TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: March 4, 2009

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

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FTS-HHS-HCFA

Moderator: John Albert
March 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'd like to ask a question the command to do so will be star 1. Today's call 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: Thank you. Good afternoon everyone. I wanted to welcome you all to one of a series of ongoing discussions we've had with affected group health plans related to Section 111 MSP reporting requirements. Again this call is directed to group health plans; if you are a non-group health plan meaning worker's comp, liability, no fault insurer please check the schedule at the insurer reporting Web site which is cms.hhs.gov/mandatoryinsrep for other conferences that - teleconferences we'll be hosting with the non-group health plan community. Again this is for group health plans.

We wanted to provide a couple of updates before we went into question and answers, one of them is that we just approved for publication the latest version of the GHP user guide. It will be dated March 4, 2009, that should be showing up on the mandatory insurer Web page fairly shortly. If you are not subscribed to the listserv please do so. There is, on the main page for the mandatory insurer reporting Web site instructions on how to sign up for a list service so that you can be notified when updates are made to the Web site.

And again that will be forthcoming. This will address hopefully a lot of the questions that we've received either through telephone or through the CMS resource mailbox. To date we've received approximately 600 very detailed questions on the CMS resource mailbox and we encourage you to continue to submit those as well as any suggestions for additional information or materials you would like to see from us as we near the implementation date of the secure Web site.

A couple of things that - because we are already in transition with our existing voluntary data share partners to the Section 111 reporting a couple of things have come up that I'd like to just briefly touch on before we get an update on what you'll be seeing in the GHP user guide. The first is is that there's questions concerning testing and everyone should know that (there'll) be contractor tests on Mondays and test files received by the close of business on Friday are processed on Mondays.

During the testing phase you should try to send records for those active individuals age 65 and older thus assuring more matches to CMS's data. You know, if you can somehow screen out the people for your test file of 100 individuals who are 65 and have Medicare that helps with testing.

The other thing is that as soon as you do receive your signed profile report back please reach out to your EDI rep as soon as possible to get those - the testing process started. The sooner you engage with them the better that way you'll be able to meet your production deadline and begin a test quickly.

We also wanted to stress too that continued communication with your EDI rep is critical for the success of your implementation. They are there as a resource for you. They are dedicated - you are assigned a dedicated EDI resource and they are there to help you set this up from a technical perspective.

Finally please stay in communication with them regarding, you know, that when you want to submit files, things like that, so again, you know, stay in touch with them regularly, I guess that's a key thing to remember.

With me today - I also want to introduce a couple of folks that are going to be here on the call as resources. The first is Pat Ambrose, the second is Bill Decker and the third is (William Sevogna). And with that I would like to turn

it over to Pat who's going to provide an update regarding some of the changes to the GHP user guide.

Pat Ambrose: Thanks John. I'm just going to spin through the list of changes that are in version 2.1 of the GHP, the Section 111 GHP user guide, as John said will be posted very shortly out on the Web page.

We have refined the definition of active covered individuals and the alternatives for reporting for Section 111 - reporting on your MSP input file either by use of this definition of the active covered individuals and the age thresholds as indicated or by use of the finder file or query method that's in Section 7.1.

We've also added some examples of what an active covered individual is. We have replaced Section 7.1.6 to reflect registration that will now transfer to the COB secure Web site as of April 1. All GHP RREs who have not yet registered will register beginning April 1 on the COB secure Web site.

Step by step instructions have been added and also information on the data that you need to go through the registration and account setup process is included in the user guide. That same information will be available on the homepage of the Section 111 COB secure Web site as well.

We updated Section 7.1.7 to inform former VDSA and VDEA partners of changes made to the query only file layout. It will now, as of April 1, will start testing with the format that will use the RRE ID. And starting April - I mean rather July 1, 2009 production files for the query only file should include the RRE ID.

However, the software and COB system will allow you to continue to use the old format of the query only file. All new GHPs should use the new layout that's included in the user guide. And former VDSA/VDEA partners have an option as to whether to convert their software to use or RRE ID as opposed to their old VDSA/VDEA ID. I would recommend that you do convert to use your RRE ID going forward.

And the only change to the query only file is the header and trailer records where in the past we had a two fields of four byte VDSA/VDEA ID and a five byte contractor ID those fields have been combined into one RRE ID. Again you can continue to use the old format if you so choose.

References that were made in the past to test (Hartley) multiple employer, multi-employer plans, plans using an hours bank arrangement, were updated to basically reference any plans or other plans that also use an hours bank type of arrangement so you'll see some changes related to that, mainly that is the use of the plan sponsor 10 in the employer 10 field on the MSP input record and on the 10 reference file.

We also made a change related to putting the plan sponsor TIN in the employer TIN. You may do so however previous instructions had said on the TIN reference file to put the letters PF, standing for plan sponsor, in parentheses at the end of the name on the TIN reference file.

We don't actually want you to do that for the time being you should report those TINs using TIN indicator of E, for employer. In July we're adding a new indicator for plan sponsors and we'll update the guide and provide information on that at a later date.

We also made a note that when validating the TIN information we are not trying to match the corresponding name and address of the TIN provided with IRS data we're mainly just validating that number. There was a question on one of the previous calls related to that.

We also updated the section on the extension for reporting pending fee, small employer exception requests. This is the same information that is already posted to the Web page in an alert dated January 8. That was just included in the user guide as well.

New paragraphs related to or entitled initial reporting when the employer size reaches 20 was added to further clarify the reporting requirements regarding employer size.

We also have updated information on health reimbursement account reporting. RREs are not to report on health reimbursement account coverage until the first - rather the fourth quarter of 2010. And further instructions will be provided at that date. We found that we need to probably add some insurance coverage type in order to identify this type of coverage especially from other GHP coverage.

We added to Section 7.2.7 an exclusion for reporting coverage for stand alone behavioral and mental health care benefits. That's similar to excluding the excluding related to dental and vision coverage as well.

John Albert: The fourth quarter is July, calendar - not calendar but fiscal, right?

Pat Ambrose: No fourth quarter 2010...

John Albert: Okay.

Pat Ambrose: ...we're referring to October, November, December.

John Albert: Okay.

Pat Ambrose: But that's, yeah...

((Crosstalk))

Pat Ambrose: Challenge reports. We've also updated requirements to state that tri-care coverage and Medicare Advantage plan coverage should not be reported on the MSP input file. Tri-care - Medicare is always primary to tri-care and Medicare Advantage coverage is Medicare coverage so we don't need that reported to us on the MSP input file.

In addition to that we've updated some information related to calculating the number of employees. RREs should use the total number of employees in an organizational structure, the parent, subsidiaries, siblings, rather than just the number of employees and the particular subsidiary being reported on.

In addition in the case of a subsidiary of a foreign company the employee count should reflect the number of employees worldwide for the entire organization not just the subsidiary.

We have updated a couple of sections to add a recommendation that RREs utilize the Medicare health insurance claim number or the HIC number on input records on all files whenever that data element for a covered individual is available.

The COBC will pass back the Medicare HIC number on files for those individuals identified as Medicare beneficiaries and we highly recommend that you save that number associated with the individual and use it for further reporting. That is the official CMS identifier for Medicare beneficiaries.

We updated Section 7.3.1 to state that the query only file is transferred in the (X12.270.271) version (4010). And there are plans to upgrade to the (5010) version. The tentative date is January 2011; more information will be provided at a later date on that.

Section 7.5 was replaced to reflect how the testing process will now work on the COB secure Web site. After you have registered for the COB secure Web site once you start sending in test files the results of your test files will be tracked by the system and that information, statistics and related information to testing will be displayed to users of the COB secure Web site.

Section 8.1.1 was updated to list the information your account manager must provide for the Connect Direct file transmission on the COB secure Web site in order to complete account setup. So if you're choosing that method there is a fair amount of information needed about the destination files and your (AG&S) account information etcetera. This section has been updated to note that you need to have that information collected or you won't be able to complete the account setup process steps.

Section 8.1.2 was replaced to reflect secure file transfer protocol or secure FTP happening on the COB secure Web site as of April 1, 2009. So the information you need about the ports to use and all of that will be provided in this updated version of the COB - of the GHP user guide.

Likewise Section 8.1.3 was replaced to reflect using the COB secure Web site for the HTTPS file up and download methods. In the past the COBC for VDSA and VDEA, voluntary file exchanges, we had been using the CMS data center and mailboxes on the - at the CMS data center for these file transfer types.

We now, starting in April and for all new GHPs registering, will use the COB secure Web site and you'll have one centralized location for both tracking your file status, communication with the COB - with the COB on Section 111 and file transfer and all of that information will be in one place.

The language for the Section 111 data use agreement that you will see on your profile report and also on login warnings for the COB - the Section 111 application on the COB secure Web site has been updated, minor modifications were made to that data use agreement.

Section 11 was updated to reflect the implementation of the Section 111 application on the COB secure Web site. This is just an overview of how the Section 111 application will work on the Web site. A complete detailed user guide will be available once you log into the site and other information available on the homepage of that site.

This user guide that we're publishing now is mainly for the file formatting and you'll have a separate user guide for the actual functions on the COB secure Web site.

We made some minor modifications to Section 12 on contacting the CMS and the COBC for Section 111 reporting basically to refer you to your EDI representative first in that section rather than calling the generic COBC helpline.

The description of the RX BIN number, which is field 27 of the MSP input detail record and field 16 of the non-MSP input file detail record has been updated. This - the edit for that field when it's required for reporting drug coverage will require that the RX BIN be a six-digit number.

John Albert: This is John. Since we started doing data exchange to coordinate the new drug benefit that went into effect a few years ago it turns out that there are - there have been data submissions where people are not using the - I guess the BIN number is always a six-digit number. And we have received through our files some BIN numbers that were only five digits which caused a lot of problems at the pharmacy point of sale for administering benefits.

So we were requested to and are putting in an edit that will require that that number be a six-digit number.

Pat Ambrose: Okay. The definition of the values for field 19, employee coverage election, of the MSP input file detail record was updated in Appendix A to state that a value of 2, which stands for subscriber and family, should also be used when the coverage election represents subscriber and spouse. That was a question that had been submitted and came up on a previous call.

