TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: May 6, 2009

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

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FTS-HHS-HFCA

Moderator: John Albert
May 6, 2009
12:00 pm CT

Coordinator: Good afternoon everyone. Thank you all for standing by and welcome to today's conference call. At this time your lines have been placed on listen only for today's conference.

During the question and answer portion of our call you will be prompted to press star 1 on your touchtone phone. And to record your name in order to ask your question. Please limit your question to just one question for today's conference.

Today's conference is also being recorded and if you have any objections you may disconnect at this time. I would now like to turn our call over to Mr. John Albert, sir you may proceed.

John Albert: Thank you. With us here at CMS is Barbara Wright, Bill Levenger, Bill Decker and Pat Ambrose will be the principal speakers today. We thank everyone for joining, this is one of continuing series of group health plan open door teleconferencing events. Again this is specifically geared towards group health plan reporters.

If you are a worker's comp liability no-fault insurer please refer to the Section 111 Web site for those conference calls that are scheduled for that particular subject area.

We do apologize for the lapse in getting the teleconference number up on the Web site. I guess the good thing is for those attending is that hopefully you

will be able to get more of your questions answered because of fewer people than normal on this call.

Just for your information right now CMS has over 1200 GHP (responser) reporting entities registered at the secure Web site. Also pending publication in May I'm not sure if it's actually out yet or not. But the something that people have asked for in the past. Is information to help them gather information from employees and beneficiaries. We have an employer cooperation document that is imminently pending release if it isn't already out there.

Next week we expect to release a series of questions in the form of like a questionnaire that can be used by (responser) reporting entities just to solicit missing information. In particular the Medicare health insurance claim number or SSN if they don't know what their HIC number is.

I don't know how we're going to go along as we have on the rest of, most of these calls. And we're going to start with a presentation by Pat Ambrose to answer some of the more technical issues that have come up. And then we will also go through many of the questions that have come in through the CMS resource mailbox.

I can't stress enough that the best way to get your questions answered is to use that resource mailbox. You know, as its processes evolve people are finding out direct contacts and things like that. It does not guarantee consistent answers and also makes it so that it's more difficult for us to answer most of the questions.

So again please refrain from direct contact with individuals at CMS or the COB contractor. You know, other than of course your request for technical

questions with your EDI representative. And use that CMS resource mailbox for especially the more policy related type questions as it relates to the Section 111 implementation.

So again we do pay attention to those and codify them and organize them et cetera and try to answer them on these calls as well as all of the materials. I recognize that some people are submitting the same question several times because they either think or maybe the question isn't answered timely enough for them.

But again we do pay attention to those questions. And it's the best way to get good documentation from CMS in our materials regarding your specific policy or operational question.

With that I'd like to turn it over to Pat Ambrose who will provide some information and then Bill Decker and myself will be answering some questions and then there will be a Q&A session open to everybody. Pat.

Pat Ambrose: Thanks John. I'd like to go through a few things related to registration testing follow up from the last call and updates that we are in the process of making to the GHP user guide for Section 111.

First off if you haven't registered please do so as soon as possible. The registration process will stay open and will remain open for an indefinite period of time. In the event that you need to register for additional RRE IDs if you're reporting structure has changed.

Note that those who only have health reimbursement account or HRA information to report those RREs do not need to register at this time.

RREs who only have HRA coverage to report should wait and register by May 1 2010. That will give you enough time then to test prior to the required reporting period. Or the start of the reporting period for HRA information which is that last quarter of 2010. CMS will issue additional reporting instructions for HRAs.

If you have already registered and you are an HRA only RRE then please contact your EDI representative. And you can have your RRE ID that you registered for deleted and removed from the system.

In addition we are adding a note to the registration section of the user guide. This note is concerning entities that may not need to register for Section 111.

So in addition to the HRA RREs that we're asking wait to register until May 1, 2010. We're also adding a note that carve out coverage is considered stand alone coverage for the vision, dental, behavioral mental health.

So if you are an RRE particularly a TPA there were examples on previous calls of TPAs that provided only stand alone coverage for dental, vision behavioral or mental health. And you have nothing to report as a result for Section 111 then you do not need to register until such time that you may have something to report for Section 111.

Related to the current registration process. If you provided an incorrect individual for your authorized representative or account manager during the new account set up or account. Or rather the new registration or account set up stuff please contact your EDI representative to have that information corrected.

RREs will be able to change their file submission later if needed. And in order to make a change to the final submission method that you've already selected, you will contact your EDI representative to make this change.

If you registered for an RRE ID and you don't actually need that RRE ID or you registered by mistake again contact your EDI representative to disable that RRE ID number.

RREs can register for more RRE IDs at later dates as I mentioned or discontinue the use of RRE IDs later if you are reporting structure changes. And again registration will remain available for future needs in this regard.

As you are registering as a new Section 111 THP reporter. The RRE ID status will change to production. A production status as soon as your MSP input file testing requirements are passed.

At that point you can send both MSP input files and query only files. And the query only files can be submitted on a monthly basis, as soon as your status for your RRE ID is turned to a production file.

So you may submit query only files prior to July 1, 2009 and prior to when your initial MSP input file is due.

Refer to the GHP reporting user guide the how to menu option and the help pages on the Section 111 COB secure Web site. As well as the Section 111 COB secure Web site user guide. After you log into the system for help while you're going through the registration process and subsequently the testing process.

On the last call there was a question regarding retro-active enrolment and finding out about GHP coverage, at a date later than that enrolment actually or the coverage period actually started.

CMS would like you to report this information after it's discovered for retro-active enrolment with the correct enrolment date or accepted date of that GHP coverage.

These records may be flagged with the late submission indicator in the event that you've missed that 45 day grace period. But there is no systematic fine imposed at this time for that. We're more interested in getting your information in the door.

If the late submission indicator is set the record will still be processed. And it does not count against the error threshold the FP error threshold for the MSP input files.

We had a couple of questions recently about health savings accounts and flexible savings accounts. Or HSAs and FSAs coverage information for HSA and FSA are not to be reported and you don't need to register it, if that's all you have to report.

Problems have occurred during the new registration step on the COB secure Web site, related to the page where you're asked to provide corporate structure or subsidiary information.

You must provide a TIN for each applicable subsidiary you list on this page. And that TIN must be different from the TIN supplied for the RRE ID on the initial entry page. As well as all the TINs listed on that corporate structure

subsidiary page, all of those TINs must be unique and must be different within one RRE ID.

So if you have trouble with that corporate structure or subsidiary page it is not actually required at this time in order to complete the new registration step. So you may click on continue and skip it for now and then your account manager can come back and update this information on the COB secure Web site at a later date.

Now note that if you're registering for multiple RRE IDs you can use the same TIN. This requirement in the system for a unique TIN is within one RRE ID request all the TINs that you provide must be unique.

Other changes that we're in the process of making to the GHP user guide and which we hope to have published toward the end of next week or the week following.

We are adding an event table to help clarify when to send update records. But please note that this is not a change in requirements. The current user guide does cover these situations but we're trying to put that in the form of a table to add further clarity.

The definition of an active current individual in Section 7.1.2 is being updated. To state that individuals with ESRD are included without regard to their age in addition to without regard to their family members to their or their family members current employment status. An additional note is being added to further clarify what is meant by an individual known to be entitled to Medicare.

If the entitlement reason is ESRD it won't change after the individual turns 55 and ESRD patients are the one time when retirees would be reported on the MSP input file and the only time.

In regard to reporting individuals under the age threshold who are known to be entitled to Medicare. CMS accepts that the RRE knows that an individual is entitled to Medicare when they have a health insurance claim number or the Medicare PKN on record. Or they're paying primary or secondary claims to Medicare for a covered individual that has GHP coverage due to the subscribers current employment status.

In this case the RRE knows that the individuals entitled to Medicare and should submit a record for this person with their HIC number on the MSP input file.

This means that the RREs should check their internal enrolment or other insurance or coordination of benefit files or their claims payment records for these circumstances.

However this does not imply that the RREs should send an MSP input record or a query record for every covered individual under the age threshold to determine Medicare entitlement. If they have no reason to believe that the individual is entitled to Medicare.

In Section 7.2.2. we're updating to add the new values for the TIN indicator. And S will stand for plan sponsor and F will stand for federal employers as indicators on the TIN reference file.

These indicators become effective with files processed after July 1, 2009. Both are for use with the employer TIN field your MSP input records do not

need to be resubmitted. If you resubmit TIN reference file records using these new indicators if you've already submitted that TIN. Unless you change the name and address associated with the TIN.

So if you've already submitted TIN reference file records within E for either a planned sponsor record or a federal employer TIN record. Then you may resubmit those TIN records on an updated TIN reference file with your next quarterly submission, or with your quarterly submission after July 1, 2009.

And again you do not need resend all your MSP input file records that are associated with that. Unless you're changing the actual name and address associated with the TIN.

In Section 7.2.7 we are updating that to state that RREs are not required to submit records on the MSP input file that reflect GHP coverage periods of less than 30 calendar days.

