1	Transaction attempted to update/delete an MSP or primary or supplemental drug occurrence locked by the BCRC. No update or delete accepted via Section 111 reporting. Do **NOT** attempt to resubmit this record. Insurer/TPA RREs are advised to contact the associated employer/other plan sponsor to verify the accuracy of data submitted by the RRE. If changes are necessary, contact the BCRC Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired. Primary or supplemental drug occurrences.	No	Yes
SPH2	Transaction attempted to override the SPH0 error without prior notification. RREs will receive this error if they submit an Override Code on the first attempt of the update/delete, as well as an SP disposition code. You must first receive the SPH0 error and then submit the Override Code on the record in your next quarterly file submission after verifying that the override is appropriate and necessary. Primary and supplemental drug occurrences.	No	Yes
SPT0	No matching, valid TIN Reference File Detail Record was found for the **Employer** TIN submitted. Causes/resolutions: An incorrect employer TIN was submitted on the MSP Input File Detail Record. Correct and resubmit MSP Input File Detail Record. A corresponding TIN Reference File Detail Record was not submitted for the employer TIN or was submitted and rejected with errors. Refer to errors returned on the TIN Reference Response File. Submit updated/corrected TIN Reference File and resubmit MSP Input File record.	No	Yes
SPT1	No matching, valid TIN Reference File Detail Record was found for the **Insurer/TPA** TIN submitted. Causes/resolutions: An incorrect insurer/TPA TIN was submitted on the MSP Input File Detail Record. Correct and resubmit MSP Input File Detail Record. A corresponding TIN Reference File Detail Record was not submitted for the insurer/TPA TIN or was submitted and rejected with errors. Refer to errors returned on the TIN Reference Response File. Submit updated/corrected TIN Reference File and resubmit MSP Input File record.	No	Yes

Section 111 GHP Rx Error Codes

These codes only apply to records submitted for prescription drug coverage.

Table D-3: Section 111 GHP Rx Error Codes

Error Code	Error Description
RX 01	Missing Rx ID
RX 02	Missing or invalid Rx BIN. Must be 6-digit number; cannot be all the same number
RX 03	Missing Rx Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 06	Missing/Invalid Retiree Drug Subsidy Application Number
RX 07	Beneficiary does not have Part D enrollment
RX 09	Invalid Action Code
RX 10	Record not found for delete
RX 11	Record not found for update
RX 12	Invalid Supplemental Type
RX 18	Invalid Rx PCN
RX 19	Overlapping Rx Coverage
RX 20	Overlapping Rx Coverage, new reporter (informational edit; does not cause rejection)

Section 111 SEE (Small Employer Exception) Response Codes

Table D-4: SEE Response Codes

Code	Description
SA	SEE-Medicare ID (HICN or MBI) accepted. Record bypassed and not submitted to CWF. Disposition code of BY has been applied. RREs will also receive this response code for the following: Drug Only Coverage: • Full SEE overlap. MSP/Drug Coverage: • Full SEE overlap with both. • Full SEE overlap on Drug, no Part A Entitlement. • Full SEE overlap on MSP, no Part D Enrollment.
SN	SEE-Medicare ID not-accepted. SEE Medicare ID could not be confirmed. Record processed as normal MSP occurrence. Disposition code should be used to determine subsequent processing required. RREs will also receive this response code for the following: Drug Only or MSP/Drug Coverage: • No SEE coverage found. • No SEE overlap.
SP	SEE-Medicare ID partially accepted. SEE Medicare ID confirmed, but insurance effective period outside of SEE effective period. Disposition code should be used to determine subsequent processing required. RREs will also receive this response code for the following: Drug Only Coverage: • Partial SEE overlap. MSP/Drug Coverage: • Full SEE overlap with MSP, partial overlap on Drug. • Full SEE overlap on Drug, partial overlap on MSP. • Full SEE overlap on Drug, no overlap on MSP (entitled but no overlap). • Partial SEE overlap on MSP, partial SEE overlap on Drug. • Partial SEE overlap on Drug, no overlap on MSP (entitled but no overlap). • Partial SEE overlap on MSP, no overlap on Drug.

Section 111 TIN Reference Response File Error Codes

Table D-5: GHP TIN Reference Response File Record Errors

Error Code	Field	Description
TN01	TIN—Field 1, TIN Indicator I	Invalid Insurer/TPA TIN received on TIN Reference record where the TIN Indicator equals I. TIN cannot be validated by the BCRC. Must be a 9-digit numeric code and must be a valid, IRS-assigned TIN. TIN cannot be blank or all spaces. If you believe the TIN to be valid, contact your EDI Representative to supply supporting evidence. Your EDI Representative will then update the system to mark the TIN as valid and then you may resend the record.
TN02	N/A	Not used at this time.
TN03	Name—Field 2, TIN Indicator I	Invalid Name (Insurer/TPA name) received on the TIN Reference record where the TIN Indicator equals I. Field cannot be blank. Must contain at least 2 valid characters. The first two characters cannot be blank. Spaces are allowed between words in an insurer plan name. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Insurer name cannot contain only the following word(s) as a default: SUPPLEMENTAL, SUPPLEMENT, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NA, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHEILD, or MEDICARE. Special characters other than, &, - ‘. @ # /: ; are not allowed.
TN04	Address Line 1 – Field 3, TIN Indicator I	Invalid insurer/TPA Address Line 1 where the TIN Indicator equals I. Insurer/TPA Address Line 1 field is missing or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
TN05	Address Line 2 – Field 4, TIN Indicator I	Invalid insurer/TPA Address Line 2 where the TIN Indicator equals I. If entered Address Line 2 must not contain any characters other than alpha, numeric and special characters, A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
TN06	City – Field 5, TIN Indicator I	Invalid insurer/TPA City where the TIN Indicator equals I. Insurer/TPA City is missing or contains characters other than alpha and special characters A-Z, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
TN07	State – Field 6, TIN Indicator I	Invalid insurer/TPA State where the TIN Indicator equals I. Insurer/TPA State is missing or contained a value other than a valid US postal state code. **A value of FC is NOT allowed for the state code of the insurer/TPA.**

Error Code	Field	Description
TN08	Zip Code – Field 7, TIN Indicator I	Invalid or missing insurer/TPA ZIP Code where the TIN Indicator equals I. ZIP Code must contain 5 numeric digits or 9 numeric digits.
TN09	N/A	Not used.
TN10	TIN Indicator – Field 8	Invalid TIN Indicator. Must contain one of the following values: E = The TIN field contains a valid TIN (EIN) for an Employer. I = The TIN field contains a valid TIN for an Insurer/TPA. S = The TIN field contains a valid TIN for the plan sponsor of a multiple employer/multi-employer plan. F = The TIN field contains a valid TIN for a Federal employer. Z = The TIN field reflects a foreign employer that has no valid TIN. The TIN field contains a fake or pseudo-TIN for the foreign employer.
TN11	Insurer/TPA Demand Mailing Name – Field 9, TIN Indicator I	Invalid Insurer/TPA Demand Mailing Name. The field contains a value other than spaces but the TIN Indicator was not equal to I. The TIN Indicator is I, but the field contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote. The TIN Indicator is I, the Insurer/TPA Demand Address Line 1 is non-blank but the Insurer/TPA Demand Mailing Name is blank.
TN12	Insurer/TPA Demand Address Line 1 – Field 10, TIN Indicator I	Invalid Insurer/TPA Demand Address Line 1. The field contains a value but the TIN Indicator was not equal to I. The TIN Indicator is I and a non-blank Insurer/TPA Demand Mailing Name was supplied, but the Insurer/TPA Demand Address Line 1 is missing or the field contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
TN13	Insurer/TPA Demand Address Line 2 – Field 11, TIN Indicator I	Invalid Insurer/TPA Demand Address Line 2. The field contains a non-blank value but the TIN Indicator was not equal to I. The TIN Indicator is I, but the field contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.

Error Code	Field	Description
TN14	Insurer/TPA Demand Mailing City – Field 12, TIN Indicator I	Invalid Insurer/TPA Demand Mailing City. The field contains a non-blank value but the TIN Indicator was not equal to I. The TIN Indicator is I and the Insurer/TPA Demand Mailing Name is non-blank, but the Insurer/TPA Demand Mailing City is missing or the field contains characters other than alpha and special characters A-Z, space, &, dash, @, #, /, comma, semicolon, colon, period, quote.
TN15	Insurer/TPA Demand Mailing State – Field 13, TIN Indicator I	Invalid Insurer/TPA Demand Mailing State. The field contains a non-blank value but the TIN Indicator was not equal to I. The TIN Indicator is I and the Insurer/TPA Demand Mailing Name is non-blank, but the Insurer/TPA Demand Mailing State is missing or contained a value other than a valid US postal state code.
TN16	Insurer/TPA Demand Mailing Zip – Field 14, TIN Indicator I	Invalid Insurer/TPA Demand Mailing ZIP. The TIN Indicator is I and the Insurer/TPA Demand Mailing Name is non-blank, but the Insurer/TPA Demand Mailing ZIP does not contain 5 numeric digits followed by 4 spaces or 9 numeric digits. Must be all spaces if the TIN Indicator is not equal to I.
TN01	TIN – Field 1, TIN Indicator E, F, S or Z	Invalid Employer TIN where the TIN Indicator equals E, S, F or Z. TIN cannot be validated by the BCRC. Must be a 9-digit numeric code. If the TIN Indicator is not equal to Z, must be a valid, IRS-assigned TIN. If you believe the TIN to be valid, contact your EDI Representative to supply supporting evidence. Your EDI Representative will then update the system to mark the TIN as valid and then you may resend the record.
TN03	Name – Field 2, TIN Indicator E, F, S or Z	Invalid or missing Employer Name received on TIN Reference record where the TIN Indicator equals E, S, F or Z. Field cannot be blank. It must contain at least 2 characters. Special characters other than, &, - ‘. @ # /: ; are not allowed.
TN04	Address Line 1 – Field 3, TIN Indicator E, F, S or Z	Invalid Employer Address Line 1 where the TIN Indicator equals E, S, F, or Z. Employer Address Line 1 field is missing or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, and quote. Must be equal to all spaces if State Field 6 is equal to ‘FC’.

Error Code	Field	Description
TN05	Address Line 2 – Field 4, TIN Indicator E, F, S, Z	Invalid Employer Address Line 2 where TIN Indicator equals E, S, F or Z. If supplied, Employer Address Line 2 must not contain characters other than alpha, numeric and special characters, A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote. Must be equal to all spaces if State Field 6 is equal to 'FC'.
TN06	City – Field 5, TIN Indicator E, F, S or Z	Invalid Employer City where TIN Indicator equals E, S, F or Z. Employer City is missing or contains characters other than alpha, numeric and special characters A-Z, 0-9, space, &, dash, @, #, /, comma, semicolon, colon, period, quote. Must be equal to all spaces if State Field 6 is equal to 'FC'.
TN07	State – Field 6, TIN Indicator E, F, S or Z	Invalid Employer State where TIN Indicator equals E, S, F or Z. Employer State is missing or contained a value other than a valid US postal state code or 'FC'. Cannot equal 'FC' if the TIN Indicator equals F.
TN08	Zip Code – Field 7, TIN Indicator E, F, S, or Z	Invalid Employer ZIP Code where the TIN Indicator equals E, S, F or Z. Employer ZIP Code field must contain 5 numeric digits or 9 numeric digits. Must be equal to all spaces if State Field 6 is equal to 'FC'.
TN17	Foreign Employer Address Lines 1-4—Fields 15, 16, 17, 18, TIN Indicator E, F, S or Z	Missing or invalid Foreign Employer Address Line 1-4 supplied where TIN Indicator equals E, S, or Z. The State Field 6 contained the value FC for Foreign Country, but the foreign address lines 1-4 contained all spaces or non-alphanumeric characters; or the state code supplied was not FC and the Foreign Employer Address Lines 1-4 were not equal to all spaces. Must equal all spaces if TIN Indicator is F.
TN18	Fields 3-7, TIN Indicator 'I'	Invalid insurer/TPA address where TIN Indicator is 'I'. The address supplied was insufficient or missing components needed to determine a unique match to the postal database.
TN19	Fields 3-7, TIN Indicator 'I'	Invalid insurer/TPA address where TIN Indicator is 'I'. The address matches one to which mail is undeliverable, such as a vacant lot.
TN20	Fields 3-7, TIN Indicator 'I'	Invalid insurer/TPA address where TIN Indicator is 'I'. The apartment number was not found in the postal database or was not supplied for an address that requires apartment number.
TN21	Fields 3-7, TIN Indicator 'I'	Invalid insurer/TPA address where TIN Indicator is 'I'. The house number or box number was not found on the street.

