

TRANSCRIPT
TOWN HALL TELECONFERENCE

**SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
ACT OF 2007**

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DATE OF CALL: March 26, 2013

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
March 26, 2013
1:00 p.m. ET

Operator: Good afternoon, my name is (Sarah) and I will be your conference operator today. At this time, I would like to welcome everyone to the MMSEA Section 111 Town Hall teleconference for Group Health Plan.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

John Albert, you may begin your conference.

John Albert: Thank you, operator, and good afternoon, everyone. For the record, today is Tuesday, March 31st, 2013, and again, this is the GHP Section 111 town hall teleconference. As we state at the beginning of every one of these calls, we put out a little disclaimer that on occasion, we may say things during these calls that contradict the formal written guidance that appears at the Section 111 Web site. Where that does occur, again, the materials that are out on the Web site are the ultimate authority for the instructions related to Section 111 reporting, so again, we're human, and we sometimes do contradict what's in the materials. But the materials, until they're modified through subsequent updates, are still the official guidance.

One thing I will mention very briefly is that we have an updated Section 111 user guide that just was approved for posting, and we expect to see it out hopefully today on the Web site, so there's some minor updates, nothing significant, so to speak, but again it's just a more updated version of the guide.

This call is a little bit different. As you saw on the announcement, we're going to be talking about the new commercial repayment center. We're going to go through that process initially, and then have a Q&A session related to that announcement. Then we're going to move on to a presentation and Q&A for the GHP Section 111 reporting.

So I'll start out with an introduction, and that is as part of its reorganization and restructuring of the MSP operation, the centers for Medicare and Medicaid Services is transitioning all group health plan recovery activities to its new commercial repayment center. The CMS recently awarded the CRC contract to CGI Federal Incorporated, and plans to fully transition responsibility for GHP recovery case work to that entity on or about May 13th, 2013.

What will not change is that the COBC will continue to perform all COB activities, that includes the handling of all of the Section 111 reporting activities. Also, the MSPRC will continue to perform all liability insurance, no-fault insurance and workers compensation recovery case work. Section 111 and other data processing methods, et cetera, will not change at all. Again, this only affects GHP recoveries. The non-group health plan activities, which you all probably should not be on this call if you are, are not affected by this.

We want to remind everyone, too, that while we traditionally – these calls are geared toward 111 and we're talking about this new CRC process, we want to remind everyone that the Section 111 mailbox is to be used only for Section 111-related questions, and also that, you know, we will provide answers to those questions, as we always do during the calls, or through updated material.

And again, as I mentioned before, the key date is May 13th, 2013. Again, that is when all GHP recovery activities will move to the new commercial repayment center. Transition updates will be posted to the CMS.gov Web site, and we encourage people to sign up for updates and notifications. Also, subscription lists can be found on the following sites, which includes the mandatory insurer reporting home page, as well as Medicare COB information and MSPRC.info. Information provided during today's call will

be posted on the CMS.gov MSP recovery general information page, and MSPRC.info. Also, transcripts will be posted soon after this call as well, which will, you know, basically record all of the information that's provided today.

The CRC will be providing information on upcoming events, and with that, I'll turn it over to Mr. Rob Rolf of CGI Federal, who will introduce the commercial repayment center to you all. Thank you.

Rob Rolf:

Thank you, John. Again, this is Rob Rolf, and I'm the project director for the commercial repayment center. Just a little bit of information about CGI. CGI is a top five global technology and business services company, founded in 1976, and with more than 72,000 professionals operating across the country. CGI is a committed partner to CMS, in having worked with the agency for over 13 years. We currently support nearly 2/3 of CMS' mission-critical systems and services, impacting over 45 million beneficiaries and one million providers and suppliers.

Some of the systems that we currently are working with CMS on include the payco system, the fraud investigative data base, Medicare appeal system, the federal health insurance exchange, and CMS Web sites including medicare.gov.

In January, we began working with CMS and the outgoing recovery contractor to ensure a smooth transition of activities between the current provider and a new commercial repayment center. On May 13th, the MSPRC will cease operations and we will begin formally functioning as the commercial repayment center, working all past, present and future GHP debt. We will have new telephone contact numbers and post office box addresses for GHP-related case work, and this information, again, will be posted to the MSPRC info and CMS.gov Web site approximately a week prior to May 13th.

We will have a complete history of all GHP cases that are currently in process, including copies of all your communications and correspondence. We will have additional updates forthcoming, and including Webinars that will be scheduled to be held on April 17th, May 1st, and May 13th. These

Webinars will be an opportunity for you to learn more about the commercial repayment center and understanding how this change affects you.

John Albert: OK. I guess, operator – thank you very much, Rob – Robert, I said. Operator, we can go straight into a Q&A session now, in terms of any questions that folks may have about the CRC.

Operator: At this time, I would like to remind everyone, in order to ask a question over the phone, please press star then the number one on your telephone keypad. And we'll pause for just a moment to compile the Q&A roster. Your first question comes from the line of (Nancy Fortier) with UFCW employers' benefits. Your line is open.

(Nancy Fortier): I'm just curious about the Webinars. Will we get notified the same as we did on this call, so that we can participate in those?

Nathan Crawford: They'll actually be – this is Nathan Crawford. There will actually be a separate registration process, and we'll be posting that information on the cms.gov Web site, under the normal MSP general info information, and the MSPRC.info pages, and it'll actually provide you with a link on how to register for the Webinars, and kind of the announcements for posting. So again, they'll be April 17th, May 1st and May 15th.

(Nancy Fortier): OK.

Operator: Your next question comes from the line of (Francis Ruvel) with Horizon BCBS. Your line is open.

(Francis Ruvel): Hi. I was wondering if I can ask, will you be using the HIGLAS system for your recoveries, or a new system?

Male: I mean, all CMS processes are migrating to HIGLAS, so the answer is yes.

(Francis Ruvel): OK, and if I can ask another question, will you be continue using the PPN process also?

Male: Yes, that's going to be an existing process.

(Francis Ruvel): It will be. Do you have any plans to improve the responses that we receive? Currently, we're receiving responses that are really generic, such as, you owe us a balance because the remaining claims were not addressed, and they're not specifically providing us with the dates of service or the claims that they have as still open. So that's a major issue for us, to resolve a debt.

Male: We appreciate your comments, and you know, we don't really have a direct response for that at this time, but obviously that's part of this process, is continual improvement, so ...

(Francis Ruvel): So will the Webinars address some of these issues?

Male: Yes.

(Francis Ruvel): OK, great, thank you.

Operator: Your next question comes from the line of Lynn Wentz with Blue Cross Blue Shield. Your line is open.

Lynn Wentz: Good afternoon. This question is possibly premature, but I just wanted to pose it, because it is a concern for our plan and possibly others. Our demand receipts over the past few months, and going back even a little farther than that, have been unusually low. And so that gives rise to the concern, or the question, is there a backlog of demand cases that could come to us in higher volumes, following the May transition? And you may not be able to completely answer that question yet, or may not have access to those volumes. But I wonder if you could just address the question in general, thanks.

Male: I can tell you that our goal is to basically make sure that the work flow is consistent in frequency across – you know, over time. So yes, we're very aware of that issue, so ...

Lynn Wentz: I think what plans are probably concerned about, though, is should we expect – and again, this question may be premature – but for our planning purposes, should we expect a dramatic increase in demand cases coming to us in the few months following May?

Male: There definitely will be an increase, but you know, I wouldn't say dramatic.

