TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: December 3, 2008

TARGETED AUDIENCE: Group Health Plan and Prospective Responsible Reporting Entities Only.

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FTS-HHS HCFA

Moderator: John Albert
December 3, 2008
12:00 pm CT

Coordinator: Thank you for holding. Parties will be in 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. Bill Decker.

Bill Decker: Hi - good afternoon, everybody, my name is Bill Decker and I'm with CMS here in Baltimore. Each of you have already had at least some familiarity with my voice and perhaps and email or two from me.

This afternoon's session is for GHPRREs and prospective RREs only. The non-GHP reporter intend to be a non-group health plan reporter, this is not a call for you.

Secondly, we're going to try to limit this call - as hard as it will be - to technical questions about the Section 111 reporting process and try to limit - I hope you will try to limit your questions to us to the technical issues that are -

that have come in up in your experience as you're preparing to start Section 111 process.

With me this afternoon - with us this afternoon - is John Albert, Barbara Wright and myself - all from CMS. There were a number of folks who work with us at our various contractors. Presenting most of the material today will be (Pat Ambrose). With (Pat), backing her up will be (Steve Foray) and other folks from a contractor that we have that does our technical work. And sitting next to me is Bill Ford, who runs the EDI Department at the COBC.

There are other CMS employees and other people who could be available to answer any questions you have. But I suggest that right now, I turn it over to (Pat) and we get started.

(Pat Ambrose): Okay - thanks, Bill. I have a few items to go over and then we'll open it up to get as many of your questions asked and answered. So you can start getting into queue now for asking that question.

And the first announcement is that we will have a series of computer-based training made available to all Section 111 responsible reporting entities. Right now, we have developed training material or training courses for group health plans responsible reporting entities.

These courses basically go over the information that's in the GHP User Guide with some additional examples and diagrams that you might find helpful to explain certain concepts. So the training covers reporting requirements, file transmission, file formats and file processing.

You will need an Internet connection - Internet Browser - to take the training courses. They are self-paced and self-managed so you can go at your own

pace and take whatever courses are applicable to you and skip courses that you may not be interested in.

An announcement will be posted on the Section 111 Web page which is www.cms.hhs.gov/mandatoryinsrep. That posting will be made in the near future. In that posting, we will explain to you how you go about registering for these CBTs - or computer-based training courses.

Our current VDSA and VDEA partners, who have already been assigned an EDI representative at the COB contractor, may contact their EDI representative to register for the courses. All others - since you may want to take - and I would advise that you take these courses prior to registration in April. All other GHP responsible reporting entities may call the COB contractor EDI department at 646-458-7740 - 6740 - no, type in my presentation, I'm sorry. So let me repeat that number. It's 646-458-6740.

Again, this information will be posted out on the Web site for you. When you register, you'll have to provide the enrollee's name, your learner's name, phone, email address and you will receive an email with instructions and how to navigate to courses and outline of the curriculum.

Next information that I wanted to provide you before we open it up to question and answer has to do with the update to the GHP User Guide. We're working on updates now and most likely will have those published early next week. The first change that we're adding are a series of what we're referring to as compliance flags that will be added to the MSP Response Files as of April 2009.

I have some more information about those flags to provide you in a moment. In addition to that change, we're adding some clarification to the data element

descriptions related to some of the questions that have been submitted by response reporting entities and others. Some of these are related to reporting specifically for third party administrators or TPAs, self-insured entities and reporting on (Chas Hartley) multi-employer group health plans.

We also - and I mentioned this on the last call. We removed the reference to the file transfer protocol or FTP over the AT&T global network services - the AGNES. That's using the Connect Direct - rather, you must use the Connect Direct file transmission method over AGNES. FTP is not an option.

Now we still will make your FTP available on the COBC secure Web site. This reference was only if you were using the AGNES private network to transmit your files. FTP is not an option. You must use Connect Direct. And again, I repeat - your FTP will be an available option on the COBC Web site.

We also added some further clarification regarding the TIN reference files. Clarification has been added regarding the document control number or the DCN. Note that this number needs only be unique within the current file being submitted. And it will be returned on the - on all records in the corresponding response file.

We also added some clarification that the limit on queries that can be submitted through (Basis) - which as entitlement enrollment query application. That limit is 200 per Section 111 reporter ID or RRE ID. So you may - if you register and have more than one reporter ID, you will be able to query in (Basis) for up to 200 queries per RRE ID.

Man: (Unintelligible).

(Pat Ambrose): Per month - yes - I'm sorry. Also updates have - are being made to the descriptions of the error codes - the FP error codes and the RX error codes where applicable to further clarify their meaning and the corrective actions that you should take.

We're adding some additional clarification on the use of the pseudo-TINs - again to note that a pseudo-TIN is only allowed for an employer TIN (unintelligible) identification number. You may use the pseudo-TINs for employers until January 1, 2010. And at that point, you must have obtained a valid TIN and resubmit all the records with the valid TIN that you had used if you had submitted with a pseudo-TIN previously.

And other updates are going to be made based on the Section 111 TRA comments that were received and the response that CMS is working on.

Now I'll go over what these compliance flags are. And again, this will be documented in the new GHP User Guide next week when we publish that. We're adding a series of ten flags to the end of the MSP response file using existing filler. So we're not changing the record length.

These flags follow the late submission indicator. They're very similar to the late submission indicator but they're defined separately. They are also similar to error codes with one exception is that when you receive a flag in the compliance flag, when you receive a code in there, we're not actually rejecting the record.

We are going to process the record but we're sending back a flag to you on the response record to let you know that there still was something that was not completely compliant with the requirements for Section 111 reporting on your MSP input file.

The two code values that are currently being defined - one is for sending an invalid insurer TIN. This is a TIN that could not be validated by the COB contractor. You may have the TIN that matches on your TIN reference files but we were unable to determine that this tax identification number was a valid IRS assigned TIN or EIN. You'll also get this flag when you're using the pseudo-TINs rather than using a correct tax identification number.

The second code is the same thing except for the employer TIN. So if we are unable to validate that employer TIN that you've submitted or it's a pseudo-TIN, the record will be processed but you will receive a flag indicating that this TIN that was submitted for the employer is not correct and you need to go back and find that.

Again, you have until January 1, 2010 in order to collect the valid TIN for your employer customers. However, you to submit a valid insurer TIN as of January 2009. And these compliance flags though are not being added to the record until April 2009.

The action you would take is to examine these flags if they're any codes in there and then correct your internal systems in order submit the correct TIN when it becomes available. CMS will follow up with responsible reporting entities that has the issues with submitting invalid TINs per se.

Actually at this point, I'd like to open it up to questions and answers. And then we have a series of other materials that we can present. But we'd like to offer up as much time as possible for answering questions that you have. And if time permits, we'll come back to the presentation and (unintelligible).

Coordinator: If you'd like to ask a question from the phones, press star 1. Please unmute 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 (Barbara Collinson) from (Frontguard).

(Barbara Collinson): Hi - I have two questions. The first one has to do with healthcare reimbursement accounts and the coverage types. It states that you are - we don't have HRA available as a type if you're doing the basic reporting. So does that mean you don't - if they have HRA only you don't report it in the basic or do you use one of the available values?

Man: We're pondering the answer to your question right now.

(Barbara Collinson): Okay.

Man: Just a second.

Man: Excuse me - could the person who posed the question tell us specifically what two fields they're looking at so we can check this real quick?

(Barbara Collinson): Yes - on Page 72 and it's Field 8, coverage type.

Man: Medical (unintelligible). (Unintelligible) reimbursement account.

Man: Coverage type Z?

(Barbara Collinson): Yes, but there's a statement that says basic reporting option includes hospital and/or medical coverage. Expanded reporting option includes all coverage types.

Man: Well that expanded option is prescription drugs.

(Barbara Collinson): Yes - so what I'm saying is if you have...

Man: If it's a drug only coverage, you don't have to report it under the basic option.

(Barbara Collinson): So if you have an HRA only but it covers medical non-drug charges, how do you report that?

Man: You report it as a Coverage Type Z.

(Barbara Collinson): Even though it says it's not valid for the basic? Am I misunderstanding what that means? Expanded reporting option includes all coverage types.

Coordinator: Are you ready for the next question?

Man: Actually, we're going to have to get back to you on that in terms of that reporting...

(Barbara Collinson): Okay - and how will you get back to me?

Man: It's going to be through the updated User Guide that we're working on.

(Barbara Collinson): Okay. Can I ask my second question? And this may have been addressed already in the User Guide revisions but there is a statement in the User Guide that says that we should send back but are not required to the MSP effective date. But that field does not exist on the input file. And then there's a whole bunch of error messages that have to do with conflicts in the MSP effective date or term date and other information which the RRE is expected to correct.

And yet they're not even sending that date. So I don't know how that can happen.

(Pat Ambrose): Okay - hi, this is (Pat Ambrose). I have added on clarification in the User Guide related to the error codes and information about the MSP effective and termination dates.

(Barbara Collinson): Okay. I thought maybe you had.

(Pat Ambrose): Yeah, you as the responsible reporting entity obviously do not send the MSP effective and termination dates. The COBC system determines those. So your responsible for sending the actual effective and termination dates of your GHP coverage.

(Barbara Collinson): So how would we correct errors that are - those kinds of errors? For instance, one of them says that - like, 55 says, MSP effective date is less than the earliest beneficiary Part A or B date. And sense we're not sending any of that data and yet it's listed as something already supposed to fix.

(Pat Ambrose): Yes, ma'am, I'm aware of that and we have actually changed that particular error to a COBC responsible error.

(Barbara Collinson): Okay.

(Pat Ambrose): And it will not be an error that you would have expect to fix and you should not receive that error except in, you know, very unusual cases. And if you did, you'd contact your EDI rep. So we have basically the types of errors that you would receive if you submitted an invalid date in one of those fields that, you know, didn't have the date checking.

(Barbara Collinson): Okay, so when we see the new User Guide, I think my other issues will probably be corrected so I'll look forward to that. Thank you.

Man: Thank you for your very excellent questions. That's what we're looking for.

Coordinator: Your next question is from Elizabeth Wilson from Health Plans.

Elizabeth Wilson: We were wondering if it's possible to submit our entire file every quarter as opposed to submitting additions, deletions and so forth.

(Pat Ambrose): No, we actually do require that in your initial file, it would be if you're a new reported all add records. And then subsequently it would be add updates and deletes. Adds for anything new and update to change anything that you have received a 01 disposition code on. Or a delete - you actually remove a record that was sent in error. We're doing them in order to keep the file size limited to a minimum on a quarterly basis.

Elizabeth Wilson: Okay - we understand that. That involves a lot of extra tracking on our part to submit the data that way. We also are wondering, in the registration and initial process, working with the COBC, are we going to get response files during that process so that we know what to expect when we are filing for the first time officially.