Error Code	Field	Description
TN22	Fields 3-7, TIN Indicator 'I'	Invalid insurer/TPA address where TIN Indicator is 'I'. The street name was not found in the ZIP Code.
TN23	Fields 3-7, TIN Indicator 'I'	Invalid insurer/TPA address where TIN Indicator is 'I'. The ZIP Code was not found in the postal database.
TN24	Fields 9 – 14, TIN Indicator 'I'	Invalid insurer/TPA demand address where TIN Indicator is 'I'. The address supplied was insufficient or missing components needed to determine a unique match to the postal database.
TN25	Fields 9 – 14, TIN Indicator 'I'	Invalid insurer/TPA demand address where TIN Indicator is 'I'. The address matches one to which mail is undeliverable, such as a vacant lot.
TN26	Fields 9 – 14, TIN Indicator 'I'	Invalid insurer/TPA demand address where TIN Indicator is 'I'. The apartment number was not found in the postal database or was not supplied for an address that requires apartment number.
TN27	Fields 9 – 14, TIN Indicator 'I'	Invalid insurer/TPA demand address where TIN Indicator is 'I'. The house number or box number was not found on the street.
TN28	Fields 9 – 14, TIN Indicator 'I'	Invalid insurer/TPA demand address where TIN Indicator is 'I'. The street name was not found in the ZIP Code.
TN29	Fields 9 – 14, TIN Indicator 'I'	Invalid insurer/TPA demand address where TIN Indicator is 'I'. The ZIP Code was not found in the postal database.
TN18	Fields 3-7, TIN Indicator 'E', 'F', 'S', or 'Z'	Invalid employer address where TIN Indicator equals E, S, F or Z. The address supplied was insufficient or missing components needed to determine a unique match to the postal database.
TN19	Fields 3-7, TIN Indicator 'E', 'F', 'S', or 'Z'	Invalid employer address where TIN Indicator equals E, S, F or Z. The address matches one to which mail is undeliverable, such as a vacant lot.
TN20	Fields 3-7, TIN Indicator 'E', 'F', 'S', or 'Z'	Invalid employer where TIN Indicator equals E, S, F or Z. The apartment number was not found in the postal database or was not supplied for an address that requires apartment number.
TN21	Fields 3-7, TIN Indicator 'E', 'F', 'S', or 'Z'	Invalid employer address where TIN Indicator equals E, S, F or Z. The house number or box number was not found on the street.
TN22	Fields 3-7, TIN Indicator 'E', 'F', 'S', or 'Z'	Invalid employer address where TIN Indicator equals E, S, F or Z. The street name was not found in the ZIP Code.
TN23	Fields 3-7, TIN Indicator 'E', 'F', 'S', or 'Z'	Invalid employer address received on TIN Reference record where TIN Indicator equals E, S, F or Z. The ZIP Code was not found in the postal database.

Appendix E MMSEA Section 111 Statutory Language

The Medicare Secondary Payor Mandatory Reporting Provisions
Of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

SECTION 111 – MEDICARE SECONDARY PAYOR

(a) In General—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraphs:

(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS-

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been --

(I) a primary plan to the program under this title; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) ENFORCEMENT-

(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

(C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS-

(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) REQUIRED INFORMATION- The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT- For purposes of subparagraph (A), the term 'claimant' includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT—

(i) IN GENERAL—An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN—In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii)Workers' compensation laws or plans.

(G) SHARING OF INFORMATION—The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) IMPLEMENTATION—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(b) Rule of Construction—Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

(c) Implementation—For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines

appropriate, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

Appendix F MMSEA Section 111 Definitions and Reporting Responsibilities

Attachment A—Definitions and Reporting Responsibilities

(Attachment A to the Supporting Statement for the MMSEA Section 111 Paperwork Reduction Act (PRA) Federal Register (FR) Notice published February 13, 2009.)

SUPPORTING DOCUMENT FOR PRA PACKAGE FOR MEDICARE SECONDARY PAYER REPORTING RESPONSIBILITIES FOR SECTION 111 OF THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007.

Note: The second paragraph under Liability Self-Insurance was revised subsequent to the initial publication of this Attachment on August 1, 2008.

DEFINITIONS AND REPORTING RESPONSIBILITIES
GROUP HEALTH PLAN (GHP) ARRANGEMENTS (42 U.S.C. 1395y(b)(7)).

INSURER

For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), an insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third-party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

THIRD PARTY ADMINISTRATOR (TPA)

For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. 1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(7):

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7), agents may submit reports on behalf of:

- Insurers for GHPs
- TPAs for GHPs
- Employers with self-insured and self-administered GHPs

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

The CMS will provide information on the format and method of identifying agents for reporting purposes.

LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION (42 U.S.C. 1395y(b)(8)) – INSURER.

For purposes of the reporting requirements for 42 U.S.C. 1395y(b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.

CLAIMANT:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in "1)" or "2)".

APPLICABLE PLAN:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the "applicable plan" as defined in subsection (8)(F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers' compensation information this would be the Federal agency, the State agency, or self-insured employer or the employer's insurer.

NO-FAULT INSURANCE:

Trade associations for liability insurance, no-fault insurance, and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.

LIABILITY SELF-INSURANCE:

42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade, or profession. See also 42 C.F.R. 411.50.

Where an entity engages in a business, trade, or profession, deductible amounts are self-insurance for MSP purposes. **However**, where the self-insurance in question is a deductible, and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible.

WORKERS' COMPENSATION LAW OR PLAN

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), a workers' compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses. The term includes a similar compensation plan established by an employer that is funded by such employer directly or indirectly through an insurer to provide compensation to a worker of such employer for a work-related injury or illness.

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(8):

Agents may submit reports on behalf of:

- Insurers for no-fault or liability insurance
- Self-insured entities for liability insurance
- Workers' compensation laws or plans

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

TPAs of any type (including TPAs as defined for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7) for GHP arrangements) have no reporting responsibilities for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8) for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Where an entity reports on behalf of another entity required to report under 42 U.S.C. 1395y(b)(8), it is doing so as an agent of the second entity.

CMS will provide information on the format and method of identifying agents for reporting purposes.

Appendix G Reporting Employer Size

Reporting Employer Size

This appendix is intended as an overview of the MSP regulations related to employer size and how they affect Section 111 reporting. However, RREs must refer to 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170 for details on the calculation of employer size. Additional information can be found in Chapter 1 of the CMS MSP Manual at https://www.cms.gov/manuals/downloads/msp105c01.pdf. All Medicare manuals can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The MSP Manual is shown as publication 100-05 on that page. Also refer to Section 7.2.4 and the Small Employer Exception page on the CMS Website at https://www.cms.gov/medicare/coordination-benefits-recovery/employer-services/small-employer-exception for an explanation of a related Small Employer Exception (SEE).

MSP regulations for beneficiaries entitled to Medicare due to age or disability require information on employer size to determine the correct primary payer. Employer size is not a factor if the beneficiary is entitled to Medicare due to ESRD. Employer size is based on the number of employees during specified time periods, not the number of individuals covered under the GHP. When calculating the number of employees, RREs should use the total number of employees in an organizational structure (parent, subsidiaries, and siblings) rather than just the number of employees in the particular subsidiary being reported on. Subsidiaries of foreign companies must count the number of employees in the organization worldwide. If the employer is part of a multi-employer/multiple employer plan, this field should reflect the size of the **largest** employer in the plan.

Employer size is reported using the Employer Size indicator in Field 16 on the MSP Input File Detail Record. The Employer Size indicator values reflect categories that are based on MSP regulations related to the number of employees **during a specific time period** which affect whether Medicare is the secondary payer in conjunction with the reason an individual is entitled to Medicare (age and disability). A value of '0' is used to report an employer size of 1 to 19 employees, '1' is used for 20 to 99 employees and '2' for 100 or more employees.

RREs must follow the MSP regulations when determining employer size. It is not just a count of employees as of the current reporting date. The employer size reported for GHP coverage on an MSP Input Detail Record is associated with the coverage dates being reported, not the actual date you are submitting your files. If you are reporting a coverage period starting in 2019, you need to look at the number of employees during 2018 and then keep track of changes throughout 2019. The employer size is reported according to the dates of coverage for the individuals and what the employer size indicator is calculated to be during those dates of coverage.

Reporting a change in employer size is not as simple as just reporting the effective date of when the actual number of employees changed. It is to be reported with effective dates according to MSP regulations regarding when the change affects whether Medicare could be primary or secondary as explained below.

Working Aged Provisions

Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of their own current employment status with an employer

that has 20 or more employees; or the current employment status of a spouse of any age with such an employer. These individuals are known as the "working aged." Medicare is the secondary payer to GHPs for the working aged where either: a single employer of 20 or more full and/or part-time employees is the sponsor of the GHP or contributor to the GHP, or two or more employers are sponsors or contributors to a multi-employer/multiple employer plan, and at least one of the employers has 20 or more full and/or part-time employees.

The 20 or more employee requirement is met if the employer employed 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. **So, when the number of employees first equals 20 or more, a change to employer size is not immediately submitted. The change in employer size is not reported until the date the employer has had 20 or more employees for 20 or more weeks in a calendar year. The effective date of the employer size change would be the first day of the 20th week that the employer has had 20 or more employees in a calendar year. Note that the 20 weeks do not have to be consecutive. A change that involves employer size increasing to 20 or more employees is likely to occur mid-year or later.** The requirement is based on the number of employees, not the number of people covered under the plan. Employers who did not meet the requirement during the previous calendar year may meet it at some point during the new calendar year, and at that point Medicare would become the secondary payer for **the remainder of that year and through the next year even if the number of employees subsequently drops below 20.**

When employer size shrinks to less than 20 employees, the earliest Medicare could become primary is January 1 of the following year. There is no "20 week rule" for employers that get smaller. There is not a scenario where an RRE would submit a change to lower employer size with an effective date of anything other than January 1st.

Working Aged—Example 1:

Assume an employer employed 20 or more employees for all of 2006. For the years 2007 and 2008, the employer always had fewer than 20 employees. For the first 6 months of 2009, the employer employed 20 or more employees.

Medicare would be the secondary payer to GHP coverage during all of calendar year 2007 because there were 20 or more employees during the preceding year, 2006. Medicare would be primary to GHP coverage in 2008 because the employer had fewer than 20 employees during 2008 and fewer than 20 in the preceding year of 2007. Medicare would be the primary payer for the first 19 weeks of 2009 based on the number of employees during 2008. Starting week 20 of 2009, Medicare would become secondary and remain secondary for the remainder of 2009. Since the employer employed 20 or more employees for more than 20 weeks in 2009, Medicare will also be secondary for all of 2010.

For this example, we chose not to list an employee count for the year 2005 Therefore, it is unknown if Medicare was primary or secondary for the first 19 weeks of 2006.

Working Aged—Example 2:

On the flip side, assume an employer employed 20 or more employees for all of 2006. For the years 2007 and 2008, the employer always had 20 or more employees. Medicare would be the secondary payer during all of calendar years 2007 and 2008 because there were 20 or more employees during the preceding years, 2006 and 2007 respectively.

For the first 6 months of 2009, the employer employed less than 20 employees. Since there is no "20 week rule" for employers that get smaller, Medicare will not become the primary payer over

GHP coverage until January 1, 2010. Medicare will remain primary payer in 2010 until the employer employs more than 20 employees for more than 20 calendar weeks in the current year. Remember, the 20 weeks do not have to be consecutive. Medicare will become secondary payer as soon as the 20-employee, for 20 weeks threshold is met.

For this example, we chose not to list an employee count for the year 2005. Therefore, it is unknown if Medicare is primary or secondary for the first 19 weeks of 2006.

Working Aged – Example 3:

Assume an employer has 20 employees for all of 2008 and for 21 weeks at the start of 2009. That means Medicare will be secondary to GHP coverage in all of 2009 and all of 2010. If the employer went down to 15 employees for the 31 remaining weeks of 2009 and all of 2010, nothing changes. Medicare is still secondary to GHP coverage for all of 2009 and 2010. However, starting on January 1, 2011, Medicare would be primary for at least the first 19 weeks of 2011 since the employer did not have 20 or more employees for 20 or more weeks in 2010.

Disability Provisions

Medicare is the secondary payer for claims for beneficiaries under age 65 who have Medicare because of a disability and who are covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. An LGHP is a GHP that covers employees of either: a single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or two or more employers or employee organizations where at least one employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year. Medicare is the secondary payer of benefits if a single employer employs 100 or more employees or if the GHP is a multi-employer/multiple employer plan that covers one employer that employs 100 or more full and/or part-time employees.

The 100 employee or more requirement is met if the employer employed 100 or more employees on 50% or more of its business days in the previous calendar year. **Therefore, the employer size changes related to 100 or more employees can only occur effective Jan 1st and depends on the number of employees throughout the previous calendar year.**

Disability—Example 4:

Assume an employer employed 100 or more employees in both 2006 and 2007. In 2008, the employer had fewer than 100 employees for 75% of its business days and in 2009, employment increased to over 100 employees for more than 50% of its business days. Medicare would be the secondary payer to GHP coverage in 2007 because the employer had 100 or more employees during 2006. Medicare would be secondary to the GHP coverage during 2008 because in 2007 the employer met or exceeded 100 employees for the entire year. Medicare would be primary payer for all of 2009 because the employer employed fewer than 100 employees for more than 50% of its business days in 2008. Medicare will be secondary for all of 2010 because the employer again had 100 or more employees on more than 50% of its business days in 2009. Please note that the MSP status for 2006 is dependent upon the number of employees employed in year 2005, which is why the MSP status of 2006 is not mentioned in this example.

Setting the Employer Size Indicator

It is recommended that RREs obtain employer size information from employers on **at least a yearly basis**. This information must include enough detail for the RRE to make the employer size determination according to the MSP regulations (20 or more employees for 20 weeks or more in the current or previous calendar year and 100 or more employees for 50% or more of the employer's business days in the previous calendar year). So, an RRE needs to retain employee counts or changes to those counts by employer, by business day, by calendar week, and by calendar year in its internal systems database. Then the employer size indicator must be calculated and stored by specific date ranges that apply to GHP coverage dates. When GHP coverage is reported, the employer size indicator associated with the specific GHP coverage dates must be reported on the record. If the employer size indicator has different values during the span of the GHP coverage dates to be reported, multiple MSP Input File records must be submitted to reflect that.

On January 1st, the Employer Size indicator could be determined by the following series of checks:

- If the employer had 100 or more employees during the prior calendar year for 50% or more of the employer's business days, then set the indicator to '2'.
- Otherwise, if the employer had between 20 and 99 employees for 20 or more weeks in the prior calendar year, then set the indicator to '1'.
- Otherwise, if the employer did not have 20 or more employees for at least 20 weeks in the prior calendar year, then set the indicator to '0'.

If the indicator is different than what was previously reported, then submit the appropriate update and add transactions to reflect the change in size as will be described below. Remember that the Employer Size indicator for a multi-employer/multiple employer plan is based on the largest employer in the plan.

In addition, RREs must inform employers that they are responsible for notifying the RRE of any changes that occur during the course of a calendar year that could impact the employer size determination related to the 20 employee or more requirement described previously. In other words, the employer must notify the RRE when they have increased to a size of 20 or more employees for 20 or more weeks during the current calendar year so that the RRE can submit the appropriate changes for GHP coverage dates affected by the change in a timely manner for Section 111 reporting.