The record layout for the MSP response file trailer record has been added. We erroneously omitted this trailer record from the previous guide.

The header and trailer record layouts for the query only file, as I mentioned previously in Appendix B have been updated to use the nine-byte RRE ID in lieu of or instead of the four and five-byte fields for the old VDSA ID and contractor numbers. Again former VDSA/VDEA partners who were already

in production using the query only file may continue to use the format that they're using now.

Appendix F, from version 2.0 was removed as it no longer applies. It was related to HTTPS and secure file transmission methods at the CMS data center. Since that is moving now to the COB secure Web site as of April 1 there was no need for that information any longer.

If you have any questions on that, if you're still using your CMS mailbox you can contact your EDI representative. We do recommend if you're using a CMS mailbox right now for secure file transfer or HTTPS that you contact your EDI rep after April and convert over to using the COB secure Web site so that all of your Section 111 reporting and file tracking can be done in one place with one set of login IDs.

Appendix H from version 2.0 was replaced to include the entire updated attachment A to the Paperwork Reduction Act supporting statements. This reflects the updated PRA notice in the Federal Register as of February 13 I believe the date was. And Appendix H from version 2.0 was renamed as Appendix G.

Okay that summarizes the changes that we're making to this guide.

John Albert: All right and this is John again. I had a couple of other points I wanted to make based on the previous call and other comments that we've received since then. One of the things that was added was a clear statement regarding the submission of data regarding who you must report.

And that statement clarifies that while we do offer two options, that we feel based on past experience will allow responsible reporting entities to fully

comply with the requirements. We just need to reiterate again that the Section 111 law does not require (SPN)s or HICNs of someone who is not a Medicare beneficiary and also for whom Medicare secondary payer laws do not apply.

The problem is of course that many, you know, entities out there don't necessarily know who has Medicare so we offer these options as a way to basically help you cover all the bases so to speak. We've received those kinds of questions not only from industry but also even from individuals who are, you know, saying why am I being asked to provide this when I'm not a Medicare beneficiary.

And we're going to try to address more of that type of stuff through our outreach efforts. We've actually already provided language, for example, to the Medicare and You handbook, things like that, alerting people to this law.

Basically Section 111 does not apply to anyone who is not a Medicare beneficiary; it does not apply to anyone for whom MSP doesn't apply and it also doesn't apply to prescription drug benefits. There is no requirement to report prescription data under the Section 111 legislation. That is an option under the expanded option to allow you to coordinate not only MSP but also non-MSP drug coverages.

We would hope that most people that offer drug benefits would report them. We're not, you know, most people that, you know, offer a comprehensive policy their coverages do chose to report them all. But again it is not a requirement of Section 111.

Another thing I wanted to reiterate too is that as I mentioned earlier just on the GHP alone we've received about 600 written inquiries or questions all very

detailed and all very good questions. And as Pat just went over we do attempt to address all those questions and concerns through the user guide.

But one thing I need to stress is that we cannot answer MSP policy or basically vet whether or not in a particular situation you need to report. So and so; that is up to the responsible reporting entity to determine whether or not the individuals that they cover are reportable under the Section 111 - under legislation and the MSP statute. We are, you know, we can't get into those kinds of questions, we're, as you know, depending on how you ask it you can get 10 different answers.

So we would ask that you please refrain from asking those questions because right now we're basically trying to get the reporting process defined as clearly as possible for everyone. So please, you know, seek your internal counsel to answer those questions for you.

Another question that's come up also that's related to the SSN/HICN, again we are going to prepare a - are preparing a - basically a letter that you can use with your affected population. That basically can have that individual, you know, sign and inform them that here's why we're asking for this information; this will help you rest assured that, you know, you can demonstrate to CMS that you're using your best efforts to collect the health insurance claim number of SSN if they are unwilling to provide the Medicare number.

Another thing I also wanted to touch base on very quickly and that's since we are now in production with many of the existing partners it is very critical that you do not include people for whom the MSP rules do not apply on the MSP input file.

We've had several examples where large groups of retirees have been (sent) on the MSP file and retirees should not be sent because we don't - we can't make the determination whether someone is MSP or not other than through the, you know, the different - depending on when the coverage was offered and when the person becomes Medicare.

But essentially by including someone on the MSP file you were telling us that if they have Medicare, Medicare should be the secondary payer. So please review your submissions. It's very critical that in looking at any response files or even sooner that you inform your EDI rep of a potential issue regarding this so that we can work to basically correct that.

This happened in the past under our voluntary program and we did receive two files that included thousands of retirees on an MSP file which resulted in our building MSP records and denying benefits to affected beneficiaries for which Medicare really is the proper primary payer so please keep that in mind. We can not - you sending us a list does not - we cannot basically discern whether someone is MSP or not. You are telling us that by sending us those individuals on that MSP file.

Another question that's come up a lot and I'll just touch real quick and we have in the past and that is people are asking questions about whether or not, you know, once they register how do they change things or can they, you know, change agents or register under different RREs. That process is open indefinitely.

I mean in terms of if your business model changes or you want to change that or you want to change from the standard option or basic option to the expanded option you can do that at any time; there's no restriction on that.

So it's not like once someone registers in April that that's the way they have t submit for eternity, you can, you know, just by contacting your EDI rep change those methods of submission. We know that that happens all the time, for example, we had an entity years ago that was using a particular agent to report and that agent was doing a particularly bad job and they wanted to change how they were submitting.

You can do that at any time you want, so. Other than that, Bill, did you have anything to add?

Bill Decker: Yeah, John. Hi, thank you. Hi everybody. Good afternoon. This is Bill Decker. I just want to say a couple of things about the data exchange process itself. The first thing that I want to mention to everybody on this call is that when you talk to your EDI rep - you need to be talking to your EDI rep about EDI issues, about data exchange issues.

The reps - the EDI representatives are well trained and they're well versed in MSP. But they are not policy experts and they're not - we don't expect them to be policy experts. We don't want you to be asking them questions about how MSP works or not; those are questions that should be directed to us, not to your EDI reps.

We find out your asking questions of them because they ask us the same questions and indicate they came from you. It would be much simpler if you just directed them to us.

The second thing that I want to reiterate, I know John touched on this is that we get lots and lots of questions in our mailbox, our dedicated Section 111 mailbox. And as you heard already on this call today those questions have generated a whole raft of changes in the user guide and the questions that

come in are in fact read and digested by staff here at CMS and frequently result in changes in the way we're operating the program.

We can't answer each question that comes in directly but we certainly do look at all the questions and I think it's fairly clear from what you heard Pat and John talk about today that with our paying attention we want you to keep sending those questions in as you think of them.

The last thing I'll say is this: That we have had - those of you who are going to be new responsible reporting entities and signing up in April it may be useful to you to know that we already have 83 former VDSA and VDEA partners that have successfully made the transition into Section 111 reporting.

All of them have registered. Most are in testing and we even have a fair number, about 15% or 20% of the former VDSA/VDEA partners who are actually in production on Section 111 now. Consequently we are happy to report that with only a couple of glitches it has been a smooth transition for the former partners. And it's taught us a lot about how this process is going to work. And I think it'll be very beneficial to all of you who are coming in beginning in April.

We're continuing to do everything we can to make the process as smooth and as clean for everybody. And if it doesn't seem to be let us know. Most of you do so we're happy with that. And at that I'm finished and we're ready for you guys...

((Crosstalk))

John Albert: And one final note again, again with the CMS resource mailbox that is your best bet for getting information to us. That is seen by all and recognize that

people are anxious to get their questions answered and will do their best to try to contact individuals directly at CMS, things like that, that is no guarantee that - or probably even less of a guarantee that your question will be answered.

While we do occasionally return phone calls the best bet again, and we ask everyone to please put that into the resource mailbox. We do pay attention to all of those and those are distributed to the entire team here of many individuals who have to - or are charged with essentially implementing this process.

With that I would like to turn it back over to the operator to open it up for questions.

Coordinator: Yes sir. If you'd like to ask a question at this time please press star then 1. You'll be asked to un mute your phone and record your name as your name is required to introduce your question. Once again please press star 1 to ask a question and it'll be just a few moments while we wait for the first.

Our first question of the day comes from (Bob Gerkin), your line is open.

(Bob Gerkin): Thank you. Just a few quick questions, our data person just wants some clarification on some points. Dependant codes, let's see I guess we're looking at Page 84. If we don't specifically define in our system domestic partners we just put all that under 02 spouse and common law, correct?

John Albert: Well the problem with spouse is that the MSP rules, depending on the relationship of the working age rules versus the disabled rules are different.

Bill Decker: (Unintelligible).

John Albert: Yeah, I mean, yeah. We really do need you to capture those separately because the MSP rules for working age versus disabled are different.

(Bob Gerkin): For domestic partners you need to...

John Albert: They would be treated as a family member not as a spouse.

(Bob Gerkin): Not as a spouse.

John Albert: Yeah. They are not treated as a spouse.

(Bob Gerkin): Okay. Considering that we don't have that separately indicated at this point for plans that do allow that we'd submit it at this point as - they're in our system as spouses, partners. Go with best available information and change it in the future as we can acquire the information then?

John Albert: Can you hold on just a second?

(Bob Gerkin): Sure.

John Albert: Yeah, I mean unfortunately the risk with including them would result in a potentially erroneous MSP record. You know, we could say that you could submit them and hope that that particular reason for entitlement doesn't affect, you know, there's no differentiation but unfortunately the MSP laws are set up, they're - depending on how they're entitled it affects whether or not Medicare is secondary or not.

The working age rules recognize spouse and the primary policy holder. The ESRD and disabled recognize family members.

(Bob Gerkin): Okay. Recommendation for moving forward pending getting those defined?

John Albert: I mean I would say that, you know, I would probably report them and if it turns out that there is an inappropriate denial those can be corrected manually so...

(Bob Gerkin): Okay.

John Albert: ...that kind of covers your base but still though we would expect you to eventually develop for and submit that information.