Man: You guys are current VDSA or VDEA partners?

Elizabeth Wilson: No.

(Pat Ambrose): Are you referring to testing - I'm sorry - I missed the first part of your question.

Elizabeth Wilson: Yes.

(Pat Ambrose): Yes - you will receive response files to the test files that you submit.

Elizabeth Wilson: Okay.

(Pat Ambrose): And again, work through those. Those will have the same types of error codes that you might receive in production. Obviously you'd be making changes to your system to avoid those error codes hopefully. And any questions that you have, you can work with your EDI - your assigned EDI representative.

Elizabeth Wilson: Okay - and once we - when we're submitting our initial files or some other point, what if we do not have the social security number for a covered member? Are we - do you want us not to submit that name with the file?

(Pat Ambrose): No, we would not want you to submit that - the record would just be rejected. We have to have a valid ticket number, Medicare health insurance claim number or a valid SSN in order to process the record.

Elizabeth Wilson: Okay.

(Pat Ambrose): You do have until January 2010 to collect the SSN of your dependent. You're expected to have the SSN for your subscribers with your initial file submission. Once you have collected those SSNs, then you're required to submit that information retroactively.

Elizabeth Wilson: Okay - another question - thank you for indulging us. What can we expect a response time to be between the time we submit, say, a quarterly update and we get the response back from the COBC about any problems that might be in the file?

Man: You should get a response back within 30 - between 30 and 45 days - no more than 45 days.

Elizabeth Wilson: Okay - so then we would have - we would be submitting the following quarter to correct any of those errors. Is that right?

Man: Right.

Elizabeth Wilson: Okay. Somebody was looking - are we - is there a choice or is there an assignment between filing monthly or quarterly?

(Pat Ambrose): The query only file and the non-MSP file may be submitted as often as monthly or you could submit them quarterly. The MSP input file must be submitted only quarterly during your assigned file submission timeframe.

Elizabeth Wilson: Okay - thank you very much.

Coordinator: Your next question is from (Aaron Mercon) from (W Mutual).

(Aaron Mercon): Hi - we have a number of questions so bear with us please. They're not that complicated hopefully. The first one is, we are wondering about records for individuals that are rejected on the first or whenever their first enrollment submission would be.

If they have status changes in the interim period from their rejection to when they actually get accepted on the files that we send in, are we required to submit multiple records subsequently to represent the changes - their status changes - from the rejection to the current month or how do you want us to approach that?

Man: In terms of if you don't succeed in getting the record posted - in fact it was a Medicare beneficiary and it gets to the point that the guy or - had changed his coverage, for example, then it's possible you will be needing to submit multiple coverage records, if that's what you're asking.

(Aaron Mercon): Okay, so....

(Teresa Wilcox): Yeah, so if they're - I'm going to jump in, this is (Teresa Wilcox) with (Aaron). So if we have - that's exactly what we're asking - multiple effective dates for a person because something changed - their policy number, their type of coverage changed - you want that entire history of what they've had since they were 45?

Man: No, just basically from the January 1, 2009 period of coverage.

(Teresa Wilcox): Okay - but go from January 1, 2009 to January 1, 2019, if they've got 20 different history kind of information with different effective dates because of different policies or coverage, you want every single effective date and every single type of coverage since January 1, 2009. Is that correct?

Man: I mean, in a sense, yes. The driver of all this is the matching criteria which is coverage types, efficient relationships, effective date of the coverage - you have a HIC number. You know, essentially you are building unique periods of coverage on our database. So if in your extreme example, you are sending - you some reason couldn't get the information for ten years and you wanted to - you finally had what you needed, you would send, you know, however many periods of coverage, you know, on that one file, essentially.

(Teresa Wilcox): Well, it's not that we wouldn't have the information. The issue is the person is 45 - let's say, in 2009. So we begin to send the person but you reject them until they're a Medicare beneficiary.

Man: Well, that is...

(Teresa Wilcox): So in ten years, they become a Medicare beneficiary and I'm sending that person every quarter.

(Pat Ambrose): We only want you to send the most current information.

Man: Yeah.

(Teresa Wilson): That's the question, I guess, okay. So...

Man: If it didn't match to our system because they weren't a beneficiary, then don't worry about it.

(Teresa Wilson): So when we send the information - on the date we send it - send that current information and don't worry about anything prior to then.

Man: Right.

(Pat Ambrose): Yes - with the accurate effective and end dates for their coverage.

(Teresa Wilcox): Right - but my point is - so if we had a change on our side where the effective date of coverage changed from 01/01/09 to 06/01/2009 - for whatever reason it changed. I would no longer have to send you the 01/01/09 to 05/31/....

(Pat Ambrose): That's true.

(Teresa Wilcox) ’09 data - okay.

(Pat Ambrose): That’s true.

(Teresa Wilcox): Okay - that’s good. That’s our question.

(Aaron Mercon): Okay - and so here’s the second question we have. It’s relating to COBRA. We’re wondering if individuals on COBRA are considered to be necessary to report? And if they are, are they active covered individuals or inactive covered individuals?

Man: I mean, the only time you would need to report a COBRA person is if they were entitled to SRD. And then in that case, they would be - they’re not working but there is an employment status indicator on the record lay out that allows you to tell us, you know, you’re reporting this person, not because he’s an active covered individual per se.

But under COBRA, the SRD coordination period into COBRA - into the COBRA (unintelligible) for that 30 months - that’s the only person we would expect you to report who has COBRA.

(Aaron Mercon): Okay - that’s the question - thank you.

Coordinator: The next question is from (Bob Brausberg) from (COBRA Permanente).

(Bob Brausberg): Yes, hi. My question is, on the response file that we receive back, if we get a disposition code of 01 for one of our records, does that mean that the record has been accepted as is or may be expect to find some SP error code on an 01 response?

Man: There will be no SP error codes on an 01 record.

(Bob Brausberg): Thank you.

Man: That indicates the stuff didn't process.

(Bob Brausberg): As is.

(Pat Ambrose): The 01 disposition code reflects the fact the COBC has accepted the record and created an MSP occurrence and for - and I'm referring to the MSP input file. So when you receive a response back with an 01, we've actually created an MSP occurrence meaning the GHP coverage during that period of time is primary to Medicare.

(Bob Brausberg): And you've created that coverage based on all of the exact information that we sent you.

(Pat Ambrose): Yes.

(Bob Brausberg): Thank you.

Coordinator: The next question is from (Bill McGuire) from American Community Mutual Insurance.

(Bill McGuire): Hello, I have three questions. The first one has to do with group policy number which is still Number 17 on the input file. We have a couple of different fields - we're not sure which one to use.

One of the group number - which identifies the group uniquely - one is a policy number which really is unique for the employee and their family members. I'm not sure which one of these we should be sending you.

Man: I mean, the Field 18, which is the individual policy number, that's generally the (unintelligible) specific information.

(Pat Ambrose): (Unintelligible).

Man: Yeah - so the group policy would be the - I can't remember what you said, but the first example.

(Bill McGuire): I'm sorry - I couldn't hear you.

(Pat Ambrose): Could you repeat what your options are for...?

(Bill McGuire): We have a - for a number - for Number 17 which is group policy number, we have a group number which is associated with the group - that uniquely identifies the group. And we also have a policy number which associates the employee and the family members on their policy.

(Pat Ambrose): Right. And we would expect you to put the group number in that Field 17.

(Bill McGuire): Okay.

(Pat Ambrose): And then the Field 18 would be policy number.

(Bill McGuire): Okay - that was my next question. So the policy number though - again - and for Number 18, it's not unique to the person, it's unique to the family. So is that what you want, the policy number?

(Pat Ambrose): Yes, that is what we're expecting.

(Bill McGuire): Okay, okay - and then one last question. Are we ever going to get information on a beneficiary that we have not sent to you? For example, if you get a - if COBC get a death date and we don't have it yet, would you be sending that to us unless we had already sent you - unless we had sent you a record with some other updates?

(Pat Ambrose): We do not return a date of death on the response file and we would not return any information to you on a - that's unsolicited, so to speak.

(Bill McGuire): Okay.

(Pat Ambrose): So, you know, we would only be sending you response records for the individuals that you submitted in your incoming file.

(Bill McGuire): That's what we thought - just wanted to make sure. Thank you.

Coordinator: Your next question is from (Jonathan) from Medcom.

(Jonathan): Yes - we have - we administer HRAs and also self-funded group health plans. And would we need to submit two separate files or would we need to submit one combined file.

Man: Self-funded group health plans and an HRA are both considered GHP under most circumstances. And I don't see any reason why we would want - we would ask you to mix - why we would ask you to separate out your GHP reporting.

(Pat Ambrose): I guess the basic question behind that is are you the responsible reporting entity...

Man: Right.

(Pat Ambrose): For each of these...

(Jonathan): Yes.

(Pat Ambrose): Groups that you're mentioning. If you are the RRE, then no, you don't need separate files. If they're included in your registration, you report them in the same file.

This is something I may actually like to add a comment - this is something that has come up a couple of times in the past. There is some flexibility in terms of your reporting. For example, let's suppose that you have two separate eligibility systems.

(Jonathan): Exactly.

(Pat Ambrose): You may, if you prefer, you may register twice and get two Section 111 responsible reporting IDs and send in two files and they'll be processed entirely independently and response files created entirely independently.

On the other hand, if it's more - if it's easier for you to combine those files, you would register once and send one combined choice.

Man: Your choice.

(Jonathan): Yes - that answers my questions. We do have two separate systems and it would be easier for us to do a separate file. So thank you very much.

Coordinator: Your next question is from (Julie Martinez) from the Writers Guild.

(Julie Martinez): Hi, this is (Julie) with the Writers Guild industry health plan. And we're a multi-employer trust and I wanted to find out if we had to report separate EIN numbers for each of the reporting - eligibility reporting?

(Pat Ambrose): Is this a Taft-Hartley...

(Julie Martinez): It is.

(Pat Ambrose): In that case, we have - and I'm updating the User Guide for this information. You may in the employer EIN, submit the plan sponsor EIN, the GHP EIN.

(Julie Martinez): Very good - that answers my question.

Coordinator: Your next question is from Elbert Tolson from Tucker Administrators.

Elbert Tolson: Yes, hello - thank you for taking my call. I'm kind of a late bloomer to this. My question has to do with the registration process. I believe it has to be done by January. So I'm trying to get some information on where do I go about finding - at least the registration process?

(Pat Ambrose): Are you a current voluntary data sharing partner?

Elbert Tolson: We're a third party administrator - a TPA.

(Pat Ambrose): No - okay, so that answers my question. You're not currently exchanging data with the COBC.

Elbert Tolson: No.