Nathan Crawford: Well, and, to your point – this is Nathan Crawford again – we are in a transition phase right now, transitioning out from the MSPRC, the GHP workload, so there are no current demands going out during this transition phase. And then once the CRC picks up everything, you will see demands for the first time, if you haven't gotten them in a couple months. So it will be an increase from zero to something.

Lynn Wentz: That's very helpful. So we will not receive demands between now and May, then.

Nathan Crawford: Yes, we're in the transition phase, so we're transitioning to the CRC, and the CRC will be the first demand that you would see.

Lynn Wentz: All right, thank you very much, I appreciate it.

Operator: Your next question is from the line of Jason Richard, with Blue Cross Blue Shield. Your line is open.

Jason Richard: Actually, I had the same question that Lynn Wentz just asked, so thank you.

Operator: Your next question is from the line of (Sandy Mills), with WellPoint Incorporated. Your line is open.

(Sandy Mills): My question was, how is the contractor going to resolve old cases, if they don't have access to the old systems that we need?

Rob Rolf: This is Rob Rolf, and the – again, since January, we've been working with both the incumbent contractor and CMS to ensure a smooth transition, including all of the data of all the case files, all the images of letters of correspondence, and call logs that – of any contact with the existing contractor. So as of May 13th, we will have all of that history in our systems accessible to us, and we expect to be able to continue and answer any questions, and pick up directly where any case left off.

(Sandy Mills): So, will that include cases that the current contractor shows closed?

- Rob Rolf: That includes all case history, not just those that are open and current, but all case history is being transitioned.
- (Sandy Mills): OK, thank you. I had one more question. Will there be a new person we can contact for existing special projects and urgent escalations, and how will the current projects be transitioned? Let me give a little more detail. We have key people that were helping us, that we're not able to get cases resolved through normal means, there are other extenuating things to consider, and we have people that we were working with that no longer are able to help us at this point, so we're dead in the water on things. And we're wondering who ...
- Male: That's something we're still working on during the transition period, to see how the current operations handles things, and see how we need to handle them in the future. So it might be something that we cover on the Webinars, but most likely we're going to have to just discuss it with the incumbent contractor, and find out what kind of special processes exist that we can replicate, or how we need to change the process.
- (Sandy Mills): Thank you.
- Operator: Your next question comes from the line of (Bobbi Sandler), please state your company. Your line is open.
- (Bobbi Sandler): I'm calling from Highmark. My question would be, I know that you said that the telephone number would change as well as the PO box, and it would be forthcoming, about a week prior to the transition. I was wondering if we could get it any sooner, since we'll have to set up vendor files, and that can take some time.
- Male: Yes, we wanted to put it at least one week in advance, so we don't get prematurely correspondence to that location, because we are going to be forwarding all the existing mailboxes on to the CRC for any GHP correspondence that happens to end up at the old PO box, that will be forwarded and routed to the new PO box at the CRC. So, we still have to determine, I guess, if it is taking a bunch – some time to do transition of addresses in your systems, then we can consider posting that earlier.

(Bobbi Sandler): OK, I appreciate that, thank you.

Male: Sure.

Operator: Your next question comes from the line of (Lynn Cascani) with Capital District. Your line is open.

(Lynn Cascani): Hi, this is (Lynn). I was just wondering, during this time, are you going to take the opportunity to enhance the coordination between CGI to the department of treasury, to the collection agencies, and – because we have extremely old cases that may come back and haunt through the collection agency. We can never talk to anybody at the treasury. When we call MSPRC, they don't know anything. There's like no communication through those three branches, and it makes it very hard, especially when you've submitted the correct information that should close the case, and it just gets into a loop. So I was just wondering if that should be enhanced as well.

Barbara Wright: This is Barbara Wright. We're listening to any comments that you have right now, but any of these that are getting into the (inaudible) that are talking about specific claims, and specific things where you'd like to see improvements, they're certainly not things that we have comments on right now. To the extent that we're able, we may have comments during a Webinar, and we'll certainly look at the issues, but we're not prepared to talk about details of the recovery process right now, particularly under the new contractor. Can you hang on just a second? One thing that we did mention before, while there will not be any new GHP demands until the transition takes place, if you have any outstanding debts, you should continue to communicate with the MSPRC on those outstanding debts, or if the debt is with the treasury, communicate with the treasury.

Male: OK?

(Lynn Cascani): Yes, thank you.

Male: Yes, I just want to reiterate that again, we don't really want to take calls related to specific complaints on this call. We'd prefer that you please ask questions you might have about the CRC itself, and those types of questions.

Again, with the Webinars coming up, there will be ample time for more specific questions to be addressed via those three Webinars, that will be taking place in April or May.

Operator: As a reminder, if you would like to withdraw your question, please press the pound key on your telephone keypad. Your next question comes from the line of Ellen Holbrook with Blue Cross Blue Shield. Your line is open.

Ellen Holbrook: Yes, the question we have is, what steps are being taken to ensure that timely response from the new COB&R to defenses received – what assurances can you give us that the new COB&R will be able to respond timely? Is there going to be any type of overweight by CMI, or CMS?

Male: So in general, we are looking to try to have a smooth transition from the incumbent to the CRC, and so we are looking at workloads to make sure they're worked down to low volumes, to make sure that the actual transition to open correspondence that is being currently worked, is minimal. And then when the CRC gets that, that they're able to work that and retain that. And we are going to have heavy oversight into that, just to make sure everything's going smoothly during that transition period.

Ellen Holbrook: OK, will there be any type of allowances made if the CRC is not timely, and the demand gets referred to the department of treasury as a result?

Male: Yes, we have controls in place to make sure that debts are not referred to treasury, if they still have outstanding correspondence in the queue.

Ellen Holbrook: OK, my question is more specifically where they have responded with inaccurate information, didn't respond to something correctly, and we're coming back and telling them that, but in the meantime, the demand gets referred to treasury.

Male: Yes, I mean that's a singular instance. If it comes to that, then we'll have to deal on a one-on-one basis. But we're making sure that the CRC is going to be transitioning fully, the training in place, the standard operating procedures. CMS has got, I guess, heavy oversight into all parts of the transition process, to make sure that those kind of gaps don't happen.

Ellen Holbrook: OK. I had one other question. Will the CRC be making tools available for the health insurers to use, such as the interest calculation tool that we currently use from the incumbent entity?

Male: Yes, I think that kind of detailed information will be available during the Webinars.

Ellen Holbrook: OK, thank you.

Operator: Your next question comes from the line of (Debra Edwards) with Empire Blue Cross. Your line is open.

(Debra Edwards): Hi, I just have two questions. I know that the effective date will be May 13th, and we're not going to be receiving any new demands. Is the process of the PPN going to continue as well first, before we get the demands?

Male: Yes, there will be a PPN process to validate any potential demands.

(Debra Edwards): OK. And, are they currently working on the demands that we have returned, will we be getting rebuttals between now and May, if there are any?

Male: That's all being handled by the MSPRC currently, and so anything up to May 13th will be worked by the MSPRC. After that fact, if there's any open correspondence that has not been answered, it will be turned over to the CRC to be answered.

(Debra Edwards): OK, thank you.

Operator: Your next question comes from the line of (Whitney Thomas) with WellPoint Anthem Blue Cross. Your line is open.

(Whitney Thomas): Hi, my only question was, I have a large open case, and when should we stop sending checks to the Oklahoma address?

Male: I guess, like I had stated previously, we will be re-routing and forwarding all the PO boxes, so anything that you send in to the MSPRC PO box that is

around that time frame, if it doesn't get, I guess, if the MSPRC doesn't get it, they will be re-routed directly to the CRC, to deposit and apply the payment.

