TRANSCRIPT
TOWN HALL TELECONFERENCE

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

DATE OF CALL: October 27, 2009

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

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FTS HHS HCFA

Moderator: John Albert
October 27, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer session of today's conference. At that time you may press star 1 on your touchtone to ask a question.

I would also like to remind parties that this call is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Bill Decker. Thank you sir. You may begin.

Bill Decker: Thank you very much (Diane). Hi everybody. My name is Bill Decker and I am with CMS in Baltimore, Maryland. It is Tuesday, the 27 October and where I am it is about 1:00 o'clock in the afternoon, a little after 1:00, (depending) on where you are it may be earlier.

Welcome aboard. This is a Group Health Plan. That is a GHP Section 111 call both technical and policy. The last call we had about Group Health Plan GHP Section 111 business was on September 15 so it has been about six weeks. We anticipate we will have lots of interesting questions today.

With me here in Baltimore is Pat Ambrose and Cindy Ginsburg at this point. A few other staffers will be joining us as time goes by. I did want to mention that everything in the user guide that is on the Section 111 Web site is as up to

date as we are going to have it for at least a little bit. Pat will probably talk a little bit about that when she gets into her presentation.

But regardless, the - if you have questions that are about policy, what is in the user guide and what is on the Section 111 Web site is what the official word is on Section 111 as far as CMS is concerned.

I have had a couple of people suggesting that they have heard from other folks that there is other information out there. And while that may be true, it is not ours. And ours is what is in place to give you the official guidance on the (in) Section 111 implementation.

Pretty much all GHP reporters are now registered and in process of (initiating) testing or in fact are reporting. And we are pleased with the way it is going. We think that there are still - we know that there are still some issues that certain particular health plan reporters might have. And we will be discussing some of those as the call goes on today.

This call will go for two hours. We will take questions after Pat Ambrose makes a presentation for you all. And when you ask a question or - we would ask you to limit your time online to one question with one follow up. There are a number of people who are going to want questions - want to ask questions and we want to give everybody as much time to get their questions in as we can.

I think that is all the general information that I want to cover. Am I am happy now to turn it over to Pat Ambrose who will give you a presentation on new and upcoming GHP information.

Pat Ambrose: Okay. Thanks Bill. First of all some general announcements. There has been a couple of recent postings to the dedicated Section 111 Web site for mandatory reporting that can be found at www.cms.hhs.gov/mandatoryinsrep.

On that Web site you will find some updates to the reporting do's and don'ts page. That page can be accessed by clicking on the option for it on the left hand side of the home page.

Also we have posted an updated version of the X12.270-271 companion guide that provides information on mapping for the query only X12.270-271 files. This is on the GHP page or the GHP tab of the mandatory insurer reporting Web site. And that document is dated September 24, 2009.

That document is only necessary for those who are using their own X12 translator for the 270 and 271 transactions. It is not necessary to be used with the HIPAA eligibility wrapper or the H-E-W also known as the HEW software. If you are using the HEW software, you do not need this companion guide.

We do expect to make some updates to the GHP user guide and publish that by the end of the year. None of these changes are anything that significant but rather will add come clarity to issues that we have talked about on these calls. And again that will be published before the end of 2009.

Please note as we discussed on the last call that RREs that submitted their first production MSP input file last quarter may ignore the late submission flags that were set and returned on MSP response files. There was a system problem that erroneously marked records as late even though they could not have been submitted earlier since this might have been your first file submission.

Another announcement or clarification that we want to make is that RREs or their agents must process their response file to the MSP input file. So you must process the MSP response file. It contains critical information regarding your Section 111 submission.

Process your response file from the last quarter first before sending your next quarterly submission, even if that means that the - your next quarterly submission might be late. If you are expected to be late, you should contact your EDI representative.

However, CMS would rather have the Section 111 files processed correctly rather than submitted on time without the proper processing. So again, please make sure that you are obtaining a copy of your MSP response file and processing that and taking the appropriate actions that are outlined in the user guide prior to creating your next quarterly file submission.

We would also like to remind you that you only need to submit delete records in the case where the record was previously accepted with an 01 disposition code. There is no need to delete a record that was sent but not accepted and in fact it will be returned with an error since we are likely not to be able to match it to an existing record.

Remember that you are not to delete a record when an individual's GHP coverage ends. In that case, when GHP coverage ends, you are to send an update with a termination date in the record, not a delete transaction. Again please refer to the user guide on the proper use of delete transactions.

Another reminder about ongoing file processing - files that are completely rejected, for example perhaps you sent in your MSP input file without a TIN reference file or without corresponding TIN records on that TIN reference file

needed for some of your MSP input detail record and it resulted in a large number of rejects or the entire file being rejected.

In that case you should be discussing the situation with your EDI representative and in most cases your EDI representative will instruct you to correct the problem and resend your MSP input file as soon as possible, not waiting for your next quarterly file submission to fix a problem as serious as that.

So again, in serious problems, particularly where your entire file might have been rejected with an FP, each record rejected with an FP disposition code and SP error code please make sure you work with your EDI representative to correct that problem right away.

Another announcement related to refund or rather old registration, if you erroneously or accidentally registered for an RRE ID that you no longer need or have since abandoned, perhaps you started the registration and decided that you needed to start the process over, please make sure that you have asked an EDI representative to have that unused RRE ID number deleted.

A set of targeted emails are being sent to authorized representatives and account managers associated to what appear to be unused RRE IDs so that the COBC can clean up its database and get an actual count of actual RRE IDs in use.

CMS does not have any more information at this time regarding the use of the plan sponsor TIN in the employer TIN field. This is an outstanding issue that we have discussed on the last couple of calls. The same - the status is the same at this time. At a minimum, you must use the plan sponsor TIN in the

employer TIN field when the GHP is a multi-employer - multiple employer plan operating under an hours bank situation.

CMS is considering expanding the use of the plan sponsor TIN in the employer TIN field to other conditions, but that decision has not yet been made.

There is also an outstanding issue of how to report an employer on the TIN reference file where the employer may not have a US address or a Tax Identified Number or a TIN to accurately identify that employer on the TIN reference file. Again, please stay tuned for further information on that. We do not have any further guidance at this time.

Likewise, another outstanding issue is the Health Reimbursement Account or HRA reporting. The requirements for that reporting have not yet been finalized, but rest assured that you will be given adequate time once those requirements have been published in order to report that information for Section 111.

That is it for my general announcements. I am now going to go into answering some of the specific questions that were sent to the Section 111 email address.

The first question asks that if a member record being sent on the file, the MSP input file has all zeroes in the SSN field. Will CMS try to validate it? That is, could this result in an SP error code that would also contribute to the overall error threshold.

Zeroes in the Social Security number or SSN field are actually treated by the system the same as submitting the SSN with all spaces. If you provide the Medicare Health Insurance Claim Number or HICN also pronounced the HIC

number, if you have provided the HIC number and that HIC number is matched to a Medicare beneficiary as well as three out of the four of the other matching fields for matching individuals, then the zeroes will be essentially - in the SSN will be ignored.

If the HIC number is not matched or not provided and you also are submitting zeroes in the SSN, then the corresponding response file record will be returned with a disposition code of 51. So zeroes in the SSN will not generate an FP disposition code and will not generate an SP error code. And I think that answers that question.

The next question had to do - was actually attached to a longer list of other issues that I am not going to address at this time. However, this is one part of that question that I am able to address and it has to do with the requirement for users of the Section 111 COB Secure Web site to update their password on the COBSW every 60 days. And a request was made could we change that to every 90 days so it would coincide with the quarterly reporting requirement.

Unfortunately we cannot change this requirement. That - where you are forced to change your password every 60 days, this is a Federal security standard to which CMS must adhere. I suggest that you make it a habit to log onto the COB Secure Web site once a month and update your password. And if you make that part of your monthly routine, that would probably be the easiest thing to do. However, you must change it within every 60 days.