(Bob Gerkin): Okay.

John Albert: We understand your desire of course to report the individuals that, you know, may be, you know, affected by the disability or ESRD provision.

(Bob Gerkin): Okay.

John Albert: So...

(Bob Gerkin): Okay, the tax ID number files where the field is shorter than the group name do you prefer a truncation or abbreviation or does it matter to you?

John Albert: It doesn't really matter, I mean, as long as it's, you know, primarily it's the mailing address not the name that matters.

(Bob Gerkin): Okay. Okay. Okay parent company in Colorado, wholly owned subsidiary in Arizona, can we report both of those together, one file, one RRE?

John Albert: Yeah.

(Bob Gerkin): We set up - okay. Do you have ESRD criteria posted on the Web site somewhere? Questions coming up is, you know, if we get a mistype on the diagnosis code we're using or some other way that we may send up somebody ESRD that is not that may cause an issue.

John Albert: Well I mean in terms of who you send, you know, whether you call them ESRD or not it's really what - how they're entitled to Medicare and Medicare makes that determination.

((Crosstalk))

(Bob Gerkin): So if we send up somebody ESRD and Medicare does not determine them so there's not going to be a bad outcome for the individual?

John Albert: No, I mean, if they're not entitled to - if they're not entitled to Medicare due to ESRD and that's the only reason you're sending them then we wouldn't build a record.

(Bob Gerkin): Okay so they're just going up as just in case. Okay. Now say we have an individual who goes back through multiple coverage changes; let's say he's a covered individual, he goes back through family coverage, individual coverage, family coverage...

John Albert: Those would all be separate records.

((Crosstalk))

(Bob Gerkin): We're going to take him all the way back to the first date of his medical coverage, correct?

John Albert: No we're looking for the coverage that was in effect as of 1/01/09. So if he had like a self coverage and he changed in December of '08 to a family coverage so we would only require that family coverage forward. The record that was current as of 1/01/09.

(Bob Gerkin): Oh okay so if his family status - let me clarify this. If his - if he is covered as a family status, family coverage as of 1/01/09 and that coverage began 12/01/08 prior to that he was individual coverage you only need to see his records back to 12/01/08?

John Albert: Yeah.

(Bob Gerkin): Excellent. That makes...

John Albert: I mean, if he had the same coverage for 10 years like from - I'll give myself as an example, I've had Blue Cross Family for six years and my effective date, you know, was 2003. A first record reported on me would be starting January 2003 and open ended through today.

(Bob Gerkin): Right. But if you had changed to individual coverage only as of December 1 we 'd only go back to December 1 on you then?

John Albert: Hold on just a second. Sorry we're back.

(Bob Gerkin): Okay.

John Albert: We haven't changed our - yeah.

(Bob Gerkin): Okay, all right. And she just wanted to confirm that you don't get any retirees ever whether they're ESRD, not, never, correct?

John Albert: Well it would be - it could be ESRD if it's in the coordination period.

((Crosstalk))

John Albert: ...coordination period.

(Bob Gerkin): We have them indicated as a retiree.

Bill Decker: If they're a retiree but they're receiving dialysis they qualify as an asset covered individual.

(Bob Gerkin): So if they are a retiree and they're defined as ESRD you want to see them right?

Bill Decker: Yes.

(Bob Gerkin): Okay.

John Albert: Yeah, I mean, on the current employment status only applies to disabled and working aged.

(Bob Gerkin): Okay. Now when we set this up in April there's going to be no problem setting up to use the query file at a later date; we're not going to be prepared to use that right away, is that a problem?

John Albert: That's fine. The query file is for - is only for your alls use, we don't do anything with the query data.

(Bob Gerkin): Okay. And when I look on the Web site the only link I'm seeing for the user guide is the one from December 17. Where am I finding the updated user guide?

John Albert: That's not out yet. As I mentioned it will be published most likely this week.

(Bob Gerkin): Oh.

John Albert: So if you're not on they listserv please subscribe to it and you'll get a notification when an update has been sent to the homepage.

(Bob Gerkin): Okay great. And as I said earlier thanks for your time.

John Albert: No problem.

Coordinator: Next in queue is (Kathy Schuster), your line is open.

(Kathy Schuster): Yes, thank you. I've got a couple questions. One is in the user guide for the TIN file field number eight, it's called the TIN indicator; do we need to send a record for us as a health plan insurer and a second record for us as a health plan employer?

John Albert: If you are both an employer and an insurer reporting, yes.

(Kathy Schuster): Okay. The other question is in the user guide for the MSP files field number 20 it's called employee status, if a record is being submitted for someone

other than the employee such as spouse or dependent what value do we put in this field?

Pat Ambrose: It reflects the subscriber's or employee's status. So if, for example, let's suppose you have a husband and wife and the husband is the employee, the subscriber...

(Kathy Schuster): Okay.

Pat Ambrose: ...and in an active status. If you are to report a record for both individuals for the husband and the wife because they both are fitting the definition of active covered individuals then the employee status - and let's suppose the wife was not working, the spouse was not working...

(Kathy Schuster): Okay.

Pat Ambrose: ...both of - the employee's status would reflect the active employment or current employment status of the subscriber or the husband on both records.

(Kathy Schuster): Oh that helps. Thank you. And then I had a question, in the CMS online training they were explaining that if we send a record in the MSP file and there isn't a match that we are supposed to continue to send that record until a match is found. We were trying to understand what the purpose was behind that because, for an example, if we sent a 45 year old and there wasn't a match we're thinking we'd be sending that record for 20 years before there'd be a match.

John Albert: Well the reason why you're - it's not that you have to send them it's that at each reporting interval you have to look at that group of people that you insure. And if the MSP laws would still apply to that person, you know,

assuming you don't know whether they're a beneficiary or not, we would advise that you send that person each time because again someone may not have Medicare entitlement status today but tomorrow they may.

We don't have a way of keeping that old data. I mean, you have to tell us that the person is still essentially would be MSP. So for example you send somebody on your first file who's age 56 and, you know, tomorrow he becomes entitled due to disability and in the case of that individual Medicare should be secondary. If you don't send him on your next file we're not going to know to build an MSP record; you need to continue to submit that person.

Obviously most people will attain Medicare status when they turn 65. But you do have the individuals that could be MSP due to disability or ESRD, that's why we're saying to continue to resubmit those.

(Kathy Schuster): Okay. And my last question is...

John Albert: The other option of course is if you're using the query file you can continue to query every quarter and then when say the person did become eligible for Medicare - entitled to Medicare you would then correspondingly look to see if you need to send an MSP record on your next file. So there's just two ways of doing it, you can keep sending them on the MSP file or you can query until there's a match and then try to build an MSP record if it applies.

(Kathy Schuster): Okay thank you. And my last question is for registering as expanded or basic in the CMS online training it said that if we submit (E02) files to CMS that that would be similar as being compliant as registering as expanded? So we're - our health plan is planning on submitting (E02) files so we're thinking that we don't need to register as expanded.

However, we would like to report drug information in our MSP file. So we're wondering if we can register as expanded but instead of sending a non-MSP file if our (E02) file would suffice and still allow us to send our drug information on our MSP file?

John Albert: Yes, yes. We do allow that option for (COBA) trading partners. A lot of them submit supplemental drug records and query records through the (E02) transmission.

Pat Ambrose: But what the user guide was trying to tell you was that in order to be an expanded - in order to use the expanded reporting option you have to submit drug information in some fashion either on the MSP files for coverage that may be primary to Medicare or on the non-MSP files for supplemental. In lieu of sending supplemental information though on the non-MSP file it is possible to use that (E02) record reporting on your - if you're also involved in the (COBA) claims crossover exchange.

(Kathy Schuster): Oh that's great.

Pat Ambrose: So you would want to register as an expanded reporter, register selecting the expanded reporting option. And you do not have to submit a non-MSP file since you're reporting your supplemental on the (E02) and then - but let's suppose you don't even offer any supplemental coverage you would still comply with the requirements for the expanded reporting option if you're providing us prescription drug coverage information on the MSP files.

(Kathy Schuster): Okay.

Pat Ambrose: Okay.

John Albert: Yeah, there are a lot of existing - the former VDSA/VDEA partners that use the (E02) file to report supplemental drug data and to query through that process. That's an option that the existing partners have and use. In fact the biggest chunk of data we receive regarding retiree drug coverage is on the (E02) process.

Pat Ambrose: And then the advantage for you registering as an expanded reporter or using the expanded reporting option is that then in the file exchange we will provide Medicare Part D coverage information back for those individuals found to be Medicare beneficiaries who have that coverage.

Bill Decker: And one additional advantage to being an expanded reporter is that you can use that non-MSP file if you wish for its other two functions, for (RVS) reporting or in its query form.

(Kathy Schuster): Yes. Okay thank you for your help.

Coordinator: Once again if you have a question please press star 1. Our next question comes from (David Pittman), sir your line is open.

(David Pittman): Yes I have a question about the change in the user guide regarding plans with hour banks, the multi-employer type plans with hour banks. Since we haven't seen the user guide I can't ask a specific question so I'm just asking for a little bit more clarification about what the change is and what the intent of it is.

Pat Ambrose: The change really - there's not much of a change other than we do want you, as stated before, to put the plan sponsor TIN in the employer TIN field. The change has to do with we don't want you to put that (PS) in parentheses at the end of the name on the TIN reference file. Instead we're going to add a new TIN indicator.

So when you start testing assuming you're a new GHP reporter, when you start testing in April you'll submit a TIN reference file, you'll use the plan sponsor's TIN in the employer TIN field and again this is just for those hours bank arrangements.

And on the TIN reference file you'll put the plan sponsor's TIN in the TIN field, use a TIN indicator of an E for employer for the time being and just put the regular name for the plan sponsor with no open paren PS close paren.

Starting in July we will make available a new TIN indicator on that TIN reference file for plan sponsors. I'm not sure of the value off the top of my head, probably a P but don't quote me. And at that time you can send in a new TIN reference file to update that particular TIN record and use the P indicator; that's all that will be required at that time.