(Whitney Thomas): OK, thank you.

Male: So, you don't have to worry about dates. I mean, May 13th is when the official cutover is, so we'll have that address out there for you guys to re-route your mail within a week.

Male: And as we said, you want to continue to work the current debts, so that you're not accruing additional interest, and so that they aren't referred to treasury if they don't meet.

(Whitney Thomas): OK, thank you so much.

Operator: Your next question comes from the line of Tonya Lee of Blue Cross Blue Shield. Your line is open.

Tonya Lee: Yes, I have a question about the Section 111 file. Are we still going to be sending it to the same people? I mean, is that process going to stay the same as it is now?

Male: Yes, yes, all current, you know, COB activities remain with the COB contractor, including the submission of Section 111 files.

Tonya Lee: Even after May?

Male: Yes. Again, the CRC is only handling GHP recovery activities.

Tonya Lee: OK.

Male: Not front-end coordination activities.

Operator: And once again, if you would like to ask a question over the phone, please press star then the number one on your telephone keypad. Your next question comes from the line of (Norman Rice) of Washington State Health. Your line is open.

(Norman Rice): Hi, this is (Norm Rice) with the Washington State health care authority, and my question has to do with the ability to update addresses in – with the CRC. It seems in the past that once a demand has gone out to a bad address, there hasn't been any way to really correct that, and correspondence is repeatedly sent to a closed PO box or street address.

Male: One thing I would comment on is, the addresses we use are the addresses that are sent in on the Section 111 files. So anything that is sent in through that method, we have a hierarchy of trust, of what addresses we want to trust. The ones that come in through Section 111 are the primary addresses that we use. Updates to those addresses, we like to receive through the Section 111 process, because that's where you guys are reporting to us, and that's where you need things to be sent. And so, as a general rule, that's what we're going to use as our primary address.

As far as updates in the future process, it's something to be determined on how we can use that to be able to have the correct address across MSP systems. So not just for Section 111, because we don't want to update your Section 111 address with something that we got in through the CRC. So we need to make sure we're consistent across the board.

(Norman Rice): Yes, and I understand that, and my concern is that as a state, you know, we have 300 state agencies, and we've got four health plans that maybe send in different information at times. And if there's a PPN that goes out for any agency for the state of Washington, for state employees, state retirees, you know, we need to really consolidate that. We had a problem that we were trying to fix, and consolidate all of this in one area for folks who actually know what they're doing, and resolving these cases. So when you have different information coming from different TPAs with the Section 111, we have mandatory reporting that's gone out, and then that PPA no longer contracts with the state of Washington, so it's kind of hard to resolve that. Just wondered if there's a main contact point, to try to resolve these issues.

Male: Well, really the main contact point would be the reporters for Section 111. I mean, they're giving us the data, and they're getting the data, you know, from you all. So the best way to resolve that is to make sure that they're reporting

the right address, you know, for each of the, you know, many agencies or municipalities, whatever you want to call them, that they'd be reporting on. That really is the best way to do it, because again, if a change is made by somebody calling in to COB, the TPA could come in and technically override that report with a subsequent update on their end. So really, the best way to fix the problem is for you to work closely with your insurers, and make sure the data that they're giving us is correct and accurate.

(Norman Rice): Yes, and I'm more concerned about data – old data from a TPA that is no longer contracted with us, from 2010, and they're saying they no longer have the file, and they can't correct the file. For example, send in – send in bad information on a Section 111 file. But I'll try to contact someone off line.

Male: Can you hold on for just a second?

(Norman Rice): Sure.

Male: We're back. Yes, I mean the short answer is that the CRC system will allow for those updated addresses to be taken in and utilized.

(Norman Rice): OK. Thank you very much.

Male: That was an issue that we had in the past, but that has recently been corrected and this will be part of the new process as well, so ...

(Norman Rice): Good news.

Operator: Your next question comes from the line of (Barbara Patterson) with United Health Care. Your line is open.

(Barbara Patterson): Thank you. We just have a question at UHC if any of the demand packets and the PCN packets, are those going to change in the – in the way that we get those, and if they will always look the way that they have looked in the past.

Male: There may be some minor differences in formats of letters and things like that, but nothing significant. It's going to be the same process where, you know, we send something out to you, you guys respond, and the process in general is not going to be changing.

(Barbara Patterson): Excellent, thank you so much.

Operator: Your next question comes from the line of (Lynn Cascani) with Capital District. Your line is open.

(Lynn Cascani): Just a quick question. I recently was signing up for the portal registration. Should I cease that? Or should I continue that, because that is with MSPRC.

Male: If you were signing up for the MSPRC portal, that's actually only for non-group health plan information. So that wouldn't be applicable to this transition, which is only group health plan activities – recovery activities.

(Lynn Cascani): Because they did ... I'm sorry, they did send me ...

Male: I was just going to say that you can continue it, but if your business is trying to get non-group health plan information, then please continue to register for the MSPRP, the recovery portal, with the MSPRC, because they're continuing on. They're moving forward with the NGHP, and they're going to continue that contract with recovery activities for the non-group health plan.

(Lynn Cascani): OK, thank you.

Operator: Your next question comes from the line of (Precious Chavez) with Florida Blue. Your line is open.

(Precious Chavez): Thank you. We wanted to know, is there any way that we can get a copy of what the new format will look like, because we're already receiving these and doing an automated process, so we want to make sure that our system is able to accept how the new copies will look.

Male: Yes, if you attend the Webinars, we'll be providing more information, and on line at the cms.gov site, as time passes. Closer and closer to the transition, we'll have more and more information available.

(Precious Chavez): OK, thank you.

Operator: Your next question comes from the line of Shelley Wernholm. Please state your company. Your line is open.

Shelley Wernholm: Hi, this is Shelley Wernholm from Medical Mutual. I have a question, if the new CRC will have a dollar threshold set on – there's requests we get for a quarter, if maybe the interest calculator, which we're assuming we're using correctly, but there's a lot of complaints from employer groups that they get charged a quarter, or a nickel, and sometimes – the ones I'm asking about are less than a dollar. Is there going to be something ever implemented about that, within the CRC?

Male: Hold on for just a second.

Shelley Wernholm: OK.

John Albert: This is John. I mean, you know, basically we are all kind of scratching our heads here, because that should not be occurring. We have processes in place to prevent that from happening, so we'll have to go back and see. I mean, I don't know if you have any examples or whatnot that you can share with us. We'd like to see, because ...

Male: If you have any recent examples, we'd really like to see those.

Shelley Wernholm: Is there an e-mail address that they could be sent to?

Male: Yes, just send them to the resource mailbox for now, that's fine. I mean, we normally don't do that, but that's fine. That way, we'll all pick it up.

Male: But in your subject line, just put demand or follow-ups under such-and-such, so we can pick it out easily.

Shelley Wernholm: OK.

Operator: Your next question comes from the line of (Peggy Wilson) with First Medical Health. Your line is open.

(Peggy Wilson): Good afternoon. I work with the Medicare division, usually on our health plan, and I'm coming across a lot of situations with the mandatory reporting

involving work comp, liability group and non-group coverage. And it's involving cases of identity theft, where I've confirmed that the person that is either working, or has a work comp claim, is a fictitious person in another state. And I'm just like beating my head against the wall here, because we report to the medic, the medic doesn't do anything, and every quarter, you know, I'll make an update to get the case removed, and every quarter it reappears. Are you going to be addressing this, since identity theft is, you know, such a huge issue these days?

