TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: APRIL 8, 2009

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

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FTS-HHS HCFA

Moderator: John Albert
April 8, 2009
12:00 pm CT

Coordinator: Thank you for holding. Parties will be on a listen only mode until the question and answer session of today's conference.

At that time you can press star 1 to ask a question. This call is being recorded. If you have any objections you may disconnect.

I'd like to introduce your first speaker Mr. John Albert.

John Albert: Good afternoon everyone. Thanks for participating. For those on the call, just to make sure you're on the correct call, this is a call directed toward the group health plan responsible reporting entities under Section 111.

Tomorrow there will be a call for specifically just to workers compensation reporters. Today's call though is specifically GHP.

I have a couple of people in the room with me who will be doing presentations, answering questions, etc., myself, John Albert, Pat Ambrose, William Decker and Barbara Wright.

For those on the call, if you don't know it the Section 111 secure Web site went up on April 1 and it is working. We have people registering right now.

Pat is going to go into some more details about that. But essentially the process is functioning. And for those that are existing or old VDSA partners,

they will be receiving a letter very shortly with their pass code as well so that they can go in and register with the secure Web site.

There was a moment recently where the Web site went down for a little while. But that problem has been corrected. We will try to notify the public through alerts, through the mandatory insurer reporting Web page regarding any issues that come up with that secure Web site.

With that let's turn it over to Pat Ambrose who wants to do a presentation that will hopefully answer some of the many questions we've received through the resource mailbox at the CMS mandatory insurer reporting Web page that you can submit.

And then Bill Decker will briefly mention an update on the letters that people are asking for to facilitate developing for SSNs from employers and beneficiaries. And then I'll come in and offer some more words of wisdom. Thank you, Pat.

Pat Ambrose: Okay thanks John. As John said, Section 111 COB secure Web site, which we often abbreviate as the COBSW is now available for GHP RREs to register.

This Web site is live and in production. Please do not submit test data or test out the Web site. Anything that you enter there will be considered production data.

The Web site URL is www.section111.cms.hhs.gov. You will first be shown a log in warning page. Click on the accept link to accept that log in warning, and then you'll be able to view the home page.

New GHPs who have not yet registered for Section 111, new GHP RREs that is, need to perform the new registration Step 1. In that step you will receive your RRE IDs.

And after Step 1 new registration is completed, a letter will be mailed to your authorized representative with a PIN, a personal identification number, that your account manager will then use to con - to complete Step 2, the account set up step.

Former VDSA and VDEA partners who have converted to Section 111 RREs need to wait until you receive the letter with your PIN. And then provide that PIN to your account manager. And pick up the registration process on the COB secure Web site with Step 2, the account set up.

You already have RRE IDs assigned since you registered back in October. So there's no need to perform Step 1 for a new RRE ID. You would just pick up and start working with Step 2, account set up.

The letters to the former VDSA VDEA partners who have converted to Section 111 are in the mail now.

Please refer to the appropriate user guide, reporting user guide section on the registration process. And review that information thoroughly before you come to the Web site.

In addition on the Web site, under the how to menu option, there is documentation to help you through the registration and account set up process.

There's a how to get started and also a how to invite designees and how tos to answer other particular questions.

In addition as you're going through the new registration and account set up steps, there are help pages assigned or associated with each page that you see. So feel free to click on that help page link for additional information and guidance.

There is a COB, a Section 111 COB secure Web site user guide that is geared toward how you maneuver around the Web site. However, that user guide will not be available to you until you log in as a user.

So in order to receive help and instruction on the new registration and account set up steps, you need to refer to the reporting user guide and also to the how tos and the help pages that are on the site.

Once you obtain your log in ID, after you log in there will be under that reference menu option, you'll see the COB secure Web site user guide there available to you for viewing or download.

Please remember to register for the computer based training, the CBTs. You do that from the Section 111 mandatory interest dedicated Web page.

There are CBTs that go through the registration and account set up processes step by step, showing you actual screen prints of the Web site pages and how you complete that information.

Again the first step, if you do not have an RRE ID or need an additional RRE ID, is to use the new registration button on the Section 111 home page.

This will assign your RRE ID. It's absolutely critical that during the new registration step you provide information about your authorized

representative, not your account manager or any other user, but your authorized representative.

For information on who is an authorized representative, please see the user guide and the how to get started on the Web site. This is typically an executive of the responsible reporting entity.

You might make a note of the responsibilities that that individual has. And the profile report including the data use agreement that they must sign.

The authorized representative is never a user of the COB secure Web site. The users of the COB secure Web site will be your account manager and your account designee.

That new registration step also assigns your EDI representative at the COB's fee whom you may contact with questions and issues.

If you have already performed the new registration step and now realize that you provided the wrong individual for the authorized representative, then please contact your assigned EDI rep or call the main number.

The main COBC EDI department number is 646-458-6740. After the new registration stuff is completed, or as I said before if you are a former VDSA VDEA partner you will see that your authorized representative will receive a letter in the mail with your personal identification number or the PIN.

That PIN needs to be given to your account manager, who will come to the Web site and perform Step 2, the account set up.

This step must be done by the account manager themselves because as you go through that process, you are performing a self registration for your own individual log in ID and password.

Account set up collects all the rest of the information we need related to the RRE ID assigned to file submission timeframe. You provide information about connect direct file transmission.

Make a note that you need complete information for that file transmission method if you selected, including your AGNS account and other information that's listed in the user guide and the how to.

While you're going through the account set up process and actually new registration if you are asked for a national association of insurance commissioner company code or NAIC code.

And you do not have one, you may default that field to five zeros. That goes for the NAIC number that's asked for the - are associated to the RRE ID as well as any subsidiaries.

Please provide the NAIC number if you have it though because that helps us to validate your account.

The new registration and account set up steps must be performed for every RRE ID that you need. The question - we've received some questions about how many RRE IDs you need to report.

This really depends on the number of MSP input file submissions you need to make per quarter. It may depend on the number of claims system, or rather

enrollment systems you have, different data centers, entirely different software systems that are creating your files for Section 111.

And it would not be practical for you to roll up these files into one and submit it under one RRE ID. In that case you may apply for two RRE IDs and use one for each file submission.

Another example might be if you are using reporting agents and the reporting agent is sending one set of coverage information from their system or a different location.

And you or another agent is sending a separate set or a separate MSP input file per quarter from a different location. In that case you would need more than one RRE ID for each of those file submissions.

You do not need to get a separate responsible reporting ID or RRE ID for each subsidiary if you will report all of that subsidiary information together.

If you are a TPA who is processing claims for multiple group health plans, we have several questions from TPAs who are handling Taft-Hartley multi employer, multiple employer group health plans.

If the TPA is the responsible reporting entity, then the TPA may register for one RRE ID and report all the GHPs under one RRE ID.

The TPA TIN would go in Field 22 of the respective MSP input file. And the employer and plan sponsor TINs go in Field 21 of your MSP input file.

All the TINs that you supply on your MSP input file then must be represented by a record on your TIN reference file.

There's no matching done between the TINs that you provide at registration and the TINs that are on the MSP input file in the TIN reference file.

However, we would expect that the TIN you're using for your (REE) ID obviously matches at least one of the TINs that you are submitting on your MSP input file in that insurer or TPA TIN in Field 22.

There's no limit to the number of RRE IDs that you may request and report under. However, the fewer the better in terms of ease of management.

When you finish registering and you need to invite account designees for example, you must invite your account designees by RRE ID.

So if you have 30 RRE IDs and the same account designee needs to be associated with each of those 30, then you will have to invite that designee, perform that action of inviting that designee 30 times over.

So it's in your own best interest obviously to limit the number of RRE IDs. But there is no particular limit on our part.

Again the number of RRE IDs should be determined by how you are actually submitting your files, physically submitting your files.

I'm now going to try to answer some of the questions that were presented to the resource mailbox. And then of course we're opening it up for questions later in this call.

We had one RRE report that they had trouble fitting the name of their RRE in the RRE name on - during new registration on the COB secure Web site.

And abbreviation of the name is fine to fit into that field. Please try to use standard abbreviations like CO for company and INS for insurance.

Also you may, if you're company name begins with the word the, you could exclude that. And we will most likely then with your use of standard abbreviations be able match that appropriately and validate your information.

A question was asked whether an RRE can submit a query file or a finder file prior to the first MSP input file. And the answer is yes you may do so.

Obviously you need to do so in time to process that query response and create your first MSP input file by your production live date.

Another question was asked is, is it mandatory that the RRE provide the HICN number or the HIC number on the MSP input file for anyone who was under the age of 45?

Yes, there's an edit in the system that requires a HIC number or an HICN be provided for any individual on the MSP input file who is under the age of 45.

You may submit people under the age of 45 on your query file. There's no particular edit there. Yes, and obviously you may submit the query with the SSN for that individual.

Another question was asked about the X 12 270, 271 format for the query only input file. If you are using your own ANC X 12 translator, it was - you need the mapping documents.

Right now you should contact your EDI representative for that. But we are working to post that information on the Web site and make it downloadable. It's not available yet. And we'll announce that when we're able too.

There was a question about the coverage election field in Field 19 of the MSP input file. How would carriers report spouse only, child only or spouse child only information?

I believe and I look to the other speakers on this call, but I believe that you would use the indicator for family coverage in that case.

Man: Yes.

