# TRANSCRIPT
# TOWN HALL TELECONFERENCE

## SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
## 42 U.S.C. 1395y(b)(7) & (8)

**DATE OF CALL: November 5, 2008**

**SUGGESTED AUDIENCE: Group Health Plan Responsible Reporting Entities Which Currently Have a VDSA or VDEA with CMS.**

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**FTS-HHS HCFA**

**Moderator: John Albert**
**November 5, 2008**
**12:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the question and answer session, please press star 1 on your phone.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I'll turn today's meeting to John Albert. You may begin.

John Albert: All right, thank you. First of all, CMF does apologize for the confusion over the phone number that was out on the Web site for those that - obviously you all got the right number since you're here. But the correct number for this conference call is 1-800-593-0695. So if there's anyone that you think may want to attend this, please try to send them an email or contact them, etcetera, to get them onto the phone call.

We have a lot of material to go through today and - oh - and the pass code is MMSEA111 - that's MMSEA111. With that, I'd like to turn the call over to Mr. (William Becker) of CMF who will provide a brief introduction and the presentation will begin. Thanks.

(William Becker): Thank you, John. My name is (Bill Becker) and I'm also working here with - at CMF on the Section 111 implementation that we all are actively engaged in. My official title is director of data sharing agreements but I generally - most of you, if you know me at all, know me as the person who's attempting to get the group health plan insurers involved actively in Section 111 reporting.

And we - that's the purpose - the purpose of this call is for folks who already know they will be reporting under Section 111 as an RRE and who are interested in knowing the technical details about how the reporting process will take place. This is not going to be a policy overview - although we obviously will be touching on certain policy points. This is much more technically oriented, dealing with the data elements themselves in file layouts, how the technical aspects of the data exchange will take place and how we have structured them.

With me today on this call is John Albert, who you just heard. I'm going to turn it over to one of our major colleagues by the name (Pat Ambrose), who's going to be basically leading the call today. Also with me in the room is (Steve Foray), also (Ed Frazier) and finally (Bill Ford). (Steve) and (Ed) work as - with our contractor on data exchange and (Bill Ford) works pretty much directly with me at the coordination of benefits contractor in New York City.

It's a good group and I think we can answer any question that you have as we go forward. There will be some time at the end of this call for Q&A session. We don't know how much time there will be because we don't know how quickly we'll be able to move through the material. I do want to ask you to make sure that you write down your questions as you think of them because if you don't get a chance to ask them on this call, you can send them to our

mailbox - our dedicated Section 111 mailbox which you can access through our Web site.

As I say, there will be a time for some Q&As in this call but we don't know how much there will be and we don't also know how many questions we'll have. so if your question doesn't get answered on the call, please send it to us. And with that, I'll turn it over to (Pat Ambrose) who will take it away from here - thanks.

(Pat Ambrose): Thanks, (Bill). First, I'd like to just make a clarification about - throughout my presentation I'll be referring to voluntary data sharing agreement and voluntary data exchange agreement partners versus those responsible reporting entities that will be new to this type of reporting and data exchange with CMF. So currently we have the VDSA or VDEA partners who are transitioning to Section 111. This is a group of healthcare plans and Blue Cross Blue Shield plans that have been voluntarily sharing GHP coverage information with CMS and has signed either a VDSA or VDEA agreement.

Most of the insured and some of the employer VDSA and VDEA reporters must transition to Section 111. Your VDSA or VDEA agreement will actually end with the implementation of Section 111. And then we refer to the new GHPs, those are those entities that are not currently involved or exchanging data with CMF under a VDSA or VDEA.

If you maintain a coordination of benefits agreement with CMS for the purposes of receiving claims paid by Medicare for secondary payment by your plan, that is not considered a VDSA or a VDEA - so just some clarification. And throughout my presentation, I'll try to be clear when I'm directing information specifically at the VDSA and VDEA partners for making the transition and when it's directed to the new GHPs.

On documentation that's available - hopefully you all are very familiar with the Section 111 Web site - www.cmf.hhs.gov/mandatoryendsrep. On that main page, there are a couple of downloads that you'll find helpful for your GHP reporting process. the first is a document - the registration process download. And that contains the data elements that we'll collect during registration. The VDSA and VDEA partners are registering the paper form.

However, all the other GHPs - the new GHPs - we'll register on the few (unintelligible) Web sites beginning in April 2009. Also on that main page, you'll see an implementation time line. Just a couple of notes there - the VDSA and the VDEA partners should be registering now. actually, your forms were due into the COB contractor by the end of October. Of course, we're accepting those forms now.

You should be involved in testing and your first production file submission will be during the first quarter 2009 when - during your newly assigned submission time frame - and we'll talk a little bit about that.

Also on that implementation time line, you'll see that all other GHP responsible reporting entities again are to register on the COB secure Web site starting in April. You will test the Section 111 process between April and June 2009 and your first production file submission will start taking place between July and September of 2009 according to your assigned file submission time frame.

We've made some changes to that Web page recently and there are now on the left hand side some links to GHP page and then one also specifically for liability worker's comp and no-fault responsible reporting entities. On the GHP page, the most important document that you should download is the

GHP user guide. You need to be on the lookout for updated versions of that guide, information that we talk about today - there are some new information or changed information that we will update in that guide at a later date.

I do want to point out that there's a checklist in Section 6.6 of the user guide that you might find helpful to help guide you through this process. so I'm also in my presentation making the assumption that you have downloaded this user guide and read it over so we're not going into great specific details unless we get there during the question and answer session.

Also on the GHP Web page is just the paper registration process - this is for the VDSA and VDEA partners only to use for their registration. A couple of other downloads - one entitled data elements provides some additional information, definitions of active covered individuals. Most of that information is in the GHP user guide. You'll also see a section on the small employer exception - or a download on the small employer exception - that information is in the user guide at this point as well.

We are going to offer computer based training modules. You are able to register for those courses. Currently the VDSA and VDEA partners may register through their EDI representatives - their COBC EDI representatives. all others will register for these courses by calling the COBC help line which you can find in the last chapter of the user guide.

The CDTs are basically based on the information that you'll see in the user guide with some additional examples that you might find helpful. Not all the courses are available yet so it will be later this month. So again, keep checking Section 111 Web site for updates. In order to get on the notification list, you need to click on the four email updates and notification link at the bottom of the page and follow the instructions.

Next I'm going to talk about the registration process. you will find information on the Section 111 registration process in Section 6.1.6 of the user guide. The purpose of the registration is to certify that the registrant is a valid responsible reporting entity for Section 111. It will also assign - to this process you will be assigned a Section 111 reporter ID - sometimes we refer to that as your RRE ID. You will need this number on - in order to submit your files. That number is placed in the (unintelligible) record of each incoming input file.

Through the registration process, you will develop a Section 111 reporting profile. This profile includes estimates of those - the volume of data that expect to be submitting so that we can assign you an appropriate file submission time period and pursue (unintelligible) planning purposes. You will also be assigned a production live date and a file submission time frame. that's a seven-day window for each quarter - each calendar quarter during which you are to submit your MST input file.

In addition, the registration process will establish necessary file transfer mechanisms and you will also be assigned a COBC electronic data interchange representative which we will from here on out refer to as your EDI rep.

Note that responsible reporting entities must complete the registration whether it's via paper or via the COBC secure Web site. This registration cannot be performed by your agent. However, you will name your agent and provide agent information during the registration process.

Some more specifics related to the VDSA and VDEA partners. Download your registration attachment or form off of the Section 111 Web site on the

GHP page. Note that if you select Connect Direct via the AT&T global services network, you need to do - you need to also include the Connect Direct Transmission Information Form.

This is needed so that we can develop your Section 111 profile even if you are currently transmitting files under your VDSA or VDEA using that method. Also, note the file data names for the data exchange will be different for Section 111. So again, you provide that information on that Connect Direct Transmission Information Form.

Your authorized representative must sign the attachments, must sing the last page of your registration before you send it in. so please make sure that that form is signed prior to sending it over to the COB contractor. And again, VDSA or VDEA and partners and registration forms are due now.

Later, the VDSA or VDEA partners will be invited to come to the COBC secure Web site. All the information that you're supplying now on your registration form will be loaded into the system. Prior to April 2009, you'll be mailed a PIN - personal identification number - that will be mailed via US Post to your authorized representative.

Your authorized representative will identify or name your account manager who will bring that PIN to the secure Web site, obtain his or her log in ID and validate the account information that's been loaded to the system. And from that point out, you'll manage your account information on the COBC secure Web site.

So while you are not register on the COBC secure Web site at the current time, you will use the COBC secure Web site for managing your account and monitoring your file statistics in the future.

All other GHPs or new GHPs who are not VDSA or VDEA partners will register on the COBC Web site starting in April. The registration will be initiated. During that initiation, you'll provide your authorized representative information and company information. The COBC will validate that information and then mail a PIN or personal identification number to your authorized representative. The authorized representative will then identify your account manager and your account manager will come back to the COBC secure Web site and perform the second step of setting up your account information using that PIN.

The account manager is essentially your technical contact and that person is responsible for managing the overall day-to-day Section 111 reporting process. more information will be posted on this registration process on the COBC secure Web site at a later date and we'll also put that - update the GHP user guide.

After your registration has been processed, you will be sent an email with your profile report as an attachment. The email will go to your authorized representative. This profile report contains all the information that you applied during registration and during account set up. And the purpose of it is to allow you to verify that this information is correct. It will also - the profile report will also contain your EDI representative contact information and email name - email address and a phone number.

In addition, the profile report will contain your Section 111 reporter ID - or RRE ID - which I mentioned before you'll need on your file submissions. It will also contain your quarterly file submission, time frame or that seven-day window during which you are to submit your MSP input file each quarter. In addition, it includes a data use agreement. And for those who select a Connect

Direct File Transmission Method, will include destination data set names that you are to use to transmit your files to the COBC. And the COBC (V-Cam) connection information for (Agnus) as well as you need to complete that connectivity.