This only applies to coverage periods with specified termination dates. Not to periods that are open ended. So if you are reporting a coverage period that is open ended that should continue to be done. This is only when you have a coverage period with an effective end termination date and that time span is less than 30 days.

Updates are being made to the guide for the description of the threshold errors, we've made a change to the threshold error. It used to be that we looked for the number of records on an MSP input file or a non MSP input file coming in. And if more than 10% of those records were delete the file would suspend with a threshold error.

This check has been lowered, this threshold has been lowered and so any file that comes in with more than 4% of the records as delete will be suspended with a threshold error.

You will receive, your account manager will receive an email indicating that the file's been suspended. And you need to contact your EDI representative to discuss the situation mainly to make sure that RREs are properly using the delete function.

We are also, and there's no changes that need to be made to your processing as a result of that threshold check. The file is not necessarily deleted it may be released for processing if the delete records contained in it are acceptable.

There's a new threshold error being added to check the ages of individuals that are submitted on an MSP input file. This age threshold is going in just to make sure that our RREs are not sending retirees on their MSP input files.

The check has after data analysis performed by CMS in the COB contract. Or we found that the threshold should be set at if more than 13% of the individuals reported are age 79 years-old or older. Then again the file will suspend for threshold error and you should contact your EDI representative to discuss the situation.

Again this is just a safety check to make sure that you haven't accidentally reported retirees on your MSP input files.

Again let's go back to the reporting of ESRD individuals that they should still be reported regardless of their (being) behind their GHP coverage.

I'm also adding a section related to describing the severe errors that a file might suspend for. If a file is submitted with a missing or improperly formatted header or trailer record. Or the record counts don't submit or match those record counts on the file don't match what's submitted on the trailer record. The file will suspend with a severe error you are to contact your EDI representative.

In these cases the file will actually be deleted and your EDI representative will provide you with instructions for sending a corrected file. As to what time frame you should use.

We're updating Section 7.4.2.1 to note that the N records on the non MSP input file are not limited to just inactive covered individuals. In other words you may query on any individual on that non MSP input file. But remember when you submit a non MSP input file. It must contain it cannot contain only N records it must be also submitted with your D records which reflect supplemental coverage and those D records are only to reflect inactive covered individuals.

Section 7.5 is being updated to further clarify the testing process. No requirements are being changed, however, do note that if you submit a test file with more than 100 records that test file will be rejected and not processed.

RRE ID accounts that have been in a testing status for more than 30 calendar days will receive an email sent to the account manager and authorized rep. Indicating that the account may be at risk of non-compliance since testing has not been completed.

This 30 day notice is simply a warning and for informational purposes only. Please be sure that your EDI representative is kept informed of your testing progress and any issues that you may have encountered along the way.

The time period for testing is essentially from the date the RRE ID is set to a testing status. This occurs once the profile report has been marked as received, returned signed and received by the COBC. So it's between that point and the first day that your first production MSP input file submission time frame begins for that RRE ID.

If you run the risk of not completing testing on time in time for the required submission of your initial MSP input file. Please notify your EDI representative immediately and even after the RRE ID has been put into production status. You may continue to send test files for any file type that you deem necessary.

If an RRE ID is not yet in a production status and production files are submitted for any file type that file will be rejected.

Additional information on the secure file transfer protocol or SFTP file transmission method is being added to Section 8.1.2 to help explain better the direct restructure under each RRE ID. Using your secure FTP client or other software for example a command line interface. You will sign onto the Section 111 secure FTP server, provide your credential the log in ID and password.

If the log in ID that you provide is associated with more than one RRE ID then you must first navigate to the directory or mailbox for the RRE ID that you want. And then navigate through the sub-directories for the submission or the response file directory that's listed in the guide.

Section 11 was updated to add a list of the emails that are generated automatically by the Section 111 system and included the recipients of each of those emails. We're adding a list of acronyms as a new appendix.

And that covers my initial announcements so I will turn it back over to John and Bill to Bill Decker for some questions to answer some questions that were presented.

Bill Decker: Thanks Pat really appreciate that. I'm Bill Decker and I am also with CMS here in Baltimore and good day to all of you who are on this call.

We have a range of things we want to discuss as a consequence of a lot of questions that we received. And from other information that we have received since the last call that we've had with our GHP reporters. And we're going to go over that now.

I'm going to start with a couple of points here that is information just general information we received first. We've been told by people we understand and believe. That some insurers have been advising some employers to register or to attempt to register as RREs.

And we want to point out again that there is very, highly unlikely that any employer would ever need to register as an RRE unless they were self insured and self reporting and not using a TPA for claims payments.

If they're not they don't have to register and there certainly wouldn't be any way for them to register. We would advise any insurers on this call not to make those suggestions to employers.

The second thing I want to get to is that if you're an RRE or believe you're an RRE you need to register. But you need to understand and read the definition of RREs before you register.

We've had information coming into us a lot of information asking if they are an RRE if someone is an RRE, am I supposed to register? And we can't actually answer that question with any degree of certainty because we don't know your exact situation.

You need to read the materials on the Web site, decide if you're an RRE and then attempt to register. You'll find out very quickly if you are an RRE or not that way.

The third general area I want to cover once again is go back to one of my favorite subjects and I'm sure it's one of yours. The issue of social security numbers.

We've gotten some information that some entities are insisting that children people who are in the country, who are working on worker visas. But they're not American nationals and they have children and they're covered by a group health plan.

The insurer is asking for the social security numbers of these children and advising the parents of the children to go to the social security administration and get the SSN for these kids. And that probably is not going to happen because the kids aren't American nationals and thus won't be eligible to get an SSN.

Once again we require we need to have a Medicare ID number being reported to us by RREs. RREs can report SSNs to us if they need to. But the

requirement what our requirement is principally for the healthcare identification number.

And that is associated with people who have social security numbers. And people that have social security numbers are people who are Americans and have social security numbers but not anybody else. So start from that and much of that will go around this because that will come up again in some of the other questions and answers we have.

One of the questions we did get in the mailbox was a question about whether hearing aids and hearing exams are covered and need to be reported? And the answer is no hearing aids and hearing examinations to check for hearing loss are not a covered benefit under the Medicare program. Thus do not need to be reported to us by any RREs.

Generally speaking you don't need to report on anything that Medicare doesn't pay for whether we mention that specifically in our documentation or not. There are a lot of benefits that are items that Medicare does not pay for. And if we had chosen not to put a list in our documentation at this point because the list changes. And we don't want you to think that that's the be all and end all.

But you need to know which benefits Medicare doesn't cover and those lists are available all over the place. You can find them easily on the Web site or just go to the publication that all Medicare beneficiaries get called "Medicare and You." There's a page in there that has a pretty good list of all the benefits that are not covered by Medicare.

We got a question from a one of our RREs asking if the RRE how will the RRE determine which of its deductible plans have an associated HSA? This is actually a two part answer here.

One part is that it's up to the RRE to know what benefits it needs to be reporting on to us. So we can't possibly tell you what you should be reporting on we don't know what your, how you're structured or. And we can't give an answer about whether, how you would find out whether you report on a benefit.

The second part of the answer though is the health savings account in any case are not reportable to us and so you don't need to worry about reporting them.

The next one we have is a question that came in from a children's hospital. Asking about the criteria for reporting a pediatric patient or a minor. And the minor is receiving SSDI benefits.

The general answer to that is that you would report anything at all about this individual minor. Who is receiving care from you if the minor is a Medicare beneficiary for any reason an MSP will be supplied for reporting.

We got a question asking if a TPA let's see, what was the exact question? How often they should collect information from the carriers on behalf of carriers regarding employers size? And the answer to that is annually is okay.

We got a question from an RRE asking us to advise that on a proper relationship coding for a step-child. And the answer is code for child in that case not other.

Pat Ambrose: Which is code 03.

Bill Decker: Right. Those are the principal points that I wanted to make and I have now made them and so I'll turn it over to John Albert who will address a couple of others.

John Albert: Okay another questions this has kind of come in before but we'll address. And that is question raised by other carriers. That there are some concerns that the federal employees employers do not have TINs and the associate address will not be where the correspondence should be sent.

I just wanted to inform everyone on the call that we have been working with the office personnel management. And they have agreed to provide all of their plan, group health plans under the federal employee health benefits system. With a consistent EIN and mailing address to be used for federal employees.

Now we are not going to be the ones to provide that because we can't get into the determining or coordinating benefits between OPM and the plans. But and we have actually just recently reached out to OPM yet again. Because we continue to receive these questions after this was agreed to at an FBHB carrier conference over a month or two ago.

But again in terms of finding out what that OPM address should be you should work with OPM to get that. They are going to be using and we are okay with that using one EIN and address for all federal employees. So please reach out to your OPM contacts whoever they may be. We will continue to remind them from our end but we cannot be the ones to provide that specific information because what happens if it changes. You know, we want to make sure you’re getting it from the correct source.