Pat Ambrose: I, we will add clarification in the next user guide for that. I apologize. I wasn't completely prepared to answer that.

Another question was asked about the employee status Field 20 of the MSP input files, what codes is to be used for disabled members, a Code 1 or 2? You should use the code that reflects the subscriber's status no matter what the reason for entitlement is.

And so if that subscriber is - has current employment, then you should reflect that. And if not then you should reflect that.

There was a question about whether the COBC will remove spaces or hyphens in names when matching against our Medicare beneficiary file. And the answer is no, we do not remove spaces or hyphens.

Basically we're matching names, as the Medicare beneficiary would have provided their name to the social security administration. We get our name

information from SSA. And so however it is stored by SSA is what we're matching against.

Another question about do I have to register and obtain an RRE ID for every subsidiary? And we answered this earlier. The answer is no, it really depends on the number or how - of MSP input files that you will submit each quarter.

The new registration step on the COB secure Web site does ask for subsidiary information. But you if you are reporting all your subsidiary information under one RRE ID that's perfectly fine.

There was a question about reporting on the initial file and break in coverage. We've answered this on a separate conference call in the past. But you are only to send a record for the coverage information that was open and effective as of 1/1/09.

And use the effective date for that coverage if it was prior to 1/1/09. There was a question about if a person was covered under a GPH with fewer then 100 full or part-time employees and is received Medicare benefits due to disability.

If that person is reported on the MSP input file, will this erroneously result in the creation of an MSP occurrence? The answer is no, as long as the employer's size field indicates there are less than 100 employees, using an indicator of employer size of zero or one.

In that case when you report this individual, and if their entitlement is indeed due to disability, then you will receive an SPES and an SP - error code and an SP disposition back. And we will not create an MSP occurrence.

Remember that you are only to include active covered individuals on the MSP input file. If this disabled person is a retiree and not covered due to current employment, then they should not be submitted on your MSP input file, because in that case of course, Medicare would remain primary.

Barbara Wright: Pat, with respect to the 100 employees, remember that if it's a multi employer plan it's whether or not any employer from that multi employer plan meets the threshold. It's not whether the specific employer for that individual meets it.

Pat Ambrose: Okay yes, thank you for that clarification. A question came up about agent testing.

If you, if an RRE is contracted with an agent to provide your Section 111 file, that agent must perform testing on the RREs behalf. And testing must be done for each RRE ID.

In the latest version of the GHP user guide, the testing requirements are outlined. Every RRE ID must pass these testing requirements.

So if an agent is representing 100 different RREs using 500 different RRE IDs, they will need to submit test files for every RRE ID under which they will be submitting files.

Obviously once you have gone through the testing process from your system one time, the subsequent testing for subsequent RRE IDs should be fairly routine.

Another question came up to confirm checking the age of an active covered individual, the age threshold of 55 and later, being the 45s and over for reporting.

This check on the individual’s age should be done at the time that you’re creating your file for your next file submission timeframe.

Another question was asking about upcoming changes to the GHP user guide. The only known change at this time that may affect your processing are new TIN indicators for the TIN reference file that will become effective in July.

These TIN indicators, one is for plan sponsor, when you’re providing the plan sponsors. TIN in Field 21 rather then the actual employer and that we've discussed the requirements related to that.

It has to do with the hours bank arrangements for multi, multiple group health plan reporting. For the time being you would use the employer indicator. As of July we'll have the plan sponsor indicator there.

They'll be an update to the user guide to explain what to do to change your indicator on anything you might have submitted previously.

We are also adding a TIN indicator to the TIN reference file for Federal employer entities.

The rest are minor corrections or clarifications based on questions that people have been asking. Some of these clarifications include test files must be limited to 100 records.

If you’re - if you submit a test file over 100 records, then it will actually be rejected by the system and not processed.

You'll be able to view the results of your test files on the COB secure Web site after you log in.

Another change that we're making is to add a notification that you will receive an email to your account manager when a file was sent and rejected for a severe error, such as a major formatting issue like not having a header or a trailer record or the like.

You'll also see notification of that on the COB secure Web site. At this time, oh there's also a change to the threshold error for the percentage of deletes in the file.

That threshold is being lowered. It should not change your internal processing in any way. And the next user guide will indicate at change to that percentage that we're using for that threshold error.

There was a question about initial file submission and then subsequent quarterly updates. For instance, someone has single coverage through January 31, 2009.

But as of February 1, 2009 they have family coverage. Both records were sent as adds in the initial file. And received 51 disposition codes, because we were unable to match that individual reported to a Medicare beneficiary.

So the question is what do you report then for that particular individual's coverage ongoing? And the answer is only report the record for the current coverage.

And in this particular example, that would be the coverage that begins February 1 going forward. If they - we won't change our information about whether they were a Medicare beneficiary for that prior period.

There was a question related to what value should be used for the employee status if a member with ESRD is currently employed or has coverage based on current employment.

And regardless of their Medicare entitlement, that indicator for employee status should reflect the subscriber's current employment status.

So if they are covered by current employment status, then a value of 1 should be submitted.

Another question came up related to a separate entitlement query process that some of you might use based on your status as a Medicare advantage plan or a Part D plan.

That process is completely unrelated to Section 111 query. And so in order to query individuals for Section 111 reporting, you must use the query only file. If you're an expanded reporter you may use the end records on your non-MSP file.

And then you may also use the basis application. The data use agreement is fairly clear on Section 111 reporting and the use of that data. And it is a completely, entirely separate query process.

Another question came up on what CMS is expecting on the TIN reference file and whether they expect it to contain all employer groups under contract. Or only those TINs that have active covered individuals that are reported.

The answer there is that only the TINs that were submitted on your MSP input file should be included on your TIN reference file.

Another question came up about reporting active covered individuals who do not have an SSN, but rather have maybe a green card or some other form of identification.

We only accept the SSN or the HICN, the HIC number for an individual. If they do not have either of those, we cannot accept or process the record.

And most likely if they do not have an actual SSN, they are not entitled to Medicare anyway.

There was a question that came up about reporting from active covered individuals that are under the age of 45. Possibly in your system when you're trying to figure out whether this individual, you know, it's kind of a timing issue about their age.

There is no particular penalty if you report someone under 45 without the HICN number or the HIC number. However, on that record, on the MSP input file you will get an SP 99 error. And the record will be returned with an SP disposition code.

If there are relatively few or a minor number of these, it should not affect your processing. If you were to dump your entire set of individuals with, under 45 with no HIC number, you will hit the threshold error for having too high a percentage of SP errors. And your EDI rep will be following up with you on that.

The question about email notifications that go to the account manager or account representative, and if we could make any modifications to that while the account manager or the authorized representative might be out of the office or on vacation or something of that nature.

No arrangements can be made at this time to re-route those emails to another individual. Your account manager needs to take responsibility to forward those emails as appropriate.

However, also note that all of your users associated with your RRE ID on this Section 111 COB secure Web site have access to information about the file status.

So as - if an account manager is out of the office, an account designee can log on to the system and check the status of file processing and see all that information.

The information that you are notified via email will also be available on the Web site.

A question was asked about the difference between an authorized representative and an account manager. I'd like to point you to where these rules are described in the reporting, the GHP reporting user guide. As well as in the how to get started, under the how to menu option on the Section 111 COB secure Web site.

Again remember that your authorized representative cannot be a user of the Web site for any RRE ID.

Your authorized representative is described then in those documents. Your account manager is that person who is going to manage the day to day responsibility of your reporting. And your account manager is obviously a user of the COB secure Web site.

The reason that we have these two roles is to in a sense for security purposes, to have more than one person involved in your reporting structure.

And essentially have that authorized representative approving your account manager. They must be different individuals.

A question came up about can I register our company at the corporate level or do I need to register each entity? Again, you may register at the corporate level if you are reporting all of your information under one RRE ID.

And that's it for the questions that I was going to cover at this time. I know it was a lot. Thank you for bearing with me. We're doing our best to get back to you thought.

John Albert: Yes, this is John. Thank you Pat. I just wanted to, you know, these questions are questions that have come in through the CMS resource mailbox on the manager ensured reporting Web page.

So again, as we've stressed before the best way to get your questions answered is to submit them through that resource mailbox at CMS.

I know people are trying to call us directly, things like that. But to ensure that all of us here get access to those questions, and we do read them as you can tell from Pat's lengthy explanation of sort of answers to some of the questions - to many questions I should say.

You know, again we encourage you to continue to submit those. You know, for entities that are now a registering on the secure Web site, obviously they now have an EDI rep assigned to them that can assist them with more technical questions.

But again, questions concerning more policy related, especially in terms of as this is implemented. Those should come still through the resource mailbox to CMS directly.

But in terms of technical support, you - once you register and have that EDI rep, you can start working with them directly to answer some of your more technical questions regarding the set up of the files and the business rule, etc. and other processing that.

And Bill do you want too?

William Decker: Yes hi John.

John Albert: Bill Decker is going to give us an update on a couple of little things that we're working on that we know are very important to a lot of people out there.

William Decker: Yes hi everybody, good afternoon to you all. My name is Bill Decker. I work with John and Pat and Barbara. We're sitting here along with a number of our other colleagues who are passing me notes and asking me to tell you things.

I just wanted to cover a couple of things quickly here. All having to do with the air - in the area of the collection of and use of social security numbers, either directly or indirectly.