Again, I remind you, the profile report must be signed as well. Signed just the last page and return that to the COBC. So both the VDSA partners who are registering now and new GHPs will register in April will receive a profile report via email to your authorized representative. Your authorized representative must sign that last page of the profile report and return it to the COBC.

This profile report needs to be returned to the COBC signed before your testing can begin. I have something to talk about - silent transmission method. You could refer to Section 7 of the GHP user guide for additional information. The COBC is recommending and CMS is recommending that if you anticipate that you will be transmitting on average more than 24,000 records on your MSP input files on a regular basis, we recommend that you choose either the secure FTP file transmission method or the connect rep file transmission method.

HGTPS involves a file up and download process where you must be a logged in user of the Web site and that session must remain open while the files are up and downloaded. And so given the time factor and what would be reasonable for a user to wait for the file up and download, after our calculations we think that a limit of 24,000 records would necessitate you using a different file transfer method.

So the methods are Connect Direct - otherwise known as NDM via the AT&T global network services or AGNUS. Contact your local AT&T business

services office or an AT&T reseller to establish an account for AGNUS if you currently don't have one. We recommend if you are choosing this method and you are going to - and you need to establish a new account that you get this process as soon as possible since it may take up to a few months to set up.

If you have problems or questions with that, you may call the COB Help Desk and request information. You'll be referred to an EDI representative to help you.

The AGNF supports TCPIT and SNA. There is an error in the user guide where it indicates that FGP is a possibility over AGNF - that is not true. You must use Connect Direct or NDM in order to transmit files using this methodology.

The next file transmission method that's available currently only to VDSA or VDEA partners is secure FTP or HHTS file up and download via a CMF electronic file transfer mailbox. So those VDSA or VDEA partners who are currently using secure FTP or HHTS may continue to do so using their same mailbox, same user login IDs. However, there will be different data names for Section 111. And I refer you to Appendix F of the user guide for the file naming conventions that will be used.

For secure FTP, under this methodology we recommend that you use the sterling connect enterprise secure FTP client which is you can purchase from Sterling Programs for $200.

Now later - when the secure Web site - the COBC secure Web sites become available in April 2009, we will provide the opportunity to use secure FTP and HHTPS via the COBC secure Web site. No special set up is required. You'll use your same COBC secure Web site log in IDs for these methods. Those

that are currently using the CMS mailbox may want to change and use secure FTP or HHTPS on the COBC secure Web site instead so that you have sort of a one stop shop in order to not only transfer your files but also monitor your file statistics and activity related.

We also recommend if you're using secure FTP via the COBC secure Web site that you use the Sterling Connect enterprise secure FTP client. No software - no additional software is needed for file up and downloads via HHTPS on the COBC secure Web site. But that again, is just for smaller amounts of data due to that user session that's required during transfer.

We'll post more information about the secure FTP and HHTPS options on the COBC secure Web site in the user guide at a later date as we approach the April time frame.

Next I'm going to briefly talk about the reporting options that you can see defined in Section 5.2 of the user guide. The basic reporting option represents the minimum reporting requirements for Section 111. It includes the submission of Medicare secondary care also known as you MSP input file for hospital and medical coverage of active covered individuals.

Optionally, as a basic option submitter, you may use the query only file that's in the file of the XEX1227271 entitlement query file. With the basic options, the COBC will only return Medicare entitlement and enrollment information for Medicare parts A, B and C which reflect hospital medical coverage only.

The expanded reporting option is very similar to what our current VDSA or VDEA partners are exchanging data under. It represents the basic reporting option plus the exchange of prescription drug coverage information. Again, it

is optional - this expanded option, but we're very interested - I'm sure you are in exchanging prescription drug coverage information with Medicare.

So the expanded option includes the exchange of your MSP input file for primary medical, hospital and prescription drug coverage for active covered individuals. It also includes a new file type and non-MSP file which - under which you report supplemental prescription drug coverage records. And you also have the opportunity to submit retiree files for the retiree files subsidy program.

And in addition, that non-MSP file allows for you to submit entitlement and enrollment query records as well. In addition, under the expanded reporting option, you may optionally use the query only input file, the X12270271.

Under the expanded reporting options, the COBC will provide response files with entitlement and enrollment information for Medicare parts A, B, C and D - Part D being the prescription drug coverage.

If you sign up for the expanded reporting options, you must provide CMF with information about drug coverage for Medicare beneficiaries on a regular basis, either as primary drug coverage on your MSP input files, supplemental drug coverage records on the non-MSP input files or your retiree - RDS retiree file records.

Now I'm going to talk a little bit more specifically about the MSP input file which is required for all responsible reporting entities, no matter what reporting option you choose. Refer to Section 6.2 of the user guide - all responsible reporting entities are required to submit a MSP input file on a quarterly basis during your assigned file submission time frame - that seven-day window you'll be assigned.

This is the file that the COBC is using to determine GHP coverage that should take primary to Medicare. First, the COBC takes the input records and checks to see if the individual reported is entitled or enrolled in Medicare. And the COBC - if so - and the GHP and the Medicare coverage overlap and it's determined that that GHP coverage - your GHP coverage - is primary to Medicare, the COBC sets up what we refer to as Medicare secondary care or MSP occurrences.

And MSP occurrence just represents a period of time that your GHP is a primary and Medicare is the secondary payer. These records are posted - these MSP occurrences are posted by the COBC on other Medicare systems. One is the common working file - that is where the medical and hospital coverage information for MSP occurrence is posted. And the other file is the Medicare beneficiary database where MSP occurrence is related to prescription drug coverage are posted.

On this MSP input file, you are reporting on active covered individuals. Again, these are individuals that are more likely to be - to have GHP coverage that is primary to Medicare based on their active employment status. Refer to Section 6.1.2 in the user guide for your definition of active covered individuals. So essentially again, one of the primary criteria for being an active covered individual is that your GHP coverage is based on active employment. The subscriber, in other words, is working.

You are to report any active covered individuals who fits the definition including the subscriber - his or her spouse and any dependents that happen to be over 45. So for example, if the subscriber is under the age of 45 but his or her spouse is over the age of 45, you would only make a report on your MSP input file for the spouse who is over the age of 45.

On the MSP input file, you're submitting one record per individual. On the information submitted - particularly the social security number reflects the individual - whether it be the subscriber, the spouse or the dependent. You're not just submitting the subscriber information.

Also, it's important to note that you should submit one record per each period of GHP coverage. If you have an individual who is defined as - or has GHP coverage in intermittent periods - so maybe for the first three months of the year and then for some reason they do not have coverage for the next three months but they're back on your roles subsequent to that, you would reporting separate records for each period of GHP coverage with the appropriate effective and termination dates.

It's important to remember that if the GHP coverage is not terminated, it's still in effect when you make your report, to provide an open-ended termination date. In addition, as far as the definition of active covered individuals, anyone with kidney disease, regardless of their age or employment status should be reported. This is for end stage renal disease coordination or ESRD coordination purposes.

And lastly, any individual that you happen to know already isn't a Medicare beneficiary - regardless of their age, please report them as well again. You know, based on their - if they have GHP coverage based on active employment. If you make a report on your MSP input file for an individual who's under the age of 45, you must include the Medicare health insurance claim number or (unintelligible).

The MSP input file - you will send in first an initial file. Basically this will be a larger file submission and it should include your entire population of active

covered individuals. The reporting is to be retroactive, regardless of when your production live date is. It's retroactive to any coverage that was open as of January 1 of 2009. However, the effective date should reflect the actual coverage effective date - even if it was prior to January 1, 2009.

So for example, if you have someone on your roles with open active GHP coverage since 1995, their effective date should reflect that date in 1995. Anyone who is off your roles prior to 1/1/2009 does not need to be reported. And as a special note to the VDSA or VDEA partners, you do not need to resend records that were already accepted as MSP occurrences in our current and open and not in need of any updates.

After your initial MSP input file is submitted each quarter, you'll submit a quarterly update file. This includes adds, deletes and updates only. This is not a full file replacement. Basically anyone -when you go to create this update file, you need to check your roles to look for individuals who need a definition of active covered individuals and keep sending any records that you sent previously that did not receive a 01 disposition code -I'll talk about this a little bit more.

But records that you send in for individuals who are not found to be Medicare beneficiaries will usually receive a 51 disposition code on response file. If that individual still is enrolled in the GHP and still needs a definition of an active covered individual, that record should continue to be resubmitted with each quarterly update file.

Once you have a record that has been accepted as an MSP occurrence - in other words, it is received a 01 disposition code, you do not need to resend that information unless there's a change that needs to be made. So only resend

it if you have information to update or if you actually need to delete the record.

Speaking of delete records, if coverage terminates for an individual or they become - they no longer are an active covered individual because they retire, do not send a delete record for that. A delete will complete remove the MSP occurrence and make it look like the GHP coverage was never primary. You're to send an update record with the termination date filled in.

Delete records on this MSP input file and pretty much across the board throughout this entire Section 111 process, delete files - or delete records are only to remove records that you sent completely in error. For example, if you sent a record for someone who is retired and does not have coverage as an active employee, then you had an erroneously submitted that on your MSP input file and you need to remove it so that the COBC can remove that MSP occurrence and claims can pay correctly.

If you need to change a key field on an MSP occurrence - this is also covered in the user guide - the key fields that are reported by the responsible reporting entity are the effective dates, the coverage type and the relationship to the subscriber. You need to change one of those fields, then actually in that circumstance you need to send a delete first for the old record and then send an add. So that's one exception to the rule as far as sending delete records.

That's because if you just sent an update and tried to update the effective date, we would end up adding - instead of correcting the original record, we will just add a new MSP occurrence because it's a queue field.

Now I'm going to talk a little bit on - specifically about data elements on the MSP input file that some responsible reporting MSPs or others have submitted

as questions. One question that's come up frequently is related to employer size. You need to check off the employer size and update it before each quarterly report. Employer size is calculated based on the number of employees - not subscribers and not the number of covered lives in the GHP.