The real point is is that we had made a mistake by telling you to put paren PS close paren in the name on the TIN reference file. And that's turned out not to be such a good idea. Did that...

(David Pittman): Well yes. I was really asking also if there was any kind of clarification about the types of plans that that would apply to. We administer a number of multi-employer plans that don't technically have an hour bank but where we look back six months or 12 months and combine all the hours worked for various employers over a larger period of time.

And the same problems that an hour bank plan would have would apply to that kind of plan. And I wanted to know if there was reason why we couldn't use the same approach with plans like that where it's a multi-employer plan and we are combining hours over a longer period of time?

Bill Decker: You can use the same approach.

(David Pittman): Thank you. That's all for me.

Coordinator: Next in queue we have (Mark Durgerabidian), your line is open.

(Mark Durgerabidian): Thank you for taking my questions. I have four questions from (Harvard Pilgrim Healthcare). First question is referencing Page 34 of the existing user guide. We have a question regarding what disposition code or error messages will be provided when the social security number or HICN number on the individual's record cannot be matched to other fields? We just weren't clear on what that messaging will look like back from CMS.

Pat Ambrose: If you send us the records that we cannot match to and, you know, the format of the record is correct but we cannot match that information to a Medicare beneficiary you get a disposition code of 51 back on you response record.

(Mark Durgerabidian): Okay. All right thank you. Second question is in regards to response files. Based on the user guide it states they'll be sent back to the RRE within 45 days of receipt of our input files. Is it 45 days calendar days or business days?

Pat Ambrose: Yes, and that's a good point, I'm glad you brought it up. Throughout this user guide whenever we're referring to a number of days it's always calendar days.

(Mark Durgerabidian): Okay. Excellent, thank you. Third question is, as part of the registration process CMS is requiring an email address. One of the things we've talked about as an organization is setting up a generic address such as

cms111@harvardprilgrim.org. Is that something we can do as part of this process? We're looking to have several staff have access to this box.

Pat Ambrose: No, we actually ask that the email addresses that you provide pertain or are owned by a particular individual. That said your account can have multiple people associated with it. So you may have one account manager but you can have an unlimited number of account designees. And those, you know, it is true that the emails that we send back will mainly go - will only go to the account manager. There are some occasions where we send it to the authorized representative but that isn't a user of the Web site.

So for now only the account manager will get that email communication back and will need to forward it on to others that may need to see it. However, as far as logging in and viewing information and transferring files and the login ID and password that you need for secure FTP file transfer for example you may use any person's email to obtain a login ID and password. But that email we do ask be unique to a particular individual and there's user agreements and login warnings and the like that are related to that. It's a CMS security requirement.

(Mark Durgerabidian): Okay, fair enough. Our last question is in regards to (Harvard Pilgrim) plans to register for the basic reporting option. And on Page 83, field eight, coverage type on the MSP input file seems to indicate the valid values when reporting under the basic option, J for hospital, K for medical only, A for hospital and medical.

(Harvard Pilgrim) is - we cover hospital, medical and drug benefits. So I'm just curious what proper coding we should use in that field. It just seems incorrect to do J and K.

John Albert: Yeah, I mean, you can use the W code.

(Mark Durgerabidian): Okay, that's what we figured but wanted to check.

John Albert: We - I mean I guess like the question would be why would you not then sign up for the expanded I guess?

(Mark Durgerabidian): Right.

John Albert: So...

(Mark Durgerabidian): Okay so the W code.

John Albert: If you, I mean, you know, if you use the W code that's going to trigger edits for drug data. So if you don't provide - if you don't provide the required drug data that - it doesn't affect the posting of the hospital medical MSP record but an attempt to build a prescription drug MSP record will result in a separate disposition code that will - an (RSP) code essentially, you know.

Pat Ambrose: What you need to do if you're going to use a W is go back - through the other fields and note that there are certain prescription drug-related fields that are required when you use a coverage type of W.

John Albert: Or any of the drug...

Pat Ambrose: And if you're not providing that drug coverage information you have to use then just those coverages that are without the drug coverage.

(Mark Durgerabidian): Okay fair enough because we are going with the basic option so that makes sense.

John Albert: Okay. Thank you very much for your time.

Pat Ambrose: Well and let me make one more point about that...

(Mark Durgerabidian): Sure.

Pat Ambrose: ...that even if you are a basic option submitter you can submit drug coverage and that will be accepted and processed.

John Albert: Yeah.

(Mark Durgerabidian): Very good. Thank you.

Coordinator: Next in queue we have (Nancy Morgan), your line is open.

(Nancy Morgan): Hi. I just had two questions. One is that the input file says you need a last name required and a first initial required but we have a lot of participants who only have one name so how would you like us to handle that?

John Albert: One name?

(Nancy Morgan): Well I'm from the Screen Actors Guild's health plan, that's a entertainment industry so you can imagine that we have a lot of one-named people.

((Crosstalk))

John Albert: Yeah, I mean, I guess I would consider it the last name. It would still potentially - if that's what's on SSA's enrollment database and you have the date of birth and the gender correct then that will result in a match.

(Nancy Morgan): Okay.

John Albert: If you think it is a first name then put it in the first name field. I mean three of the four of the, you know, the first initial, first six characters of the last name, date of birth and gender are required so if you're missing one of them it can still match. We basically use the database that we use is basically the Social Security Administration's enrollment database to determine whether or not that person is who you think they are essentially.

(Nancy Morgan): Okay. Thank you. And we also have a lot of married participants so are you anticipating that we would send one file where, you know, the husband is a participant and the wife is the dependant - I mean the wife's file where she's the participant and her husband as the dependant...

John Albert: Yeah, yeah. If the reporting and requirements apply to both then yes, that's more and more common.

(Nancy Morgan): Awesome. That's what I needed. Thank you.

John Albert: Sure.

Coordinator: Next in queue we have (Anita Branch), your line is open.

(Anita Branch): Hi I just have one question here. When I send in a record for someone who is under age 45 and disabled I'll receive a code back from the MSP response file indicating that person is disabled and entitled for the Medicare. Now if say two years down the road that person comes off of disability do I need to send in another record indicating such? And if so how is that down?

John Albert: No you don't need to. I mean once - if their entitlement ends I mean we will know that and we'll essentially terminate that record. It won't result in, you know, Medicare denying claims. So there's no need to submit them. Now of course when they turn 65 and age into the system and if they still are, you know, an active worker and covered or, you know, have coverage through an active worker then you would need to submit a new MSP record.

(Anita Branch): Okay.

John Albert: Okay?

(Anita Branch): Thank you.

Coordinator: Next in queue we have (Mike Cochran), your line is open.

(Mike Cochran): Yes I just wanted to confirm that the reporting requirements for health reimbursement accounts and health reimbursement account type plans has now been pushed back to fourth quarter of 2010? Is that correct?

John Albert: Yes.

(Mike Cochran): Okay. And then the second part is if an RRE does not have any other product to report other than an HRA or HRA type product do those RREs still register on 4/1?

John Albert: I think we, well, and more of that's forthcoming; we can't answer that at this time.

(Mike Cochran): Okay.

John Albert: So, and actually we probably shouldn't have said what we just said anyway because it's not been officially released on the Web page so.

(Mike Cochran): Okay, will that be clarified then in the new...

John Albert: Yeah.

(Mike Cochran): ...user guide as to when those entities will register?

Pat Ambrose: Well actually the new user guide that we're getting ready to post I don't believe addresses the registration so...

John Albert: We're going to probably end up doing a special alert just for HRAs.

(Mike Cochran): Okay.

John Albert: So...

Bill Decker: But the original - the original piece to that information we can stick with.

(Mike Cochran): That the reporting is delayed until fourth quarter 2010?

Bill Decker: That's correct.

(Mike Cochran): Okay, thank you.

Coordinator: Next in queue is (Pamela Deweiss), your line is open.

(Pamela Deweiss): Yes, hi, hello. We are a specialty managed care company and we pay mental health and substance abuse claims for our contracted group health

plans. Earlier in the introduction you made some statements about the new Section 7.2.7 and that standalone mental health and substance abuse benefit coverage did not need to be reported.

Pat Ambrose: Yeah, let me read you the section from the user guide would be the easiest thing. “Behavioral mental health care services are generally not covered benefits in the Medicare program. When offered as standalone products behavioral and/or mental health care GHP coverage is not to be included in Section 111 reporting.”

“However RREs are responsible for being aware of situations where health care services are covered by Medicare and paying primary to Medicare for all beneficiaries who have such standalone coverage when appropriate.”

(Pamela Deweiss): Okay so in other words there’s another resource out there of which I can draw some conclusions about when standalone would be reportable and what standalone is? Because these health plans generally do have, you know, medical coverage and either they’re managing claims and payment for the physical health benefit or they’re contracted with a different carrier. We’re doing strictly mental health substance abuse.

Pat Ambrose: In that case the coverage would not be reported. And that the other...

Bill Decker: Let us think about this one. Have you send this in to the Section 111 reporting mailbox?

(Pamela Deweiss): I’m sorry, repeat that question?

John Albert: Have you sent that comment into the resource mailbox?

(Pamela Deweiss): Yes I have.

John Albert: Okay, did you include like your contact information?

(Pamela Deweiss): I did.

John Albert: Okay.

Pat Ambrose: So the issue is that this coverage is not technically standalone but they have different (PPA)s or...

(Pamela Deweiss): Exactly.

Bill Decker: It's basically carve out coverage, right?

(Pamela Deweiss): It is, exactly.

Bill Decker: Okay. Yeah it's - if you've got a master group health plan and it carves out those benefits, farms them out to another insurer and technically it's coverage under the master group health plan but it's not the same insurer and it's not...

(William Sevogna): In addition to processing the claims do you make the payments?

(Pamela Deweiss): I'm sorry, repeat the question?

(William Sevogna): In addition to processing these claims do you also make the payments?

(Pamela Deweiss): Do we also make the payments? Yes.

(William Sevogna): Okay, was your question clear as to the nature of the contractual relationship between you and the master plan?