The next question is asking for clarification regarding a correction to the HIC number or the SSN. And so the question - I am just going to read the question.

It says I am trying to identify which RRE action to apply when a user corrects a HIC number or SSN when they originally sent a record which identified the correct person but contained an incorrect HIC number or SSN.

We do list the HIC number as a key field for MSP occurrences. So if you have sent a record and received an 01 disposition code and then find that you need to make a change to the HIC number or SSN that was submitted, this falls into the category of needing to send a delete add.

I am somewhat confused about this question because it indicates that they identified the correct person, but submitted that person with an incorrect HIC number or SSN. And so if it was the correct person, it seems unusual to me that you would match three out of the four other characteristics being parts of the name, the date of birth and the gender of that individual.

However, again the HIC number and SSN are key fields. And so the safest thing to do in this condition is to follow the instructions for submitting a delete record followed by an add record with the corrected key field information.

Now one other thing I would like to note is that many of you might be aware that the Medicare Health Insurance Claim Number or HIC number may change over time. In some cases, someone having Medicare coverage through a spouse, they will have their own unique HIC number but it might be their spouse's Social Security number followed by a suffix of V. And then if their spouse then subsequently passes away, the HIC number for that individual may change to their own Social Security number followed by a suffix of A. It is just one example where HIC numbers may change their other circumstances.

In those cases, we do not need to be notified of a HICN number change. The CMS is notified of HICN number changes by the Social Security Administration and we keep a record of all the old HICN numbers that map to the most current HICN number.

So in the case of the normal course of events where someone's HICN number changes, you may actually continue to send the old HICN number and still get a match. You certainly do not have to go through the delete add process.

We will - when we are matching a transaction that you send to us, we will return the most recent HICN number attached to that individual. And if you need to then subsequently send an update record, you may use the new HICN number for that person without performing the delete add.

So a normal change of HICN number does not require the delete add. If you did send an incorrect number before, then you would follow that delete add process.

Again, it does seem kind of strange to me that the correct person was sent but not - but actually did match to a Medicare beneficiary but I will not go further into that.

Another question was submitted regarding an individual being the account manager for 25 different RRE IDs that are Taft Hartley funds and have banked hours. They work under an hours bank type of arrangement.

And they are acting for - asking for clarification on what defines an active covered individual in this situation of an hours bank. The basic rules for eligibility under the hours bank versus then how they would be reported.

I am not able to out - answer this question in great detail. But what I can do is provide a reference to the CMS Medicare MSP, Medicare Secondary Payer Manual that do cover this topic.

In the GHP User Guides you will see a link to those manuals. This is actually in the first chapter. They are each in - each chapter is in a separate download. I will give you the site or the site address or URL here, but if you are not able to copy it down accurately, please check the User Guide and you should be able to find the MSP manual in question that covers this topic.

So that can be found at www.cms.hhs.gov/manuals, M-A-N-U-A-L-S forward slash downloads D-O-W-N-L-O-A-D-S forward slash MSP105C as in Charlie, 01 dot PDF. The other chapters in the MSP manual can be found by a similar naming convention rather than the 01 dot PDF. Chapter 2 for example is 02 dot PDF. So hopefully that MSP manual will answer your question about the hours bank situation.

There was another related question asking to further clarify active employment as we are unsure if individuals on long term disability are considered actively employed and must there be compensation that was subject to employment tax to be considered actively employed.

Again I point you to that same MSP manual Chapter 1. It does have a section on current employment status and a definition of current employment status in that chapter, but it is the best reference that I can give you at this time.

Another question was asked related to the RRE responsibilities changing for GHP due to the TPA or Third Party Administrator performing the claims payment function.

So when a self-insured GH - the question is when a self-insured GHP moves from TPA A to TPA B on a date that we will refer to as the transition date, there are two possibilities. Either TPA A continues to process run out claims incurred before the transition date or more often TPA B processes run in claims that were incurred up to one or two years before the transition date.

In scenario number 2, TPA B would have to load into its systems at least a year or two of eligibility history prior to the transition date and may in fact load much more history.

For purposes of Section 111, should TPA B treat the transition date as the earliest possible accepted date for covered participants and beneficiaries under the plan or should TPA B's earliest possible effective date be the earliest incurred date that TPA B would consider as part of its run in responsibilities up to one or two years prior to the transition date.

Or should TPA B report to CMS the earliest date of continuous eligibility it has in its records regardless of whether or not TPA B would ever process claims incurred more than one year or two prior to the transition date.

In this case of a transition, the new TPA reporting should report the earliest date of continuous GHP coverage it has on record. Most likely, hopefully, the prior TPA reported this information already and it will not be new information. But we certainly do want the earliest date that the RRE is aware of the GHP coverage if it is reportable under Section 111.

It is possible that some of these records that they are new to us could be marked as - with the late submission flag, but there is no need to worry about that if you have a record of the transition. And what you are doing at this time, the late submission flag could essentially be ignored. There is not automatic

fine or penalty that is imposed on an RRE just because the late submission flag is indicated on the response record.

Another question was asking about clarification on Section 111 GHP requirements for reporting ESRD beneficiaries who are beyond the coordination of benefits period and for whom Medicare is therefore primary to GHP coverage.

Essentially the answer - they went on to ask in particular if an ESRD beneficiary’s coordination of benefits period ended prior to 1/1/2009, should we exclude this beneficiary from our Section 111 GHP reporting process?

And the answer is no. These individuals are actually considered by definition active covered individuals. Always send active covered active individuals and those that fit that definition in particular of having ESRD always send them on your MSP input file.

The CMS and COBC determine when Medicare is primary, not the RRE. The COBC will determine the MSP effective date and end dates taking the ESRD coordination period into account. The RRE is only responsible for submitting information about its own GHP coverage, not making determinations about Medicare coverage and when Medicare is primary or not.

Send any - send the record and any changes to key fields or fields used to determine MSP with the appropriate effective and termination dates. And what I would most like to refer you to is the event table in the user guide for setting those dates appropriately.

We have members - another related question, we have members who are in their 30 month coordination period for ESRD. These members are not signing

up for Medicare until month 28 or 29. We send these members on our quarterly submission and receive a disposition code of 51 on a majority of them since the SSN could not be matched and other fields could not be matched to the Medicare beneficiary.

The member then enrolls in Medicare and Medicare becomes prime. We would not send the member in the next quarterly file submission. The GHP User Guide is very explicit regarding sending active covered ESRD members, but in these cases, no MSP events can be created. Can you please advise?

Again, you are to send and continue to send these individuals. The CMS and COBC will figure out the coordination period and send up the appropriate MSP occurrence when the GHP is primary.

Another question regarding GHP and non-GHP reporting - a question has surfaced if independently purchased supplemental insurance products such as long term care of long term disability and short term disability are required to be reported under Section 111.

Our understanding at this moment is since these are not GHP related products, reporting is not necessary. The questioner goes on to ask if these products fall into the non-GHP arena for Section 111 reporting.

I can say that, you know, you need to take a look at the definition of a GHP for MSP purposes in the MSP manual but these products as indicated are not considered GHPs - employer sponsored GHPs and therefore not reportable under GHP Section 111 reporting.

I am not sure if anyone here at CMS can answer the question at this time regarding the non-GHP reporting for these products. So we will not answer that portion of the question at this time.

If we have a question or here is another question that was submitted to the Section 111 resource email box. We have a question about the employee status field 20 on the MSP file. This is the employee status that is indicating one for active and two for not-active.

The description of the field indicates that a value of one should be used for people that are actively employed and two for not-actively employed. But two is also qualified as you use only for individuals with ESRD.

It is our understanding that this field asks - the field asks for the working/not-working status of the policy holder and not of the beneficiary. Is this correct or do we need to keep - need to map the working status of the beneficiary?