First is I'm going to repeat something that Pat just mentioned a couple of minutes ago which is the non-ending, the never ending questions about whether or not we want to hear about anybody who does not have a social security number.

And the answer to that is always no. Essentially we need to have you tell us about people who have either a social security number or more preferably a Medicare ID number, a Medicare HICN.

That is, HICN is our primary ID. We use the social security number to match against our database when you don't have a HICN.

We cannot match any information against our database if we don't have either a health insurance claim number or a social security number.

As a consequence, if someone doesn't have a social security number, you're likely to find that that person also does not have a Medicare ID number because that person will not be eligible for the Medicare program.

You have to have a social security number in order to be eligible for the Medicare program be to - in order to be assigned a Medicare health insurance claim number in any case.

And if you don't have a social security number, you're not going to have one. If an individual does not have an SSN, the individual will not have a HICN.

Consequently we don't, you don't need to send us anybody - any information about anyone who does not have an SSN.

There is no substitute that we will accept for an SSN. Information from a green card or visas or any other official documentation that Governments may issue is not a substitute for an SSN and we don't accept it.

That's - I wanted to get that pretty clear right up front. And then I want to go into a little bit about what happens if I can't get a social security number to send and I don't know what the HICN is?

We are approaching this question in a number - in at least two different ways. One is first of all we're providing some guidance for employers to use as they go through the process of working with their insurers.

And this is a document which will be instructions to employers to tell them why it is that it's useful and to their benefit to cooperate fully with their insurer partners, their group health plan partners.

The second document we're working on is a document which will be available to employees so that employees can indicate to interested parties employers or insurers whether or not they are Medicare beneficiaries.

That's as much as I want to get into a description of what those two documents are. Both of them are in the final stages of preparation. And we hope to have both of them out by the end of this month.

That's as much as I can tell you about when we might see them at this point. But we are working very hard on getting them to you.

I've spoken with and corresponded with a number of entities that have been out there who are very interested in this issue. And we just want to reinforce to you that that is coming forward.

Another thing I want to talk about, another one item I want to talk about is that a colleague of mine has suggested it would be good if we did this, and I think it's true.

We want to reinforce to all of you, particularly the new responsible reporting entities who are not are former VDSA or VDEA partners. That one of the primary requirements of reporting any information to us for coordination of benefits under the old program or Section 111 is that you send us an MSP input file once every quarter.

Sometimes some entities may find that they have nothing to send in a particular quarter. In which case they will send us an empty file.

The point is you need to send us something every quarter, whether it's real data or whether it's just an empty file. And we wanted to reinforce that for you.

That ends my little presentation here this afternoon and we'll turn it over to the next speaker.

John Albert: This is John again. Some - to answer some additional questions that have come up, and again as you can tell we get a lot of questions because we're talking forever on this.

But the first, another question that's come up repeatedly is about questions concerning disagreements with Medicare's data about that particular beneficiary.

For example the date of birth we have, you know, isn't the quote "correct" date of birth. All I can say to that again is that the information that we rec - that we used to validate whether or not someone is in fact a Medicare beneficiary comes straight from the Social Security Administration.

They're the ones that handle Medicare enrollment on behalf of CMS. And if you dispute the information passed back to you regarding changes to the name, date of birth, gender information on the file.

The only way that that can be corrected is by having the beneficiary contact the Social Security Administration directly. Until that actually occurs, that is the official government record of that individual's name, date of birth and gender.

So I just wanted to put that out there. So I guess we, you know, we hear questions about your data is wrong. And I can just say that, you know, for the most part, in most cases the data we have is correct because it comes straight from SSA.

And even if it is wrong, it's still correct in the eyes of the government until the beneficiary can prove otherwise through the Social Security Administration and get that information changed.

In which case it has been reported on to CMS. There is somebody speaking on the phone that is not me.

Anyway, the - another thing too that comes up constantly is if somebody is not a Medicare, or is not a, we don't want you reporting retirees essentially on the MSP file.

Any record that you send to Medicare to CMS on the MSP input file is treated as if Medicare should be the secondary payer assuming that we match correctly to an identifying beneficiary.

So do not send retirees for example on the MSP file. The only exception might be under 65 ESRD folks.

In terms of, there's also questions come up about the auxiliary query function called basis. Basis is a dial up feature that allows for a very limited number of queries per month.

It is not used to, it is not intended to be used in place of the query file, which is far more efficient and can allow many more queries to take place.

But it is there as an extra tool between your file submissions if you need to look somebody up, etc.

I wanted to touch on the TIN issue again. And I know that Pat talked about it earlier. But again if you are making an update to a TIN address, you need to resend all those previously accepted records so that update can be applied if that's what you want to those previously accepted records.

So for example, the address of the employer moved. And you needed to let us know that. And you submitted a record that was a closed period of coverage that ended say a couple of months ago.

You need to resend that information with that TIN so that we can essentially know to overwrite that beneficiary's record with that new address information on CMS's system.

A question came up about not registering. All I can say is that if you don't register as a GHP by the end of the month, you are putting yourself at risk for non-compliance. That’s all we can say about that for now.

We are going to put a notice out regarding registration for health reimbursement accounts. We’re looking at delaying that registration. We will put a notice out.

Please make sure you’re signed up for the list service if you aren't already. So you get that as soon as possible.

Again, in terms of how to register, under how many RREs. We try to allow that to be as flexible as possible. Either one corporate can register for RRE ID on behalf of many subsidiaries.

Or in some cases, the subsidiary may register on behalf of all the other subsidiaries in the company. We do leave that up to you.

The main thing is we want to get your data. With how many RRE IDs you do it through that is up to you in terms of how your business is organized.

Again, I will stress again that if you have technical questions and have registered, please start contacting and working with your EDI rep. We have received numerous technical questions from some RREs through the CMS mailbox.

And a lot of these questions are very, for a lack of a better word, down in the weeds technical questions regarding implementation. And once you register, please use the EDI reps.

That way you can talk to a live person and hopefully get those answered very quickly.

And in terms of domestic partners, there's questions coming in still about whether, you know, whether a state recognizes a domestic partner as a spouse and how do we report that.

For Federal reporting purposes a domestic partner is a domestic partner whether or not a state recognizes that person as a spouse or not. There's actually a Number 20 indicator for domestic partner. Please use that.

So there are also in terms of additional outreach because people are always asking, one of the things we're looking at doing is we're coming up on our next cycle of the employer IRS, SSA, FEMA data match process.

We're looking at putting information in that mailing to all employers that we - where we identify individuals that have W2s telling them about the Section 111 reporting process and why you need to provide the SSN to that insurer.

And I guess in terms of further encouraging them, the success of Section 111 will determine whether or not we eliminate or get rid of the IRS data match process long-term.

So the employers - if anything that's one incentive for them to provide that information, so they don't have to answer the data match questionnaires every year or so.

I think that's, oh and the other last thing to is the questions have come in regarding carve outs. Again, if - it is not a covered Medicare service, meaning it's not part of, you know, its not an acute care type of policy, don't report it.

Obviously the acute care information would be reported under the regular GHP insurance. But for the carve outs unless, you know, the service is not covered by Medicare, you don't have to report it, register, etc.

We can't say that enough. If it’s something that needs - in simplest terms, if it’s something that needs to be coordinated with Medicare because Medicare covers it, yes you would need to report that information.

But in most cases, that’s probably not true. It’s covered under the acute care policies of the regular group health plan policy. And they would be the ones reporting information on carve out folks.

That is all I have. Now Barbara Wright I think wanted to add a couple of things as well.

Barbara Wright: John mentioned domestic partners, please keep in mind that although domestic partners aren't spouses for our purposes, they are considered other family members for that criteria.

Secondly, I don't think anyone’s mentioned this yet. We've gotten several inquiries from people who have individuals who have railroad HICN. And please know even though some of those are different such as they start with W, under some occasions that are systems will take in those HICNs.

And those were the only two short things I have right now.

John Albert: Okay operator, we'd like to open it up now for questions.

Coordinator: If you'd like to ask a question from the phones press star 1. Please un-mute your phone and record your name.

To withdraw your question press star 2. Once again it's star 1 to ask a question. Please stand by for the first question.

The first question is from (Marianne Bowers).

(Mark Gegaribidian): Yes actually (Mark Gegaribidian) from (Harvard Tail Rump). Thank you for taking my questions. Just a couple quick ones regarding the registration process.

This is really a yes or no question. Can the account manager be an agent?

Pat Ambrose: Yes, as long as the authorized representative for the RRE approves that person as their account manager and provides that person with the TIN, there's nothing to prevent that from happening.

(Mark Gegaribidian): Excellent, okay. And my second question is referencing the registration process document that was produced on 9/24/08 it talked about the technical contact.

And the question is does that person need to be an employee of the company? And I would assume do they need to be different then the account manager?

Pat Ambrose: There is no technical contact any longer now that we have rolled out the Section 111 COB secure Web site.

(Mark Gegaribidian): Okay.

Pat Ambrose: The user roles are, essentially on the old paper form that we used back in October, the technical contact sort of played the role of account manager.

But it is - that person is not defined as the account manager any longer. So I would encourage you not to actually refer to that old documentation, but rather look at the current Version 2.2 of the GHP reporting user guide and the how tos that are on the Web site for information about user roles. The technical contact is no longer applicable.

(Mark Gegaribidian): Okay very helpful, thank you.