Again note:

- an **increase** in size to 20 or more employees is effective as soon as the employer reached 20 employees for at least 20 weeks during the current calendar year.
- a **decrease** in size to less than 20 employees could only be effective as of January 1st.
- an **increase** in size from less than 100 employees to 100 or more employees can only be effective as of January 1st.
- a **decrease** in size from 100 or more employees to less than 100 employees can only be effective as of January 1st.

If an RRE is unable to obtain the employer size related to a GHP in order to report in time, the Employer Size should be defaulted to a value of '2' (100 or more employees) and then later corrected with Update records as needed when an accurate size can be calculated. The importance of employer cooperation with data collection by RREs for Section 111 is

documented in the "Alert to Employers" that can be found as a download on the Mandatory Insurer Reporting for Group Health Plans (GHP) page of https://go.cms.gov/mirghp. It is in each employer's best interest to provide accurate employer size to Insurer and TPA RREs in a timely manner to comply with MSP regulations, reduce coordination of benefits costs and reduce the number of possible recovery actions that could be made against them.

Reporting Changes in Employer Size

Employer size changes must be reported in a manner slightly different than most other changes that are reported. For example, when an employee retires, the termination date on the update transaction submitted reflects the actual day the employee retired. When employer size changes occur, the termination date generally will be later than the date the actual employer size change occurred. The termination date is later because of the way the Medicare regulations work. When employer size changes, RRE's will need to determine if the change in size impacts the order in which benefits should be paid. If Medicare is becoming primary or secondary under either the Working Aged or Disability provisions, update transactions for all affected Active Covered Individuals must be submitted which reflect the date when the 20 employee or more for 20 or more weeks requirement or the 100 employee or more for 50% or more of the business days in the previous calendar year (Jan 1st) requirement is actually reached. First, the date of the employer size indicator change is determined and then that is applied to any GHP coverage records open at that time.

If the employer size indicator changes from less than 20 employees to 20 or greater or the employer size indicator changes from less than 100 employees to 100 or greater, any previously reported records **accepted with a '01' disposition code** must have an update transaction submitted to terminate the existing record and an add transaction must be submitted to reflect the new employer size indicator. The effective date of the GHP coverage on the Add record is set to the date the employer size indicator changed. If employer size indicator changes from 20 employees or greater to less than 20 or employer size decreases from 100 employees or greater to less than 100, any previously reported records **previously accepted with a '01' disp code** must have an update transaction submitted to terminate the existing record and an add transaction must be submitted to reflect the new employer size indicator. The effective date used in the add transaction is not the date the employer size change actually occurred but rather it must be equal to the date Medicare becomes secondary under the Working Aged or Disability provisions if employer size is increasing, or the date Medicare becomes primary under the Working Aged or Disability provisions if employer size is decreasing. The Termination Date used will always be the day before the Effective Date as calculated for the change in the employer size indicator.

When RREs are creating their initial files for Section 111 reporting, they must report coverage retroactively back to January 1, 2009. If there are changes to employer size indicator from this date to the current reporting timeframe, an RRE may need to send multiple Add records with associated Effective and Termination Dates on the initial file for one individual to reflect different categories of employer size during the coverage period if applicable. In addition, the first time you report on an Active Covered Individual you may have to report multiple records of GHP coverage if there are multiple associated employer size indicators for the coverage period being reported.

Other notes:

Throughout this explanation of reporting employer size and the examples provided, we have stressed that the RRE needs only submit Update records reflecting the last day of a particular employer size indicator in the termination date for records previously accepted with a '01' disposition code. In most cases, when an RRE submits a record reflecting coverage for a Medicare beneficiary entitled to Medicare due to age with an Employer Size of '0', the record will be returned with an 'SP' disposition code and the SPES error code since Medicare is primary, not secondary, and the BCRC did not create an MSP occurrence. Likewise, if the Medicare beneficiary is entitled due to disability and the Employer Size reported is '0' or '1', a disposition code of 'SP' and the error code of SPES will be returned. If the Employer Size indicator value increases, RREs are required to send Add records for these individuals again even though they were previously sent and rejected. The new Add records should reflect the new Employer Size indicator and the Effective Date should be reported as the later of the change to the Employer Size indicator or the individual's GHP effective date. The reason for a Medicare beneficiary's entitlement may change so it is recommended that at the point of an employer size indicator change, the RRE resubmit previously rejected Add records for all Active Covered Individuals that are Medicare beneficiaries for reconsideration of MSP.

In general, Effective Dates (Field 10) reported on all Add records should reflect the **later** of the effective date of the Active Covered Individual's GHP coverage and the effective date of the employer size indicator.

As stated elsewhere in this guide, RREs are only required to report Active Covered Individuals that are Medicare beneficiaries on the MSP Input File. RREs may either use the definition of Active Covered Individuals and the associated age thresholds to report; or query Active Covered Individuals first and only report those that are found to be Medicare beneficiaries.

Reporting an Employer Size Change – Example 5:

An employer had 40 employees for all of 2009. The RRE submitted Add records for the employees and dependents that were Active Covered Individuals and Medicare beneficiaries and 5 of these records received a '01' disposition code meaning that the BCRC created MSP occurrences for them to indicate that Medicare was the secondary payer. All of these individuals were entitled to Medicare due to age (worked aged).

During 2009, this employer employed 20 or more employees for the entire year. Based upon the fact that the employer employed 20 or more employees for all of 2009, we know that the GHP will be the primary payer of benefits under the Working Aged provision for GHP coverage in all of 2010. On these original Add records, the employer size was submitted with a value equal to '1' meaning 20 to 99 employees.

On 1/31/2010, the employer terminated 25 employees, making their total number of employees 15. If these terminations ended the GHP coverage for any of the individuals for whom records were previously submitted and accepted with a '01' disposition code, the RRE must submit Update records for them on their next quarterly update MSP Input File with the corresponding Termination Date. The update transaction should include the following data elements: the Transaction Type = 2 (Update), the Employer Size = 1 (the value entered on original submission), the Termination Date = 01/31/2010, the last day of GHP coverage prior to the termination. All other fields should match the values that were sent on the original Add record. No further reporting will be required on these individuals since they are now not considered Active Covered Individuals unless their status changes at a later date.

Since the GHP remains the primary payer under the Working Aged provision for the remainder of calendar year 2010, the employer size indicator remains the same and an update transaction should not be submitted for the remaining Active Covered Individuals until the employer size indicator is re-evaluated as of 1/1/2011. At this point, the RRE will determine how many employees were employed for at least 20 weeks during the calendar year and submit any required update transactions to reflect changes made to the employer size indicator.

On 1/1/2011, the RRE determined that the number of employees for this employer remained under 20 for the remainder of 2010. Since the employer did not employ 20 or more employees for 20 or more weeks in 2010 (the prior calendar year) or yet in 2011 (the current calendar year), Medicare is primary to the GHP under the Working Aged provision starting 1/1/2011. Therefore, the effective date of the change in employer size is 1/1/2011 (**not** 1/31/2010). The employer size indicator changes to '0' as of 1/1/2011. The RRE should submit update transactions for any of the Active Covered Individuals for whom GHP coverage continues and whose records were previously submitted and accepted with a '01' disposition code on their next quarterly update MSP Input File.

The update transaction should include the following data elements:

- Transaction Type = '2' (update)
- Employer Size = '1' (the value entered on original Add record)
- Termination Date = 12/31/2010 (the last day that the GHP was the primary payer or the last day the employer size indicator was calculated to be 20-99 employees)
- All other fields should match the values that were sent on the original Add record.

The RRE should also submit add transactions for these same individuals and any new Active Covered Individuals to report the change in the employer size indicator effective 1/1/2011. The add transaction should include the following data elements:

- Transaction Type = '0' (add)
- Employer Size = '0' (the new value—employer with 1-19 employees), the Effective Date = 1/1/2011 (the date the new employer size indicator change became effective)
- All other fields should be submitted with the RRE's most current information.

Most of these Add records are likely to be returned with an 'SP' disposition code and error of 'SPES' if the beneficiaries are entitled to Medicare due to age or disability due to the new employer size of less than 20 employees. However, it is advisable to submit these records just in case the reason for entitlement for any of these individuals has changed.

Reporting an Employer Size Change – Example 6:

In early 2010, an RRE submitted Add records for all of the Active Covered Individuals who were Medicare beneficiaries covered by a certain employer GHP, which were accepted by the BCRC and returned with a '01' disposition code. The employer had 80 employees for all of 2009 so when the Add records were submitted, the Employer Size field was submitted with a value of '1' on each record meaning 20 to 99 employees.

The GHP for the employer was not a multi-employer or multiple employer plan, thus the GHP was the primary payer of benefits under the Working Aged provisions and Medicare was the primary payer of benefits under the Disability provisions of MSP. On 1/1/2011, the RRE determined that the number of employees for this employer remained 80 for all of 2010. Since Medicare remains the primary payer of benefits under the Disability provisions of MSP and the GHP remains the primary payer under the Working Aged provisions, no change is made to the

employer size indicator as of 1/1/2011 and therefore no update transactions are required to previously posted records.

On November 1, 2011, the employer purchased another company that had 30 employees. With the purchase, the total number of employees at the company is 110. The new employees were not eligible for GHP coverage. On 1/1/2012, the RRE calculated the number of employees for the previous calendar year and determined that although the company now has 100 or more employees, Medicare remains the primary payer of benefits under the Disability provisions of MSP because the employer did not have 100 or more employees on 50% or more of its regular business days during the preceding calendar year, 2011. No change is made to the employer size indicator as of 1/1/2012 and no update transactions are required to previously posted records.

During calendar year 2012, no change was made to employer size. On 1/1/2013, the RRE calculated the number of employees for the previous calendar year (2012) and determined that the employer had 100 or more employees for all of 2012. The effective date of the change to the employer size indicator is 1/1/2013 per MSP regulations, not 11/1/2011 when the new employees were actually added to the company. Therefore, for the records previously submitted and accepted with a '01' disposition code which reflect continuing coverage under the GHP, the RRE must send both an update transaction and an add transaction to report the change in the Employer Size field on their next Quarterly Update MSP Input File. The update transaction would have a Termination Date of 12/31/2012, the last day Medicare would be primary under the Disability provisions which is the last day the employer size indicator was '1'. The add transaction would reflect an Effective Date of 01/01/2013 and the Employer Size value submitted would be '2' meaning 100 or more employees. As of 01/01/2013, Medicare would be the secondary payer under the Working Aged and Disability provisions of MSP. Both the update and add transactions should be submitted on the first Quarterly Update MSP Input File in 2013.

The Update record for each affected record will include the following data elements:

- Transaction Type = '2' (update)
- Employer Size = '1' (the value entered on original submission)
- Termination Date = 12/31/2012 (the last day Medicare is primary under Disability MSP)
- All other fields should match the values that were sent on the original record.

The Add record will include the following data elements:

- Transaction Type = '0' (add)
- Employer Size = '2' (the new value—used for an employer with 100 or more employees)
- Effective Date = 01/01/2013 (the first day the GHP is primary under the Disability provisions of MSP. This is the day after the termination date of the Update record and reflects when the employer size indicator changed to '2'.)
- All other fields should be submitted with the RRE's most current information.

Reporting an Employer Size Change – Example 7:

Suppose an RRE previously submitted Add records for 40 Active Covered Individuals who are Medicare beneficiaries for a particular GHP. On the original Add records, the Employer Size was entered with a value of '1' reflecting 20 to 99 employees. 39 of the original Add records were accepted with a '01' disposition code because these were beneficiaries entitled to Medicare due to age. However, the Add record for Jane Smith was rejected with an 'SP' disposition code and SPES error because Jane Smith was entitled to Medicare due to Disability and the Employer Size reported is less than 100.

During 2009, this employer hired an additional 100 employees who were employed for more than 50% of its business days in 2009. Based upon the fact that the employer employed 100 or more employees for 50% or more of its regular business days in 2009, we know that the GHP will now be the primary payer of benefits for Ms. Smith under the Disability provision for her GHP coverage during all of 2010. The employer size indicator changes from '1' to '2' as of 1/1/2010.

On the file submission for the First Quarter of 2010, the RRE should submit an Update record for each of the 39 records previously accepted with a '01' disposition code that is still open (hasn't already been updated with a Termination Date). An Update record is not required for Ms. Smith because the original Add record that was submitted for her was not accepted with a '01' disposition code.

The Update records should include the following data elements:

- Transaction Type = '2' (update)
- Employer Size = '1' (the value entered on original submission)
- Termination Date = 12/31/2009
- All other fields should match the values that were sent on the original record.

The RRE should also submit add transactions for all of those 39 individuals previously reported and accepted. These Add records will document the effective date of the new Employer Size indicator. In addition, the RRE must submit Add records for any new Active Covered Individuals that were added to the plan since the last file was submitted. Lastly, the RRE should submit an Add record for Ms. Smith since she is still an Active Covered Individual who is a Medicare beneficiary and now, due to the new Employer Size indicator, her GHP coverage will be primary to Medicare. In other words, the RRE should be submitting Add records for all Active Covered Individuals that are Medicare beneficiaries to report the new value in the Employer Size indicator. These Add records must have an effective date of 1/1/2010 which reflects when the employer size indicator changed.

The Add records will include the following data elements:

- Transaction Type = '0' (add)
- Employer Size = '2' (the new value—used for an employer with 100 or more employees)
- Effective Date = 01/01/2010 (or for newly covered individuals, the effective date of GHP coverage if later)
- All other fields should be submitted with the RRE's most current information.

Reporting an Employer Size Change – Example 7a:

Given the same conditions as given in Example 7 directly above, suppose that one of the new Active Covered Individuals for which the RRE needs to report in first quarter 2010 was hired November 23, 2009 and her GHP coverage was effective on that date (11/23/2009). Also suppose the RRE's file submission timeframe is the first week of the second month of each quarter so a record for this individual was not submitted in the RRE's fourth quarter 2009 MSP Input File. When the RRE initially reports the GHP coverage for this person in its first quarter 2010 MSP Input File, since the GHP coverage to be reported for this person spans a period of time with two different employer size indicators, two Add records must be submitted, one to reflect the employer size indicator of '1' for the coverage prior to 1/1/2010 and the other to reflect the employer size indicator of '2' for the coverage that continues 1/1/2010 and subsequent.