Multi-employer plans, multiple employer plans, group health plans must have employer size for each employer on - and I refer you to the MSP rules related to have 20 or more employees for working age situations and more than 100 employees for disability situations. These rules depend on at least one employer in that multi-employer group health plan having 20 or more employees or 100 or more employees.

Another question that has come up is what is meant by the policy holder. In Section 111 documentation when we refer to the policy holder, we are meaning the employee or the subscriber. Another question was related to the document control number or DCN. This is a number that is generated by you, the responsible reporting entity. It's used for record tracking purposes. You can create whatever number you so choose. And example might be that you might use the (unintelligible) date of the report plus some sort of record counter and maybe part of your member ID. And this is to allow us to more easily track your input file records and relate them to then response file records.

TTAs that are reporting as response Section 11 responsible reporting entities should put their TPA - tax identification number - in the insured's tax identification number or TIN. Self funded employers who are responsible reporting entities reporting should put their employer tax identification number or employer identification number in the insure TIN. And there would be an insurer applicable.

Also for self funded plans, the individual policy number - we suggest that you use the covered person's member ID as assigned by the employer. Basically this is the - while you may not actually have a policy, this is meant to be a number of how you uniquely identify this individual in your system.

If you do not have a group number under a self funded plan, then just plug with some valid value. It is a required field. Multi-employer GHPs - if you are defined - if that multi-employer GHP is defined as a tax partly plan, then please put the plan sponsor tax identification number or employer identification number in the employer EIN. We'll update the GHP user guide to reflect this information as soon as possible.

Next I'm going to talk about the TIN reference file or the tax identification number reference file - TIN reference file. Information on this file can be found in Section 6.2.2 of the user guide. The TIN reference file contains records for every TIN or EIN submitted in Field 21 and 22 of the input file. Those are the insurer and employer TINs.

TINs submitted on the MSP input file must match an entry on the TIN reference file in order to be accepted. A TIN reference file is somewhat unique in that it does not have a separate response file. You send it to the same location as your MSP input file. If it does not process all your - if your TIN reference file does not process, all your MSP input records will fail for invalid insurer and invalid employer TIN.

On the TIN reference file, you're asked to provide a mailing address associated with each insurer and employer TIN. That address should reflect the place to which healthcare and insurance coordination of benefit issues should be directed. In other words, your claim office where you would want demands sent to.

We recommend that you always -when you submit your TIN reference file that you always submit the entire set of TINs. However, that is not actually required but that would ensure that the appropriate updates are made. You only need to submit your TIN reference file when you have changes. Everyone - VDSA, VDEA and new GHP plans must send a TIN reference file with their initial Section 111 MSP input file submission. However, subsequent quarterly updates, you need to only submit a TIN reference file if you actually have changes or additions to make.

Let me talk a little bit about what we refer to as pseudo-TINs. This is a situation where we understand that a lot of insurers may not currently have valid TINs for employers. The TIN reference file includes an indicator - a TIN indicator and one value is referred to as a pseudo-TIN. You have until July 2009 to get valid employer TINs.

You're only allowed to use the pseudo-TIN indicator for employer TINs or EINs. It's not for the insurer or your own responsible reporting entity agent. This pseudo-TIN indicator does not apply to new GHPs since your first production MSP input file is due in the first quarter of 2009.

With your third quarter - so again, speaking specifically to the VDSA or VDEA partners are transitioning with the third quarter 2009 transmission, you must resubmit your TIN reference file with valid employer TINs and resubmit all the MSP input file records previously sent with those pseudo-employer TINs.

The COBC will then begin validating TINs and will include an invalid TIN indicator on the MSP response file. We'll update the user guide with this information. We're going to accept your MSP input file records since we want

to post the MSP occurrences to make sure that Medicare (unintelligible) claims correctly. However, we are tracking whether valid TINs are submitted or not. And if by your third quarter submission - third quarter 2009 submission - you must be submitting valid TINs you're be at risk of non-compliance.

The MSP response file - information on this can be found in Section 6.2.9 of the user guide. You must react or take action to the - on this file. You must take action to correct any errors that are reported back. you must make updates to your internal system in some cases.

On this MSP response file, if the COBC finds the individual reporter to be a Medicare beneficiary, then Medicare coverage information is supplied back. We suggest that you save the HIC number for subsequent updates - that's that Medicare Health Insurance Claim number. This would - you don't have to but it would insure that any subsequent updates or deletes are matched.

We also recommend that you save the MSP accepted date and termination date if provided to know whey your GHP is primary and Medicare is secondary. On the MSP response file, there are two sets of disposition codes and that's a result of the hospital and medical coverage and the MSP coverages being posted on the CWF and the drug coverage MSP occurrences being posted on the NBD I mentioned previously.

As far as disposition codes go, a 01 means that your record was accepted and an ASP occurrence was created. You may send in a perfectly acceptable record. However, if that individual is not found to be a Medicare beneficiary or your GHP coverage doesn't overlap Medicare coverage, we will not create a MSP occurrence and you will not get a 01.

Instead, that individual is not found to be a Medicare beneficiary, most likely you will get a disposition code of 51. When in those circumstances, you needed to keep sending that record with each quarterly update until that individual is no longer covered by you GHP or no longer fits the definition of an active covered individual.

So basically on an - once you get a 01, you may discontinue reporting that record unless you have an update or delete to make. If you've got a 51 disposition code, we expect you to continue to resend that record.

A disposition code of FP - the FP stands for an internal systems notation of secondary payer. FP disposition codes imply that you've hit one of the - an error or an FP error. So essentially getting an FP disposition code back 99% of the time means that that record is in error and you need to react and fix it.

The error codes are listed in Appendix D of the user guide. When you go to fix a record that you received an FP disposition code, submit the correction on your next quarterly file submission - no interim files for error corrections are accepted are expected. There's some exceptions - you in rare cases may receive an FP disposition code and some FP error codes that are COBC responsible rather than responsible reporting entity responsible.

Normally, these errors are cleared from those records prior to the creation of a response file. But in some again, rare cases, you may see some of these so we have provided those COBC responsible error codes in Appendix D so you can make a distinction in your programming for processing response files.

If you receive an FP disposition code and a COBC responsible error, just resubmit that record on your next quarterly update file. Another exception is the FPEF error code which is related to the employer size. If the employer size

is such - COBC is not creating an MSP occurrence according to established rules for working age, etcetera, there's nothing you can do obviously to change the employer size. So you will in some case get an FP error - FP disposition code with this FPEF and we ask that you resend that record with your next quarterly file submission. Obviously each quarter you're updating the employer size and so the conditions can change.

There's also an exception, you may receive an error code about an invalid - and again, this is a rare circumstance - an invalid termination date when the Medicare coverage and the GHP coverage don't overlap. And obviously you can't change that circumstance either - we ask that you just continue to resubmit those records on quarterly updates.

I'm not going to go into great detail about the prescription drug disposition code or the RX disposition code. Please see Section 6.2.9.3 of the user guide. Only those reporting under the expanded option will receive an RX disposition code. I recommend that you base your response file processing on insurance coverage type. And if you look at that section in the user guide, it will tell you if you are submitting a record with only hospital and medical coverage, what disposition and error codes you need to look at. If you are also including drug coverage, again, looking at both disposition codes and both sets or error codes might be necessary.

It's possible that if you're submitting a record that reflects coverage of combined hospital and medical and prescription drug coverage, that we will accept and post an MSP occurrence for the hospital medical and reject - well actually, usually it's the other way around. That we would accept the record for the prescription drug coverage and post an MSP occurrence for that and have an error or some kind of problem with the hospital medical coverage and actually reject the record for that purpose. So you need to check those

disposition codes and in that case make the appropriate changes, resend the entire record.

When you hit a threshold error such as too many records on your file reflecting (unintelligible) too many records on your file being receiving an FP error, you may hit one of these threshold errors. You will receive your account manager or technical contact will receive an email and your EDI rep will also be notified. You'll need to work with your EDI rep through the threshold and severe error since no response file can be created.

I also wanted to make a note that the COBC does not save any records submitted that were returned to you with a disposition code other than 01. Those records that are returned to you with a disposition code of 01 are posted as MSP occurrences and we have a record of that. We don't keep a record of anything sent that was returned with a 51 disposition code or received an FP error code - disposition code.

On the response file you'll see a submission indicator. Essentially what this means is that the record submitted has an accepted date that is 135 days prior to the start date of your file submission period. If you look at the GHP user guide, you'll see an explanation of this - of a 45-day grace period that we give you. If your final submission period begins June 1 and the effective date of the GHP coverage is within 45 days prior, you can wait until your next file submission to submit that record.

This grace period gives you some time to update your internal files with new enroll leads before you submit them for Section 111. We do receive records late - they will be accepted and processed. However, we are tracking that and the late submission indicator will be set to a Y. there's no action that you need

to take I know - other than possibly to update your operation or your systems in order to report more timely.

At a later date when the COBC starts validating TINs on your TIN reference file and NST input files, there'll be an invalid TIN flag on that response file will update the user guide with that information.

Next, very quickly I wanted to mention a couple of things about the query-only file. This is available as an optional file submission to both basic and expanded reporter - see Section 6.3 of the user guide. This file allows you to query for Medicare beneficiary coverage information. Most likely you're querying on inactive covered individuals and trying to answer the question of when is Medicare primary for your retirees.

You might have someone on your rolls who's covered on a retirement plan but is not covered by Medicare yet and it would be of interest to you to know when they do become covered by Medicare in order to update your internal systems and know that Medicare is going to pay primary in that circumstance.

Note that on the MSP response file, we are sending back information about anyone we find to be a Medicare beneficiary, we will get coverage information back. this allows you though to query for those people that you are not planning on your MSP input file.