Another question that came up too and this is one that's kind of an it depends answer. And that is I'll read the question specifically. When a GHP terminates its relationship with a third party administrator in order to self administer or switch to another TPA. And the terminated TPA no longer has any responsibilities for GHPs to run our claims et cetera et cetera. How should we report this?

Should we, you know, the question was, do we delete and re-add? Or do we provide a termination date, you know, an update with the termination date of the old coverage and a new start date based on when the new TPA takes over?

And really kind of is an it depends question. And that is in terms of the assumption of the liability for the old claims payments processes. It depends on, you know, where new correspondence should be going. Should it still be going to that old TPA? Or should it be going to the new?

If it's a case of where the old TPA basically just ceases to exist from planet earth and the new TPA takes over all responsibilities. I assume that you would want to update all existing records with the new TPA information.

Otherwise it's possible that the submitter would ask, or submit the termination date on the old with the old TPA and the new TPA would submit new open coverage rows reflecting the address for the new TPA. So it's kind of an it depends situation.

And we ask you to hold on for just a second.

And, you know, again the issue is again that if the old information is not updated or if it's, how do I want to say it? You know, just keep in mind if the

old TPA ceases to have responsibility for cases. And that information is not updated the new TPA could potentially receive demands for older cases.

So I mean we can't really define, you know, for you how that occurs but essentially just keep in mind that an existing record out there. A valid record exists with that information and that if stuff is coming in after the fact.

You know, it's a question of whether or not that old TPA still has responsibility for handling those claims or not. And who would be responsible also for any recovery action. So you have to look at it that way.

Again if, you know, if someone has, you know, a more specific example that they would like to provide, like their particular case. By all means document it and send it to the resource mailbox and we'll try to assist where we can.

A couple of other things I just wanted to add before we get into the general Q&A. And that is first of all I wanted to thank everyone on the call for providing feedback on the materials.

It's very helpful where if someone finds, you know, for example a specific contradiction in some of the materials. Things like that they can point that out to us, we appreciate it.

Obviously there's a lot of materials out there and there's no guarantee that it will be 100% accurate across the board. Non-conflicting across the board so we do appreciate that, we're only human here so we're doing the best we can on that.

The other thing too is that, you know, we take these questions and use that to develop new processes and materials. Such as the event table that Pat mentioned in reaction to some of the questions out there.

Again if there are any comments that people have on those materials or any new ideas for outreach that you'd like to suggest. Please do so to the resource mailbox.

Finally I'll just remind everyone again that computer based training modules are available. They are free of charge to all, there is some information out there, I know there is other entities offering quote "computer based training" et cetera but they're not associated with Medicare.

Our computer based training are free of charge and there are a lot of them. So please take advantage of those and again provide feedback comment questions on that as well.

I will also state what I have said every call and that is CMS is most interested in building a good quality data exchange and not (seen) as something CMPs also in terms of required data.

The only data required by CMS are is MSP data essentially. I know that a lot of people are being asked for SSNs and they don't have Medicare et cetera and we are not asking for information on non-Medicare beneficiaries. We're only asking on Medicare beneficiaries where Medicare is in fact the secondary payer. So that is the only reportable data mandated by the Section 111 reporting.

What? Oh okay Pat was waving over to me as I was getting ready to wrap up. That she had a few more things to address as well then we'll get to Q&A.

Pat Ambrose: Yes John I'm going to address some of the other questions that were submitted to the mailbox.

John Albert: Oh okay.

Pat Ambrose: A question was asked about reporting individuals once it has been determined that the employer does have more than 20 employees. Should the initial date of coverage be reported or the date the employer reached that 20 employee threshold?

You should report effective termination dates according to the associated value that reflects the employer size. The associated value in the employer size indicator.

You can submit a record with the original date and a termination date with the employer size equal to zero for less than 20. And then when you determined under the appropriate MSP rules that the employer size has surpassed or is 20 or more.

Then you can report the record with again an update to term the initial record reflecting less than 20 employees. And then send an update or an add record with a indicator of the value of 1 or 2 as applicable to the new employer size.

Note that if you submit a record indicating that the employer size is less than 20. And the reason for entitlement for that Medicare beneficiary is due to their age or disability. There is that FPEF error, there is logic in the system to not create an MSP occurrence in cases where the employer size and the individuals entitlements to Medicare indicate that Medicare should be primary.

Now you don't have to, as we've also stated report until that person their coverage does reflect MSP. So that initial record you don't have to report initially until that employer size reaches that threshold.

Again there's edits in the system I refer you back to the user guide and the description of the FPEF error. Also there are references to the MSP rules founded 42CFR Part 411 particularly 411.101 and 411.170 on the employers size calculation.

Again it would be only filled an MSP record for this period as applicable to the reason for entitlement and uses that employer size indicator as well.

Question was asked about the SP47 error code. SP47 states that the beneficiary MSP indicator is not on for delete transaction. Essentially if you will get an SP47 back when you're attempting to delete an MSP occurrence. Or attempting to lead a coverage previously reported. But the COBC can find no MSP occurrences for that individual on the CWF file.

An SP49 you'll get back on a delete transaction if we can't match the delete transaction to an existing MSP occurrence but there are other MSP occurrences out there.

So essentially SP47 and SP49 can both be received back for a delete transaction, where we're unable to actually match the delete transaction to an existing MSP occurrence.

You need to check that record to make sure that you're sending the appropriate key field information for the matching process.

A question was asked concerning the RRE ID assigned during the new registration steps. The RRE ID is the same thing as the Section 111 reporter ID and it is the number that you place in the header and trailer records of your input files.

On some of the reports and pages that you see you might the leading zeros might not be printed. But when you're submitting your files you should use those leading zeros as those reporter ID or RRE ID fields on the input files are numeric.

Another question was asked what sources does the COBC use to validate your incoming data? The COBC is editing data against Medicare files including those in the COB system on CWF. And on the Medicare beneficiary data base system or MBG.

We do receive or Medicare does receive entitlement name, date of birth, gender information of that sort from the Social Security Administration originally. But we do not actually physically edit against the SSA data.

Another question was asked will SP errors be posted on records returned with a disposition code other than SP? And the answer to that is no. You will only receive SP errors on records that receive a disposition code of SP. You will not receive SP errors on for example a response file record that is being sent back with a disposition code of 51.

If a record is returned with errors but the RRE is not able to correct it before the next quarterly MSP input file is due. Should that record be sent anyway? The answer to that is no, if you do send it again with the same errors it will get rejected again. CMS and the COBC system do not keep a track of records that

you previously sent that were rejected with errors. So it's probably in your best interest to wait until that record is corrected to resubmit it.

Another question was asked whether a TIN can be submitted on the TIN reference file for which you are not actually reporting any coverage information on your MSP input file?

And the answer to that is yes actually. We require that every MSP input record has matching TINs have TINs that match TIN reference file records. But if you submit your TIN reference file record with more TINs than you actually are using on your MSP input file that's okay.

Another question was asked about what field 33 the last query date on the MSP response file is? This field is not related to when an RRE last queried. This is actually the date the last time the COBC sent a record to CWF. So essentially field 33 the last query date on the MSP response file can be ignored by RREs. I don't see what you would need to use that for.

A question was asked about the extensions for reporting dependents to allow more time to collect the SSN or HIC number. The health insurance the Medicare Health Insurance claim number for these individuals. Please see section 7.2.8 of the user guide. I think that it's clearly explained there.

Another reporter noted a discrepancy between the descriptions for the error codes SP39 and SP40 related to the employer name and address. The error descriptions for SP39 and SP40 are incorrect and will be changed in the next user guide.

The errors refer to employer name and address, and in some cases as we've said previously the name and address might actually relate to the plan sponsor,

as opposed to the actual employer in the case that the multiple employer GHP is using an (unintelligible) arrangement.

A question was asked about what characters can be submitted in the last name? The question was specifically asking about SP14 but the error code actually related as SP13. Spaces, apostrophe's, hyphens in last names should be submitted as you have it stored in your system.

The Social Security Administration provides Medicare with beneficiary names and we check against whatever SSA has provided us for a beneficiary name. Basically the name that should be submitted is that that is shown in their, either their social security card or their Medicare card.

A question was asked about when the F12 270 271 companion guide will be available? We hope to get that out and available later this week or early next. Please contact your EDI rep we are planning on posting the (mapping) documents for the F12 270 271 on the COB secure Web site. But I don't have an actual date for that. In the meantime your EDI rep can provide that information for you.

We're also planning on making the employer, rather the HEW H-E-W software available for download off of the COB secure Web site but that's not yet available. Again contact your EDI representative to get a copy of the HEW software at this time. That's it.

John Albert: Okay with that operator we'd like to open it up to questions and answers.

Coordinator: Thank you so much. At this time if you would like to ask a question please press star 1. Be sure to record your name at the prompt so that I may introduce you to ask your question.

Please limit yourself to one question and one follow up. Once again it is star 1. Please stand by for questions.

We have a question from (Barbara Colsen) your line is open.

(Barbara Colsen): Hi this may have just been answered but I'll go ahead and verify. If we are sending an update on a record that's been previously accepted let's say the coverage selection has changed. I know that we, the first one, the first iteration with the previous coverage would be an update. But the second iteration with the new coverage is that an update or an add?

