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: October 1, 2008

TARGETED AUDIENCE: Group Health Plan and Liability Insurance (Including Self-Insurance), No-Fault, and Workers' Compensation Entities – Overview and Introduction to the Implementation of Section 111.

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FTS-HHS HCFA

Moderator: John Albert
October 1, 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 to ask a question.

Also this call is being recorded. If you have any objections you may disconnect at this time. I'd now like to turn the meeting over to Mr. John Albert. You may begin sir.

John Albert: Hi. Thank you. My name is John Albert. I'm with CMS. I'd like to welcome you all to the first full open door forum regarding Section 111 of the Medicare Medicaid (Ship) Extension Act of 2007.

First of all I wanted to lay out some high level points about the meeting and things that you should know ahead of time before we get into the body of the presentation.

The first thing is I wanted to also mention that we have two other speakers in addition to myself, (William Decker) and (Barbara Wright) who will be doing

parts of the presentation.

First this presentation will be regarding implementation of the Medicare secondary payer reporting provision of Sections 111 of the Medicare and Medicaid Ship Extension Act.

This presentation is not designed to function as sort of an MSP 101. Section 111 has no impact on existing MSP rules as defined under the MSP statute.

Questions regarding MSP policy should be submitted via the regular processes used today.

This is the first of a number of open door forum teleconference for the mandatory MSP reporting under Section 111. And CMS will be sponsoring additional more technically oriented calls which will address both GHP and non-GHP reporting separately in future calls as we roll out the requirements.

We will also as part of this call because it is more broad based and the first full audience call, we'll be addressing mandatory reporting with respect to both group health plan arrangements as well as liability insurance including self insurance, no fault insurance and workers' compensation.

And we'll try to be sure to mention at the beginning of each topic which of those two subject areas we're addressing.

Part of this presentation will also include a listing of the data elements and discuss the frequency and processes for reporting under Section 111.

The primary dates that everyone should be familiar with are that the GHP arrangement under the law is - the date of the beginning of reporting starts on

1-1-09. And for liability insurance, including self insurance, no fault insurance and workers' compensation, that date is July 1 of 2009.

Of course I wanted to mention up front what we refer to as the 800-pound gorilla in the room. And that is the issue with compliance. I know that that - been hearing from many outside entities to date tat is something everyone is very concerned about.

I wanted to reiterate from CMS's perspective that CMS is focusing on complete and accurate reporting and not the penalty phase of this legislation.

To allow for a smooth transition for all, CMS is using a phased implementation approach. Compliance from a timeliness standpoint -you are compliant from a timeliness standpoint if you're compliant with the timeframes set by CMS and its instruction regardless of whether the initial reporting is subsequent to January 1, '09 for the GHP and subsequent to July 1, '09 for the liability workers comp and no fault insurance.

Another highlight I wanted to mention to is that reporting under this process will be fully electronic. And another thing I wanted to mention also is that I'm sure you all know that is that CMS has a dedicated Web page for all official instructions regarding this reporting process. That website is www.cms.hhs.gov/mandatoryinsrep all one word.

Documents mentioned during this presentation are or will be available on this Web page.

As mentioned earlier did not look for regular MSP policy guidance on this Web site.

Also on that Web page are links to the Paperwork Reduction Act package which was published earlier in August and includes its own comment process.

Within that CMS Web page there is a resource mailbox and a listserv that allows you to sign up for regular alerts in terms of additions or changes to the documents on the Web page.

The resource mailbox which is to be used independently of any comments through the Paperwork Reduction Act process provides you a format to submit written questions to CMS.

We do not have the resources to answer questions on an individual basis. But of course, we want to take in as many questions as possible so that we can address them through the Web page itself.

CMS is also aware that there are other articles or documents out on the Internet et cetera disseminating information about Section 111. I mention this because we have, you know, seen other things out there so far, have been pointed to other sources of information.

I'll need to reiterate that the CMS Web page I mentioned earlier is the only source of accurate information regarding Section 111. Those other documents are not to be used in terms of interpreting your obligations under Section 111.

Finally, I wanted to state that we appreciate all of the feedback CMS has received since the legislation was passed. And again, we encourage you to continue to submit comments and questions through the Web page.

At this time I'd like to turn it over to (Barbara Wright) who will talk more about who must report and when.

(Barbara Wright): Thank you (John). First I'd like to talk a little bit about the genesis of Section 111. As most of you should be aware, Medicare has always been secondary to workers' compensation from the inception of the Medicare program. Congress then proceeded over a period of time to add requirements making Medicare secondary for Medicare beneficiaries who have group health plans, coverage under certain circumstances and for all liability insurance including self insurance and no fault insurance.

CMS has had various ways of collecting information regarding other coverage. What Section 111 does is place everyone more or less on equal footing by having mandatory reporting for all areas.

For GHP arrangements having continuous reporting will help ensure that we have minimal mistake in payments and recovery efforts will be easier both for CMS and employers because everyone will be dealing with more recent data.

Much of the liability insurance no fault and workers' compensation efforts will remain pay and (chase) because CMS does make conditional payments when matters are in dispute.

However, even here more complete information regarding situations for the no fault insurer or workers' compensation has accepted responsibility for ongoing medicals should result in lessening of some of CMS's pay and (chase) efforts.

So to talk about who must report, a first point I want to make sure that everybody understanding the responsible reporting entities. CMS in case we use abbreviations during this discussion, we often abbreviate that just as RRE. And a responsible reporting entity is the entity responsible for complying with

Section 111.

We've received questions asking whether or not a responsible reporting entity can shift responsibility by contract to their TPA if the TPA is not a responsible reporting entity, for instance, for liability insurance.

And our answer is no. You can't simply shift the responsibility by any type of contract no matter whether you use an agent or report in whatever manner you report in. The underlying responsibility for compliance remains with the RRE.

One of the questions that has come in connection with that too is Section 411.25 of 42 CFR 411.25 talks about the third party payers obligation to report information to CMS.

We are looking at the issue of whether or not we believe Section 111 eliminates any obligations under 41125. So know that that question has already been asked.

A second question along that same line is whether or not if someone self reports or talks to us in the NGHP context liability no fault or workers' compensation context, if they tell us about a situation before there's a settlement or a judgment, award or other payment, does that mean they don't have to report under Section 111?

And the answer is no. Prior notice does not substitute for compliance with Section 111.

In terms of responsible reporting entities for group health plan arrangements, we continue to get questions about exactly who should report. In simplest form, if there is a claims processing third party administrator, and you need to

look at TPA as defined an attachment A to the supporting statement to the PRA federal register notice. And that is available on our dedicated Web site as a download.

If there is TPA as defined in our document, then they have the ultimate reporting responsibility for group health plan arrangement situation.

If there isn't the claims processing TPA and there is an insurer, the insurer has the ultimate reporting responsibility.

Employers who are self-funded and do not have a separate claims process in TPA have the reporting responsibility in that situation.

If there's a self-funded employer who has what they are calling a third party administrator for certain types of actions but it's something short of processing claims, the TPA - that type of TPA does not have reporting responsibility.

For liability insurance including self insurance, no fault insurance and workers' compensation, again, we have definitions and reporting responsibility on that Attachment A to the supporting statement.

The biggest difference there if you're comparing it to the group health plan situation is for liability, no fault and workers' compensation. TPA no matter how they're defined do not have the underlying reporting responsibility under section 111. All TPA's will be acting as agents in that situation. The statute places the responsibility on the applicable law or plan. So TPA's in that situation will not be RREs.

We think it's important that everyone who's dealing with liability insurance,

no fault and workers' compensation understand the statutory definition of self insured.

An individual or entity that engages in a business trade or profession and assumes any risk by not purchasing insurance is deemed to be self insured.

So it's important that everybody understands that and know that there can be reporting obligations deriving from that.

Employers particularly could be in a situation where they are not the responsible reporting entity with respect to their group health plan insurance but are a responsible reporting entity versus - with respect to liability insurance because they are self insured.

So keep that in mind that entities could have more than one reporting responsibility.

With respect to agents, we encourage the use of agents, but CMS is not sponsoring agents. It's not certifying agents. Any selection of an agent is up to the responsible reporting entity.

And as we said before, the reporting - responsible reporting entity retains the ultimate responsibility for Section 111 compliance even if they use an agent.

In terms of who must be reported, one of the documents we already have on our Web site was put up on September 25. And it talks about group health plan data elements, who must be reported.

And going through that a little bit in brief, CMS is requiring the reporting of all active covered individuals. And then this document defines that as being

individuals covered in a group health plan age 45 through 64 who have coverage based on their own or a family member's current employment status.

The second category under that is all individuals covered in a group health plan age 65 or older who have coverage based on their own or spouses current employment status.

The third category is all individuals covered in a group health plan who have been receiving kidney dialysis or who have received a kidney transplant regardless of their own or a family member's current employment status.

And the fourth category is all individuals covered in a group health plan who are under age 45 and are known to be entitled to Medicare and have coverage in the plan based on their own or a family member's current employment status.