This file - the query only file - can be submitted to any time, there's no submission time frame assigned to it. However, you cannot send a query file more often than monthly. The COBC will provide you with what we refer to as the HIPAA eligibility wrapper or queue software. The file layouts for the query only file that you see in Appendix D are the flat files that actually are inputs and outputs to and from the queue software.

Your EDI rep will send you a copy of this software if you so choose to use it. The queue software again will convert those flat files that you see in Appendix D into the X21270 and take the 271 response and convert it back to a flat file for your processing. The queue software you take and load into your own system and use before sending - transmitting the files to the COBC. And then after you've received your response file to further process it.

If you're using your X12 translator and do not wish to use the queue software, contact your EDI rep who will supply you with the appropriate mapping documentation that you use for that.

Next topic is the non-MSP file - see Section 6.4 of the user guide. This is for only expanded option submitters. On the non-MSP file you are submitting information about your inactive covered individuals - mainly retirees and dependents. We implemented this file with Medicare Part D in order to obtain information on drug coverage that is supplemental to Medicare. So it's very different from the MSP input file where we're looking for coverage information that is primary to Medicare. On anonymous P file, we're trying to determine what prescription drug coverage does a Medicare beneficiary have that would be supplemental to Part D.

This anonymous P file contains three different record types - D records - D as in drug records - are what you use to report supplemental drug coverage. The N record or query record and the non-reporting records and S records - S as in subsidies -for reporting your RDS retiree file records.

Something important to note about the non-MSP files - if you are submitting retiree files using S records, do not miss S records in the same file as your N and D records as your query and supplemental drug records. S records are to

be submitted on separate files. Your N and D non-MSP files can be submitted at any time but no more often than monthly. The S record files for your retiree drug subsidy files - those can be submitted according to the RDS requirements - they do not have the same restriction as the anonymous P file with the N and D records.

The D records submitted on the anonymous P file results in the COBC hosting a supplemental drug record and the Medicare beneficiary database. This information is used to route drug claims and to calculate the Medicare beneficiaries true out of pocket expenses.

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The anonymous P file works in a very similar fashion when it comes to - first you'll submit an initial file followed by update file submissions with Add, Delete and Update Transactions. You'll receive a response file - see Section 6.4.7 of the user guide for information on this anonymous P response file. Again, the processing is similar to how you would process your MSP response file.

At this point, we're not ready yet to turn the call over to Q&A but we're getting close. So if you have a question, you might want to get into queue now. how do they ask questions?

Coordinator: Excuse me - this is the conference coordinator. Just press star 1 to ask a question.

(Pat Ambrose): Okay, thank you. I'm going to continue though with the presentation while questions are queuing up. Please keep your questions limited to a technical nature for this call.

Next topic I want to cover briefly is testing. VDSA or VDEA plans will essentially be testing for Section 111 using the same methodology as they used for their VDSA or VDEA data exchange. You should be testing now for Section 111. This is essentially an interactive process - we're working closely with your EDI rep.

The testing of the query only file for VDSA or VDEA partners is not necessary at this time since there's no change from the VDSA file format to Section 111. That format - that file format will be changing at a later date. Testing for VDSA or VDEA plans is complete when both the COBC and the responsible reporting entities sign off.

Now in April 2009, we're implementing a more automated testing process. new testing requirements are going to be published on the Section 111 Web site in the user guide. The testing will still include submission of an initial file followed by an update file so the requirements about that initial file you must successfully post so many ad transactions. And then in your update file, you must be able to post some additional adds, perform some deletes successfully and perform some updates successfully.

The system - the COBC system - will track your testing results. You'll be able - your users of the COBC Web site will be able to log and see your testing results as you progress. Your account manager or technical contact will be able to actually move you from a test status to a production status. Once the COBC requirements for Section 111 have been met and the account manager is satisfied with testing.

During this testing process, you'll still work closely with your EDI rep to answer any questions and assist with any technical difficulties. You must complete testing by your production live date for your MSP input file

submission time frame. so essentially your testing time frame that's from the receipt from your assigned profile report up until your production live date.

Note that the test environment is essentially a mirror image or production that's updated on - a couple of times a year. so it's not exactly the production environment as far as Medicare beneficiaries. But we are expecting you to submit production data for your testing purposes. Of course you'll use different data names in that process.

Next, I want to talk about the emails that you'll be receiving from the COBC for Section 111. I already mentioned that your authorized rep will receive your profile report via email - the profile report will be an attachment to that email. If we do not receive your profile report back in a timely fashion, your authorized rep and account manager - also known as your technical contact - will receive an email warning you or reminding you to submit that signed profile report.

Your account manager will receive an email when your registration has been processed, your profile report has been received back and you have been moved - your account has been moved to a test status. When testing has been completed, your account manager will receive an email stating that you're in a production ready mode.

You'll also receive warnings about not completing testing and moving to a production status in a timely fashion since that of a warning nature that will go to your authorized rep and to your account manager. Your account manager will receive an email each time the COBC has received a file and also a subsequent email when your response file is ready - whether it's been transmitted via EDM, Connect Direct or whether it's ready for download.

You'll receive emails, your account manager will receive emails when a file hits a threshold or a severe error. If we do not receive your MSP input file during the time frame - during your assigned time frame, then your authorized rep and your account manager will receive a reminder about that file.

And then other emails will be issued as you use the COBC secure Web site - maybe you're changing your user information, things of that nature. The emails will come from the COBC VA - V as in Victor, A as in apple - at ghimedicare.com email address. And we suggest you update your Spam filters so that these emails will be received and not go to Junk Mail or be rejected.

Lastly, a couple of points on the COBC secured Web site. See Section 10 of the user guide. We will (unintelligible) a very high level overview, we will be providing much more information and computer-based training on the COBC secure Web site at a later date. Note that your authorized representative will not be a user with a login ID and password for the COBC secure Web site. But instead, your authorized representative will be named and must assign an account manager to finish the accounts set up and manage the overall account.

The user role set on the COBC secure Web site will be an account manager who again is managing the overall process, updating your account information and monitoring file processing and statistics. The account manager can also invite what we refer to as account designees. These may include agents who are performing file uploads, file up and download for you. Or just someone who's working with the account manager to perform file transmission and monitor file statistics.

So again, registration will take place on the COBC secure Web site. You'll monitor your testing there, you'll monitor your production files processing, you'll be able to view statistics for a particular file, what areas were hit and a

summary of the records process. historical information about file submissions, you'll be able to up and download files via HTTPS and transfer files via secure FTP.

So now at this time, operator, we'd like to turn it over to questions.

Coordinator: Thank you. We'll begin the question and answer session. And again, just to remind everyone, it's star 1 to ask a question. Please unmute your phone and say your name when prompted. We'll introduce you by your name and you can press star 2 to withdraw a question.

And we do have questions in queue. The first one will be (Cheryl Miller). You may ask your question.

(Cheryl Miller): Hi, this is (Cheryl Miller) from Blue Cross of Northeastern Pennsylvania. We currently execute a VDEA with CMF. And we query every month for Medicare status and then we send on a quarterly basis to CMF where we're primary. And we're having a concern about sending records to CMF that we know are going to reject because the person doesn't have Medicare or the person - Medicare is primary because of the over age 45 requirement. Is there going to be anything to take care of situations where plans that have been reporting and do queries and make sure they have their Medicare data can get past that requirement?

Man: We're not discouraging anyone from not sending us data where they know person is not a Medicare beneficiary or would not essentially be defined as an active covered individual. So those entities that want to rely on that process where they first query for entitlement data and then provide detailed records where essentially they feel comfortable with the response from CMF, that

person is or is not a Medicare beneficiary. They can continue to use that process.

Just keep in mind that you cannot rely fully on the CMF response for the ultimate responsibility for reporting that person who is defined as an active covered individual. I mean, this assumes that again that the query is done at the right time and also that the information submitted on the query file is correct and that you know, we can actually find that person as a Medicare beneficiary.

There's a reason why we have the 45 and over rule is because we are telling people out there - this is how the current non-Blue Cross process works - they may submit full files of the records of individuals who would be classified as active covered individuals if we identified as having Medicare entitlement. That is the process we developed to allow people compliance who - they don't necessarily - we're not asking them to send us every person on their role who would have Medicare. But we are asking that they send us everyone age 45 and over which will help us identify, you know, 97, 98, 99% of potential MSP situations.

That is why we ask for the actual Medicare health insurance claim number that you're going to submit individuals younger than age 45 because we basically don't want to encourage people to submit full files of all of their covered lives which would, you know, basically increase the volume of records that would need to be processed by both the submitter and CMF.

And in short, you can use that process but it doesn't necessarily guarantee compliance with the Section 111 reporting requirements.

Woman: And that last statement is the kicker because unless it does and we can say, you know ,we're doing our best effort to collect all the information - we query Medicare obviously, we ask for it on a form, you know, the enrollment forms and everything. Then we basically have to send you everything because our legal department says you have to be in compliance. And now we're exchanging date that, you know...

Man: Well again, if you are certain that the person is not a beneficiary, then you do not need to send them on that file.

Woman: But how we would be certain that they're not unless we ask them everyday, did you apply for Medicare - no. Did you apply for - that's why we do the query every month to see if the person has, you know, applied for Medicare. We're not going to mail letters to all of our membership every month to find out whether or not they've become eligible for Medicare.

Man: Although we can't - I mean, we don't have, you know, I mean, we have a document that referenced that - I don't know if it's out yet or not but it should be soon and a document - a one-page summary of at risk for non-compliance. And I mean, I can't say that you necessarily would be in full compliance if you missed some people because I would be - you wouldn't. but at the same time, CMF is not out to look at penalty issues first. It's more about getting good quality data.

Woman: And that's where we're going too because we would prefer to send quality data, not get bogged down in rejects neither one of us needs to see. And yet as long as all the documentation - the user guide and everything have that requirement written the way it is, we have no choice but to comply with the requirement as it's written, not as you say you would prefer to receive the stuff because we can't get it in writing from anybody that hey, that's okay.