John Albert: There are a lot of, you know, there are a lot of older documents out there for reference. But really what people should be focusing on is the actual user guide Version 2.2 I think it is that's out there now.

That is, that basically folded a lot of that old piece mail documentation into one comprehensive document.

Then of course, once someone registers the secure Web site user guide will be made available to them as well. So please again refer to the user guide as the official how to do this document.

Barbara Wright: And we continuously post which version it is. So that by going to the Web site you can make sure that you are looking at the most current version.

((Crosstalk))

John Albert: Next question please.

Coordinator: The next question is from (Michelle Cole).

(Michelle Cole): Hello?

John Albert: Yes we're here.

(Michelle Cole): Hi, thanks for take - I've got a couple of things. Simple one first, mailbox, is that the PL number that you're referring to, the PL at whatever?

John Albert: Yes.

(Michelle Cole): Okay because I haven't been able to find it on the Web site. I've only been able to find it in a document. So I wanted to make sure that was the right one.

John Albert: Yes, there's a download on the home page that has the how to contact us and the address.

(Michelle Cole): Okay. All right thanks. Now, the more - I need to refer back to what John was talking about with discrepancies. Because I need to kind of, we need to know what to do.

The first question is what is the route we need to take if we dispute an 01 finding? If you tell us that your secondary, but we do our investigation and we feel that Medicare is primary. How do we dispute that?

John Albert: Well why - I guess the first question back would be why would you report it if you're a primary? Or, you know, if Medicare is primary? That should not be included on an MSP file.

(Michelle Cole): But now, all right, I have to think about that.

John Albert: Remember, the MSP file is to report potential MSP situations. If you include someone like say a retiree, I mean we're - you're telling us on that MSP file that this person, if they have Medicare, Medicare should be the secondary payer.

But if you send us people for who Medicare should be the primary payer on the MSP file, that's going to result in a bad record being posted.

(Michelle Cole): All right, well - my colleague is a...

Woman: We could allow - well actually that situation that happens all the time is, I mean we could verify working status and there'd be a confusion. And they'll say oh the person is retired, the person is working, the person is laid off, whatever.

And sometimes it is not what is reported. And so say that happens and...

John Albert: Then you can submit basically either an update or a delete transaction depending on the situation.

If you erroneously report an MSP record, and find out that say for example you reported a record with a coverage effective date of 1/1/09 and it termed on March 31 of '09.

And you find out stuff's been going - and, you know, we build an MSP working age record, you find out subsequently the guy retired 10 years ago.

You would on your next file submit a delete transaction type to remove that record from our system.

Now if it's a question of submitting a record and just needing to update it, meaning that it's a valid MSP record. And the guy retired, you know, tomorrow.

Then you would come back and update that record with the termination date. That's how you handle that. But its submitter driven in terms of how that occurs.

So if you discover errors, and that has happened in the past where you say accidentally put retiree, and they're posted as a working age beneficiary because you're telling us that, then you can delete it.

(Michelle Cole): Okay. Just going to think about that for a minute.

John Albert: And this is the kind of infor - you know, again this is the kind of questions that you should be able to get help with from your EDI rep once you register as you work to build and test this process.

(Michelle Cole): Well okay, all right. And I don't know if this would be the same kind of question. I mean we did register, but we just did that this afternoon.

You touched again regarding disputes, I guess what we need to know is what do you want us to send back?

Let's say, you know, we send you something. You get us the response, or they get us the response file 45 days after. You tell us that the date of birth really isn't 1932, it's 1923.

We go back to the member we say, you know, social security says your birth date, and they say hell no. You know, I was born in 1932. So then we send

them off to social security to take care of that because, you know, social security obviously fat fingered it.

So okay, what do we do if that hasn't been resolved within the time period between the time we get the response file and we have to report the next time?

John Albert: Well luckily if we accepted the record that meant that the other three identifiers were enough to match so you'd still be okay.

(Michelle Cole): All right.

John Albert: The problem that can occur though is that what happens if, you know, later on in your system you fat finger another one of the data elements and you somehow get the, whatever the spelling of the last name wrong suddenly.

So now you have an incorrect date of birth and an incorrect name. That's where the risk is. So, again the information that we pass you you should be using as legitimate information because it is.

In the eyes of the Federal Government, it is the correct information no matter what the bene says, until the beneficiary effectuates that change at Social Security Administration.

And it's very common, as you know for people to like lye about their age, things like that. And we've seen it time and time again. So the date of birth is obviously one that's, you know...

(Lynn): This is Lynn, and we did have this actual situation that happened that Medicare had the person's effective date a different date. And we got a copy of the card which said a different date.

So there are situations that we have to send them off and go get this fixed. It's not something we submitted or fat fingered, it's at the - where you're getting your information was incorrect.

And like we're saying, should we just keep submitting? Because we know it's true and we know that it was something that the Social Security Office has to fix. Or do we, you know, do we...

John Albert: Just keep submitting it.

(Lynn): Keep submitting it. Okay.

John Albert: Keep submitting it.

(Lynn): All right, thank you.

(Michelle Cole): And I think, yes, that takes care of it. Thank you.

John Albert: Okay sure.

Coordinator: The next question is from (John Lance).

(John Lance): Hi, I have two questions. The first one on the tunu- on the employer - employee's datas. We read the law some lose on the 20 weeks minimal stay within an employer group.

So the question is if the employer changes funds on the 20 to 20 and above and the subscriber change with that. Does the subscriber member have to stay

with the same employer for at least 20 weeks before his information have to be reported to the CMS?

Barbara Wright: Could you hang on a second?

(John Lance): Sure.

Barbara Wright: We're back.

William Decker: Is the total number the full and part time employee just associated with that employer, whether or not there is a subscriber member or not. You count the number of employees, individuals currently listed as employees.

They don't have to be working on a particular day, as long as they're on the employment role.

(John Lance): Okay because we read this, probably we over-read it. But we read it somewhere else where it says it has to be 20 weeks, consecutive 20 weeks with the company or with the employer.

William Decker: No, it's not - nowhere does it say that it's a consecutive 20 weeks. The rule is that if an employer had at least 20 full and part-time employees on every working day, now that doesn't mean 20, at least 20 have to be working on that day.

Have at least 20 employees on every working day in 20 or more weeks in a given calendar year. The MSP for the working age is effective for that year and for the subsequent year.

(John Lance): Okay I got you. Thanks you very much. Second question is about ESID members. We have a state program, Massachusetts State, program Commonwealth Choice, you know, for the uninsured or uninsured.

They are not a group plan that they are joined, you know, these members join outside of an employee group. And we understand that those members should not be sent to CMS but because they are not through the employment.

But if some of those members are ESID members and the state (unintelligible) members, should we report them to CMS?

William Decker: Two things, Number 1 if we're - and this sounds to me like you're talking about some kind of an association multiple employer group health plan.

If when you're talking about these non-group type members...

(John Lance): It's non-group type of members...

William Decker: So actually you're talking about they're not associated with an employer that has 20 or more employees.

(John Lance): Yes.

William Decker: Okay well that sounds to me like an association plan which is the multiple employer group health plan.

Barbara Wright: Hang on just a second.

William Decker: If you're talking about a plan that is established and qualifies as a group health plan under our definition, then you're - it's covering an ESRD person.

During the coordination period that plan is primary for the coordination period because the rule is that if they have group health plan coverage on any basis, the plan is primary.

Now the issue probably is whether or not this arrangement you're talking about qualifies as the group health plan. And we would need to see exactly the statutory language that you're using to describe this plan in order to make that determination.

(John Lance): Okay we will send you that email on that. The next question is about the retro enrollment. And we have contractual requirements to allow employee groups retro eligibility for ailments and terminations.

Our contracts are 60 days and some are even 90 days for activity, meaning we re-enroll that person, that member 90 days after his or her actual effective day.

So, but based on the requirements, the CMS user guide on members joining less than 45 days prior to the call of submission, two dates don't need to be submitted into the (falling machine) by those who were effective more than 45 days need to be on a current submission.

So we're wonder we may be at risk of appearing to be out of compliance with late reporting for those members, for those retro members.

Is CMS allowing for retro activity? And how do we indicate that on the MSP?

Barbara Wright: Hang on just for a minute.

(John Lance): Sure.

Coordinator: Does that conclude your question?

John Albert: Yes I guess the answer to that is that you would need to maintain documentation showing that retroactive enrollment, that's all. Because other, I mean the system is set up, you know, based on the effective date of the coverage to determine whether or not someone is ask risk for compli - non-compliance.

And if you're doing retroactive enrollments, you would definitely want to keep documentation showing that.

(John Lance): Okay we probably were receiving some SP error code and we just keeping thinking those were the cause of that.

John Albert: Yes, that's...

Pat Ambrose: You'll actually, in the case of reporting it late, or appearing to report it late, you'll get a compliance code, a compliance flag will be set. Or rather, I'm sorry, it's the late submission indicator will be set.

We will still process the record as usual. And, you know, it will be counted in that late submission count. However, again if you have the documentation, if there's further follow up subsequent to that, you know, you will be able to demonstrate that it could not have been reported earlier.

John Albert: I guess this is a good point and time to do my song and dance that again CMS is much more interested in complete and accurate data then it is in any type of civil monetary penalties, etc.

And the best thing that people can do is to keep documentation regarding what they did. And the secure Web site is designed to provide tools to essentially allow you and CMS to know where each other stands so we don't have to get into that mess later on down the road.