Pat Ambrose: That would be an add record.

(Barbara Colsen): Thank you.

Coordinator: Thank you. Next question comes from (Maryanne Bowers) your line is open.

(Mark): Yes thank you for taking our question (Mark) (unintelligible) from Harvard Pilgrim. We actually registered with CMS online as an RRE as a 417. But we have not heard back from CMS, we've also left messages with our EDI rep and have not heard back? So we're just concerned about that what should be our next steps?

Bill Decker: You basically have just taken the next step.

(Mark): Okay.

Bill Decker: By calling in on the EDI team and the COBC team is actually listening in on this call. I know they've gotten your message now.

(Mark): Okay.

Bill Decker: It should be back, they should be in touch with you very shortly.

John Albert: There is an elevation process in the user guide right?

Bill Decker: There is an elevation process in the user guide that you can follow.

(Mark): Okay great. Thank you very much.

Bill Decker: (Barb) you may continue.

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

(David Pitman): Yes you mentioned earlier that query files would be accepted after we had completed the testing process and been approved for production. What about basis queries, when would they be available?

Pat Ambrose: That would be the same scenario that once your RRE ID is in a production status. You'll be available to make or be allowed to make those basis inquiries.

(David Pitman): Good and is there any limit on which type of people, I mean, let's say we're only reporting active covered individuals. Are we allowed to also use basis for inquiring on inactive covered individuals? What are the terms there?

Pat Ambrose: Yes you are.

(David Pitman): Oh okay is that documented somewhere?

Pat Ambrose: Probably not I'll make a note of that thank you.

(David Pitman): Okay thank you.

John Albert: And again we would strongly encourage you to use the query file it's much more efficient overall.

(David Pitman): Oh yes we're planning to do that, I just wanted to know what all of our options were.

John Albert: Okay.

Coordinator: Thank you. Our next question comes from (Jamie Hirshman) your line is open.

(Jamie Hirshman): Thank you. I just wanted some clarification you were talking about changes to the GHP user guide. And I was wondering when that will be available?

Pat Ambrose: I'm hoping to have that, it's under review right now and we're hoping to have that published some time next week.

(Jamie Hirshman): Right thank you very much.

Pat Ambrose: Again let me just, you know, quickly say that there are no actual requirement changes we are adding those new indicator for the TINs. The rest of the changes are really for clarification purposes only.

John Albert: Yes and I mean there are , that and along with some other documents that I mentioned regarding the letters, or questionnaires that can be used with beneficiaries. They were trying to make it that they all kind of come out at the

same time so that we don't have to go back and like do another update a week later kind of a thing. So we're shooting to get that out next week. Two weeks at the absolute latest.

Coordinator: Thank you. Our next question comes from (Neil Urihara) your line is open.

(Neil Urihara): Hi. I have a question, actually I emailed a question but I never got an answer to it. But my other question was the effective date of the file if we, the input file the initial one. If we have members that are, have been covered since like 2007 2006. I was told that when we send them we don't send the effective date. We need use to 1.01.09 as the effective date?

John Albert: No use the effective date of that current coverage so if the person has had the same coverage for two years then use the start date of that coverage.

(Neil Urihara): Okay because the EDI representative told me that we don't use the original date we use 1.01.09.

John Albert: That's wrong.

(Neil Urihara): That's what I was told, that's was my question that's what I was told.

John Albert: That...

Man: (Unintelligible).

Pat Ambrose: We'll follow up on that.

John Albert: Yes.

(Neil Urihara): And also sorry if I had to do something but I emailed this question a lot of times and I've never gotten a response even listening to your call. But if the group size is less than 20 you're saying we don't have to report these individuals?

Pat Ambrose: Not completely true, keep in mind that where there's a multi employer plan...

(Neil Urihara): I understand this is a regular employer on his own, not part of an employer plan. They are a mom and pop store they have five employees and they're all over 55.

Bill Decker: It's not the number of individuals in the group it's the number of full and part time employees. And the example you cited you said five employees. Five is less than 20 employees.

(Neil Urihara): Correct.

Bill Decker: However, you had 25 employees but only five in the group, that group would need to be reported.

(Neil Urihara): No this is a regular employer that only has five employees. Not part of a multi employer they're just, they're a...

John Albert: Okay that we just wanted to make sure because people get confused about that particular topic. But yes if it's a standalone and they're the only ones in the group and there's five of them. Then, you know,...

Bill Decker: They're all the employees.

John Albert: Yes and they're all the employees then you're correct they would not have to be reported. Except for the SRD...

(Neil Urihara): Right exactly we have a lot of small business employers enrolled with us in our health plan and they're all standalone.

Pat Ambrose: Well you appear to have said something that's contradictory. You're saying they're all standalone but they're enrolled in your plan. Sounds like a multi employer plan.

John Albert: Yes.

(Neil Urihara): No we are a medical insurance company we do employers, employers register their company with us to get health coverage right.

Pat Ambrose: Okay so you're not saying you have them all in one plan?

(Neil Urihara): No that's maybe that's why I'm confused is because we're a medical insurance company and we sell health plans to employers for their employees.

Bill Decker: I would encourage you to look at the CMS Web site under Medicare Coordination of Benefits Employer Services. And read the piece about the small employer exception. Whether we describe what we consider to be a multiple employer health plan.

And if you are not that then you're right you don't have to then, you wouldn't have to report. But you need to be sure that you're not off or sponsoring or being a planned administrator for a multiple employer plan. That's basically what we're saying.

(Neil Urihara): Right a multiple employer, my interpretation of a multiple employer plan is, we have these groups out there that handle medical benefits for multiple employees on the island. And they just submit everything to them that would be a multiple employer plan.

Bill Decker: No a multiple, we described what constitutes a multiple employer plan in some detail on the Web site. If there's some sort of an organization that facilitates the attainment of the group health plan insurance. It's a multiple employer plan even if each employer has a separate contract.

Pam Ambrose: So if you haven't checked out that Web site and even if you have please go back and read it again. And if you still have some misunderstanding after that then you potentially need to contact us.

John Albert: Repeat the address for the Web site.

Bill Decker: It is on the CMS.HHS.gov Web site you can click on Medicare and then coordination of benefits. And then employer services and under employer services multiple employer exception.

(Neil Urihara): Okay so it's not under the mandatory insurance rep guide right?

John Albert: No I mean we've purposely are leaving he policy stuff out of that because they're, .we don't want the Section 111 it's not there to be an MSP how to manual. It's there to tell you how to report data to CMS through this process. Independent of the MSP laws and how they apply.

Bill Decker: You do need to check the other Web site to get a good rating for yourself on that.

(Neil Urihara): HHS.gov and you click on Medicare?

Bill Decker: Coordination of benefits, employer services, small employer exception.

(Neil Urihara): Okay thank you.

John Albert: Thank you.

Pat Ambrose: Also for all of you if you check Page 92 in the guide is where under training and education and I believe we give you information for various sites.

(Neil Urihara): Okay thank you.

Coordinator: Your next question comes from (Sue Hildebrand) ma'am your line is open. Miss (Hildebrand) is your line on mute?

John Albert: Okay next question.

Coordinator: Next question comes from (Peter Brink) sir you line is open.

(Peter Brink): Yes excuse me. My question is regarding to the HRA reporting the guide says that HRA accounts are not to be reported until the fourth quarter 2010. Does that mean the account itself or the insurance medical insurance that that person has?

Bill Decker: Well we'll start with HRA reporting doesn't need to start until after that anyway. Now that’s been changed.

It’s the individual add as a group health plan in addition to an HRA the group health plan needs to be reported now. And the HRA information would

supplement or works in conjunction with the group health plan doesn't need to be reported until 2010.

(Peter Brink): Okay that's what we were assuming I just wanted to clarify it thank you.

John Albert: All right, okay. Threw us off it was like two questions in one.

Coordinator: Our next question comes from (Amy Miller) your line is open.

(Amy Miller): In relationship to the TIN file we have multi plan employers that want all the communication to go to the associations, chamber, trust or union, which is no problem. However, we have multi plan employers that want all the correspondence to go to the individual employers.

If we load the association TINs we would have many addresses and COBC would only take the last one. Can we load the individual employers TINs in these situations so the addresses are correct?

John Albert: Can you hang on just a second?

((Audio Break))

John Albert: I guess the are you referencing Taft-Hartley type reporting? Because if that's the case we're asking for the plans sponsor information because that's typically where we would want to address that type of information.

I mean basically everything is at the record level and there's, you know, every record will have an associated, you know, a particular TIN for the employer slash plan sponsor or and the insurer.

So, you know, without knowing a specific situation it's a question of, you know, where again how do you want the coordination of benefits correspondence directed. In particular any type of recovery action that takes place after the fact if CMS identifies the past mistaken payment.

It should be going to that entity responsible i.e. the employer or planned sponsor for Taft-Hartley that's going to be essentially refunding those monies.

(Amy Miller): Okay thanks.