The first Add record will include the following data elements:

- Transaction Type = '0' (add)
- Employer Size = '1' (20 to 99 employees—the employer size indicator in effect 11/23/2009–12/31/2009)
- Effective Date = 11/23/2009 (start of the individual's GHP coverage)
- Termination Date = 12/31/2009 (last date the employer size indicator of 1 applies)

The second Add record will include the following data elements:

- Transaction Type = '0' (add)
- Employer Size = '2' (100 or more – the employer size indicator in effect 1/1/2010 and subsequent)
- Effective Date = 1/1/2010 (effective date of the employer size indicator change)

Reporting an Employer Size Change – Example 8:

Suppose an RRE previously submitted Add records for 10 Active Covered Individuals for a particular GHP with an Employer Size value equal to 0 meaning 1 to 19 employees. This employer did not employ 20 or more employees for 20 or more weeks in 2008 so Medicare must be primary to GHP coverage at the start of 2009. The BCRC determined that Medicare is primary rather than secondary for the coverage reported on these 10 Add records and returned an 'SP' disposition code and an SPES error code on each corresponding response record.

On January 5th, 2009, this employer hired an additional 10 employees who worked for 20 or more calendar weeks in 2009. These weeks happened to be consecutive in this example although that is not required under the 20 week rule. Starting week 20 of 2009 (May 18, 2009), the GHP became primary payer under the Working Aged provision and remains primary for the remainder of GHP coverage in 2009 because the 20 or more employee threshold was met as of this date. Remember, as soon as the 20-employee threshold is met, Medicare becomes the secondary payer under the Working Aged provision for the remainder of that year and through the next year. As of 5/18/2009, the employer size indicator changes from a value of '0' to a value of '1.'

In the RRE's second quarterly submission, they must submit add transactions for all Active Covered Individuals in the plan. It is important that the Effective Dates reported are 5/18/2009 or the effective date of a particular individual's GHP coverage if that is **after** 5/18/2009. This will ensure that the BCRC creates an MSP occurrence starting at the date that Medicare becomes the secondary payer. Update records are not required since no previously submitted record was accepted with a '01' disposition code.

The Add records will include the following data elements:

- Transaction Type = '0' (add)
- Employer Size = '1' (the new value—used for an employer with 20-99 employees)
- Effective Date = 05/18/2009 (or the effective date of the individual's GHP coverage if later)
- All other fields should be submitted with the RRE's most current information.

Initial Reporting When Employer Size Reaches 20 and Employer is Not Part of a Multi-Employer/Multiple Employer Plan

As stated previously in this guide, if an employer has less than 20 full and/or part-time employees as defined in 42 C.F.R. Part 411.101 and 42 C.F.R. Part 411.170, and the employer is not part of a multi-employer/multiple employer GHP, then the covered individuals under that plan do not have to be reported under Section 111 unless a covered individual is receiving dialysis or has had a kidney transplant (ESRD). However, records for all Active Covered Individuals in these plans may be submitted with the proper value in the Employer Size (Field 16). If reported and the BCRC determines that MSP does not exist, then an SPES error code will be returned as explained in Section 9.2.1.

If coverage was not previously reported for any individuals due to the employer size being less than 20 employees, and subsequently the number of employees increases to 20 or more, the affected covered individuals must be reported on Add records if they meet the other requirements to be included on the MSP Input File. When these Add records are submitted, you must use the later of the effective date of the new employer size indicator or the individual's GHP coverage effective date in Field 10 (Effective Date) of the MSP Input File Detail Record rather than simply the effective date of the individual's GHP coverage. This will ensure that the BCRC creates an MSP occurrence starting at the date that Medicare becomes the secondary payer.

Appendix H Unsolicited MSP Response File Specifications

Unsolicited MSP Response File Header Record

Table H-1: Section 111 GHP Unsolicited MSP Response File Header Record—600 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Header Type Code	4	1-4	Alpha-numeric	Contains a value of 'USOH'.
2.	RRE ID	9	5-13	Numeric	Section 111 RRE ID.
3.	File Type	4	14-17	Alpha-numeric	Contains a value of 'USOL'.
4.	File Date	8	18-25	Numeric Date	Date file created by the BCRC. (CCYYMMDD format).
5.	Filler	575	26-600	Alpha-numeric	Not Used. Filled with spaces.

Unsolicited MSP Response File Detail Record

Table H-2: Section 111 GHP Unsolicited MSP Response File Detail Record—600 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Transaction Type	4	1-4	Alpha-numeric	'USOL'
2.	Medicare ID	12	5-16	Alpha-numeric	Most current Medicare Beneficiary Identifier (MBI) or most current Medicare ID (Health Insurance Claim Number [HICN]). **Note:** The MBI is also known as the Medicare Number to CMS' Medicare beneficiaries.
3.	Beneficiary Surname	6	17-22	Text	First 6 characters of the beneficiary's last name.
4.	Beneficiary First Initial	1	23-23	Text	First letter of the beneficiary's first name.
5.	Beneficiary Date of Birth	8	24-31	Numeric Date	Date of birth of the Beneficiary. (CCYYMMDD format).
6.	Beneficiary Sex Code	1	32-32	Alpha-numeric	Beneficiary Gender Code
7.	Interested Party DCN	15	33-47	Text	Most recent Document Control Number successfully submitted by the interested party RRE on its MSP Input File. Use this field to assist in matching the Unsolicited MSP Response Detail Record to your previously submitted coverage records.
8.	Filler	2	48-49	Alpha-numeric	Not Used. Filled with spaces.
9.	Last Transaction Type	1	50-50	Alpha-numeric	Last action performed on the MSP occurrence by the BCRC based on information from the entity identified in the Modifier Type Code and Modifier Name (Fields 33 and 34). Values: '0' = Update '1' = Delete
10.	Entitlement Reason	1	51-51	Alpha-numeric	Reason for beneficiary's Medicare Entitlement: Values: 'A' = Aged 'B' = ESRD 'G' = Disabled

Field	Name	Size	Displacement	Data Type	Description
11.	Coverage Type	1	52-52	Alpha-numeric	Type of insurance coverage reflected on the MSP occurrence. Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'R' = Health Reimbursement Arrangement (HRA) 'U' = Drug Only (network Rx) 'V' = Drug Only (non-network Rx) 'W' = Comprehensive Coverage – Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Prescription Drug Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage – Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx)
12.	Insurer's Name	32	53-84	Text	Name of the most current insurer/TPA Medicare has associated with the MSP occurrence.
13.	Insurer's Address 1	32	85-116	Text	Address Line 1 for the most current insurer/TPA Medicare has associated with the MSP occurrence.
14.	Insurer's Address 2	32	117-148	Text	Address Line 2 for the most current insurer/TPA Medicare has associated with the MSP occurrence.
15.	Insurer's City	15	149-163	Text	City for the most current insurer/TPA Medicare has associated with the MSP occurrence.
16.	Insurer's State	2	164-165	Alpha	State for the most current insurer/TPA Medicare has associated with the MSP occurrence.

Field	Name	Size	Displacement	Data Type	Description
17.	Insurer's Zip Code	9	166-174	Alpha-numeric	ZIP Code for the most current insurer/TPA Medicare has associated with the MSP occurrence.
18.	Filler	9	175-183	Alpha-numeric	Not Used. Filled with spaces.
19.	MSP Effective Date	8	184-191	Numeric Date	Effective Date of the MSP occurrence posted on the Medicare CWF.
20.	MSP Termination Date	8	192-199	Numeric Date	End date of the MSP occurrence posted on the Medicare CWF. * All zeros if open-ended (i.e., if coverage is not terminated).
21.	Relationship Code	2	200-201	Alpha-numeric	Covered Individual's Relationship to Active Employee: Values: '01' = Covered Individual is Active Employee '02' = Spouse or Common Law Spouse '03' = Child '20' = Domestic Partner '04' = Other Family Member
22.	Policy Holder's First Name	9	202-210	Text	Active Employee's/Subscriber's First Name Medicare has associated with the MSP occurrence.
23.	Policy Holder's Last Name	16	211-226	Text	Active Employee's/Subscriber's Last Name Medicare has associated with the MSP occurrence.
24.	Policy Holder's SSN	12	227-238	Alpha-numeric	Subscriber/Employee SSN Medicare has associated with the MSP occurrence. May contain all spaces if none was supplied by an RRE or other entity.
25.	Employer's Name	32	239-270	Text	Name of the most current employer or other plan sponsor Medicare has associated with the MSP occurrence.
26.	Employer's Address 1	32	271-302	Text	Address Line 1 of the most current employer or other plan sponsor Medicare has associated with the MSP occurrence.

Field	Name	Size	Displacement	Data Type	Description
27.	Employer's Address 2	32	303-334	Text	Address Line 2 of the most current employer or other plan sponsor Medicare has associated with the MSP occurrence.
28.	Employer's City	15	335-349	Text	City of the most current employer or other plan sponsor Medicare has associated with the MSP occurrence.
29.	Employer's State	2	350-351	Alpha	State Code of the most current employer or other plan sponsor Medicare has associated with the MSP occurrence.
30.	Employer's Zip Code	9	352-360	Alpha-numeric	ZIP Code of the most current employer or other plan sponsor Medicare has associated with the MSP occurrence.
31.	Group Policy Number	20	361-380	Text	Group number Medicare has associated with the MSP occurrence.
32.	Individual Policy Number	17	381-397	Text	Individual policy number Medicare has associated with the MSP occurrence.
33.	Modifier Type Code	3	398-400	Alpha-numeric	Code identifying the type of entity that last changed the MSP occurrence.
34.	Modifier Name	32	401-432	Text	Modifier Name/Description of the last entity that changed the MSP occurrence.
35.	Change Reason Code	2	433-434	Alpha-numeric	Code identifying the reason for the last change to the MSP occurrence (if known).
36.	Last Update Applied Date	8	435-442	Numeric Date	Date the BCRC last changed the MSP occurrence. (CCYYMMDD format).
37.	Current Medicare Part D Plan Contractor Number	5	443-447	Alpha-numeric	Contractor Number of the Medicare Part D Plan.
38.	Current Medicare Part D Enrollment Date	8	448-455	Numeric Date	Effective Date of coverage provided by Medicare Part D Plan (CCYYMMDD).
39.	Current Medicare Part D Termination Date	8	456-463	Numeric Date	Termination Date of coverage Medicare Part D Plan (CCYYMMDD).

Field	Name	Size	Displacement	Data Type	Description
40.	Part D Eligibility Start Date	8	464-471	Numeric Date	Earliest date that beneficiary is eligible to receive Part D Benefits – Refer to Field 38 for Part D Plan Enrollment Date (CCYYMMDD).
41.	Part D Eligibility Stop Date	8	472-479	Numeric Date	Date the beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 39 for Part D Plan Termination Date (CCYYMMDD).
42.	Filler	14	480-493	Alpha-numeric	Not used. Filled with spaces.
43.	Current Medicare Part A Entitlement Date	8	494-501	Numeric Date	Effective Date of Medicare Part A Coverage. (CCYYMMDD format).
44.	Current Medicare Part A Termination Date	8	502-509	Numeric Date	Termination Date of Medicare Part A Coverage (CCYYMMDD format). *All zeros if open-ended (i.e., if coverage is not terminated).
45.	Current Medicare Part B Entitlement Date	8	510-517	Numeric Date	Effective Date of Medicare Part B Coverage. (CCYYMMDD format).
46.	Current Medicare Part B Termination Date	8	518-525	Numeric Date	Termination Date of Medicare Part B Coverage (CCYYMMDD format). *All zeros if open-ended (i.e., if coverage is not terminated).
47.	Current Medicare Part C Plan Number	5	526-530	Alpha-numeric	Contractor Number of the current Medicare Part C Plan in which the beneficiary is enrolled.
48.	Current Medicare Part C Entitlement Date	8	531-538	Numeric Date	Effective Date of coverage provided by current Medicare Part C Plan. (CCYYMMDD format).
49.	Current Medicare Part C Termination Date	8	539-546	Numeric Date	Termination Date of coverage provided by current Medicare Part C Plan. (CCYYMMDD format). *All zeros if open-ended (i.e., if coverage is not terminated).
50.	Rx Insured ID	20	547-566	Text	Insured's Identification Number for prescription drug coverage.
51.	Rx Group Number	15	567-581	Text	Group Number for prescription drug coverage.
52.	Rx PCN	10	582-591	Text	Rx Processor Control Number.

Field	Name	Size	Displacement	Data Type	Description
53.	Rx BIN	8	592-599	Numeric	Benefit Identification Number for Rx processing.
54.	Filler	1	600-600	Alpha-numeric	Not Used. Filled with spaces.

Unsolicited MSP Response File Trailer Record

Table H-3: Section 111 GHP Unsolicited MSP Response File Trailer Record—600 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Type Code	4	1-4	Alpha-numeric	Contains a value of 'USOT'.
2.	RRE ID	9	5-13	Numeric	Section 111 RRE ID.
3.	File Type	4	14-17	Alpha-numeric	Contains a value of 'USOL'.
4.	File Date	8	18-25	Numeric Date	Date file created by the BCRC (CCYYMMDD format).
5.	File Record Count	9	26-34	Numeric	Number of response detail records contained in this file. Does not include the header and trailer records in the count. Will contain a value of all zeros if there were no Unsolicited MSP Response records to transmit to the RRE for the month.
6.	Filler	566	35-600	Alpha-numeric	Not Used. Filled with spaces.

Appendix I HEW Installation and Configuration

About the Latest HEW Software

To support RREs that provide primary prescription drug coverage, the HEW application has been modified to accept new prescription drug coverage information in an GHP 271 X12 file, which will then convert and include the new data in the fixed-length S111 Query Response flat file.