(Pamela Deweiss): I'm not understanding that question.

(William Sevogna): Okay, was it clear from your question that the coverage that you - or that you administer was part of a larger plan and that you were only administering certain sections of the larger plan?

(Pamela Deweiss): That is correct.

(William Sevogna): And that you were contracted with the other plan for that purpose and you were making the payments?

(Pamela Deweiss): That's correct.

(William Sevogna): Okay all of that was separately identified?

(Pamela Deweiss): In the question that I put in the resource box?

(William Sevogna): Yes.

(Pamela Deweiss): I don't know. I'll certainly resubmit it.

John Albert: What is - do you mind giving us your name right here?

(Pamela Deweiss): Sure it's (Pamela Deweiss), the company is Value Options.

John Albert: Okay, thank you. Yeah, please, if you don't mind provide any additional detail.

(Pamela Deweiss): Okay.

John Albert: Thank you.

(William Sevogna): Yeah, for everybody on the call that's a point we really do want to get clear very quickly because it's going to come off what some (unintelligible). So we'll be happy to address that as quickly as we can.

(Pamela Deweiss): Thank you.

Coordinator: Next in queue is (Scott Blankenship), your line is open.

(Scott Blankenship): John, you mentioned a resource mailbox. I know it's being - email sometimes is mentioned. Is this - if I wanted to submit a question it is the email address that's on today's agenda?

John Albert: I don't know - I don't have the - basically on the homepage of the mandatory insurer reporting Web page, the home page...

(Scott Blankenship): Yes.

John Albert: ...at the very bottom there are - there is a - I guess it's a link to - yeah, it's a link to - I can't remember what it's tilted but it's at the very bottom of that page.

Pat Ambrose: First there is the email address to send in questions as we've been talking about, that is on the agenda for this call.

John Albert: Oh is it, okay.

(Scott Blankenship): The (PO110173SEC111)?

Pat Ambrose: Yeah.

(Scott Blankenship): Okay and I would just submit a question and put it - group health plan on the subject line and that's how you'll get it?

John Albert: Yeah.

(Scott Blankenship): Okay great because there's just more than one type of email address out there when I'm searching through the site and I just wanted to get that straight.

John Albert: Yeah, do not use the how to submit feedback one, that actually goes to like the Web administrator; that concerns the...

(Scott Blankenship): Right.

John Albert: ...you know, the architecture of the page itself. We want the question.

(Scott Blankenship): Right, thank you very much.

Pat Ambrose: And then, you know, another point to that though in order to get the notifications, the automated notifications for when the Web site is updated down at the bottom of the mandatory insrep Web page there's a link that's called for email updates and notifications. You click on that and it'll take you through a series of screens where you enter your information and email address so that you're put on that listserv that John was referring to earlier.

(Scott Blankenship): Okay, I'm at the mandatory insurer reporting page, where is that?

John Albert: That's toward the bottom of the page.

Pat Ambrose: Yeah, it's toward the bottom of the page. I'm trying to find that. I guess later in this call I can recite what the...

(Scott Blankenship): Oh I see it, I see it. Thank you very much.

Pat Ambrose: Would you mind reading that link to everyone?

(Scott Blankenship): Sure at the very bottom of the page - it's almost to the very bottom it says related links inside CMS and then there's a link that actually says for email updates and notifications. But be warned - be careful because several lines below that there is another link that says submit feedback and I believe that's what you were talking about...

John Albert: Yeah.

(Scott Blankenship): ...John.

John Albert: Yeah, don't use that one.

(Scott Blankenship): Do not use that one, correct.

John Albert: Yeah.

Pat Ambrose: Right and...

(Scott Blankenship): Thank you.

Pat Ambrose: And the link that you just read off is in the version of the user guide that's on the Web site as well too I just didn't have it handy in front of me, sorry.

(Scott Blankenship): Okay, thank you very much. That's all I had.

Coordinator: Next in queue we have (Albert Poulson), your line is open.

(Albert Poulson): Yes, hello? Hello?

John Albert: Yeah, we're here.

(Albert Poulson): Oh okay, thank you, I was on the speaker and I picked up the handset. I just have a few questions. One thing I've been confused about is - and I may have overlooked it in the mandatory GHP user guide; what is the Web site that we will access to register in April?

Pat Ambrose: That will be published in the new version of the user guide within a matter of days. The Web site is section111.cms.hhs.gov.

(Albert Poulson): Can you repeat that again?

Pat Ambrose: Section111.cms.hhs.gov.

(Albert Poulson): Okay.

Pat Ambrose: It's not going to be available until April 1.

(Albert Poulson): Until April 1, okay. Now let's say April 1 one registers then how soon would you be able to accept test data, the day after?

Pat Ambrose: As soon as you complete - there's a two step process on the Web site and once that's - those processes have been completed then you'll receive a profile report sent to your named authorized representative via email as an attachment. Your authorized representative needs to sign that and send it back to the COBC. And after the COBC has it checked off essentially that it has received your signed profile report you can start testing.

(Albert Poulson): Okay, wonderful. All right, just a couple other - dependent social security number, I know this has been discussed in the past. We have written all of our participants and all of our groups - we're a third-party administrator first of all. What I'm trying to ascertain now is you have a participant in the plan that categorically does not want to submit the dependents' social security numbers. What do we do?

Bill Decker: There's a - let me take the first stab at that. This is a question we've gotten perhaps 500 times. And I know that we've tried to answer it before and we'll give you yet another crack at this.

(Albert Poulson): No you have answered it and it's been great but we're trying to formulate a letter saying it's mandatory. We just want to make sure the wording is correct to get everybody to comply.

Bill Decker: The primary ID for Medicare reporting is the Medicare ID number, the Medicare HICN, the Medicare Health Insurance Claim Number. That's the number that we need primarily to do any kind of matching against our database.

(Albert Poulson): Okay.

Bill Decker: If that number is not available to us - if we are to do a match on the database we will then have to have a social security number in lieu of the HICN, okay? That way we can do a match. From the perspective of the people supplying us the information the best information you can give us is the health insurance claim number, the Medicare ID number.

If you are interested in knowing if someone you have as a potential person to be reported to us under Section 111 is a Medicare beneficiary or not and you do not have a health insurance claim number for that individual the way you can check against our database is through that individual's social security number.

(Albert Poulson): Okay. All right that helps me out quite a bit. So then you would not - okay, I understand. Then the other one I have is you talked this afternoon about EDI rep. Is that the EDI rep in our company or is that an EDI rep outside of our company?

John Albert: No we're talking about the electronic data interchange rep at the coordination of benefits contractor that you will be working with to exchange data. They are your primary contact with CMS at the coordination of benefits contractor.

(Albert Poulson): And how do you obtain their information so that you can contact them if you need to?

John Albert: You will receive that once you register with CMS...

((Crosstalk))

(Albert Poulson): Okay.

John Albert: Yeah, on the profile report that we send back to you once you do your electronic, you know, your registration we will send you back a profile report which will include that information.

(Albert Poulson): Okay. Thank you very much.

John Albert: And again just to reiterate again there is no requirements on anybody to send us information on individuals who are not Medicare or for whom the MSP statute does not apply at this time. So I just want to make sure that, you know, there seems to be a misconception out there that somehow we are requiring SSNs of all these people age 55 and over.

And many of them, you know, there is no requirement to send that data. Again the requirement is to report MSP situations to us. But of course, you know, again, as Bill said, most people don't know if they have Medicare or not because they don't have the health insurance claim number. So we do allow those as options for essentially helping you shore up your data on your end to make sure that you're not missing anyone you are supposed to be reporting to us.

(Albert Poulson): So then in other words a good faith bet would be send everything the first time then receive the response back and then after that you can cut the amount of data that you would send in the input file?

John Albert: Yeah, that's one of the methods that a lot of current partners use right now is they use the query file to just send us - because again most of them may not have - if they had the health insurance claim number they would know that they have Medicare.

But most people may only have the SSN of the individual. And they provide the SSN, name, date of birth and gender and we can try to match that to a Medicare health insurance claim number, pass that back, and where there is a match you can then make that further determination whether or not the MSP statute would apply to the individual. And that you, you know, should or do not have to report that particular person for MSP purposes.

(Albert Poulson): Okay, thank you so much.

John Albert: The benefit to the GHP community is that this also allows you to identify under 65 people who are retired and for whom Medicare is the primary payer because just as often the reporting entity doesn't realize they are paying primary for somebody who has had Medicare due to disability for years. And this allows you to identify those situations on your end where you may be making your own mistake in primary payments. So it's a - for the GHP community this is very bilateral exchange in terms of usefulness.

In fact over time we've made the determination that there's probably more mistakes in payments identified on the GHP side than there is the Medicare side in terms of total dollars out there.

(Albert Poulson): Okay. Thank you so much.

Coordinator: Next in queue is (Tina Nubeck), your line is open.

(Tina Nubeck): Hi, we had - just wanted to clarify some information on the HICN for the MSP files. It says on - in the current guide that it's required if the active covered individual is under 45 and on disability or ESRD. Although right below that it says populate with spaces if unavailable. We currently do not

store that number in our system. Once we start getting our response though we're going to start storing it when we get it back from you.

They just want clarification on - for the initial file. As long as we're sending an SSN we do not need to send a HICN?

((Crosstalk))

John Albert: Yeah, I mean for under 45s we are requiring the health insurance claim number and part of that is to basically discouraging - to discourage mass dumping of data which basically would require both the - both the CMS and the submitter to run through a lot more data than is necessary. We encourage you to use the query file to look up those health insurance claim numbers. That's all.

((Crosstalk))

John Albert: Forty-five and over and SSN will be accepted.

(Tina Nubeck): Okay so if we send somebody 45 and under without a HICN they will kick out as an error?

Pat Ambrose: Correct. It's an ST99 I believe.

(Tina Nubeck): Okay, thank you very much.

Pat Ambrose: Now again let me clarify that that's an error on your MSP input file but as John stated you could send those people on the query file in order to obtain a HIC number.

(Tina Nubeck): Okay. Thank you very much.