(Pat Ambrose): You will register beginning in April 2009 - April 1, 2009 on the COBC secure Web site. More information about the actual steps for that will be posted shortly. On the Overview page of the dedicated Section 111 Web site, which is www.cms.hhs.gov/mandatoryinsrep. On the Overview page, there is a download that discusses the registration process.

Elbert Tolson: Okay.

(Pat Ambrose): And maybe the confusion with the January date is you will need to report on your first file submission individuals who had coverage under your plan - active covered individuals who had coverage as of - that was open as of January 1, 2009. However, you won't start submitting your production file until July 1, 2009 or subsequent.

Elbert Tolson: Okay - now - okay, I'm confused. You gave me - I have July, April and then January.

(Pat Ambrose): Also, there's a timeline document out on that same Overview page that would be helpful.

Elbert Tolson: Okay.

(Pat Ambrose): So the dates that you need to remember are register April 1, 2009. And you will start testing after your registration is complete.

Elbert Tolson: Okay.

(Pat Ambrose): During registration, you will be assigned a production live data file submission time period. And that will be sometime subsequent to July 1, 2009. So you will start submitting production MSP input files sometime subsequent to July 1, 2009.

Elbert Tolson: Oh, okay - gotcha - that's good. All right, thank you, that answers my question.

(Pat Ambrose): Before you go, I heard you say you were new to this and you're a TPA.

Elbert Tolson: Well, we're a TPA and we've had one or two persons on each one of the conferences but I'm the manager and now I need to be involved. So I decided to be part of this one.

(Pat Ambrose): What I wanted to make sure is the industry uses the term TPA in a broader sense than we're using it for these reporting purposes. Make sure that you are a TPA as we defined in Attachment A to the supporting statement for the Paperwork Reduction Act package that was published on August 1, 2008 which essentially, you need to be - the claims processing TPA. If you're a TPA that performs administrative functions only, you are not a responsible reporting entity for GHP purposes.

Elbert Tolson: No, we pay claims.

(Pat Ambrose): Okay.

Elbert Tolson: That's the bread and butter of our business.

(Pat Ambrose): Okay - no, we've had some people that only do the administrative functions and I call and ask whether or not they're a responsible reporting entity.

Elbert Tolson: No, we pay claims. And then along with that then, we also administer and pay claims for Section 125 cafeteria. Does that date also have to be submitted?

Man: I don't think so - no. No, we'll get something on the Web site about that. But our initial response is probably not.

Elbert Tolson: Okay.

Man: We'll check.

Elbert Tolson: All right - thank you.

Coordinator: Our next question is from (Donnie Holmes) from Blue Cross and Blue Shield.

(Renita Ronson): Hi, this is actually (Renita Ronson) from Blue Cross Blue Shield of Alabama. And we have a question about a timeline for testing. When should we start testing you - I'm sorry - when should we start sending you a test file with all of our input records to your system? And how are we expecting to get a response, whether it process sign? Do we actually need to wait for your response file or do we get any communication from you?

Man: You can begin testing as soon as you're ready.

(Renita Ronson): Okay.

Man: Are you registered?

Man: When were you registered?

(Renita Ronson): We are registered. We are already reporting to you guys and we have posted - made our first file within the new guidelines in the beginning of January. So I just wanted to make sure that we have enough time that if we send you a file, that we do get a response and that way we make sure that what we send you is fine.

So I just wanted to know the timeline that you have set for testing for people - for companies already reporting to you.

(Pat Ambrose): You should receive a response file from your test file submission within about five days.

(Renita Ronson): Okay.

(Pat Ambrose): And I just want to make sure that you have filled out - if you're - you are current VDEA partner.

(Renita Ronson): Yes.

(Pat Ambrose): And you have filled out the paper registration form and submitted that to the COBC?

(Renita Ronson): Yes, we have.

(Pat Ambrose): Okay - great. And then please send your test file as soon as possible.

(Renita Ronson): Okay - thank you.

Man: (Unintelligible) identify the test file name.

(Pat Ambrose): Oh, yes. Your profile report should include the data set names that you should use for your testing file submission.

Man: Have you received that?

(Renita Ronson): Yes.

Man: Profile reports from the response to your registration.

(Renita Ronson): Yes.

Man: Okay.

(Pat Ambrose): And also makes sure that your authorized representative has signed that profile report and returned, I guess it's just the last page or...

Man: Yeah, the last page.

(Pat Ambrose): The last page of it to the COBC.

(Renita Ronson): Yeah - we're done on that.

(Pat Ambrose): Okay, great.

(Renita Ronson): Thank you.

Coordinator: Your next question is from Candi Opal from Trustmark.

Candi Opal: My question was already answered - thank you.

Coordinator: Your next question is from (Abraham Hasan) from Kaiser.

(Abraham Hasan): Hi - I'm working on the EDI department at Kaiser. And I have a project that we need to send and receive files from CMS. We already have current jobs that do that. I need to know how to contact your EDI department to get more information.

Man: 646-458-6740. Okay?

Man: Okay - next question.

Coordinator: Again, it's star 1 if there are any further questions. I'm not showing any further - just a second. Your next question is from (Sheila Nelson) from Anthem Blue Cross Blue Shield.

(Sheila Nelson): I have two questions. Currently, we are a VDEA agreer. We have two VDEA IDs and five plan IDs and we currently send five files. Do the two VDEA IDs equate to two reporting entity IDs and will we go from five files down to two or do we continue sending the five files?

Man: It's pretty much up to you in terms of how you want to do it.

(Sheila Nelson): Okay - because I didn't see anywhere on the file where we would put a plan ID.

(Pat Ambrose): No, there is no longer a plan ID. You need to submit your Section 111 files with the Section 111 reporter ID - sometimes referred to as the responsible reporting entity ID or RRE ID.

(Sheila Nelson): Okay, so if we want to continue with the five, then we need to apply for five different RRE IDs?

(Pat Ambrose): Yes.

(Sheila Nelson): Okay.

(Pat Ambrose): And if you're a current VDEA partner, you should have submitted a paper registration form and you'll have to submit it five different times to get the five different numbers and then continue with your, you know, that file transmission structure.

(Sheila Nelson): Okay - we already did file but we only had two VDEA IDs. So I'm thinking we only applied for two reporting entity IDs. But now we really need to come back and ask for three more, right?

(Pat Ambrose): I guess. I'm kind of confused between what you're referring to as the plan number and the VDEA number.

(Sheila Nelson): The VDEA number kind of said, like, what kind of business it was, whether it was - from what I understand of the description.

(Pat Ambrose): I think...

(Sheila Nelson): They were completely unique and the plan ID was more like a state, like our Missouri, or Wisconsin. It was more like, different.

(Pat Ambrose): What organization were you from again?

(Sheila Nelson): Anthem Blue Cross Blue Shield.

Man: Anthem (WellPoint)?

(Sheila Nelson): Yes.

Man: They have multiple VDEA numbers.

(Sheila Nelson): Right, we do have multiple but we have - currently we have two VDEAs and five plan IDs. And the file, we can break it down by plan ID. But that plan ID has been removed off the file.

Man: So you have two VDEA numbers but you report for five different plans under those two numbers.

(Sheila Nelson): Exactly.

Man: Right. So you could continue the same way or you could apply for separate RRE ID numbers for each one of those plans.

(Sheila Nelson): But how would we - on the file - how would we distinguish what plan the file was for? So if we only have two reporting IDs but we still have five plan IDs, how do we flag on those files which...

Man: Well isn't it through, like, the group health plan number on the individual record?

(Sheila Nelson): No. Our group IDs is something completely different.

(Pat Ambrose): (Unintelligible) their EDIs...

Man: Yeah.

Man: Yeah.

Man: Okay.

(Pat Ambrose): How about you have an assigned EDI rep from your original registration, correct?

(Sheila Nelson): Yeah, I'm sure.

(Pat Ambrose): I think maybe you ought to give them a call and talk through this and Bill Ford's here, the manager of the COBC EDI department is here and he'll make sure he follows up with you to, you know, to get your registration completed properly.

(Sheila Nelson): Okay - and I have just one other question please.

(Pat Ambrose): Sure.

(Sheila Nelson): If we send in an individual as an add record, is that interchangeable with the change record? So if you already have them on the system, you would just update any information?

(Pat Ambrose): Yes.

(Sheila Nelson): Okay. So on our first file, could we send all of our people just to make sure that the response file that we get back, we're in complete sync with you?

Man: I mean, there is new information on the Section 111 file. But, you know, you can do that.

(Pat Ambrose): Yes.

(Sheila Nelson): Just for the first - just for the original file.

(Pat Ambrose): You need to adhere to the definition of an active covered individual...

(Sheila Nelson): Got it - yes - got it - right.

(Pat Ambrose): And you may resubmit all of those records. However, as it - the COBC is already set up and the key occurrences for people you have submitted as a VDEA partner in the past, you do not need to send an update for them. But if you do send them as an add, it will process as an update and you'll receive a response back.

(Sheila Nelson): Okay - thank you.

Man: Can I get your last - your name?

(Sheila Nelson): (Sheila Nelson).

Man: Okay - thank you.

Coordinator: Your next question is from (Kay (unintelligible)) from Nationwide.

(Kay): Good afternoon. We want to follow up with the eligibility versus the claims that the TPA handles. So you all really want eligibility files, you want to know who all we are ensuring, not necessarily who we've had claims for?

(Pat Ambrose): That's correct - for GHP. Now being Nationwide, you most likely are going to be reporting under the non-GHP or the worker's comp no fault liability reporting for Section 111.

(Kay): We're going to be doing both.

(Pat Ambrose): Right - and now I need to make sure that you understand that you must register separately.

(Kay): Okay - yes, we do.

(Pat Ambrose): And send these files completely separate from each other.

(Kay): Okay.

(Pat Ambrose): And for GHP, we are looking for eligibility information, enrollment information in the GHPs. And so we do not want you sending claims but rather sending coverage information.

(Kay): Okay.

(Pat Ambrose): Information about covered individuals.

(Kay): Okay. And then what you're saying is for the non-GHP, we don't have anyone to send until we get a claim.

(Pat Ambrose): Yes.

(Kay): Okay - you understand that - okay.

Man: And for non-GHP again, you're not sending us information on claims that are simply pending. It's when you had a settlement, judgment, award or other (unintelligible) which means you either resolve or partially resolve the matter or for example, typically for worker's compensation or no fault you may have assumed ongoing responsibility - either until a cap is met on med pay for no fault or for worker's compensation, you may have ongoing responsibility for medical. Those get reported.

(Kay): Yes - yeah, we know that. You guys here...

Woman: We - yeah - we do have a question along the lines of, we have two (unintelligible) that administer of business and unpaid claims. But we have one TP that does the eligibility side that gets sent over to a different TPA that pays the claims. Who should the file come from?

