TRANSCRIPT
TOWN HALL TELECONFERENCE

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

DATE OF CALL: February 4, 2009

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

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FTS HHS HCFA

Moderator: John Albert
February 4, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. After the presentation we will conduct a question and answer session. At that time if you would like to ask a question the command to do so will be star 1.

Today's conference is being recorded, if you have any objections you may disconnect at this time. And now I would like to introduce your host for today's call, Mr. John Albert. Sir, you may begin.

John Albert: Good afternoon to everyone from CMS. This is one of many of a series of teleconference calls to discuss the group health plan reporting requirement for Section 111. Again this call is targeted toward the group health plan responsible reporting entities.

On - as far as Section 111 we want to get right started, we know we just had a couple of calls last week, we hope you found them informative.

We're going to continue on with those discussions and answer hopefully more of your questions. We know that we still had some people in the queue when we had to stop the call last time at 3 o'clock.

To get started I just - we're going to go over a couple of brief statements, offer a couple of brief statements regarding particular issues that have come in since last week and then we'll jump straight to Q&A.

So with that I'd like to turn it over to Miss Pat Ambrose who will address a couple of quick points on her end.

Pat Ambrose: I just wanted to quickly review the upcoming changes to the GHP user guide. It has not been published yet but we're hoping to get that out within a week or so.

The changes as mentioned in the last week's call have to do with adding record layout for the MSP response file. That was missing from the original guide, there is a trailer record at the end of the MSP response file and that will be added to this new version of the guide.

The trailer is comprised of 800 bytes like the other records on the response file. There's a two byte record indicator which is T0, a 9 digit RRE ID, a four byte file type which would be MSPR which matches the header record, an 8 digit file date that matches the header record, a record count, a nine digit record count an then the remaining part of the record is just filler.

Also an upcoming change will be the format to the query only file. The only change there is to add the RRE ID as opposed to the old DDSA ID.

So currently on the record that you see - record layout that you see in the user guide, you'll see a four digit VDSA plan ID and a five digit contractor ID, those will be replaced with a nine digit RRE ID.

There's also some new information being added for the alert that's already on the Website on the GHP page regarding the small employer exception. There will be new information about file transfer for the secure - the COB secure Website.

We'll implement a new Section 111 secure Website beginning in April and the file transfer methods for HTTPS, which is a file upload download process with an active user session that will take place, that will be transitioned to the COB secure Website and secure FTP will also be available on the GOV secure Website.

Some more information will be provided on those two methods in the updated user guide. In addition to that, as discussed last week, we're going to add some information about how you go about registering on the COB secure Website.

First you need to decide how many RRE IDs you will need and that has - depends on how you're going to transfer your files to the COBC for Section 111 reporting.

If you need to transfer more than one or submit more than one MFP input file per quarter because of perhaps reporting by subsidiaries or reporting by different agents and you're not rolling up all of your MSP input file information into one consolidated file, you'll need more than one RRE ID.

And you'll go through this registration process for each number that you need for reporting purposes.

After that you also need to decide who will be your authorized representative, this is an individual at the RRE who is able to be held accountable for the Section 111 reporting requirements.

Next you need to identify who will be your account manager, this is the individual that will be responsible for day to day management of your file exchange with the COBC.

Your account manager could be an individual at the RRE or could be an individual at an agent if you so desire. Lastly you need to decide about what individuals would play the role on the COBC secure Website as account designees.

Note that the authorized representative is not a user of the secure Website, but the account manager and account designees are.

The first step in the process is to come to the Website and provide certain basic information about the RRE. The COBC will validate that information and then mail once validated, mail via US post a letter to the authorized representative with a personal identification number or a pin number.

The authorized representative needs to give that pin to their identified account manager who will come to the site and perform the second step which we're referring to as account setup.

During that step the account manager will get their individual user ID and password and they will also complete the information necessary for account setup for that RRE ID.

And again they will come multiple times to the Website as needed for however many RRE IDs you decide you need for reporting purposes.

Each individual will only have one user ID and password for the Website, however. Part of that account setup is also choosing a file transmission

method which I mentioned earlier will - you'll have HTTPS file upload and download and secure FTP via the COB secure Website.

And you'll also have a connect direct over the (agnus) network will remain the same. Once that account setup has been completed, a profile report will be then sent to the authorized representative.

The authorized representative needs to sign the last page of that profile report and return it to the COBC.

Once that's completed, testing can begin. A couple other notes, I noticed that someone had asked a question about what version of the X1227271 we use for transferring the query only file.

We're currently using the 4010 standard. Eventually we will move to the 5010 standard, the exact date is not definite but it will probably be in production by January 1, 2011.

So it's quite a ways out at this point in time. And that's it.

John Albert: Next Bill Decker wanted to present a couple of responses to some of the questions we've received through the resource mailbox here at CMS.

Bill Decker: Hi, good afternoon everybody, or good morning, good afternoon everybody. This is Bill Decker also with CMS and I just want to give a - mention four points and sort of a general overview.

We keep getting the same sorts of questions on each of these points and I want to go over them one more time on this call before we get started.

And when I'm finished I will turn this call over to Barbara Wright who will pick up on some more specific items.

The first item that I want to go over with you all again is on the - we keep getting questions about whether it is okay to report people to us or age 45 or do we have to report people to us who are only age 55 and above.

The age 55 and above reporting option is exactly that, an option. You - the requirement is age 45 and above. For a time you can choose to report only folks to us who are age 55 and above.

But that is an option that will expire after a certain period of time and if you wish to start off right off the bat giving us people who are 45 and above on your MSP files and your query files, that's fine with us, we encourage that.

Really if you have questions about whether you can start at age 45 the answer is yes, absolutely and that is backing for standard.

The second point I want to go over with you all is the IM - the issue about the use of the old voluntary data sharing agreement materials.

With the Section 111 reporting if you are Section 111 RRE you may not use, you cannot use, you will not be permitted to use any of the old voluntary data sharing agreements files or file formats.

All of you who were former voluntary partners know that those of you who are going to be becoming RREs and signing up with us starting in April need to know that.

We have said in a number of places and I'll say it here again that the voluntary data sharing agreement materials can be useful to you to give you an excellent idea about what it is you will be reporting and how the reporting process works.

But they are not exactly like the Section 111 reporting and you can't use any of the formats or file layouts that are in the voluntary data sharing agreement materials.

The third point, a quick one I believe is this one, once again we get questions about when it is that I can use the delete instruction the delete function on a file, on an input file.

And I think our bottom line instructions on this have always been and will continue to be only use delete when you have previously sent information about an individual to us in error.

Remember that sending us a delete instruction actually removes the - actually removes people from our database.

And you really should not use the delete function at all until you have checked with your EDI rep and make sure you ask the EDI rep if that's the proper instruction to give to us before you go any further with it.

The last point I will bring up is the question about - we've had a couple of questions about how we validate TINs and what the validation of the TIN input file means to you.

We take the TIN information that you give us, the TIN numbers themselves and the associated addresses and we check them against both internal

databases that we have and a number of commercially available databases that are in wide use throughout the industry.

If the numbers are - they match up and are valid against the various ways that we validate what we are checking in TIN, they will for our purposes be valid.

And that is I think I hope I answered all the questions about how we validate the TIN information we get.

John Albert: We're essentially looking to see if it's merely a valid TIN number. We recognize that of course the power of this process is that it allows the submitters to instruct where COBC related information should be sent.

And that address that is included with that TIN reference file may not be necessarily the IRS address associated with that Tin. We're not looking to validate that address, we're looking to validate the TIN is in fact a real TIN.

That's pretty much it in a nutshell. So again if you're giving us an IRS address associated with a TIN that may not help you because it may not be the place where you want those types of communications to be directed to. So the purpose of again this process as it was and it was a voluntary process is it gives you the ability to tell CMS and its Medicare secondary pay recovery contractor who it needs to contact and where when it comes to coordination of benefits and/or recovery activity.

Bill Decker: That was John Albert and thank you for expanding on that John. I'm going to turn this over now to Barbara Wright, thank you.

Barbara Wright: Thank you. The first thing I wanted to mention briefly is there are outstanding issues still dealing with HRAs, those are still under discussion. As soon as we

reach a decision on any information or special reporting with respect to HRAs we will do that by an alert if it's too late to include it in the updates that Pat Ambrose just mentioned.

So we do hope to have some information out to you within a couple weeks on the HRAs. The second thing is we're continuing to get questions where people are asking whether or not the insurance that they provide is subject to this reporting.

And you have to work through a process to find out whether or not you're responsible reporting entity for purposes of Section 111. The GHP user guide has two appendices, Appendix G has the statutory language for Section 111 and Appendix H has what was published in as part of the supporting statement for the paperwork reduction act package for Section11 in the federal registrar.

There's Attachment A is called definitions in reporting responsibilities and that's in Appendix A. In order to determine whether or not you are an RRE with respect to this process, you need to look at that statutory language in connection with the definitions and reporting responsibilities.

The type of question we get in will say for example we're a third party administrator, but the incoming doesn't give us enough information to tell whether they're a third party administrator under a generic definition or under the definition that we put forth in that Attachment A.

And that's crucial for group health plans, if there is a claims processing PP or a third party administrator as we define it in attachment A, they are the RRE for non-GHP, PPAs as we define it are not the responsible reporting entity.

So you need to work through the first process and know whether or not you're TPA and then go on to the second step of whether or not you're a responsible reporting entity.

You also need to decide whether you're a responsible reporting entity from GHP separately from making that decision for non-GHP. One of the questions that came in mentioned a whole host of different lines of business that they alleged they were a TPA for.

And some of the parentheticals in that mentioned things like accident insurance, life insurance, certainly accident insurance sounds on the surface like it's liability insurance.

If you want definitions of group health plan insurance, liability insurance and no fault insurance, you need to go to the federal register, but go to federal regulations and 42CFR411.101 gives the definition of a group health plan, 42CFR411.50 has the definitions both of liability insurance and no fault insurance.

There is also a very specific definition of self insurance as part of liability insurance in Attachment A. And of course the other type of coverage that's subject to this is workers compensation.

But we haven't had any questions about whether or not someone knows that they're providing worker's compensation.

So if you still have a question of whether or not you're RRE, if you work through that process and you have a specific problem then let us know. But a general question into just lining out areas of business and asking what you need to do, there's no way we could give you a specific answer.