Man: Yeah, well, it's - unfortunately, I mean, the responsible reporting entity is - they are the ones who are responsible for telling CMF about MSP. But at the same time, you know, if CMF made the blanket statement that that would make everybody in compliance, that doesn't do anything to address the issue of the quality of the data on the input file for query purposes.

But I mean, we've received lots of these comments and we understand your concerns and we're trying to work out a process that would satisfy, you know, all obligations for both CMF and the responsible reporting entities in terms of this legislation. So we've definitely heard that question. But I don't want to take up too much time on this because this is more of a - probably more of a policy question. Again, I'm asking - since we do have the correct technical folks here, if they could keep their questions of a more technical nature regarding the process itself.

Woman: Okay.

Man: But I thank you very much.

Woman: Thank you.

Coordinator: Our next question comes from (David Pittman). You may proceed with your question.

(David Pittman): Yes, I have a follow up to the previous question but I first wanted to ask the question that I originally wanted to ask which is, on the response file, the MSP effective date, would that ever be a future date? If you - you said if you submitted the record for somebody that had already applied for Medicare and

was accepted but would begin at a future date, would we receive back that future date?

Woman: No, it would never be a future date.

(David Pittman): Okay.

Woman: What?

Man: It's possible. It would be slightly in the future by - yeah - a week or two. We will receive notification that Medicare - a beneficiary is eligible for Medicare potentially one month ahead of time.

(David Pittman): Now are we seeing that with the retiree subsidy program that we often get back Code 11 records with future Medicare effective date - and that's why I was asking whether the same thing would apply in this situation.

Man: If they haven't actually gone through the application process, then it wouldn't pass through. In cases where the application I guess has been received and processed and a date is out there, if CMF has that date in the system, then potentially I guess you could have by, like a few weeks or so. That's about it - you're not going to get the dates for like two years out or anything like that.

(David Pittman): Okay - this second question is sort of related to the previous caller. If we had say a married couple where the member was 44 but the spouse was 46, we would obviously have to submit the information for the spouse. If we also submitted the member at the same time - even though we're not required to because we know that the member is not Medicare eligible - would that record be rejected? I mean, if we - is that an error is that just an unnecessary record?

Woman: Yeah, the record for the subscriber or the individual who is less than 45, unless you included the (HIT) number, we'll get an FP error with an FP99 error code saying that you've submitted a record for someone under 45 without the (HIT) number.

(David Pittman): Okay, SP99 - okay, thank you. That's it.

Coordinator: Thank you. Our next (unintelligible) comes from (Barbara Carlson).

(Barbara Carlson): Hi - I'm confused about the MSP effective date because the document implies we're sending one. For instance, there are error codes that says it's invalid effective date but that doesn't appear to be a data element that (unintelligible) file.

Woman: The effective date that you're sending on your input file is actually the effective date of your GHP coverage. I'd have to defer to (Steve) as far as what those errors might - if there's an error that is described...

(Barbara Carlson): (Unintelligible) the error is invalid MSP effective date.

Man: Probably a formatting error.

(Barbara Carlson): So we're not sending it. So why would we get it? Why would we be getting errors on data elements not being sent? Maybe I was reading too much into this.

Man: You didn't send the record - you're not going to get an error on that.

(Barbara Carlson): Okay - for the purpose of saving these occurred periods of effective and term dates so that we can appropriately send you updates and terminations based on the occurrences that you created - is that correct?

Woman: The MSP occurrences - yes. However, if you continue to send the effective date, the original effective date that you sent on your GHP coverage will still match it up.

(Barbara Carlson): Okay - and there was another thing - another place where it's implied that I might be getting a MSP effective date that did not relate to my own coverage. Are you responding exactly to the coverage that's sent on the input file or for instance, someone has two plans and someone else has sent one and is created in occurrence - is it possible that I would get an MSP effective date for the other plan?

Man: No - it's based only on the records that you submit. There's essentially a one-for-one response for every record submitted and it's clearly based on the processing of that record and that coverage you submit.

(Barbara Carlson): Okay - and one more question - for the kidney disease, the definition if we send it if we know they have a history of kidney disease or they've had dialysis - what if we don't know if they have (unintelligible) renal disease and so, I mean, by your definition, so we don't have a (HIT) number)? Should we be sending them because of our medical information so that you can know about us or do we only send them once we find out they actually have Medicare?

Man: We would only want the ones that we find out that - once you know that they have Medicare.

(Barbara Carlson): Okay - thank you.

Man: Let me go back to your - one thing I pointed out in terms - it is possible that you could receive two response records for one input record the reason for Medicare entitlement changes during that period. So for example, somebody went from disable to age we went back two response records that would show MSP periods for the Medicare entitlement due to disability and then Medicare entitlement for the period due to age.

(Barbara Carlson): Okay - but (unintelligible) our own file is being sent and the data contained in that file for that person.

Man: Yeah, and there is an indicator that tells you that that record - response record was split into two responses.

(Barbara Carlson): Okay - thank you.

Woman: I'd like to go back to the question about the FP31 - the invalid MSP effective date. We need to make an update to the user guide to more accurately describe that error. But that is a responsible reporting entity response for error. And it does imply there was something invalid about the GHP effective date that you submitted on the MSP input. So it really just is a matter of correcting the description in the user guide - I apologize for that.

Man: That's what these calls are for.

Coordinator: Our next question comes from (Margaret Godown).

(Margaret Godown): Yes - good afternoon and I'm probably asking a very silly question. But we've had the inquiries about the terminology for the original coverage

effective date. We have our IT people saying whatever we've got loaded in the system and of course on compliance (unintelligible) if they were originally effective back in 1995 with the original plan at the PBA, we may only get the date that we've actually used the transfer date - say, 2002. Which date do you want?

Man: Well we prefer the original date of continuous coverage - this is for everyone on the phone, this is an example where I'll use myself as one - I've had the same Blue Cross Blue Shield coverage for over ten years. The reason we're asking for that original effective date is that it ensures that we - basically, if we get information from multiple sources, that we don't end up posting separate records because the effective date of coverage is one of the matching criteria that we use when we decide whether to update an existing record or build a new record.

So if you gave us, for example, the effective date of that coverage of say, you know, 2002 when in fact, you know that person has had that coverage since 1995, it's possible, you know, that there would be two records essentially to be posted out to our system. If somebody else through other processes reported that 1995 date, this just kind of ensures that we don't have duplicate records out on our system so that someone tells us there's no longer MSP, we can close all the correct records. That's the reason we ask for that.

(Margaret Godown): Excellent - thank you very much - I appreciate it.

Man: Next question.

Coordinator: (Unintelligible), you may ask your question.

Woman: Yes, my question has to do with the ability of RREs to get data now about Medicare eligibility and entitlement of their commercial members. We have thousands of our commercial members who reach 65 each month and we are trying to get their Medicare entitlement information. When the RRE process kicks in, it will be much easier. What do you suggest we do to get that information now?

Man: Well I mean, most people we advise essentially, you know, because we are allowing additional time, for example, to collect the SSN information which is what we hear is the most difficult core data element to get by most. But we encourage people to use, for example, their open reenrollment periods as a chance to ask that missing information.

But in terms of giving access to Medicare entitlement data, we would be obviously prohibited from doing that without any type of a signed data use agreement, you know, this all comes down to the various HIPAA privacy act regulations, etcetera.

So we encourage you to use, you know, whatever standard reenrollment processes you have to gather that information. That's what we've heard from existing voluntary data share partners that typically use that enrollment period to gather any additional information if they don't currently have.

Woman: And so, if we were to query the common working file, we would need to do it in a HIPAA compliant manner with the 270271 interchange?

Man: I do have that access through some other source that, you know, that's fine. It's not going to be through this particular process.

Man: Unless you're already.

Man: Yeah.

Man: Pending data (unintelligible).

Man: If you are exchanging data with us through the current voluntary process, then you do have the ability to perform the current function already and you can use that at any time.

Woman: Yeah, well we're not - we're a new reporter.

Man: Okay.

Woman: So the query only input file is basically part of the RRE reporting and not something that stands apart from it.

Man: Yeah, I mean, it's not actually a technically a reporting. It's just a tool that you can use to query. I mean, the reason we have that out there for group health plans is that they may also have a need for data on retirees that they don't know have Medicare. And so for example, you may be paying primary for somebody who's age 57 and you don't know that that person is actually covered under Medicare and Medicare is also paying primary. So it's a tool to allow you all to coordinate benefits correctly as well.

Woman: And can that be used now or only when the required reporting begins?

Man: Only when the required reporting begins.

Woman: Yeah, you must register and test each file type and then you can start using that file.

Man: We're not trying - we don't do that because we - because of - well we do that because you need to have a relationship with us, a formal relationship with us before you can query our database. Otherwise, we are - we would be in violation of (unintelligible) privacy act that we have to operate under and you would too. So you need to have that relationship established with us before you can begin to use - begin to query the databases in any way, shape or form.

Woman: Okay, thank you.

Coordinator: Next question - (Diana McNesky).

(Diana McNesky): Yes - hi. I actually had two questions. The first one had to do with reporting information in Section 16- employer size. And it gives me three options - I can use zero for 1 to 19 employees, 1 for 20 to 99 or 2 if it's 100 or more employees. Underneath it states the employer size rule. Because of the situation we're under, we do have situations where there's 100 more employees. We have some that are under and over 20 and we applied for the MSP exception. Because this employer size rule is telling that if we have anybody who fits this group of 20 or more or 100 or more, we should then automatically put down 1. Doesn't that then imply that the employer is too large for the exception?

Man: If you go through the proper process for the small employer exception, COBC will have a record of the granted and approved exceptions and will bounced the name individuals against that list. If the individual is on that list, it will not create an MSP record for that individual.

(Diana McNesky) Okay, regardless of what I put down for the employer size.

Man: Correct.