So again, when in doubt, keep documentation.

Barbara Wright: And what I would add to what John is saying is these records will be used for recovery purposes as well as to process current claims.

It's critical to us that you don't report inappropriately in terms of groups of retirees, etc. Where we have the highest number of complaints in terms of potentially recovery demands being issued or other actions, most of the time that situations where the MSP status has been reported inappropriately.

If it had been, if the - if it hadn't been reported, we wouldn't be sending the recovery demand. And we don't want to involve you or your clients or anyone else when we don't have a situation where Medicare should have in fact been secondary.

So there will be ramifications beyond just the reporting. Your accuracy will help you out as far as any further interactions with the MSP program with CMS.

(John Lance): Thank you very much. How about the documentation, can we send those documentations through the COB SW or just keep it?

John Albert: No.

Barbara Wright: You don't - keep it in case or if at any point there's an audit.

(John Lance): Okay got you. Next question...

John Albert: Much like, you know, in terms of insuring data security all that - those processes need to be documented. We would advise you to do the same thing on your end to make sure that all those processes and business rules, etc. are documented.

So that, you know, that way you're okay, we're okay, we're all okay.

(John Lance): All right, thank you. Next question on DCN document control number, on the user guide Page 49, there's a third bullet states that each detailed record on MSP file must contain a unique DCN generated by the RU. I understand that.

But on the same bullet later on it states that the DCN only needs to be unique with the current file being submitted. So is the DCN unique for each detail record or each submitted MSP file?

So if it's the file then, there would be many different DCN for all the records.

Pat Ambrose: It is by record on the particular file. So let's say you sent an add record for John Smith with the DCN Number 1. And the next quarter you sent an update record for John Smith, you don't have to use the same DCN Number 1 on that separate file.

You could use, you could - or you could use another, you know, counter or number. So on one particular quarter's submission each of the detailed records needs to have a different DCN.

And because its purpose is to help match up, and especially with conversations about issues with the files and so on, to match up the DCN on the input record to the DCN on the response record.

But it's only unique within the detailed records of that particular quarterly submission. It - from quarter to quarter, if you're reporting an update for the same coverage for the same person, you can use the same DCN if you wanted, or different ones for each file.

(John Lance): Okay got you. Next question is about MSP and profile. If a member change from employer to employer, you know, they, you know, jump ship, change jobs.

And can we just send an updated record for the member reflecting the new employer group? Or should it be an update record with a term date for the previous coverage with the previ - with the older employer then add transaction for the new group?

Pat Ambrose: You are to term the first record by sending an update in the termination date. And then an add record for the new employer, and obviously new TIN associated with that.

(John Lance): Okay, all right, the last question, thank you very much. The last question will be on the multi employer side, we have some intermediary, some kind of agents to provide for enrollment, premiere collection, communication, admin functions, mostly admin functions on behalf of small group employees less than 20 subscribers, you know, 20 employees.

Are we correctly interpreting this arrangement as being a multi employer group as defined by CMS? If so, are we correct in concluding that we wouldn't need to report all (unintelligible) insurance rule, this intermediary.

William Decker: What you described sounds exactly like what we have defined as the multiple employer group health plan. You need to report all individuals whether or not they have, are associated with an employer of 20 or more or 20 or fewer.

(John Lance): But I think we read somewhere else that, I don't remember the exact page, is about multi employer basically for the financial purposes, you know, those employer groups, those small company group together.

John Albert: I don't mean to cut you off, but I mean basically you, I mean you’re going - we can't vet whether or not, you know, you report under, you know, depending on how you say it.

I mean you need to understand that you need to report per the MSP statute and what the definition CMS uses for a multi employer group heath plan, etc.

So in the interest of time I'd like to move on if that’s okay.

(John Lance): Sure, of course. Thank you very much.

John Albert: Thank you.

Coordinator: Your next question is from (John Downey).

(John Downey): Good afternoon. Thank you for taking my call and questions. You've answered most of the questions I have already in this call.

We were looking at the use of basis - B-A-S-I-S. But as a health plan we already have access to MBD in March 4 eligibility.

John Albert: You can't use that process for purposes of Section 111. They are two unique processes and two unique data use agreements.

Pat Ambrose: And likely the people that you're querying under that marks or the other process you're talking about, it's probably related more to the Medicare coverage you're providing them.

And so again, you know, and in Section 111 we're asking you to report on, you know, your private or commercial GHP coverage to us so that we could determine who pays first.

But as John said, you are to be using the Section 111 query processes.

John Albert: I can't - we can't answer in terms of your data use agreement regarding your MBD access as I'm assuming is some type of a Medicare plan.

But I mean I can tell you right now that there is no way that that would be allowed to be used for outside of the scope of - for which that access was originally granted by CMS.

So as Pat said, there are probably going to be many individuals that you would want a query on that have no association with whatever product or group you're dealing with in terms of your current MBD access.

(John Downey): That's where I was getting my (unintelligible).

John Albert: Okay.

(John Downey): Thank you so much.

John Albert: Sure, no problem.

Coordinator: Your next question is from (Armand Webber).

John Albert: Yea.

(Armand Webber): Hello, thanks. Have a quick question on the relation Field 12 on the input file. The manual when it talks about providing a delete transaction says that you match on the MSP occurrence fields, which is the HICN MSP insurance type relation code and MSP type.

And it says to produce or to generate a delete transaction if that relation code changes. But further on down the manual also says that if the relation code changes, we should provide an update and an add transaction.

So which one is it? Is it the term and add or is it the update and add?

John Albert: Well assuming the original information was correct, it would be a term and an add. The only time you would ever delete is if you erroneously indicated on the prior submission what that relationship code was.

So if you told us that the relationship code was 01 self, and in fact it should have been 02 spouse or common law spouse, then you would delete that old record and resubmit.

But, if you're merely, if the person is merely changing, you know, for whatever, you need to just basic update that information. You would term the old record and add a new record.

Man: Okay. I think we're going to have to do a term and an add. We are a multiemployer fund and members can self-pay for family coverage, so it's possible that I would send you a segment one time that says this member has single and then have to change that to family. So, I guess that's going to be a cancel and an add.

Man: Yeah. Delete is only used, again, is only used to remove erroneously submitted information that was accepted by CMS. It should never be used to do updates of which including termination of existing coverage. A delete essentially wipes out the record as if it never had showed up on CMS's system which, in most cases, you don't want to do.

Man: So, I believe you said a cancel and add - should that be a termination?

Man: Yeah.

Man: I meant term and add.

Man: It's an update transaction to essentially terminate the coverage and then a new add to indicate the new coverage type.

Man: Is anyone equating the word cancel to delete?

Man: Yeah.

Man: Okay, yeah, sorry about that.

And then, a couple of quick clarification questions and I think you mentioned this earlier. For the multiemployer plans, we're going to be sending you a single TIN record and we would use that same TIN number in Fields 21 and 22, which is the employer TIN and the insured TPA TIN, is that correct?

Woman: Not exactly, I don't think. Let me try this and say in the insured TPA TIN it should be the RREs TIN being reported. And, then, and that's Field 22.

Man: That's right.

Woman: And, you would have then, a corresponding record on your TIN reference file with that. And then, for each individual, it's within that file there are multiple GHPs, multiple plan sponsors, being reported. The plan sponsor's TIN is to go in the employer TIN of each applicable record. And then, every plan sponsor TIN that was submitted in Field 21, also needs a record on the TIN reference file and you would use different TIN indicators on that TIN reference file.

Man: Right. But we are a Taft-Hartley multiemployer plan, so we will just be sending you...

Woman: Oh, oh, yes. I'm sorry, so you have, essentially, you're reporting on one plan.

Man: That's right.

Woman: And so, yeah, they would be one and the same. I'm sorry.

Man: Okay, that's fine. And one more question, the manual says that when you are changing an open-ended date to an open-ended termination date to an actual termination date, you would use an update. But, if you have a - if I sent you a

record and you accepted it, and that record had an ending date, would that ending date also be changed with an update transaction?

Woman: Yeah.

Man: Okay. That's it, that's all I have.

Coordinator: The next question is from (Laura Rockne).

(Laura Rockne): Thank you for taking my call. Excuse me. I have a couple of things I just need clarification on. When I'm reading the desk CMS definition of a multiemployer group, would you consider chambers of commerce as well as associations to be under that?

Man: Yes.

(Laura Rockne): Okay. And now, with respect to the chambers of commerce, are we to report each individual employer participant's TIN and employer size? Or can we just report the chamber who is the plan sponsor.

Woman: Yes, we have to.

Man: You can't report the plan's sponsor.

(Laura Rockne): Okay. That makes things a lot easier. And the last question that I have, when we change to BH45...

Man: Can we go back? This is something we might want to ask you to submit in writing because it really applies regarding the plan's sponsor for the Taft-Hartley plans or hour bank program.

If it's a multiemployer plan that's not Taft-Hartley and doesn't operate on an hour banks concept, you do have to report the individual employers.

(Laura Rockne): Okay. Yeah, this wouldn't be a Taft-Hartley.

Man: Yeah, that's why again we would discourage these kind of phone questions. We'd rather see those in writing because, depending on how you phrase it, you might get a different answer every time.

(Laura Rockne): Yeah. I sent...