And that's all from me right now. Operator, I think we're ready to take questions.

Coordinator: Yes ma'am. If you would like ask a question at this time, please press star 1. You'll be asked to unmute your phone and record your name as your name is required to produce your question.

Once again star 1 to ask a question. Our first question today comes from (Mark DerGarabedian), your line is open.

(Mark DerGarabedian): Thanks for taking my question. (Mark DerGarabedian), Harvard Pilgrim Health Care.

Just have a couple questions if I may, two of them are regarding TINs. First question is how should the health plan report on members that have continuous coverage through multiple employer groups over a period of time where one of the tasked employer groups is no longer in business.

Or within the health claim that has no longer a business relationship with, so in other words we don't have that TIN information because of those situations, how should we report that information.

John Albert: Well the new organization took over since the responsibility for that coverage then you would just report the new information.

(Mark DerGarabedian): But let's say it's a company that went out of business, we're no longer affiliated with, we don't have a contract with them any longer. Do we need to track down that TIN or...

John Albert: You're talking about reporting retroactive coverages?

(Mark DerGarabedian): Right, there's continuous coverage so the person let's say goes back to you know 1/1/96, they've had continuous coverage, they're covered through X employer but they've jumped from employer to employer.

And one of those employers went out of business, we no longer have that TIN on file, how should we report that information?

John Albert: Could you hold on just a minute please?

(Mark DerGarabedian): Sure.

Coordinator: Mr. Albert, are you still on the line sir?

(Mark DerGarabedian): Actually it's (Mark).

Coordinator: Correct, has your question been answered or...

John Albert: Oh I'm sorry, we were discussing here internally before we responded. So it sounds like basically then that responsibility ended with that old employer, because it's a new employer sponsoring that coverage?

(Mark DerGarabedian): That's correct. But would we need to report the historical TIN information? Okay.

John Albert: No, that's a different employer.

Barbara Wright: You need to report the coverage that was in effect prior to 1/1/09 and that continued on or after 1/1/09.

John Albert: Right?

(Mark DerGarabedian): So we wouldn't need to go back, it's my understanding if they have continuous coverage there's a potential where a person is covered let's say back to 1/1/96...

John Albert: But it's a different sponsor.

Barbara Wright: But what we're looking at right now is your responsibility is for the coverage that was in effect immediately prior to 1/1/09 and continued on and after 1/1/09.

And coverage through a different employer or a different insurer is not a single continuous coverage, it is multiple path coverage.

John Albert: Right.

(Mark DerGarabedian): Right, that's the issue, but there's no break in coverage, so...

Barbara Wright: But there is a...

John Albert: Well there is a break because it's a different sponsor.

Barbara Wright: Right.

(Mark DerGarabedian): Okay, so once it becomes a different sponsor, that's considered a break even though the person - okay.

Barbara Wright: Let's say the person had Aetna 1996 to 1999, they had Cigna starting in 1999 and then in 2004 they switched to Blue coverage for a specific plan.

You would just be reporting the Blue.

(Mark DerGarabedian): Right, but I guess I'm getting at if they're covered through a different company, I'm talking about you know they worked for Fidelity, then they worked...

Barbara Wright: No, a group health plan is specific to a particular employer, so we're looking at the coverage that was in effect immediately prior to 1/1/09 and continued as of 1/1/09.

(Mark DerGarabedian): Okay, so the TIN issue as far as the employer group changes wouldn't be an issue in your eyes. In other words we wouldn't need to worry about past...

Barbara Wright: No, you just need to worry about reporting for that specific coverage that's in effect immediately prior to 1/1/09 and that continues as of 1/1//09.

(Mark DerGarabedian): Okay. All right, I get - let me go to my second question. The TIN question again comes up with regard to a reporting individual who's let's say covered through an actual employer.

But the employer is a subsidiary of a group health plan that's sponsored by a parent company. Harvard Pilgrim in this case has the TIN of the parent company.

Would it be okay if we reported the TIN of the parent company because we have the contract with the parent company and we're basing the size of the group health plan based on that parent company not the actual employer?

John Albert: Yes.

(Mark DerGarabedian): So that's okay?

John Albert: Yes.

(Mark DerGarabedian): Two more, three more questions. How many years back must be the reported time frame for members that let's say have Medicare due to ESRD or a disability?

So how far back do we need to go?

John Albert: Well we're only asking for coverage that was in effect as of 1/1/09. Yeah, if that current coverage that was still in effect as of 1/1/09, we're asking for the start date of that coverage.

(Mark DerGarabedian): So again I go back to if they had continuous coverage, they're covered through you know Harvard Pilgrim and they went back to 1/1/1996 and they've had continuous coverage and they're still effective on that 1/1 - or 12/31/09, my assumption is we still need to report those members.

John Albert: That coverage is in effect today, yeah. Through the same employer, same insurance, same you know coverage type, things like that.

(Mark DerGarabedian): So we could go back - I guess my question is how far back do we need to go? I mean is it conceivable we could go back? You know because there are some member that may go back beyond you know let's say '96.

John Albert: Could you hold on for just a second?

(Mark DerGarabedian): Sure.

John Albert: Yeah, sorry I was taking a few minutes because we're just trying to hash through your questions and make sure we give you an accurate response.

I mean basically if you're talking - you know you're talking about ESRD situations which have a 30 month coordination period, we're not sure why you would need to report someone on ESRD back in 1996 for example.

But again if - yeah, who's no longer a beneficiary - so again the rule is that you know if they have coverage and the person's a beneficiary as of 1/1/09, we need that current coverage that's in effect on 1/1/109.

But if there was a gap in - change in coverage or there was a period of time where they were entitled to Medicare there's no reason to report back that old information.

We're just being for current open coverage records essentially.

(Mark DerGarabedian): Okay, so as far as we can go back you want that information as long as they're effective as of that you know 1/1 or 12/31/09.

John Albert: Yeah.

(Mark DerGarabedian): Okay. Couple more questions, I appreciate the time. What's the data retention requirements for the data in the file? Is there any retention requirements that you're putting in place for us?

Barbara Wright: Section 111 includes no specific record retention requirement. Any record retention requirements that exist under other statutes and provisions would be what you need to follow.

What we put in the PRA the first time was just sort of a heads up to everybody that there are other laws out there such as the false claims act provision where claims can go back at least ten years.

Or other situations where people might want to take that into account in making their determination of how long to keep records. In the PRA we had no intent to imply that we were imposing a 10 year rule or anything along that line.

(Mark DerGarabedian): So it's really our call.

Barbara Wright: No. It's your call but to the best of our knowledge, failure to keep records isn't an automatic defense if there's some provision that someone would need the information under.

(Mark DerGarabedian): Okay, fair enough. Two more questions, one is regarding registration. We're reviewing the registration process, one of the things it talks about is providing estimated numbers of covered individuals.

And speaks to the age piece and it talks about over the age of 45 upon registration, however since the age threshold was temporarily raised to 55 do you want the estimates for ages 45 or above or 55 or above?

Pat Ambrose: We're still hoping to get estimates for 45 and above and you know it's just a ballpark so don't labor over it.

(Mark DerGarabedian): Okay.

John Albert: That's for planning purposes on our part to kind of space the work out evenly across the border.

(Mark DerGarabedian): Fair enough, we just wanted to (unintelligible) you guys, okay great. My last question we did ask this last week, I just want final confirmation, we're still going back and forth within our organization as far as our legal department.

Are members that are covered through what we're calling our first seniority or freedom product where we know that Medicare is secondary and Harvard Pilgrim is assuming the responsibility if you will.

Do you still want us to report those members? I know we've talked about it last week. You did confirm that you do want us to report those members but I just want absolute confirmation.

Barbara Wright: I don't - none of us - we're all looking at each other. We don't believe that that was what we said. We never said that you should report an individual for GHP purposes in a situation where you know Medicare is in fact primary.

(Mark DerGarabedian): Okay, what I'm saying is that Medicare is secondary. In other words we're - Harvard Pilgrim in this product, you did confirm last week that if it's - if Medicare is primary, we have what's called an enhanced product.

We're not going to be recording those members. But in the case where Harvard Pilgrim is assuming responsibility, we're primary, it's first seniority or freedom product, do you want us to in fact report those members?

John Albert: Yes.

(Mark DerGarabedian): Okay, so we do need to in fact report those members.

Barbara Wright: Where Medicare is in fact secondary, you must report and you must do that even for individuals who are under 45. The 45 is a - like a catch all provision and it helps identify who's a Medicare beneficiary.

But you do have responsibility for knowing what people you insure who are under 45 and where Medicare would in fact be secondary such as ESRD.

(Mark DerGarabedian): Okay. All right, that's helpful, so we just wanted absolute confirmation of that. We will not be reporting the - when we know Medicare is primary but in this case it sounds like we will need to be reporting out for those members where Harvard Pilgrim is assuming the responsibility we believe Medicare is secondary.

But we're still going to report those members.

Barbara Wright: And the other thing along with the people that are under 45, I think (Pat) can confirm, I think we have in the user guide that if you're under 45, if the individual is under 45 you are in fact expected to report their Medicare claim number, not just the SSN.

Pat Ambrose: Yeah, we refer to that as the HIC number, HICN and yes, if the individual is under 45 regardless of the temporary raise of the threshold to 55 the edit is if

you're reporting on someone who's under 45 you must submit the Medicare health insurance claim number or HIC number.

I'd like to just add one point of clarity when we're talking about whether you report or not. We were referring in that last discussion about the MSP input file.

For those who are reporting under the expanded option and using the non-MSP file, you are reporting information about supplemental drug coverage to Medicare on that particular file.

So just as a point of clarity there.

(Mark DerGarabedian): I appreciate the time, thank you so much.

Coordinator: Next in queue is (Bill Monroe), your line is open.

(Bill Monroe): Thank you. I have a few questions. The first one has to do with something that was mentioned last time and just want to confirm this.

We have an individual who satisfies all the following and my understanding is this person would not be reported. The company size is less than 20, they are not in a multi-group plan and they are not ESRD.

Can you confirm that they would not be reported?

John Albert: Yes, that's correct.

(Bill Monroe): Okay and where does it state that in the guide just for my information?

Barbara Wright: Well if you look at what an active individual is.

Pat Ambrose: I do have to agree that the guide is not necessarily clear on the point of not reporting if an employer is - has less than 20 and the employer is not in a multi-employer group health plan.