(Diana McNesky): Okay - that's good.

Man: If we don't find them on that list then there's the potential that we would build that MSP record then. That's why that - I mean, the employer size determines there's MSP based on entitlement due to disability or age or MSP.

(Diana McNesky): Right, right - I'm aware of that. I just didn't know what to do for those few that we've gotten exceptions on. My other question has to do with number 21 and 22 with regards to employer TINs and (unintelligible) TINs. Now we're (unintelligible) fund and we have as a result a plan identification number as well as a TIN - okay. So which number are we reporting under or both of them - do we just put identical information down?

Man: If you're an insurer or a TPA, which is separate and distinct from the multi or multiple employer plan where it has the insured TIN, you put your TIN down. In place of employer, you put down plan sponsor's name and the plan sponsors that (Hartley) plan TIN.

(Diana McNesky): Okay - we think we got that - thank you.

Woman: Ready for next question?

Coordinator: Yes, we have (Erica Wagner), you may ask your question.

(Erica Wagner): Yes, I have a few questions. My first question is related to disposition codes. We are - our coverage is comprehensive so we will be including drug information in the MSP file. If we were to receive a disposition code - the first disposition code that (unintelligible) gave us an 01 showing the record was

accepted but the RX disposition code showed 51, we understand that we're supposed to send that same record again. Is that correct?

Woman: Well yes, it shouldn't happen because a 51 indicates that we did not identify that person as a Medicare beneficiary and that should be the same whether it's hospital medical coverage or the drug coverage. But technically, yes.

(Erica Wagner): Okay, so if we were to resend that record, what would we get on that second response for that first disposition field in Field 8 since that was already indicated to us that it was an Add. Would we receive an FP error?

Woman: No, you would get an 01. We would treat it as an update.

(Erica Wagner): Oh, you would - okay. All right - my second question actually is in - we signed the VDSA but we're not in production yet but we're still transitioning with the first group so we're expected to go live in the first quarter of '09. Now under VDSA, we were supposed to go back to 1/1/07 for coverage information. Is it true now with Section 111 we only have to send those that are -that have coverage as of 1/1/09?

Man: Yes.

(Erica Wagner): Okay - so we don't have to go back two years.

Man: No.

(Erica Wagner): Okay. And my last question is in regards to the non-MSP file. We do want to send actually - excuse me - the query only file. We do want to submit those. Do we have to test those at the same time as MSP or if we choose to, can we test those later and start submitting those later next year?

Woman: It can be done later.

(Erica Wagner): Okay - those are all my questions. Thank you.

Coordinator: Next we have (Aaron Larson).

(Aaron Larson): Yes - we have a question. We have individuals that are covered on multiple plans as an employee on one plan and say as a spouse on another plan. This could be with the same or different employers. Our question is this - do we need to send these individuals once or do we need to send them twice in that they're covered on multiple plans?

Woman: You would send them twice.

(Aaron Larson): okay - so once under the one ID and then the second one under the second ID obviously.

Woman: That is correct.

(Aaron Larson): All right, that's it - thank you.

Coordinator: Next question is (Elizabeth Mason).

(Elizabeth Mason): Hi - I actually have two questions. One about the registration process - we're reporting our existing data sharing partners communicated with to start the paper registration process last month or is that something they just - how did they know about doing that?

Coordinator: It has been posted on the Section 111 Web site and targeted emails did go out to the distribution list for the VDSA or VDEA partners.

(Elizabeth Mason): Okay - so if you had an agreement like that, you would have received an email saying you need to do this paper registration some time in October?

Woman: Yes.

Man: Under the VDSA you have provided us with a technical contact and an administrative contact and those are the individuals that would receive those emails.

Woman: Okay - and my second question is about the actual data element for entities who are reporting for multi-employer plans. For each individual, is there a separate field for the employer - an employer sized field for each individual - we have people that change employers throughout the year. so is that something...

Man: Again, for the - those types of multiple employer plans, you would - and the employer field, you would put the name of the plan sponsor in the plan sponsor's, i.e., the (unintelligible) plans or whatever the nature of the plan TIN - as well as their mailing address instead of the employers.

Woman: And is that something that needs to be entered for each individual or for...

Man: For each individual - yes.

Woman: For that plan. You just put in that plan number and then you list all of your covered employees.

Woman: Well each MSP input file record reflects an individual and each has an employer TIN. And then you have one TIN reference file that has one record per TIN that has the detail information where you would be putting in, in this case, the plan sponsor and plan sponsor address associated with that TIN.

Woman: Okay - so in the individual file records, no information from the employer needs to be entered.

Woman: The TIN needs to be there - NCL21 and 21...

Man: The TIN of the plan sponsor.

Woman: Yes.

Woman: Okay - and then the employer size, is that something also - is that also in the big file or is that each individual file record? Is there a question about employer size?

Woman: Well employer size is a field on each individual's record.

Man: Use the employer size for the largest employer that you end up dealing with.

Woman: Okay - so if they change employers over the course of the year, we just use the largest employer...

Man: Right. If you've got an employer - if you've got any employer that's over 100 and most (unintelligible) plans are familiar - have at least one employer over 100, I would use that code.

Woman: Okay - thank you so much.

Coordinator: The next question comes from (Melissa Rossi).

(Melissa Rossi): Hi - I'm from United Healthcare. I want to go back to something that was asked earlier. For those members that we have previously identified as Medicare primaries who are VDSA processing, if you're now requiring that we submit all 45 and above in the first file, how will Medicare make a privacy determination versus updating all matches as MSP?

Man: We're not asking you - we're not making the privacy determination - the submitter is. They are telling us if this person is defined as an active covered individual and they do have Medicare, then Medicare should be the secondary payer to that GHP benefit. If you know the person is, for example, a retiree over the age of 65, you do not want to put them on the MSP file because we will build a MSP record for that person which would be incorrect.

Woman: Right. but I think that the over 65 retiree is very obvious. It's those individuals that we may not yet know have Medicare or those individuals who have Medicare for disability or end stage renal disease and for whatever additional COBC rules, are primary to Medicare. We would not submit them to you but those individuals who are deemed primary to us based on what we know, we would submit to you.

Man: I think there's some confusion there. you're going to submit individuals who - that meet the definition of active covered individual. A retiree would not be the definition of active covered individual. Now if you've got an active covered individual and you know that their spouse is Medicare disabled, you know, that information is what we're going to need.

What you don't know that the spouse is entitled to Medicare on a basis of disability, the fact that you indicated that the employee or the main person is an active covered individual, that would tell us that is something we would end up sending an MSP record for, assuming the size and the other criteria were met because they had coverage based on someone's act of covered individual status.

Woman: But we have retirees who are 50.

Man: Then don't (unintelligible) them on the MSP file.

Woman: They're not working...

Man: They're not active covered individuals.

Woman: Your GHP coverage needs to be based on - in order to be an active covered individual in part - that part of the definition based on employment is active employment. So that person who's a retiree would not be reported on the MSP input file. You could report them on the non-MSP file though.

Man: I mean, you have to look at it this way. For every worker or person you insure, would they fit the definition of active covered individual. If yes, then, you know, we would advise you to report them. And if we determine that that person is a Medicare beneficiary, we will build an MSP record. But if they are not an active covered individual, they should not be on that MSP file to begin with because we don't want to build essentially erroneous MSP records.

So it's not so much that you need to know whether they have Medicare - which is why we have the process where you submit all active covered individuals. Essentially, you're sending us a finder file and if we identify

anyone on that file, say 100 people, that is an active covered individual because you told us that and we determine that they have Medicare, we will build an MSP record and let you know that that person has - we've now built an MSP record for that person.

Woman: So we couldn't have a 50 year-old retiree in the first 30 months of their ESR date?

Man: That would fall within the - remember, you also had in your definition of active covered individual anyone that you knew had - was undergoing dialysis or receiving dialysis treatments. So even though they did not qualify because of active employment, they qualified because they had dialysis. And we would look at the fact that they had dialysis, we determined that they had Medicare on the basis of ESRC, we would check to see when the Medicare coordination period would have been. And if that period had not expired, we would set up the record if the coordination period had expired, we would not have set up the record.

Woman: Okay - thank you.

Coordinator: Next question comes from (Linda Olvie).

(Linda Olvie): Hi, I have a question to confirm my missing (unintelligible) effort? And it's in regards to the MSP input file, fields 9, 12 and 15. If I use those three fields in combination, I'm interpreting that we need to have the policy holder SSN in order to send records for our family members. So i.e., I have a 47 year old spouse and I'm not sending a 38 year old policy holder, I need to have the policy holder's SSN to send that spousal record?

Man: Yes.

(Linda Olvie): Okay. That was it - thank you.

Coordinator: Next question comes from (Stephanie Stemi).

(Stephanie Stemi): Hi - I actually have a couple of questions. One is just to clarify what we had just been talking about. And I think the confusion was, for a person who is disabled, they are covered though by an active plan. But that plan, actually due to the size, would make Medicare's primary. So what we're saying, even though they are an active covered individual, we are still not going to put them on the MSP file?

Man: If you put them on the MSP file and the employer size indicated is less than 100 and it was not a multiple or multi-employer plan, then MSP record would not be established because of the edit that would be being used. So I would suggest you put these people on your file and let the edits take care of it so you don't run the risk of not having reporting someone that you should have.

(Stephanie Stemi): Okay - that's what I was concerned about. That makes sense. The next question I have is today, for our non-MSP, we actually send our drug, our inquiry and our subsidies on the same file that's separated all by different headers and trailers. Are you saying that that is no longer allowed, that the subsidy has to be an entirely separate submitted file?

Woman: No - I'm sorry - I probably should have been more specific. You'll see pictures of this in the user guide. As long as they're separated by the headers and trailers, you're okay.

(Stephanie Stemi): Okay - that's good. And then the other - the last question that I have is, when we are using our group health plan effective dates, I'm not sure how to do

that. If I have somebody who was an active MSP beneficiary and now say tomorrow they are getting ready to retire, I would actually be using that same effective date then on both my MSP and my non-MSP file. And I'm not sure how that would work for you.