(Pat Ambrose): Responsible reporting entity is the claims player. If you want to use - if this is all within your same company, we don't really care who submits the file on behalf of the company. If the claims paying TPA is outside your company and in - I'm sorry - if the administrative TPA that you're talking about is in a separate company than the claims paying TPA, then they may want to use them as an agent. But the responsible reporting entity is the claim paying TPA.

Woman: Thank you.

Woman: Okay.

Woman: And then I have another question. We've been trying to call a telephone number 800. The first time we got through, they took a message and said

someone would call us back. No one did and we tried to call that number again and it doesn't seem to be - it rings and then goes busy. So is there another phone number we can call with not-technical questions so much?

Man: That is Section 111 related?

Woman: Yes.

Man: That's 646-458-6740.

Woman: Okay - so not the 800 number that's in the User Guide.

Man: No, we have - we're actually experiencing a problem with the 800 number right now. We're trying to correct that.

Woman: Okay.

Woman: Okay - thank you.

Woman: And I have another question about, you want individuals 45 years and over. What about the other dependents? You don't want the children and all that? You just want if it happens to be a husband and a wife?

(Pat Ambrose): You need to look at that definition for active covered individuals.

Woman: Okay.

(Pat Ambrose): You have a dependent who is 45 and older - yes, we want them reported. However, if the dependent is less than 45 and you do not know of them being

a Medicare beneficiary already, you are - they are not a - classified as a covered individual and do not need to be reported.

Woman: Okay.

(Pat Ambrose): And you could have a case where the subscriber does not get reported because he or she is less than 45 but their spouse, who is covered, is over 45 and you would submit a record for the spouse.

Woman: Okay - or even if that spouse is 25 and on Medicare for disabilities.

(Pat Ambrose): Then you would send them because they would fit that definition of active covered individual.

Woman: Great - thank you very much.

Coordinator: Your next question is from (Brenda Wright) from NBA.

(Brenda Wright): I just need a little bit of clarification here. We are a TPA paying claims. The January 1, 2009 deadline for the initial submission. Just how are we to submit that information if we have not registered and do not register until April. We will not have the information required for the headers much less the log in information.

(Pat Ambrose): You do not start reporting until after July 1, 2009. But in that first report, you need to go through your files in a historical fashion and look at who had coverage that was open as of January 1, 2009 and report their information.

(Brenda Wright): Okay - thank you for that clarification. One more clarification please - if it is just strictly an HRA, are we to report the individuals for that?

(Pat Ambrose): Yes.

(Brenda Wright): For all HRAs.

(Pat Ambrose): Stand alone HRAs.

Man: If the HRA is part of or offered as part of a group health plan arrangement and you - it fits the same rules as any other group health plan arrangement for reporting purposes.

(Brenda Wright): Yes, I understand that. But if they are not associated with a medical plan, they are a stand-alone HRA...

Man: What are they for if they are a health reimbursement account but they're not for medical?

(Brenda Wright): They're not associated with the medical group. They're just the - there is another medical company representing them. They're a medical plan but we hold an HRA in which we process those claims that they submit the EOBs from the other medical.

Bill Decker: I would recommend that you check the IRS definition of HRA to be sure that that's what we use the - for our definition. And if the HRAs that you're servicing meet the IRS definition for an HRA, then you're probably going to have to do business with us. If they aren't - they don't, they have to have some sort of medical connection for one thing.

And if they don't, then you may not have to do - not have to interact with us. It would be best I think to double-check the status of the HRA as you're

talking about. And then if you still had questions or issues, you can get back to me. My name is Bill Decker and I have an email address that's I'm sure you can use to send me any further questions you have on this.

John Albert: Actually - this is John Albert - I would send them through the resource mailbox that hopefully you've seen on the insured reporting Web page. That way we make sure everyone here gets that question. Yeah, that would be a better idea - yeah.

(Brenda Wright): Okay - thank you.

John Albert: Thank you.

Coordinator: Your next question is from (Melissa (unintelligible)) from United Healthcare.

(Melissa): Hi - I needed some clarification. If we have a self-funded customer who wishes to opt out of the data exchange and submit the data directly on their own to Medicare or through their TPA, can they do so? And this is with the understanding that we, as United Healthcare, are their claim payer.

Woman: You are - from your description - if you're the claims processing TPA or the insurer who's processing claims and you're the responsible reporting entity, you have the responsibility for doing the Section 111 reporting. If they want to enter into a separate VDEA for some reason, they can do so but it doesn't eliminate your responsibility. And our RRE cannot, by contract or otherwise, eliminate their reporting responsibility.

(Melissa): So, I guess that puts us in a quandary because if the customer says, I do not want you sharing my eligibility with Medicare, I'll handle it on my own...

Woman: They don't have that choice.

(Melissa): Okay - all right. I have to say, I presented this question in writing via the email twice and I've never received a response.

Woman: Well, in terms of the email, we have hundreds of questions in the mailbox and we keep constantly trying to update them and group them and answer as many as we can in revised versions of the documents we put out. We cannot answer individual question to specific individuals or we would have no way of making sure that everyone was receiving the same information.

(Melissa): Is the qualification that a self-funded customer cannot preclude us from sharing their eligibility, us as the RRE - is that available in writing somewhere?

Woman: I don't know that we've put it in writing at this point. But among other things, beneficiaries by virtue of having claims submitted on their behalf have agreed that anyone can release information about them to CMF for purposes of coordination of benefits. And that's specifically in one of our regulations for 42CFR411.24.

(Melissa): Okay - thank you.

Coordinator: Your next question is from (Christa Lasowskis) from Cigna.

(Christa Lasowskis): Hi - thank you. My first question is in regards to the TIN file. It says that we don't have to submit a new TIN file every time unless there's changes. But would it be okay if we did send the full TIN file each time?

(Pat Ambrose): Yes.

(Christa Lasowskis): Okay - thanks.

Coordinator: Our next question is from (Bob Wellstead) of Kaiser Permanente.

(Bob Wellstead): Yes, could you give us some guidance as to how long we should retain the response files we get back from you? Is it like the standard ten years or less?

(Pat Ambrose): You need to make your own decision what you're going to do for business purposes. We mentioned ten years in the TRA only as an alert that businesses should take into account that there are other statutes out there that might effect how long you wish to keep records. Section 111 itself has no specific record retention requirements.

(Bob Wellstead): Okay, thank you - that answers that question. And one final question - when can we expect the updated User Guide to be available on the Web site?

Woman: Yeah, I think early next week sometime we should have that posted out there.

Man: That's the GHP User Guide.

Woman: The GHP - yes.

(Bob Wellstead): The GHP - yes. Okay, thank you.

Coordinator: The next question is from (Maureen McGee) from Blue Cross Blue Shield.

(Maureen McGee): Hi - I just need some clarification on the collection of social security numbers for dependents. Am I correct in my statement that for any existing

group that we have on board right now, the dependents that don't have social security numbers, we have until January 1, 2010 to collect that, correct?

Man: Yes.

(Maureen McGee): For groups that come on board with an effective date of 01/01/09, all the social security numbers must be there, correct?

Man: Yes.

(Maureen McGee): Okay - because what I thought I heard was dependents would not have to be reported until 2010.

Woman: That's my fault - I misspoke earlier.

(Maureen McGee): Okay - no, I feel better now that I understand it. Thank you so much.

Woman: And I'd like to just refer everyone to what is in the currently published GHP User Guide on that topic of dependent SSNs. That's the correct language and I do believe I misspoke earlier in this call.

(Maureen McGee): Thank you.

Coordinator: Our next question is from (Mary Beth Palmer) from (HealthSouth).

(Mary Beth Palmer): Hi - we are a Blue's plan and we are a current VDEA partner. We did file our registration on the 31st of October and we still have not received the profile report back. Is that to be expected?

Man: No, that's not to be expected. When I get back to the office, I will look for it.

(Mary Beth Palmer): Okay - and because we have not received that back in addition to a couple of additional questions we're waiting for responses on, we're very concerned about the timeline. And I don't know if that's being revisited at all at this point.

Man: Timeline in relation to anything in particular?

(Mary Beth Palmer): We're very concerned about meeting the 01/01/09 deadline in getting our file over to you.

Man: You don't really have a 01/01/09 deadline right now. Once we process your registration form and we give you a profile report, you'll be assigned a production date.

(Mary Beth Palmer): Okay.

Man: 01/01/09...

(Mary Beth Palmer): And will you work with us if we're having difficulty meeting that production date?

Man: Yes.

(Mary Beth Palmer): Okay. My next question is - and I'm not sure this is a question for you to answer or the Blue Cross Blue Shield Association. We do process claims for SEP and for NASCO which is the auto companies. Do you know if the individual Blue's plans are supposed to report the eligibility for them or if they will be coming from one central location?

Woman: I'm sorry - you're going to have to repeat your question. We were...

(Mary Beth Palmer): Okay - we process claims for FEP which is the federal employee...

Woman: Yes.

(Mary Beth Palmer): And we also do it for NASCO which are your auto workers. Okay, the NASCO eligibility is handled out of Michigan. The FEP eligibility is actually housed in Washington. However, we have access to the eligibility for the members we actually service. So my question was whether or not the individual Blue's plan would not be responsible for reporting the FEP and NASCO eligibility. Of course, that would be done out of the Michigan area and the Washington area. And again, I don't know if it's you that should answer this or if that needs to be directed to the Association.

Man: Speak to the FEP plan and we can't speak for the auto workers.

(Mary Beth Palmer): Okay.

Man: We don't have any - much control over that (unintelligible).

(Mary Beth Palmer): Okay - I didn't know - I know you had been in discussions with the Blue Cross Blue Shield Association. I thought perhaps maybe that came up.

Woman: But you said you're the claims processor, not the Blue's plan itself, right?

Man: No, they...

(Mary Beth Palmer): The FEP claims are actually processed in the area where services are rendered. But the eligibility itself is housed down in Washington.

Man: The FEHB plans, you mean. That's for the (unintelligible) plan - the Blue's plans operating inside the Federal Health Benefits Program?

(Mary Beth Palmer): Yes.

Man: Okay. I would ask you to look for information about that in the User Guide. We are working out the arrangements now to handle the FEHB reporting. And I don't think it's been finalized yet.

(Mary Beth Palmer): Okay, because I haven't seen anything in regards to that and we have directed questions but we haven't received any responses. And what I'm concerned about is design. If we send a file over to you folks, I assume the response - like, if we send one big file, I assume the response file is going to be one big file coming back. And if we do need to do the reporting for FEP and for the auto workers, we're going to need to break that out. So that's going to change our plan design - our program design.

Man: Yeah.

(Mary Beth Palmer): Which will effect the timeline.

Man: Right.

Coordinator: Are you ready for the next question? The next question is from (Mandy Gribbin) from Premera Blue Cross.