Changes for Version 5.0.0

- Prior versions of HEW only had one input/output directory for all the format types. In this release, the directories have been created separately (Figure I-8) so you can configure the query file paths individually.
- The log file used to be overwritten every time HEW was run. With this version, the log file is never overwritten. New entries are appended to the end of the file.
- This version (not previous versions) can now be automated (see Command Line Process for details).

Installation

The following describes the steps for installing and configurating the latest HEW software on the Windows platform. For details regarding the HEW file specifications see Appendix B.

1. To download the program, log in to the Section 111 application at https://www.cob.cms.hhs.gov/Section111/
2. Select the HEW Software Download from the *Reference Materials* menu to download the .exe file to your desktop.
3. Click the HEW .exe file to begin the automatic installer, following the screen prompts (Figure I-1).

   Note: It is important to select the correct install option (Figure I-2). If in doubt, select *Everyone*.
4. Click Next to confirm the installation (Figure I-3).
5. Click Close to exit (Figure I-4).

   An icon for the HEW application is installed on your desktop and in the Windows menu (Figure I-5).

Figure I-1: Welcome to HEW Setup Wizard

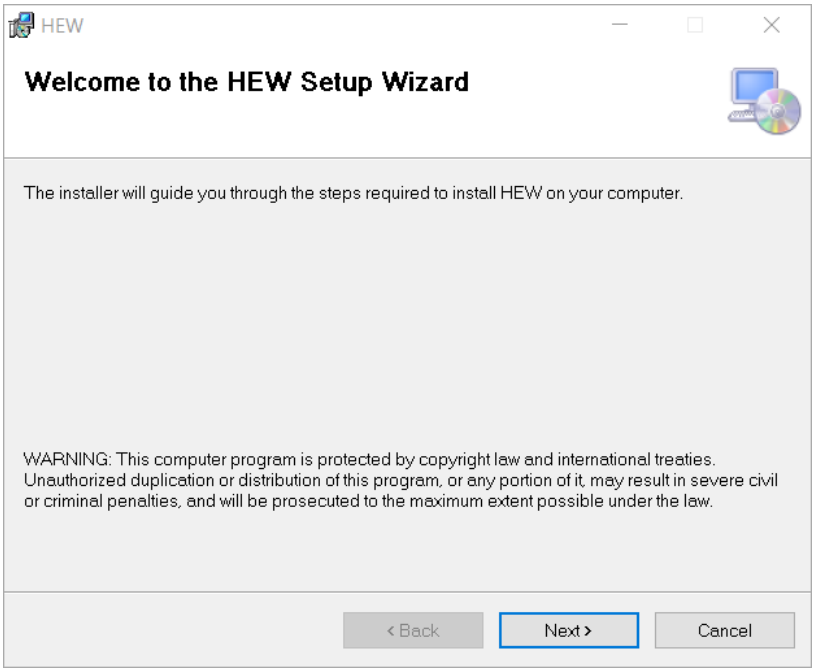


Figure I-2: Select Installation Folder

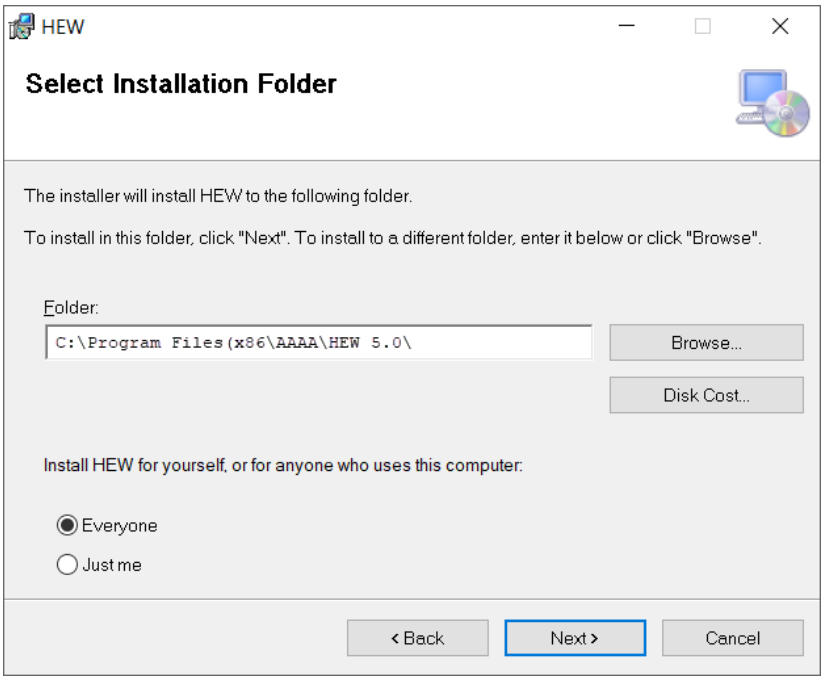


Figure I-3: Confirm Installation

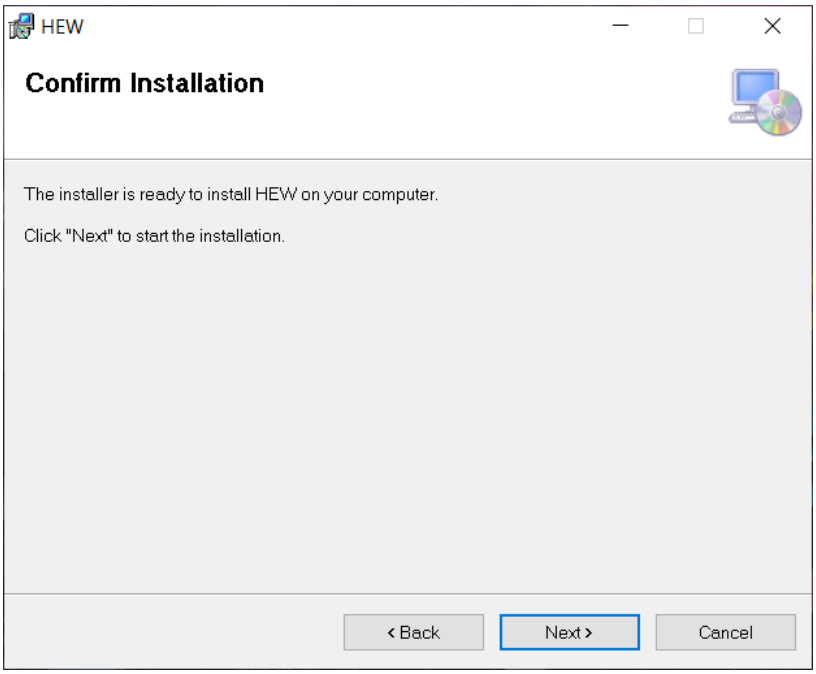


Figure I-4: Installation Complete

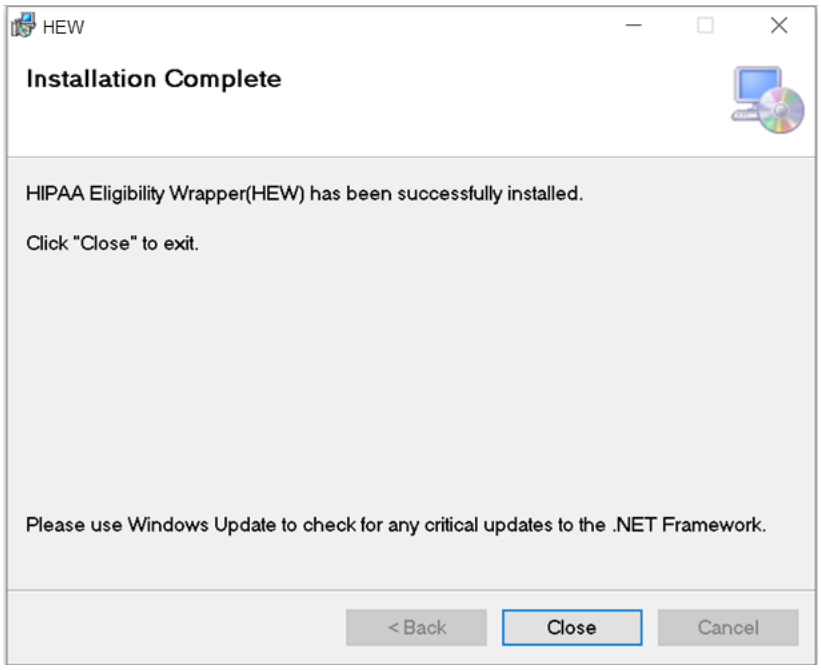


Figure I-5: Desktop Icons (Old and New)

Settings

Once you launch HEW, you can then specify your application settings. To open the *Settings* menu:

1. Click the HEW application icon to launch the program.
2. Click the **Settings** icon or select *Settings* from the *File* menu.

   The *HEW Settings* menu appears (Figure I-8).

Figure I-6: Menus and Icons

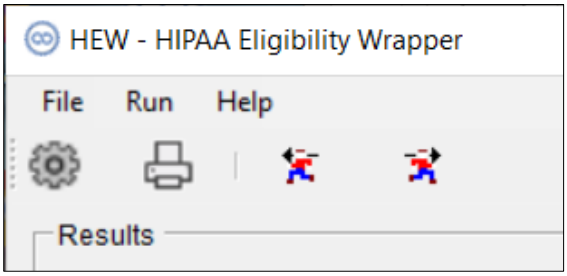


Table I-1: Menus and Icons

Item	Description
Menus	Options include:
File	Settings, Print, and Exit
Run	271 Inbound and 270 Outbound
Help	Contents (Help) and About (Version, Copyright, and Warning)
Icons	Functions:
Settings	Opens the *Settings* menu
Print	Prints results shown in *Results* panel
Run 271 Inbound	Runs the 271 Inbound query
Run 270 Outbound	Runs the 270 Outbound query

Figure I-7: File Settings

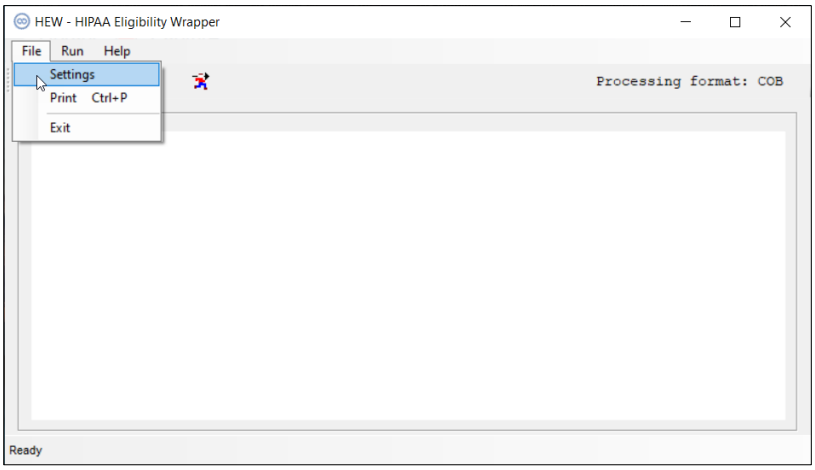
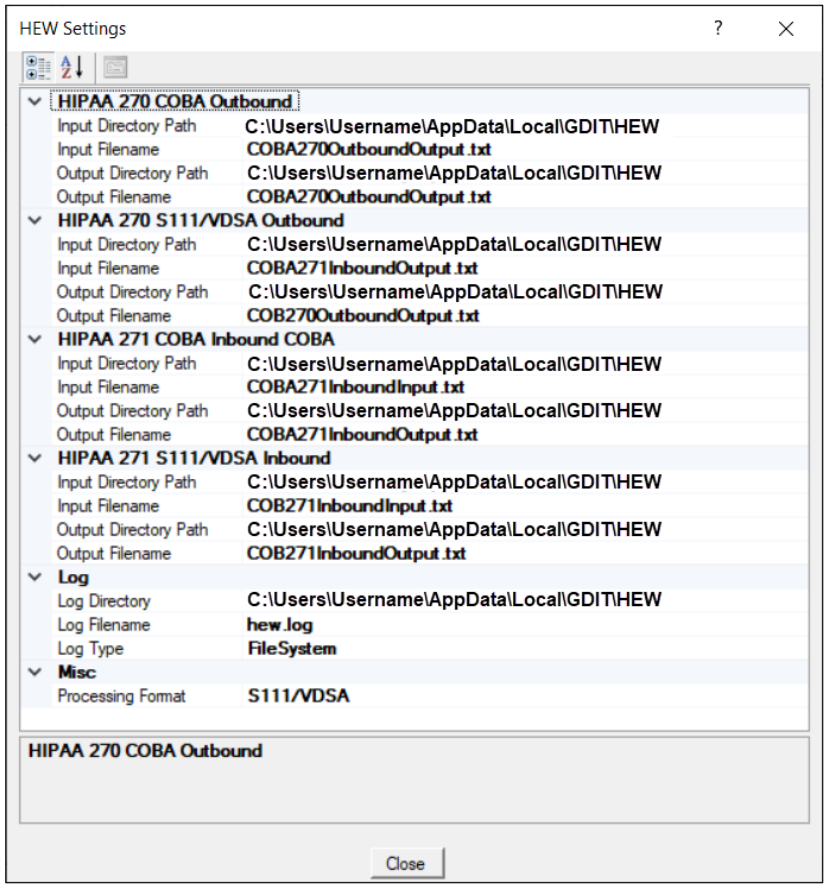


Figure I-8: HEW Settings



Changing Settings

From the *Settings* menu, you can change the defaults for the input and output directory paths, log type, and processing format.

- To change the destination of a selected directory, click an Input Directory Path, Output Directory Path, or Log Directory and then click the three-dot menu icon (…) to select a different folder location (Figure I-9).
- To change the processing format (i.e., S111/VDSA or COBA), double-click Processing Format under Misc. and select a different format from the drop-down menu (Figure I-10).
- To change the log type (Event Viewer, File System, or Both), double-click Log Type and select a different log type from the drop-down menu (Figure I-11).