When you're reporting these under age 45 individuals you must submit their health insurance claim number, that not just the social security number.

In general, an active coverage individual is someone who may be Medicaid eligible and is currently employed or the spouse or other family member of a worker who's covered by an employed individual's group health plan group health plan and who may be eligible for Medicare.

Medicare may be secondary for some of these individuals, not for all of them. We're using the age band of 45 to 64 to be sure and cover all individuals who experience has shown frequently are missed by employers or insurers in terms of determining Medicare status.

We in order to enable entities not to have to report their entire population, we

did cut it off at 45. But disabled individuals frequently can be under that age and so can ESRD who may even be children.

So the categories I read you before do allow or provide for reporting those individuals as well.

Other factors considered in who must be reporting - who must be reported with respect to group health plan arrangements.

Responsible reporting entities must have Social Security numbers for all spouses and other family members who are active covered individuals in addition to having the social security numbers for subscriber.

Responsible reporting entities must submit the social security numbers for all spouses and family members who are active covered individuals and whose initial date of coverage is January 1, 2009 or later. They have to submit the SSMs for these individuals in their initial file submission for Section 111 reporting and all subsequent submissions.

However where responsible, a GHP responsible reporting entity has a file submission that includes individuals who's active - I'm sorry, where they have individuals where the coverage started before January 1, 2009, they do have until their file submission in the first quarter of 2010 to submit the social security numbers for spouses or other family members. They have to have it for subscribers no matter what time period their coverage fell in.

But if they were covered prior to the 1-1-09 date, they do have the extra year to get that information.

You should all be aware that CMS considers that term family member to

include any individual covered by the plan because of his or her association with the employed individual. For example, domestic partners are considered family members.

Another point with respect to group health plan initial submission is that the responsible reporting entity must report on the all active covered individuals with coverage as of January 1 2009 regardless of the assigned date for a particular responsible reporting entity's first submission.

Therefore if you're a new reporter and you're not registering until April of 2009 and your actual first submission isn't until the quarter starting with July of 2009, you are still required to report all covered lives who fall within the active covered individual categorization as of January 1, 2009.

If the start date or a termination date for coverage for a particular individual occurs within 45 days prior to the first day of the responsible reporting entity's submission window for a particular quarter, then CMS is granting the responsible reporting entity the ability to essentially skip a report or do it. You have the ability to essentially submit it a quarter late.

An example would be your reporting submission window is the first week of July. If that's true and you picked up someone for new coverage as of June 25, you would have until the quarter starting for October of that year to actually submit that individual.

We request that you submit people as soon as possible but we recognize that we need to leave time for everyone to process files, receive information on new enrollees, et cetera. So we've added that 45 days.

The GHP user guide when it's published, will provide an example of actually

exactly how to calculate that 45 days so that everyone is interpreting the 45 days the same.

Another major point for group health plans responsible reporting entities is the issue of employer size. Employers size relates to the number full or part time employees. It's not the number of covered lives under a particular group health plan.

And the employer size is critical to determining primary versus secondary payment responsibility.

Under the law, Medicare is the secondary payor to group health plan for beneficiaries who are 65 or older and working and covered under employee sponsored and/or contributed to group health plan or they're 65 or older and covered under a working spouse's group health plan.

If the employer has 20 or more employees or if there's a multiple or multi employer plan, if at least one employer in that whole plan has 20 people, then the MSP working aged rule applies to every employer, employees that are in that plan.

In a few minutes I'm going to discuss the small employee exception. But know that as a basic premise if you're in a multi employer plan, if anybody has 20 or more, then the MSP rules apply to you as an employer even if you don't have 20 or more.

The second category where Medicare is secondary for group health plan is for beneficiaries who are disabled and have coverage under their own or family member's group health plan for an employer who has 100 or more full or part-time employees.

Again it's slightly different if you're in a multi or multiple employer plan. In that instance, if any one of the employers that is in that plan has 100 or more, then the MSP rule for the disabled apply to every single employer that's in that plan.

Last, with respect to end stage renal disease, if someone is covered by a group health plan on any basis, Medicare is secondary for a 30 month coordination of benefit period.

The responsible reporting entities must report all active covered individuals for all employers who are part of the multi employer plans regardless of the number of full and part-time employees for a particular employer.

The responsible reporting entities must have employer size information for all of the employers in a multiple or multi employer group health plan.

As I stated before, I want to talk a little bit about what's called the small employer exception. Again, there is a specific document posted on CMS's Web site. The date on it is September 22. It specifically listed as a reminder about employer size versus covered lives.

The small employer exception. If you're in a situation where - if an employer is in a situation where there's multi or multiple employer plans and at least one of the employers has 20 or more full or part-time employees, then absent further action the MSP rules for the working aged apply to everyone.

However a plan -- or they may delegate the responsibilities to the insurer -- a plan may request a small employer exception for a particular employer or particular individual if that particular employer has less than 20 full or part-

time employees.

In other words, if there was a multiple employer plan and it had ten employers in it and only one of those had over 20 employees and the other nine plan - the other nine employers, if the plan wished to request an exception from the MSP rules for the working aged it would have to submit the appropriate documentation to our coordination of benefits contractor to identify the specific employer, the specific individual for whom the exception was granted - or was requested. And CMS is being request to grant the exception to our coordination of benefits contractor.

There is detailed information about the small employer exception request process on our coordination of benefits Web site.

It's important to note for the small employer exception that that group health plan must request it and CMS must approve it. It's not a unilateral action by the employer.

Additionally, an approved exception will fly only with respect to specifically named and approved beneficiaries associated with the specifically named employer participant and the specifically identified multi employer plan. It - this exception is only for the working aged. There is no similar type of exception or exception for disability situations where a multi employer plan has 100 or more.

All approvals are prospective. And last, in terms of the ESRD situation, again, there is no exceptions for employer size related to any one that's in a multi employer plan. Employer size is not a determining factor for ESRD.

For purposes of requesting the small employer exception, the term multi

employer group health plan means any trust or plan or association or other arrangement by one or more employers, to contribute, sponsor, directly provide health benefits or facilitate directly or indirectly the acquisition of health insurance.

So if such facilitation exists, the employer is considered to be a participant in the multi employer GHP even if it has a separate contract with an insurer.

The document we posted on the Web site gives specific information about how this will affect the record layout and data that's submitted. So you can all take a look at that for those purposes.

For liability insurance, no fault insurance and workers' compensation situation we don't have a parallel document to the two I just went through posted yet. We expect to have something up within a couple of weeks definitely sometime this month.

So what I thought I would do is run through some of the policy issues that have been showing up in questions.

We've received literally hundreds of questions in the last couple of days. And we haven't had a chance to go through all of them or put down final answers to all of them.

You should take the comments I'm making right now as where CMS is headed, that you need to wait until we have the actual document on the Web site as being official instruction.

And everyone should keep in mind both for group health plan and for liability insurance, no fault insurance and workers' compensation that the PRA

process, the Paperwork Reduction Act process is not complete yet. There is always some potential for change when the final PRA notice is issued. So we all need to keep that in mind.

With respect to liability insurance, no fault insurance and worker's compensation we've received several questions about reportable events as of July 1 2009. What does the date July 1, 2009 signify?

Does it have to do with the date of the injury, the date of the payment, the date someone's made a preliminary agreement or what?

For us, the determination has been made that the trigger is the date of the settlement judgment award or other payment. It's not that date of the injury. So if you have a pending case as of July 1 that you've got the settlement judgment award or other payment on or after July 1 its reportable. It's not the date of the payment.

If you have a situation where you've reached an agreement on a settlement and you formalized it but payment is going to be delayed for six months, that doesn't mean that you delay reporting it for six months.

And it's not just a preliminary arrangement. It's basically where we expect to end up with the final issuing on paper in our instructions. It's going to be a written obligation where there's an agreement or notice of obligation.

If you have a situation where there's a formalized settlement agreement, it's going to be when that settlement is dated as an effective date.

If you have a situation where there isn't a formal settlement that there's simply a notice that you're paying the claim, so you're taking action along

that line, it would be when the formal notice goes out.

If the only notice is checked then we would be looking to consider the date of the check.

If any of you have comments why you believe these are not the appropriate dates, then our mailbox that John mentioned before is where you should submit those comments.

In terms of what gets reported for the amount, please note that the data elements that we put in the supporting documents to the PRA notice talk about contested cases, resolved cases, various language along that line.

We've received a lot of questions about those. We're in the process of trying to come up with more generic terms that we believe will cover every situation.

In terms of the amount to be reported, we're looking at essentially what is the payment obligation of the liability insurer, the no fault insurer if it's a situation where you've got a lump sum.

If you assumed responsibility for ongoing medical, then that's what we want to know. But if you have a situation where it's settled and you foreclosed all future medicals, we want to know that total payment obligation.

If you're doing it through a structured settlement, we want to know the total amount, not how much your first payment's going to be.

If you have a requirement in settlement that is purchasing an annuity, we need to know the total value of the payout of the annuity, not the first payment or subsequent payments.