Man: We don't want to, you know, we don't want to, you know, misunderstand your question and give you bad advice. Because, when it comes down to it, the MSP statute is what needs to be followed in terms of...

Woman: I think the user guide, though, is clear, that...

Man: Yeah.

Woman: ...we're doing this for the Taft-Hartley or user - or an hours bank arrangement and for only that.

(Laura Rockne): I did submit this question; it was a three-part question at the time. So, I was still - I hadn't heard back so we just needed clarification.

Man: Okay.

(Laura Rockne): And the last question I have, since we have the delay in reporting age 45 individuals, will that be retro back to what they're coverage was as of 1/1/09?

Man: No.

Woman: No, no.

Woman: Remember that, even though we've got those age limits, you have a responsibility for reporting anyone who's a beneficiary, no matter what age they are.

(Laura Rockne): Right.

Woman: So, while that age 45 and 55 is to help you do it in an easier way, until the age 45 kicks in, if someone below that age is a beneficiary, you're still reporting them.

(Laura Rockne): Oh, no, I understand that completely. This is somebody that we were not sure of when we go to change it.

Man: Right.

(Laura Rockne): Okay, that's all I have. Thank you.

Man: Okay, thank you.

Coordinator: The next question is from (Theresa Wilcox).

(Theresa Wilcox): I want to cheer too. Just a couple of questions, thank you, to make sure we're clear. So, if we have a person who is 55 in 2008, November 12, 2008, let's say, and they have continuous coverage from 1/1/07, is their earliest effective date 1/1/07 and not their 55th birth date?

Man: Right.

(Theresa Wilcox): Okay. And then, because part of that coverage time they were under age 55, I still don't need a HIC number, because they were 55 on the day I report. Is that correct?

Man: That's correct.

(Theresa Wilcox): Okay, great.

Woman: And, we're back to unless they're a beneficiary. The reporting of everybody over 55 or over 45, does not eliminate your obligation to determine the beneficiary status of anyone who's below that age. If someone is ESRD, for example, or they are totally disabled, you still need to report them if they're a beneficiary.

(Theresa Wilcox): Right. That I understand. So, that wasn't just for your "normal" employee.

Next question, kind of along the same lines, I think I got most of this clear. If someone turns 55 on April 2, 2010, and they have single coverage through 5/31/09 and double coverage starting 6/1/09 open-ended, and assuming I'm reporting them in the second quarter 2010, because they're 55 age as of will be not in the first quarter, it'll be in the second quarter, for the second quarter 2010...

Man: You're making our head hurt.

(Theresa Wilcox): I'm sorry.

Woman: Maybe what would be easier is if we go back and report or restate, there is no penalty for failing to report someone who's not a beneficiary. So, don't worry quite as much as you are about the 45 versus 55 and when you're submitting it. Because, if they're not a beneficiary, we don't care.

Man: And, here's one other thing for you to keep in mind, the age 55 reporting rule or option that we give you, is exactly that, an option. If you have people - if you want to start reporting at age 45, it's perfectly acceptable to do that. That way, you would eliminate all these questions you're having about switching between 55 and 45, for example.

(Theresa Wilcox): The same question would apply if they were 45 as long as you're reporting at 45. The real question again, goes back to - and I think you might have just answered it. Based on, I'm already into my second year, I do not have to go back to 2009 and report all of their coverage in 2009, right? Just whatever is current now for them because they met the age threshold.

Man: Um, hmm.

(Theresa Wilcox): Correct?

Woman: Right. You should provide their original effective date of that coverage but, you know, you don't have to go back and report multiple records for changes and coverage since 1/1/09.

(Theresa Wilcox): Okay, great.

Man: Just current coverage.

(Theresa Wilcox): Okay. We had one other - another kind of that sort of question. If after my initial file is reported, I then get somebody retroactively enrolled from let's say, 1/15/09 to September 30, 2009 and I'm in the fourth quarter, this person isn't even effective now. Do I have to report them?

Man: Yes.

(Theresa Wilcox): So, we sent our third quarter initial file, then somebody got enrolled 1/15/09 to September 30, 2009, now, I'm in my fourth quarter going to report, do they get reported?

Woman: Yes.

(Theresa Wilcox): They do? Because they're not effective as of the date I'm reporting but they do have 2009 coverage.

Woman: Let's go back again if they're not a beneficiary, don't bother. If they are a beneficiary, then we need to know about that coverage even though it ended sometime in that year.

(Theresa Wilcox): That's the iffiness, we don't know if they're a beneficiary or not, that's why we're pulling in the right age...

Woman: No, part of what you should be doing is utilizing the query function that's available to you and you will use that to determine if someone is a beneficiary.

The age 45/55 is an option, but it doesn't guarantee that you're finding all beneficiaries. You have to have a way to find those that are under that age limit which, presumably, you'll largely use the query function.

(Theresa Wilcox): Actually, we were not establishing that query. I understood that was optional.

Man: Well, I don't - as a GHP, I can't imagine why you wouldn't because that would also allow you to collect entitlement data on your retirees. You may be paying primary for folks who have Medicare and for who Medicare is the primary payer. So we strongly advise that you use that not only to fulfill your reporting obligations, but to realize the cost benefits to your own program in terms of the mistaken payments you may be making on your under 65 retirees.

We strongly encourage you to use that. It is, you know, historically, our VSA and VDA partners have probably across the board saved more than CMS has by having this kind of bilateral data exchange. So, please take advantage of that query file. It's a tool designed to help you reduce cost to your benefit program, not only in terms of MSP but, in particular, for your under 65 retirees that you don't know who have Medicare.

Woman: And using the age 45 to 55 does not give you a safe harbor or a pass if it fails to identify everyone who is a beneficiary.

(Theresa Wilcox): Well, and this question isn't even related to age, they're 59, they're whatever, they're well, affected, the real point is at the time I create the file, they do not have coverage. But, I had not reported them in the initial because they were not our system on our files.

And so, it was after the initial, it was my understanding was we don't forever have to go back to the 1/1/09.

Man: Well, I'll tell you what, let us go back and take a look at the guidance that we have out and if, you know, I think I understand what you're asking and we

can, you know, address it from here. We just want to make sure that all of our guidance is consistent. We'll go back and take a look at that selection process and make sure that it is consistent. Because, I mean, obviously, if you're not understanding it, that means we could probably clarify something in that guidance. Let us take a look at that so we can keep going with other questions.

(Theresa Wilcox): Okay. That's kind of my question, do we forever go back to 2009 and find members that were effective any time?

And we have some questions on disability. Our disability manager is arguing whether or not we should send somebody on disability? We think the regs say they do, he's saying, and I want to read this, please, "A disabled employee does not meet the criteria in this bullet point to make Medicare a secondary payer. They are not working, nor do they have current employment status as contemplated in the law and regulations. If the employee were receiving compensation that was subject to employment tax, such as FICA, then they would be in employment status, but this is not the case."

So, I'm not sure still whether or not to send you somebody that is disabled. We do not yet have them on Medicare, so we don't think they're a beneficiary. Do we still have to send them? But they're the right age criteria; they're disabled and used to be working and they're still listed as being a part of that employment - employer - covered under the group health plan.

Man: If they're enrolled in Medicare - okay, how old are they?

(Theresa Wilcox): Let's say they're 58.

Man: If they're 58 and they do not have coverage based on hours bank.

(Theresa Wilcox): I didn't hear that last part.

Man: They don't have hours bank coverage.

(Theresa Wilcox): (Unintelligible).

Woman: Hours bank, he's saying.

(Theresa Wilcox): Okay. I'm not sure what that is, but okay.

Man: That is they do not have coverage based on current employment status and Medicare would be primary. They were a beneficiary.

(Theresa Wilcox): They have coverage based on they used to be employed and they became disabled and now they are under a disability payroll.

Woman: What (Bill) was saying was an exception is in certain jobs, certain categories, whereas, people earn their coverage while they're working and they use it at a later date. That's an oversimplified explanation of hours bank. If you have someone that's in the disability status you named, but is entitled coverage based on their past work under an hours bank concept, then we could still be secondary.

(Theresa Wilcox): So, you're saying we should report.

Woman: No, I'm not saying you should report it, not if there's the hours bank concept.

If you need assistance on that particular issue, please send a note to our resource mailbox.

(Theresa Wilcox): Okay and we'll clarify that with our disability manager as well.

Our last question has to do with changes and we understand that if the key field change, we send a term and an add or if they get corrected we send the delete and an add. We want to make sure what requires a change otherwise. There are several required fields, if any of those change, does that trigger us sending you a term and change - a term and an add?

Man: Yeah, I mean, basically, if any of the key matching fields change, then you would need to send, you know, an update to essentially close that old record and then send a new add.

(Theresa Wilcox: I understand that.

Man: Even on stuff that's not part of the matching criteria though. I mean, if there's updated information, you need to pass to us, then we would ask that you pass it to us.

(Theresa Wilcox): And that's my question. Anything else we understand on the key field, we have to do that. Anything else that is not a key field but is called a required field.

William Decker: Let the TIN.

(Theresa Wilcox): Well, we know on the TIN, we got that answer. We've got surname, first initial, date of birth, sex, policyholder's first name, policyholder's last name, employee coverage election and employee status; any of those required fields trigger the change.

Woman: Actually, changing a last name does not trigger an automatic update. In the user guide there is a section about describing reporting changes when information that we use to determine or to set up our MSP occurrences, when those fields change, we need an update because it will impact MSP. And those are fields in addition to the key fields.