John Albert: Does that?

(Amy Miller): That helps thank you.

John Albert: But again, for, again it all comes down to every single coverage record will have an associated employer and insurer address associated with it on the TIN file.

The thing to remember is that you can't have the same TIN with multiple address. Because if that's the case yes we will only read one of those addresses and you don't want that so we just have to, you know, be careful with that with the TIN file that's another part of your question. I know we had that before.

(Amy Miller): Okay thank you.

Coordinator: Our next question comes from (Helen Moyer) your line is open.

(Helen Moyer): Yes we still have a little confusion here about the employer size change. Because when we were reading he law on I forget the exact section of it. It

seemed as though it said that when the size of the employer goes to 20. That it remains at the above 20 status for the remainder of the year and the next year coming.

But yet the way we're getting it from you guys is that the minute they have more than 20 employees for the 20 weeks. They should, you know, the carrier would become primary and we're not clear as to how this works and also in reverse. If for example they're under 20, I'm sorry, above 20 and then go under, like when does Medicare become primary and when do - does the carrier become primary?

You know, like because here's the thing. If we're going to only go out after the employer size once a year, unless we tell our group as soon as you reach this 20 threshold for the 20 weeks you must report it to us immediately and vice versa, you know, we would only know when we go out that one time a year that their category has changed.

So we're not clear on how this works, like how long do you say primary versus us being primary? Does that make sense what I'm saying?

Man: No, if you're a secondary when we're - I'm assuming you're talking since you mentioned 20 for working (days)...

Woman: Right, right.

Man: ...Medicare is secondary if the employer has had 20 or more employees for 20 or more weeks in the current or preceding calendar year.

Woman: Okay.

Man: So if there were 20 or more employees in 20 or more weeks in 2008 and then it dropped to 15 and it's 15 in 2009, Medicare is still secondary through 2009.

Woman: Okay.

Man: There's 20 or more - there's 20, at least 20 weeks in the preceding calendar year.

Woman: And does it go the same way with if, like you guys were primary because they were under?

Man: If we were primary as soon as during the year that the employer had 20 or more for at least 20 business weeks then we automatically becomes secondary. We do not need to be consecutive (unintelligible).

Woman: Oh so Medicare gets the unfair advantage?

Man: That's the way Congress chose.

Woman: Well that is true though. So basically if we're paying, we're on the hook for until the year ends and the next year.

Like if somebody - let's say now I find out in October of 2009 that an employer goes over 20 employees. So now I'm supposed to report it immediately this - I'll start reporting these employees that the group went over 20.

(Barbara Wright): They've been over 20 for over 20 weeks...

Woman: Right, right.

(Barbara Wright): ...for the requisite time period.

Woman: Right.

Man: Yes. You would report it as soon as you are aware of that information. Now if for some reason you didn't become aware of that information for essentially later date you would report it effective with the date that the 20 week requirement was satisfied.

Woman: Okay. So in other words if I write out every December and that's when I find out that they've gone over the 20 threshold than I would use that December date?

Man: No. You'd use the - for the effective date you would use the date that they went when they hit the 20.

Woman: Okay. But then wouldn't I be getting a compliance issue because let's say I found out in August and my file is due in September?

(Barbara Wright): If you have documentation showing you went out once a year...

Woman: Yes.

(Barbara Wright): ...then you wouldn't - as long as we've said you have to go out once a year you'd be compliant for purposes of Section 111 reporting.

Woman: Okay.

(Barbara Wright): The potential disadvantage to you is either the employer, TPA or the insurer is if you do that only once a year and don't ask them to alert you when they go over that, you're more likely to receive a recovery demand.

So you may want to do a combination of the two, routinely go out once a year but alert your employers that if they notify you then you can proactively head off the possibility of recovery demands which we don't want to issue and employers, and insurers, CPAs don't want to have to deal with.

So if you can do sort of a combination it might save you a lot of time and effort in the long run.

Woman: Okay.

Man: I think also put an edit in your enrollment system that if for that particular employer suddenly there's at least 20 people listed as employees...

Woman: Right.

Man: ...for and it's some sort of an exception report to be generated so that you can follow-up.

Woman: Okay so bottom line is we should really be instructing our groups that if they reach the over 20 category they should be letting us know right away?

Man: I - I'm a little bit concerned about your use of the word over 20. It's the 20 or more.

Woman: Right.

Man: At least 20.

Woman: Yes I'm sorry, 20 or more.

(Barbara Wright): We do count that one person.

Woman: I'm sorry. But then I just want to make sure I'm clear in the other way. In reverse if they drop below 20 on October 1 too bad for us. We still have to stay primary for the rest of this year and all of next year?

Man: Correct.

Woman: And when is the effective date of change, the beginning of 2011?

Man: Yes.

Woman: Yes.

Man: As long as they're still under 20 for at least - having hit the 20 for at least 20 weeks (since then).

Woman: Okay well that would be really helpful if you could update the user guide with that information because it's really not clear in there.

Man: Okay, well thank you. We'll...

Woman: Okay, thanks guys.

Coordinator: Our next question comes from (Erica Walsh). Your line is open.

(Erica Walsh): Hi. We're going to be obviously asking for our members to provide us with their Social Security numbers where we don't already have them. But we're concerned that some members may come back and refuse to provide that information to us regardless of how much information we give them that this is being requested from CMS, it is going to be kept secure.

Is there - as long as we're documenting our good faith efforts to get this information are - is there any leniency as far as the penalty that we'll be incurring?

(Barbara Wright): I think John indicated earlier in this call that we're still working on model language. And in fact we've sent some drafts out to different groups to comment on that insurers and TPAs will be able to use to document their efforts.

(Erica Walsh): Okay. Thank you.

Man: And that includes a, you know, requesting a signature for someone who even refuses to provide that information so.

(Erica Walsh): Okay great. Thank you very much.

Man: And then again we hope to have out in the very, very near future.

(Erica Walsh): Thank you.

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

Hello. Your line is open. Do you have your mute done?

The next question then comes from (Terry Blake). Your line is open.

(Terry Blake): Hi. I'm (Terry Blake) from (Hansen). And I need some clarification on something I heard you say and something I've been reading in the user guide regarding the active covered individuals.

Our understanding originally well as of now, is that we have to send all people 45 and older or actually all people 55 and over and then 45 and older in 2011.

And something you've mentioned on the call today is a the note that's on Page 21 almost deludes to the fact that you don't send all people now. Can you clarify that please?

Man: Well the requirement is to only send us people where there's reportable MSP information. There's - again, there's different ways people can choose to satisfy that requirement.

One option is to essentially look at your file of enrollees and not knowing whether they have Medicare or not just asking the question of each one of those individuals if they had Medicare and Medicare would be secondary based on the coverage we're offering, report that individual.

The other way you can do that is to weed out all the people that the MSP rules don't apply. And you can do that through for example the query file. You get back, you know, who has Medicare, who hasn't, who doesn't and then develop and build MSP records accordingly.

The primary thing that, you know, we're trying to focus on is that the required reporting is MSP reportable coverage.

(Terry Blake): Right but so we...

Man: And we are not requiring you to send us people that don't have Medicare. But again, if you don't know if whether they have Medicare but they have employer group health plan coverage and they are a worker, or covered by a worker who has employer group health plan coverage, and they have, you know, 10,000 employees and you don't know whether they have Medicare or not and you just want to be safe - put them on the file if you'd like. Or you can query and see if they have Medicare and then put them on the file.

(Terry Blake): Okay I just wanted to clarify because it almost sounded like we shouldn't be sending them. But it is all right to send them...

Man: Yes.

(Terry Blake): ...doing it that way...

Man: Yes.

(Terry Blake): ...or the other option is the finder file or the query file.

Man: Yes that - I mean that’s based on a long running process that has worked well for many of our existing old VDSA partners. They basically send us a finder file where if the person had Medicare, Medicare would be secondary.

(Terry Blake): Right.

Man: And of course in many cases they may not have Medicare.

(Terry Blake): Right.

Man: And so no record was built. But where they do have Medicare we build a record or they query first and then send only the ones where they identify as having Medicare.

(Terry Blake): Okay I just want to make sure we weren't incorrect by sending everyone.

Man: Okay. Yes.

(Terry Blake): All right.

Man: Yes. Okay.

(Terry Blake): Thanks a lot.

Man: Sure.

(Terry Blake): Bye-bye.

Coordinator: Our next question comes from (Stephanie Sammy). Your line is open.

(Stephanie Sammy): Hi. Just have a question in regards to the FP52 error. We actually have never received any of those back in the past years that we've done our processes. Our first file we got back quite a few. One I was looking at and what I'm finding is those are the ones that state that it's an invalid patient relationship code.

We got these all back on members who were under 65 at the time they became entitled to be ESRDs. They're still in that coordination period.

When we sent them on the file we're sending them as a sponsor dependent stating that it is MSP. Because they are now aged when it comes back we're getting that code to say that we can't have a sponsor dependent as a working aged individual.

Do you know if something changed?

Man: Something changed in the status that there may be a systems logic problem which we'll get into.