The answer is that it does refer to the employee or policy holder who is not necessarily the beneficiary that you are reporting, or the active covered individual that you are reporting on that individual record.

So you should only be reporting people who have coverage due to active employment on your MSP input file with the exception of a case when the individual being reported has ESRD. If you look at that definition of active covered individual, you will see that you are to report those with ESRD regardless of the employment status of the policy holder or the employee related to that coverage.

So, if the policy holder is a retiree and dependents are still covered, the policy holder is not to be reported unless he or she has ESRD and nor should any of

the dependents be reported on the MSP input file unless one of them has ESRD.

So hopefully we have cleared that problem up. The qualification was made to the value 2 in that employee status field because on the MSP input file, the only time that you should be reporting a record that reflects a case where the policyholder is not active is in the case where the individual being reported is an ESRD patient.

Another question was asked whether we will change the process to send an email to someone other than the account manager when files have been processed and the other various email notifications that our system generated for Section 111 reporting.

Again, take a look at the user guide. There is a list of the emails that are sent out by the COBC for Section 111 reporting. And that table also indicates who are the recipients of the emails.

There is no current plan to change the recipient of the Section 111 automated emails. The RRE has the responsibility to decide who may be the account manager and the account designees associated with their RRE ID. That is not up to the agent, but rather up to the RRE. And in fact it is the authorized representative who is official approving the account manager and subsequent account designees by virtue of approving the account manager by signing the profile report.

Your agent cannot dictate to you as an RRE who the account manager must be. So, what I suggest in the case where your agent is an account designee and is hoping to receive an email that are automatically generated concerning

Section 111 file processing, that your Account Manager should forward these related emails to the appropriate account designee.

Also note that the account designee may check the Section 111 COB Secure Web site at any point in time as long as they have an active log in ID and password to check on file status.

Please note that response files are created in the nightly batch process so there is no need to check a mailbox if you are using the https or Secure FTP file transfer process.

There is no need to check a mailbox more than once per day. If a response file is not shown as available by 8:00 am then no file will be added until after the next batch cycle runs on the next business day.

So, again, there - if you are checking on a daily basis, there is only need to check once per day.

Okay. Pardon me for a minute. Another question was asked - we will be submitting a full file with - a full file with our TIN reference file in our first quarter input file.

I think what they mean is they are submitting a complete TIN reference file. If you notice the high error rate on the Tax Identification Number or on the TNI reference file, will it follow your normal rejection suspension rate?

Yes it will. Problems with the TIN file will most likely result in a much higher error rate though on the MSP input file. If one TIN field is bad on a particular TIN reference file record, then all associated MSP detail records will be

posted with that error and returned with an SP error code, applicable SP error code.

This questioner also went on to ask where should we expect a disposition code to be returned on the 271.

I refer you to the companion guide, the X12.270-271 companion guide the CMS document control number. All those mappings for the 270 and 271 are in that companion guide. And if you do not see what you need or have confusion after reviewing that companion guide, then please contact your EDI representative for additional help.

And, the last part of this question is when CMS and the COBC anticipate going to the 5010 version of the X12.270-271 format.

And at this point in time, that is still slated for the - sometime the year 2011. We will provide more information on that as soon as we can.

The next question had to do with - and is somewhat related to the prior question - had to do with getting SP25, invalid insurer name errors on MSP detail records.

Most oftentimes when you are receiving the SP25 error, it means that you do not have a corresponding - an appropriate corresponding TIN record on your TIN reference file.

And what we are seeing quite often is that the TIN indicator is not correct. So for example, if you submitted an MSP input detail record with a particular TIN in the insurer TIN, that particular TIN must also be listed as one of the records on the TIN reference file with a TIN indicator of I for insurer.

In many cases we are finding that these TIN records are submitted incorrectly with an E for employer TIN as opposed to insurer TIN. So please take a look at your TIN reference file. Mostly likely that would be the problem.

Now in the case - what is happening then in the system is that when it goes to process the detail record, it does not find a corresponding TIN record with a TIN indicator of I in the TIN reference file. Therefore it is not finding a corresponding TIN record and therefore any of the related fields for that insurer, such as insurer name are marked in error. So that, in this case, is probably why you are getting the SP25.

So, hopefully that is going to clear up some of the confusion. Now the SP25 is not to be confused with the compliance flags related to TIN validation. If you submit the appropriate TIN reference file records that you need for your detail records, that record will be accepted.

However, if we are unable to validate the actual TIN on our list that we use for valid IRS assigned Tax Identification Numbers, then we will flag it with a compliance flag.

So again, the SP25 is most likely a problem with your TIN reference file and that TIN indicator, the compliance flag, has to do with the fact that we were not able to identify the TIN itself as a valid Tax Identification Number.

In those cases of the compliance flag, if you have submitted the correct TIN then contact your EDI representative and they will ask you for appropriate documentation to demonstrate that that TIN is indeed valid and they will add it to our valid list and you will not receive that compliance flag in the future.

Another question was asked that we have received several response records with SP52 errors. All the response file records indicate the beneficiary's Medicare and settlement reason is due to age.

We validated the mapping of our X spouse relationship code to the CMS relationship code of 04 with our EDI rep. All beneficiaries in question are either ex-spouses or domestic partners of the policy holder.

The data in our system is correct so there is nothing to change. We will continue to send these beneficiaries but expect that we will get the same error each time. Can you please advise on anything else we should do relative to these beneficiaries?

In this case, you may continue to send those individuals and you will continue to receive the SP52. In actuality, there is no need to continue sending these individuals unless their relationship changes. But I suggest that you continue to do so and there is no penalty or, you know, adverse result as a - from sending those records.

The reason that the SP52 is received is that these individuals are entitled to Medicare due to age, but the GHP coverage is through someone other than their own, or someone other than their own employment or that of the spouse, and therefore the GHP coverage is not considered primary to Medicare.

So again, I advise in this circumstance that you continue to send those records and expect to get the SP52. And as long as that relationship code remains the same, you will continue to get it. Obviously if the relationship code changes, then send an add record with the new value.

Another question was asked - could you please let us know if members that have one of the following products need to be submitted on MSP - on the MSP input file - Medicare supplement, Medicare Advantage, coverage related to asbestoses or asbestos settlement.

None of these conditions are reportable on the MSP input file under GHP Section 111 GHP mandatory reporting.

So, after that long list, hopefully I provided some answers that people were looking for. And I will turn it back over to Bill Decker.

Bill Decker: Thanks Pat. And if anyone has questions about what Pat was describing to you, and I am sure that there may be, you can either have the opportunity to ask them during this call or send them to our resource mailbox and we will address them again.

I have a couple of questions that I want to get to and give you some responses to at this point. Between the last call and this one, we had a variety of questions come into us concerning in general the Social Security number issues set.

I am going to talk about some of those questions here, the ones that have general applicability. Some of them are specific to particular situations and we will not go into those here but I do want to cover some of the ones that are more general.

We had four or five questions actually about what happens if I use the model language I provided to the individual. The individual does not return the form to me. What happens in that case? Are we still in compliance etcetera, etcetera?

The object here is to give that model language to an individual who is resistant to supplying a Social Security number or even a Health Insurance Claim Number, Medicare ID number.

If the - ideally, if the individual chooses not to provide the number to the GHP insurer, the individual signs the form saying that and returns that signed copy of the form to the insurer. If the individual does not sign the form, in fact does not - is basically non-responsive, our suggestion to GHP insurers in this case is to make a notation of that, add it to the copy of the form that you have kept, that you submitted to the individual and keep that in your records.

And if it ever comes around, (there were) question what your activity was with that individual, you will have a record saying we gave the form to the individual. The individual never returned it to us.