(Michelle Zimmer): Hello, this is actually (Michelle Zimmer) from Premera Blue Cross. You mentioned earlier that if we submit - continue to submit pseudo-TINs, we will receive an error on the MSP response for the invalid TINs. Currently our

pseudo-TINs are unique and when this changes, we may have multiple records on the TIN file with the same TIN number. Would those MSP records then be rejected with an error of invalid TIN or would the TIN file be rejected? Would there be an issue?

Man: No, I mean, it's, I mean, that's the way it works now. You can have multiple records for one - with one TIN number. I mean...

Woman: First of all, let me point out that it's not actually an error but a compliance flag. And then when you resubmit - when you - so your currently sending in these records - or you will be sending these records with a pseudo-TIN. When you obtain the correct TIN, you'll resubmit your TIN reference file with the - that new corrected TIN and associated employer name and address information.

And then each record that had been sent previously with a - with that pseudo-TIN that you have now replaced with a valid TIN, can be resent and associated with that valid TIN. And if you are using one pseudo-TIN for multiple employer TINs that you have not yet obtained, then you most likely would then be updating your TIN reference file with some multiple employer TINs and then putting those correct employer TINs on each of your MSP input records and sending those as updates to the corrected TIN on each of them - which ever employer TIN is associated with that individual.

(Michelle Zimmer): Okay.

Man: (Unintelligible) interim your files (unintelligible) with pseudo-TINs are not going to be rejected. It's just being notified that we know that it's not a real TIN and that you'll have to eventually send us a real TIN.

(Michelle Zimmer): The records will be saved - that's what you guys said - okay. Because currently our pseudo-TINs are unique. And in the future one MSP record on the input file, the Field 21 or Field 22, may relate to multiple records on the TIN reference file. And currently it does not now so we wanted to know if that was an issue.

Woman: I'm kind of confused about that. I mean, there still is going to be a 1 to 1 relationship. So you get the corrected employer TIN, you're submitting that on the TIN reference file - so let's say it's Number 1. And then you'll resubmit your MSP input record with a Number 1 in the employer TIN field.

Now the insured TIN is the other - I'm not sure I really understand your concern.

Man: Are you saying right now that if you had 10 beneficiaries and they all had the same employer that you would submit 10 different pseudo-TINs?

(Michelle Zimmer): No.

Man: Submit one pseudo-TIN for those ten employees because the pseudo-TIN linked to the one particular employer, correct?

(Michelle Zimmer): Correct.

Man: All right - okay. So when you - if you do that under Section 111 reporting, you'll get a compliance flag back saying it's a pseudo-TIN and we know it is and we're still going to process the record, we'll be able to chug along just like everybody else does. And eventually, you'll know that we know that we are expecting you to supply a real TIN for that employer.

(Michelle Zimmer): Okay. We just needed to make sure that the TIN was not supposed to be a unique key for the TIN reference file.

Man: (Unintelligible) - sure.

Man: The TIN is for the employer insured.

Man: Well what do you mean by, you were checking to be sure that it has to be unique or it doesn't have to be unique to the TIN reference file?

(Michelle Zimmer): Right now, one TIN number may have a couple different employer names and addresses related to it.

Man: That's not going to - that current won't allow that to process, right?

Man: No (unintelligible).

Woman: Yeah, if you're sending in - the TINs on the TIN reference file must be unique. And if you're sending in multiple records with the same TIN on the TIN reference file, the system is just taking the last one in process and it's not saving the multiple information. And so it's really just saving the last record on the file for that particular TIN.

That TIN on the TIN reference file is unique - must be unique. It's a key essentially to the file.

(Michelle Zimmer): Okay.

Woman: Okay.

(Michelle Zimmer): Thank you, that answers the question perfectly. That's what we were looking for. So the record will be saved on the - from the MSP but will get a slide back that has the invalid TIN if there are multiple TINs that refer to the...

Man: And you're currently sending three identical pseudo-TINs with three different addresses. We're only going to be picking up that third address right now. So you need to make sure - look at your current process even before you go to Section 111 because what you're telling me is that we may have a lot of incorrect addresses on our system, right?

(Michelle Zimmer): No, our current process is unique. The pseudo-TIN we have is unique in our system.

Man: Okay.

Man: Sending three addresses on the same is not going to work.

Man: Right.

Woman: Yeah - and that's - I think somebody here has understood what you're saying. So if you send us - if you plan to send us three different addresses for one TIN on that TIN reference file, we're only going to keep the last one.

Man: Last address.

Woman: Yeah. You know, that's the TINs that you're sending on the TIN reference file must be unique.

(Michelle Zimmer): Okay. Information - yeah - that's very important for us to ensure that we have all data cleanup when we switch to the new TIN. So thank you.

Woman: Okay.

Coordinator: The next question is from Elbert Tolson from Tucker Administrators.

Elbert Tolson: Yes - I'm back - thank you. The dependent social security number - I guess I have two questions here. Well no - one. What happens if a group participant in that group refuses to give us the dependent social security number?

Man: Well I guess the first answer is you obviously can't report that individual. But as Barbara Wright was explaining earlier, that person, if they are a beneficiary is obligated to give us, you know, give you that information to provide to CMS.

Man: You remember that you can always - you need to ask for either the Medicare ID number - what we call the health insurance claim number - for the social security number.

Elbert Tolson: Well in our case...

Man: Now a Medicare beneficiary has to tell you their Medicare ID number if you ask for it.

Elbert Tolson: Okay.

Man: Okay - that's a requirement. If you don't have a Medicare ID number and believe that the individual may be a beneficiary in any case, we need to have that individual social security number. You can't get the social security number if the individual won't give it to you and the individual is in fact a

Medicare beneficiary. You're not going to be reporting a beneficiary to us that you are obliged to report to us. That's the way that plays out.

Elbert Tolson: Okay.

Man: We can't process anything that comes in that doesn't have either a HICN or a social security number.

Man: And we are in the process of developing materials that you can use to facilitate the collection of that information, such as information on CMS letterhead, etcetera. We recognize the difficulty but the long and the short of it though is that if you do not report that individual to us and you are under the law required to do so, that's a compliance issue.

Elbert Tolson: Do you know when this letter will be available to us?

Woman: There already is one document available on the Web site. It should be on the Overview page. If you don't see it there, check the GHP page as well. But I believe the document was actually dated as far back as June. But it's an alert about the collection of SSNs and TINs. And it explains why CMS is collecting this information and why people may have their insurer come and ask them for this information, that it is appropriate in the context of Section 111 and that it is on CMS letterhead. And at the very end of this document, which is just one page, it says if they want to confirm that this document is an official government issuance it lets them go to our Web site and find it.

And several insurers have said that they find this very helpful in going out and explaining why they're getting the social security numbers.

Elbert Tolson: Now can we take that letter, send it to our groups without penalty of plagiarizing and use it as...

Woman: It is specifically on the Web site for you to distribute as you see fit.

Elbert Tolson: Wonderful.

Woman: And you may not alter it. But you know, you may use the document.

Man: As is.

Elbert Tolson: Okay - wonderful. Then my other question is, social security numbers, to my knowledge, are now administered by hospitals for infants that are born. If the infant becomes a dependent in terms of that participant wanting to put them on their plan we still have to supply the social for that infant?

Woman: Typically you're not going to be reporting a child that's under 45 unless you have reason to believe that they're a Medicare beneficiary so that they could fall into one of the active covered individual situations. Normally, the main situation that would pertain to infants is possible the SRD coverage where they could then be a Medicare beneficiary. So typically you're not going to be reporting infants.

Elbert Tolson: Okay - then help me here - this brings another question. None of the participants in any of our groups or customers are under Medicare.

Woman: How do you know that?

Elbert Tolson: How do we know that?

Woman: These are group health plans?

Elbert Tolson: That's a good question for me to find out. But let's explore that just a little further. Suppose we had none. In other words, we pay no claims for any individual that's under a Medicare plan.

Man: Then you have nothing to report to us.

Woman: And if you've registered, you would be sending no file, right?

Elbert Tolson: Well we still have to register though.

Woman: It's kind of hard for us to believe that you would be insuring in any major way a situation where the insurer - the group health plan insurer - would have absolutely no Medicare beneficiaries involved.

Elbert Tolson: Well that's what I was - that's why I'm involved in this now as a late bloomer because that's what I was told. But I'm going to explore it further and make sure. Now with that being the case, if we have probably one group, then the file that we send would only have one group's information. We would not send all of our groups, right?

Man: You're a GHP reporter and you're reporting as a responsible reporting entity. And I would recommend and I think we would all say to you, you should be reporting on all the groups you have.

Elbert Tolson: Okay.

Man: That's what the requirement is. You may be surprised on your return files to find that there are in fact Medicare beneficiaries covered by these groups that

the groups themselves may not even know about. That is very typical of what happens when people start to query our database.

Elbert Tolson: Oh, okay - so that can help us act as an audit because when we get the return file we will know more than what we did when we sent the file.

Man: That's right.

Elbert Tolson: Wonderful. Okay - that's all I have. Thank you.

Coordinator: Your next question is from (Jeff Coonehand) from (EPIC Health).

(Jeff Coonehand): Hi there -a couple questions. On the MSP response file, Fields 3 and 4 - it says that you'll send back corrected name and corrected first initial periods of what we should do with that because we can't - because it's a truncated last name, we can't just put that into our system. So what should we do? Would we typically go back to you and get the full name?

Woman: No, we're not able to supply that. So you're probably right, that it's not pertinent. It's more just informational. So...

(Jeff Coonehand): Okay.

Woman: See what Medicare uses to match that individual to our files as a beneficiary.

(Jeff Coonehand): Okay. Let's see - the other - you answered the question on COBRA before but we couldn't hear you. Could you go over that again?

Woman: I believe that we said generally speaking, someone covered under a COBRA plan is not considered an active covered individual because they do not have

coverage based on current active employment. However, if they have end stage renal disease - ESRD - ESRD is not dependent on active coverage. And so - on active employment. So if that individual who is covered in a COBRA plan is known to have end stage renal disease, they should be reported and you would use the employee status bill would be a 2 for inactive.

Otherwise, someone covered under a COBRA plan should not be reported on your MSP input file. They're not covered based on active employment.

(Jeff Coonehand): All right - and last question - on the test files - I think that they read that should only have 100 records - is that right?

Woman: We are asking that you limit them to 100 records - yes.

(Jeff Coonehand): Okay - and then as far as the process, you have to send the file back that has valid beneficiaries on it so we have to make sure really on our test file that we - I mean, we should send some people to you that are over 65? Is that - does that sound like...

Woman: That would probably be a good idea. And we should note that you may continue testing. We will be implementing testing requirements in April that say that you must successfully process 25 add records and so many updates and deletes, etcetera. However, once you - and so - and that will be enough to satisfy CMS's requirements for testing.

However, you may continue to send test files to test other conditions until you feel comfortable with your situation.

(Jeff Coonehand): Okay - all right, that's all I had - thank you.