(Stephanie Sammy): Okay. I do know a bunch of them that I called on it was just that there wasn't even information in CMS regarding ESRD.

Man: I can tell you that there have been some recent issues in terms of are not getting some of the ESRD...

(Stephanie Sammy): Okay.

Man: ...information. But you're working with your EDI rep then on this?

(Stephanie Sammy): Right. I actually have some examples I'm going to forward over to him then.

Man: Okay. Yes please do so because then we can work it through from that end. But again, we are aware of some potential issues with some of the ESRD data that's coming over...

(Stephanie Sammy): Okay.

Man: ...or some missing information. But thank you for - we appreciate your again bringing that up and being proactive about calling and reporting this stuff because there are a lot of things that happen outside of our control with CMS's systems here internally that, you know, sometimes a line of code is changed somewhere far down the line that could impact like this process so...

Man: We'll also check the just the...

Man: Yes.

Man: ...systems logic.

Man: Yes.

(Stephanie Sammy): Okay. And I just wanted to make sure that the ones that we were correcting that even though they are aged now because they were sponsor dependent at the time they received their entitlement that it was still okay for us to send them.

Man: Yes and you should be continuing (to update) primary...

((Crosstalk)).

(Stephanie Sammy): Okay thank you.

Coordinator: Our next question comes from (Sue Paget). Ma'am, your line is open.

(Sue Paget): Thank you. I just have a question that may hearken back to one of the first callers who was concerned about registering and not receiving a response.

And we did register. We received our RR EID. And I successfully completed the account setup.

And I also went so far as to assign a single designee just to see what that process was like. Although of course I expect to sign others later.

But I have heard nothing since then. Now should I be concerned or is there a period of time before - I would've thought that I would've received like a confirming email about the designee.

Woman: Actually no, you won't see that. But when you're logged back in as the account manager you will see that account designee on your designee listing and under the RR EID, and the status as to whether that designee has registered or not.

(Sue Paget): Okay.

Woman: Is your question related to - did you receive your profile report?

(Sue Paget): Yes.

Woman: Okay so after the account setup stuff and then the COPC issues the profile report your authorized representative needs to sign that last page and return it to the COBC.

(Sue Paget): Okay.

Woman: At that point you will actually get an email that indicates after it's been received back and logged in the system you'll get an email that indicates your RR EID is in a testing status.

(Sue Paget): Oh okay. You know, she did send back the signed authorization. So maybe we just have to sit tight for another couple of days.

Woman: Yes it's - I'd give it a couple weeks and then contact your EDI rep about and if a profile report has been sent back but you have not been changed to a (tuffing) status.

And again the designee, now if that's a separate issue they should have received their invitation email which they then personally follow a link in that to register for the site. And you as the account manager can monitor their progress on this after you log into the Web site, you know, by selecting designee - the designee maintenance action off of your RRE listing.

(Sue Paget): Okay. She's been on vacation for a few days so I'll know for sure I suppose by Monday if there's a problem.

Woman: Okay.

(Sue Paget): Thank you.

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

(Fran Frolic): Thank you. Could the file receipt notification be expanded to send the email to more recipients than just the authorized representative and account manager?

The reason I ask is because the people like me who are concerned and worried about the files and make sure that they're going and so forth don't always see this notification unless those two people send it down to us.

Woman: First off the file notification that the file has been successfully received by the COBC or that a response file has been created and is available, those notifications only go to the account manager.

We have a - we have noted that we need to make this more flexible but that change can't be made at this time.

However if you're an account designee and interested in monitoring the - or the file processing, you can always log on to the COBC secure Web site, go to - you'll be brought to that RRE listing page. And you'll be able to for production files you would select that file results action and see your file listing and the status of your file.

So even though you don't get an email you can monitor that information there. Likewise for test files you would use the test file results action.

And at a later point in time we hope to make that email delivery the little more flexible.

(Fran Frolic): Thank you very much.

Coordinator: Thank you for -- thank you. Our next question comes from (Jolene Kazmar). Your line is open.

(Jolene Kazmar): Yes. I would like to know whether employers stop loss coverage is contemplated under Section 111?

Man: To whom is the stop loss coverage making payments?

(Jolene Kazmar): The employer.

Man: Is it making the payment through the employer or through the - it's making it through the employer that is self-insured?

(Jolene Kazmar): Yes.

(Barbara Wright): You're not asking a group health plan question right now correct?

(Jolene Kazmar): Correct.

(Barbara Wright): Okay. This call is limited to group health plan issues.

(Jolene Kazmar): Okay.

Man: But there's two calls scheduled next week for NGHP. Please, you know, submit your questions through that call.

(Jolene Kazmar): Okay, can I ask another question?

Man: If it's GHP related, yes.

(Jolene Kazmar): Is a plan called Fixed Indemnity where a claimant gets a fixed amount for a hospital assignment or a doctor's office visit. Is this limited benefit product contemplated under Section 111?

Man: Yes.

(Jolene Kazmar): The answer is yes?

Man: Yes.

(Jolene Kazmar): Okay, thank you.

Coordinator: Thank you. We have a question from (Nadia Rios). Your line is open.

(Nadia Rios): Hi. We have - I was looking at an implementation guide Page 37 when it has note about the multi-employer plan. We have a group that doesn't exactly fit this little explanation. It's a multi-employer group that represents lots of small employers.

And reading that I want to know if we are expected to submit to plan sponsor's TIN or are we expected to submit each individual employer's TIN?

Our arrangement is with Associates Trust, not as each individual employer.

(Barbara Wright): What we've said generally in the instructions is where you have a Taft-Hartley plan or you have one that is specifically based on hours bank coverage...

(Nadia Rios): Yes.

(Barbara Wright): ...that you should be reporting the plan sponsor. But otherwise you need to report the employer information.

Man: Since it sounds like this would be considered a multiple employer plan, and remember that if any of the employers have at least 20 employees the MSP rules for the working age apply unless there has been a small employer exception granted.

(Nadia Rios): Right. And I guess I wasn't concerned about the size part. I understood it's more so the employer's tax identification number.

This trust fund they have over 1000 individual employer groups. So are - is the expectation we have to submit all of these tax IDs?

(Barbara Wright): It's in the Taft-Hartley plan and it's...

(Nadia Rios): So it's not. It's - that's what I said. It doesn't fit what's on Page 37. That's why I'm asking the question.

So other than size which I already understood I want to understand as far as the address and the employer tax ID.

(Barbara Wright): If you'd like to write us...

(Nadia Rios): I have. It's been out there since January.

(Barbara Wright): Could you reforward it and specifically put - just put May 6 call follow-up in the subject line to make sure we haven't lost it anywhere?

(Nadia Rios): And who is that talking now so I could reference your name as well in the email?

(Barbara Wright): This is (Barbara Wright). It will be addressed by others here as well.

(Nadia Rios): Okay.

(Barbara Wright): So if you want to put that that's fine.

(Nadia Rios): Okay I can do that. Thank you. But otherwise you cannot answer my question right now?

Man: Please describe your - the situation in detail.

(Nadia Rios): Right now you want or...

Man: No, I mean in your email.

(Nadia Rios): Okay. I will do that.

(Barbara Wright): I mean based on the information we have at this point we have to stick with what's in the guide. But we want to make sure we have all of your information. And if we can offer an alternative, you know, we want to consider that.

Man: Yes.

(Nadia Rios): Well I guess I'd like to know because what this group has told us that their legal counsel got direction from CMS. And I didn't realize CMS was taking direct calls from individual groups.

So I will certainly follow-up in an email. But I just hope that someone actually responds to the email soon.

(Barbara Wright): If you could also give us any information you have about their legal counsel giving advice because we are responding separately.

(Nadia Rios): I didn't think so but, you know, I have to ask.

(Barbara Wright): Okay.

Man: Yes, sure.

(Nadia Rios): Okay, thank you.

Coordinator: Thanks. Our next question comes from (Teresa Wilcox). Your line is open.

(Theresa Wilcox): Thank you. Actually my question is very similar to the one just asked. We are a trust. We cover multiple employers that are owned by one employer. Our thoughts were we would send each employer's TIN but us - our address is the plan sponsor address for each of those TINs because we want questions about claims coming to us not to the (employer).

(Barbara Wright): It won't just be questions. It will be actual demands.

(Theresa Wilcox): Demand of the group health...

(Barbara Wright): Demands for repayment to the extent any are required to be issued.

(Theresa Wilcox): Well that's fine. But it's payment on claims right? Because that is our job not each of the employer's job. So is that valid to put in our address?

(Barbara Wright): We need - if you are a TPA where you're claims processing so you're a TPA or / insured that we routinely give a courtesy copy to the insurer or TPA of record -- whichever is listed -- you know, as the insurer. And we send the demand normally to the employer.

Now if you put the same address down for both that is not proper.

(Theresa Wilcox): Okay. But you can assure us then if there is a demand for claim payment the insurer TIN and address will get that.

(Barbara Wright): They get a courtesy copy.