I'll take a note to maybe make an update to make that more clear.

Barbara Wright: The active covered individuals are addressed I believe on Page 19 in Section7.1.2. And in it - you know it talks about an active covered individual are the ones that have to be reported, so.

(Bill Monroe): Right, I saw it in there, but I just didn't', there's really no mentioned of company size less than 20 that I can see except in one note.

And that was you could maybe imply that from that note, but I wasn't - you know. Well that's okay, as long as you confirm that that's fine.

Bill Decker: Yeah, I mean the issue with the - as we started getting into like MFP law and policy and we're trying to be a little guarded against making the what essentially is a technical implementation manual, an MFP policy guidance manual.

We prefer to rely on the other existing information that is out there. But of course you know some of these you know cut down to the core of this and we're trying to answer those questions as well while we can.

Barbara Wright: If you're interested in general information or more education in terms of when we're primary and when we're secondary, you're invited to visit the COBC

Website and of course look at the MFP regulations that are in 42CFR part 411.

(Bill Monroe): Okay, but I'm just interested in the purposes for this particular requirement for this GHP MSP reporting and that is that this is a requirement.

John Albert: Yeah, I would also check out the computer based training that we offer as well because I think some of the modules for that get more into what needs to be reported and what doesn't in terms of size rules and things like that.

(Bill Monroe): But the guide who is supposed to be the definitive rule for these requirements, is that correct?

Bill Decker: We've answered your question though, correct?

(Bill Monroe): Yeah, I understand. Okay now, the next question is at the beginning of this call you mentioned that a delete would only be if the previous information was sent in error and to check with the EDI rep first.

And I just wanted to - I thought you said it was already in the guide but then I noticed in the guide on Page 40, correct the MSP occurrence information, (unintelligible) delete, it's saying here if it's in a delete when we're correcting, I guess the social number, effective date and so on.

Pat Ambrose: Yes, that's correct. Our explanation at the beginning of the call might not have been completely thorough but that section is very important that if you need to go back and change a - one of the key fields of an MSP occurrence, you need to send a delete record followed by an add.

The point to really remember is we only want you to send a delete record when you're actually removing information from our files. If you are terminating, if you're sending information to terminate a coverage period, send an update record, not a delete.

And that update record would include the termination date of the coverage. So the guide is correct, and please follow that. The point we were trying to make earlier was to try and stop people from sending delete records when someone drops off the enrollment roles.

Okay?

(Bill Monroe): Okay, thank you. Also one more question, there was some discussion a very long discussion about social security number requirements last time.

And there was mention that some kind of language would be put on the Website regarding that.

Now I'm just wondering if you've decided on that yet and is that going to change the requirements here because as I understand it we're still going to be fined if we don't get the social security requirement or social security number.

And what is our...

Barbara Wright: What we said we'd put up is information to make clear one point that was made during the extended discussion, that failure to report someone who is not a Medicare beneficiary cannot subject you to a fine.

(Bill Monroe): Oh okay. Very good, thank you very much.

Coordinator: Next in queue is (Jean Garrity), your line is open.

(Jean Garrity): Yes, I just have a question to follow up on the previous caller regarding the under 20, on Page 84 of the user guide it says employer size you would use a zero if it's 1 to 19.

When would we ever (transmit) anyone to use a zero?

Bill Decker: GSDR.

(Jean Garrity): Okay. And then what would we do if we had an employer size 19 and they grew over 20, we would start submitting them but the data obviously is going to be the original date that they were....

John Albert: You need to go back to the regulation site that we gave you before and Bill do you have those?

(Jean Garrity): Right, I know when they grow over the 20 consecutive weeks, but how is it going to show in the transmission that we didn't have to report them earlier because they were 19.

John Albert: First of all you need to be looking at the regs to know what time period you know the change - it's not like they - it's not like you count it one week and it goes up and the next week it goes down and then it goes up again.

(Jean Garrity): Right, you have to have the 20 weeks for the prior year or the consecutive year.

But when we report since we...

Bill Decker: You would want to term the old record and update - or send an add for a new record.

(Jean Garrity): But there won't be an old record, there was never a record because we didn't report the (unintelligible).

Bill Decker: Oh well than strike that.

Barbara Wright: Is the effective date the date that the company...

(Jean Garrity): Goes over 20 or is it the effective date the members had the coverage where it's going to show we were in non-compliance because we didn't transfer earlier but they weren't required to be transmitted.

Barbara Wright: It's the effective date when the coverage is in fact primary to Medicare based on when the effective dates have changed before the size.

(Jean Garrity): Okay, so if we had a client that's 19 for seven years, goes and hits the 20 threshold according to the law, we would send it the date - the 20 threshold according to the law would be their effective date?

Bill Decker: Yes.

(Jean Garrity): Not the effective date with the plan.

Bill Decker: Right.

John Albert: And again we'll reiterate you're talking about a situation that doesn't involve a multi-employer, multiple employer group health plan.

(Jean Garrity): Right. Yes, a single employer only, so it's just their effective date would be the date that they would have to be reported, not the date they were covered under our plan.

Bill Decker: I mean we - there are Medicare entitlement effective dates and then there are the group health plan effective dates. But they often have no relation to when the actual MSP effective date occurred and that's what we're really concerned about is you know putting a record on our system where there's actually MSP.

And that would be when this employer grew over 20 and assuming the guy was you know working aged.

(Jean Garrity): Okay. And it's a multi employer had all under 20, would the multi-employer need to be submitted at all or no because none of their clients are over 20.

Bill Decker: Not unless there was an ESRD (bene) in one of those.

(Jean Garrity): Oh, only ESRT.

Barbara Wright: Would you hold on just a second please?

John Albert: Okay, sorry we're back.

Bill Decker: The answer we gave was correct.

(Jean Garrity): So if a multi- employer has one ESRD even though they're under 20, do we only report that one ESRD member?

John Albert: Yeah, that is the only required reporting would be that one individual, yes. We allow everyone the option of submitting those other people just to you know be sure that they didn't miss somebody.

But again the requirement is only for Medicare beneficiaries that you report information.

(Jean Garrity): Okay. And then my last question is regarding if the plan is replacing Medicare, so instead of Medicare such as a tri-care plan, there is no Medicare at the same time, we would not report those people, correct?

John Albert: Correct.

(Jean Garrity): Okay. And same with like a Medicare advantage, we're technically replacing?

John Albert: You could report tri care as supplemental though, a drug record.

(Jean Garrity): Right but for the actual standard reporting we're assuming there's not really an employer, you know from...

John Albert: Tri care is never primary to Medicare so you don't report tri care (benes) as primary to Medicare as MSP record.

(Jean Garrity): So then with a Medicare advantage plan as well we're also replacing Medicare. We're covering the Medicare through our own plan, so would they need to be reported?

John Albert: No.

(Jean Garrity): So Medicare advantage doesn't need to be reported as well?

John Albert: No.

(Jean Garrity): There's no coordination.

John Albert: No Medicare advantage. We're looking for the private coverage, the private Medicare.

(Jean Garrity): Right, I'm only asking because the previous gentleman was asking regarding the freedom and the first seniority plans were Medicare advantage plans, where they're replacing. So it's not making Medicare secondary, they're actually acting as Medicare.

John Albert: Oh okay.

(Jean Garrity): So you would not need to report them is what - okay, that was my question. Thank you.

Coordinator: Next in queue is (Annette McNair), your line is open.

(Annette McNair): And then - or do we - once we choose to do that we have to do that all the time. What happened to them?

John Albert: We only heard a partial question there.

Bill Decker: Who's speaking on the phone? You're up for a question.

Coordinator: Miss (McNair), go ahead and restate your question.

(Annette McNair): Oh, I didn't realize that you had called on me. We're looking at - we're considering using the finder file option that was discussed in the user guide.

We wanted some more information on it before we made a decision on that. This would be when we would send all of our records in, all of our employee spouses in with the - on a query file prior to our reporting day.

And then once we got the information back our understanding is we would only be required to send in the records on the people that there were hits on in the finder file.

But we had some questions on how that would actually end up working out.

John Albert: Well let me state first off, say it again because we said it a bunch of times, there's no requirement to report people that you know are either not Medicare beneficiaries or for which Medicare is the primary payer.

(Annette McNair): Okay, so we would sort once we got our response file back on our query we would sort those people out by the ones that we would pay primary on, and those people we would report on.

John Albert: Yes.

(Annette McNair): Is that correct?

John Albert: Yes, and again I will just put that little caveat that you know the query file is only as good as the data it receives and we have a pretty rigorous matching criteria.

So it's important that if you're going to rely on the query file to determine whether or not someone has Medicare entitlement, you need to make sure that the name, date of birth, gender as well as the social are accurate, so that we have a high likelihood of matching them to a Medicare health insurance claim number if it exists.

But yes, you can use that query file to weed out all the people who are only the Medicare beneficiaries and report just those people on your next MSP input file.

(Annette McNair): Okay, so what you're saying is if we have an error in our information, the query file won't weed it out the way the MSP file would.

John Albert: Well no, they both work the same way, that's - you know basically just for people that haven't read the guide as thoroughly as that we match on the social security number first of all which must be included.

As well as three of the four of the personal characteristics which is the first six characters of the last name, first initial of the first name, date of birth and gender.

If three of the four of those match to that social security number and a corresponding health to charge claim number, we consider that a match.

(Annette McNair): Okay. Then we would also - we're interested in how long in advance, in order to be able to adequately use this, how long in advance would we need to send the query file to make sure we got a response file back in time to process it before our reporting days?

Do you have any idea?

Barbara Wright: Because there's a 45 day grace period connected with every quarter, you will always have a sufficient time if you do it on a regular monthly basis.

(Annette McNair): Okay, well I was just thinking the month before if we reported it the month before we may not have got a response back by our reporting day.

John Albert: You would actually have until the following quarter to submit that information.

(Annette McNair): Okay, so we would have the whole quarter to put it all together and send it in. Also if we had any individuals in between when we sent our query files that we newly enrolled, in between when we send our query file in and when we're required to report on those, would we just be required to report that the ordinary information on those, everybody over 55, everybody that we know that's under 55 that has Medicare?

Would we still be able - have to fill in that gap?

Barbara Wright: You need to look at how often you're sending that query file because if someone had coverage effective let's say in May, well let's make it coverage effective in June.