Coordinator: Our next question comes from (Jamie Hershman), your line is open.

(Jamie Hershman): Thank you. I have a couple of questions. My first one is what are the benefits for a plan to use the expanded reporting option?

John Albert: That you would be able to fully coordinate your prescription drug benefit with Medicare's prescription drug benefit. As I mentioned before you may, for example, have individuals under age 65 who have Medicare and you don't know about it and they also have a Medicare Part D plan, you will get that information back confirming their enrolment in Part D in which case Medicare most likely is the primary payer.

The other benefit is that paying it right the first time is a lot cheaper than dealing with any potential recovery efforts on the part of CMS for mistaken payments.

(Jamie Hershman): Okay. And on the non-MSP input file can you clarify exactly we should be reporting on this file? It says that it's inactives and we're assuming that those are retired people who are dependants?

John Albert: Yes. Basically people for whom MSP would not apply.

Bill Decker: Basically people for whom Medicare is not the secondary payer.

John Albert: Right.

(Jamie Hershman): So Medicare would be prime for them?

John Albert: The general people will say these are retirees.

(Jamie Hershman): Okay.

John Albert: With prescription drug coverage.

(Jamie Hershman): Okay.

((Crosstalk))

John Albert: Yeah or the dependants of retirees.

Bill Decker: It's not a simple categorization but it's basically anybody for whom Medicare is not a secondary payer.

John Albert: Which is the majority of Medicare.

Bill Decker: Right.

(Jamie Hershman): Okay, that just confused me again because I thought - okay I just need some clarification. We are not going to be submitting - we have a retirement plan where Medicare is primary for those members who are retired. Okay? And so we are - but we're not submitting those people.

John Albert: Right. You would only - the only time we would - you would maybe want to do that again is if you elect the option of submitting the expanded version. And you want to report that retiree prescription drug coverage to Medicare to help facilitate point of sale coordination of benefits you would use that non-MSP file to report any retiree prescription drug coverage information.

(Jamie Hershman): Okay. Great, thank you.

John Albert: I didn't mean to muddy it up for you.

(Jamie Hershman): That's all right. One last question, this is kind of general. I don't even know if you're going to have an answer for us but how are we supposed to find out if we have members who have become Medicare beneficiaries due to a disability? We're planning to, at renewal, to ask for updated information on our members after this initial reporting of everything. I guess it's - I'm sorry?

Bill Decker: Sorry, I thought you were finished with your question. If you're using the expanded version of the Section 111 reporter process you can query for everybody in your retired community or anybody at all, the fact that you have any relationship with as an employer or an insurer. And you can ask the Medicare database if they are Medicare beneficiaries and we will tell you. That's not submitting an MSP or non-MSP file to us it's just asking us if someone is a beneficiary. You can ask that question of anybody who's 45 age or older.

John Albert: Or anyone.

Bill Decker: Or actually anybody.

John Albert: Yeah, let me clarify a little bit because it's not just the expanded version that you can query it's anyone who's exchanging data with us can query on anyone they cover for Medicare entitlement status. Again the key thing is is if you don't have a Medicare health insurance claim number you must have the social security number and then of course the name, date of birth and gender. And we will tell you whether or not that person has Medicare based on the information you've submitted to us.

Bill Decker: There's a variety of ways to query.

(Jamie Hershman): That's great. Thank you very much.

Coordinator: Next in queue we have (Denise Verico), your line is open.

(Denise Verico): Hi, this is (Denise Verico) from Fidelity Security Life. I have a couple questions. One is: Are you using the employer term synonymously with associations? Because we do have association groups that we cover therefore we would not have employer relationships.

John Albert: Association - the association thing is a multiple employer health plan. I mean I don't want to - because I don't want to like basically, as I mentioned earlier we get into trouble when we start trying to vet whether or not someone has to report or not. We can assist but again you can't take our answer here on the phone as being the final...

(Denise Verico): Okay how do I...

John Albert: I guess because we don't - we're not quite sure we understand the question.

(Denise Verico): Okay, let me give an example...

((Crosstalk))

Bill Decker: ...mean by association.

(Denise Verico): Associations are fishermen, they are an association by location, they aren't employed by anyone; it's a group of people that come together and get a

group health plan because they are fishermen. Or maybe they are Boy Scout leaders, they aren't employed by anyone, that's part of this association.

Bill Decker: Submit your question to the mailbox and describe in detail...

(Denise Verico): An association.

Bill Decker: ...by an association because what you're describing is not generally how we've seen association defined.

(Denise Verico): Okay.

Pat Ambrose: But this coverage is not due to current employment...

Bill Decker: But they're self - they may be self employed individuals...

(Denise Verico): Correct.

Bill Decker: And that's where it gets interesting because they - self employed individual can have employees so they can be an employer. That's why it gets complicated and that's why I want to see these definitions.

(Denise Verico): Okay. That's one challenge I have. So I'll submit a question to the box.

Bill Decker: And us too.

(Denise Verico): The second one is...

John Albert: Provide your contact information as well.

(Denise Verico): Absolutely. The second question is we're having difficulty identifying employer size because we don't have that information on any system as far as a contract negotiation. And it's basically in paper for these hundreds of employer groups.

John Albert: I mean, you know, we can't provide, you know, any advice in terms of how you need to gather that information. But essentially I would ask if you don't know the employer size how do you know whether Medicare is primary or not? So I mean that's, you know, that's something that, you know, is not a new requirement so that's been around since the working age rules were first passed years ago.

So we can't provide, you know, best practices for gathering that information except that these are the requirements to essentially - for you and for CMS to fulfill it's obligations under the statute. I know that's a pointy headed answer but it's the best we can do.

(Denise Verico): So we just don't know at this point. If we are not able to identify employer size...

John Albert: You have to identify employer size. That's what I was saying; those are the requirements to report that information under the statute. I mean, you can, you know, default to 100 or more if you want but, you know, that again would potentially result in erroneous MSP records being built.

Bill Decker: Particularly for small employers.

John Albert: Yeah, yeah, for small employers that's the only risk of that. I mean, I know there are ways to correct those after the fact but again CMS, while we do not have final guidance out regarding - is a full blown compliance requirement but

it's something that we are looking at; we don't want bad data. So but generally, I mean, when we don't get that information we default to 100 or more since most MSP situations involve large employers.

(Denise Verico): Okay, thank you.

John Albert: Okay?

(Denise Verico): All right.

Coordinator: Next in queue we have (Larry Whitehurst), your line is open.

(Larry Whitehurst): Yeah, this is (Larry Whitehurst) from (Dean) Health Plan. I got a couple of questions. You did talk about the not any need to report tri-care or Medicare Advantage. (Dean) has a cost plan. We have a cost plan through CMS and what we actually do is pay primary for Part B charges, Medicare pays primary for Part A charges and then I believe at the end of the year they garner up and cipher off whatever who owes what.

How would we report those people or would we report them?

John Albert: I don't know if anyone here can answer that question. I mean other than the fact that if it s non-Medicare coverage that Medicare should be secondary to that is the information you need to report through this process.

Bill Decker: You have a Medicare cost plan?

(Larry Whitehurst): Yeah, it's a Medicare cost plan.

Bill Decker: Right so you're a Medicare - you're already in the Medicare system with the cost plan, yes?

(Larry Whitehurst): That's correct.

((Crosstalk))

John Albert: Yeah, and you don't report Medicare coverage to...

Bill Decker: Right.

John Albert: ...CMS we're looking for the private coverage.

(Larry Whitehurst): Okay so the cost plan would also be not reported, that's fine. And as far...

John Albert: Any Medicare coverage should not be reported though this process. We already know who has Medicare it's the private group health plan coverage that needs to be reported through this process.

(Larry Whitehurst): Okay so if we have a person that has end stage renal disease that's on a oh let's say we do - and we do have several of them, we have some that are age 65. That because (Dean) was paying primary prior to them turning the age of 65 that we are - we have, you know, we've notified COBC that Medicare is secondary for the 30-month period.

So once the 30-month period ends Medicare becomes primary and if we have people that are Medicare primary where they have fulfilled the 30-month period of coordination do we report them or not?

Bill Decker: If Medicare is primary...

John Albert: If Medicare is primary then no.

(Larry Whitehurst): Okay. That's good. Okay good enough. I'm done. Thank you guys.

John Albert: Okay, sure.

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

(Bill Monroe): Hello. Thank you. I have several questions. One, we have a situation - all of our groups have a key employer and that employer may or may not be where we send the bill. And the question is - this is not a Taft-Hartley as I understand it because they're not sharing hours. Each person works for an individual company. But should we be sending the key employer TIN or the individual employer TINs?

John Albert: What's the relationship between the key employer and the other employers?

(Bill Monroe): They're like the group contact for that so that there's - we have questions and we have correspondents like policies. We go to them and we may send the billing to them too but not necessarily. Sometimes we bill the individual companies.

John Albert: I mean in those cases I think that that would be up to you to determine because the primary reason we're asking for the employer information is to, you know, who do we address COB issues to, to the key employer or that other whatever you call them. I mean that - the main thing is we do need essentially an employer address that, A, would be used for prepayment COB issues as well as any potential recovery activities on CMS's part.

(Bill Monroe): Okay.

John Albert: We do allow that flexibility in terms of how you want to, you know, slice it I guess you'd say.

(Bill Monroe): Okay.

(William Sevogna): It sounds like that there's a key employer and other employers in the plan it's the multiple employer plan.

(Bill Monroe): It is a multiple employer plan as I understand it, yes.

(William Sevogna): So they could report the plan sponsor.

John Albert: Yeah, yeah. Yeah, I mean they could - you guys could, you know, report the plan sponsor in that case.

(Bill Monroe): Okay.

Bill Decker: Which would be the key player.

(Bill Monroe): Yeah, if that happens to be where the recoveries are addressed and the COB. Okay. Thank you and then number two our understanding is that in general we're not reporting to you someone we know Medicare would be primary. For example if there is a group that's less than 20 and they're not part of the multi-group plan...