(Theresa Wilcox): Because we are definitely the ones going to be paying that, not the employer. They would expect us to handle it.

(Barbara Wright): Our routine practice is to send - to issue the demand to the employer and to send a courtesy copy to the insurer/TPA. We can normally tell by the name alone whether an entity is functioning as an insurer or as a TPA.

For example one of the Blues plans could either be listed because they're the insurer. They might be listed because they are the claims processing TPA. But we do give the courtesy copy to whichever one we have of record.

(Theresa Wilcox): Okay. Okay thank you.

Coordinator: Our next question comes from (Gail Zelmer). Your line is open.

(Gail Zelmer): Yes. This is in regards to the HRA coverage. I just want clarification on your statement that if a member has medical coverage along with the HRA coverage that you would need to send the medical coverage and not the HRA?

Man: Yes.

(Gail Zelmer): What if the HRA coverage is embedded within the medical coverage? How would you separate that record?

Man: Right now we're only going to be posting a record based on that medical coverage. HRA will be a different coverage type. And we're not asking for that information until the end of next year.

(Gail Zelmer): You okay thank you.

Man: If send an email describing how this embeddedness process works it might be helpful for us conceptually.

(Gail Zelmer): Okay we'll do that. Thank you.

Coordinator: We have a question from (Rochelle Delagram). Your line is open.

(Rochelle Delagram): Hi. I wanted to go back to the question about the fixed income or fixed payment policies. And it's our understanding that Medicare doesn't coordinate benefits with these type of policies. So why would we need to submit them?

Man: If that's an employer group health plan that is an indemnity policy we do coordinate benefits with them.

(Rochelle Delagram): But if it is an individual policy like a per day policy or a surgical policy or cancer policy would we have to report that?

Man: Specific illness policies generally are not reported. However we have - you have to be careful when you say it's an individual policy. If there's employer involvement it's considered a group health plan.

(Rochelle Delagram): Okay.

Man: In other words the employer cannot go out and buy individual policies for its members for its employees and then say they all have individual policies.

(Barbara Wright): And I would also keep in mind, even for those policies that we've said do not have to be recorded under 111, you are required to know when they are paying for services that are covered by Medicare. And if they are, you know, qualify as a group health plan you do need to pay appropriately regardless of whether or not you've reported them for Section 111 reporting.

(Rochelle Delagram): Well we still are not certain about this. These policies are thought - are offered in addition to our indemnity policy.

Man: Do you offer them to an employer who will then offer them to an employee?

Man: Right but the...

(Rochelle Delagram): These are paid by the employee.

(Barbara Wright): These are - could you repeat that? There was a sidebar going on here.

Man: Yes. Could you repeat what you just said?

(Rochelle Delagram): The employer offers to the employee that it's all employee paid?

Man: Doesn't matter. If there is employer involvement in any manner it's considered group health plan.

(Barbara Wright): Could you hold on for a second please?

Man: Okay well I - we appreciate these comments. And obviously we have -- we don't want to hold up the call with some more discussions internally here. But obviously this is still, you know, an evolving process and there's always unique situations that can come up there.

(Barbara Wright): And if you want to follow-up on an earlier email or send...please make sure to specify whether you're talking about this limited benefit plan being in addition to the major medical group health plan or whether it is the only coverage that's being facilitated by the employer.

(Rochelle Delagram): Okay. We can do that then.

Man: Yes. Thanks.

Coordinator: We have two follow-up questions. The first one comes from (Mariane Bowers). Your line is open.

(Mariane Bower): Thank you for taking this call. Will the response file provide SP errors on members that are submitted that don't have MSP occurrences?

(Barbara Wright): You will get SP errors back on records that have a disposition code of SP.

(Mariane Bower): Right.

Woman: And so if, you know we - you know, if we reject a record before we've determined whether we were going to post an MSP occurrence, you know, we might send you back errors and then you send it back and we return it, you know, indicating that there's no coverage. I don't know. You've kind of stumped me there.

You will get a 51 first. You know, we're going to check the entitlement first.

(Mariane Bower): Okay.

Woman: Let me ask you this. Why - what's your concern? Why are you asking the question?

Man: Are you talking about situations then where the coverage doesn't overlap the Medicare entitlement in any period or...

(Mariane Bower): Well we've never submitted before. We are not a VDSA. And so we're just curious about it.

You know, we've been putting together our system et cetera...

Woman: Yes.

(Mariane Bower): ...and just trying to understand are we going to get a 51 or, you know, if somebody doesn't have, legitimately doesn't have an MSP occurrence could we get other types of errors other than a 51 on this, you know, the individual...

Woman: Yes well the 51 is not a - an error.

(Mariane Bower): Right.

Woman: It's just indicating that we could not match that person to a Medicare beneficiary.

So I would set up the system by disposition code and say, you know, if I got an 01 grade, you know, do, you know, take the (HIC) number off of that and other information that you might desire related to their Medicare entitlement.

If you get back a 51 then that means that they're not matched to a Medicare beneficiary and take your actions based on that. But you will not see error codes on that 51. You will not see SP error codes.

(Mariane Bower): Okay.

(Barbara Wright): Again, you need to be a little bit careful though at least in terms of the way you phrase your question. You wanted to know essentially that we'd be discovering a legitimate MSP occurrence.

You need to only submit records for people who if they are Medicare beneficiaries Medicare would in fact be secondary.

For instance, if you submit a group of retirees we will build records for them.

Man: MSP records, inappropriate MSP records.

Woman: Right. We're very clear on what to not submit.

(Mariane Bower): Okay.

Woman: We know that we don't submit on people that are Medicare primary.

(Mariane Bower): Okay.

Woman: Okay. Thank you very much.

(Mariane Bower): Okay.

Coordinator: We have one more follow-up question from (Jamie Hirshman). Your line is open.

(Jamie Hirshman): Thank you. I'd just like just some clarification on when CMS is going to commence their coordination.

For example, if we have - if we report that a member is effective on 6-1-08 and we find out during the submission that they've had Medicare we haven't been aware of that.

Is CMS going to send us a recovery demand for payment for the - for that period up to the date that we notify you?

(Barbara Wright): CMS is going to follow its normal recovery demand process. And right at this moment we aren't issuing any GHP demand letters because we're trying to make sure the new start ups for this reporting are submitting correct information so we don't send out a bunch of erroneous ones if someone submits a bad file.

So whatever parameters we're using for recovery will be the proper ones to be used.

Okay great. And just one other thing. There's a lot of confusion on our part and probably other plans about this 20 week waiting period for when a group size becomes greater than 20 or 20 or more.

Would it be possible, you said you're going to send something out in the GHP user guide. But would it be possible to send out some clarification separate from that document that we could receive sooner?

(Barbara Wright): Well I don't think we've made a commitment to put it in the user guide per se. It's perhaps more likely that we will have piece or an alert that we can put on the COBC Web site. And on our Section 111 Website we would just put an alert that this is now available there for people to look at.

So since what you're really looking is MSP policy per se, not 111, it will probably be posted on that other Web site but would be a separate document.

Man: Yes, we will definitely see what we can do with that to make sure that, you know, the other appropriate CMS Web pages are clarified, updated or if we can - since the questions are coming out, you know, look at them and maybe modify them or whatever to address this what has been a common question today.

So again, that kind of feedback is very useful that sometimes points us to other parts of our, you know, non-Section 111 materials that could be clarified or, you know, whatever so...

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

Coordinator: We have no further questions at this time.

Man: Okay, all right. Wow that's - could operator, can you tell us the number of people on the call right now?

Coordinator: Two-hundred and seventy.

Man: Two-hundred and seventy? Okay. And no more questions. Okay well with that...

Coordinator: Excuse me gentlemen, we just had one that came in if you'd like to take it.

Man: Sure.

Coordinator: From (Sue Hillenbrand).Your line is open.

Man: Go ahead (Sue).

Coordinator: (Sue Hillenbrand), Unity Health Insurance, your line is open.

(Tammy Meyers): Hi. I'm unsure of how you got the name of (Sue Hillenbrand). But this is (Tammy Meyer). I actually buzzed in earlier in the call but for some reason my name never came up.

We have just a couple of questions. I want to verify the effective date of record that we need to send. I have a couple of examples.

We have members that's effective 1-1 of 2008 to 9-1 of 2008 for the ABC Company. And then as of 9-1 of '08 is active with the XYZ company and open-ended.

Do you want us to send only the 9-1 of '08 record with the correct company?

Man: Yes.

(Tammy Meyers): Okay. And then the next scenario is the members effective 1-1 of 2007 to 5-1 of 2008. And the employee coverage election is equal to one. And then effective 5-1 of '08 the employee coverage election becomes two. Would you expect to see both of those records or would you only want to see the current?

Man: You're only required to spend send the current one. But again, we're never going to refuse valid insurance information in this process.

(Tammy Meyers): Okay. So really we're only required to send the most current record at that time?

Man: Yes, as of the 1-1-09 date.

(Tammy Meyers): So a record that's been in effect as of 1-1 of '09.

Man: Yes.

(Tammy Meyers): Okay. That's all I had. Thank you.