Do you have a responsibility to try to get the information from that individual again? We would recommend that you do so. You can either try right again - again right away or try again later. But remember the object from our perspective is to get good data about folks who are Medicare beneficiaries. And if you can help us do that, we will really appreciate it.

Let me go through a couple of these other questions. What is an employer to do with an employee who does not have a Social Security number but is authorized to work in the United States? Is a green card number applicable?

The answer is no. An individual without a Social Security number is not a US citizen. The individual has to have a Social Security number to become a Medicare beneficiary in essence. And without an SSN, an individual would not be a Medicare beneficiary and the bottom line for us is you are telling us

about people who are Medicare beneficiaries, not about people who have SSNs necessarily but whether - are they Medicare beneficiaries.

If an individual does not have an SSN because the individual is not a citizen, is not a resident of this country, it is not for whatever reason, the individual will not be a Medicare beneficiary at least until the individual does somehow get an SSN.

And at that point, may become in the future a Medicare beneficiary but that is certainly not of much consequence to you at the moment that the individual does not have the SSN. No SSN, no Medicare beneficiary status, no need to collect - try to collect an SSN, no need to report and no reason to even think that providing any other number would be useful.

Let me go through my list here - see what the last ones were. If an employee uses an alternate number rather than their SSN to identify themselves for their health benefits, does the employee have to divulge their SSN to their employer for the purpose of compliance with reporting requirements and does an employee have to divulge their dependent's SSN?

Again, the object of this reporting is to tell us about Medicare beneficiaries. If it is useful for an RRE to collect an SSN to check to see if an individual may be a beneficiary, then by all means collect the SSN.

An alternate number will not help us. We do not collect alternate numbers used like for example in my state the driver's license number on my driver's license is not my Social Security number. It is an alternate number. If I were to provide that to CMS, they were to run it, they would not find any information at all about me because it is not an SSN and it is not a Medicare ID number. It has to be one or the other.

Please do not suggest to someone that they could provide an alternate number and please do not provide alternate numbers to us.

Does an employee have to divulge dependent's SSNs? If asked, an employee's or active covered individuals should if they have dependents provide SSNs if asked to RREs or at least to employers who might then provide them to RREs.

Eject - the object here once again is within a HICN, without a Medicare ID number, if there is a Social Security number we may be able to find whether or not the individual identified by the SSN is a Medicare beneficiary and that is what we are after.

If that could be explained folks, it might make it a little bit easier. When we explain it to folks who actually write into us on this issue or call us on this issue, that does make it a little bit easier for them and helps them make up their mind.

Simply saying, we have to have your SSN is generally not as useful in our experience as saying we could use your SSN because and then explain why. That is a little bit of advice. However you want to handle that of course is up to you.

We had a couple of other subjects here. One is that a number of people have asked where are the transcripts from past calls? Are they on the Web site? When are they going to be on the Web site?

The answer is transcripts will be on the Web site as soon as we can find space on the Web site for them. And the - our Web Manager here in our division has

told me this morning that she anticipates that we will have that space and the transcripts will begin showing up sometime next week.

In the meantime, if you are desperate to have a particular transcript, you can send a request for it to our dedicated Section 111 mailbox and our - the person who does the transcript management on our Web site will respond to you with a copy of the transcript.

We actually have the copies of the transcripts. The issue is not that we do not have the copies. It is that we do not have space on our Web site for all of them at this point. And we are attempting to arrange that space - finishing up the arrangements for that space as we speak.

The next issue I will bring up is about HRAs, Health Reimbursement Accounts. We have a lot of folks who want to know about whether - when we are going to talk about how to report on HRAs.

We are reaching final closure on this issue. I suspect that sometime next week we will have information here in CMS that we can begin to post on the Web site about reporting for those of you who are involved with Health Reimbursement Account and GHP issues.

You can ask us questions about it today but really I will not be able to tell you anymore today than what I have just told you. We are very close to closure on the HRA issues and we are going to be getting to that again next week.

A lot of things will happen next week because frankly a lot of folks who are working on this issues this week will not be in the office for the second half of the week. We will be on work travel so some of this stuff is going to have to

wait till early next week. But in any case we will get to it and we wanted you to know that ahead of time.

If there is anyone else here who has anything they would like to bring up now, I think that we are pretty much done with our presentation. And once again, when you do get a chance to ask your question of us, identify yourself and the organization you are with.

You can have a question and you can have one follow up. But then please if you need to ask more questions, ring back in and we will see if we can get to you before the call is over. And (Diana) you can open it up now for questions.

Coordinator: Thank you. We now begin the question and answer session. If you would like to ask a question, please press star 1. Please un-mute your phone and record your name clearly when prompted. Your name is required to introduce your question. To withdraw your request, press star 2. One moment please while we wait for the first question.

Our first question comes from (Scott Darer). Your line is now open.

Jane Lindsay: This is (Scott Darer). On the file it says - we are calling from Blue Cross of Idaho and this is Jane Lindsay with (Scott). It says that in the absence of a group size, the default is two which would be greater than 100. What we are wondering is if a group fails to give us a group size, are we supposed to report it to you as a two and are they Federally required to give us that group size on an annual basis?

Bill Decker: The requirement to give you the group size is important for us. And if you are reporting to us you are going to have to get it from them. That is the Federal requirement such as it is.

As to what particular group size to report to us, if there is no group size reported to you, I do not have an actual answer to that question. I do not think anyone else here does either. This is the first time it has come up. It is an interesting question.

We should probably have it by some folks but frankly speaking, anyone reporting to us on Group Health Plan coverage would be, we would think, ordinarily collecting group size from the folks they are doing business with. So that is what we would think.

But if in such cases someone will not give you group size, that becomes an issue for CMS under MSP reporting responsibilities that you and the employer have. And we would like to know about that.

If you have parties that will not provide you with the size of their firm or the size of their company for some reason, you might want to let us know about that through our resource mailbox and we can follow up on it.

Jane Lindsay: Thank you.

Coordinator: We have a question from (Jason Heiman). Your line is now open.

(Jason Heiman): Hi. This is (Jason Heiman) with United Health Care. I have asked this question in previous calls dating back to May or June and it is surrounding the tax ID number for groups that may not necessarily have tax ID numbers. For instance foreign embassies come to mind.

Still have not heard an answer on what we should do in a case if a group just simply does not have a tax ID number and how we should proceed with reporting that TIN.

Bill Decker: Hang on just for a second please. We will get right back to you.

(Jason Heiman): Thank you.

Bill Decker: Yes hi. We are back. In general, a foreign entity - a foreign employer, quote unquote, may not in fact have a tax ID number. If that employer however is, as in your example, an embassy in the United States...

(Jason Heiman): Um-hmm.

Bill Decker: ...they may have workers who are American citizens working for the embassy. And in which case I will have to have an EIN, an Employer ID Number because they are going to have to report to the IRS on the - they are going to have to report tax ID information about their workers to the IRS even if they are not reporting on themselves to the IRS.

In such cases, if they have an EIN you can use that instead of a TIN and in registering and having them register or registering (them).

(Jason Heiman): Okay.

Bill Decker: And in cases where they might not have even an EIN, you can suggest to them that they contact the IRS and get one and that way they can use one. Other than that, there is not a great deal that we can provide you with advice on.

We have an interesting situation in the United States where Native American nations, which have lots of businesses, do not actually have TINs themselves but they do have EINs because they have to report on their employees.

And they also need to report to us under Section 111 and they are reporting under their EINs. And that can - that is a viable alternative.

(Jason Heiman): Okay. So suggest I try to get their EIN and use that in place of a TIN. If they do not have one, suggest that they get it. What if for some reason they just refuse to do that? Do we have any recourse or is it the fairly standard if you have the problems and we continue to try just document our efforts in case they, you know, raises its head later on down the road?

Bill Decker: Document your efforts now and I can guess (in the) case it raises its head somewhere down the road - that is a good way to put that.

(Jason Heiman): (Right).