Now, if a person's last name changes, that doesn't have to automatically trigger an update to us. We already have their name based on Social Security Administration information. Now, if you reported the wrong person, you know, so you reported an incorrect SSN or HIC number, that is a different story.

So, there is documentation in the user guide on that. You know, you don't necessarily have to trigger an update if something that is not listed there in the user guide in those section have not changed.

(Theresa Wilcox): We have reviewed that, but we still had the questions. But we'll go back and do that on those required fields whether or not it's one of those changes we have to send you a change.

Woman: Now, as (John) said, we'll take and process the update without question.

(Theresa Wilcox): Okay.

Woman: But we will take it as an action to go back and look at the event that trigger updates, etcetera, and try to add some clarification to that.

Man: Essentially, the matching criteria that we use to match to a previous disseminated record is, if they do in fact match, we overlay the existing record with the new information. Otherwise, we create a totally new record. So, for

example, if the patient relationship is different, that would result in a new record being created. Whether you call it an add or an update, the process is still the same.

We take a record and compare it to what we have on our system where they match, we overlay the information; where they don't, we build a new record.

(Theresa Wilcox): Okay, I think that helps us.

Man: And we would encourage you, again, if other information is not part of that matching criteria changes, we would encourage you to provide that as an update and it should overlay with whatever new information you have.

(Theresa Wilcox): Okay.

Man: Okay?

(Theresa Wilcox): That's all I have. Thank you very much.

Coordinator: The next question is from (Albert Tolson).

(Albert Tolson): Yes, thank you for taking my call. Can you hear me?

Man: Yes.

(Albert Tolson): My question is, I think, simple. When you do the registration process, this will be my first time, and I went out to the site, I got to the page where you accept the agreement. My question is, if you don't finish the registration process at that time, can you go back and resume or do you have to start all over again?

Woman: You have to start all over again. Now, when you get that login warning page and you click on "accept," all that's going to do is take you to the homepage where you can browse around and look at the menu options and the how-to's. What - once you have clicked on "new registration" on that button and started through the process, you must finish it completely and the same goes for account setup. If you don't have all the information and can't finish it, there's no way to save the information entered during the new registration and account setup stuff and come back later.

(Albert Tolson): Okay. Can you give me, based upon the (unintelligible) some other participants, approximately how much time you need to allot to do this process?

Woman: It kind of depends on what type of information you're submitting, but I would think that the new registration processes for a new RRE ID, if you have the information ready, on hand, it would take you about ten minutes.

(Albert Tolson): Oh, okay.

Woman: Now, if you're entering a lot of subsidiary information maybe it'll take you a little longer than that.

Account setup if you're selecting the secure FTP or HTTPS file transmission method, again, that'll probably take you 15 minutes. The connect direct transmission information takes a little bit longer to input but, certainly, less than half an hour and I would think, really, less than 15 minutes.

(Albert Tolson): Okay. You don't do the - thank you, you don't do the account setup until after you've received back your number, right?

Woman: You've got it.

(Albert Tolson): Okay, okay. So then you do one one day, then you wait and do the account setup another day.

Woman: Exactly right.

(Albert Tolson): Okay. Thanks.

Woman: If you have concern whether you've got all the information after just reading it in the user guide, go to the CBT training and, if you go through that, it'll prompt you and you'll see whether you've got what you need to do the actual registration.

(Albert Tolson): So, in other words, the CBT training is sort of like a prelude to the live, so if you do that successfully, put in the same information then you'll know you're pretty good.

Woman: Well, the CBT, you don't actually do data entry. It's just is showing it to you as someone else is doing it. But, it still will show you every single page and every single data element in excruciating detail.

(Albert Tolson): Okay.

Man: And, it will certainly show you every piece that - identify for you all the information you will need when you go live on the registration and do it yourself.

(Albert Tolson): Okay, so it's advisable to take the CBT course.

Woman: Absolutely.

(Albert Tolson): Alright.

Man: Everybody on this call should be taking the CBT course.

(Albert Tolson): Alright, thank you.

Coordinator: Our next question is from (Bill Gerlach).

(Bill Gerlach): Hi, good afternoon, thank you for taking my call. My question is regarding small employer exceptions. Our understanding is that the COBC will be providing some information to RREs once a small employer exception is given to a particular employer. Can you clarify what exact information will be delivered to the RRE about that particular employer?

I do know that there's a field for an SEEID on the file but, you know, will the information coming from COBC just be an ID or will there be additional information as well?

Man: We're not reporting.

Woman: We don't report when we grant a small employer exception, (Bill).

Man: When the request a small employer exception, is submitted by the plan or the authorized insurer, the response whether or not it has been approved goes back to that entity. I believe in the Section 111 reporting you can indicate whether or not you believe that a small employer exception has been granted and compare it against the file. And, if it has then, you say it has been granted

and our file says that it's been granted and MSP record is not established if the requisite data elements match.

If you say that there's been a small employer exception and it's not on the list, I believe you get some kind of an error code.

Woman: This is information that the RRE needs to obtain from the plan and/or the employer. If you don't and you're reporting based on the employer size, which is the largest employer within the multiemployer plan, then it will build a record and say that we are, in fact, secondary. If the exception has been granted, you don't want that record built because we aren't secondary.

So, that is a key piece of information that you need to have from either the employer or the plan, which individuals the small employer exception has been granted for. And, as we've allowed some additional time in there, at this point, you also want to know is there any request pending for anyone.

(Bill Gerlach): Okay. Thank you.

Woman: Take a look at Section 7.2.4 of the user guide as far as how to report a covered individual for whom a C has been granted and the C response code that we provide that regarding the actions that the COBC took based on the information submitted and whether there was a C granted, etcetera.

(Bill Gerlach): Okay.

Man: Based on that input file and you're telling us that you believe that C was granted, if you get back something from us that disputes what you've basically input, that mainly is a trigger to you to make sure that, you know, that appropriate process has been followed and the C has been granted,

etcetera. It's mainly just used as a - provided as a tool for you to determine that, hey, in fact, CMS is aware of the small employer exception.

Because that can affect also the MSP effective date if exception was granted for a particular period of time and it is outside of the coverage period you're reporting, then we will build an MSP record. In some cases, the coverage may be from January to December; but the C expired in June and so we don't rebuild an MSP record, you know, from July to December, that kind of stuff. So...

Woman: And the responsible reporting MCS, the insurer or the claims processing TPA, if we build a record that's making them primary and they're not primary, they're going to be concerned. So, if you're acting as an agent and you get back this type of erroneous response, that's clearly something that your client is going to want to know about so that they can take corrective action if necessary.

(Bill Gerlach): Okay, thank you. I appreciate it.

Coordinator: The next question is from (Jaime Hirschman).

(Jaime Hirschman): Yes, thank you. My question kind of keeps changing. My first question though, is the information I keep receiving on this call, we were planning to use the non-MSP input file in place of the query-only file to find out if we have - if any of our Medicare, I'm sorry, not Medicare, any of our dependents under the age of 45 have Medicare due to disabilities or ESRDs. And, I'm not sure, is that a better way to go than using the query file?

Man: Are you going to be reporting prescription drug coverage information for retirees?

(Jaime Hirschman): No, we're not.

Man: If that's the case, then you can't use the non-MSP file, you would have to use the query-only file. The reason for that is because there's a HIPAA-required transaction data set for query and response files. For those entities that are reporting either supplemental prescription drug coverage or acting to submit files to the retiree drug subsidy contractor through that non-MSP file, they can use that for query. But, if they're only going to be doing queries and not reporting any kind of supplemental retiree prescription drug coverage, then they're going to have to use the HIPAA-required format that is used where the transaction is purely for inquiry, Medicare entitlement inquiry and response.

(Jaime Hirschman): I see. And can you direct me to the section in the manual that will clarify that?

Woman: Yeah, if you look at the section in the manual on the non-MSP input file, it does indicate that you can't submit a non-MSP input file with only the N, as in the letter "N," query records. It has to have at least - it has to have the other records, the D record, where the supplemental is reported and so...

Man: That's why we have, I mean, we have to, I mean this is outside of our control, we have to have that query-only file where someone's only going to be using - would only use that function for query and that's something beyond our control. I know it sounds a little goofy, but it is a HIPAA-required transaction.

(Jaime Hirschman): Okay. And, if we're going to use that, we can use the query-only file for anybody under the age of 45 - any age?

Man: Anybody. Anybody that you cover.

(Jaime Hirschman): Okay. And when can we start doing that because production doesn't start until July, when can we start submitting a query-only file and getting actual information from that so that we're prepared on 7/1.

Man: July.

(Jaime Hirschman): I'm sorry?

Man: It won't be available until July.

(Jaime Hirschman): That's not going to be available until July. Okay.

Woman: It has to be in your RRE ID has to be in a production status. In other words, you have to have passed your test requirements for the MSP input file in order to send any production file, including the query-only.

(Jaime Hirschman): Okay, and that will be available, even if we pass production, say on June 1, we still can't submit anything - I'm sorry, pass the test on June 1, we still can't submit anything in production until July 1.

Woman: Yes.

(Jaime Hirschman): Okay.

Woman: I'll double check that, but that's my understanding anyway.