Male: Have you sent a message in on this to the resource mailbox?

(Peggy Wilson): No, sir, I haven't. This is actually my first encounter on this call. I normally deal directly with the consortia folks.

Male: You need to send something in to the resource mailbox. You were also, as far as I could tell, referencing generally (inaudible), and this is a GHP call. So if you would send something into the resource mailbox, we'd appreciate it.

(Peggy Wilson): OK, I am getting group health information as well, where people are working using the person's ID and they're working in another state. And I can't get the employers', you know, group plan to remove the coverage.

Male: If you could send some details in, again, we can look into it.

(Peggy Wilson): OK, thank you.

Operator: Your next question comes from the line of Ellen Holbrook with Blue Cross. Your line is open.

Ellen Holbrook: Hi, yes. I wanted to go back to the dollar thresholds for just a second. And I realize that it should not be occurring for, you know, small amounts on demands being issued, but my question is, what about refunds being issued? Are there going to be any dollar thresholds on that? I mean, we get refunds for a penny. And so, we're just kind of wondering if there's something that can be done about that.

Male: We don't think that should be happening for that low an amount. If you can send us some examples.

Ellen Holbrook: Yes, we can. Where should I send that?

Male: Resource mailbox.

Ellen Holbrook: And what is that?

Male: It's – I don't know the exact address. If somebody wants to tell us what it is ... it's on the home page of the Section 111, as an attachment.

Ellen Holbrook: OK, great.

Male: And again, operator, and for the folks on the call, if you could please try to keep your questions related to the CRC process, any questions you have about that. We're again getting into the weeds regarding specific GHP recovery policies and things like that, and we're not really here to answer those kinds of questions. We want to, you know, for the folks that are on the call and want to find out more about the CRC, please ask. Because otherwise, we are going to have to move on very shortly to the regular Section 111 presentation and Q&A processes. Thank you.

Operator: Your next question comes from the line of Francesca Rawleigh with the Marwood Group. Your line is open.

Francesca Rawleigh: Hi, thank you for having this call today. I just have a question. Since you're enhancing the CRC recovery process, I was wondering if CMS would consider issuing CMPs for beneficiaries and insurers that don't report claims, in the future.

Male: Yes, the law wouldn't quite allow us to do that.

Francesca Rawleigh: I'm sorry, what did you say?

Male: I said, we wouldn't be able to do that.

Francesca Rawleigh: OK, thank you.

Male: I mean, beneficiaries have requirements and others do, but they're under different statutes and what-nots. So I mean, Section 111 is geared toward insurers.

Male: Yes, CMS are not something we can do at random. They're only an issue, generally if they're specifically provided for by law. The penalties that are associated with Section 111, in the statute, can be directed to the RRE. That doesn't mean that other entities don't have responsibilities under the law.

Operator: Your next question comes from the line of Ellen Holbrook with Blue Cross Blue Shield of North Carolina. Your line is open.

Ellen Holbrook: Yes, the only other question that I have so far is, the national provider identifier, that disappeared with the incumbent MSPRC. Will that be re-included on facility claims once they start getting issued again?

Male: That's something that we'll have to cover in the Webinars. We're not prepared to answer that right now.

Ellen Holbrook: All right, thank you.

Operator: Your next question comes from the line of (Laura Babcock) with United Health Care. Your line is open.

(Laura Babcock): Hi, thank you very much. I was wondering if the first output of information will be PPNs or demands, and/or will they be simultaneous, when CRC takes over?

Male: The way the process goes is that, before any demand can be issued, it does have to go through a PPN process to validate that demand. So, the first thing that will go out the door is a PPN.

(Laura Babcock): OK, and do you have an estimated time of when the demands will follow that?

Male: No, that's something that we may cover in the Webinars – upcoming Webinars.

(Laura Babcock): OK, thank you.

Male: Is it also possible that there will be some cases transitioned, that have had the PCNs, but haven't yet had the demands, or that the demands will be issued by the ...

Male: Specifically, all PPNs have been demanded, therefore there is no demand in cue to be issued. So it would be – the only thing that – the first thing to go out, and the only thing to go out first, would be the PPN.

(Laura Babcock): OK, thank you very much.

Operator: And there are no further questions ...

Male: The first thing to go out and the only thing to go out first would be the (TPN).

Female: OK, thank you very much.

Operator: And there are no further questions at this time. I turn the call back over to the presenters.

Male: OK. Thank you, operator and thank you everyone. Thanks to (Rob) as well and (Nathan). We wanted to move on to the second part of this call, which is the – which is the support of the GHP Section 111 reporting. And the first thing we have is a presentation by Jeremy Farquhar of the Coordination of Benefits Contractor. Jeremy?

Jeremy Farquhar: Just a quick reminder, I have spoken to this on past calls but I want to remind all again regarding the unsolicited MSP file process. The COBC collects coverage data from numerous sources. That being the case, there will occasions where records via Section 111 may be updated with information coming from somewhere other than Section 111 file submission.

Prior to the implementation of the unsolicited response process, the Section 111 RRE would have – would have had no way of knowing if changes were made to the data which they had previously reported. Now, it already has the option to receive the unsolicited response file which will tell them if the record which they had submitted has been updated or deleted.

The unsolicited response files are generated monthly on the second Sunday of the month. The file will contain a response for each record updated or deleted by another source during the timeframe since the generation of the last unsolicited file.

Each response record will contain all of the data elements as they present – as the presently reflect to – on Medicare's database. In addition to this, the response will indicate the type of entity from which the information have been received and when available, the name of the updating entity along with the general reason for the update, which was (inaudible).

Maintaining the data provided via the unsolicited response file in conjunction with the data from the standard MSP response file will provide the RRE with the clearest picture of exactly what coverage data Medicare has on file for their insurer group at the present. Situations where updates being received by alternate sources may appear to be in conflict with their own data, the unsolicited response will help the RRE determine where the conflicting information is originating from. Although not required to do so, RREs are encouraged to use this information to investigate and rectify discrepancies with beneficiaries and employer groups.

Another significant benefit of the unsolicited MSP response file is that for any record on which the RRE receives an unsolicited response the RRE may send the hierarchy override code on their subsequent quarterly MSP file without first having received a hierarchy reject code on a prior MSP response file. Before doing so, the RRE should research the insurer that information is accurate in instances where there appears to be a conflict and RRE that does not participate in the unsolicited response process would first have to submit an update on their quarterly submission, wait for a response with that hierarchy reject and then submit an update with the hierarchy override code on their next quarterly file.

Participation on the unsolicited response process would allow for the RRE to rectify any possible discrepancies much more expediently as oppose to having to wait an entire additional quarter to do so. For further information regarding

the unsolicited MSP response file process, please refer to the unsolicited response user guide addendum. Actually, in addition to the user guide addendum that was published previously that the unsolicited response information will also be present in the updated version of the GHP user guide so you can actually just refer to the GHP user guide. And that can be downloaded from the MSP mandatory insurer reporting website within the group health plans subsection.

Speaking of the updated GHP user guide, since the – actually the start of this call, the email notification has gone out. Some of you may have received it, indicating that the new GHP user guide has been posted and it is presently available on the CMS website.

For a summary – and that is available under the group health plan subsection. For a summary, the changes found within the new version, please refer Section 1, but some of the updates include the following. As noted, information previously included within unsolicited MSP response file user guide, initially published as separate addendum on 6/28/2011 has now been added to the GHP guide. Content of alerts which had been posted since publication of the prior version of the user guide, such as those regarding changes to HRA reporting – HRA reporting requirements, published 9/27/2011 and the new employer size error SP91 published 11/30/2011 have also been added. And information pertaining to outdated compliance flags which are no longer utilized due to the implementation of address validation has removed. Compliance flag fields within the MSP response are now indicated as being for future use and are presently populating the spaces.