Man: I mean - can I just add one thing for clarity here and the other people here I know will tell me if I'm wrong. The test files that you send and that we return to you are about - include information about real people. But they're not what we would call live files. And they're not going to be processed by us for posting or in any way shape or form enter our own data system.

So anyone who wants to send test files with folks who they know, for example, are absolutely sure they're Medicare beneficiaries to see what we - what they get back as a test do so won't effect anything that we already have on our own databases.

Coordinator: Are you ready for the next question?

Man: Yes.

Coordinator: The next question is from (Susan Shepherd) from Excellus Health Plan.

(Susan Shepherd): All right - thank you. I need a little further clarification on the TIN reference file for basic reporting option. Is this a required file or is it optional?

Woman: TIN reference file is required.

(Susan Shepherd): Okay - because in Section 521, the first paragraph, that's not stated.

Woman: Okay - I'll make sure we make that update.

(Susan Shepherd): Okay, so it would need to be included on the form that you fill in - the registration form?

Woman: No, the TIN reference file is an electronic file that is transmitted with your MSP input file. It has the same record length; it is a separate file with its own header and trailer. However, it is transmitted basically the same destination as the MSP input file.

(Susan Shepherd): Okay. So the registration form would be covered when you enter the MSP input file.

Woman: Registration is an entirely separate process. The VDSA and the VDEA partners have already registered via using a paper form.

(Susan Shepherd): Right.

Woman: The regular GHPs will register by completing information on the COBC secure Web site using an interactive Web application. And during that registration process, you will be submitting a tax ID number for your responsible reporting entity organization. That's not the same necessarily as the TIN that you might submit on your TIN reference file.

The TIN reference file is insurer or TTA TINs and employer TINs that are associated with the records that you're submitting on your TIN reference file with those individuals. And in the case of the insurer TPA TIN, it might be the same one that you used for registration or it might include that and others since you might have multiple TINs that you might use for different processing - claims processing offices or something of that nature.

(Susan Shepherd): Okay - thank you.

Woman: Operator, is there another question?

Coordinator: One moment please. (Ray Amos), your line is open for questions. Please state your company.

(Ray Amos): Thank you. I have a couple of questions. I wanted to find out on the TIN file, you stated it had to be sent completely every time. Is there a reason why it's sent completely versus just changes or updates like the MSP file?

Man: It doesn't have to be sent completely every time. You can send just the changes that have occurred on the file. It can work either way. If you want to send the complete TIN file, that's fine. If it's a portion, that's fine also. Just as long as every record on the MSP input file, there's a TIN number there and we have a match that has been sent currently or previously on your TIN reference file. (Unintelligible).

(Ray Amos): Okay - I've got another question for you. When we've - we sent our MSP file and you sent a response back and (unintelligible) a correction. And you've provided the DCN number. We send you a DCN number, you send us one back. When we send it next quarter, this record's been fixed. Do you - are we - do we need to send either one of those DCN numbers back or can - will there be a new one?

Woman: No, you can develop a new one. The DCNs are just for within that particular file to be - to aid in matching records going back and forth. So you do not - we will send - you will send us a DCN, you will send COBC a DCN. On the response file , they will send you your DCN and I think there's also one that says the COBC has generated for their own purposes.

(Ray Amos): That's correct - yeah, I saw that. That's why I was wondering if we - on the corrected record if we had to supply COBC's DCN back.

Woman: No, it's really just used in case there are questions that you're working through with your EDI rep and you know, if there - if either party is looking at the file, you know, they might be looking at a particular DCN to help them in solving a problem.

(Ray Amos): Okay - my last question I've got is when we send - I noticed that in the alpha fields, that if we send, like, names and stuff in lowercase, you're going to be returning everything in uppercase. Is that going to cause us a problem if we continue sending it in upper and lower case?

Woman: No.

(Ray Amos): Okay - thank you.

Woman: I mean, we basically take all lower case and convert it to upper case. So it doesn't matter.

(Ray Amos): But you're not going to flag them as errors or problems, correct?

Woman: No.

(Ray Amos): Okay - thank you - that was all my questions.

Coordinator: Next question is from (Lisa Sabatelli) from Cigna.

(Lisa Sabatelli): Thank you - the woman that asked the clarification with regard to dependent socials effective 01/01/09 actually got that clarity for me so thank you.

Woman: Next question.

Coordinator: Our next question is from (Brian Fellow) from Northwest Administrators.

(Brian Fellow): Hi - thank you for taking my call. I have a follow up to the Taft-Hartley tax ID number on the employers. You had earlier mentioned that we could supply the tax ID number for the plan. What about the employer size information? Can we also supply the number of covered individuals in the plan or do we still need to do the individual employer info?

Man: Yeah - employer.

Man: The employer...

Woman: The employer side should reflect the individual employer.

(Brian Fellow): Okay, the number of individual - okay, the individual employer. And again, is that the number of employees covered by the plan or just the number of employees in general?

Woman: Employees. If it's a multi-employer plan, you're looking at whether or not any employer in that plan has (unintelligible). Not just whether or not the particular employer has (unintelligible) size.

(Brian Fellow): Okay, so I guess a follow up to that - so if one employer has over 100 - and I think that's the threshold - well, I guess there's a few different graduated thresholds but let's just assume everyone has over 100 - or excuse me - at least one has over 100. Then do we then on each sort of record for each active covered individual, we would put the, you know, the indicator of employer size - they would essentially all be the same because there's one employer over 100?

Man: Yes.

(Brian Fellow): Okay -excellent.

Man: And we tried to explain - put that in the description on the record layout, you know, to quantify that, you know, if it's part of a multi-employer plan, you're really looking at the largest employer.

(Brian Fellow): Right.

Man: Multi-employer plan.

(Brian Fellow): Right.

Woman: Wee are applying updates to the User Guide related to these types of questions specifically for the Taft-Hartley multi-employer plans. So look for an update in the User Guide next week on that.

(Brian Fellows): Great - thank you very much.

Coordinator: Your next question is from (Larisa Thurman) from (Shaft Administrative Services).

(Larisa Thurman): Hi - my question has more to do with the active covered individual definition. And we have a plan that we administer benefits for - a self-funded group - and they're a tribe. And not all of them are actually employees. Some are just tribal members who don't work. Would they fall under that active individual cap and would we have to report on them?

Man: No.

(Larisa Thurman): Okay - thank you.

Coordinator: Your next question is from Elizabeth Wilson from Health Plans Incorporated.

(Elizabeth Wilson): Hi - thank you. We wanted to confirm our understanding that as a TPA, we'll register and we'll one RRE number and than all the 200 or so plans that we submitted information for then would be identified through their TINS - is that right?

Woman: Yes.

Elizabeth Wilson: Okay - good. And then we had another question.

Man: How do we handle - say, on January 1, 2009 a particular individual has coverage so we send you this record. And then they terminate prior to the end of January. So we send you a record at the end of the first quarter that says they've terminated. And then in September, they come back on the plan again. What do we send you for the eligibility effective and term dates?

Woman: You would send us an Add record in the next file submission, that current file submission with that September effective date and most likely an open-ended termination date.

Man: I would then send you a delete record, right?

Woman: No delete. We want to keep that information that they were covered in January. We may have posted an MSP occurrence for that. It may effect claims for dates of service within that time period. So that information should stay since that coverage was actually open during that time period. And then

you would send an add record - add transaction for the coverage that started in September and essentially maintain that ongoing as a separate occurrence.

Man: Every coverage that closes out, you would send an update transaction that would include term date. And then if they reenrolled or whatever they were changing plans, you would send another add record. You never want to use the delete transaction except in cases where you sent erroneous information to CMS.

Man: Yeah, that's what I thought - okay.

Man: What if it happens in the quarter itself? If we have somebody who is term in the quarter and comes back on the quarter with the last in coverage?

Man: Two records.

Woman: Two records.

Man: Two records - okay. So we can have multiple records for every individual?

Woman: Yes.

Man: Okay.

Woman: For start and end dates - yes.

Woman: Thank you.

Man: Bye-bye.

Coordinator: The next question is from (Cathy O'Neal) from (Health Cooperative).

(Vicky Stein): Hi, this is actually (Vicky Stein) at (Group Health). And my question is actually about the file transfer protocol. Is that appropriate to ask about today?

Woman: Absolutely.

(Vicky Stein): Okay - I read in here and would like to confirm that if we already have FTP software that will support the SSH protocol, we can use that?

Woman: Yes.

(Vicky Stein): Okay - because we like to script it. And the second thing I would like to confirm is in the data exchange preparation procedures book, it lists the URL that we will be using and it lists a port of 10022 and SSH is typically just Port 22. Is that a typo or is that a unique port that we will need to use?

Woman: What was the document that you're looking at?

(Vicky Stein): It's the data exchange preparation procedures underscore 004 from July 20...

Woman: Are you a - you're going to be registering in April and setting up your file transmission in April?

(Vicky Stein): Yes - should that be something I ask at registration time.

Woman: Yeah - you'll be given different information. You will not use that document starting in April. What's happening is for our voluntary data submitters, we had set up secure FTP through a facility at the CMS data center.

(Vicky Stein): Okay. And the other data center will be ready by April, is that what you're saying?

Woman: Yeah.

(Vicky Stein): Oh, good. Okay - well then I will ask my questions in April.

Woman: Okay.

(Vicky Stein): Thank you very much.

Coordinator: Are you ready for the next question?

Man: Yep.

Coordinator: The next question is from (Sonya Barerra) from (Anbed Hart Health Plans).

(Sonya Barerra): Hi - good afternoon - thank you. Most of my questions have been answered but I just want to summarize to see if I got the right idea. In a prior statement, you said do not send the regular social security if your HIC number is not available. Then I am to conclude that when this information is complete in our files, it's when we're going to send the record for the first time with a transaction type of zero or an add and this should contain only the last plan or coverage information for this member.

And that from there on it will always be a number 2 for change, even when a member is being terminated?

Woman: That's almost true. The information that you send - once you change the social security number for this individual, you need to go back and look at what coverage was open as of 01/01/09 and subsequent.

(Sonya Barerra): Okay.

Woman: And send in records reflecting that. So if they were covered as we discussed in an earlier question, they were covered for only a couple of months then their coverage ended or they were no longer an active covered individual. There might be a start and termination date and then a second record. But lets suppose that they had continuous coverage. You need to go back to 01/01/09 and send us the actual effective date of the coverage, even if it was prior to 01/01/09. As long as it was open then and send it a record.

We were talking about policy and group number and fields like that, is it acceptable to send the most recent information for that once (unintelligible).

Man: Additionally, if you know someone was not a Medicare beneficiary up until a certain date, you don't need to send us the coverage until that date. So that was one of the examples of someone didn't become the beneficiary for two or three years. We don't need to know about the coverage prior to that entitlement date if you know what their entitlement date is.