Man: Yeah, you'd actually use the effective date of when they retired for submitting a supplemental drug record - if that's what you're talking about.

(Stephanie Stemi): Okay, so that that point, even though they're still being covered by their same employer coverage and it's still the same employer, I'm going to change my date based off of when they retired.

Man: Yeah. I mean, for example, if somebody, you know, received coverage on January, you reported that with an MSP effective date of January1 and then retired on March 30. You would send and update to that original record terminating that old MSP record now because you're using the non-MSP file for either subsidy or say, for drug reporting. You would send a supplemental drug record with an effective date of March 31 and it would be open ended until, you know, whenever they stopped that coverage or changed it.

(Stephanie Stemi): Okay - thank you very much.

Coordinator: We have (Jeffrey Miller).

(Jeffrey Miller): Thanks - I appreciate you guys taking the time again today and I commend you on your patience. Just a quick question on the response about the late submission indicator. Considering the grace for the subpopulation of dependents on our book of business prior to 1/1/09, will the logic be implemented in the response process as it relates to that late submission indicator to take that into consideration? Or because of the gap between the

original effective date and the reporting date, will they come back with that positive submission indicator.

Woman: We've taken that into account.

Man: Okay. And then the follow up on the future date - as part of our existing voluntary sharing now, we notice a higher than expected frequency of future dates. As an example, I'm looking at a quarterly file - response file now and I'm seeing July 1 of 2009 Part B effective date. Any comments?

Man: Yeah, I mean, could you send some examples of those to your EDI rep? we'd be curious to see...

Man: Sure - I mean, we see, you know, and we've surfaced this in the past because we've seen, you know, steady occurrence of future dates being provide. And then with a subsequent quarter file, we see that it's been changed. And most commonly it's a scenario with Part B where I think there may be have been a presumption the individual would enroll and then subsequently after that enrollment date's past, they find that they have it, they defer that enrollment.

Man: A lot of these disabled?

Man: I don't know if I can pinpoint it to an entitlement situation or not.

Man: That would be about the furthest out you could see.

Man: I can reach out to our EDI specialist and insure those with them.

Man: Okay, appreciate it. Thank you.

Coordinator: (Cathleen Williams).

(Cathleen Williams): Yes, I just had a - sorry - I just had a question about the testing. We are currently a submitter so I vaguely heard that you said we don't have to test if we're currently a submitter?

Woman: That's not correct. You don't have to test the query only files.

Woman: Okay.

Woman: But you must test the MSP input file and the non-MSP file.

Woman: Okay - and when we do the testing, is that going to be just testing format or are we actually going to be able to test the actual data. can we get an idea of what we're going to be dealing with?

Woman: We are expecting you to be testing the actual data.

Woman: Great - okay. Fantastic - thank you.

Coordinator: (Unintelligible).

Man: Yeah, we have an IT question. We understand the preferred file format for the MSP input is (unintelligible) update. And I ask if we can just submit a full file recorded?

Man: The short answer is no - but it's - it ends up causing a lot more problems than (unintelligible). And CMF as a whole has moved away from full file replacement type files just because they end up causing more problems than they solve. So the answer is no.

Man: All right - thanks.

Coordinator: (Mandy Gribbin). Go ahead, (Mandy). We have (Mandy Gribbin) - are you there.'

(Michelle Zimmer): Actually this is (Michelle Zimmer). I'm with (Mandy) at Premier Blue Cross. We are currently submitting a VDA file - we have three questions. First question is, you stated that the delete that we send, we need to send the delete first and then the Add. Does it necessarily have to be in that order?

Woman: Yes.

Woman: Okay - and....

Woman: Let me if I could just clarify, that's when you're sending a Delete and an Add in order to update a key field on your MSP record.

Woman: We would be sending a different effective date - correct.

Woman: Yeah - okay, yes. Then it's a Delete Add and the Delete should come first in the file.

Woman: Okay. The second question is related to the response files. If we do not receive an 01 disposition since we received a 51 or an SPS - you want us to resubmit those records only after they are fixed, correct?

Man: yes, I mean, if you get back an SP error code, I mean, there's no point to submitting it if it hasn't been corrected. It would just error out yet again.

Woman: Exactly. We just want to make sure we heard that right - okay.

Woman: However, you are expected to fix it by your next quarterly file submission.

Man: Yeah.

Woman: Absolutely.

Man: Okay.

Woman: And the third question is...

Man: Can we go back to your first question for a second?

Woman: Sure.

Woman: Can you just elaborate more on when you described the scenario that you're going to delete a record, why you're looking to delete that record?

Woman: Say for instance, a member is switching from Medicare secondary to Medicare primary...

Man: Oh, no, no, no - you don't want to delete that record. You want to send an Update to turn that existing MSP coverage. If you delete that record, that essentially erases it as if it was never was posted to our systems and you don't want to use - it's very critical to understand for everyone out there that a delete transaction should only be used to remove erroneously reported data to CMF.

A classic example of that, send a retiree on your MSP file and we build an MSP record and start denying claims for primary payment by Medicare.

That's the only time we would use a delete. If you're simply entering a termination date of existing coverage, you send that as an update transaction.

Woman: Right - but if we had sent the incorrect effective date...

Man: Okay - yes. If you reported to us that, you know, here's an MSP record and the effective date was February 1 and you realized after the fact that I need to fix that and then say January 1 - then yes, you would delete that existing record and provide a new Add.

Woman: Okay.

Man: Okay.

Man: The existing record...

Man: Yeah, because the existing record was incorrect and essentially erasing it from the blackboard.

Woman: We just weren't sure if you had to have that Delete in there first because it's got a different effective date, we weren't sure it would sweep through and do the Add and the Delete is not doing the same record.

Man: It doesn't really matter though.

Woman: As it turns out, it doesn't matter.

Man: Yeah.

Woman: I mean, in the case of the effective date.

Man: Yeah, because you're sending another effective date, it would still process separately independently of the other one anyway.

Man: The point is here that you've got to delete - you really need to delete the erroneous information. And if you don't delete it first, you may forget.

Man: That's happened.

Man: Yeah.

Woman: Yeah, we were just thinking about the extra time that it takes to sort those huge files. The last question was on testing. We will be sending, of course, our production for Section 111 as an Add Update Delete file. For the testing, it was stated that the initial file that we send needs to be Add and the second file needs to be Add Update Delete. Because we're sending product AUD only, can we send the initial test file as an Add Update Delete - just do two rounds of that Update Delete?

Woman: Are you current VDSA or VDEA partner?

Woman: We are currently a partner - yes.

Woman: Yeah - then that makes sense. And it should process fine. You'll be working with your EDI rep as you go through this process as well too.

Woman: For the new partners, essentially the testing is supposed to mimic, you know, your production file submission. And of course, the first time you send a file it would have to be all Add. But I understand your situation being different.

Woman: Okay - great. and we are sending production data for our testing, correct?

Woman: Yes.

Woman: Okay - super. Thank you.

Coordinator: Next question (Bob Wilson).

(Bob Wilson): Yes, I have a clarifying question around the duties on updates and requirements. If any of the fields used in the matching process but the member demographics changes, do we send an update record or a delete or an add?

Woman: Can you give us an example?

Man: Well...

Woman: For example, the name changes or something of that...

Man: Yes, that would be an example - yes, the name changing, say due to marriage.

Man: So for in the name changes, no, that would require and update and delete process.

Man: Yeah, I mean (unintelligible).

Woman: Yeah, actually, it's going to first do the match to find the person on the Medicare role. And so when you - and so we do not need you to send a delete and an Add in that circumstance. It's only those key field for the MSP occurrence. So it's the last name which we use in matching, trying to find the Medicare beneficiary changes - that's okay. And you can just send an update

because we'll take that name and use it in the matching algorithm first trying to find out if you're a Medicare beneficiary. And then we'll be making the update.

Man: But in that scenario then, if it didn't match because you had different information than us, then we get FP error.

Man: Well that would still...

Woman: Yeah, we do need to match an exact match on the social security number and then the three out of four remaining (unintelligible). Hopefully that person has update their Medicare information, you know, their information with Medicare and we would have that name update on the Medicare database.

Man: Hopefully.

Man: Yeah, I mean, that all actually comes from, as I say, the efficiency of the matching criteria. And if a beneficiary needs to make, you know, they have - the beneficiary only can go to the Social Security Administration and make those changes. Once those changes are reflected at the Social Security Administration, CMF then receives that information and we update that, you know, on our files accordingly.

And we do, I mean, that information, I mean, is cross walked as well. We can have multiple changes to a person - not only the name but also the health insurance claim number can change as well because of, you know, marriage, death, etcetera. So all that is cross walked in our system.

Man: Yeah, I was thinking more of the scenario, I mean, of course by the time delay of the process you just described. I mean, there's going to be examples when the timing is well and you haven't updated (unintelligible) files.

Man: And than can happen.

Man: Yes.

Man: I have sort of a follow up question along that then. If any of the - suppose the matching fields don't change but any of the required fields change, does that require an update record?

Man: Yes.

Man: Yes - okay. Not a Delete and an Add.

Woman: Correct.

Man: Right - okay. And what about if the group size changes from one category to another - either up or down for that matter. Do we have to resend everybody in that group or just the ones that we would have resubmitted on the next (unintelligible) file?

Man: Well I mean, that's like a multi-part question. The first is if the employer size changes, we would want you to turn that existing record and send a new Add record to reflect the new coverage based on the change in employer size.

Man: Yes - okay - that was the answer I was looking for.

Woman: I'm sorry - I just want to go back to your second question where you had referenced that you were changing the key field.

Man: Yes.

Woman: Would you have to send a Delete record? Can you give an example of one of the key fields you're referring to?

Man: Data (unintelligible).

Woman: Okay, so you're talking just about the personal characteristics.