And your next reporting window was some time in - let's say it was July 1. You don't have to report that person who just had an effective date in June. You've got a built in 45 days as sort of a grace period.

So if you're doing a query file at least every 30 days, you should always be able to catch everyone before you run out of that grace period.

(Annette McNair): Okay. Is there any limit on the number of query files we can send at a time? The records in the query file, sorry.

Pat Ambrose: There's the likely record count in the trailer record for the - so there is a limit, I don't have it right in front of me but you can check that record count in the trailer record and see.

(Annette McNair): Okay. And if we use the query file once, I mean the finder file option once and we decide we don't like it or we only want to use it on occasion, we can switch back and forth to how we report?

John Albert: Well you always have to report the MSP input file but the query file is your option to submit.

(Annette McNair): Okay, but if we're using the finder file option, should we continue to use it all the time or can we just use it occasionally?

John Albert: It is a tool for you because remember you also can use that finder file to identify beneficiaries where Medicare is the primary payer so you yourself...

(Annette McNair): I was attracted to it using that option is we would find out people we weren't aware of.

John Albert: Don't do anything with the finder file, that is only tool for you all to use. We don't care if you use it or you use it every month, it doesn't matter.

Bill Decker: You send it to us, we tell you who we found and send it back to you. Then you have the choice of what you do with that information next. Of course the reporting you're going to send us an MSP file.

(Annette McNair): Okay, but the MSP file in that case would only be the one we had identified that we were the primary payer on, right?

John Albert: Yes.

(Annette McNair): Okay, thank you.

Barbara Wright: I just also wanted to add that the query only file, you'll receive a response file within 14 days of submission if not sooner.

(Annette McNair): Okay.

John Albert: Usually sooner, right? Most of them are turned around very quickly.

(Annette McNair): Okay. I think that was all.

Bill Decker: Thanks.

Coordinator: Next in queue is Larry Whitehurst, your line is open.

Larry Whitehurst: Yeah, this is Larry Whitehurst at Dean Health Plan. I understand the turnaround time is - or the grace period I guess is the 45 day response back from COBC once we send the file.

But I'm just wondering because this is supposed to be eliminating paper work is there going to be any kind of dedicated number or for example email because there may be a discrepancy between what COBC tells us as far as who is primary or not?

Barbara Wright: Two things to your question. First your reference to the grace period, what we were talking about in terms of the grace period is we can't expect you to have information necessarily to have a timely submission on someone who just signed up the day before.

You may not have the paperwork yet, so what we built in is a period that if they're effective dated within 45 days of your file, scheduled file submission date, you can delay reporting on that person until the next quarter.

That's what we were talking about for the grace period.

John Albert: I understand, you basically have about 135 days from the establishment of that private group health plan coverage to when it is actually due to be reported to CMS if in fact it is an MSP situation.

Larry Whitehurst: Okay then when we report it to - in other words, we send the file, we wait for the reply file, in other words the one telling us it's accepted, it's not accepted, we have a discrepancy, whatever.

I between the time that we receive that file back, once we do and determine that there is an issue between us and COBC as to for example who should pay primary for - let's say for example ESRD or even disability.

Say for example group, what employer number you have may be different than what we have. Is there going to be a specific place we can talk to somebody at COBC, write a letter to at COBC other than just like through CFR 42 to try and cure it before an MSP demand letter comes out of COBC.

Barbara Wright: There's a couple things going on in what you said. It sounds like you're talking about - you are going to be reporting to us on someone where you believe that Medicare is in fact secondary to the coverage you're reporting.

And unless there's some error in the data that we're able to identify, we're simply going to accept your report and we will build a record from that.

Larry Whitehurst: Okay.

Barbara Wright: And so we're not sure exactly what type of dispute you're talking about. We can get group health plan information from other sources and occasionally information we have from another source as opposed to direct from you, might be what generates the demand letter.

But our hope is eventually generates a demand letter out a completely different contractor.

Larry Whitehurst: Okay.

Barbara Wright: So what we're hoping is this universal reporting directly by the responsible reporting entity will cut down in the erroneous records and cut down situations where we've had conflicting information because of the fact that it's universal.

Larry Whitehurst: Okay, good enough.

Bill Decker: There's situations where again you send something that you determine say a month after you sent it, oh we sent you something incorrect or whatever. I mean there are manual processes to remove that record if it really needs to be but otherwise we would advise you to submit that correction on your next file.

Larry Whitehurst: Okay, thank you.

Coordinator: Next in queue is (John Ling), your line is open.

(John Ling): Thank you. Couple of questions, first question is does Section 111 apply for Medicaid members?

Barbara Wright: First of all we heard you say Section 101 and we are referring to Section 111.

(John Ling): One eleven, sorry.

Barbara Wright: Okay, of the Medicare Medicaid ship extension act of 2007. The Section 111 provisions are specific amendments to the Medicare secondary payer provision. They do not entail any requirement for the Medicaid program.

(John Ling): Okay, thank you very much. Next question is we understand that we have two options for reporting, one is basic, one is the expanded. We just wonder does COBC plan to require all GHPs to use extended option in the near future or what kind of timeline about that?

John Albert: No, at this time the legislation only requires the reporting of hospital medical coverage for purpose of coordinating Part A and Part B benefits.

We strongly encourage anyone to report that you know prescription drug coverage information because again it results in a full coordination of benefits.

And considering that many, many people out there have comprehensive coverage that includes prescription drugs, you know we think it's a wise

investment for both the Medicare program and the GHPs to - I mean to fully coordinate that.

Because again if you know if we're paying right to begin with on the hospital medical side we want to make sure that we're also paying right on the Part D side as well the benefits of coordinating A and B expand to Part D as well.

Then you also have the other option of submitting the retiree drug subsidy information as well and there are insurers out there that kind of serve as agents on behalf of employers who are interested in doing that.

So - and thirdly getting - doing the expanded option also provides you with Medicare Part D entitlement data that the basic option does not.

So it's just a way to keep everybody you know fully coordinated essentially. So we strongly encourage people to submit that data.

(John Ling): Okay thank you. The next question will be I know last week you had a teleconference on the GHP, when you plan to post the transcripts on last week's teleconference?

John Albert: They should be up pretty soon.

Barbara Wright: They should be up shortly, we have to go through a process to get those.

(John Ling): Okay.

John Albert: We just received them internally here today.

(John Ling): Okay. Next question is we understand you have an email PO110-173 section of 111 comments. Having comments that you (unintelligible), can we submit questions, you know besides this phone conference call?

If we submit questions when we you know expect, get a response?

Barbara Wright: When you submit questions you'll get an automated reply that says this is a message only box and you won't get an individualized reply.

What Bill Decker was doing at the beginning of this call was going over new issues that had shown up in that mailbox.

John Albert: Yeah, and we take that, we don't have the resources here to provide individual responses, but we definitely take that information in and use that to improve or clarify the written materials. As well as, you know, at the beginning of every one of these town hall teleconferences we try to provide feedback based on those questions that have come in since our last teleconference.

Bill Decker: John and I sat I guess when this morning or yesterday afternoon and went through all the questions that had come in since the last conference and went over all of them to put together the kinds of comments that we had at the beginning of this call.

We do that before every call.

John Albert: Let me reiterate, it is the most effective way to get your answers is to use that mailbox. It is the one thing that we - everyone here has access to and works through and makes sure we address.

We can't guarantee that any kind of emails, telephone calls will be returned because otherwise we'd never get the implementation done, I'm sure you can understand that.

(John Ling): Thank you very much, and the last question will be on Section 7.2.9.5 which is on Page 50 on our latest user guide, talking about a fine level and threshold errors, you have three different levels - threshold at 10% or more of the total records that (unintelligible) 20%, so forth.

So for these levels, specifically for 20% one, it says 20% or more of the total records, the sale the way the disposition code of 22 errors. Was this 20%, I just wonder how you calculate this 20%.

Would this 20% include those SP calls that are described in Section 7.2.9.2 Page 47? Your Page 47 talks about some special consideration for now over (unintelligible) and Medicare coverage, talks about some SP codes which we can ignore.

But if we can ignore those SP codes will these SP error codes will be included in the 20% threshold on Page 50?

Pat Ambrose: Yes, those SP error codes that might be perfectly acceptable situations, they are unusual but they might be acceptable, they are included in that calculation of 20%.

However, your file will not be flat out rejected. If you do hit the 20% threshold error, the file is suspended, you will get an email indicating that.

You are to - your EDI rep will also be notified but your obligation is to contact your EDI rep and discuss the situation.

You'll look at the errors on the file and come to a determination as to whether that file should be released for processing or whether you have a problem in your system that you need to correct and go back.

So hopefully you know it will be a rare circumstance, and if it is due to those unusual conditions or some other reason, we can let the - release the file for processing.

So it's really a matter of just stopping the file to make sure that there isn't some sort of grave error in your system and we shouldn't process it.

(John Ling): For all intents and purposes, I'm not sure if the question would be there, so these thresholds, will these thresholds be part of a non-compliance or that's just there for - to make sure to find you know we send a clean file?

John Albert: I mean we haven't you know released anything related to data quality compliance issues.

But I mean the point of these thresholds is essentially to alert you and CMS that there may be a problem with the submission and try to get it fixed, which is the primary goal of this process, is to get good clean data.

So these thresholds that we put in there, this is something we've - this comes from experience with our voluntary program, it just is a way to make sure that you know both CMS and the submitting entity you know is submitting good clean data and we're receiving good clean data.

Because this just happens from time to time where somebody's file will just have a lot of errors. A lot of times it might have been because of some minor

coding change on their end and this is the way to alert the submitter that hey, there's a problem with your data.

So that's all that's for.

(John Ling): All right, thank you very much, that's all for me.

Coordinator: Next in queue is (Frances Fikes), your line is open.

(Frances Fikes): Hi, good morning, good afternoon. This is just a real quickie and it may have already been answered before I could join. When we are doing our testing in the April through July time period, can we just test one file to ensure that we are hitting all of the fields, etcetera that are required for actual submittal?

Do we have to do if we have 20 clients, do we do 20 of them or can we just do one for testing?

Pat Ambrose: Are you an agent?

(Frances Fikes): No, we are a third party claims administrator so we are the RRE.

Pat Ambrose: Okay. I believe you may roll up all your files and report under one RRE ID, if that's not feasible because of your particular claims systems or whatever testing is required by each RRE ID that you register for.