We received a number of comments about what do we mean by reporting on the ongoing responsibility and that this appeared to conflict with our directions to report once there's been a settlement judgment award.

For workers' compensation or no fault insurance, frequently there's a situation where workers compensation is paying for medicals on an ongoing basis or the no fault insurance is paying until an exhaust limit is reached.

In those situations we're asking you to report when the responsibility is assumed and again, once the responsibility is terminated. We do not want to have you report every single bill, every single dollar amount you're paying.

Responsible reporting entities will be responsible for reporting on individuals for whom they have ongoing responsibility on or after July 1 2009.

So if you have - if you're a worker's compensation RRE, and you have a responsibility for a group of people that that responsibility was assumed sometime in the past but they are still entitled to submit claims for medicals, et cetera, then we need that situation reported to us.

Again, similar to the GHP arrangement situation, we've realize that you haven't necessarily been tracking information in terms of who may or may not be a Medicare beneficiary and may or may not be collecting SSM.

So for those folks where the ongoing responsibility was assumed prior to July 1, 2009, just as we were looking at a year extension for information on spouses and dependents with group health plan situations we're looking at the year extension for obtaining information on those people for whom the ongoing responsibility was established prior to July 1, 2009.

What we would be interested in receiving comment on is exactly how often responsible reporting entities should be required to check that a person becomes Medicare eligible.

If for instance someone that you have a settlement - not necessarily a settlement, you assume ongoing responsibility on say July 10, 2009 and the person's not a Medicare beneficiary at that time, you are required to report once they become a Medicare beneficiary. But CMS wants to be reasonable in terms of how often you should be required to update your records to determine Medicare eligibility for these individuals.

So again, if you have suggestions on how best to make that work, please send your comments as soon as possible to our mailbox.

In terms of timing of reporting, it will be quarterly for liability no fault and workers' compensation. And it will be only quarterly.

We've had several comments that are asking whether or not they can report weekly or if they can report only once a year. And the answer is basically quarterly and only quarterly.

Another issue for liability no fault workers' compensation is that we've received a fair number of questions that really go to MSP policy, not pure implementation of section 111. So we're compiling some of those issues and we'll look at putting a pointer on our dedicated Web site for the mandatory reporting and addressing some of those policy issues most likely on our coordination of benefits contractor Web site or on that site as well as our Medicare secondary payor recovery Web site.

Some of those types of issues people have asked about is whether or not if there's a zero verdict does that mean there has to be any reporting done?

Now a simple answer wouldn't cover all the issues. We have to look at whether or not if it's a jury verdict, generally we defer to hearings on the merit by a court of competent jurisdiction.

On the other hand we're not bound by the allocation of the parties so that if two parties agree that there's zero reliability but there's still a payment as far as we're concerned, we have a potential recovery claim against that amount. This goes to the issue of perhaps a nuisance settlement.

Many times people wish to claim when Medicare's looking at a recovery that this is just a nuisance settlement. It didn't really cover any medical.

CMS's recovery rights are determined when primary payment responsibility has been demonstrated.

And if you look at our statutory language, primary payment responsibility can be demonstrated through a judgment, compromised release or otherwise. So we will have a more detailed answer on our Web site.

We've received a number of questions about verification of entitlement for liability no fault and workers' compensation. We are looking - are still working on a model form that could be used for collection of this information. But we're not reaching any final results on that right now until we have further discussions with our council as to whether or not we can give access for liability insurance no fault and workers' compensation to responsible reporting entities to have a query function for Medicare entitlement.

We have questions out to our council right now in terms of whether or not we can legally do this, if we can, how we can do it and what type of limitations we would have to impose.

We also have several questions about low volume submitters. And none of the questions that I've seen so far come in give any specifics about what the submitter thinks is a low volume.

Right now our plan is for everything to be electronic submission. And if someone is looking beyond for something beyond that, they need to give us more information in terms of how or why we should have an exception to our standard electronic process. We don't plan on any such exception at this time.

The next point that came up several times in questions is the definition of the word claim. Commenters have asked that we make sure that we specify that we're not talking about a single service, that we're really talking about a liability claim as a whole or a no fault claim as a whole or workers' compensation. And that is our intent. We will look at refining the definition.

There have been several other comments about other definitions. And the general complaint is that CMS's use of certain terms does not comport with the industry standard for workers' compensation or for a particular term that doesn't match what we use for liability insurance.

However, since CMS has regulations that define many of these terms, where we have a regulatory definition we have to use that.

The other issue is that we need to have definitions which match our needs for coordination of benefits and recovery purposes.

An example along this line is we received a couple of comments that have to do with date of instance. CMS defined date of instance in the attachment with data elements in the supporting statement but ours is tied to if there's an implant for example it's the date of implant. If it's a drug that's adjusted, it's the date of first (adjunction).

I believe we had comments from the Department of Labor and some others in terms of the idea that under state law or certain other situation for their purposes date of incident is defined as the date of compensation or for exposure situations it's the date of last exposure.

So we will make very clear what definitions we're using but we will not necessarily be able to accommodate the requests that we switched the definitions to match the exact definitions used by the industry.

We've also had a number of comments - - and I'm not sure if I'm repeating myself at this point, but we've had a lot of comments that are really outside the scope of section 111.

We've had a number of comments -- and I'm not sure if I'm repeating myself at this point, but we've had a lot of comments that are really outside the scope of Section 111.

We've had a number of comments about liability, Medicare, set aside arrangements. And we've had questions about staffing, is CMS going to staff up so they can take care of those, what are we doing about additional conditional payment issues, et cetera.

If you have comments that don't relate directly to implementation or questions, you should submit them through the normal process.

With respect to liability Medicare set asides, in general, CMS does not have the same formalized process as for workers' compensation. But the obligation with regard to protecting Medicare's interest is the same for both workers' compensation and liability situation.

Another major issue from several of the questions is that CMS has taken the policy position that when there is a liability situation -- this is for liability insurance including self insurance -- and the incidence occurred before December 5, 1980 or if it's for example exposures, that all exposure ended before December 5, 1980, that CMS will not assert a recovery claim.

So individuals have asked whether or not there is some way to deal with this in the reporting that we could perhaps exempt some of this.

So we're looking at the issue. We don't want reporting of things that clearly would not be a situation where we would be secondary.

Along the same line, individuals have asked if there are situations involving multi district litigation in class actions or large product liability situations, is there some way that these would not precede through the regular process?

If someone has suggestions on the way that would work we would be happy to hear them. But otherwise they are clearly reportable once there's a settlement, judgment or award.

In terms of submission of file for liability, no fault and workers' compensation, some general questions that go along with the deadlines and when things must be submitted is folks have asked whether or not the files that are submitted can combine both group health plan information and

liability no fault and workers' compensation information if the responsible reporting entity has responsibilities for both areas.

And the answer is no. No one's going to be able to mix group health plan information with the liability no fault and workers' compensation. There will be differences in the record layout.

In terms of mixing less than that, yes, a responsible reporting entity can mix information from lines of business between liability no fault and workers' compensation because the record layout will be specific and we'll be able to sort that.

But there will have to be a separate file for each responsible reporting entity. If a particular entity is acting as an agent for multiple responsible reporting entities, they will have to submit a separate file for each responsible reporting entity. However there can be multiple file submissions on the same date.

We've also been asked whether or not the issue of reporting on a ongoing responsibility situations versus single reporting when there's a settlement judgment award can be mixed. Yes, we expect that to be mixed. You can report both of those in the same file. There will be a response file in all situations.

And last in this general category is we've had questions or statements that just reporting under section 111, particularly for liability, no fault and workers' compensation its design or its intent is only to put Medicare or CMS on notice, that we should not be requesting information beyond the minimum needed to put us on notice.

And CMS has a different position on that. The statute says that we can specify

data to be reported, that it's necessary not just for coordination of benefits in general but also for purposes of any applicable recovery.

So to the extent we need information for Medicare secondary payer recovery claim, that type of information is included in our data element.

And at this point I think I will turn it back over to either John or (Bill).

(Bill Decker): Hi. My name is (Bill Decker). Thanks (Barbara). I'm going to cover some things that (Barbara) didn't. There may be a few left.

First thing I'm going to talk about here is in general the registration process, I know we've gotten a lot of questions about the registration process, specifically, when does it happen, who has to register, why - what does it mean when I register? And I'm going to go through a couple of those points now.

This is the registration process for responsible reporting entities. Again, the acronym that we use here is RRE for Responsible Reporting entity. But the term Responsible Reporting Entity is the term that is defined in the documentation already up on the Web site.

On that Web site you will find a document called the Implementation Timeline. That document has a outline, gives you an outline form, the registration date that you're going to need to be paying attention too.

The date on the document on the Web site which is the implementation timeline is September 24.

For new group health plan RREs, registration will start for section 111

reporting on April 1, 2009. This will be electronic registration. And it will be only through a particular Web site which I will discuss in a couple of minutes.

The - we have a group of - group health plan reporters who have already been reporting to us on a voluntary basis, reporting essentially the same data to us on a voluntary basis. They have already been - we've already had a call with them. And they know that they will be transitioning into the section 111 reporting process a little bit earlier than new GHP reporters. And we have a separate registration process for them, and interim registration process.