Bill Decker: The other thing that you should - well probably all of you are interested in knowing it that this is an issue that we are actually trying to find a solution for. It is taking a little bit longer than we wanted to. But in the meantime, those are the options you have - document, suggest that they get their own EIN or if they have an EIN use that.

(Jason Heiman): Okay. Now on our file submission, if we do not have anything to put in there, I am guessing, you know, sending in a blank TIN, should we substitute all nines, all zeroes, you know, pseudo TIN in reference or is there a not necessarily a proper way but a preferred way that we should do that or...?

Pat Ambrose: (No). You cannot report them at all if you have no EIN or TIN to use in the employer TIN field.

(Jason Heiman): Okay.

Pat Ambrose: And so it will not be accepted. It will not be accepted on the TIN reference files...

(Jason Heiman): Okay.

Pat Ambrose: ...at this time. You know, but as Bill said, we are trying to develop a solution and provide you...

(Jason Heiman): Okay.

Pat Ambrose: ...with a way to report this in the future.

(Jason Heiman): All right that works. Thank you very much.

Coordinator: Our next question comes from (Tammy Meyer). Your line is now open.

(Tammy Meyer): Hi. This is (Tammy Meyer) with United Health Insurance. And the question I have is in regards to the TIN file. We did receive some compliance code errors back this time around for the TIN not being valid. However when we validated with the group they said the TIN was correct.

And I had contacted our EDI rep and she said that we just needed to correct the records and resend them. But if we verified that it is correct, how do I get that correct...

((Crosstalk))

Pat Ambrose: The EDI representative does have the ability to accept documentation from you that this is a correct number. So there has to be, you know, there is not one specified document that we need but something, you know, if an official nature that indicates that the TIN submitted is indeed valid.

And then going forward, these records will not be marked with that compliance flag. So there is, you know, in the event that the TIN is correct, obviously there is nothing you can do to change it to resubmit. The EDI rep does have the ability to make that update to the system.

So if you, you know, I guess what I would suggest is that you send your EDI representative an email requesting this and you can indicate that you were told to do so by Pat Ambrose on the GHP call today. And if they have any questions they can forward that to me and I can clear that up for them.

(Tammy Myer): Well when you say documentation, what type of documentation do I need to send her to stop - something in writing that we verified it is correct or do they need something from the group or...?

Pat Ambrose: I am afraid I do not have something offhand or I cannot remember the documents offhand. But, you know, a fax or a copy of a tax document, you know, an IRS tax document that has that number on it would suffice. I just do not know off the top of my head.

It is not simply just an email saying, you know, yes it is correct. Obviously there needs to be some documentation that that is an IRS assigned identification number.

Bill Decker: In general what we have asked for in the past and used in the past is anything that comes from the IRS that has a tax number on it or an EIN on it.

Pat Ambrose: So you would have to obtain that from your employer group and forward that along.

Bill Decker: Right.

(Tammy Myer): Okay. Thank you.

Coordinator: We have a question from (Allison Lewis). Your line is now open.

(Allison Lewis): Hello. Good afternoon everyone. My question is, we live near the Canadian border and we do have a group that is in - where are they?

Woman: Canada.

(Allison Lewis): Ontario. Their province numbers and different things like that do not match anything for the United States address information.

Pat Ambrose: Right. So...

((Crosstalk))

Pat Ambrose: ...you are unable to submit their address information on the TIN reference file.

(Allison Lewis): Right. Even on the group level.

((Crosstalk))

(Allison Lewis): And so...

Pat Ambrose: We do have that as an outstanding issue that we need to address along with this TIN problem as well and are working to provide guidance on that.

(Allison Lewis): Are you - you are addressing it on an employee level also then right?

Pat Ambrose: Yes. So...

(Allison Lewis): And...

Pat Ambrose: ...well not really the employee, but employer.

Woman: Well employee and...

((Crosstalk))

(Allison Lewis): Well we have employees that have Canadian address also.

Pat Ambrose: Right. But you do not submit addresses for covered individuals...

(Allison Lewis): Okay.

Pat Ambrose: ...on your MSP input file. Only insurer and employer or RRE and employer.

(Allison Lewis): Okay. What was the other one (Lisa). I am sorry. This is (Lisa). She had a question.

(Lisa): If we have - we have verified that we have an employee or insurer's last name or Social Security number and we submit it and it is coming back as erred. For

some reason you have a different, you know, last name or maybe a different Social Security number.

But we have gone back to the member and our client and verified that the information we have in our system and are submitting is correct. How do we handle that? How do we fix or resolve that?

Pat Ambrose: The individual needs to change their information through the Social Security Administration...

(Lisa): Oh okay.

Pat Ambrose: ...and that will then make its way to Medicare and consequently the Section 111 reporting process.

Bill Decker: That is not a terribly unusual situation. People's names changes, people gave incorrect information when they signed up for Social Security. A variety of things can happen over time.

The only way the Social Security information and the Social Security Administration can change any of that, fix it in our terms, is to have the individual who has the information contact Social Security Administration him or herself. We cannot do it.

(Lisa): Okay. Thank you very much.

Bill Decker: Right.

Coordinator: Our next question comes from (Michelle Cole). Your line is now open.

(Michelle Cole): Hi. We are having a terrible time with (testing) and unfortunately our EDI rep has not been terribly helpful. So, I have a couple of questions relative to test files.

The first one is can we, you know, we have been told we have to have 25 records accepted but we are not really sure what that means. Do they all have to have 01s in order for us to be sure that those records were submitted? Are there any - is there any ever - ever any time when a record would be considered accepted - would come in with an SP error anyway?

Pat Ambrose: No. In order to pass the testing requirements, it is an 01 disposition code that you must get back for that add record to have been considered as accepted.

(Michelle Cole): Okay. And how will we know if our update and delete records were accepted and processed correctly? What kind of a code would we get back on that?

Pat Ambrose: You get an 01 back on those as well.

(Michelle Cole): Okay.

Pat Ambrose: And then the counts should show on the COB Secure Web site file listing or actually test file results page.

(Michelle Cole): I mean we have seen test file results page that have the same number of records on it as to what we submitted.

Pat Ambrose: Okay.

(Michelle Cole): But we have been told that nothing was accepted.

Pat Ambrose: It - that page also shows counts for accepted records as deletes, updates.

(Michelle Cole): Yes. And I have not found that. We have not - we have had - we have also had an awful time with the COBC Web site.

Pat Ambrose: Well there is a user guide for that Web site that you can download once you are logged on under references I believe it is.

(Michelle Cole): All right. Now - well, just one more thing. If we are not getting what we need from our EDI rep, who do we escalate to?

Pat Ambrose: Well in the user guide there is a set of individuals to escalate.

(Michelle Cole): Okay.

Pat Ambrose: And I believe it is in the - I do not have the chapter offhand but I think it will be pretty obvious when you look at the Table of Contents. But basically we first ask that you go to a supervisor level and that individual is named and phone and email address provided, then the manager level and then the COBC project director is actually there as your last step. And allow each of those individuals some time.

Could I have your RRE ID please?

(Michelle Cole): Oh, 1 - I believe it is 10745.

Woman: One o seven four five.

Pat Ambrose: Okay. And your organization name again?

(Michelle Cole): Capital District Physician's Health Plan.

Pat Ambrose: Okay.

John Albert: Hey this is John Albert who just joined the call. The section that has the elevation protocol, contact protocol is Section 12.2.

(Michelle Cole): Okay. Because yes we having - we are - we have not - what has been happening is we have not been told whether we have been accepted or not. We have asked questions. We have not received answers.

They do not process our files when we submit them. It is two weeks before they get processed after we upload them.

Pat Ambrose: Yes. I mean I do understand your frustration and we appreciate your feedback. And we will make sure somebody follows up.

(Michelle Cole): Okay. Thank you very much.