(Frances Fikes): Okay, all of our clients are separate employers, and they are also funded. So then I am assuming what you just said is that if we have let's say 20 separate clients self funded plans, there would be 20 TIN registered.

So we would have 20 files.

Pat Ambrose: No, actually the registration is by the responsible reporting entity, and since you are the responsible reporting entity, in that circumstance you can register one, the RRE ID will be assigned to you and you can report all of those records on one file to the COBC.

You'll distinguish the various employers in there by the employer TINs that you're using. On the file will be - there's a field for your TPA TIN and then there's a field for the employer, the various employer TINs.

So in the circumstance you're describing, you may register once, get one RRE ID and test one file and submit all those records on one file submission each quarter to the COBC.

(Frances Fikes): Okay but - and I think I understood to do it when it was live, but just for testing purposes, because we are still trying to get those dependent social security numbers from all of our clients.

We do have one client that part of their open enrollment is that the participants must provide that. So we could use that file as a test file because it's complete to make sure that we are hitting all of the mandated fields.

Pat Ambrose: Okay.

(Frances Fikes): That's what I'm saying, can we just - we just run one to make sure we have it all covered and then incorporate when it's time to go live all the other...

Pat Ambrose: Yeah, yeah.

(Frances Fikes): ...clients in one rolled up file.

Pat Ambrose: Yes, the testing requirements will be published in the next version of the GHP user guide. And there are some requirements that you must pass, you'll have to submit at least two MSP input files.

We have so many successful adds, deletes, updates within those files. However, and so the COBC has a, you know, a certain requirement that you must pass.

You may continue to test the account manager on the COBC secure Website of your account manager will actually be the entity that will or the person that will turn your status on to a production status.

So what you're saying is yes, you may send in some initial files that might only contain information or records for some of your clients and pass the testing criteria.

And then when you get the rest of the data you can either you know just roll it in and send it in to your production file assuming it's all going through the same system, and there's no need...

(Frances Fikes): You all want eligibility...

Pat Ambrose: Yeah, and so there's no need for testing when you combine the rest of your employer clients in there, that's fine with us.

However it's your choice, you could continue to send test files after you've passed the testing requirements as well. So yeah.

Bill Decker: Testing procedure is in place for a couple of reasons, the main reason is to make sure that the RRE and the COBC can actually move the data back and forth to each other correctly.

The second reason it's there is so that you know that you're giving us the best information that we - the kind of information we need. The third thing that you should know for testing is that the data that you're sending us is not live data, it's test data.

We don't bump it up against our databases, we just use it to see if the systems are functioning. Only when you go into production are you sending us live data.

(Frances Fikes): Right, okay. Thank you very much.

Coordinator: Our next question is from (Rob Metz) of Independent Blue Cross, your line is open.

(Rob Metz): Yeah hi, good afternoon. I have a few questions for you. We're I guess one of the lucky RREs who have the reporting date of January 15 of 2009 so we've actually already submitted production files to COBC and are awaiting information back.

Based on the definition of active coverage individuals, we had a pretty large amount of records that we sent through. Apparently COBC was not ready to handle that just as yet and has asked us to continue testing with them.

Based on that information, is CMS and the amount of return records we're expecting to get back that would need to be corrected, will they take into account the time to research those records, correct and resubmit in the future?

Because that could take a longer time than we had anticipated given our next reporting period will be April 15. And I know you had mentioned the 45 grace, the 45 day grace period.

John Albert: Yeah, obviously if for some reason the file is not - cannot be returned for whatever reason then obviously that kind of slip it in to the next submission report if that's what you're referring to.

Bill Decker: Did you finish, were you - did you finish your testing procedures with the COBC?

(Rob Metz): Yes.

Bill Decker: Did they tell you you were done?

(Rob Metz): We had several test files that we've sent through, I think it was two passes on that, but when we sent through our production file it was rather large. And they had asked us if we can continue testing with smaller files until they flipped us into production.

So we're not quite at production yet according to them but they have our production files right now. So we're continuing to work with them, however when that file comes back because of the number of records we're going to have significant work to do on our side to correct and you know resubmit by the next quarter.

Bill Decker: I would ask you to contact your EDI representative and have your EDI representative contact me.

(Rob Metz): Yes, we have been working with them, so we're in....

Bill Decker: Yeah, just have them contact me and tell me what the situation is. This is a technical call that we should be handling off.

(Rob Metz): Okay, that's fine. The next question I have is does CMS have any recommendations on how the health plan should process a returned file for members getting the 51 disposition code?

The reason I ask that is because the 51 code that comes back is really a code that signifies that the record is not found. However it does not tell us it wasn't found because they're not Medicare eligible or it wasn't found because maybe it was an invalid SSN or HICN.

Barbara Wright: We can't tell the difference. What - when you submit a file what we're doing is telling you whether or not the person can be identified as a beneficiary based on the information submitted.

We have no way to tell whether it doesn't identify the information because you submitted incorrect data or because they're not a beneficiary.

John Albert: Yeah, I mean if you submit (John Smith) you know social 123-45-6789 but you had the gender and the date of birth wrong, we're not going to find them as a Medicare beneficiary because not enough of the matching criteria added up essentially to give us confidence that (John Smith) is in fact the (John Smith) with 123-45-6789.

Barbara Wright: So ones that are rejected that you have some other reason to believe that they are a beneficiary, like for instance....

John Albert: You may want to do further development you know with that beneficiary.

Barbara Wright: If you submit someone that's over 65 or is 65 or older and you don't get a hit as a beneficiary, you may want to do some further checking.

(Rob Metz): Right. So there's - it will be obvious SSNs where maybe a subscriber did not want to supply an SSN so we used another number.

But there's other cases where subscribers don't want to submit an SSN?

John Albert: Don't even bother submitting in another number because again there's no point to it. The SSN is mandatory.

(Rob Metz): Right, correct. And from what I heard from last week's call you said that if we believe the SSNs are incorrect we shouldn't even submit those records.

John Albert: Correct.

(Rob Metz): No use in submitting those. And also from what I hear that you're saying is that we're only required to submit on the MSP files those who we believe are Medicare eligible.

Barbara Wright: The only ones you're required to submit are those that are Medicare eligible. It's not a matter of your belief because they are Medicare eligible.

(Rob Metz): If they are, right, correct. So failure to report someone who is not a beneficiary would not result in a fine.

John Albert: And Medicare eligible and for which your plan should be the primary payer to Medicare. Let me just clarify that, we don't want retirees to have Medicare, we're looking for the working aged or disabled.

Barbara Wright: No, any penalty if we ever reach the stage of dealing with the penalties, penalty is not going to be based on who - or the size of your company's number of actually covered individuals.

It's going to be based on any failure to actually report Medicare beneficiaries for which you are primary.

(Rob Metz): Okay, that's fine. And I guess the last question is two parts, will CMS issue any additional announcements that either CPAs or advisor groups advising them about the requirement for SSN collections?

Barbara Wright: I guess I'm not sure what your question is.

(Rob Metz): I think there was announcements going out that talked about you know CMS and Section 111 requirements and it kind of talked about you know this is a government requirement, now it's a mandate.

We will be asking for SSNs for subscribers and beneficiaries.

Barbara Wright: Well we have an - we do have an alert that's available on the Web page that responsible reporting entities are free to use to assist them in collecting SSN information or EIN information or HICN information.

(Rob Metz): Okay.

Barbara Wright: We are receptive if someone believes there is language that would be helpful to them that we would agree is helpful, we would consider posting a different type of alert, but we have not received any particular suggestions from the industry.

Man: Okay. And I guess the follow up to that is do you have a recommendation or a recommended approach for health plans for the members who are 55 and above who refuse to provide an actual SSN?

Woman: It is still on our list that we are looking at a possible model (form) to supply to assist people in collecting information or if they for some reason cannot get it. But that is where we are at right now.

Man: Yes, I mean, as you heard from last week's call, there is some resistance from subscribers to supply that information - healthcare, either employer or healthcare provider. That is why I asked the question. But that was it. Thank you very much.

Coordinator: Next in queue is (John Downey). Your line is open.

(John Downey): Thank you for taking my question. Our IT Department has asked which contractor is being used to process the data. Is it Lockheed Martin?

Woman: It is our Coordination of Benefits Contractor, the Contractor that has that contract. They use subcontractors where it is appropriate for various aspects of their contract, but it is our Coordination of Benefits Contractor that has traditionally had the responsibility for updating our records.

(John Downey): Okay.

Pat Ambrose: This is Pat Ambrose. Just as a note, the files are being transmitted directly to the COBC and their data center which happens to be a separate facility from the CMS data center. So perhaps that is why they asked that question.

(John Downey): Understood. I thank you kindly.

Coordinator: Next in queue is (Tammy Myer). Your line is open.

(Tammy Myer): Hi. Our questions, the first question we have is we have one large state group that has piled up all our state entities. How do we report this? Do we need to report TINs for each of the different payroll offices associated with that state group or do we need to find out if there is one state EIN?

Woman: Are you an agent or an RRE?

(Tammy Myer): We are an RRE.

Man: You have a state government as your business relationship?

(Tammy Myer): Right. And they have several smaller groups...

((Crosstalk))

(Tammy Myer): ...or they are not called groups...

Man: And who did you...

(Tammy Myer): ...but they are...

Man: Who did you sign the contract with?

(Tammy Myer): The state of Wisconsin.

Man: The state - did you say the state or the state?

(Tammy Myer): The state of Wisconsin, yes.

Man: Yes.

Man: Yes, I mean it really is, I mean, I would probably discuss that with the state. But I mean the state would be fine if that is - but again, just keep - the thing to keep in mind is where do you want communication going related to COB issues and in particular recovery issues if they exist, you know, demand letters.

Would they, you know, that - but you could not report just the state if that is - but again, that address associated with that particular EIN is where the, for example, recovery letters, you know, communications are going to be directed.

(Tammy Myer): Okay, so basically if, you know, if we only have one like (strict) address for the company itself and then we have, you know, the fund goes to Madison, the fund goes to (Barilou), (unintelligible) City, then really we need a separate EIN for each of those (proven).

Man: Well if that is what they want. I mean, again, it is, you know, who handles any recoveries today? Is it at that local level or is it the state level? And it...