Notes:

The directories can be located anywhere and mapped to any drive. However, if you plan to use the command line mode and you specify a network location, make sure the drive is mapped or available **before** executing the application.

If you select the log type *Event Viewer* or *Both* option, you will be prompted to verify that you would like to create a new Event Viewer source. Click **Yes** and follow the remaining screen prompts.

Figure I-9: Changing Directory Path

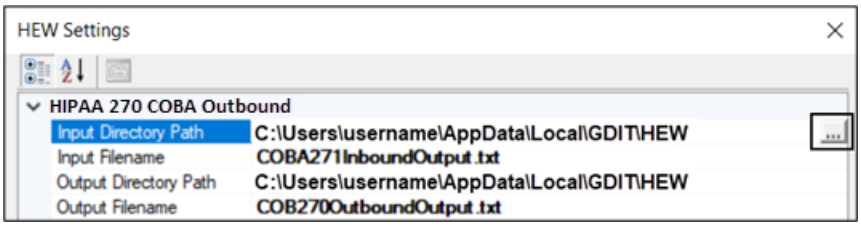


Figure I-10: Changing Processing Format

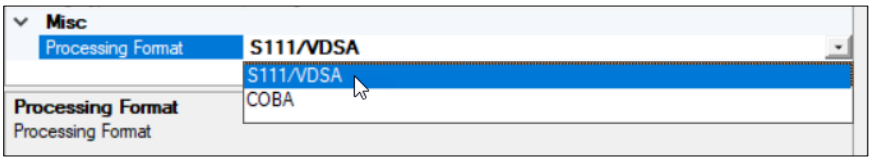
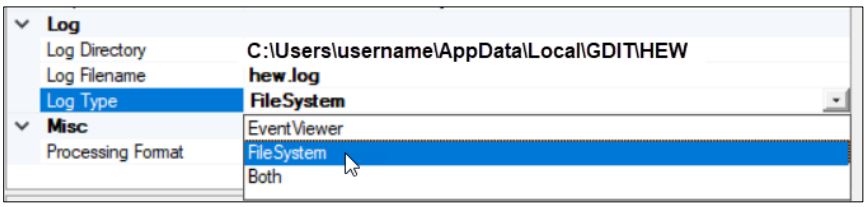


Figure I-11: Changing Log Type



Running Reports

Once you have mapped your drives, and have configured your settings (or have accepted the defaults), you can run your queries any time. Clicking the **Run 271 Inbound** button, for example, will display the input file results and location corresponding to the settings specified in the *Settings* menu. To cancel the processing, click **Stop**.

Pre-Processing Input Files

For Inbound files, the input files are pre-processed to ensure the file is properly formatted (i.e., each line is exactly 80 characters). If errors are detected, processing stops and the issues found are listed (Figure I-13).

For files that complete processing successfully, the last line of the results includes the command line argument options that can be used to automate the process just completed (Figure I-14).

Figure I-12: In Process Inbound 271 S111/VDSA Query (Example)

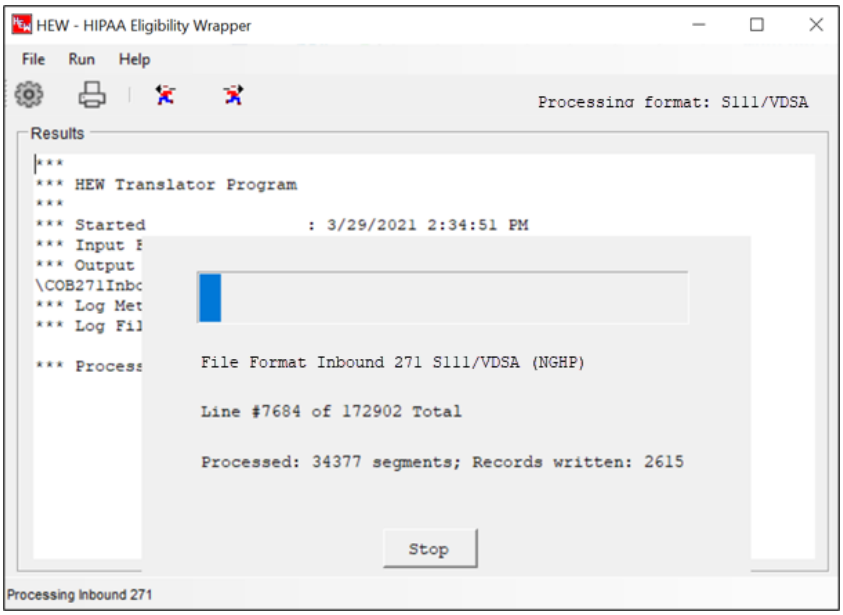


Figure I-13: Pre-Processing Errors (Example)

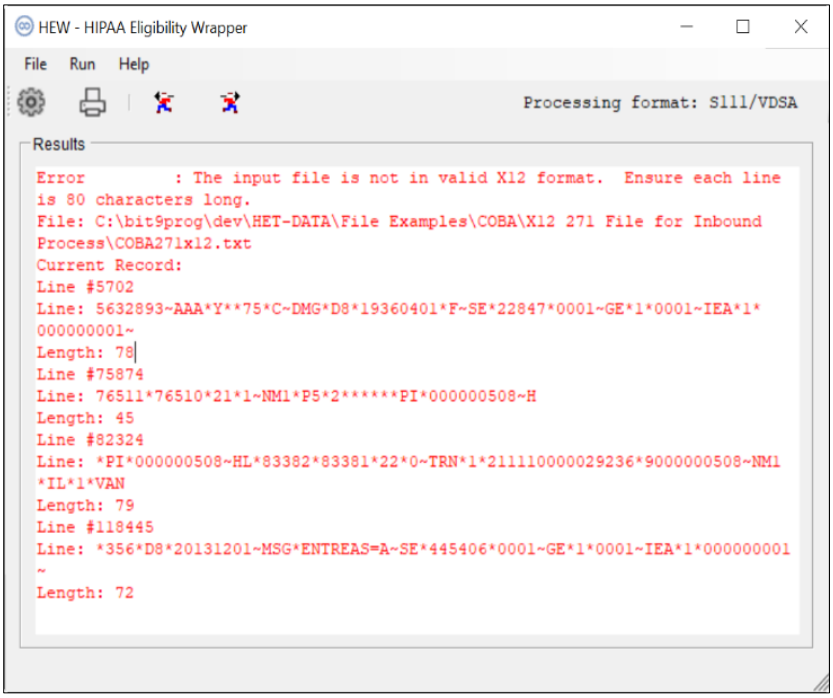
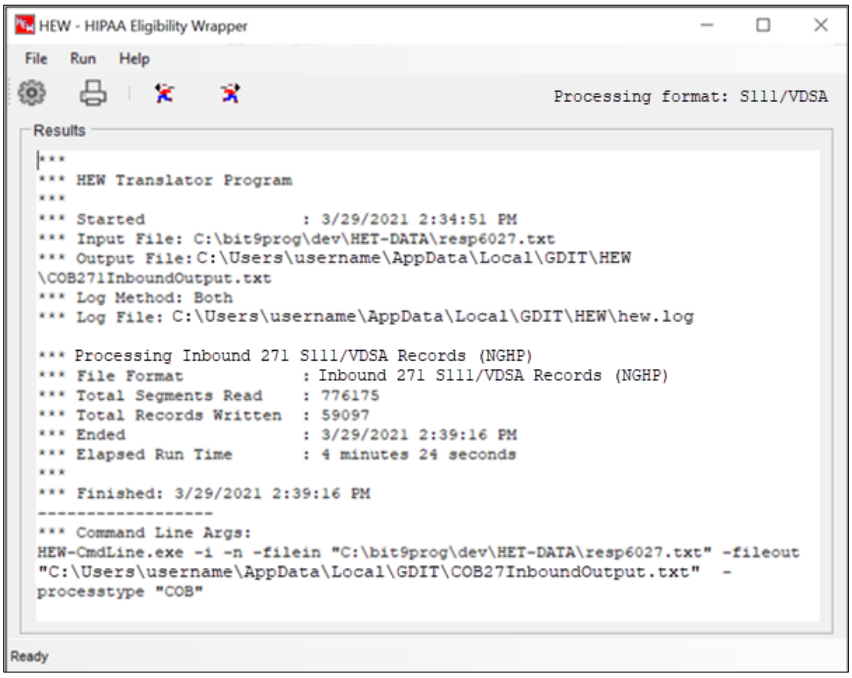


Figure I-14: Completed Inbound 271 S111/VDSA Query (Example)



Error Files

In addition to pre-processing inbound files to check formats, if other errors occur during processing, an error file is created. The name of the file is the same as the input with the extension of .ERR and is stored in a sub-directory of the input file location and is named ERRORS. The format of the file is JavaScript Object Notation (JSON) and contains 4 fields per error record.

- FIELD 1: “ErrId”—Unique numeric identifier for each error record
- FIELD 2: “Segment”—The complete record segment in which the error occurred
- FIELD 3: “ErrSegment”—The part of the Segment in FIELD 2 that caused the error
- FIELD 4: “ErrMsg”—The error message that was generated during processing

If errors occur, the processing will continue but will not output a results file. Instead, the errors will be displayed in the results screen in red text (Figure I-16) and logged in the error file.

Figure I-15: Error File (Example)


```
{
  "$schema": "json-schemaErrors.json#",
  "InputFilename": "NGHP271x12.txt",
  "allerrors": [
    {
      "ErrId": 1,
      "Segment": "HL*70129**20*1~N031",
      "ErrSegment": "N031",
      "ErrMsg": "Incorrect/Unknown Segment"
    },
    {
      "ErrId": 2,
      "Segment":
"HL*132183*132182*22*0~TRN*1*211120000159380*9000030783~NM1*IL*1*GIERCE*K~REF
*IG*448986892~REF*NQ*250011171926302~AAA*Y**75*C~DMG*D8*1952032079*21*1",
      "ErrSegment": "DMG*D8*1952032079*21",
      "ErrMsg": "DMG03 - GenderCode must be 1 character. 21"
    }
  ]
}
```


Figure I-16: Results File with Processing Errors (Example)

File Run Help

Processing format: S111/VDSA

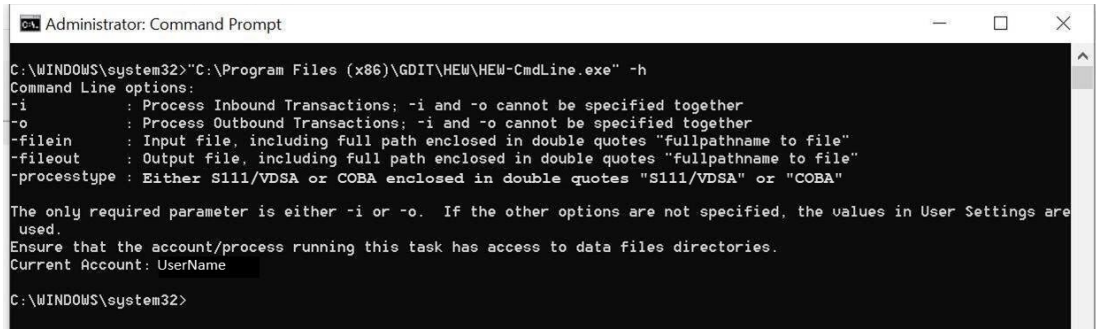
Results

```
***
*** HEW Translator Program
***
*** Started                : 4/27/2021 1:06:54 PM
*** Input File: C:\bit9prog\dev\HET-DATA\NGHP271x12.txt
*** Output File: C:\bit9prog\dev\HET-DATA\NGHP271x12-OUT.txt
*** Log Method: FileSystem
*** Log File: C:\bit9prog\dev\HET-DATA\hew.log
*** Processing Inbound 271 S111/VDSA Records(GHP)
Error         : Incorrect/Unknown Segment
Current Record: HL*70129**20*1~N031
Segment - N031

Error         : DMG03 - GenderCode must be 1 character. 21
Current Record: DMG*D8*1962032079*21*1
Segment - DMG*D8*1962032079*21

*** File Format            : Inbound 271 S111/VDSA Records(GHP)
*** Total Segments Read    : 3482869
*** Total Records Written  : 312886
*** Ended                  : 4/27/2021 1:07:56 PM
*** Elapsed Run Time       : 1 minutes 1 seconds
***
*** Finished: 4/27/2021 1:07:56 PM
------------------
*** Command Line Args:
"C:\Users\todd.bannar\OneDrive - GDIT\Documents\Visual Studio
Projects\HEW2\HEW\bin\Debug\HEW-CmdLine.exe" -i -filein "C:
\bit9prog\dev\HET-DATA\NGHP271x12.txt" -fileout "C:\bit9prog\dev
\HET-DATA\NGHP271x12-OUT.txt"  -processtype "S111VDSA"

*** Errors occurred while processing. ***
Therefore, no output file was created.  The error details were
logged and can be viewed here:
C:\bit9prog\dev\HET-DATA\ERRORS\NGHP271x12.ERR
```

Command Line Process

To launch HEW from a command line interface, open a command prompt and enter HEW-CmdLine.exe. Then enter "-h" to view the command line argument options.

Figure I-17: Command Line Mode and Options



About Process Automation

For version 5.0.0, but not previous ones, the Command Line process can be automated by using the Windows(10) Task Scheduler. Keep the following points in mind when attempting to automate:

- By default, the data and error files are stored in the user's APPDATA directory: C:\Users\username\AppData\Local\GDIT\HEW
- If the default file to process in the configuration file does not contain a path, then it looks in the default data directory listed above.
- Regardless of where you install the software, make sure that you are pointing to the HEW-CmdLine.exe file.

The user or process running the Command Line process must have **full rights** to the directories listed above. If the process runs from the application or user interface but not the command line, try running the Command Line process with administrative privileges. Right-click the Command Line file and select Run as administrator. If an error does occur while running it via the command line, any errors should be written to the log file located in the default directory listed above (Figure I-15). If the log file does not contain any errors, but the file was not processed, it may mean the account from which you are running the command line does not have read/write permission to that directory. You can always open a command prompt with administrative rights, navigate to the directory and type in: hew.exe -on at the command prompt to see if there are any messages.