John Albert: Yeah, unless they have VSRD they wouldn't be reported. But even if they have VSRD if they're beyond the coordination period they wouldn't be reported.

(Bill Monroe): Right, right.

John Albert: Yeah, we do not want people on the MSP file for which Medicare is legitimately the primary payer.

(Bill Monroe): Right so if we know it's a small group, less then 20, and they're not part of a plan that, you know, the multi-plan that has an employer of more than 20 can we just not report them because they would...

John Albert: Right.

(Bill Monroe): Okay.

John Albert: Yeah, we don't want you to report them. I mean...

Pat Ambrose: In fact there's an update to the user - in the user guide coming out there's an update regarding that...

(Bill Monroe): Okay.

Pat Ambrose: ...clearly state if it's not a multi-employer plan and there's less than 20 employees you don't need to report.

(Bill Monroe): Okay and the last question then is if we know someone is Medicare - is on Medicare, we have the HIC number and we know they're disabled whatever the reason might be then that's the other case where Medicare would be primary, we know that. So then we would not report them, correct?

John Albert: Correct.

(Bill Monroe): Okay.

John Albert: Yeah, again I can't stress enough that is Medicare is properly the primary payer based on the MSP statute do not put them on the MSP file because what that will likely result in is us building an erroneous MSP record and denying claims for primary payment which is something we don't want to occur.

(Bill Monroe): Okay, thank you.

John Albert: Okay.

Coordinator: Next in queue we have (Laura Blahosky), your line is open.

(Laura Blahosky): Hi, we have limited IS resources so there's a few things I'd like to confirm. It was my understanding from the introduction and then from the first caller that basic reporting options can be changed down the road to the expanded option. And also the optional query only files, we don't have to do that right away but say two, three years from now we can call up our EDI rep and say now we'd like to test our query only files? Is that correct?

John Albert: Yes although I can't imagine why somebody wouldn't want to use the query file.

(Laura Blahosky): Okay.

Bill Decker: And the other thing you get - from the sound of your question I think that you need to know this also is - excuse me if I'm wrong - but if you're going to call your EDI rep and say now we want to use our query only file you're going to

have to have a query only file to send to the EDI rep. It doesn't originate with the COBC it originates with you.

(Laura Blahosky): Right. We would have...

Bill Decker: You'll have to develop for the query only file in the beginning.

(Laura Blahosky): Right - okay so we would have to develop for it now during 2009?

Bill Decker: If you wanted to use it now yes, develop for it now; if you wanted to wait two years you could wait until then. But as John points out the query only function - a query function for anyone is an extremely useful function to have right at the beginning.

(Laura Blahosky): I agree. Also the basis system it's my understanding that we could use that basis by filling out a request form, which is Attachment E in the user guide that we just complete that and we don't have to be using the query only input files in order to use basis up to 200 times a month?

Pat Ambrose: That's correct.

(Laura Blahosky): Okay. And we don't need any special software or anything to use basis so you just need to fill out that request form?

Pat Ambrose: Right you'll fill out the form and your EDI rep will send you instructions. It is a Web-based tool but not an Internet-based tool at this time.

(Laura Blahosky): Okay.

Pat Ambrose: And, you know, there's a dialogue process essentially. And, you know, that involves a user interface and you manually keying in the information we need to match an individual to a Medicare beneficiary.

(Laura Blahosky): Okay. Thank you very much; that's all I have.

Coordinator: Next in queue in (Rich Glass), your line is open.

(Rich Glass): Yes, thank you for holding this call today. We are an HRA administrator and I just wanted to clarify a couple of things; most of what we were going to ask has already been answered. First of all the testing period, I assume that's going to be delayed as well? Would that likely take place in 2010?

John Albert: At this time yes but again we'll give you the official answer, you know, through the Web.

(Rich Glass): Okay. When would the first report be due if it's for the fourth quarter of 2010?

Pat Ambrose: That depends on your assigned file transmission period.

(Rich Glass): Okay. All right and then I just wanted to clarify the social security number issue for dependants. Again this is in the HRA context. If an employee has a spouse that's over the age of 55 and refuses to provide an SSN and we don't have the HICN how would we report that spouse?

John Albert: You won't be able to.

(Rich Glass): Okay. So we don't...

John Albert: And again we are looking to provide additional materials that will help you get that information and also document your attempt to get that information.

(Rich Glass): Okay. Very good.

Bill Decker: You might not be able to report that spouse as John points out but it doesn't - but we still need to have information about that spouse.

(Rich Glass): Okay so as long as we follow the good faith efforts that you outline we'd be okay?

John Albert: Yeah, I mean that will all be documented on the Web site.

(Rich Glass): All right, very good. Thank you.

Coordinator: Next in queue we have (John Isin), your line is open.

(John Isin): Yes, thank you. I represent a pharmaceutical benefit manager or PBM. And as such they're a (PPA) for prescription drugs only. The first thing is that they have their own Medicare Part D prescription drug plan or PDP. And even though technically that might qualify as a GHP obviously they don't need to file - they don't need to submit an MSP for that plan, correct?

John Albert: Correct.

Bill Decker: Correct, they're already a Medicare plan.

(John Isin): Okay. Secondly they obviously pay claims for, just as a (PPA) for other people, other plans, other clients. And I assume if the clients for whom they

are paying claims elect the basic option then the client, the PBM doesn't have any responsibility of reporting anything.

John Albert: There is no obligation - Section 111 does not effect prescription drug benefits. There's no requirements on anyone no matter what they elect to report.

(John Isin): Okay so what happens...

((Crosstalk))

John Albert: If they sign up - if the responsible reporting entity which again is not going to be a PBM...

(John Isin): Right.

John Albert: ...and it's not going to be, I mean, that's something between you and that - if that responsible reporting entity says that I want to report prescription drug coverage that's either primary or secondary to Medicare, I mean, that is up to them to figure out how to do that. There's, you know, that doesn't obligate you to do it on their behalf. That's between you and that responsible reporting entity.

(John Isin): Well I guess my question was if the plan sponsor elects the basic option then the PBM doesn't have to do anything. But if the plan sponsor elects the enhanced option then does the PBM have to fill out the MSP input file? In other words...

John Albert: No, that's up to the responsible reporting entity. If they contract with you to do that on their behalf that's, again, between...

(John Isin): Okay.

John Albert: You don't have to do anything; you are not required under the statute to...

(John Isin): Okay.

John Albert: ...report information. You would essentially be an agent on behalf of that RRE most likely.

(John Isin): Okay. And well here's the thing then typically the prescription drug, again, as a earlier question, it's a carved out benefit. So the people generally have a medical plan and the prescription drug plan. If the plan sponsor or the RRE elects the enhanced I guess they have to talk with the medical (PPA) and determine whether they're going to fill out the file or whether the PBM would fill out the file? In other they both wouldn't fill it out right?

Bill Decker: You have to go back - we'll start here, if the only entities that report to us are responsible reporting entities under Section 111. A PBM is under almost all circumstances will not be a responsible reporting entity under Section 111. And as a consequence won't be doing any reporting under Section 111 for any reason directly with Medicare.

If a PBM is working with or for some other sort of an entity in a drug benefit relationship, whatever that other entity that may or may not be, an RRE has to report or not report to Medicare. And the - and its relationship with the PBM is entirely separate and outside of any reporting that any other RRE has to do.

Basically if you have an arrangement with some plan to provide pharmacy benefit administration for the plan and the plan has to report under Section 111 it will be the plan reporting. You will not - or should not at least - be

asked by - you certainly won't be asked by us to fill out any forms or do any reporting. If that - if you are asked to do that you are being asked by the people you have a business relationship with not by CMS.

(John Isin): Right so if the RRE wants the enhanced they could ask the PBM to supply the prescription drug information. But what I'm getting at is since the medical (PPA) has to fill out the MSP files if the client wanted the PBM to file something would it just be the non-MSP files or what I'm saying is the medical (PPA) and the PBM wouldn't both be filling out the MSP input files...

John Albert: That's correct, yes. I mean I think you're, you know, I think I see what you're getting to in terms of the - yes, I mean, the RRE can't break up the submission at that level of detail, they have to supply one file per RRE with the hospital, medical and prescription drug data. So yeah we can't - we're not accepting separate streams of data for the same RRE from different sources.

(John Isin): Yeah, and so what I'm getting it as if they want the enhanced then the PBM really couldn't fill out the MSP file they'd have to provide the prescription drug information to the medical (PPA) for them to submit the MSP file...

John Albert: It all depends how you - again we don't, I mean, it depends on how they contract. I mean, there are PBMs that could potentially report all that if they choose, you know, if they are an agent of the RRE but generally no. So I mean, you know...

(John Isin): Well either the PBM or the medical (PPA) is going to have to give their information to the other person.

John Albert: Yes.

(John Isin): Okay. One last question, I'm certainly new to this and I think I may have overlooked a very important nuance. I was reading this that basically for the MSP input file that actives over 55 in general need to be reported but I thought I heard today one of you say that they only need to be reported if they're Medicare eligible?

John Albert: We're trying to say that, you know, in terms of the requirements under Section 111 you are only required to report individuals for whom Medicare is the secondary payer. Obviously not everyone knows who on their list have Medicare, they may only have an SSN so to ensure that they don't miss anybody that we encourage them to report anyone for whom if they had Medicare, Medicare is the secondary payer. So that's all.

(John Isin): So what I'm getting it is I was thinking of - I've got another client, a typical employer client, and I was thinking that they would have to basically submit every active employee over 55. And you're saying that's not the case?

John Albert: That's not required it's just that that's an option that we offer you for purposes of...

(John Isin): Okay it's...

John Albert: ...doing the reporting. I would strongly suggest that you go back and if you haven't already register for the computer-based training which kind of breaks this up into smaller more digestible pieces of information.

(John Isin): How do I do that? Where do I find that?

Pat Ambrose: That's on the Web site.

John Albert: Yeah, it's on the homepage of the Web site. There's a...

Bill Decker: Section 111 list...

John Albert: ...GHP subsection and an NGHP subsection.

(John Isin): I'm on the overview page.