Man: It is kind of an analogous situation to having a GHP contract situation with a national employer like General Motors for example. It is going to have lots and lots and lots of subsidiary TINs out there.

The - but you are - that may not be an issue. It - really the question is where do you want the communications to go to and who wants them to go there.

Man: Yes.

Man: We need to have a TIN to identify that you are working with GM.

Man: We need an employer address essentially.

((Crosstalk))

Man: Every record needs an employer address whether it is the same address for your entire, you know, all those groups under that state contract or separate addresses for the different localities. I mean that is something that we leave to you all to decide and work with your customers on that.

(Tammy Myer): Okay.

Man: Okay?

(Tammy Myer): Another question we have is in regards to the TIN file. I know in the user guide it states that we can either (unintelligible) upper file submission and then anyone after that would be like any newly added TIN or a changed employer. But during the CBT course it says we can have two options - we can submit a full file each quarter or we could submit the update. It is okay if we submit a full file each quarter?

Woman: Yes.

(Tammy Myer): Okay. The other question we have is we have a member that is part of a group that is less than 100 employees. He is disabled and on Medicare, however the group is owned by part of a larger foods chain which would be over 100.

And I guess we were wondering who would be primary in that case and what group name or the EIN should be used on that file?

Man: Go by the larger group size and report them.

Man: You aggregate the employer to the largest possible (with stead).

Man: Okay?

(Tammy Myer): So we go to the largest group even though we do not have a contract with them.

Man: Correct. If it is a subsidiary of a parent, and you do not have a contract with the parent and you know that the parent has over 100 even if the subsidiary has fewer than 100, you go with the larger number of the parent.

(Tammy Myer): Okay.

Woman: We allow you to do RREs on a lower level basis for your convenience in terms of routing paperwork, corresponding and everything else. But for purposes of the MSP rules, we are looking essentially at the parent corporation.

Man: And its subsidiaries, the entire organization.

Man: So you would report that person as being employed by someone with 100 or more.

(Tammy Myer): Okay. And then I believe our last question is in regards to multiple effective data records. I think you kind of touched on this a little bit, but I just wanted to confirm. If for example we sent you a record with an effective date of 12/1/08 where the employee coverage election was three -- meaning subscriber and child -- but then as of 2/1/09 we changed it in our system to the coverage election of one subscriber only, would you then expect to see a record from the 12/1/08, 2/1/09 where the subscriber and child...

Man: Describe the full relationship.

(Tammy Myer): And then 2/1/09 forward where the open end states the subscriber only? Is that what you are expecting?

Man: Hold on.

Yes, you would report both of those records.

(Tammy Myer): Okay.

Pat Ambrose: You would, initially you might have reported just the 12/1/08 record ongoing with just the three, relationship three.

(Tammy Myer): Uh-huh.

Pat Ambrose: Then you might send an update record to show - to terminate that as of 1/31/09 and then you would have a new record as an add with a 2/1/09 effective date open ended termination date and that new relationship code.

(Tammy Myer): So really the only time you expect to see the multiple effective date records are really - if for example there was a change in that employee's coverage election or the group changed or the, like group size I guess would be another one or the employment status.

Woman: Yes.

(Tammy Myer): Okay. All right, I believe that is all we had. Thanks very much.

Coordinator: Next in queue is (Brian DuBiel). Your line is open.

(Brian DuBiel): Hi, yes. I had a couple of questions related to this small employer exception processing. Specifically, when you guys return a disposition code of BY and the SCE response code of SA, if we have a subsequent change transaction on that record should we send an update or an add transaction to CMS?

Woman: If we returned a BY, we had bypassed creating a record. I actually need to look up the specifics on it. But basically, if we have not added the record as an MSP occurrence, then you would need to send an add on a subsequent update.

(Brian DuBiel): Okay. And I had another question kind of related to that scenario. And that should be sent as an add transaction still on the MSP input file?

Woman: Yes.

Man: Yes.

(Brian DuBiel): Okay. If for whatever reason that small employer exception indicator changes where we would send a transaction to say that it no longer applies, and I guess we would just take the HIC number out of that SCE field on the record layout, should that be sent as - I am assuming that should be sent then as an add transaction because the small employer exception does not apply anymore?

Man: Yes.

Man: Yes.

Woman: Also remember that the Plan Administrator or a designated insurer on their behalf is responsible for updating any small employer (exceptionary) cost. If they have changes where they want additional employee/spouses covered or deleted, they have an independent responsibility, independent of this 111 reporting to get that information to the COBC.

(Brian DuBiel): But don’t they have to tell us that so that we either put the HIC number in that new field or take it out of the new field?

Woman: I agree that they need to communicate with you. I am just reminding people that it is not - that Section 111 is replacing anything that needs to be done for the small employer exception process.

(Brian DuBiel): Okay. I have the same kind of questions related to if you send us back a SCE response code of SP where you partially accepted the small employer exception, if we have a subsequent change transaction on that type of record so you did build potentially an MSP occurrence, what should we send there, an add or an update transaction?

Woman: An update.

(Brian DuBiel): Okay. Well I think - I think that was it.

Coordinator: Next in queue we have (Linda Mendell). Your line is open.

(Linda Mendell): Hi. Thanks for taking my call. I had a question about HSAs. On Page 43 of the user guide it says that CMS will not consider HSAs to be reportable under Section 111 as long as Medicare beneficiaries may not make a current year contribution to the HSA.

My question is eligibility make HSA contributions is done on a monthly basis so that if somebody became enrolled in Medicare mid-year, that individual could still make HSA contributions for part of the year. And I just wanted to confirm that even if somebody made HSA contributions for the month before he or she enrolled in Medicare, the HSA - there is still no reporting associated with the HSA.

Man: Correct.

Man: That is correct.

Man: As long as it was done be - as long as the contributions were made before they became enrolled in Medicare.

(Linda Mendell): Okay. Because it said current year because it would be in the same year, it would just be in months. So really it should be - it may not - it is really a monthly thing as opposed to a year.

Man: In some places the regulations refer to yearly and other places it is monthly. It depends on however it is set up. A lot of HSAs I have seen do not let somebody go into it if they are going to become a Medicare beneficiary during the year.

(Linda Mendell): I do not think that is true.

Man: Well...

Woman: Well either way, if they made the contribution...

((Crosstalk))

Man: ...they became a beneficiary, you do not have to report it.

Woman: ...before they became a beneficiary, don’t worry about it.

(Linda Mendell): Okay. And I have a second question and this has to do with the healthcare reform lot in San Francisco where employers are required to make contributions to (Q) programs run by the city. One is a medical reimbursement account program and one is an actual medical coverage program where individuals can go and see doctors.

And because those are contributed by - because there are employer contributions, it seems like the city would be an RRE for those programs. Is that correct?

Woman: Who processes any claims with respect to that?

(Linda Mendell): The city or a vendor hired by the city.

Woman: Well if you look at our definition of who is the RRE for group health plans, it is - the only time it is the employer is when they are both self-funded and they do not have a separate claims processing PPA as defined in the Attachment A I referred to earlier which is in Appendix H of your user guide.

(Linda Mendell): Um-hmm. Well my concern was not so much that the employers would be responsible. My concern is that I was not sure that the city was actually thinking of itself as an RRE.

Woman: Well the city will not be unless it is self-funded and it does not have a separate claims processing PPA. If there is a separate claims processing PPA, that PPA is the RRE for GHP purposes.

(Linda Mendell): But as far as you are concerned, the medical reimbursement account program, for example, somebody is going to be an RRE for it.

Man: The medical reimbursement account is essentially is self reimbursement account, yes.

(Linda Mendell): And the fact that it is a city mandated program does not change that result.

Man: It does not change it. The same thing applies where you have got some states have got these pool that small employers can go into to get insurance for their employees. They are either on a voluntary or mandatory basis. Those too have to be reported.

(Linda Mendell): What about the issue that the city requires contributions for all employees except those that are enrolled in Medicare?

Man: (I think if you) - if you have got an example of that...

(Linda Mendell): It is in the ordinance.

Man: Well, (send to the comment) the site to the ordinance so we can look at it.

(Linda Mendell): Actually I have. I can resend it.

((Crosstalk))

Man: Then - yes (do).

Man: Yes resend it and just on your heading say San Francisco ordinance or something.

(Linda Mendell): Yes, it is a site. Yes, I will resend it. Thank you. That was it.

Nancy: Next in queue is (Lisa Sabatella). Your line is open.

(Lisa Sabatella): Hi, thank you. We have a behavioral subsidiary that is strictly in the business of providing benefits and paying claims on a carve out basis where the underlying medical coverage is provided by another carrier.

And a question has come up - they are going to be registering in April. This is a later initiative. The question has come up as to what coverage code they need to be submitting on their file. They will be using - they will be filing under the basic option.

Man: What do you mean by coverage code?

Man: Yes.

Man: When you say - what do you mean by coverage code when you are saying that?

Pat Ambrose: You mean field A coverage type...

((Crosstalk))

Woman: Yes, coverage type.

Pat Ambrose: Okay, so it is J hospital only...

((Crosstalk))

(Lisa Sabatella): Yes.

Man: Yes.

(Lisa Sabatella): Both.

Pat Ambrose: So I am not...

Man: I mean right now, I mean it - I assume it covers all expenses and it would be - should be submitted under Code A hospital medical.

Woman: You said this was a carve out of something else, other coverage?

(Lisa Sabatella): It is only mental. It is primarily mental health and it is also behavioral which is mental health and substance abuse.

Woman: We are discussing behavioral and we are looking at some updating to the GHP user guide in the near future. So, if - we suggest you just wait a week or two and we will probably be answering your question in the update.

(Lisa Sabatella): Oh, okay.

Man: I mean are these services covered by Medicare as well?

(Lisa Sabatella): Could you repeat that I - it broke up.

Man: Are these coverages covered by Medicare as well because that is the other thing.

(Lisa Sabatella): Well that was the - that has always been a question of ours...

Man: Okay.

(Lisa Sabatella): ...in that, you know, what of these diagnosis types would typically be covered by Medicare?

Woman: Well, well, we are specifically working on some language for the GHP user guide (so it is) behavioral site services. So...

(Lisa Sabatella): Um-hmm.

Woman: ...that should be out very shortly.

Man: And there are other resources that will tell you - official government resources that will tell you exactly what it is that Medicare covers. So, we are trying to harmonize what we are doing here with...