But even the current transitional partners will be registering on April 1 through the electronic process. The registration for non-group health plan RREs starts on May 1, 2009.

Section 111 takes place - takes effect on January 1 for GHP RREs and on July 1, 2009 for non-GHP RREs as we've already discussed.

Since we are not asking new RREs to register until after those dates, we're not requiring new group health plan or non-group health plan RREs to begin sending us data on those effective dates.

We've had a number of questions about whether if I'm a GHP do I have to start sending you information on the 1st of January. The answer is no.

Then we have a - then we have - the tangential question that always comes up is well how will I be in compliance with Section 111 reporting if I don't have to give you anything on January 1st? The answer to that is you will begin your compliance with Section 111 reporting at registration. And as long as you do register on the assigned dates within the assigned timelines you'll be initially in compliance with Section 111 reporting.

And as long as you continue reporting under the Section 111 reporting you'll remain in compliance.

All registrations are going to be electronic as I said before. And all will be made through a secure Web site that will be operated by our coordination of benefits contractor.

The secure Web site then becomes known by the acronym the COBSW. And that is the - where you will be going to register. And it will also be the portal through which you will submit information to us when you do begin to transmit information and from which you will get information in response.

I'd like to remind folks that it is RREs that are required to complete and submit the electronic registration on the first page of the registration document which is up on the Web site we make it clear that agents are not permitted to complete and submit a Section 111 RRE registration.

Again, the definitions of ensure and third party administrator entities are in Attachment A of the supporting statement dated August 1, 2008 which is on the Section 111 Web site. And I urge you to review those definitions if you have any questions.

If an RRE is using or will use an agent in the Section 111 reporting process, the agent information section of the registration form must be completed. Even though the agent won't be responsible for the information, we have to know who the agent is.

RREs will also be able to get help with the registration process through a computer based training course which is in the process right now of being

developed.

Course materials will be available at the time registration is to begin and should be available well before that. So you'll be able to see what it is you'll have to do at registration by going on to a particular Web site and taking the computer based training.

That is a rough and general overview of the registration process. And it applies to as I mentioned before both GHP and non-GHP RREs. Everybody is going to have to register. It will always be electronic. All reporting will be electronic.

I will discuss the data submission process a little bit later. But right now I want to turn it back over to John who's going to give you a general overview of the data elements that will be - that need to be exchanged and a brief discussion regarding the collection of social security numbers and Medicare ID numbers. Thanks.

John Albert: Thank you (Bill). This - the first part of this discussion centers around the GHP or group health plan reporting requirements.

CMS has a document that's titled Transitioning Into Section 111 Reporting available currently on the CMS Web page. This is a summary document that includes the following record layouts for the GHP reporting entities.

A full comprehensive user guide is forthcoming in the near future. And in addition, a user guide for liability insurance, no fault insurance and workers' compensation responsible reporting entities will be available at a later date as well.

The first thing for those that are new to this process, the GHP reporting process is based on what we refer to as the voluntary data share agreement process that CMS has been performing since 1998.

We currently have several hundred entities out there that are exchanging data with CMS based on group health plan coverage.

The purpose of this exchange essentially is to allow CMS to build of records of coverage on its system and coordinate benefits accordingly. At the same time, the voluntary data share process also provided - provides submitters with Medicare entitlement data that they can also use to coordinate benefits on their side.

The first thing in terms of the new requirements under Section 111 is there are actually two options available to responsible reporting entities who are considered group health plans or TPA's.

The basic option we refer to coordinates the minimum necessary data to coordinate the Part A and B Medicare program with hospital medical coverage.

There's also an expanded option which includes the ability to send and receive information related to Part D prescription drug coverage.

Now I want to talk about briefly an overview of the MSP input file and the data elements associated.

There are several groups of key data elements that make up coverage information. The first grouping of information is the personal information about the covered individual. That would include the social security number

or (Hicken) or health insurance plan number which is the Medicare claim number, the name of the individual, date of birth and sex.

This information is used to essentially validate whether or not that person is in fact a Medicare beneficiary.

There are also on each record there's a transaction type which tells us essentially whether the information you were submitting into us is either new, an update to information previously submitted or in the case where information was submitted erroneously, a delete transaction.

There's also a group of information that includes basic coverage information that we need to build a record on our system. This includes the start and the stop date of the coverage, the type of coverage and other information such as policy numbers.

We also ask for an employer, an insurer EIN or TIN identification number that is submitted via a separate TIN reference file that includes the name and address of the employer and insurer that offer that coverage to that particular beneficiary.

As part of the expanded option, we also include fields that allow the submitter to provide us with prescription drug coverage information on the record so that we can also provide in response, Medicare Part D entitlement information as well.

One other data element on there and (Barbara) did talk about earlier was a small employer exception. And this data element basically asks you to tell us if the person was submitted and approved for the small employer exception. This allows us to verify or to help you verify that the exception has been

granted.

Once you send a file into us you'll receive a response file after we process it. And every single record, coverage record that you submit to us we'll receive a response record in turn. Basically we provide you with all the information that you submitted to us on your response record as well as what we refer to as disposition codes which tell us or tell you whether or not the record was accepted or not.

And if the record was not excepted we include a listing of error codes. These error codes tell you that there was potentially something wrong with the data that you sent us. An example would be a format is incorrect, an incorrect character, et cetera.

When you receive a record back that includes an error code, we do expect you to - attempts to correct that error and resubmit that record on the following quarters file.

One final thing on the record layout that again is available as part of that transitioning into Section 111 reporting guide includes a late submission indicator. This is to let you know that the record you submitted to us was outside of the timeframes that we've set in the requirements.

In addition to the MSP input and response files, group health plans also can submit what was referred to as a non-MSP file under the expanded option. There's a couple of things but I won't go into too much detail because of time considerations.

But essentially the three functions of that file are to allow GHP responsible reporting entities to query Medicare entitlement data for purposes of

coordination on their end. It also allows the submitter to submit records of drug - private prescription drug coverage that is supplemental to Medicare.

And for those that have business arrangements with employers, we do allow submitters to use the non-MSP file to submit retiree drug subsidy files on behalf of employers who are claiming the subsidy for providing retiree prescription drug coverage.

For entities that are using the basic option only which includes the reporting of hospital medical coverage only, we also have a standalone query file that will allow you to receive Medicare entitlement data for parts A, B and C only.

And with that that is basically a high level description of the GHP reporting data elements. And now I'd like to turn it over to (Barbara Wright) who will go into a brief discussion of the non-group health plan or workers' comp liability no fault insurers reporting entity file layout that is forthcoming.

(Barbara Wright): In general the process that John described in terms of submitting files and getting a response filed et cetera will apply to liability no fault workers' compensation too. So I'm not going to say any more about that.

We have data elements that we put as an attachment to the supporting statements as a PRA notice. And we received a number of questions about those.

As John said, some of the basic information about names, date of birth, sex, et cetera, we used those to validate whether or not we have that correct social security number when someone submits it and connect it up with the Medicare health insurance claim number.

We have other different categories on our data elements because we need the information or recovery actions as well as posting records where there's ongoing responsibility.

So we have a section for the liability no fault workers' compensation that deals with situations where the injured beneficiary is deceased or you've got a survivor action or a and a state action, et cetera. We need to know who the claimant is in that situation. But we still need the information about the beneficiary.

Along the same line we have to have information about who is the primary plan, in other words, who is the insurer or (workers comp) that's involved in this situation?

There's a section about policyholder and information about policy numbers that we've received some questions on. Again and we need to know different information for GHP because - I'm sorry, different information than is needed for groups health plan situation because the policyholder, policy number isn't necessarily connected to the beneficiary in any way.

We need to have information that we can identify this back to what the insurer is reporting because they won't necessarily have a completely separate record of the beneficiary. And we have to have multiple ways to tie this back together.

We have a section for to be in your party or the claimants attorney or other representative. This is because in our experience in most situations there is some type of representative. And we need to be able to contact that individual so that we're not contacting just the beneficiary with resulting inquiries back to you as the insurer or workers' compensation entity which could have been

eliminated if we just dealt directly with the attorney or other representative.

We need a significant amount of information about the incident. And one of the questions we've gotten is why did we reference WCIO codes and what are they?

And this is - WCIO is Workers' Compensation Insurance Organization. They have standardized codes for two or three of the areas that we have listed in the incidence section.

We are open to using other standardized codes if there are ones that cover this broad area. The one that appeared to us that covers most types of situations are the WCIO code. If there are other sets of standardized codes out there that you believe would give equally this type of information we would like to know what those sets are and what recommendations you have.

We've already discussed the fact that date of injury is an issue of concern to some liability no fault workers compensation insurers and that we'll be addressing that.

We've also discussed the fact that under the section for resolution that we're looking at clearer terminology that people will be able to understand little bit better.