Command Line Examples:

Inbound 271 S111/VDSA

HEW-CmdLine.exe -i -filein “C:\bit9prog\dev\HET-DATA\Test.txt” -fileout “C:\Users\username\AppData\Local\GDIT\HEW\COB271InboundOutput.txt” -processtype “S111/VDSA”

Inbound 271 COBA

HEW-CmdLine.exe -i -filein “C:\bit9prog\dev\HET-DATA\Test.txt” -fileout “C:\Users\username\AppData\Local\GDIT\HEW\COBA271InboundOutput.txt” -processtype “COBA”

Outbound 270 S111/VDSA

HEW-CmdLine.exe -o -filein “C:\bit9prog\dev\HET-DATA\Test.txt” -fileout “C:\Users\username\AppData\Local\GDIT\HEW\COB270OutboundOutput.txt” -processtype “S111/VDSA”

Outbound 270 COBA

HEW-CmdLine.exe -o -filein “C:\bit9prog\dev\HET-DATA\Test.txt” -fileout “C:\Users\username\AppData\Local\GDIT\HEW\COBA270OutboundOutput.txt” -processtype “COBA”

Appendix J Alerts

Recent Alerts related to GHP Section 111 reporting are posted on, and may be downloaded from, the Section 111 web site: https://go.cms.gov/mirghp. To view older Alerts, click on the **Archive** link on the left-hand side of the page or https://go.cms.gov/MIRGHPArchive.

Appendix K Acronyms

The following table contains a list of acronyms related to Section 111. It includes abbreviations related to both GHP and Non-GHP (Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation) reporting.

Table K-1: Acronyms

Acronym	Description
ANSI	American National Standards Institute
ASCII	American Standard Code for Information Interchange
BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits Program
COBA	Coordination of Benefits Agreement
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COBSW	COB Secure Website
CRC	Commercial Repayment Center
CWF	Common Working File
DBA	Doing Business As…
DCN	Document Control Number
DES	Data Encryption Standard
DOB	Date of Birth
DOI	Date of Incident
E02	COBA Drug Coverage Eligibility
EBCDIC	Extended Binary Coded Decimal Interchange Code
EDI Rep	Electronic Data Interchange Representative
EGHP	Employer Group Health Plan
EIN (FEIN)	Employer Identification Number (Federal EIN)
ESRD	End Stage Renal Disease
FSA	Flexible Spending Account
GHP	Group Health Plan
HEW	HIPAA Eligibility Wrapper Software
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HICN	Health Insurance Claim Number
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
HTTPS	Hypertext Transfer Protocol over Secure Socket Layer

Acronym	Description
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IACS UID	Individuals Authorized Access to CMS Computer Services User Identification Number
ICHRA	Individual Coverage Health Reimbursement Arrangement
LGHPs	Large Group Health Plans
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MSP	Medicare Secondary Payer
NAIC	National Association of Insurance Commissioners Code
NDM	Network Data Mover
NCPDP	National Council of Prescription Drug Programs
NGHP	Non-Group Health Plan or Liability Insurance (including Self Insurance), No-Fault Insurance and Workers' Compensation
Non-MSP	Non-Medicare Secondary Payer
ORM	Ongoing Responsibility for Medicals
PDAR	Prescription Drug Assistance Request
PDC	Prescription Drug Coverage
PDI	Prescription Drug Inquiry
PIN	Personal Identification Number
PRA	Paperwork Reduction Act
RDS	Retiree Drug Subsidy
RRE ID	Responsible Reporting Entity Identification Number or Section 111 Reporter ID
RREs	Responsible Reporting Entities
Rx BIN	Prescription Benefit Identification Number
Rx PCN	Prescription Processor Control Number
SCHIP	State Children's Health Insurance Program
SEE	Small Employer Exception
SEP	Special Enrollment Period
SFTP	Secure File Transfer Protocol
SNA	Systems Network Architecture
SPD	Secondary Payer Development
SSH	Secure Shell
SSN	Social Security Number

Acronym	Description
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
TCP/IP	Transmission Control Protocol/Internet Protocol (Internet Protocol Suite)
TIN	Tax Identification Number
TPA	Third Party Administrator
TPOC	Total Payment Obligation to Claimant
TrOOP	True Out of Pocket
TrOOP Rx BIN/Rx PCN	TrOOP specific drug payment code
URL	Uniform Resource Locator (Website address)
VAN	Value Added Network
VDEA	Voluntary Data Exchange Agreement
VDSA	Voluntary Data Sharing Agreement
VTAM	Virtual Telecommunications Access Method

Appendix L Previous Version Changes

Version 7.8

Section 111 users can submit requests to their EDI Representative online in addition to phone and email correspondence (Chapter 17).

The "as of" date has been removed since implementation of the new change reason codes (Table 9-7).

To reduce errors in address checks, it is no longer advisable to enter all zeros when entering a ZIP code (Appendix D).

A note regarding IEQ and DTM modifier type codes has been removed as they have been discontinued (Table 9-6).

Clarification has been added regarding RREs who submit quarterly files with active members ages 45 through 64 (Sections 7.3.1 and 10.1).

Effective July 2026, to ensure consistent editing of insurer names across all sources for records, and to reduce calls and requests to delete or correct insurer names, additional values have been added to the list of invalid values (Appendix D).

Version 7.7

As previously communicated, the RX19 errors will no longer be applied to incoming records for Responsible Reporting Entities (RREs) who are not the original reporter. Instead, a soft edit, RX20, will be generated (Sections 9.3.1 and 12.6).

Verbiage has been added to clarify that a member's most current Medicare ID will be provided when a match is found. If no match is found, the position will be filled with spaces (Appendix A, Appendix B, Appendix C, Appendix H).

Effective July 2026, to ensure consistent editing of insurer names across all sources for records, and to reduce calls and requests to delete or correct insurer names, additional values have been added to the list of invalid values (Appendix D).

Version 7.6

Starting April 2026, new reason codes will be available to further improve granularity and clarity of updates to MSP and drug coverage records. The new codes have been added to the *Change Reason Description* table with an asterisk (*) (Table 9-7).

Version 7.5

As of January 5, 2026, the RX19 errors will not cause incoming records to be rejected for responsible reporting entities (RREs) who are not the original reporter. Instead, a soft edit, RX20, will be generated (Sections 9.3.1, 12.6, and Appendix D).

Version 7.4

A new paragraph has been added to the Section 111 Overview chapter to provide additional information about data reporting requirements.

The RX19 error description has been updated.

Version 7.3

A non-submission notification email will now be generated automatically instead of a physical letter when a GHP RRE fails to submit their scheduled quarterly GHP MSP input file (Section 17.4.

The *Late Submission Indicator* (Field 82 on the MSP Response File Detail Record) will now be set to "Y" when the later date of either the Effective Date (Field 10 on the incoming MSP Input file record) or the Part A add date from MBD is greater than 135 calendar days before the start date of the RRE's file submission period. Additionally, compliance flag fields have been renamed warning flag (Section 9.6 and Appendix A).

Version 7.2

Information on how to resolve TIN address errors was added (Sections 8.3 and 8.9).

Version 7.1

To prevent the creation of overlapping drug records, add or update transactions for drug records with new coverage dates that either fall within or overlap existing coverage dates for a matching primary or supplemental prescription drug record will be rejected with disposition code "SP" and the new Rx error, "RX19 – Overlapping Rx Coverage" on the Section 111 GHP MSP Response File Detail Record for primary records or the Section 111 GHP Non-MSP Response File Detail Record for supplemental records (Sections 9.3.1 and 12.6 and Appendix A, Appendix C, and Appendix D).

Note: The RX19 error code only applies to submissions reported by the same RRE. Transactions for any combination MSP/drug coverage type (W, X, Y, 4, 5, or 6) will only be rejected for the drug portion of the record.

The email address for contacting an Electronic Data Interchange (EDI) Representative has changed to COBVA@bcrcgdit.com. However, COBVA emails coming from CMS will now show the address as COBVA@mail.cms.hhs.gov (Chapter 18).

Version 7.0

A section has been added on civil monetary penalties (CMPs) (Section 7.8).

Instructions have been updated for signing up for CMS.gov website updates (Chapter 2, Chapter 18, and Chapter 19).

Version 6.9

For Section 111, GHP RREs that offer primary prescription drug coverage and opt in to receive unsolicited alerts from the S111 portal will now receive information for drug coverage types U, V, W, X, Y, Z, 4, 5, and 6 in the *Unsolicited MSP Response File Detail Record*. Additionally, the response file will include several new fields for drug-only or drug/MSP records (Section 9.10 and Appendix H).

All mentions of Internet Explorer have been removed as it is no longer a supported browser (Section 17.5).

The Hierarchy section has been clarified and simplified (Section 9.9).

This guide has been clarified to reflect that correcting Insurance Coverage Type 'A' to 'W' requires only an update, rather than a delete followed by an add transaction (Sections 8.7, 8.8, and 11.5.1).

The HEW inquiry file layout has been edited to clarify that if not reporting a Social Security number (SSN), the field should be filled with zeros (Appendix B).

Version 6.8

Because of the large volume of duplicate reporting of prescription drug records by various contractors, hierarchy business rules are now applied to Part D primary and supplemental prescription drug record transactions (Section 9.10, Appendix A, Appendix C, Appendix D).

The *File Type* value in the *Unsolicited MSP Response File Header Record* now reads "USOL" (Appendix H).

The following changes, originally scheduled for July, will become effective October 2023:

For Section 111, GHP RREs that offer primary prescription drug coverage and opt in to receive unsolicited alerts from the S111 portal will now receive information for drug coverage types U, V, W, X, Y, Z, 4, 5, or 6 in the *Unsolicited MSP Response File Detail Record*. Additionally, the response file will include several new fields for drug only or drug/MSP records (Section 9.11.6 and Appendix H.

Version 6.7

The expiration date for the Office of Management and Budget (OMB) control number of the Paperwork Reduction Act (PRA) Disclosure Statement has been updated to 01/31/2025.

The following changes will become effective July 2023:

For Section 111, GHP RREs that offer primary prescription drug coverage and opt in to receive unsolicited alerts from the S111 portal will now receive information for drug coverage types U, V, W, X, Y, Z, 4, 5, or 6 in the *Unsolicited MSP Response File Detail Record*. Additionally, the response file will include several new fields for drug only or drug/MSP records (Section 9.11.6 and Appendix H.

Version 6.6

Clarification has been provided regarding Disposition Code field 8 and Rx Error Code fields 71-74 (Section 9.3 and MSP Response File Detail Record).

The following changes will become effective April 2023:

Because of the large volume of duplicate reporting of prescription drug records by various contractors, hierarchy business rules will be applied to Part D primary and supplemental prescription drug record transactions (Section 9.10, Appendix C: Non-MSP Input File Detail Record, Appendix D: Section 111 GHP SP Error Codes).

Version 6.5

Transmission of Query Only Files has been clarified for reporters who provide primary prescription drug coverage (Sections 6.2.1, 6.2.2, 10.2, and 15.1.1).

This guide has been restructured and formatted for easier readability.

Restructure Crosswalk

Original (v6.4)	New (v6.5)
7.1 to 7.1.7	Chapter 7
7.2 to 7.2.7.3	Chapter 8
7.2.8 to 7.2.10.8	Chapter 9
7.3 to 7.3.4	Chapter 10

7.4 to 7.4.6	Chapter 11
7.4.7 to 7.4.9	Chapter 12
7.5 to 7.6	Chapter 13

Version 6.4

Under the SUPPORT Act, Section 111 Responsible Reporting Entities (RREs) that provide primary prescription drug coverage must submit this information through the Section 111 process. To support their efforts, the HIPAA Eligibility Wrapper (HEW) Query Only Response File layout has been updated to provide the most recent Part D enrollment information for beneficiaries. Additionally, process steps for installing and configuring the HEW software have also been provided (Appendix B and Appendix I).

When primary records (prescription drug or otherwise) are submitted on an existing GHP MSP Input record as updates, the submitted Effective Date will be used for the matching criteria. When primary non-drug records (all coverage types) are submitted on the input file as updates with an Effective Date prior to the Entitlement Date, matching will be done using either the record Effective Date or the submitted Effective Date (see MSP Input File Detail Record).

Previously, the Medicare Secondary Payer (MSP) record processing rules for Small Employer Exceptions (SEEs) only applied to non-drug MSP records using the MSP GHP Input File. These rules now apply to SEE primary drug coverage records using the GHP MSP Input Detail Record (Appendix D).

Clarification has been provided for RREs regarding the submission of MSP, HEW (Query Only), and Non-MSP input files. When submitting SSNs, this field may contain either the last five digits (preceded by four spaces) or the full nine digits of the SSN (Sections 7.2.3, 7.3, Appendix A (Field 9), Appendix B (Field 6), and Appendix C (Field 1)).

Version 6.3

Because prospective Medicare entitlement records can have effective dates up to three months in the future, the Medicare Secondary Payer (MSP) Effective Date field will now accept dates up to three months in the future without rejection (Sections 7.2.5, 7.2.8, and MSP Input File Detail Record (Field 10)).

The following will become effective November 2021:

Previously, the Medicare Secondary Payer (MSP) record processing rules for Small Employer Exceptions (SEEs) only applied to non-drug MSP records using the MSP GHP Input File. Now these rules will apply to SEE primary drug coverage records using the MSP GHP MSP Input Detail Record (MSP Input File Detail Record (Field 18), Appendix D).

Version 6.2

The CMS electronic file transfer (EFT) file-naming conventions for inbound and outbound files have been updated (Section 8.1.1).

To provide more accurate direction to submitters, instead of receiving the RX 07 error code (Beneficiary does not have Part D enrollment), Disposition Code 51 will be returned for those records where the submitted individual is not entitled to Medicare Part D (Appendix D).