((Crosstalk))

(Lisa Sabatella): Um-hmm.

Man: ...with professional (unintelligible) with the other resources, that is true. And the others have said we do not have a firm answer on it yet. That is coming and you are not - I can tell you this but you are not the only person who has actually asked that question in the last month or so. So...

(Lisa Sabatella): Okay.

Man: ...we have some (unintelligible), yes.

(Lisa Sabatella): Okay, and while I have your ear, I just, you know, would like to make just one further comment in that because these products are on a carve out basis, and you are receiving the underlying medical membership from other carriers, I wondered if you knew that you would be receiving those memberships under other coverages. And so you are going to be getting a lot of duplication. Just ask - thought I would ask that question.

Woman: Yes. We understand that.

(Lisa Sabatella): Okay, thank you.

Coordinator: Next in queue is (Richard Rocatto). Your line is open.

(Richard Rocatto): Hi thanks for taking my call, appreciate your time. I think there is still some confusion, and I believe you did clear up a bit today with a Social Security number and reporting.

I have been working with some other plans and carriers and at this point, pretty much before Section 111, the common practice was if an employee did not want to give their Social, you would come up with a unique nine-digit number for your internal systems. Staff as social is usually optional.

I have been working with plans since January 1 and including my own, we are all talking about changing our systems to make it a required entry for at least the spouse, regardless of age, and the employee. It depends on whether people want to go down to a children and child level.

And I think there is just some confusion because when you look at the book -- and you may be changing it in your next revision -- when you look at the two specific sections, one about active covered individuals on Page 19 and on Page 43 when you go into the detail about SSN, it makes it look like it is required for anyone at least 55 and over in the healthcare plan. But today and from last week's call it sounds like that is changing a bit.

Man: Well again, it was never required. The problem is in basically trying to say here are options that people can use to submit data. And an option that has been used in the past by many of our voluntary partners is that they send us everybody who essentially, not knowing whether they have Medicare or not, just make the assumption that if they had Medicare, Medicare would be secondary.

That is one option. That means that you are going to be sending a lot more data though. The other option is to submit, you know, use a query file for

example or just develop on your own for those individuals where you know they have Medicare and Medicare is secondary.

So there has never been a requirement to report Social Security numbers and data on people that are not Medicare beneficiaries. And also, who even if they are Medicare beneficiaries for which Medicare is not the secondary payer.

(Richard Rocatto): I understand what you are saying, but with all due respect...

Man: And we are going to - and we are going to make some edits to that language to clarify that.

(Richard Rocatto): That would be perfect because...

Man: Yes.

(Richard Rocatto): ...when you read the first paragraph on Page 43 and you read the first bullet on Page 19 and you are, and like many of my co-workers, you are in a conference room of programmers and...

Man: Right.

(Richard Rocatto): ...other people, they take it literally and it would be a big help if you could rewrite that.

Man: Yes.

(Richard Rocatto): That would be phenomenal. That is it, thanks.

Man: Okay.

Coordinator: Next in queue is (Barb Hegan). Your line is open.

Man: Hello?

(Barb Hegan): They are covered in employee. I am concerned about the dependent and their age. Do you only want people who are under 45 that are on Medicare if they are a dependent or do you want all dependents?

Woman: If they are a Medicare beneficiary, you need to report them whether they are under or over age 45. What you have the option of is doing a mass reporting without knowing whether or not someone is a beneficiary for those that are above 45.

If they are below 45, you have to determine for sure whether or not they are a Medicare beneficiary and only report them if they are, and report their Medicare health insurance claim number rather than just the SSN.

(Barb Hegan): So if they are under 45, we need to report them only if they are on Medicare and they have a HICN?

Woman: Yes.

Man: Yes.

(Barb Hegan): Okay, but did you say everybody over 45 should be reported?

Man: No. We are saying - we are saying that again, there is two ways of doing this. We are saying that for terms of submitting information, you have that option of submitting full files of all potentially active covered individuals over...

((Crosstalk))

(Barb Hegan): ...over (unintelligible) files.

Man: ...actually (do).

Yes, or just sending the Medicare beneficiaries, that is all. We are just, I mean we apologize if there is some confusion out there regarding this process and we will again try to clarify some of that language.

Man: The first cut on all of this is that you need to send us any information about anyone that you are covering or that you have a member of group health plan and for whom Medicare is secondary payer if that individual is a Medicare beneficiary. That is anybody of any age. Okay? You need to send us that information.

(Barb Hegan): Okay.

Man: What we have been trying to do with some of these options for you to search our database is just to find that information before you send us a file. The basic requirement to send us information about any Medicare beneficiary, you know, or you should know of, exists and will always exist.

What we are trying to help you with here is giving you options and giving you help in finding the Medicare beneficiaries that you then have to report to us.

With the a - with the 45 plus, we are giving an option of sending a finder file to us and having us report back to you those individuals that we might find on our database that are in fact Medicare beneficiaries.

With the under 45s we are telling you that you need to send us any information about any Medicare beneficiary who is under the age of 45. And to do that you need to send us that information, including their health insurance claim number, their Medicare benefit ID.

We are not asking you to send us anybody on a finder file who is younger 45, but you still need to tell us about Medicare beneficiaries that are younger than 45. And that is kind of the bottom line on this.

All the other issues that are surrounding that requirement are who to include in the finder file. How many times to send it in? All those other issues are tangential. So the basic fact is that you need to send us information about...

((Crosstalk))

Man: ...Medicare beneficiaries for whom Medicare is a secondary payer.

Woman: And part of that is looking at the definition of active covered individuals. If John Smith is over 65 and his sole coverage is - and he, you know, has no ongoing employment relationship now and his sole coverage is retiree benefits, then you are not going to be reporting him because Medicare...

Man: Is not secondary.

(Barb Hegan): Oh, okay.

Woman: So do not fall into the trap of - and with a couple of the voluntary agreements we did have a problem in the beginning where entities sent us their entire retiree population. And no we do not want that.

Pat Ambrose: In fact, their claims will be paid incorrectly. If you mistakenly send retirees on your MSP input file, we will post MSP occurrences, make the assumption that Medicare is secondary and deny their claims. So it is important that those individuals not be reported on the MSP input file.

(Barb Hegan): Okay. Can I ask another question?

Man: Sure.

(Barb Hegan): What about this H-E-W software? What percentage of people - of your clients use that?

Pat Ambrose: I think just about all of the VDSA, VDEA partners with the exception of maybe less than 10 out of say 120 are using the H-E-W or the (HEW) software. However it is your choice. You may use your own (ANSI trans) or X12 translator and your EDI rep will provide you with the mapping documents or you may use a copy of the HEW software and use the (flat file) formats that are in the Appendix of the user guide as input and output.

Man: If you are not submitting a non-MSP file which allows for the query function, again as a GHP I would definitely want to be taking advantage of that again for not so much for the Medicare secondary payer identification, but also to find out, you know, to identify for example your retirees who are under 65 and have Medicare. This is where your plan may be paying improperly on your end.

Pat Ambrose: Can I ask a question to clarify your question, did you mean - was your question out of those that are using the query only file, do they use the HEW

software or not or was your question how many submitters actually use the query only?

(Barb Hegan): I was just - how many people use the query only.

Pat Ambrose: Oh. I do not have that information actually. So what I said before was incorrect.

Man: Oh you mean, well I mean most of the individuals we exchange data with use one or other - use non-MSP or use query.

Woman: Okay.

Man: You know. Again, for GHPs, I mean if there is a real, you know, it is a gift in terms of being able to look up those individuals where Medicare, you know, would be the primary payer. So because again, many GHPs, you know, they covered somebody. They had no idea the guy retired last year. He is 60 years old and disabled and Medicare is primary and that GHP is also paying primary.

(Barb Hegan): Oh.

Woman: One of the...

Man: So it is a real tool for GHPs to do a lot of cost avoid.

Woman: One of the incentives for the voluntary agreement from the beginning is particularly large employers who joined in those - were able to realize significant savings by finding out all the situations where they were

continuing to pay primary in retiree situations where they should in fact have been secondary.

Man: And two quick points here and then we have to move on. The first quick point is that historically, who used what query function depended largely upon the size of the reporter. And I will not go into how that (parses) out but that is basically what it was. The larger reporters used one type and smaller reporters used another.

But the major point here is that I do not want to confuse anyone on the call. We talked a little bit here about the voluntary process. The voluntary process really no longer exists. Once again, do not use it, do not intend to use it, do not send us anything on those files, etcetera.

We had a voluntary process in place for ten years. It gave us a lot of good information. We have now fully transitioned to the Section 111 process.

(Barb Hegan): Okay thank you. Thanks for taking my question.

Coordinator: Next in queue is (Peggy Taylor). Your line is open.

(Peggy Taylor): Thank you for taking the call. The question is along the lines of the TIN file of course. If you have a group that is not a (may wau) and it is not a multi-group employer plan, it is not a state plan but there are multiple employers attached to the group health plan because of - for example, they might be a controlled group. Do you have to submit the employer ID number for each employer...

((Crosstalk))

(Peggy Taylor): ...or just the group plan? In the user guide it says that you are supposed to submit each employer ID number rather than the plan ID number, so I am confused.

Man: We are going to put you on hold and come right back to you.

((Crosstalk))

Man: The - unfortunately we cannot really answer that question right now and what we are going to ask is if you could submit your contact information to the Section 111 mailbox with the subject - a clear subject line so we can identify that and provide us with your contact information?

Woman: If you would spell out your question again in...

((Crosstalk))

Man: Yes.

Woman: ...but specifically say, you know, you can say give today’s date as a call question and say summarize however you want in the subject line, whatever you consider the most relevant point.

Man: We just do not want to give you misinformation that is all.

(Peggy Taylor): I understand. It is very confusing. My second question is regarding authorized representative. Is that - is it - does it have to be a corporate officer or an employee of the corporation that can be the authorized representative?

The way I understand what you have said each time, and the way it is in the user guide is that the authorized representative has to be someone with the corporation that has the authority to bind the corporation, not just an employee. Is that correct?

Man: Yes. Yes. I mean, you know.

Man: It has to be someone with a corporation who has the authority to enter into a contract.

Man: Yes.

(Peggy Taylor): Correct. Okay. That is what I needed to know. I thank you very much. I will send that information to the mailbox.

Woman: Thank you.