Pat Ambrose: Thanks.

Coordinator: Our next question comes from Danielle Omans. Your line is now open.

Danielle Omans: Thank you. This is Danielle Omans with the Benecon Group in Pennsylvania. And I am wondering if there are any plans to create a Web based data entry system or a template for the data input file? Many of our smaller clients do not have IT staff and they do not have the technical knowledge to create a data file in the proper format.

John Albert: This is John. I mean there are some activities looking at implementing such a process but we do not have at this time any confirmed design or date for implementation. Obviously we recognize there are a lot of small reporters out there and that this process is maybe not best geared to a small reporter. But it is something that is under discussion here at CMS. But unfortunately right now the primary focus is implementing the process as it is right now.

Danielle Omans: Oh.

John Albert: But we definitely - and again we have - we are definitely interested in any suggestions people have as well because I mean, you know, you know your customers probably better than we do and, you know, in terms of suggestions on how to do that.

But the thing to keep in mind is that any solution that CMS implements has to meet all of its various and very rigorous data security design protocol etcetera. So, direct entry can get a little touchy sometimes.

Danielle Omans: Yes. We are actually researching some vendors for some of our clients. And there are vendors out there that handle that for the client but it is rather expensive. So we were just wondering maybe if there were some plans for the future.

John Albert: Yes and actually as something we are always interested in too is, you know, what are these - just anecdotally, what are these vendors promising and what are they charging because that might be something that would drive that as a priority for CMS if, you know. We would recognize that there is obviously any time there is something like this, you are going to have consultant groups that want to get in because they can often do it better, faster, cheaper.

But we have also heard complaints about some of what - some of these groups want to charge. So again, we are not out to make this difficult for anyone. It is just based on the process that we have, it is geared towards getting the larger submitters up and running as soon as possible to kind of follow the 80/20 rule in terms of getting as much data as possible from the get go.

But of course, for the smaller folks that can prove to be a little more challenging. But there definitely are an awful lot of vendors out there who are doing this. And I would hope that if they do need a vendor that they could find someone that is fairly reasonably priced.

Danielle Omans: Okay. Thank you very much.

John Albert: But again, please send - send in, you know, again we always want to know like alternatives or suggestions for other ways of doing this. So.

Bill Decker: Send them to the resource mailbox.

Coordinator: Our next question comes from (Peachy Pleasants). Your line is now open.

(Peachy Pleasants): Good afternoon. My name is (Peachy Pleasants) and I am from Care First Blue Cross-Blue Shield. I have two hopefully small questions. The first one is, does CMS have any policy or anything associated with DUN numbers. We wanted to know if you would accept a DUN number in lieu of a tax ID number.

Pat Ambrose: No. We do not use DUN numbers to identify companies or individuals. So, you know, it will not be accepted as a valid...

Man: I do not remember...

Pat Ambrose: ...identifier.

(Peachy Pleasants): Okay. And then my second question is do the penalties, the $1000 a day per member per day does that also apply to the non-MSP file?

Bill Decker: No. There is no requirement to send a non-MSP file. The only requirement is to report MSP individuals to CMS. So.

Pat Ambrose: However, if you are an expanded submitter, you are expected to submit drug coverage either MSP on your MSP input file or supplemental drug coverage on your non-MSP file. But there is no compliance issues related to the non-MSP file submission.

John Albert: Yes. The drug portion of the reporting is still the - we still call the voluntary side of things. And that, you know, if someone signs up for - to report the drug data and they do not, basically we will just send their access to Medicare Part D and (unintelligible) that...

(Peachy Pleasants): So no fine - let me see. So no - there - it is still voluntary. I mean we are still doing it but we just - we do not know if we are doing as much as we should be. But as long as we are reporting, especially since we are an expanded RRE, then we should be okay?

John Albert: If you are an expanded reporter, then you should not be reporting these non-MS - with non-MSP in the file. That is the basic requirement.

((Crosstalk))

Bill Decker: And MSP drug tests.

John Albert: As John said, right, as John said there you will not be complying with Section 111 reporting...

Bill Decker: Correct.

John Albert: ...through (unintelligible) problem is working on the non-MSP input file. But you still would have to use it.

(Peachy Pleasants): Okay. And we do. Okay. That is my only question. Thank you.

Coordinator: Our next question comes from (Robert Driscoll). Your line is now open.

(Robert Driscoll): Hi. Thank you. My name is (Rob Driscoll). I am from (Elta) Incorporated. And my question has to do with identification of groups who are plan sponsors. And we have unions who have inquired with Health Net who have indicated they have consulted the user guide and did not find any language that states why CMS needs to know which groups are plan sponsors.

So I guess my question is, why is it necessary to provide that information and what is going to be done with that information?

Pat Ambrose: Well as far as what we are asking for on the - when you are identifying the group in the employer TIN field and then on the corresponding record on the TIN reference file, we do ask that if it is an hours bank arrangement which often times these unions Taft-Hartley type plans are, that they be identified when you report your TIN that you use a TIN indicator of S for plan sponsor.

Since those are the, you know, as far as the subsequent demand and recovery efforts go that that is information that is needed for Medicare for subsequent steps as they use this data.

So that use of the S in the TIN indicator is described in the user guide as related to GHPs that operate under an hours bank type of arrangement.

(Robert Driscoll): Okay. I will look for that clarifying language. I actually it open to that page so I will keep looking at it. But thank you.

Pat Ambrose: Yes. I mean, do a search on hours bank and/or the TIN indicator and you should see that. It is also in the file layout of the TIN reference file in the Appendix as well.

Now I do not know if someone here at CMS has additional...

John Albert: No. I mean it...

Pat Ambrose: ...anything additional to add to that.

John Albert: ...it is mainly the notification that it is a plan sponsor versus an employer is mainly critical to any recovery efforts.

(Robert Driscoll): Okay.

John Albert: It is also an attempt to channel the recovery letters to those entities that are most capable of responding to them. This is based on input we receive from industry as we roll this out.

So the use of the plan sponsor allows CMS to work with essentially fewer entities in any recovery that it may have to do. That is - I say may because again it is assuming we identified any past mistaken payments.

It is much easier to go through a plan sponsor and basically industry agrees that rather than having to deal with the 10 or 15 different employers associated with this one particular beneficiary in hours bank, it is a lot easier to work through a plan sponsor.

That was, you know, something that we worked with and received comments from industry on as being kind of the best way to go about resolving any Medicare debts that would be discovered as a result of this process.

(Robert Driscoll): Okay. Thanks. So centralizing the coordination of the response (unintelligible).

John Albert: Yes.

(Robert Driscoll): Okay. All right. Thank you.

Coordinator: Our next question comes from Beth Owen. Your line is now open.

Beth Owen: Yes. My name is Beth Owen and I am from Management Services. I am an Administrator of a Self-Insured Plan for about 1000 employees.

And I understand the objective is to get the SS numbers for the Medicare eligible individuals. Our healthcare provider has not required the Social Security numbers for spouses or dependents previously. Is Section 111 now requiring the reporting of the Socials for all spouses and dependents or are they only requiring those Medicare eligible individuals.

John Albert: It is only those Medicare eligible where Medicare would be the secondary payer of benefits. So that is the requirements in terms of what to report. And actually the element that we really want is the Medicare Health Insurance Claim Number.

But in acknowledging that a lot of systems out there do not necessarily have that on hand, we also allow you to submit in lieu of the HICN, a Social Security number as well as that, you know, name, date of birth and gender of the person.

But really the reporting is - the only required people report on are folks who have Medicare and for whom Medicare is the secondary payer of benefits. So this would be your working age, working disabled and ESRD folks in the coordination period.

So it could be a retiree with retiree benefits. There is no MSP. There is no requirement to report that person.

(Beth Owen): Okay. And will it be mandatory anytime soon that you require the Social Security numbers on everyone?