Last, we also previously discussed the fact that we're looking at a model form for collecting SSN information as well as our ability to give some type of query function for validation of beneficiary entitlement. I think that's all we need on the liability no fault workers' compensation element. I'll turn it back over to (Bill Decker).

(Bill Decker): Thanks again (Barbara). I will now tell you a little bit about the data exchange process itself. We've talked a lot about why you have to submit this data, why - what the data elements are, what our definitions are, are all the information we've got coming in from you.

And now I'm going to tell you what happens actually when we set up a data exchange process with you.

This will apply generally both to GHP and non-GHP responsible reporting entities. Where there are differences I'll make note of those differences. But in general this is what happens.

You'll make a - you will submit data to our coordination of benefits contractor through that data exchange Web site that I mentioned in my earlier presentation.

For GHP responsible reporting entities, you're going to submit to types of files. You're going to submit GHP input files, I mean MSP input files. And you're going to submit if you choose to, essentially non-MSP input files.

The input - the MSP input file is a quarterly - will be submitted on a quarterly schedule. And you'll get a response filed back from that MSP input file also on a quarterly schedule.

The non-MSP input and response file exchanges are either quarterly or monthly. There's a technical reason why we can have you do that more quickly. And - but I'm not going to get into that here.

However we are recommending that if you choose the expanded option and choose to send in non-MSP input files that you do choose the monthly

submission schedule.

The non-GHP RREs will submit data files to the COBC using the data exchange option they have chosen at registration.

Both the GHP reporters and the non-GHP reporters will have a couple of different technical ways they can move the data into the COBC and get the data back from the COBC. You'll understand what those technical issues are when you read the registration documentation in full and when you have had a chance to look at the user guide. And am not going to go into any detail here about what they are.

But you will make a choice when you register about how you want to move - have the data move back and forth both incoming from you and in response to you.

For non-GHP responsible reporting entities -- I think this was mentioned before -- the data exchanges for both input and response files will be on a quarterly schedule. There is no monthly schedule allowed for non-GHP reporting.

All file submissions from all responsible reporting entities will be acknowledged upon receipt. We've had a lot of questions about that. Yes, we will tell you when we get the input file from you. You'll also of course get a response file. But we'll let you know that we've got your report file just so you can be assured that we received it.

In general, how do you get to this file exchange process? And in general how does it work? I'm just going to give you a brief overview of what actually happens.

After an RRE registers, you, that is the RRE, will be contacted by CMS Coordination Of Benefits Contractor, that's the COBC again, you will be assigned your own dedicated electronic data interchange representative, what we call in shorthand an EDI rep.

And that is an individual who works for the COBC and will become your personal contact at the COBC. The EDI rep will work with you and your technical staff on setting up a data exchange process. Then you and the COBC will test the data exchange process.

Once you and the COBC determine that testing is successful you will begin production data exchanges. It's a three part process, registration, get to know your COBC EDI rep, test the file exchange. And then once testing is completed you will go into production.

This does take a little time. And in particular for people who've never done anything like this before it will seem complicated. It is a little complicated. On the other hand we already have over 200 firms doing data exchanges like this. And we haven't - and their reports to us are that once it gets established it is very smooth.

Once you are in production you'll transmit the required data to the COBC. That data is processed by the COBC. And then the COBC returns a response file to you.

You take in that response file, make any necessary corrections to your data and then begin preparing your next input file. That's the general process.

We - you send an input file to the COBC, they process it, they respond to you

with their response file. You take that response file, look at it, make any changes that you need to make on your own database based on what we have returned to you and begin to prepare your next input file.

In the GHP world where nothing is ever static, this becomes a very routine process. And it has been an as I said before, a process that once established seems to work very smoothly and easily.

We have over ten years of experience doing this. And I think that for most of you this will actually be a more smoothly functioning operation than you can imagine at this point.

All the interior details of the data exchange, for example, what do the response codes mean, when do I add new records to an input file, how much time do I have to make corrections? All that sort of information will be forthcoming. We're not going too go into that here today.

Most of these details will be covered in the two user guides we'll make available. There will be one user guide for group health plan RREs and one user guide for non-group health plan RREs.

The non-group health plan folks won't be able to use the one for group health plans and vice versa. As we pointed out earlier in this presentation today, the data elements sets are quite different between the two. And one user guide will not apply to the other.

Finally, your EDI rep at the COBC will actually be able to answer most of your technical questions. If the rep can't, then we can step up the question process to us here at CMS. But in general we have found that we don't have any problems or many problems in any case, with getting questions - getting

answers to your technical questions.

I think that's all what I'm going to cover John and all turn it back over to you. Thanks.

John Albert: Okay. In closing before we get to questions again, I want to stress that we really do want to hear from everyone if you haven't given a comment, questions through the CMS Web page.

And I'll repeat that address although you probably already have it. And anyone who searches under a common search engine like Google can find it under if they Google mandatory insurer reporting. But it's www.cms.hhs.gov/mandatoryinsrep which is insured reporting obviously.

I want to stress that there will be a lot more information forthcoming including future open door forms as I mentioned. We're also planning on offering computer based training for a lot of the information here, especially the more technical information.

We encourage you also to sign up for the list service on the mandatory insurer reporting Web page so that you can be alerted as soon as possible when there have been additions to the Web page including announcements regarding future open door forum.

We will continue to review these questions as we formulate the final guidance on the implementation of this project. And with that I would like to ask the operator if they could turn the - start soliciting questions from those on the phone.

Coordinator: Thank you. At this time if you'd like to ask a question please press star 1.

You'll be announced prior to asking your question. And to withdraw your request you may press star 2.

Once again to ask a question at this time, please press star 1. One moment please.

Our first question comes from (Catherine Siegel). Your line is open.

(Catherine Siegel): Hi. I just had one question. You said that once in production we would receive responses that would let us know what our errors are and we put begin processing those corrections.

Do we wait till the next quarter to submit our corrections or do we send you a correction file immediately within that quarter?

John Albert: No you can could wait till the next quarter.

(Catherine Siegel): Thank you.

Coordinator: Thank you. Our next question comes from (Tom Vermilla). Your line is open.

(Tom Vermilla): Yes, I'm just trying to find the layout documentation on the Web site.

John Albert: There are a series of downloads at the bottom of the - that Web page. And it includes that document or should include that document.

(Tom Vermilla): Yes, the one that says Group Health Plan Data Elements actually refers to who would submit. And I do believe that the layout documentation is missing unless I've missed it. I've opened every document.

(Bill Decker): Are you looking for that group health plan data element file layouts?

(Tom Vermilla): Correct. Both layouts.

John Albert: The - that should be titled Transitioning, the Section 111 reporting I believe.

(Bill Decker):: There is a document on the Web site called to Transition to Section 111 Reporting. And that has the file layout in it. I caution you to understand if you are a new GHP a reporter and have never been doing this process before, you can take a look at the layouts and they won't give you a precise definition of what data elements we are looking for.

But the information that accompanies the those file layouts is designed for our current data sharing partners. It's not designed for new data sharing partners.

File layouts themselves are basically the same. But you will be getting a lot more information around those file layouts with your new user guide.

(Tom Vermilla): Okay, thank you very much. I found the document.

(Barbara Wright): Okay, with respect to the liability no fault workers' compensation, there is no record layout on the Web site yet. We're working on that. And it will have a lot more detail than in the brief list, the data elements were in the supporting statement, the (PRA).

John Albert: With the six month difference in terms of the implementation dates, obviously we're focusing more on the GHP reporting requirements at this time. So - but again, all of the non-GHP or liability workers, no fault insurance reporting requirements are forthcoming as well.

Coordinator: Thank you. Our next question comes from (Mike Cochrane). Your line is open.

(Mike Cochrane): Yes, I'd like to know it this applies to standalone dental plans or to supplemental health plans?

(Barbara Wright): We are looking at framing a complete answer to that. I believe that we're leaning at this point that dental plans would not be reported. But there are some issues where people have asked us whether illness specific plans needed to be reported or not as group health plans. And we're still looking at that issue.

Coordinator: Thank you. Our next question comes from (Theresa Lynn).

(Theresa Lynn): Yes, you had made a comment at the very beginning of this meeting that this was being recorded. Will we be able to access the recorded meeting afterwards? That's question one.

Question two is you were talking about the RRE. When can they actually register? May they register prior to January 1st for group health?

And as a caveat to that question, if they want an agent listed, then will the agent go ahead and finish out all of the registration information?

(Barbara Wright): For your first question in terms of whether or not you're going to have access to the recorded information, we will have the presentation available as a transcript. And we should have it available verbally too. But it won't be available immediately. It'll probably be a week or so.

With respect to registration all let (Bill) talk about it in detail. But for the new

reporters the secure Web site for registration will not be available to them until April 1st.

(Theresa Lynn): Thank you.

(Bill Decker): That's as much as I would've said (Barbara). Thanks.

Coordinator: Thank you. Our next question comes from (Anthony Siliato). Your line is open.

(Anthony Siliato): Yes, we're a group self insurer authorized by the Department of Labor. Our sole line of business is coverage under the (Longshore) Act.