Coordinator: Next in queue is Christine Smith. Your line is open.

Christine Smith: Hi. I am from Blue Cross and Blue Shield in Michigan. And my question is in regards to SSN collection. We have individuals who are from overseas that are working and living in the United States for a period of time. These individuals are eligible for group healthcare coverage through their employer, and for internal processing they have been assigned a pseudo contract number.

We have contacted the employer for the SSN for these individuals and they are indicating that they are not on a U.S. payroll and therefore they do not have an SSN. And we would like to know how we would handle this situation.

Man: You do not need to report them.

Christine Smith: We do not need to report them. Okay.

Woman: Could you hold on for just a second please.

Man: Hold on just a second.

Christine Smith: I think that has been taken care of.

Woman: Oh. What about the Canadians though?

Christine Smith: I am not talking - I do not care about the Canadians, I want to talk about these (unintelligible) people.

Woman: Our internal discussion had to do with the way you phrased your question. If these are people that do not have SSNs then no, they do not need to be reported.

But if, for instance, you had an American citizen working overseas and they are being paid on a foreign payroll, we still need the SSN.

Christine Smith: Right.

Woman: And we still need to know if that person is a beneficiary. And you did phrase it in terms of just they are on the payroll. If they truly do not have SSNs, do not worry about reporting them.

Christine Smith: Okay, thank you. And my second question would be in regards to the MSP input file. If we chose to submit for 45 and older and we do not have all of the

SSNs for that audience, do we still have the threshold time period to collect and report by 2011?

Man: Yes.

Christine Smith: Okay. All right, thank you very much.

Coordinator: Next in queue is (Michelle Eagan). Your line is open.

(Michelle Eagan): Hi, thank you for taking our call. I am going to turn it over to one of our other people. Hold on.

Man: On the header input file, there is a file date required and we were wondering if this is the file creation date or the file submission date.

Pat Ambrose: It can be either but we would expect it to be your file creation date and awfully close to your submission date. It is writ - it is generated by you and it is mainly used so that when a problem arises, you and your EDI rep can identify what files.

Man: Okay. On the detail record for the input file, there is the effective date and the term date. Is this based on the benefit plan for the coverage with the health plan?

Woman: It is coverage information.

Man: Yes, I mean each of those effective and term dates are basically, well I guess I am not quite sure we understand your question. I mean it is...

((Crosstalk))

Man: ...you are building unique coverage rows on our system of particular coverages that that person has.

Man: But if that person changes group information, but stays on the same plan, is that going to be a new row?

Man: Yes.

Man: Okay, that...

((Crosstalk))

Man: You would want to term the old record and add a new record.

Man: Okay great. That is clear now. That is our questions, thank you.

Woman: Operator, before you take any more questions, could you give us an idea how many are in queue?

Coordinator: We currently have nine other questions in queue.

Man: And how many are signed up on the call right now?

Coordinator: Two hundred and sixty four.

Man: So we have nine questions? Let us keep going for a while.

Man: Okay.

Coordinator: Next in queue is (Rich Ravino). Your line is open.

(Rich Ravino): Thank you for taking my call. My call references basically the timing. When we have to register in April, okay, how much time do we have to test the application on our side with your folks?

And then the second question is, what is the turnaround time when we find errors with the files? How long do our - how long does our testing team have on this side of the fence to make changes, reproduce the file and then retransmit it back to you folks?

Pat Ambrose: The first question, once you register and finish your account setup, a profile report will be sent to your authorized rep. Your authorized rep will sign that and send it back to the COBC and at that point that that information is logged, your testing can begin.

And your test period then is from that date until your live date essentially the first - when your first file submission is due.

(Rich Ravino): Okay, real quick on that point. The live date, okay, if we are testing, and we are testing, and we are testing and we are having issues, we are trying to flush issues and get it tested out, when is the finite end date that our testing has got to be complete.

Pat Ambrose: Well your file is due by your assigned file submission date.

(Rich Ravino): Okay.

Pat Ambrose: If you are having trouble, what CMS has asked is that you stay in close contact with your EDI rep...

(Rich Ravino): Right.

Pat Ambrose: ...explain the situation and make sure that they are aware of your efforts. And I think there is a document that goes into that to some degree, the compliance document that is out there on the GHP page.

(Rich Ravino): Okay.

Woman: (Ask for a date).

Pat Ambrose: I am sorry. I lost track of your second question.

(Rich Ravino): The second question was basically error resolution and then file resubmission. So let us say I submit a file to you folks. You come back and say there is all these errors.

On our side of the fence here, on our organization we have a, you know, a BTA group or a Business Test Analyst group that actually handles our testing and tracks defects. And then we actually correct the defects, you know, sign the defects correct and then what have you.

What is the turnaround - the expected turnaround time, you know, once I receive a list of errors or my account exec does and then how much time do I have to resolve those errors, turn them around?

It sounds like it is basically variable. It is based on how much time it is going to take our folks here to get those problems assigned corrected and the file resubmitted. So.

Pat Ambrose: Yes.

(Rich Ravino): Okay.

Pat Ambrose: Yes. Yes. And, you know, there is no file submission timeframe for your test files other than what I already described.

(Rich Ravino): Okay.

Pat Ambrose: So yes, I mean basically you would want to do it as quickly as you can so that you can finish your testing as quickly as possible.

(Rich Ravino): So basically we have a start date, an end date, and we better get it done before that end date.

Pat Ambrose: Pretty much it.

(Rich Ravino): Fair enough, thank you.

Coordinator: Next in queue is (Judith Meers). Your line is open.

(Judith Meers): Thank you for taking my call and thank you for having these calls. They are extremely helpful. I just wanted to ask for confirmation about my understanding on your answers to the reporting of Medicare Advantage Plan members.

The vast bulk of those members are people who have Medicare primary. But occasionally, there will be Medicare Advantage members in a plan who have Medicare secondary.

And my understanding of what you said, and I would like you to correct me or confirm it, is that you want us to report Medicare Advantage Plan members when Medicare is secondary for them, but we have no obligation to report Medicare Advantage members when Medicare is primary for them.

Man: Well if you are the one offering that coverage that is secondary to Medicare, the group private coverage, that coverage needs to be reported. I mean again, it is whoever...

Woman: She said secondary.

Man: Well.

Pat Ambrose: Yes, it is the reverse.

Man: Well. Okay. I am just. Okay. Sorry. The - yes, basically we are - sorry about that. Where the other plan is primary to Medicare, whoever sponsors that, you know, those are the - that is the data that needs to be reported.

Woman: Yes, they are.

((Crosstalk))

Man: So yes, people can have Medicare Advantage and they can have private coverage that is primary to Medicare Advantage. Whoever is the responsible reporting entity for that primary coverage needs to report that data as an RRE.

Woman: And could you hold on one second?

We want to add one clarification about beneficiaries who are in Medicare Advantage plans.

(Judith Meers): Okay.

Man: Are you talking about Series 800 Medicare Advantage Plans?

(Judith Meers): Yes.

Man: Okay. The rules are that an individual cannot be enrolled in a Series 800...

((Crosstalk))

Man: ...Medicare Advantage Plans, that Medicare would be properly secondary unless they are also enrolled in the employer's regular group health plan that is also primary to Medicare.

(Judith Meers): I agree. I agree.

Man: So you would then - I believe you would have to report both.

(Judith Meers): Yes. And my question is because Kaiser has both the commercial plan in which these people have their primary - and has enrolled them in the Medicare Advantage Plan which is secondary, we would be reporting these people as part of their commercial coverage indicating that Medicare is secondary for them. That is - and I just want your confirmation or correction.

Man: Yes.

Woman: Whoever is the RRE for the commercial plan would have responsibility for reporting on that plan.

(Judith Meers): Fine, thank you very much.

Coordinator: Next in queue is (Bill Monroe). Your line is open.

(Bill Monroe): Hi thank you. Just a couple follow up questions. One, for the situation where there's individuals in a company that is less than 20, and they are being excluded from - they are not being reported because of that, the company grows to be 20 or more, or I am sorry, more than 19, then my understanding from another question was that we would then need to report the date that that size changed.

However, we - instead of the effective date that is. And if that is true, then are you going to clarify that in the definition of effective date in the guide?

Woman: Yes.

(Bill Monroe): Okay good, thank you. The other one is I thought we heard that the - well first of all, the require- we understand the requirement for reporting employer size for a multi-plan is we are reporting the largest - the site of the largest employer in that plan. But we thought we heard that that would be the size of the parent company. Is that true?

Woman: Two slightly different questions. One is what employers are in the multi-employer plan and the other is when you have subsidiaries in a parent plan, in a parent company which is used in determining the employer size.

Man: Just to give you an obvious example, General Motors has any number of subsidiaries. You would technically count the number of employees that General Motors has as including all of those in the subsidiaries.

Woman: In other words, if they had one subsidiary that had 18 people and (unintelligible), you know, but you obviously know that General Motors has more than 100 employees, you have to go with the parent company size.

Now in terms of a multi-employer plan, if General Motors happened to be part of a multi-employer plan, then everybody in that plan is going to be considered to have more than 100. And the only way they would qualify for the small employer exception is if the Plan Administrator has specifically requested it for particular employers - for particular employees who were beneficiaries or their spouses.

(Bill Monroe): But if you are insuring only that subsidiary, then...

Man: No the number of employees (means) that the overall employer regardless of whether you are the insurer only for a part of the employees.

(Bill Monroe): Okay. So you are really only looking at the parent company size.

Woman: Correct.

Man: Correct. You are aggregating. Correct.

(Bill Monroe): Okay. The guide, it talks about a multi-plan which sort of sounds like we are insuring all of those, you know.

Man: Yes, we can clarify that.

(Bill Monroe): Okay, thank you.

Man: Operator, it is now actually five after three and we need to end this call due to some other commitments. Quickly wanted to thank everyone for their participation.

((Crosstalk))

Man: We apologize that the agenda got out a little late. Hopefully the next one will be out a little earlier. We had some IT issues here. But anyway, the - we wanted to thank everyone for participating.

Continue to submit your questions through the Section 111 resource mailbox and we will attempt to continue to refine the user guide and make it even more useful.

With that, thank you.

Man: Before they ran out of time.

Woman: Yes.

Man: Thank you operator.

Coordinator: This concludes today's conference. You may disconnect at this time.

Man: Thank you.

END