Man: In terms of retroactive reporting, the thing to keep in mind is that, you know, CMS's other processes continue to function. And that includes the annual IRS SSA CMS data match process.

If you don't report that information, you know, a historical piece like was just mentioned on the caller's question, you know, we will not therefore have an MSP record necessarily for that person. Which means that the employer will have to provide that information at some point later in time which means that - what that really means is that our recovery efforts would be delayed. Which, you know, I'm not sure if that's something that people like getting is, you know, demand - older demand letters versus current.

So again, we'll never refuse valid, you know, more recent historical information through the Section 111 process. That's all.

Coordinator: We've had a couple more questions come in if you'd like to take them.

Man: Oh sure.

Coordinator: We have one from (Lila Kim). Your line is open.

(Lila Kim): Hi this is (Lila Kim) from Emblem Health. It's not really a question. I just want to reiterate two previous callers that called in about the effective date.

All the group health center pushing to be compliant with Section 111 in getting the group size information and so forth.

But once we get the information back from the questionnaires that are being sent out there's this confusion as to what effective date to use as where Medicare's primary versus super policy plan is primary over 20, under 20.

So I just wanted to push -send that out there again that there is confusion.

Man: Okay.

(Lila Kim): That's all.

Man: Yes, thank you.

(Lila Kim): No problem.

Man: Yes I wrote that one down.

Coordinator: We have a question from (Liz Eastman). Your line is open.

(Liz Eastman): Yes, good afternoon. Can you hear me?

Man: Yes.

(Liz Eastman): Okay great. We had a question. Right now we are already sending files to Medicare for the Part D subsidy. And if we signed up for the expanded version of reporting, how would that affect the Part D subsidy files we're currently sending?

Man: It doesn't. It's just that you have the option of using the Section 111 file, the non-MSP file for submitting those subsidy files.

Woman: If you're - you're already sending directly to the RDS Center?

(Liz Eastman): Yes.

Woman: I would recommend that you just continue to do so rather than complicating your Section 111 process.

(Liz Eastman): Okay. That's what we thought. Can I throw in another question?

Man: Sure.

(Liz Eastman): Okay. We were just curious about could you explain what the criteria was and why, you know, for the change in the age from 55 to 45?

Woman: Yes. We actually had folks do some data analysis with data that had been previously collected from, you know, through the other sources, BDSA and so on and came to the conclusion that, you know, the statistics, basically came to that conclusion.

Man: There is no BDSA selection. It goes back to the late 1990s. And, you know, doing a cost benefit analysis internally it was determined that the additional age band would not produce significantly more cost to CMS or the submitters in terms of, you know, the fact that IT costs have dramatically decreased in the past 10 plus years so.

Man: And also produced as pure demand.

Man: Yes.

Man: That's right. We get more information about more people coming via MSP.

Man: Which reduces our recovery efforts which reduces CMS and the employer to insurer cost associated with the dispute resolution.

(Liz Eastman): Right.

Man: It's a lot cheaper to do this electronic data exchange than to pay for both us and the group health plan.

Man: Right.

(Liz Eastman): Okay. All right. Well thank you very much.

Coordinator: We have a couple of follow-up questions. Our first one comes from (Erica Walsh). Your line is open.

(Erica Walsh): Thank you. This is maybe just a recommendation I'm asking for. We currently on our group contracts do not make the SSN field a mandatory field but we're

thinking that maybe we should do that going forward. Do you have any recommendations or comments on that?

Man: I mean the required data for CMS's purposes, the Medicare health insurance claim number of course in lieu of that we will take an SSN. We mentioned earlier that we will be providing additional material that group health plans can use to facilitate collection of that information directly from employers or beneficiaries. But they know in terms of what CMS requires it's actually the health insurance claim number.

Of course we recognize too that many insurers are set up at this time to probably only keep and store SSNs. So that's again why we allow that option.

(Erica Walsh): Okay. Thank you.

Man: So other than that we don't have much comments to say on that.

(Erica Walsh): Okay thank you.

Man: All right.

Coordinator: We have a question from (Angela Kimball). Your line is open.

(Angela Kimball): Yes. When we sent our production file in January we sent the original GHP date. But the size of the group we sent as of 1-1 of '09. And as were getting the response files back we're seeing that the MSP effective date is being sent based upon the original date in the GHP.

Some of these changed size in-between the time they went into the GHP and 1-1 of '09. And we were wondering how to communicate this to CMS.

Man: Okay. Update. You'd have to actually send an update to term the old period and send a new ad reflecting the new employer size.

So if they went from 20 or more or to 100 or more than you would need to basically send an update terming that old MSP and a new ad record showing the fact that you now have 100 or more because that again would - could impact whether we build an MSP record or not.

We don't have the way in our system of - we're not looking at in terms of matching up existing information with new information coming in. The primary match is determined for us whether or not if a new record or an update is - that the patient relationship is the same and the coverage type is the same and the effective date of that coverage is the same.

So if the employer size is different than you need to basically provide an update and a new ad to reflect that. Because MSP would only apply for 100 or more for that time when they have the hundred or more versus the 20 or more et cetera.

(Angela Kimball): So we would send a delete record...

Man: No.

(Angela Kimball): ...and then add...

Man: No, no. You do not send a delete. You send an update. A delete would essentially wipe out the record as if it never existed. So...

Woman: Send - yes, send the update with the termination date requesting the date that the employer - the day before the employer size changed and then an ad record with that date that the employer size changed and go forward and leave that probably open-ended.

(Angela Kimball): Okay, thank you.

Coordinator: Our final question at this time comes from (Barbara Carlson). Ma'am, your line is open.

(Barbara Carlson): I wanted to ask a couple of questions about SP 32 that talks about a termination date.

The first one was so forth disability benefits or a determination date cannot be greater than the first day the beneficiary turns 65.

So if you have someone that you're reporting because they have disability and they terminate let's say five days after their 65th birthday, how do I report that?

Woman: I don't know. Could you submit that question to the resource mailbox and we'll follow-up?

(Barbara Carlson): Okay. Let me ask you the next. Maybe you can help me there.

The second one is...

Man: Please identify that, you know, you're a caller on this call, all that kind of stuff so we...

(Barbara Carlson): Okay.

Man: So thank you.

(Barbara Carlson): The second one it's the same part, the same error. Termination date must be greater than 30 days after the MSP effective date.

So if I am sending - I've got a couple of scenarios there.

Let's say I'm - someone changes something March 1 and then they term March 15.

I think you told me - I think you said we don't spend periods of less than 30 days. So we wouldn't record that last iteration.

Man: Yes. Unfortunately this is something beyond our control. Our CMS system that accepts this data, the official database cannot recognize shorter than 30 day periods of coverage.

We're not sure how that change occurred years ago. But it's something that, you know, if we ever get that modified you can then - but otherwise you're just going to get an error code. So...

So anytime we spend less than 30 days worth of coverage we get an error code.

Woman: That is the...

(Barbara Carlson): But we - if I adjust the date is that right?

Man: Well I wouldn't do that because if the coverage ended I mean, you know.

(Barbara Carlson): Well okay let's take it in two different sessions. Let's say someone, the employer size changes on March 1. And the coverage election changes on March 15. What do I do for that 15 day period?

Man: I mean you can report it but again, it's never going to post to our database.

(Barbara Carlson): Okay. Let me go back to the - my original question about the termination date must not be greater than 30 days after the MSP effective date.
So if we sent you a record than let's say you accept, you give us an MSP effective date of January 1 and then in our next reporting period we see they terminated on January 15 what do I send you?

Woman: We're going to have to work through some of these things.

Man: Yes.

Woman: I do understand what you're saying and...

Man: Yes. We're very aware of this issue especially when dealing with, you know, the numerous hours bank type arrangements and things like that that are going to be receiving. So we're still working on that particular issue.

(Barbara Carlson): Okay. Thank you.

Man: I mean the goal is to have the CMS system that accepts all this data from our contractor that's actually doing the data exchange with you all. That's the goal. But of course that's not going to happen tomorrow unfortunately just like any other IT release.

(Barbara Carlson): So probably we're going to learn some issues when we start reporting and will have to work these things through.

Man: I mean the main...

Woman: Now one thing that I'd like to mention too is make sure you report it and discuss these issues with your EDI representative.

(Barbara Carlson): The software vendor, we're trying to write this for all of our clients. So we're trying to give them something that works. And then we don't have an EDI rep to ask.

Woman: Okay, I understand that. And so send that to the resource mailbox and, you know, with those scenarios there and we'll do our best to get back to as soon as possible.

(Barbara Carlson): Okay. Thank you.

Coordinator: We have no further questions at this time.

Man: Okay good. Thank you.

All right. Well I'd like to thank everyone for calling in and keep your eyes peeled for the next GHP conference call. I don't recall what the date is but they're monthly. And it's on the Web site. Other than that we are signing off. Thank you very much.

Coordinator: That does conclude today's conference call. We thank you all for participating. You may now disconnect and have a great afternoon.

Man: Thank you.

END