And everything you've spoken about today, all the information you require is regularly reported to the Office of Workers Compensation Programs and the Department of Labor.

It would seem to meet that it would be a horrible waste of resources to needlessly duplicate the process. Have you spoken to the US Department of Labor for dealing with their programs and to avoid duplicating this process?

(Barbara Wright): We've received at least one comment or detailed comments on some of these issues that we're looking at them. And I expect we will be talking to the Department of Labor. We're not interested in duplications. But without further examination we don't know for sure whether everything that we're asking to be reported is there.

For example, we know there is a distinct difference between DOL date of incident and the date of incident that Medicare requires. But yes, we are looking for ways to avoid duplication if we could do so.

(Anthony Siliato): I mean if I may it on that particular point on that date of incident, the information you request simply doesn't exist in the context of a (Longshore) Act. It just does not exist. No one will know that answer. I mean the only answer that we will know is the last date.

John Albert: As Barbara said at this time, I mean we have those comments and we are investigating further on that.

(Anthony Siliato): Thank you.

Coordinator: Thank you. Our next question comes from (Ron Meyer).

(Ron Meyer): Yes, you mentioned your user guide for GHP. When will that be available?

(Bill Decker): Hi. This is (Bill Decker). I'll answer that question. We're trying to get that up on the Web site. We wanted to have it up on the Web site the by the time we had this call. It's obviously not on our Web site yet. We're getting it up as soon as we can.

At this point because a lot of the information we're getting is actually - is actually causing us to have to reformulate some of the information that's going into that user guide we've fallen just a tad behind.

But we're going to get it up just as soon as possible. We understand that the GHP folks because GHP comes up much more rapidly would like to have that Web site. And we are determined to get it to you just as soon as we can.

(Ron Meyer): Okay, thank you.

Coordinator: Thank you. Our next question comes from (Brenda Wright).

(Barbara Wright): Well a TPA for a DHP have to report HRA plans?

(Barbara Wright): We're still looking at HRAs. We have determined that FSAs do not need to be reported.

(Barbara Wright): And how soon might you have that information available?

(Barbara Wright): We're attempting to go through all the questions we've received within the next couple of weeks and answer as many of them as possible as soon as possible. But do we have an exact date it this time, no.

Coordinator: Thank you. Our next question comes from (Roy Franco).

(Roy Franco): Yes. I'm interested in when the data element for the non-GHP will be finalized? And I ask that question because we are currently in budget period planning for update to our claim system or various claim systems.

And I know in talking with fellow members in the liability arena, many of them in the same position and many of the data elements that you're requiring while captured by our current claims system, they're not captured in a structured format. They're captured in an unstructured format which makes it impossible to comply with the reporting requirements without change to our system.

Therefore, it's problematic if we don't get the elements as soon as possible so we can get the budgets in place for '09. So just wanting to know when the elements will be finalized so we can properly prepare our budgets.

John Albert: I mean our goal is to have, you know, all of this done by the end of the year at the latest for sure. But - and we are very aware of your need for that information. But right now we still are in the process of finalizing those. And we don't have a set date for those.

We - again, in dealing with, you know, many different kinds of data exchanges administered by CMS and our many data exchange partner we're very aware of that need and are trying to get those out to you as soon as possible.

(Barbara Wright): What we do intend to do is put out something with the record layout without waiting for the complete user guide so that people will be able to see it just like they can see it for the GHP.

I would caution people to remember though a little bit of this is beyond our control. If we end up having to make changes to data elements because of something in the PRA process including the next round of comments, then we could ultimately end up changing something that's in a record layout right now.

(Roy Franco): No, I would absolutely encourage if you could do that at least it will allow us a marker to budget for us so that we can be somewhat prepare to comply with the reporting.

If we don't get any basic information in or, you know, as close to possible what the outcome might be, it's very difficult to get the funding to change the system. And then when we try to register we'll have a file that may not be able to comport with what you need.

(Barbara Wright): Thank you.

(Roy Franco): But any assistance you can provide will help.

And then I just have one additional question because it's more in line with the liability problems that we have is that if the claimant refuses to provide the social security number because there's no legal mechanism that requires that they provide it to us, there's no tax reporting of a personal injury settlement so there's no legal basis for us to ask them for that information, how do we comply?

(Barbara Wright): We are still looking at all that compliance issues. That's one of the issues that we may address somewhat in the model form that we're developing.

(Roy Franco): Okay.

(Barbara Wright): At this point we can't give any blanket statements that there's a good faith exception.

(Roy Franco): All right.

(Barbara Wright): Or anything beyond that line.

John Albert: But we do want to develop, you know, tools or assistance that will help everyone comply. So again we're - you know, those kind of comments are very helpful to us because we can prepare, you know, documentation or whatnot that can be used with a, you know, a CMS letterhead on it so to speak to facilitate collection of that information.

(Barbara Wright): To the extent that at least for people that are 65 or older that you have a real sound reason for knowing that there in all probability a Medicare beneficiary,

some of the existing regulations may help in 42 CFR, 42 CFR 41123 requires the beneficiary's cooperation with respect to coordination of benefit issues.

(Roy Franco): Yes with that - and the way I understand our regulation it works perfectly fine with the coordination of benefit contractors talking to them but not necessarily with the liability carrier. Because the regulation doesn't really, you know, give us that force of affect to ask the questions.

(Barbara Wright): No, we also if you haven't looked at it yet, there is on alert out on the dedicated Web page that can be used to explain to the public that collection of this information is appropriate.

(Roy Franco): Right. Yes and I appreciate that. That will be helpful. I do work with a group of large soft retailers, insurance carriers, trade associations as well as EPA. We formed a coalition to try to assist Medicare with their recovery effort.

We would enjoy a and opportunity to meet with you separately so that we can kind of maybe share some information to help us ease this process along.

I put that - it was in one of my questions that I submitted earlier. So I'd appreciate it if you would all like to contact us to do that. We can certainly help.

John Albert: We appreciate your enthusiasm.

(Roy Franco): You're welcome.

Coordinator: Thanks. Your next question comes from (Candy Kris).

(Candy Kris): Hello. Okay, so we've just become compliant with labor and industry side of

reporting. I'm wondering if there's any relationship between the two? I understand you guys are probably looking for different information.

However it was very expensive to get that program up and running. And so I'm wondering if we'll be able to use the same program with reporting for you guys?

And then my second question, as far as quarterly reporting, are you guys looking for all new claims that have been report - or filed? Or - and are you looking for ongoing claim updates?

(Barbara Wright): Okay, first let me confirm that you're talking about liability insurance, no fault insurance or workers' compensation?

(Candy Kris): Correct.

(Barbara Wright): Okay. As I indicated in the earlier discussions, if you accepted ongoing responsibility for the medical situations as is often the case for no fault workers' compensation, there's going to be a required report when that obligation has been excepted and a required report when that obligation has been terminated. We do not want information on every single bill.

In terms of the rest of the situations where the matter has been in dispute, we are not requiring - the statute does not require - we don't want to report for purposes of Section 111 reporting until there's been a settlement judgment award.

So typically in situations where there's been a single payment settlement judgment award, there would be nothing to update.

(Candy Kris): Okay, so say a person files a claim in January of ‘06 and it doesn't close and settle until January of ‘09, you guys want the opening information and then the closing information?

(Barbara Wright): Not necessarily what the dates you gave me. The reporting information date for liability no fault in workers' compensation, if it's a single lump settlement judgment or award is for July 1, '09 or later.

If it's a situation say with workers' compensation where you had assumed responsibility for ongoing medical prior to July ‘09, that person is going to have to be reported to us. Although as I also mentioned you'll have an extension to identify all those people for up to a year.

(Candy Kris): Okay. And you want the same information whether the individual is 20 years old or they’re 63 years old?

(Barbara Wright): If They’re a Medicare beneficiary, yes.

(Candy Kris): Okay.

(Barbara Wright): And the other thing is if you wouldn't mind, I guess I'm not necessarily familiar with exactly what program you were talking about you just complied with, if you wouldn't mind sending an email to our mailbox that's listed on our Web site.

(Candy Kris): Okay.

(Barbara Wright): Thank you.

(Candy Kris): Thank you.

Coordinator: Thank you. Our next question comes from (Shannon Sargent).

(Shannon Sargent): Hi. I have several questions related to non-GHPs. Earlier we talked about when payment is assumed and there are ongoing medicals that we should report the exhaust limit.

In some situations we may not know what our ongoing responsibility is over a period of time.

(Barbara Wright): We're not asking for dollar amount reporting. If you have a situation - if its workers' compensation and someone has filed the claim and there's no dispute, you're going to be paying for the associated medicals. If they are on Medicare beneficiary you report that to us. And you're not reporting any dollar amount.

And then subsequently let's say it's a fairly typical situation where someone tripped and broke their leg or they tripped and had extremely bad sprain and after six months the file is definitively closed out because everybody agrees there's no more related medical then you're going to be sending us notice that the file has been closed that there is no further responsibility for the ongoing medicals.