John Albert: No.

Bill Decker: Not from us it will not be. No.

John Albert: No. And I mean it never will be. There is no requirement to...

(Beth Owen): Okay.

John Albert: ...to use that for anything. That is mainly for your benefit to check to see if they have Medicare.

(Beth Owen): That is exactly what we...

((Crosstalk))

John Albert: To look them up if you do not have a Health Insurance Claim Number. Either through the reporting process or the through the query process by sending that person to us, you can, you know, use that to determine whether or not they are in fact a Medicare beneficiary.

(Beth Owen): Okay. And what is - how - I can find out people anybody over 65, but what is it - how do people typically know if someone is Medicare eligible or if they are disabled for instance?

John Albert: Well if they had disability for 24 months and filed for Social Security Disability, they would be entitled to Medicare. If they had dialysis treatment or unsuccessful kidney transplant, I mean, that - a lot of it comes down to looking at the types of claims that are being filed.

(Beth Owen): Okay. So again that would be...

((Crosstalk))

John Albert: ...related should be a trigger to investigate for possible MSPs.

(Beth Owen): Okay. That would be coming from our administrator. Okay. Thank you.

Coordinator: Our next question comes from Lucy Winn.

Lucy Winn: Hi. I am from Health Net. Our understanding is that after January 2010, we will need to report real TINs and cannot use the pseudo TINs any longer. What if - our question is what if we still have employer groups that will not provide that data. What would we report in lieu of a pseudo TIN or how do we handle that?

Bill Decker: Again, the employer groups really do need to give you their I - their TIN information. It is important - it is essential to you to report that to us. And as a consequence, it is essential to collect that from your employer groups.

We would be really interested in knowing why a particular employer would not want to give you its TIN and TIN address. And if you would send that to us in our resource mailbox, we will be happy to take a look at it.

But basically you would - the law that we are applying here requires employers and insurers to supply us with tax identification numbers or employer identification numbers and we need them.

John Albert: This goes back to way before Section 111.

((Crosstalk))

Bill Decker: Absolutely.

John Albert: Is there any - if debts are uncollectible by CMS and they are referred to Treasury for offset, we are required to give Treasury the employer identification number. We have al, you know, when we do our voluntary data exchanges, we also require the EINs as well.

Bill Decker: Everybody that does a data exchange with us, whether it is MSP - whether it is Section 111 or not needs to give us that information because if there is MSP involved, we need to have it.

Lucy Winn: Okay. So do we have any other recourse? I mean like the model language that you have provided for the individuals who do not provide their SSNs or...?

Bill Decker: Not at this point we don't. We do not have model language for employers who go - to send to an employer who will not give you an employer TIN. What we do - I will tell you and everybody else on this call, if that is an issue, we would want to hear about it and we want you to send it to us in our - via our resource mailbox.

((Crosstalk))

Lucy Winn: Okay.

John Albert: We have not really heard much in the way of that particular issue, but again, you can point to the documents that are available on the mandatory insurer reporting Web site regarding the reason for the collection. There is the one letter that we did back in August of 2008 that describes the process - what it is, why it is.

Lucy Winn: Okay.

John Albert: And you can point them to those specific things. But if they do not cooperate, they are essentially putting you at risk for noncompliance. So...

Lucy Winn: Right. Okay. Thank you.

John Albert: Probably just, you know, don't know what it is so I am not going to do it.

Coordinator: And again if you do have any further questions or comments, please press star 1 and record your name clearly. Again please press star 1.

John Albert: No other questions?

Coordinator: One moment please.

(Dave Nestler Cash) your line is now open.

(Dave Nestler Cash): Thank you. I hate to admit it, but I still have a question about Social Security number collection. I think it is a follow up to a comment you made just a few minutes ago to another caller.

I am still confused about the extent to which we have to report an individual who is an active covered individual, meets that definition, but may not be a Medicare beneficiary. And I guess it would be the case where we may not - we may not know if that individual is a Medicare beneficiary.

One of the issues, and sort of a circular issue I think we have gotten into is I am not sure - so we have a number of individuals, active covered individuals who we do not - for whom we do not have Social Security numbers. And so we cannot - for example we cannot use the query only option to check their Medicare status.

So we get into a situation where it seems like our only option to make sure we are compliant is to report them. And so then we get in the situation of having to go and ask them for a Social Security number.

And so that kind of - we find ourselves in a position to have to go out to a covered individual and say well, we need the Social Security number from you. And again they may or may not be a Medicare beneficiary. We do not know.

So, my question is trying to figure out - I am looking for additional clarity on that of whether we need to be doing that or not.

Bill Decker: You need to - once again, starting from the top. You need to be telling us about anybody who is an active covered individual and who is a Medicare beneficiary. The first number to ask for is a Medicare ID number.

If you get - ask for a Medicare ID number and do not get it for any particular reason, the second number to ask for is a Social Security number. You can ask for the Social Security number, supply it to us on a query file and we will check our own databases to find out if an individual is a Medicare beneficiary and report back to you with information about whether the individual is or is not a beneficiary.

If you suspect an individual who is not providing you with a Medicare ID number, who may be in fact a Medicare beneficiary, for example it is a working individual who is 68 years old, that individual may be in fact a Medicare ID - a Medicare beneficiary.

If that individual does not have or does not know his Medicare ID number or her Medicare ID number, you can ask for the SSN supplied to us and we will check.

The basic idea here is that the main ID number for Section 111 reporting is the Medicare ID number. A secondary ID number that can be used so that we will

check to see if an individual is a Medicare beneficiary is the Social Security number.

You - we have provided model language for you to use to approach folks who do not have or will not give either a HICN or an SSN, that is either a HICN or an SSN, to you when you have asked for it so that you can report one or the other to us, and if that individual using the model language still refuses to provide a HICN or an SSN then you can just keep that on file and that satisfies your responsibility to get the information that is necessary to be reported to us.

That is essentially and not just essentially, that is exactly the way this program is laid out. Do we require you to collect SSNs from everybody so that you can check? No we do not require that. There is nothing in Section 111 that requires that.

We do say in our user guide, and I will make this very clear, that if you are going to report anybody to us through the Section 111 input file process, the MSP input file, you have to provide either a HICN or an SSN. If you do not provide either, we cannot possibly process the file.

We want the HICN. We will take the SSN in lieu of the HICN, but we have to have one or the other. That is a requirement. Is it a requirement that you have to go out and collect SSNs from everybody out there? No. It may be useful to you to do it, but quite frankly it is not anything in the law that is required.

And can you hang just for a second please. We have a sidebar we want to do. We will be right back to you.

Okay fine. We are back and Pat is going to give you some more information.

Pat Ambrose: Oh. Well I just wanted to point you to the - make sure that you have seen the alert and the model language on the Section 111 Web site. So those for GHP happen to be on the What's New page. So it is at www.cms.hhs.gov/mandatoryinsrep. That will take you to the overview page and then click on the MMSEA 111 What's New tab that is on the left hand side menu.

And there is an alert dated May 26th called Compliance Guidance Regarding Obtaining Individual HIC numbers and/or SSNs for Group Health Plan reporting. And there is also then a model language that we have been referring to that was revised August 18, 2009 and that is entitled MMSEA 111 HICN SSN Collection GHP Model Language.

So I just wanted to make sure that you have reviewed both of those documents. And...

(Dave Nestler Cash): And we have - maybe - and this is very helpful so I appreciate it - to clarify. So we have reviewed the guidance and we have actually implemented the process where we are sending that model language to a number of our covered individuals.

So the example that comes to mind for me, and where I am going is I think I am actually hearing today that we may be doing more than we need to be doing.

So for example, I have an individual who is a 55 year old employee covered under a very large employer group plan, is an active employee, so meets that definition of active covered individual. Now, and let's say this is an example. It is an individual. We do not have a - and maybe it is not relevant, but do not have a HICN or Social for on record.