Now, just to address a couple of mailbox questions received since the last call. One question received was in regard to the reporting of MSP coverage for individuals for whom Medicare had terminated in the past. Specifically, the question was whether all beneficiaries for whom entitlement had terminated in the past should be submitted on the RRE's MSP file.

The answer would depend on whether the beneficiary's GHP coverage overlaps with the prior period of Medicare entitlement. The query response for the individual on question should contain their Medicare entitlement dates.

If Medicare coverage had terminated, then the date upon which the beneficiaries Medicare coverage ended would be provided. If the effective date of the GHP coverage is prior to the date upon on which their Medicare had terminated, then an MSP record should be submitted. If the effective date of the GH – if the effective date of the GHP coverage is after the Medicare termination then the record need not be submitted on the MSP file.

However, in such situations, the RRE should continue to submit that individual on their query file as they may regain Medicare entitlement in the future. If the individual does regain Medicare entitlement and they are still enrolled in GHP coverage based on active employment, then a record of that coverage would then need to be submitted on the MSP file.

Another was why an RRE might receive a late submission indicator in the situation where Medicare entitlement had been added retroactively. And unfortunately, the process by which we generate late submission indicators is not presently sophisticated enough to catch these scenarios. That being said, this is something that should occur very infrequently. Please note that a late submission flag is simply a warning and not an indication that a penalty will be assessed and maintain an audit trail of all RREs file submissions and upon investigation, we would be capable of determining that this late submission indicator was not actually the fault of the RRE. In such a scenario, the RRE may safely disregard that late submission indication.

And that's about all I had, back to you, John.

John Albert: OK. Next, Bill Decker is going to answer a couple of questions received related to HRA.

Bill Decker: Yes, thank you, John. Hi, everybody. My name is Bill Decker, I work here with the same group that works on all the other MSP work here in CMS. One of the specialty areas I had is the HRA area and we got a couple of questions into the resource mailbox about HRA coverage. I'm going to address the couple of that seems to be most general in the kind of questions that they were asking.

I want to preface all these though just by saying that it's important for all GHP insurers that are involved with HRA to remember that an HRA is GHP coverage. If you're considering GHP coverage at all and you have HRA – an HRA product associated with it, the HRA product is just that, GHP coverage. It isn't any else but GHP coverage. If someone has a plan with an employer that, let's say, Blue Cross Blue Shield plan, regular GHP plan, and the employer also provides an HRA product to the employee, the employee will use both of those products, the regular GHP coverage and the HRA product as group health plan and insurance.

If the – if the employee goes to a physician's office and says I have HRA coverage along with my regular GHP or I just have HRA coverage and wants to pay the provider's charges with the HRA the employee is paying with GHP insurance coverage and then provider, it means you treat that payment as group health plan insurance – group health plan insurance payment.

There tends to be some lingering confusion in the role out there about that aspect of HRA coverage simply because HRA coverage looks like it's a cash out of pocket payment, and it isn't if it's group – if it's HRA coverage. It is cash and it may be out of pocket but it's still a group health plan insurance coverage that needs to be treated as such.

I will go to now the couple of questions that we had. The first one is actually exactly that question. I have a patient that has GHP coverage as primary and Medicaid as secondary. They're also enrolled in HRA plan. My understanding is that the HRA plans pay whatever it left of the employee's portion and after the primary insurance pays and the secondary insurance pays. And again, once again, the HRA coverage is GHP coverage and pays just like other GHP coverage.

What sequence its paid in is really not relevant. It is GHP coverage. There's a – also I just want to point out that this particular question said the GHP was primary and Medicaid was secondary. I'm not sure if that writer meant Medicaid or Medicare because we are the Medicare program not the Medicaid program. I just wanted to make that clear on that one.

The other one – the other question I have on HRA came in is also a provider related question. If the patient has GHP to (inaudible) health care and they consider the charges, the claim would normally go to Medicare as secondary but they also have an HRA, how does that work? As I just explained, it works exactly as other GHP coverage works.

HRA coverage is GHP coverage. It is primary. If you have a Medicare beneficiary that is a n employed individual, actively working individual and you are paying primary. If there is no – if the employee is a retiree and has access to a retiree HRA coverage, that is secondary to Medicare. Secondary to Medicare, it is not reported as primary. That's a classic bad example of paying something to do.

The rules for primary and secondary for HRA coverage apply just as they do to ordinary GHP coverage. Thanks, John.

John Albert:

OK. And then there was one other question that someone submitted that we can go over and that is talk about a retiree who comes back as a reemployed (inaudible) on whether or not MSP applied. And the specific question said that if – ask that if the retiree (inaudible) returns to work and the employer is required to provide the same coverage under the same conditions that is furnished to other employees – meaning non-retirees, that would be an MSP situation.

I mean, there are instances where somebody could come back to a job but they wouldn't have the same rights of the regular employees in those cases. You know, it really comes down to what does the coverage stem from in terms of their work or – you know, work status. But in this example where they're saying they have the same rights as the regular employees for insurance, then MSP would apply in this case and that coverage for a reemployed retiree or a new attempt should be reported to them as paid.

Again, in terms of the MSP statute, it comes down to what is the source of the coverage for that particular person and if it's because of their current work status, then it's MSP. If it's not, then it's not MSP. That's kind of a short

answer but for that particular question that was submitted, that would be the case of an MSP.

Other than that, we are ready to open up the floor to Q&A for both technical as well as any policy questions you may have. If we get through any of the Section 111 stuff, we could go back to any other final questions for CRC who are still here in the room with us. But again, I'd like to keep it to Section 111 specific questions for now. So, operator?

Operator: Your first question comes from the line (Keisha Bolden) with Horizon Blue Cross. Your line is open.

(Keisha Bolden): Hi. I have a question as for the Medicare demand process. Currently, we are submitting our responses using paper. And is it in the foreseeable future that we were able to submit our responses electronic?

John Albert: I hate to interrupt you but that's a question that's – we're trying to keep this to Section 111, so if you could please, jump off and when we get to the end of the call, we can move on to those but we're looking for questions specifically related to Section 111.

(Keisha Bolden): Well, I'm sorry. I had – I had actually pressed it during that time and it's just coming up now.

John Albert: Oh, all right. Well, take those then for now. That's fine. OK. We apologize. Go ahead. Ask that again.

(Keisha Bolden): Currently, we are submitting our responses to MSP CRC using paper. I was wondering in the foreseeable future with CRC, are we going to be able to submit our responses electronically?

John Albert: I mean, we are always looking to enhance the process but we can't really answer that at this time. So – but yes, I mean, that's the kind of stuff that we're looking at as you probably noticed over the past five years or so. We've gone through utilizing more and more electronic formats for everything for both COB as well as MSP RC and even the worker's comp contract. So that is something we are considering.

(Keisha Bolden): OK. Thank you.

Operator: And just a reminder, if you want to ask a question, please press star then the number one on your telephone keypad. Your next question comes from the line (Andrea Flaherty) with United Care Health. Your line is open.