(Jaime Hirschman): I see. Okay, that's great. And I have one other question, on the MSP input file, it says that we need to submit for anybody who's age 45 and over, we need to submit a member with either their social or their Medicare HIC

number. But for anybody who is under the age of 45, we have to submit a HIC number. That's required?

Man: That's correct. Again, that's what the query file will get you.

(Jaime Hirschman): Okay, great. I just wanted to confirm that. And, I think that answers...

Man: The query file can be submitted on monthly production cycle versus the MSP reporting file is only actually quarterly. So, that's why it would be possible to get into production with the query file prior to maybe your first MSP input file. I'm guessing.

(Jaime Hirschman): Okay, so we can submit that - how many times a month can we submit a query on the file?

Man: One a month.

(Jaime Hirschman): I'm sorry?

Man: And also take advantage of the basis program as well for doing your online limited query.

(Jaime Hirschman): Okay. So you said we can submit it once a month. And then, how many records can we put on a file?

Man: You can put as many as you'd like.

(Jaime Hirschman): Okay, that's good.

Man: So take full advantage of the query file.

(Jaime Hirschman): Okay, thank you.

Coordinator: The next question is from (Tina Newbeck).

(Tina Newbeck): Hi, I actually have quite a few questions and a couple of things that I wanted clarification on.

The - on the clarification issues, you said that if there's a change to information on the TIN files, they are a group addresses change, my understanding was that what you were saying is any (unintelligible) from that group that has been accepted as an MSP occurrence we need to resend to get that information updated?

Man: That would be up, you know, if you want that old information updated with the new address, then yes. If you don't then, don't worry about. It's up to you. But, basically, submitting a new address on a particular TIN reference file, it does not result in the automatic updating of previously submitted records with that new address. You would actually need to send that information again. So, you know, and depending on your situation, you may want those older records back a certain point in time updated with that new address. If not, then, don't.

(Tina Newbeck): Okay. The other thing I wanted to get a little more clarification, just to make sure I understood what you were saying, right, was having to do with the correcting information versus changing information. I think the example was on the relationship code or the coverage type. My understanding, the way I'm reading it is, if I sent you John Smith and he has a coverage type of A as of January, if I find out that I sent that incorrectly, it should have been, say, a J instead of an A, that's where I would send the retransaction and a new add with the information?

Man: Absolutely correct.

(Tina Newbeck): Okay. But, if his coverage went from an A to a J say in June, I would send an update to term the first - to give you a term date for the first record that you've already accepted and then a new add from July going forward with the new information?

Man: Congratulations, you understand.

(Tina Newbeck): Okay.

Man: You got it.

(Tina Newbeck): Alright. My next question has to do with the EFRD coverage. If we send somebody that is still within their coordination period, so we're sending them with the understanding - our understanding as Medicare is still secondary - we've going - on the response file we get information as to their coordination end date? So, say that coordination end date is two months from now, so when we send our next file, that person technically is no longer - Medicare is no longer secondary because they've completed their coordination period? Do we need to send an update for them or...?

Man: No, I mean, we would convert that internally on our own.

(Tina Newbeck): Okay, so once their coordination period is over and Medicare is now primary, we no longer have to continue sending any information for that person.

Man: Yeah, I mean, assuming that that's the only reason that they're entitled. But, yes, I mean, the coordination period is tracked internally at CMS and so once

that 30-month period ends, you know, in a simplistic format, that, you know, we would term that MSP record essentially up to (unintelligible).

(Tina Newbeck): Okay.

Man: No, we track that.

(Tina Newbeck): That's what I was thinking but I just wanted some clarification on that.

Another question that came up was, if we send somebody under 45 with no HIC (No.), I know we're going to get a SP-99 error, will we also get their HIC (No.) on the response file?

Woman: No, we won't actually match that individual up against the Medicare database.

(Tina Newbeck): Okay, so the only way we could get that information from you is through a query-only file?

Woman: Correct.

(Tina Newbeck): Okay.

Woman: Or the covered individual themselves.

(Tina Newbeck): Right. Okay. And then, I know a couple these questions we were going to send in an email, but we can't seem to find where the link for that email...

Man: If you go to overview tab and scroll down to the documents there, there's a document that's called "Opportunity for Public Comment."

Man: I think it's (David Chune)?

Man: I don't remember the exact date, but in the title of the document, it says, "Opportunity for Public Comment," and it has the resource mailbox address in that document.

((Crosstalk))

(Tina Newbeck): Okay, because I thought somebody had said that it was on one of the pages and we kept looking at different pages.

Woman: It's right now, we're just kind of talking amongst ourselves about possible posting that email address in an easier to locate place. But, right now...

(Tina Newbeck): That would be beautiful.

Woman: But right now, you have to download that PDF that's called "Opportunity to Public Comment" and it's in there.

(Tina Newbeck): Okay.

Woman: And once you have that, you might want to bookmark it.

(Tina Newbeck): Oh, I will. Okay, and then, I think, looking over my notes, the last concern we had was with the once we register and we're assigned an EDI rep, the understanding we have was that we would be given a testing window. What happens if we're not ready to test when they say this is your testing time?

Woman: Well, here's what happens. In order to get to your - after you send an account setup, your status for the RRE ID changes to, it's called a setup status, you will actually see that for the RRE ID when you login to the system.

After account setup, the profile report is sent to the authorized rep and account manager. The authorized rep has to sign it and return it. Once the COBC has received the signed profile report and updated the system to that effect, the status for the RRE ID changes to testing.

Then, you may test from that point until your first production file is due in your file - your assigned file submission timeframe. The system will track your progress and, if we have not received a test file from you, you'll receive some email reminders and your EDI rep will also be kind of poked to notice that you're not making any progress on your testing and will follow-up with you and then you can just talk to your EDI rep about it.

But, you know, what is most important is that that production file is sent by your first production file submission timeframe and, again, you can be in a testing status pretty much right up until that point.

(Tina Newbeck): Okay.

Man: We think of the testing window as a period of time in which you have to test. It's not going to be benchmarked in there where you have to test on certain dates. You've got a time period and, if you are having some problems with your testing or testing setup, you need to talk to your EDI rep right away so that the two of you can work out how you will finish your testing in time to meet your production schedule because that's more important.

(Tina Newbeck): Got ya. There was just some concern that, say we registered April 1, and all of a sudden they said, okay, you've got to start testing as of May 15 and we didn't think we would be ready.

Man: Just keep talking with your EDI rep and working with them. That's the main thing if you refer back to the document from last year about the at risk for non-compliance entitled, because the main thing we're looking for is that you are engaged in working towards your production date. If somebody registers and we don't hear from them and that's not going to, you know, look good but, if you're working towards that, I mean, your EDI rep and all, they can provide flexibility and help you with getting to that production date as soon as possible.

(Tina Newbeck): Okay.

Woman: I'd like to add one more thing about registration. The assignment of your file submission timeframe is not dependent on the order in which you register, so please register as soon as you possibly can, gather all the necessary information. The file submission timeframe is, in a sense, randomly generated. What we're trying to do by the answer to your questions about the number of covered individuals and so on, is spread out our processing over the course of the quarter.

So, someone who registered on April 1, might have gotten the latest file submission period possible and someone who registered very late, at the end of April, might end up having a production file due June 1. That can't really be controlled but, then, again, as (John) said, if you're having trouble finishing your testing and getting ready for your production live date, you need to be in constant contact with your EDI rep.

(Tina Newbeck): Okay, and just another clarification. You said that the production query-only file will not be available until July 1? If we're planning to use that query-only file as our finder file before we send our first MSP file, is that something we that we relay to the EDI rep? Could that possibly put us in a later submission window?

Man: Okay, we'll take your implied suggestion and put that suggestion under advisement. But, at this time, they're not available until July.

(Tina Newbeck): Okay, because that's what we were going to use to determine who we needed to send, it's kind of hard to send the first file if we can't get that information.

Man: Yeah. I mean, primarily, that window up until July is going to be used for testing as well as there's a whole other component of this being workers' comp liability no-fault insurers who will be registering in May. So, we'll be, you know, that's what that primary window is for.

Woman: I also want to caution you not to use the response file from your test query - query-only file for your production purposes. While we have some production data in there, it's not necessarily giving you the up-to-date answer that you need. So, don't take the response file from a test query and apply it to your production processing. And, as (John) said, we'll take under consideration the point that you've raised about the availability.

Man: Testing is kept separate from production, so...

(Tina Newbeck): Okay. Yeah, I wasn't planning to do that.

Woman: Good.

Man: Good.

(Tina Newbeck): Okay, I think that's all of our questions.

Man: Operator, it's now come to 3 o'clock. Could you tell us how many people are in the queue right now?

Coordinator: There are still 19 questions.

Man: Okay, because of other commitments, we're going to have to end this call now.

I wanted to thank everyone for their questions. I hope that we answered any of them that have come in.

Operator, I'd also like to know how many people were actually in the call at the maximum number of attendees.

Coordinator: Just a second.

Man: We wanted to thank you for participating. The questions have been really great, you know, it helps us to continue to refine the materials, etcetera. And, keep - subscribe to the LISTSERV and, so that you can get the latest updates as we publish them, including announcements regarding future GHP or specialty calls that we're going to be hosting. We're going to be trying to be doing more direct outreach with our GHP and NGHP partners specific to particulars within the process.

With that, thank you very much.

Operator?

Coordinator: That concludes today's conference, you may disconnect at this time.

Man: How many were on the call, operator?

END