John Albert: Yeah, we don't have a PC in front...

Bill Decker: Yeah, if you're on the overview page click on the GHP page - the group health plan page.

(John Isin): Oh group health plans, okay.

Bill Decker: Go down to the bottom.

(John Isin): Down at the bottom all I see is downloads, related links into CMS...

Bill Decker: There you go.

(John Isin): And it's just - they're just transcripts and then related links outside CMS, help with file formats and plug-ins and submit feedback.

John Albert: Yeah, none of us have - we're not - none of us have a PC in front of us so we're...

(John Isin): Okay.

((Crosstalk))

John Albert: But it is there.

Pat Ambrose: Look at the left - the menu items on the left hand side of your screen.

(John Isin): Overview, group health plan, liability insurance and then SEA 111 what's new - oh, I see, computer-based training.

Pat Ambrose: That's it.

(John Isin): Okay thank you very much.

John Albert: Sure.

Bill Decker: Okay.

Coordinator: Next in queue is (April King), your line is open.

(April King): Hi. I just actually had questions about the HRA reporting pieces which I think have already been addressed so given that you have further information coming out and being posted on the CMS Web site shortly I will not take up your time.

John Albert: Thank you.

Coordinator: Next in queue we have (Carol Leachman), your line is open.

(Carol Leachman): Yes my question is regarding error code SP32. The way it is - the way it is worded it says termination date must be greater than 30 days after the MSP effective date. What do we do if we have a person who is on GHP coverage

for less than 30 days but we know that they have Medicare and we know that Medicare should be secondary?

John Albert: Hi Carol, this is John. I don't know if anyone in this room has had time to research that because we're not sure about the processing rules for CWF.

(Carol Leachman): Okay.

John Albert: But we will get back to you on that.

(Carol Leachman): Okay.

John Albert: I have your question right in front of me.

(Carol Leachman): Good. I know who has it now.

John Albert: Yeah, this was for instances and unusual circumstance where it's less than 30 days.

(Carol Leachman): Right.

John Albert: Yeah.

(Carol Leachman): Okay.

John Albert: CMS has some quirky rules I know that.

(Carol Leachman): Okay thanks.

John Albert: Okay thanks, (Carol).

Coordinator: Next in queue we have (Tammy Meyer), your line is open.

(Tammy Meyer): Hi we have two questions this afternoon. As we collect employer population data one time per year and it would be difficult to select this more frequently. Is this sufficient as far as sending the population, you know, determining if they're over that 20 threshold. We're only questioning it once a year is that going to suffice?

Bill Decker: You have to - you have to follow the rules that are delineated in the regulations. And if an employer starts a year with fewer than 20 then sometimes during the year achieves at least 20 employees for I believe it's 20 weeks then you need to start reporting then.

(Tammy Meyer): Okay so I know internally if we added a member to our system we have that programmed in to take the count of active employees at that time so we'd be able to catch it. However, if the employee didn't take coverage with us then we wouldn't know that they went over the 20 until the next year at renewal time.

Bill Decker: Then you run the risk of being noncompliant.

John Albert: Yeah, I mean, there's going to be more information coming out about this than I, you know, we can't, you know, obviously this is a, you know, you know, MSP is never, you know, simple. But we just want to reassure everyone again, as I said on every call, that we are, you know, very cognizant of, you know, trying to get this data organized and all that. And, you know, we're looking for people primarily to report data to us not do (CMP)s. So again we will provide additional guidance on that.

Right now we're focused primarily on building the portal itself and getting that up and running and getting everyone registered. But other than that we can't really provide anything additional on this telephone call.

(Tammy Meyer): Okay. And the last question is I believe you clarified this before but I want to make sure that we understood correct, if a member has VSRD and we know that Medicare is prime for them do you still want us to send those? And I took it as no before but I wanted to make sure.

John Albert: That's correct. They're beyond the coordination period and Medicare is primary.

(Tammy Meyer): Okay. All right that's the only questions I had. Thank you.

Coordinator: Our next question comes from (Bob Meny), your line is open.

(Bob Meny): Hi. We're a third party that facilitates communications back and forth between the - like CMS for plans. And we currently have connectivity to the COB contractor. My question is around the registration process; is this basically correct that the RRE would need to go through the registration process, they'll get the EDI rep assigned to them. And then we would work as the third party that would be facilitating the file transfer with the EDI rep to, you know, to actually get the files to the COB contractors?

Pat Ambrose: Yes, that's pretty much the way that it will work. The registration is a two-step process. The responsible reporting entity starts that process, step by, by providing information about their organization and their authorized representatives. Then we'll mail them a personal identification number of a PIN number.

At that point the RRE has to name who their account manager is going to be. The account manager could be an agent or it could be a person at the RRE that's part of that organization. So the account manager then comes back in and sets up the rest of the account including file transmission information.

And the account manager also invites other users which could be agents as well as account designees. And at that point the agent who's transferring files maybe able to work directly with the EDI rep on those technical issues. Does that answer your question or...

(Bob Meny): I think so. But people have thought that with regards to the whole registration process because I know some times in CMS's registration process people are using third parties to submit their data, that piece sometimes gets left out.

Pat Ambrose: No we fully anticipate that data may be - that RREs may be using agents to transmit data.

(Bob Meny): Okay, all right, thank you very much.

Coordinator: Next in queue we have (Armand Weber), your line is open.

(Armand Weber): Hi, we have a couple questions as the process relates to a Taft-Hartley trust fund. And as you know our members can go in and out of coverage based upon the hours that they work. And they can also self-pay for dependant coverage. So I think I'm going to have to send you many different segments with beginning and ending dates and types of coverage. Does each one of those segments create its own MSP occurrence in your system?

Pat Ambrose: Yes.

(Armand Weber): So then if I need to do changes to - I'm trying to figure out when I need to do a change to a member because the eligibility obviously can change. So then I would have - so if anything changes as far as the effective date or the insurance type or the relationship or the MSP type I need to send you a change transaction for that?

John Albert: Well not, I mean, not the MSP type that's - I mean, in terms of, yeah, I mean changes in coverage type that would result in your needing to term an old record and then build a new record.

(Armand Weber): Okay.

Pat Ambrose: Essentially what would happen if one of those key fields changes you would most likely be terminating the record and adding a new record. If you sent incorrect information in the past you might have to do a delete/add, that sort of thing.

(Armand Weber): Okay. Now another question is how far back do we need to send you an effective date? Earlier you gave an example where you had family coverage - or you're currently covered and you had family coverage since January 2008.

John Albert: The effective date of the coverage that was open on 1/01/09.

(Armand Weber): We only maintain 36 months of eligibility in our production system. It's possible that someone could have eligibility prior to that that we just don't have access to. What do you do in a situation like that?

John Albert: We'll take that under advisement in terms of, you know, earliest effective dates and what we'd want. I mean, we understand that - this question has come up before not only in GHP but NGHP as well. So we'll take that under

advisement. We're not out to ask for coverage from 20 years ago, but, you know, generally we want the current open record essentially.

(Armand Weber): Okay so we...

((Crosstalk))

John Albert: ...you know, like I said we'll look at, you know, possibly setting some type of a default to earliest (effective date).

Bill Decker: We'll be sending more guidance out on the Web site on that issue.

John Albert: And in fact if you haven't please submit that to the resource mailbox.

(Armand Weber): Okay. No I haven't done that yet.

John Albert: Okay.

(Armand Weber): Did you have any questions, (Phyllis)? Anyone else? Okay that's it for me. Thank you.

John Albert: All right thank you.

Coordinator: Our next question comes from (Stephanie Holmeyer), your line is open.

(Stephanie Holmeyer): Hi. Yes, we're a multi-employer group health plan with two plans. One of our plans includes employers who are small employers who they're working age gets approved to the exception. Field 16 on the MSP input file asks for the employer's size. In our Section 111 reporting our RRE said they're going to use the size of our largest group. Is that correct or should they

be reporting the size of the specific employer for whom that beneficiary is working?

John Albert: In that field it's the - for that individual it's the employer size of the largest employer in that group.

(Stephanie Holmeyer): Okay.

John Albert: So if the employee works for a company that has nine people but there's another employer in that group that has 2000. You would use the (2), which is 100 or more because we're basically defaulting to that because again it's the largest employer within that multi-employer group health plan that determines the size relevant to all of the employers in that group health plan.

((Crosstalk))

John Albert: Yeah, unless of course they're, you know, the only caveat is that if they are in fact claiming the small employer exception...

(Stephanie Holmeyer): They are.

Woman: They are.

Pat Ambrose: Well then you would put the - use that C HICN field for...

John Albert: Yeah.

Pat Ambrose: ...those individuals. Your employer size would still - it's still based...

John Albert: Yeah.

Pat Ambrose: ...on the largest employer in the...

(Stephanie Holmeyer): Right.

Pat Ambrose: ...multi-employer plan. However those particular individuals who are exempted in - or that you have the small employer exception for you would report with that small employer exception HICN field and that way we would know that you're claiming the exemption.

((Crosstalk))

John Albert: That's how we would know that if the person is Medicare due to age you would apply that exception to that...

Pat Ambrose: Right.

((Crosstalk))

(Stephanie Holmeyer): Okay great. Did you need anything? Okay thank you so much.

John Albert: Operator we're about out of time; it's 3 o'clock here. And did anyone want to add anything before we - okay. Before we - I just wanted to thank everyone for attending this call. There are future calls scheduled. We plan on doing these on basically a monthly basis and if we need to do a special call we will. But again continue to reference the CMS Web page mandatory insurer reporting and sign up for the listserv that we struggled to find the address for since none of us are here in front of a PC.

Operator could you tell us how many are - have been attending the call as well as how many are in the queue for questions?

Coordinator: Yes, sir. We currently have - excuse me - five additional questions in queue and it looks like the peak line count was approximately 390.

John Albert: Okay, well with that again CMS would like to thank everyone for all their excellent questions. And please continue to send those to the CMS resource mailbox. We do pay attention to those and they're trying to make this as easy as possible and specific examples, things like that are very useful to us. Thank you.

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

END