(Sonya Barerra): Okay - but suppose that from January 1, 2009, the member was active for a certain period of time and he had (unintelligible) coverage and then he changed in the middle of the year. And we would be sending one record with an add and then for that some individual, a record with a change for the second period.

Woman: I think if I'm understanding your question correctly, you would send two add records.

(Sonya Barerra): Two adds - okay.

Woman: Yeah - with the - with different starting - different effective and end dates.

(Sonya Barerra): All right - thank you.

Coordinator: The next question is from (Sheila Nelson) from Anthem Blue Cross Blue Shield.

(Sheila Nelson): I had a question on small group exception. I was just wondering if it's - when a group is approved for an exception, is it that entire group or is it per member. Do they have to apply per member?

Woman: I assume that you're talking about the small employer exceptions?

(Sheila Nelson): Yes.

Woman: Not a small group exception?

(Sheila Nelson): Yes.

Woman: We have information, both on the dedicated Web site and I would also advise you to go the COBC Web site where it contains detailed instructions for requesting the exception and what you have to submit and how it's approved. But basically the small group exception is employer specific and it's beneficiary specific. You must - you don't grant a small employer exception

to a particular employer across the board. We grant it to an employer for a particular beneficiary - for beneficiaries.

(Sheila Nelson): Okay - thanks.

Coordinator: Your next question is from (Linda Holt) from Independent Health.

(Linda Holt): Hi - I'm sorry to have to bring this up again but I need to go back to the SSN related questions here. I'm looking at Field 9 and the input file record as well as Field 15. And there is a comment on Field 9 indicated that this can be populated with nine spaces if the SSN is unavailable.

Can you explain - I guess I keep hearing either HIC number or SSN is always going to be required. So it conflicts a little bit I think with that field definition.

Man: That field says that the SSN - if (unintelligible) the HICN is not provided by the HICN, you don't need to provide the SSN. And in that case, in that field, will populate with nine spaces.

Man: We can just go back and make a quick add to that.

Woman: You know, the basic thing you need to know is you must submit either a HIC number or an SSN.

Man: Right.

Woman: And you know, the requirements are just trying to give you a default value in the case that you're submitting the HIC number and not the SSN, you can default the SSN to all spaces. You could default it to all zeros for that matter as well. And that would be acceptable.

Man: Maybe we should say something like populate with spaces if HICN provides or something like that.

Woman: Yeah - I guess we could. Does that make sense?

(Linda Holt): Yeah.

Woman: Okay.

(Linda Holt): One other question we had. I know you're making updates to the User Guide. Do you know when those updates will be made available to plans?

Woman: Yes, we're planning on publishing them early next week.

(Linda Holt): Great - thank you.

Coordinator: The next question is from (Christa Laveskis) from Cigna Healthcare.

(Christa Laveskis): Hi - thanks. I have a couple of questions actually. My first one is two parts. Is our first file under the new reporting process supposed to be a full file?

Woman: Did you say you're a voluntary submitter right now?

(Christa Laveskis): Yes - we currently are.

Woman: It doesn't have to be .

(Christa Laveskis): Okay - good.

Woman: That's also something that we're updating in the User Guide if it's not already there. But we would expect that if you have already submitted a record for an individual and an MSP occurrence has already been created. In other words, you've received an 01 response from the COBC...

Man: In the voluntary process.

Woman: Yes.

Man: Yeah.

Woman: Then it is not necessary for you to resend that information as an add or an update on your initial Section 111 file. Unless something pertinent has changed. But you may.

(Christa Laveskis): Okay - perfect. Our concern was what happens to all the existing ones that are out there so that solves that.

Woman: They stay there and then anything that you will send later as an update will be matched up to that record that was created previously in the updated slide.

(Christa Laveskis): Okay - good - thank you. And my second question is for the - it goes back to the previous question about multiple employer trusts. If we have a plan that some multiple employer trusts but it not a Taft Hartley group, can they still submit their TIN with their sponsor ID or do we need each individual TIN for each...

Man: We will go back and look at it but I think we were talking about submitting the sponsor specifically for the Taft-Hartley plan for where it was likely that

people were getting coverage based on our banks, etcetera. Where you've got a straight multi-employer plan, you should be submitting the employer information.

(Christa Laveskis): So if we have...

Woman: You've got a normal small multi-employer plan, you should simply be submitting the information about the employer. We were looking at making an exception in the Taft-Hartley ones because those people did not tend to have specifically straight ongoing coverage. They had intermittent coverage through a variety of different employers.

(Christa Laveskis): Okay - so if our small employer group has ten separate employers within that group, we need the ten separate...

Woman: Yeah - you definitely need the ten separate employers.

(Christa Laveskis): Okay. And then just a comment on Page 27 where it talks about the TIN file. It says that if you need to update it, you need to send a full replacement. So is that something that's going to be updated if we can just send - add changes?

Woman: I think the - yeah - I'll make an update to that. I think we tried to say that it should be but it didn't have to be and...

(Christa Laveskis): Okay.

Woman: I'll just change that.

(Christa Laveskis): All right, thanks - that's all I had.

Coordinator: Your next question is from (Mary Ann Bowers) from Harvard Pilgrim Health.

(Mary Ann Bowers): Thank you - I had several people here with me and the - some of the questions have been answered already.

Man: Sure - (unintelligible) from Harvard Pilgrim - thanks for taking my question. We have a situation where a scenario - we just wanted to validate. Medicare Advantage Plan with a group health plan is primary. Currently we report through an annual survey to CMS - the ESRD - (unintelligible) working age folks. Are these recipients exempt from 111 or do we need to include them as part of this process?

Man: Well the MA plan itself is not an RRE but the private GHP is responsible for reporting that information to CMS.

Woman: Is it response - well, I guess the question really remains, because we have a separate stream of reporting to CMS through an annual working age survey, we know we're primary for ESRD, we have those data exchanges in place as well as disabled - that is how we get paid.

Man: But Section 111 is separate and apart from any other requirements. If there are pre-existing surveys that need to be done for purposes of Medicare Advantage, 111 doesn't replace them and they don't replace 111.

Woman: So all these members need to be again, reported to you for eligibility.

Man: If they're a part of a GHP.

Woman: Yes.

Man: Yes.

Woman: Yes.

Man: You need to report - then yes.

Woman: Okay.

Man: All right - thank you.

Woman: Thank you.

Coordinator: Your next question is from (Christine Jacob) from Blue Cross Blue Shield.

(Christine Jacob): Yes - thank you - I have a question and a comment. For the tax ID numbers where we have people who have an individual policy - they are individual policy holders, not part of a group. We were going to use our insurer tax ID number to report for those people under the assumption that we would get the MSP demand anyway if there was that event. So if you could please confirm that.

And then the comment was for the Blue's plan that had the question about FEP. We've got communication from the Association that FEP reporting would be done out of DC and (Gary Ewing) would be a contact for that.

Man: Okay - thanks for the second part. And what was the first part?

Woman: Could you hang on just a second?

(Christine Jacob): Sure.

Woman: I'm sorry - we're going to ask that you send a separate email to Bill Decker explaining your particular situation because there's a little bit of inconsistency in talking about individual policies and group health plans at the same time. So if you wouldn't mind sending Bill Decker an email.

(Christine Jacob): Okay.

Bill Decker: Do you have my email address?

(Christine Jacob): No, I don't, Bill.

Bill Decker: Okay - it's william. - nobody else listen, okay -william.decker@cms.hhs.gov.

Man: And what is your name, please?

(Christine Jacob): My name is (Christine Jacob) and I'm with Blue Cross Blue Shield of North Carolina.

Man: Okay.

(Christine Jacob): Thank you.

Coordinator: Your next question is from (Jack Chin) from Kaiser Permanente.

(Jack Chin): Okay, my question is related to the day for us to send the production (unintelligible). I understand that you are going to assign a production last date. And when are we going to know that?

Woman: When you register, after your registration has been processed, you will be emailed a profile report.

(Jack Chin): Okay.

Woman: And on that profile report it will say what your file submission timeframe is and when your next file submission is due and that would be on your first profile report - that will be your production live date.

(Jack Chin): Oh, okay - all right, thank you.

Coordinator: Your next question is from (Rich Glass) from (Incentive Force).

(Rich Glass): Thank you - I joined the call late so perhaps you've answered several of these questions. I just want to clarify. First of all, I heard an answer about COBRA qualified beneficiaries. We are an HRA administrator for several employers. To the extent that someone is on the HRA for COBRA, do we have to report them if we don't know for sure that they're on Medicare?

Man: Yeah.

(Rich Glass): Okay. Also, the - we're not part of the voluntary program. The first file that we submit is going to be all the people who are on the HRA as of 01/01/09. Is that correct?

Man: Yes.

(Rich Glass): Plus any adds or deletes up until when?

Woman: Up through the point that you're reporting, so you'll have some sort of cut off point. We do ask - you do have - you'll see in the User Guide a 45-day grace period to allow you time to process changes to your enrollment files and get them ready for your file submission. So if someone was added to your plan within 45 days of your - the start date of your file submission period, you may wait until the next quarterly file to report them.

So you know, the cut off is truly 45 days prior to your - the date that you are - the first day of your file submission period.

(Rich Glass): Okay. There was some discussion about the small employer exception and the guidance that I've seen mostly talks about it in the context of multi-employer plans to the extent that we just simply have a small employer client that has fewer than 20 employees - not part of any multi-employer plan. Do we need to submit for them?

Man: Generally no, unless you know that...

(Rich Glass): Unless we know that there's someone on Medicare.

Man: Well on the ESRD.

(Rich Glass): On the ESRD - right.

Man: Because the working age rules and disability rules don't apply if it's a stand-alone employer with one, you know, zero to 20.

(Rich Glass): We're having a little bit of difficulty convincing our HRA clients about the need for supplying the beneficiary social security number. There's just been a lot of discussion about that. And someone mentioned a June alert. The trouble

that we've had with that June alert is it mentions nothing about HRAs and it talks in the context of mandatory insurance reporting. Is there any way we could get an updated or just so we have a single page document that we could point them to that says, this applies to HRAs as well?

Man: We can do that.

(Rich Glass): Okay. That's all I have - thank you.

Man: Thank you for the suggestion.

Coordinator: The next question is from (Jesse Terrell) from WEB-TPA.

(Jesse Terrell): Thank you. I'm calling about the language in Appendix G of the Users Guide. It indicates that there is a $1,000 per day per individual for non-compliance for not sending in their eligibility records. If we are having difficulty obtaining the social security numbers for dependents, will this Users Guide be updated to supply guidelines on what will be considered due diligence to protect us from the penalties?

Man: I mean, CMS right now is in the process of preparing documentation concerning compliance. But at this time, we don't have any further comments on that. We realize that there is, you know, the law has $1,000 per day penalty in it and, you know, obviously we understand people are very concerned about that.