You're not going to be reporting we paid $1000 to set his leg and two days in the hospital when he first broke it and then later we paid X amount for physical therapy and X amount for (why)?. It's going to be when you assume the obligation and when the obligation terminated.

In terms of exhaust we're looking at that field again to make sure we have the right information. If it's particularly no fault insurance, if there is on med pay for example, if there's a $5000 limit, you're going to be reporting hen that

limit has been reached.

Again, you're not going to be reporting every single claim. But we will give more definitive instructions about that when we post the record layout.

(Shannon Sargent): Okay, I want to clarify my question. The state of Michigan for example has no limits on medical. So we may be responsible to pay for medical care for the claimant's lifetime.

(Barbara Wright): So if you report when the ongoing responsibility started then the record just stays open.

(Shannon Sargent): Oh, okay. All right. We are a mutual company. Earlier we - you mentioned that each RRE needs to send a separate report. For the purpose of mutual companies, are each of our companies a separate RRE or is the parent company an RRE?

(Barbara Wright): We're looking at that in terms of liability no fault and workers' compensation. The position we taken for group health plan situations is we don't have a preference as to whether or not the parent reports or the subsidiaries report as long as they're all reported on. And I expect that we'll take the same type of position with respect to liability no and fault workers' compensation unless someone can point out to us why we should do it differently.

(Shannon Sargent): Well I don't think we would want it differently but - and then also we talked about a response file that there was mention of an acknowledgement of some sort. Will the two be interchanged?

(Bill Decker): Will the two be what?

(Shannon Sargent): Is the response file acknowledgement that you referred to?

(Bill Decker): No those would be separate. You'd just get a notice that we've got your file when you sent the file in. After we processed the file that you sent you get a response file.

So there's a total of - it's separate item. A total of three files going in.

(Shannon Sargent): Thank you.

(Bill Decker): Yes.

Coordinator: Thank you. Our next question comes from (Maddie Mitchum).

(Maddie Mitchum) your line is open.

(Maddie Mitchum): When do you all expect the guide to be available for non-GHP?

(Barbara Wright): As we said, we expect or we hope to get something with the record layout with the more detailed definitions very shortly. And as John mentioned, we absolutely want things out before the end of the year but we're aiming to do it much sooner if possible.

So were afraid we don't have a specific date to give you today.

(Maddie Mitchum): Do we find out just through the Web site?

(Barbara Wright): If - for anyone who's not familiar with it when you go one that Web site there's a place where you go down and it says Internal Links within CMS. And when you click on that, it gives you the ability to sign up to receive any

automatic notification any time we add something to the Web site.

So you would be - have automatic notification of the next time we announce an open door forum or when we put any user guide up.

Most of the information that will be posted to the Web site will be posted as downloadable documents. There will be very little that's actually posted on the Web page themselves.

(Maddie Mitchum): Thank you.

Coordinator: Thank you. Our next question comes from (James Irvine).

(James Irvine): Hi. In terms of your definition of a claimant that is entitled to benefits, does that mean a claimant who is signed up for Medicare benefits and or is accessing them benefits actively? In other words, they're getting paid on Medicare?

(Barbara Wright): Entitled means that they've actually enrolled in the Medicare program.

(James Irvine): Okay enrolled. Okay, that's good. Thank you.

Coordinator: Our next question comes from (David Pittman).

(David Pittman) My question was already answered. Thanks.

Coordinator: Thank you. Our next question from (Mandy Yett).

(Many Yett): Hi. I'm a little confused with when you say -a question was asked earlier regarding a claimant for non-GHP whether we should report all claims or -

and those - there was an exhaust amount that we should report. That was a question with someone from the state of Michigan.

And the answer was when we - when the - I guess the insurance assumes responsibility for payment or when they terminate payment - terminate responsible payment, I do want to confirm again, is this only for claimants who are medically entitled or possibly become - or passes their reasonable (notification) test?

(Barbara Wright): The Section 111 reporting is distinct from any actions or activities we do with respect to liability (set asides) and future medicals. The reporting is determined by when there's a settlement judgment for award or other payment.

And you need conceptually you need to split it into situations where ongoing responsibility is being assume by and will continue to be paid by the responsible reporting entity in situations where it's been in - essentially in dispute and there's like a single payment to settle the matter.

And when on the earlier question we were talking a situation where in Michigan for no fault insurance they have no exhaust limits. And therefore they would be reporting when they took responsibility for that person and it would essentially remain open during their lifetime for anything related or stemming out of that incident.

(Many Yett): I see. And when you - when the person asked about Medicare like claimants, that's also the determination - reasonable expectation tells you how a person becomes medically entitled 30 months after settlement. Is that considered in this section too?

(Barbara Wright): That's the concept that's frequently being used when people are deciding whether or not they wish to submit a proposed workers' compensation Medicare set aside amount to CMS for its approval.

(Many Yett): Right.

(Barbara Wright): And that's not the test or benchmark in terms of this reporting. It may be helpful for people to know if you have someone that's catastrophically injured and there's a good chance that that person is going to become eligible for Medicare if they're insured. Their going to become eligible roughly 30 months after their date of injury.

So it may be helpful to you to know that for other purposes or if you're paying out additional money or for example, you're continuing to assume responsibility.

But you need to separate other activities with respect to Medicare secondary payor from the reporting responsibilities.

(Many Yett): So just to clarify then is that the case, so what - you talked about earlier the reporting, it sounds to me that it would only be for the accepted claims and not just - not for denied you know, on the medical or legal basis.

(Barbara Wright): Again, we will try and pose the very specific policy type answer on our coordination of benefits site.

For example, if there's a worker's compensation situation where liability is denied but there's an actual payment made...

(Many Yett): Right.

(Barbara Wright): ...CMS purposes, that's got to be reported.

(Many Yett): But if the payment is only for determining whether to accept liability because for example they have to go through evaluation...

(Barbara Wright): That's - we're...

(Many Yett): ...that's still considered payment?

(Barbara Wright): That's one of the questions that's coming in about some very detailed, if there's a one time payment. We don't have answers to all of that yet.

But in general you need to know the rule that we're not bound by allocations to the party so that simply saying that we denied liability so Medicare can't have a recovery claim or any other information, that's not acceptable.

(Many Yett): I see. Thank you.

John Albert: This is Jon Albert. I just wanted to offer a clarification to a statement that was stated earlier about the - for getting signed up to the list service.

At the bottom of the home page for of the mandatory insurer reporting, the actual I guess icon or whatever, it states for emails and notifications, that's what it refers to at the bottom of that home page, to be able to sign up for that list service. Again it says for emails and notification.

Let's do the next question.

Coordinator: Thank you sir. (Sally Mathis), your line is open.

(Sally Mathis): Thank you. We provide claim administration services for our self insured group health plan customers. And we understand that reporting is our responsibility.
However many of our customers don't want to share social security numbers with us. But they are open to having a third party of their choosing submit the report for their membership.

Is it allowable for us to use several different agents to submit reports for some of our membership while we submit reports for other portions of our membership?

John Albert: Well I mean in terms of a responsible reporting entity, you know, we do allow as (Bill Decker) alluded to earlier that, you know, if there's an organization that has multiple subsidiaries, then yes we do allow that. And therefore each of those subsidiaries could possibly have the unique agent.

So basically every registered responsible reporting entity how they go - decide to go about doing it can have an agent submit on their behalf if that’s what you’re referring too.

(Sally Mathis): Well not really I mean because you would have one entity but several different agents.

(Bill Decker): As long as the responsible reporting entity is assuring that the data necessary for the coordination of benefits function that is required under Section 111 is coming into our coordination of benefits contractor and as long as the process that is setup is acceptable to the, COBC and the CMS, how the data streams that come into the RRE are managed is really - we really don't have any comment on that.

John Albert: But basically if it is one responsible reporting entity that's going to use multiple agents, they're going to have to register for as many agents as they're using as separate responsible reporting entities.

(Barbara Wright): Also I'll ask (Bill) or John to clarify but I want to make sure your question isn't implying that you might split information for a particular are person. They don't believe that we will accept you having one agent reporting social security numbers and someone else reporting the balance of the information for certain people.

(Sally Mathis): No, we wouldn't do that.

(Barbara Wright): Okay.

(Sally Mathis): This is strictly, you know, customer A wants to use this agent for their membership. And customer B wants to use a different agent.

(Barbara Wright): Well we've actually received requests to split the information.

(Sally Mathis): Oh okay.

(Barbara Wright): Does that answer your question?

(Sally Mathis): It does. Thank you very much.

(Barbara Wright): Thank you.

Coordinator: Thank you. Our next question comes from (Jake Reason).

(Jake Reason): Thank you. From a worker's comp perspective, obtaining the social security eligibility status can be fairly difficult.

What efforts are going to be made in order to simplify that process? And is there communication between the Social Security Administration and Medicare to improve the current process?

(Barbara Wright): As we stated before, we're in discussions with our council about being able to give people query access which I know doesn't necessarily go to your issue of getting the basic social security number. And going to Social Security wouldn't necessarily solve that either.

That maybe have to be part of what we will need to resolve through with respect to the model forum.