(Andrea Flaherty):Hi. Yes, I have a question about Section 111 reporting. We are a group health plan and have since 2009 been sending multiple request per year to those individuals who we do not have either a social security number or a (inaudible). Some of those individuals are no longer eligible for benefits through our plan and we're just briefly eligible for example for a few months in 2009. We still have been unable despite, you know, dozens of request for information to get that from them and we are looking for some guidance about what our reasonable efforts, our good faith efforts on our behalf to obtain that particular information.

John Albert: All I can say at this time is that to keep those efforts documented. Obviously, we are not doing CMPs at this time, but again, we would tell everyone to, you know, keep their efforts documented for the future. It sounds like you're doing the right thing. We recognized there are some individuals who will not provide. We did have the model language out there as well but we provided on the website that ask people to, you know, provide their SSNN or their (HCN), you know, and you can utilize that as well. We encourage that actually but just keep your processes documented and you'll be okay.

(Andrea Flaherty):Thank you.

And once again, if you would like to ask a question over the phone, please press star then the number one on your telephone keypad. Your next question comes from the line of (Angela Metcalf) with Blue Cross Blue Shield. Your line is open.

(Angela Metcalf): Hi. I have a question, does the group size come into factor for Medicare to pay primary or not for the group health plan if they have a HRA product?

John Albert: Yes.

(Angela Metcalf): It does? Because if it's less than 20, is Medicare primary?

John Albert: Well, as long as it's not part of a multi-employer group, that would be the case with the exception of ESRD.

(Angela Metcalf): OK.

John Albert: But for working age, yes ...

Female: So whether or not an HRA is primary to Medicare, it's the same rules as it would be for any other (inaudible) plans.

(Angela Metcalf): Got it. I just had a couple of questions about or the question about that group size and then active disabled. So it's active disabled. It's the same way if it's less than 100.

Female: It's identical rules. The HRA, since we're a type of group health plan. So in determining whether or not Medicare is primary or secondary, it's the same rules that would be – if you had large group health plan, if you had one that's not an HRA.

(Angela Metcalf): Got it.

Male: So for a standalone, you know, 20 or 100 and if it's a small time employer plans you use the size of the largest employer in the group to determine the size for everybody in the group.

(Angela Metcalf): Got it. Thank you very much. I appreciate it.

Male: Sure.

Operator: Your next question comes from the line of Angie Wingfield with Humana. Your line is open.

Angie Wingfield: Yes, quick question, talking about HRAs. Are HSAs treated differently?

Male: HSAs are not considered plans with united care secondary payer. Neither are FSAs.

Angie Wingfield: Thank you.

Operator: And once again, in order to ask a question over the phone, please press star then the number one on your telephone keypad.

Your next question comes from the line of Theresa Bentley with UFCW.
Your line is open.

Theresa Bentley: I'm sorry, I was on mute. I was wondering, in terms of somebody who actually is an ESRD, and then actually becomes a not entitled to ESRD, and sometimes it stays on your report for a long time, and the people try to get it fixed so that we actually stop asking for the Medicare to be primary, is there a way that we can get a term date on the reporting that you do?

Male: Well, there are rules for the 30-month coordination of benefits period.

Theresa Bentley: But I'm talking about something – I'm sorry.

Male: You're meaning like somebody who becomes entitled to ESRD, and then suddenly they are no longer, because of a transplant, or ...

Theresa Bentley: Right, a successful transplant, let's put it there.

Male: The 30-month coordination of benefits period applies. Once it's done, then Medicare becomes primary. The fact that someone has a transplant doesn't change the length of that coordination. The benefits period, there are other rules such as, I believe, that Medicare ends unless they are entitled on a different reason as well, that Medicare ends 36 months after a successful transplant. So there's other rules that apply, but the coordination of benefits period is set.

Theresa Bentley: The question is more about the Medicare continues to show as being an active Medicare, even though the patient is saying it's no longer active, I don't have Medicare. And it's very difficult to get the Part A term date on your reporting.

- Male: Can somebody at (inaudible) assist with that? I mean is there – I guess, if they're no longer entitled, then we should receive that update.
- Male: It would have to be investigated on a case-by-case basis. If you're looking for a term date for Medicare, obviously that's not going to appear on our CWF until we have information showing it's terminated. If you're talking about a situation where you as an insurer are no longer primary, because the coordination of benefits period has ended, that should be taken care of by reporting.
- Theresa Bentley: No, I'm talking about, they want us to now pay primary and we cannot get the information that says they are no longer covered by Medicare.
- Male: OK, but that's not what determines whether or not you are in fact primary. At least, that's not by itself what determines that. As long as we have it showing that they're still under the coordination of benefits period, the 30-month coordination of benefits period, then we are only going to pay secondary.
- Theresa Bentley: Right, but I'm not talking about the 30 months at all. I'm talking about after the 30 months. We should be paying secondary to Medicare.
- Male: In which case, you're reporting should take care of that, because you should be showing that for purposes of MSP, you're no longer primary.
- Male: Unless they're entitled due to another reason, like say you have people ...
- Male: Yes, if they would also qualify as working ages so that you – in any case, we need to investigate it on a case-by-case basis.
- Theresa Bentley: Right, and the trouble – yes. The trouble from the group health side is that we want to get proof that it was actually terminated, and we're unable to get that.
- Male: (Jeremy), if they contact you, can someone at (inaudible) take care of that?
- (Jeremy): Yes, if you'd like to give us some examples, we can take a look and see.
- Theresa Bentley: I'll give you three. Give me an e-mail address.

Male: I'll do it over the phone, because we don't want to be sending it through the mail.

(Jeremy): Yes, my number – my direct line is 646-458-6614.

Theresa Bentley: Perfect. And you're (Jeremy)?

Male: Yes, he is.

(Jeremy): I'm sorry.

Theresa Bentley: Thank you. Could you also advise me about the reporting that used to always indicate the date of death for all of our members and their spouses, and dependent children even if that occurred, and it doesn't show anymore? Is that something that you can address?

(Jeremy): I can look at ...

Male: Yes, we'd like to see examples there, too.

(Jeremy): Yes.

Theresa Bentley: OK. Because it was really helpful, and then as of January last year, that was the last time we actually got that. And every time we actually inquire, our IT department says they give us what you give them. I said, why did it disappear? It disappeared. OK, I'll do both of those with (Jeremy).

Male: OK, thanks.

Theresa Bentley: OK.

Operator: Your next question comes from the line of Angie Wingfield with Humana. Your line is open.

Angie Wingfield: Hi, thank you. Just in relation to the previous question that was asked, we have seen members, one in particular, that had Part A only. We were receiving on the MSP file, the monthly file. And they had Part A only, but they picked up Part B in February of 2012. However, that member did not get

reported back from CMS as picking up Part B until November of 2012. And at that time, that was the first instance that members showed up on the report as having Part B, and the Part B was dated back to February of 2011. So that was almost a, you know, nine-month span before we were notified from CMS that the member picked up Part B.

Male: That was probably – that was probably a retroactive enrollment, which does take place on occasion.

Angie Wingfield: Do they go back that far?

Male: I don't know, off the top of my head, how far back they can go.

Angie Wingfield: I mean, that just seems really long, yes. I mean, I could see a month or two, but this was almost 10 months, from February to November. I'm sorry?

Male: It would depend on what the issue was, that was causing the retroactivity. You can have people that apply for social security disability benefits, and because it's denied at many levels, by the time it's approved, they're actually not only entitled to Medicare they're entitled to some retroactive Medicare. There could have been an issue of whether or not the person was entitled to Part B, that caused some delay. We can't really tell you what caused it, but it is possible.