A new Modifier Type Code (PVR) and Name (From a provider) have been added for unsolicited MSP response files, and the DTM code (Name of employer submitting the Data Match Questionnaire Response) has been removed (Section 7.2.10.6).

The following will become effective December 11, 2021:

Under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT Act) for Patients and Communities, Section 111 Responsible Reporting Entities (RREs) that provide primary prescription drug coverage must submit this information through the Section 111 process. To support their efforts, the Query Only Response File layout will be updated to provide the most recent Part D enrollment information for beneficiaries. Additionally, process steps for installing and configuring the HIPAA Eligibility Wrapper (HEW) software will also be provided (Appendix I).

Version 6.1

To improve point-of-sale/pharmacy processing and plan payments, the criteria for several fields have been changed for users submitting primary and supplemental drug records, specifically for the Rx Insured ID Number, Rx Group Number, Rx PCN, and Rx BIN Number on the MSP and Non-MSP Input Detail Records (MSP fields 24, 25, 26, 27; Non-MSP fields 13, 14, 15, 16) (See MSP Input File Detail Record and Non-MSP Input File Detail Record).

For MSP and Non-MSP Input File Detail records submitted for a Medicare beneficiary:

If the coverage dates fall completely outside the Medicare entitlement period or the record was submitted prior to the effective date of the individual's Medicare entitlement, the record will be rejected and returned with a Disposition Code '51' (record could not be matched to a Medicare beneficiary) instead of an SP31 error code. Additionally, if coverage was terminated prior to the effective date of the individual's Medicare entitlement, the record will be rejected and returned with a Disposition Code 51 instead of an SP32 error code (Appendix D).

When Disposition Code 51 is returned under these coverage date circumstances, clarification has been provided to RREs regarding record submission processing (Appendix D).

Version 6.0

Clarification has been provided for Responsible Reporting Entities (RREs) regarding how drug records should be submitted for beneficiaries whose Health Reimbursement Accounts (HRAs) are comprehensive; that is, cover hospital, medical, and prescription drugs. For these HRAs, RREs should submit two MSP input drug records separately: one for "R" and one for "Z" coverage types (field 8) (Sections 7.2.7.3, MSP Input File Detail Record).

To return more useful disposition codes, Disposition Code 50 will no longer be returned in two cases. The first is when GHP records are submitted with effective dates outside the ESRD 30-month coordination period. These records will be returned with the 'BY' (bypass) disposition code. The second is when records are submitted with the hierarchy Override Code before having received an 'SPH0' (attempt to update/delete a record last updated by a higher-ranking source) error code first. These records will still receive an 'SPH2' (attempt to override) error but will now receive an 'SP' disposition code (Sections 7.2.10.2, 7.2.10.8, and Appendix D).

As part of CMS' commitment to the modernization of the Coordination of Benefits & Recovery (COB&R) operating environment, changes are being implemented to move certain electronic file transfer data exchanges to the CMS Enterprise File Transfer (EFT) protocol. As part of this change the exchange of data with the COB&R program via Connect:Direct to GHINY SNODE will be discontinued. The final cutover is targeted to occur in April 2021. File naming conventions and other references have been updated in this guide. Contact your EDI Representative for details (Section 8.1).

Version 5.9

Starting April 5, 2021, the following changes will become effective:

To improve point-of-sale/pharmacy processing and plan payments, the criteria for several fields will be changed for users submitting primary and supplemental drug records, specifically for the Rx Insured ID Number, Rx Group Number, Rx PCN, and Rx BIN Number on the MSP and Non-MSP Input Detail Records (MSP fields 24, 25, 26, 27; Non-MSP fields 13, 14, 15, 16) (See Sections MSP Input File Detail Record and Non-MSP Input File Detail Record for more details regarding these updates).

For MSP and Non-MSP Input File Detail records submitted for a Medicare beneficiary:

If the coverage dates fall completely outside the Medicare entitlement period or the record was submitted prior to the effective date of the individual's Medicare entitlement, the record will be rejected and returned with a Disposition Code '51' (record could not be matched to a Medicare beneficiary) instead of an SP31 error code.

If coverage was terminated prior to the effective date of the individual's Medicare entitlement, the record will be rejected and returned with a Disposition Code '51' instead of an SP32 error code (Appendix D).

Version 5.8

Patient relationship code "20" (Domestic Partner) has been removed as a valid code from the Working Aged list in the SP52 error code description.

The notes associated with the Current Medicare Part D Plan Contractor Number, Current Part D Plan Enrollment Date, and Current Medicare Part D Plan Termination Date fields (Nos. 57, 58, and 59) have been edited for clarity.

Version 5.7

To prevent a supplemental drug record from being created with a missing or invalid insurer name when a Retiree Drug Subsidy (RDS) record is submitted, a valid insurer name is now required when the Action Type is "S" (i.e., Subsidy reporting record) (see Non-MSP Response File Detail Record, Field 27). Concurrently, validation logic for error code SP25 (invalid or no insurer name) has been updated (see Section 111 GHP SP Error Codes).

To clarify input file processing requirements for Medicare Secondary Payer (MSP) occurrences, clarification has been provided in instances where beneficiaries expand or reduce their insurance coverage (Section 7.2.6.1).

For Section 111 RREs submitting drug records, additional instructions have been provided for those that receive RX 07 error codes when submitting drug records for beneficiaries who have not yet enrolled in a Medicare Prescription Drug Plan (Part D) (Section 7.2.8.3).

Disposition code 51 is sent back on query response files often because an individual was not found to be (could not be matched with) a Medicare beneficiary. To clarify, when individuals cannot be found, it is because they do not have Medicare Part A entitlement. Individuals may be Medicare beneficiaries but have Medicare Part B coverage only. For these individuals, the MSP provision does not apply.) (See Section 111 GHP Disposition Codes).

Version 5.6

To clarify Medicare Secondary Payer (MSP) input file requirements, information regarding Individual Coverage Health Reimbursement Arrangements (ICHRAs) has been added. All HRAs, including ICHRAs, Qualified Small Employer Health Reimbursement Arrangements

(QSEHRAs), and excepted benefit HRAs, are subject to the applicable MSP provisions regardless of whether or not they have an end-of-year carry-over or roll-over feature (Section 7.2.7).

Version 5.5

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Title IV Section 4002, will require Group Health Plan (GHP) Responsible Reporting Entities (RREs) to report primary prescription drug coverage through the Section 111 process for calendar quarters beginning on or after January 1, 2020.

Additionally, as of July 2019, GHP RREs that report primary prescription drug coverage using the Basic reporting option will now receive Medicare Part D enrollment information on their response files. (Section 6.2).

The retention period for downloading response files has been updated from 180 days to 60 days (Section 8.1.2 and 8.1.3).

The system has been updated to accept the valid patient relationship disposition codes of 05 (Step Child) and 18 (Parent) as valid entries (see Section 111 GHP SP Error Codes).

RREs can download the latest PC/server version of the HIPAA Eligibility Wrapper (HEW) software from the Section 111 MRA application, which is compatible with Windows 10 (Section 7.3.4 and Appendix B).

Because file uploads have been restricted to certain types, RREs using the HTTPS file transmission method can only upload files with the file extension of .txt. Any other file type will generate an Invalid File error message (Sections 7.5.1 and 8.1.3).

Version 5.4

Date formats for Severe Error header and trailer records have been corrected (Table 7-5 and Table 7-11).

Version 5.3

The contact protocol for the Section 111 data exchange escalation process has been updated (Section 12.2).

To help prevent input errors on the Section 111 *Insurer Name* field (27), additional value checks have been added to the SP25 error code (Table D-2).

Version 5.2

To meet Section 111 requirements, a Paperwork Reduction Act (PRA) disclosure statement has been added to the front of this guide.

Starting Oct. 1, 2018, GHP RREs will be required to include the Insurer Name when submitting supplemental drug (“D”) records on Non-MSP input files. As a result, a new SP25 error code has been added (Appendix Tables C-2 and D-2).

Note: Because we do attempt to convert “S” records into “D” records (Section 7.4.9: Converting an “S” Record to a “D” Record), this error may also occur if the “S” records are missing, or do not include the Insurer Name during conversion.

Version 5.1

For input layout files, the format of the Medicare ID Medicare Beneficiary Identifier (MBI) has been clarified in fields and examples.

If you provide a Medicare ID (HICN or MBI), or an SSN, on input files, the system will return the most current Medicare ID in the response files.

Version 5.0

As required by Section 501 of the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) of 2015, CMS must discontinue all Social Security Number (SSN)-based Medicare identifiers and distribute a new 11-byte Medicare Beneficiary Identifier (MBI)-based card to each Medicare beneficiary by April 2019. CMS has exempted all Medicare Secondary Payer (MSP) processes from exclusive use of the MBI. Therefore, Group Health Plan (GHP) RREs are permitted to continue to report for Section 111 mandatory insurer reporting using: full SSN, Health Insurance Claim Number (HICN), or MBI. All fields formerly labeled as "HICN" have been relabeled as "Medicare ID" and can accept either a HICN or the new MBI.

Additional Notes:

Medicare Identifier on Section 111 Response Files

The most current Medicare ID (HICN or MBI) will be returned in the Section 111 response files in the "Medicare ID" field. Consequently, if an RRE submits information with a HICN and the Medicare beneficiary has received their MBI, the MBI will be returned. Otherwise, the most current HICN will be returned. RREs may submit subsequent Section 111 information for this Medicare beneficiary using either the HICN or MBI.

Medicare Identifier on Outgoing Correspondence

As part of the New Medicare Card Project changes, Benefits Coordination and Recovery Center (BCRC) and Commercial Repayment Center (CRC) issued correspondence will use the Medicare identifier that RREs most recently provided when creating or updating a Medicare Secondary Payer (MSP) record. Consequently, if the most recent information that was received used a HICN, all subsequent issued correspondence will be generated with the HICN as the Medicare ID. If the most recent information received used an MBI, all subsequent issued correspondence will be generated with the MBI as the Medicare ID.

Direct Data Entry (DDE) Users: Claim Searches

Section 111 DDE users will be able to search for saved and submitted claims using the HICN or MBI.

When searching for claims via the *Claim Listing* page, either the MBI or the HICN can be entered in the Medicare ID field. All claims that match for the Medicare beneficiary will display in the search results, regardless of Medicare identifier that was used to establish the claim.

Retiree Drug Subsidy (RDS) Unsolicited Response Files

RDS Unsolicited Response Files will contain the HICN or MBI in the "Medicare ID" field, as sent by the RDS system.

General

RREs will still be able to use an SSN to query via the Health Eligibility Wrapper (HEW) 270/271 query process. The most current Medicare identifier, either HICN or MBI will be returned in the "Medicare ID" field.

Other Changes

The contact protocol for the Section 111 data exchange escalation process has been updated (see Section 12.2).

Version 4.9

To prevent calls to the help center to increase transaction limits, the limit for COBSW Section 111 beneficiary lookups has been increased from 100 to 500 transactions per calendar month. See Section 9.1.2.

Version 4.8

Information about the CMS Section 111 Resource Mailbox has been updated to clarify usage details. See Chapter 2 and Chapter 12.

Version 4.7

The Coordination of Benefits Secure Website (COBSW) Section 111 URL has changed to https://www.cob.cms.hhs.gov/Section111/. See changes made throughout this user guide.

Version 4.6

Updated the description for Field 19 (MSP Effective Date) to clarify how an MSP Effective Date may be automatically set to a future date (See Table A-8).

Updated the description for error code SP31 to clarify the parameters for the error code being returned: The SP31 error may also be returned if the record was submitted prior to the individual's Medicare entitlement effective date. The RRE should continue to resend the record until it is accepted, the individual is no longer an Active Covered Individual, or GHP coverage is terminated. (See Table D-2).

Version 4.5

Updated hyperlink to the 270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for Mandatory Reporting Group Health Plan Entities in Section 7.3.

The Department of Health & Human Services has adopted a policy treating same-sex marriages on the same terms as opposite-sex marriages to the greatest extent reasonably possible. Any same-sex marriage legally entered into in a U.S. jurisdiction that recognizes the marriage—including one of the 50 states, the District of Columbia, or a U.S. territory—or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, will be recognized. Consistent with this policy and the purpose of the MSP provisions, effective January 1, 2015, the rules below apply with respect to the term "spouse" under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages as described herein.

- If an individual is entitled to Medicare as a spouse based upon the Social Security Administration's rules, that individual is a "spouse" for purposes of the MSP Working Aged provisions.
- If a marriage is valid in the jurisdiction in which it was performed as described herein, both parties to the marriage are "spouses" for purposes of the MSP Working Aged provisions.
- Where an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in

question. If such an individual is reported as a "spouse" pursuant to MMSEA Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

Version 4.4

To make it clear that the most recent TIN Reference File name and address information is used for recovery purposes the "Changing TINs or TIN Addresses" paragraph in Section 7.2.2 was updated.

Version 4.3

Branding updates for the Benefits Coordination & Recovery Center (BCRC).

Version 4.2

Updated USPS links in Sections 7.2.2.2 and 7.2.6.3.

Version 4.1

References to the Medicare Secondary Payer Recovery Contractor (MSPRC) have been replaced with references to the Commercial Repayment Center (CRC).

CMS has transitioned all the functions and workloads related to GHP MSP recovery, with the exception of provider, physician, or other supplier recovery, to the CRC. The CRC is responsible for identifying and recovering Medicare mistaken payments where a GHP has primary payment responsibility. Some of these responsibilities include: issuing recovery demand letters when mistaken primary payments are identified, receiving payments, resolving outstanding debts, and referring delinquent debt to the Department of Treasury for further collection actions, including the Treasury Offset Program, as appropriate.

Clarification on how to accurately report a Coverage Termination Date (Field 11) on the MSP Input File has been provided.

As a result of the re-design of the Medicare and Coordination of Benefits pages on the CMS.gov Website, all outdated hyperlinks have been replaced in this document.

Users no longer need to register for computer-based training (CBT). CBTs can be accessed directly from the CMS website. Please see Chapter 13.