There's also we've asked the insurers to consider and look at the very issue of whether or not they have enough information. If they're required to collect information by the federal government, do they have sufficient information to pay the claims if they haven't collected all the information?

(Jake Reason): You're always going to have enough information to pay the claim. But in terms of determining the social security eligibility, it absolutely determines on social security's ability to get back that information promptly and quickly. And quite frankly that...

(Barbara Wright): Are you talking about you do or do not have the social security?

(Jake Reason): When you do not in terms of obtaining that information promptly from the Social Security Administration.

(Barbara Wright): So you don't obtain...

(Jake Reason): You have the social security number you just can't get verification from it.

(Barbara Wright): Okay. And that's what we said when we're discussing with our counsel. If people have social security numbers we're looking at our ability to give you query access here to CMS to determine whether or not an individual is a Medicare beneficiary.

However, please note that you won't just be able to query it when they made their claim because what's determinative is what their status is at the time, you've actually either initiated payment and excepted an ongoing obligation or you've done the settlement judgment award.

(Jake Reason): Well exactly. But in terms of the reporting for this process, you're going to need to go in look and at all of your claims and determine which ones are going to need to be reported and which ones aren't. And in order to make that process efficient you're going to need to be able to verify fairly promptly.

(Barbara Wright): I'd don't - just (use that) again, we're looking at giving you the best query access.

(Jake Reason): Okay. Okay.

Coordinator: Thank you. Our next question comes from (Jeff Bradburn). Your line is open.

(Jeff Bradburn): Yes thank you. I've got several questions. But most of them were kind of confirmation.

First of all regarding exact timeline, I want to confirm that the required data

elements haven't really been finalized for non-GHPs yet?

John Albert: That's correct.

(Jeff Bradburn): Okay. And it looks like our registrations are -dates are for non-GHPs begins May 1st. And that goes through June 30 of next year right?

John Albert: Right.

(Jeff Bradburn): Okay, and our go live dates are when we would start sending these files would be the first, 1-1- 2010 is that correct?

John Albert: No, October 1 for non-GHP, October 1.

(Barbara Wright): I would refer everybody...

John Albert: Sometime after October 1 depending on what schedule is set up.

(Barbara Wright): For those of you who haven't looked at it, the implementation time line is on the Web site. And 10-1-09 is when we expect the liability no fault workers' compensation responsible reporting entities to begin submitting.

You will be assigned specific submission windows for each quarter. So it won't be - some people will do their first report in October. Some might not do it till December. You will have a specific assigned date that will be arranged with you.

(Jeff Bradburn): Okay, thank you. And that helps answer my next question because (Bill) I believe you said we'd be assigned a COBC after registration and we would help coordinate our testing with that COBC. Is that right?

(Barbara Wright): Right with the EDI rep at our coordination of benefits contractor.

(Jeff Bradburn): Okay. I guess what kinds of concerns me with that is that, you know, your original recommended testing plan was 10-1 through 12-31. So I'd guess it's really kind of 6-30 through - to your deployment date. Is that accurate?

(Barbara Wright): You'll be testing during the quarter starting 7-1 through 9-30. And hopefully your first live production file will be on whatever your assigned date is for each quarter starting with the quarter that starts 10-1.

(Bill Decker): And just quickly you're going to register for (test). And then we - we're assuming that testing won't take three months and that we'll have finished testing process and be ready to start production file sometime beginning 10-1 or later.

(Jeff Bradburn): Okay, excellent. The (pay) settlements responsibilities assume you have to notify when responsibility's assumed and when it's relieved.

And I think you guys kind of, if it's never 'relieved' in traditional manner, such as an exhaustion of benefits on the policy, have we done our duty once we notify you guys? Are we done then?

(Barbara Wright): If you're in a state like Michigan yes. If there's some point under other state law where there is no possibility of reopening the workers (because) for whatever reason there are variations of state law.

But once there's no possibility of reopening it or paying additional claims, yes we would like a notification of that.

(Jeff Bradburn): Okay. All right. That's another - I guess that leads to another question. So what you're - what it sounds like you're saying is that we need to notify you when it's open and when it's closed. Is that accurate?

(Barbara Wright): Yes. Otherwise what's going to happen is beneficiaries who might still have residual affects or residual needs or for whatever reason can't be covered under workers' compensation, they're going to be jumping up and down if we're denying related claims because we still have the open record which means ultimately they might be contacting you too.

So it's in your best interest to make sure that our records are accurate as well.

John Albert: That applies to group health plans obviously as well.

(Jeff Bradburn): Then also I'm guessing I mean we should notify you guys when we reopen it right?

(Barbara Wright): Well if you've still got an open record we'll still be carrying it as an open record.

(Jeff Bradburn): Okay. Well I know just in our current format we do have - it's not unusual for us to reopen something.

(Barbara Wright): We may need to have some additional detail or discussion about the idea of closing the record. Whether or not it should be "closed" for our purposes if there's still the possibility of someone applying for and getting additional claims paid.

(Jeff Bradburn): Okay.

Man: All right.

Coordinator: Thank you. Our next question comes from (Barbara Cosin).

(Barbara Cosin): I think at the beginning of this call you talked about a grace period for submitting the social security numbers. And I didn't catch that. If you did say that could you repeat it?

(Barbara Wright): For group health plan arrangements, what we've said is you always have to have the number per subscriber. However, we recognize that some entities have not been collecting the information for spouses or other family members.

And what we said is for anyone who had their coverage start prior to 1-1-09 that you have through the end of any submissions that you do in 2009 to gather that information and report those people in your first submission the first quarter of 2010.

However, if you have people that are newly enrolled on or after 1-1-09, we expect you to have the SSM for the spouses and dependents, not just the subscriber.

(Barbara Cosin): Okay, thank you.

Coordinator: Thank you. Our next question comes from (Diana Mineski). Your line is open.

(Diana Mineski): Yes. I'm - had questions on the data sharing, the required data elements for GHP.

Specifically three items. The first one is the document control number that's assigned by the insurer. We're not quite sure what that means. And we are the

insurer. So what is the document control number that you're looking for?

(Bill Decker): That's a number that you make up yourself and assign to each record on a file so that you can track the progress of that record. It is not a number that we assign. It's for your own use.

(Diana Mineski): Okay. So if we don't use a number like that because at this point we don't, we don't - that's not mandatory?

(Bill Decker): We would highly encourage you to use a document control number. This by the way is the kind of detail explanation that we'll go into in the user guide when it comes out. And it's a question we've gotten a lot because most insurers aren't familiar with the document your phone number concept.

(Diana Mineski): Right. Not necessary for us at this time.

So the second one has to do with the employer EIN. At this point is that going to be considered mandatory again? That's not information that we've previously captured?

(Bill Decker): Yes. We do have further guidance forthcoming on that.

(Diana Mineski): Okay, as well as a way to ask them for that information that will make it kind of mandatory?

(Bill Decker): We can offer assistance for that. So again we want to - you know, these are the kind of things where if people are looking for CMS assistance, please submit that through the comment mailbox.

(Diana Mineski): Okay, will do. And the last question in that section is a question on employers

side.

Our employers tend to be very fluctuating size groups. And I know primarily it's the 20 over and under that is a concern.

Are you looking for us to then quarterly pull them how many employees they have?

(Barbara Wright): There are regulations that govern how and how you count employee size and how often you do it. If you'll take a look at 42CFR411101 which I believe has to do with large group health plans which would be applicable for disability, take a look at 42CFR411.170 and also look at 411.172 with respect to the small employer exception for the working aged, I think it will give you a lot more detail in counting employees.

(Diana Mineski): Okay. Well it's not the question. I'm counting the employees. I understand the who. That part we've been doing annually for the MFP. What I don't get is how often.

Because we have to report to you quarterly that number could change quarterly or not change at all. So how often will we have to be asking our employers how many...

(Barbara Wright): If you'll hang on just the second I've believe the regulation actually addresses how often you'll have to count.

(Diana Mineski): It does. Okay, can you give me those regulations again because I...

(Barbara Wright0: The three regulations I have a listed are 42CFR411.101 which I believe has to do with large group health plan, 42CFR411.170 which has to do with counting

the working aged and then for 411.172 which addresses the small employer exception.

(Diana Mineski): Okay. I've got it. Thank you. That's all my questions.

John Albert: Operator, I think we're about out of time.

Coordinator: Okay so no further questions.

John Albert: Okay well since we're - we basically run out of time again, I want to thank everyone for participating in this call. And as I mentioned before, please refer to the Web page for additional information and sign up for the listserv, submit comments et cetera.

On behalf of CMS I'd like again to thank everyone for participating. And we appreciate your feedback and interest in this. Thank you.

(Barbara Wright): I would like to add one statement about the, box. Can you be as specific as possible in your subject line? We have had situations where people are breaking apart their different issues, which is great for us. But then the subject line for every single one reads for example comments. And that's all it says.

So if you can be as specific as possible in your comment line - in your subject line, it will help us get to your question faster.

John Albert: Thank you.

END