Angie Wingfield: I understand that. And thank you. The reason we had found it was because a vendor that we partner with had found it prior to us getting it on the CMS file. So they were able to uncover that from, I guess, using (inaudible) info crossing prior to us receiving it. So you know, they were paid commission for the overpayment. Thank you.

Operator: Your next question comes from the line of Ellen Holbrook with Blue Cross Blue Shield. Your line is open.

Ellen Holbrook: Yes, hi. I have a question regarding the thousand dollar penalty. I haven't heard any comments. Have there been any decisions after it was lifted, on what that will be, and what we can anticipate for that going forward?

- Male: I mean, we don't have any comment on that at this time. So ...
- Ellen Holbrook: OK. And then I just wanted to add a comment back to the one who was talking about the date of death. We used to get that on the Medicare query file, and we haven't been getting that. So I know that you said you needed examples, but that information was provided on the query file that we would send up every quarter. And we're no longer getting it.
- Male: OK, we will definitely take a look at that.
- Ellen Holbrook: OK, thank you.
- Male: But examples of an individual that you know to be deceased, that you've not received a date of death on, is still something that's helpful for us, so that we can actually take a look and pinpoint the problem. So that is something that we still want.
- Ellen Holbrook: OK.
- Operator: Your next question comes from the line of (Angel Vetter) with Meridian Benefit Plan Administrators. Your line is open.
- (Angel Vetter): Hi, I'm just wondering, regarding HRA coordination of benefits, if a participant depletes their balance, but continues to work – they're a seasonal worker – and then we get a claim – a medical claim, he or she no longer has an HRA balance, how do we determine or explain to the participants how that claim gets paid?
- Male: Well, the way for that to get paid is that the HRA would have to be – or you know, the person billed – and the only way that the provider can then pick up the rest is that they show that the primary payer paid zero dollars, which is very common. And especially when it's like an annual like sum of money that's provided, and it gets exhausted. But they still – for our claims processing systems to be able to process that – as the secondary payer, you know, which would essentially be for the full amount because the primary payer, meaning the exhausted HRA, doesn't have anything left, that's pretty much the only way that that can process.

Male: I mean basically, they just need some documentation that, for the current year, whatever, that the HRA amount has been exhausted.

(Angel Vetter): Right.

Male: The HRA amount being exhausted is exactly equivalent to a normal GHP benefit coverage maxing out in a particular period of time, and not being available, even though it had a very high, say, maximum benefit level of 50,000 or 100,000 dollars, as a – as a policy benefit max. If a patient hits that maximum, the GHP insurance will not pay anything more, that triggers the transition also. The HRA coverage reaching its max is the same as any other GHP coverage benefit reaching its max.

(Angel Vetter): OK, so we can just communicate with the provider, that there are no benefits at this time, and they submit the claim showing maxed benefits.

Male: Yes.

(Angel Vetter): OK.

Male: But please keep in mind, that you can report a termination date for the HRA, the Section 111 process. That guideline changed sometime back, I believe it was October – end of September, 2011, with the changes in guidelines. If the HRA coverage does exhaust, and it's not going to be replenished – it is not a month-to-month addition to the HRA plan, you know, if that coverage is actually exhausted for the plan year, you can send an update on your Section 111 file with that HRA termination date. That is actually what you should be doing, and that will prevent future ...

(Angel Vetter): Yes, excuse me, and we are doing that. This would be an example of a participant that would – is a seasonal lay-off, and expected contribution would come when they're back, you know, working in the field.

Male: OK.

Male: Thank you, (Jeremy), now I remember.

(Angel Vetter): Thank you.

Male: Right.

Operator: Your next question comes from the line of Angie Wingfield with Humana.
Your line is open.

Angie Wingfield: My question was answered, thank you.

Operator: And once again, if you would like to ask a question over the phone, please press star then the number one on your telephone keypad. Your next question comes from the line of (Craig Wolf), with BCBSIA. Your line is open.

(Mary Overton): (Craig) has stepped out, so it's actually (Mary Overton) on the line. And I have a question kind of tagging on the one about the penalty clarifications. The smart act had also referenced changes around collecting and providing Medicare HCN numbers and social security numbers, within the Section 111 reporting. Is there any new information or guidance regarding what the changes will be in the future, around the Section 111 reporting?

Male: CMS is taking whatever steps it needs to implement the smart act, but it doesn't have any comments to make on those steps at this point. Anything that's required to be done through regulation, whether it's a final rule or an ANPRM or anything else like that, will show up on our normal agenda, and you will see things published in the federal registrar. Anything that's not being done in association with regulations, or is being done separately, as we have information available, we will make it known. But we don't have any general comments on what our plans are.

(Mary Overton): OK, is there any estimated time frame on when you believe you'll be publishing information on how these files will change?

Male: No. I mean, no, there isn't.

(Mary Overton): All right, thank you.

Operator: Your next question comes from Sheila Stovall, from Martin's Point Health.
Your line is open.

Sheila Stovall: Hi, I just had a quick question if this Webinar will be recorded, so someone can access it at a later time, and if so, where can they find that?

Male: Are you referring to the upcoming CRC Webinars, or are you referring to this particular conference call right now?

Sheila Stovall: This one today.

Male: This one today, yes. Yes, and we will make it a point to get that out. We know that some of the transcripts have been very tardy in getting out onto our system, but we will make sure this is out as quickly as possible.

Male: Yes, I'm not sure, John, she asked a recording that they could listen to. I'm not sure that we do that. What we regularly do is, this is being transcribed, and the transcription will be available.

Sheila Stovall: OK, perfect, yes, thank you.

Operator: Your next question comes from Tonya Lee from Blue Cross. Your line is open.

Tonya Lee: Yes, I had a question about the unsolicited file. You were talking about – I mean, I understand that you send to us when there have been changes made, but is there any way that you can put on there what actually has been changed? Because we're having a problem, between our records and your records, trying to figure out what actually changed.

Male: Unfortunately, there isn't anything to specifically point out the field or fields that may have changed. But all of the data elements that were on your record, or that are presently on your record, are displayed there. You can compare what you were sent, versus what is on the unsolicited file, and determine what's changed that way.

Providing an indication as to exactly what fields have changed outside of that, more specifically, is something that we are looking at as a possible future enhancement, but have no time frame for that, unfortunately.

Tonya Lee: OK, the main reason I'm asking is because I have a lot of the SP errors, you know, that I probably could override, but I can't – I mean, they're not coming up on the unsolicited file. And so, I'm trying to correspond the two, and it's not working real well.

Male: OK, it could be that you're getting hierarchy reject codes, because there's actually a record in existence already that you're trying to post, or that you would be overlaying, that was actually created via another avenue, first outside of the Section 111 process by an entity that's higher on the hierarchy tier, or it could also be a situation – and this is a more rare occurrence, but it does happen – there are occasions where a record may be locked at the COBC, and updated with a contractor number, which prevents anybody that doesn't have that authority – the locking authority – to update it.

In those cases, it's tricky. If you feel – basically, if you feel that there is an update that you need to apply to this record, and you're not sure why you're receiving this hierarchy reject, and you're certain that something needs to be updated on the record, then you can call our call center, and be escalated to a supervisor. That supervisor can assist you at the – if they determine that the update is actually warranted, then they can go ahead and help you accomplish that goal. The COBC call center number, for those that don't have it, it's 888-999-1118.

Tonya Lee: OK, one other question real quick is, are ADI reps going to change, when all this takes place?

Male: No.

Tonya Lee: OK.