I can't stress enough from CMS' point of view is that we are much more interested in good quality data than we are imposing any kind of penalties. But in short of that, you know, until we have that guidance out there, we really don't have any comment on that phase of it right now.

(Jesse Terrell): Okay - well thank you very much.

Man: But we will definitely try to answer, you know, those questions and alleviate - in our opinion, a lot of it unjustified fears of that penalty.

(Jesse Terrell): Great - thank you.

Coordinator: Your next question is from (Aaron Larson) from (Unintelligible) (Mutual).

(Teresa Wilcox): Hi, this is (Teresa Wilcox) actually again. I have a question about changes but I want to clarify because I got confused with your answer to the woman who talked about the history versus current coverage. I believe you told us when we asked the question if we were continuing to send a person, we have to continually send all of their history and you said no.

Woman: It was referring to the initial file submissions.

(Teresa Wilcox): So is that the answer on the very initial file, no matter when it's first sent - if it's sent in 2011 for whatever reason - we've got to go back to 2009 and send you all of the history of each person. Is that correct?

Woman: Yes.

(Teresa Wilcox): Which could be 15, 20 different changes - who knows.

Woman: And again, you only need to provide multiple records from multiple periods of coverage - someone who was on your roles and then off your roles.

(Teresa Wilcox): Well, I 'm - for example, one of your fields in employee coverage election - Field 19. Who does it cover? If I start with the person who's a single coverage policy holder only, there's one. If they get married and have a spouse the cover, that's two. If they have children, that's three. If they've changed from medical only to hospital and medical, there's another coverage change.

To me, that's different effective and end dates with different information in your files.

Woman: Yes - and those particular types of situations, we are trying to add more clarity in the User Guide. But that is true.

(Teresa Wilcox): So that's the answer, yes, if they went from single to double to family, you need an entry, a record for each one of those kinds of information.

Man: Yes.

(Teresa Wilcox): Now what if they've moved five times as well? Do you need five different records with each address?

Woman: You're not submitting the address for the covered individual.

(Teresa Wilcox): I'm not?

Man: No, just employer and insurer address.

Woman: (Unintelligible).

(Teresa Wilcox): Oh, okay - I'm sorry - I looked at that wrong -that's good - that's really good.

Woman: You're talking about submitting information for the first time for this individual years down the road. If they were a beneficiary this whole time, you should have been probably submitting it earlier than several years down the road.

(Teresa Wilcox): Right.

Woman: And...

(Teresa Wilcox): But that's what you're saying. The first time, everything is required, no matter how many different coverage types there are.

Woman: But again...

(Teresa Wilcox): Once it's been sent once, it's only current coverage.

Man: Right.

Woman: Yeah - the one qualifier on this is you don't have - if you don't submit it until three or four years down the road and they weren't a beneficiary until three years down the road, you don't have to submit information for the time prior to when they were a beneficiary.

(Teresa Wilcox): But we don't know they're a beneficiary until you tell us they're a beneficiary.

Woman: If you've used your query function, you may have determined their date of eligibility.

Man: I guess the thing is if you started submitting information today and we kept telling you we can't find this person as a beneficiary and you continue to send

them every quarter until eventually one day they become a beneficiary - we're not asking you to send those real old records where we already told you they're not a beneficiary.

(Teresa Wilcox): So we do have to track that in some way so we don't continue to send you that. Okay - so that clarifies it. And then just on changes. Anything in the file that changes we have to send you a change? I'm not seeing detailed information about what a change is. So is it safe to assume anything that changes? Their middle initial changes?

Woman: I am adding clarity in the User Guide for that.

(Teresa Wilcox): Okay - so we can wait and read that. One more question - if I send you - I think it's a change to send a termination. Is Field 20 where they're an active or non-active employee?

Woman: That should match your original records...

(Teresa Wilcox): Okay - so you know their terms so they're not really active. I would still send them as I'm terminating an active employee so I send a 1 in that field.

Woman: And you know, the time period that you're reporting - they were active.

(Teresa Wilcox): Okay.

Woman: So you know, you would have - you would show them as active. And then if you submitted them for some reason, subsequent to that because of ESRD or something, then they might have an inactive.

(Teresa Wilcox): Okay. And last question - on date of birth - we - there was a question about what we do with name - we really can't update that. Date of birth, I assume if there's discrepancies between our data and your data and the beneficiary tells us what we have is correct, there's some way to go about changing that. I guess they need to contact you?

Woman: They should be going through SSA for that.

Man: Yeah that information that we used to match comes straight from the Social Security Administration. If the beneficiary disputes any information that we pass back that is different than what you provided and you know, and we were still able to match, the only way that can be changed is the beneficiary going directly to Social Security Administration.

(Teresa Wilcox): Okay - all right. That's all - thank you.

Coordinator: Your next question is from (Judy Mirras) from Kaiser.

(Judy Mirras): Thank you for taking my question. I want to go back to the issue about a TPA that is the RRE for self-funded groups. We have the same situation in which a self-funded group tells us it does not want to give us the social security numbers of its people. They want - the group - the self-funded group - wants to do the reporting itself. And I had read the User Guide and perhaps incorrectly to say that that group to do its own reporting as the agent of the RRE pursuant to an agreement between the self-funded group and the TPA that is the RRE.

Woman: In that case, they would be acting as an agent, though. The reporter - the responsible reporting entity would bill the TPA.

(Judy Mirras): I totally agree with you and the RRE, the TPA is the RRE. The RRE is responsible and liable a correct and accurate and timely submission and it would be up to the RRE if it wanted to permit this in effect to be policing that self-funded group doing its own reporting. Is that your understanding.

Woman: No, that's fine. We didn't mean - I didn't mean to exclude that when I talked before. It's just that a self-funded group who is not a TPA under our definition cannot unilaterally decide that it's reporting.

(Judy Mirras): I hear you.

Woman: Instead of the RRE.

(Judy Mirras): I hear you - it would have to get the agreement of the RRE TPA to do that.

Woman: Right - if the RRE wishes to use them as its agent, it may do so.

Woman: Now from a...

Man: (Unintelligible) the self-funded group, the self-funded employer, a reporting any required data. that's the point. They just don't have to report the SSNs.

(Judy Mirras): Yes - their point in doing the reporting themselves was not to show the SSNs to the TPA. That was my understanding of their position.

Woman: I don't know - I guess my basic problem with that is how is the TPA processing claims appropriately if it doesn't have information on who is or isn't a Medicare beneficiary? It seems to me there is a basic problem for the TPA there.

(Judy Mirras): Okay. And presumably, the RRE needs to get the reply file that would indicate if any of these people in this self-funded group are entitled to Medicare as well. And in that case, the HICNs and social security numbers would have to go back to the TPA.

Woman: Well the response file is going to go back to the agent. But presumably, any agreement the TPA would set up with its agent would include provision and necessary information. I mean, there'll still be RREs - they've got the ultimate responsibility.

Man: Typically in the agent RRE relationship, the agent basically is the administrator, access data back and forth of the RRE. In fact, we'll end up with all of the data that we send out in response to the original transaction. It will pass through the agent but the RRE will - you're right - get the data (unintelligible).

(Judy Mirras): Okay.

Woman: I just wanted to make this one quick technical point there. that if you're sending in a file as the responsible reporting entity for all but this particular self-funded organization, technically you would register twice because we're only going to accept one file from you per quarter.

So the self-funded organization as an agent would use one of your RRE IDs or Section 111 reporter IDs and you would use the other to report all your other business. Does that make sense?

(Judy Mirras): Then, is it two registrations by the TPA? One for its agent and one for itself?

Woman: Yeah - and that in this strange particular case, yes, because I presume they'd be sending the file, transmitting it from a completely different location.

(Judy Mirras): Yes, that's right.

Woman: Yeah - and we have an edit in the system that will only accept one file per RRE ID per quarter. And so, you know, you would be sending in two - of they would send in one, you would send in one. And if you're using the same reporter ID, we would consider that two files and have a problem with it. So you would set up two separate RRE IDs and essentially register twice.

(Judy Mirras): You know, we don't like this idea either and we're really trying to discourage the group from doing this. But I needed to ask the question to make sure that it was permitted, even though neither you apparently nor we like it as option.

Woman: Well we have no control over who an RRE wishes to work with as an agent. I mean, that's entirely up to the RRE.

Man: (Unintelligible) no control over that.

(Judy Mirras): Okay - thank you very much for taking my questions.

Man: Operator?

Coordinator: Next question...

Man: Operator...

Man: Operator...

Coordinator: Yes?

Man: Operator?

Man: It's now about 10 after 3:00 and we've actually gone 10 minutes past our scheduled time. We would like to take one more question and then wrap it up.

Coordinator: Okay - our next question is from (Barbara Collinson). Your lines is open.

(Barbara Collinson): Yeah - I get to do first and last. I have two questions - I hope they're fast for you. The first one is, if someone has end stage renal disease as a 30-month coordination that history has passed, do you start reporting them again when that period is over if they meet the other criteria?

Man: I mean, if they're active workers?

(Barbara Collinson): Yes - but (unintelligible) an active worker?

Man: Yes, I mean, if they are, you know, if they are a beneficiary and they are considered an active covered individual.

(Barbara Collinson): So we need to keep track of when the 30-month period ends so we begin to report it once again.

Man: Yeah - and we actually provide ESRD...

(Barbara Collinson): Yeah, it's in there.

Man: On the response file.

(Barbara Collinson): And the other one - I'm going to beat the SSN number question to death - I just want to be clear - you talked I think exclusively about not having the SSN or the HICN for the claimant. What if you do have it for the claimant but for some reason you don't have it for the employee? I'm understanding we still do not submit it even if we actually know the claimant has Medicare?

Man: We ask for the SSN of the policy holder - that went in or out.

(Barbara Collinson): Okay. That's what I thought, I just wanted to make sure I understood that.

Man: Okay.

Woman: Now remember, our expectation is that RREs should have SSNs...

(Barbara Collinson): I know. I don't know if there's a situation like a resident alien or something working in the United States being married someone who is a US citizen that might cause that condition - I just don't know.

Man: Okay.

Man: Yeah, you want to...

Woman: Operator, could you tell us how many questions - how many more questions are queued up just for our information?

Coordinator: There's eight more.

Man: All right, well, I mean, we're going to have more of these in the future. I know that there's a bunch of them have been put out on the (unintelligible) reporting Web page.

At this time, I'd like to thank everyone for participating, it was a great discussion - a lot of good questions. Thank you for, you know, taking the time to go through this at a very detailed level. We've found a few things that we need to address. With that, I'd like to thank everyone for participating and we'll talk to you again. Thank you.

Woman: Thank you.

Coordinator: This concludes today's conference. We thank you for your participation. At this time, you may disconnect your lines.

END