Man: Yes - the matching...

Woman: All right - thank you.

Man: Okay. All right, thank you.

Coordinator: Next we have (Rose Heston). (Rose), you may ask your question. (Rose Heston)'s line?

(Rose Heston): I'm sorry - we're here.

Coordinator: Okay.

Woman: Okay, the first question is related to the all Adds in our first (unintelligible) exchange. I understand we're expected to send the first file on Adds. The question is, since we're - we will be looking at numbers that are from 1/1/09 prior, what will happen to the records that we previously sent that are - may

still be open because they would not fit the all Add period of 1/1/09. Are they just going to remain open in CWF?

Man: If they submitted someone who already had coverage and they continue to have coverage past 1/1/09, they're not going to be - they don't need to submit it again because the record continues to be open when ultimately the record needs to be terminated, they would submit an update just like they would in a normal course now.

Man: (Unintelligible) existing partner then?

Woman: Right - I'm sorry.

Man: Yeah - (unintelligible).

Woman: And you are required to send records, you know, just as a general rule, for any coverage that is still open as of 1/1/09, regardless of when it was, you know, what the effective date is. Now if you've already reported it as a VDSA or VDEA partner, you don't have to report it again. However, once that coverage terminates, you would come back and send us an update record with the termination date.

Man: The only thing that we're asking in terms of what you're not doing now under the old VDSA is that there are some new data elements that we're going to ask for come July, such as if you're using a pseudo-TIN, we would ask you to update with the actual TIN those records that you haven't given to us yet. But that isn't required until July.

Woman: So the records that you currently have that we're reporting to you now, will they be terminated...

Man: No - no, they won't be.

Woman: They will not be.

Man: No. there's essentially not break in the existing process for VDSA except for there are now, you know, a couple of the new data elements that we're collecting.

Woman: Okay (unintelligible) on top of what we've already been sending you even though it's a new report ID.

Man: Correct.

Woman: So our first file under the new process should be all adds. But any record that would normally have gotten an update, for example, are we still (unintelligible) those in this first file?

Man: If you need to update an existing record that you've submitted prior - previously - prior to December 31 of this year then yes, include those in those updates.

Woman: Okay - so it is okay for this first file to have the new Add or all Adds plus any updates from our previous...

Man: Yeah - I mean, it really doesn't matter. They're treated the same essentially. We're saying - we say a full file of all Adds - that's really geared toward the people who've never done this before. I mean, anybody who starts this process, you know, the first file they submit, they're all going to be Add

records, you know. but for existing partners - yes, there'll be Adds, Updates, Deletes, you know.

Woman: Okay, so we don't have to send you an Add for everybody who has been active and we've sent them to you before. We would not...

Man: No, you don't have to. You're just going to send us information about - that you haven't sent us before. You're going to add - for information you have sent us in your previous (unintelligible) reporter, it's just going to continue to treat that information exactly as you were when you were VDSA reporter.

Man: We're aware that there's, I think a statement in the user guide that we need to go back and correct that, you know, we'll go back and address that to make that a little clearer.

Woman: Right, right -that'll be helpful.

Man: Okay.

Woman: Okay - the next question I have is just around the TIN style itself - just to make sure I'm clear on this. I understand from the user guide that we are not required to send a full file (unintelligible) every quarter. We only required if there's any changes. But it is acceptable if we want to send the full TIN file every quarter?

Woman: Yes.

Woman: Yes - okay. The clarification on the testing period - I thought I heard that our testing period really extends from the point (unintelligible) throughout the first file of production. Since we are currently a VDEA partner, will - does that

mean that the period of testing is not strictly December 1 through December 30 or are you saying that our testing with COBC has to be within that time frame?

Woman: You have to complete testing prior to your initial production file submission.

Woman: Right.

Woman: So that is in February and you're testing under VDSA now. You can conceivably test through January.

Woman: Okay - so since we submitted paper registration, we have not heard back yet as to what our first exchange date will be. So you're saying once we get that notification and for example, if it is in February, then we would be okay to test in January?

Woman: Yes - but however, you could get notification that it's the first week of January that it's due. So you should be complete - you should plan on being complete on testing by the end of December.

Woman: Okay - all right. Lastly the (unintelligible) list that's going to be used to send out the email notification for file (unintelligible). I understand that that information is getting sent to the authorized representative that we put in our paper registration forms. Is that information also going to be copied to the account manager or did I misunderstand that . is all that information going to go only to the authorized representative?

Woman: Does the account manager get a copy.

Man: (Unintelligible).

Woman: We actually have to go back and check that. My notes had originally said that the profile report only goes to the authorized rep. but we believe that we're copying in the account manager or technical contact as well.

Woman: Okay - and that was my next question. The technical contact is the account manager - is that what you're saying.

Woman: Yeah.

Woman: Okay.

Woman: Yeah.

Woman: Okay - please - that would be very helpful. Because (unintelligible) account representative is not close to this process. and in order to respond timely to any of those requests, we would like to be copied at the (unintelligible) level.

Woman: Yeah, that makes sense.

Woman: Okay. The other - I'm sorry - one more question. Pseudo-TIN - the requirement to exchange the real TIN after July 1 we understand. But did I hear correctly that beginning 1/1, we can still provide the pseudo-TIN for the first two exchanges. And then by third quarter, it would be monitored and traced to determine if we have received the real TIN?

Woman: Yes.

Woman: Okay - all right. so just to make sure that I have this complete in my mind - I'm comparing the social security number requirement and the pseudo-TIN.

So if we have a member that is already enrolled and effective with us - I'm sorry - I meant is effective 1/1/09, we do have a social for that person and we do not have a TIN number, we can still send that record on our MSP file with the pseudo-TIN.

Man: Yes.

Woman: Okay. And then for the members that we currently have enrolled today prior to 1/1/09 and we do not have a social, we can still send that record with the (HIT) only and no TIN.

Man: I mean, essentially...

Woman: You'd have to have a pseudo-TIN.

Man: Yeah, you'd have to have a pseudo-TIN.

Woman: I'm sorry - a pseudo-TIN.

Man: Yeah.

Woman: Okay.

Man: In a nutshell, any record coming in after July 1 has to have the real TIN.

Woman: Okay.

Man: And if you're updating old records, you need to provide the real TIN with that update.

Woman: Okay - gotcha. Thank you.

Coordinator: We have (Judy Meir).

(Judy Meir): Yes - my question has to do with whether your unit has had any discussions with the Office of Personnel Management about it's willingness to give us social securities numbers of its beneficiaries enrolled in our plan?

Man: Oh, yes - extensively. So we're very aware of that issue. We're working directly with the FEHB plans as well as OPM and we are very aware of that concern out there.

(Judy Weir): And might you give us an idea of when we're likely to hear what OPM's posture's going to be? As you know, it's been very reluctant in the past.

Man: I couldn't answer for OPM. I mean, we've been in regular contact with them and they are aware of the issue. I know that there's - there was some movement afoot in terms of last year, a proposed regulation that would ban the use of SSNs and of course we and everyone else involved in not only insurance coordination but, you know, retiree benefits coordination, non-group healthcare plan, you know, they received a lot of negative comments on that because obviously if we don't have an SSN or (HICN), we can't coordinate benefits.

That effects me as a federal employee. And we will continue to engage with them and we understand. I mean, but I can't answer for OPM and I just want to - I'd like to - I'm not trying to cut you off but we've actually run over our time. And we do need to wrap this up and I wanted to - we'll take one more question but at the same time, again, I strongly encourage folks who have not gotten their questions answered that they can submit them through the

Resource Mailbox on the mandatory and share reporting Web page that CMF has.

And of course for those that are currently in engaged in data exchange with us, they can also start working through their EDI reps as well in terms of any clarification that they have regarding the process as we roll out the testing of this, you know, as your assigned EDI reps for the new reporting requirement.

So operator, we'll take one more question.

Coordinator: Okay, from (Kenneth Judd). You may ask your question.

(Kenneth Judd): Yeah, I've got one clarifying question with regard to privacy. We've been told in the past the typical members included as an add on the MSP file, that CMF is placing that coverage as the primary coverage - is that correct or are you guys actually applying privacy rules?

Man: No, no - you're telling that person that Medicare should be primary for by the nature of it being on that file.

(Kenneth Judd): Okay - so my follow up question to that is, if I have a member who's actively working over age 45 and has been receiving dialysis for four years, how do I include that member on the file to you or do I include that member on a file to you?

Man: I would include them because there's the possibility that they are entitled to Medicare also due to disability.

(Kenneth Judd): Right - well that's what I'm saying. The problem would be that you're going to be the primary carrier. And if I include them, you're going to think we're primary carrier.

Man: The edit will catch it.

Woman: Yeah, based on their entitlement.

Man: Yeah.

Woman: For Medicare.

(Kenneth Judd): Okay, so there is some primacy logic that you're using...

Man: Yes. I mean, we - they have to fit different size age, you know, employer size requirements, etcetera, as to whether or not we build an MSP record.

(Kenneth Judd): Right - and obviously yes, indeed, there's no employer size requirements so you're going to look at data first, dialysis - I mean, is that the logic?

Man: Yeah.

(Kenneth Judd): Okay.

Man: Yeah.

(Kenneth Judd): All right - good - thank you.

Man: Want to wrap it up?

Man: Okay - and that wraps it up and we will keep your, you know, eyes glued to your - for those that are on the list, we will continue to send out announcements, whatever regarding new materials on the Web page as well as future open door forums, information about computer-based training, etcetera, etcetera, etcetera. We thank you all, the questions were really excellent. And again, don't wait till the next open door forum. You can continue to submit questions through the Resource mailbox (unintelligible) reporting Web page. With that - thank you. Operator?

Coordinator: Yes - thank you all for calling today. you may now disconnect.

Man: Operator?

Coordinator: Yes?

Man: Could you give us a final count in terms of how many participated and also how many were still in the queue to get

END