Male: Just to follow up on some of (Jeremy's) comments regarding the hierarchy, the only – the only entities that can actually – are higher in the hierarchy than a Section 111 report, again would be the COB call center reps, and I guess the MSPRC also above Section 111, I think. So again, this is something that came in directly to the call center, and was updated by them, so that, in those cases, those are the only ones that you should be receiving those. All the

other outside sources of data are lower in the – in the hierarchy than the Section 111 reporters.

And I guess, I wanted to bring up, just this reminded me of when (Jeremy) was talking about the unsolicited response process. This is something that, for the gentleman who called from the state of Washington, and was having issues with conflicting records, if their reporting entities are not using the unsolicited response process, this is an excellent reason why we created it. Because it will tell the submitter sooner rather than later that somebody else is basically contradicting the information that the 111 submitter is submitting, and they can find out more – you know, use that process to hopefully reach out to those other entities, and find out, you know, what's going on, and basically allow you to more quickly report consistent information to the COBC. But with that, I'll turn it back over to Q&A.

Operator: Your next question comes from (Angel Vetter), from Meridian Benefit. Your line is open.

(Angel Vetter): Yes, I'm wondering how or what I can expect if I'm going to be submitting on my next file a late termination. I received termination notice from an employer back from 2012, for coordination of benefits with an HRA, and in this type of industry, it's not uncommon for an employer, the HR department, to receive untimely termination notice.

Male: You'd receive a late flag or whatever, right, (Jeremy)?

(Jeremy): That's correct, yes. There would be a late submission indicator on their response file.

(Angel Vetter): And so what does that trigger? Does that trigger fines, or what type of thing can I expect to come down the pike?

Male: Nothing at this time. I mean, basically it's telling you that, you know, based on the business rules that are set up in terms of when records are due to be reported or updated, it would – it would indicate that it was late based on the guidance that's in the user guide. That's all.

(Angel Vetter): OK.

Male: You know, in terms of people getting updated information – plans getting updated information, you know, late from employers, I mean all I can say is that it is in everyone’s best interest to report updates timely. Because again, the employers are also receiving demands for repayment, so if they get updates to us, you know, or new records to us timely, it’s important. Because it saves us all, you know, money and resources in terms of paying the claim correctly the first time. So that’s all I can say, is to continue to reach out to your customers and say hey, look, this is – this is in your best interest because – and you know, again, paying right the first time is a lot cheaper for everybody.

(Angel Vetter): Right, OK, thank you.

Operator: Your next question comes from the line of (Jane Howard) of Claims Management Incorporated. Your line is open.

(Jane Howard): Hi, there. I’m calling from a workers’ compensation perspective. When a claim has been reported properly, through Section 111 with accurate ICD9 codes, however, it does not have an ORM close date, we’re finding instances where the claimant is being denied coverage for non-related illnesses, and they are being told it is due to the open work comp claim. What recourse, other than the normal procedures, does our claimant have to ensure benefits are being paid on routine, and sometimes critical, medical needs? Or is there anything we can do in our reporting differently?

Male: Well, I mean, first of all, I mean you realize that’s an NGHP question, for the call coming up in a couple weeks. But I mean, yes, the COB call center would be the place to go for these type of emergency one-off situations, so ...

Male: And beneficiaries, when they have a claim denied up front, they always have appeal rights.

Male: Right. Yes, we do see – or at least we saw more of this occurring in the recent past with inappropriate denials of claims that were outside of the diagnosis groups or whatever, that were reported on the 111 or whatever record. We’ve

since done some outreach in education with providers, and our Medicare contractors, which seems to have significantly reduced the number of those instances from, you know, occurring. But again, I mean, you know, the COB call center, or even 1-800-Medicare, or the actual contractor themselves – the claims payment contractor – they should reach out to. And as (Barbara) said, they do have appeal rights on that.

(Jane Howard): And we do ask – I'm sorry?

Male: If it's the beneficiary – just wanted to clarify. If it's the beneficiary, they should call 1-800-Medicare.

Male: Yes.

Male: If it's the provider, they should call the Medicare contractors' provider hotline, to get adjustments made.

Male: Right.

(Jane Howard): Right, and that's the direction that we give them. However, they still find difficulty. And when I say that they're not related, I'm talking about somebody with a hand injury that's being denied cancer treatment, or diabetic treatment. So it's – I mean, I will say that it was better, however, we're seeing an increase in these instances, just in the past few months.

Male: Yes, and we ...

Male: We don't mean to be rude, but this really is a GHP call, and the other thing, in terms of these denied claims, often when we've investigated them, the reason they were denied had nothing to do with their open liability record, they were properly denied for some other reason. So, I mean we do need people to go through the process, but I think for everybody else on this call, since they're really GHP entities, we need to defer this type of discussion to the NGHP call.

(Jane Howard): OK.

Male: And we do have a – we do have an internal change request, too, that's going to handle some of the more frequent mistakenly denied claims, like the

diabetes kind of thing – that’s also – this is all part of that process, of trying to make sure that stuff is not inappropriately denied. But, again, we have to move on to the GHP questions, thank you.

(Jane Howard): Thank you.

Operator: Your next question comes from the line of (Stephanie Stamey) with Highmark. Your line is open.

(Stephanie Stamey): Hi. Just regarding HRA, I just wanted to clarify, because the new user guide that comes out is telling us that the termination date should only be submitted when they lose or cancel their coverage, but the previous alerts were telling us that we send a termination date when they’re exhausted, and an add whenever that benefit comes back the next year. Which is correct?

Male: They can be terminated if they exhaust – if it’s a yearly annuity. But if it’s a monthly, the no, they can’t be. They shouldn’t be terminated, because you’d never be able to ...

(Stephanie Stamey): Right.

Male: ... process that many. So, if it exhausts, as (Jeremy) said earlier, you know, say it’s whatever, \$6,000 HRA and it exhausts in June, you can send a term date at that time, and then re-establish it when it’s refunded the following year.

(Stephanie Stamey): OK, thank you very much.

Male: We’ll look at that language and make sure it’s clear.

Operator: And once again, if you would like to ask a question over the phone, please press star then the number one on your telephone keypad.

Your next question comes from the line of (Christine Carter) with Anthem Blue Cross Blue Shield. Your line is open.

(Christine Carter): Yes, this question has to do with back to the GHP recovery coordinator, the new process we’re going into in May. I just have a thought, that when we

were first told of the new contractor, it was called Strategic Health Solutions, was the company. What is the difference between Strategic Health Solutions and (CGI)? Is there a connection between the two, or are they two different contractors, or did something change that we didn't get a new bulletin? What's the difference?

Male: No, the Strategic Health is not the CRC, and it is not involved in any GHP recovery activities; that's another contractor.

(Christine Carter): OK.

Male: But, the CRC is CGI, that was recently awarded in January or so, and that is the contractor that will be referred to as the commercial repayment center, and goes live on May 13th.

Male: And the transition should be relatively seamless to you, as an insurer. Yes, you'll have new telephone contact numbers, and new addresses, that as I think has been said several times during this call, the underlying process isn't expected to really change at all. You may see some – you know, you're obviously going to see new letterhead, but in general, the process will be the same.

(Christine Carter): OK, thanks.

Operator: And there are no further questions at this time. I turn the call back over to the presenters.

Male: OK, thank you, operator, and everyone. This was a good call, lots of good questions. We had a lot of participants. We would encourage folks related to regarding Section 111 issues to please continue to submit those to the resource mailbox. And again, stay tuned to see the upcoming information regarding the CRC transition Webinars, et cetera, there will be a lot of information coming out in the next couple of weeks. With that, thank you, and good afternoon.

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

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