I have really, you know, we have really on its face sort of no reason to believe that this individual is a Medicare beneficiary. They are not - there is - there obviously would not be a Medicare beneficiary due to age which would be the main reason.

So I am looking at this individual now and saying well I am not sure - it sounds like I do not really have an obligation to report that individual, but what I am trying to figure out is well where is - what is my due diligence obligation to sort of fully investigate to make sure I know whether that individual is Medicare or not - a Medicare beneficiary or not.

If I can simply just based on that age threshold, make a reasonable determination that person is not a Medicare beneficiary, then that makes this a much easier process.

Bill Decker: Can you just hang on a second. We are going to go sidebar one more time. Hang on.

(Dave Nestler Cash): Thank you.

John Albert: Hey. This is John. We are back. I mean, the issue is is that you are responsible for reporting those individuals if they are, you know, have Medicare and Medicare would be the secondary payer.

You know, there is no blank slate in terms of age, in terms of whether they would or would not be especially when you are considering the amount of money involved with disabled and ESRD beneficiaries who are under age 65.

The thing to keep in mind is that, you know, there is no requirement to collect SSNs on everyone, but having that available to you allows you to query periodically to determine if in fact they have attained Medicare status.

So you may have somebody who is age whatever, 56 or 48 or whatever, and you collect that information, you know, at they are not a Medicare beneficiary at that time, but, you know, they could go on disability 12 months from now and if they are considered a working disabled, you know, there would be an MSP reportable event to have.

So it is probably, you know, it is a good thing to have that information available so that you can query Medicare to see if they have in fact a paying Medicare status and then make that determination as to whether you would report it or not.

The other thing to keep in mind is that if somebody refuses to provide information or just merely says I am not a Medicare beneficiary but does not provide you with any other information like a Social Security number, for query purposes you are going to have to keep going back to them and asking them okay are you a Medicare beneficiary now. Are you Medicare beneficiary now.

If a beneficiary, or future beneficiary, provides that information to you now that you can keep on file to query occasionally, that takes a lot of the pressure off in terms of determining whether or not you have a reportable event or not. Because you are right, I mean most people under 65 do not have Medicare. Unfortunately the ones that do are - have considerable Medicare expenses that we need to coordinate and pay correctly.

And it is definitely in anyone's interest to identify to us sooner rather than later when there is an MSP situation because it means that Medicare can make its claim payment determination properly the first time and not have to get the employer and insurer and in some cases the beneficiary involved in recovery actions which are expensive for everyone involved.

And we would rather avoid that (unintelligible) GHP side where if we get the information up front as soon as it is available, we can basically amend our - (offend) our claims processing systems and pay correctly the first time. So...

(Dave Nestler Cash): No and I - we - and I appreciate that. We definitely understand the, you know, the desired outcome here. I think where we get into challenges and we have these kind of debates frankly with our covered individuals and some of our employer groups is this question of how much is required.

And so it is, and you probably heard this feedback from others. It has been - and I cannot say this is the majority of interactions but there is enough of them that it makes this for quite a challenging process when we have debates with, again with covered individuals or employer groups about how much we are required to collect.

I think one thing that might have thrown us off is I thought we had heard in the past that if we had an individual let's say it is that 55 year old on that large group that if that person was not a Medicare beneficiary that we should sort of continue to - that if we reported them we would get an error message that says well there is - well not error but it would say there is no MSP match but that we should still continue to report them essentially until there is a match. So that would mean until they aged in, assuming they are not disabled or ESRD.

But it sounds like that is not - it sounds like that is not the case. We could simply just not report them.

John Albert: That is - I mean that is - you have two options. I mean you can build that MSP reporting record or you can query which is a simpler record to process. You can continue to query every quarter. And until they actually attain Medicare status, then report them as an MSP record. Or if you have everything you need to essentially, but you do not know whether there is Medicare or not, you can also build an MSP reporting record and submit that.

And it basically - it will be not found, not found, not found until in most cases they become 65. But, you know, there are two ways of doing it. And that is - the way this process was started is it allowed both of those options because some folks just, you know, built an MSP reporting record for that person not knowing whether they had Medicare or not and reported them. And they were not found as having Medicare so they just sent them every quarter until they attained Medicare status.

Others run, you know, the vast majority of their folks through a query file and then look at the ones where there is Medicare and then make the determination well do I need to report this person - are they retired, are they working, that kind of thing. So.,,

(Dave Nestler Cash): Right. Okay. Thank you.

John Albert: So there are different ways. And that is what the SSN getting that allows you to do is to utilize those tools that CMS provides to help you build an accurate and timely MSP file. There is no requirement that anyone do this for you because if there is no MSP, there is no requirement in terms of the Section 111 legislation, but there is nothing to prevent you from attempting to collect and

using that to basically better coordinate benefits for Medicare on beneficiaries or future beneficiaries, having that on file.

But that is outside the literal requirement of the Section 111 legislation.

(Dave Nestler Cash): That makes...

John Albert: And I realize there is a lot of misinformation out there regarding, you know, Medicare requires the SSN of every unborn child kind of a thing but that is not true. It is - what we require is the MSP data to report it to us within that timely - that timeframe specified which is, you know, the quarter or so after they attain MSP status.

(Dave Nestler Cash): Okay. Thank you.

Coordinator: Our next question comes from (John Meyers). Your line is now open.

(John Meyers): Hi. I am with WellPoint and I have a follow up question to the TIN that was asked a few moments ago. I think all of the employers are in the process of collecting the group TINs.

And the question is is in 2010 if we do not have the TIN, do we send the membership that is tied to that employer group with the pseudo TIN and continue to pursue that information and address that, you know, with the compliance flag that you would send on a response file, or do we exclude those members until we get the Tax Identification Number in?

Pat Ambrose: Continue to send it with the pseudo TIN. We will have additional information regarding this but we do not want you to stop sending something, particularly that you had already been submitting.

We hear you loud and clear that this is going to continue to be a problem. Basically the compliance flag will get set on the record, but, you know, that - it is better to have that than the record not reported at all. So if you have not been able to obtain the accurate TIN by 2010, continue to submit it using the pseudo TIN that you might have used previously.

(John Meyers): Okay. Is that compliance flag set only on those records that are accepted or on all the records?

Pat Ambrose: It is only on records that are accepted.

(John Meyers): Okay. Thank you. Thank you very much.

Barbara Wright: Operator before we go to the next question, this is Barbara Wright. Just one thing to add from the question before. I am not sure whether John mentioned it earlier but if you have any way your internal claims processing system to identify claims that you paid secondary for, if there is some way to vet those to determine who you paid secondary to, that would allow you to pick up a lot of Medicare beneficiaries.

John Albert: Yes. It is - a couple of callers back where someone was asking for help on how to identify and that is one of the, you know, like obviously the type of claim is one thing. But again if you have claims in your system, or even though you processed secondary to someone and you can determine who that was, where there is a possible MSP reportable event. So...

Barbara Wright: And I think John mentioned ESRD, but some virtually everyone who gets the ESRD ends up with Medicare coverage for some period of time. Again, that is something we need to check on on a code basis.

John Albert: Go ahead operator.

Coordinator: Our next question comes from (Scott Darer). Your line is now open.

Jane Lindsay: Hi. This is Jane Lindsay of Blue Cross of Idaho. We understand that Section 111 requires the RREs to report TIN size and group size. But what would be helpful to us if we had the citation for the law that requires the employer to give the RRE the TIN size and the group size.

We are to the stage where we have asked for the information and now we are doing subsequent follow up. And sometimes the pushback is where is the law that requires me to do that. Can you help us with that?

John Albert: I mean there is no direct legislative requirement for an employer to provide its RRE and that information but...

Bill Decker: That is an employer to provide an insurer...

John Albert: Right.

Bill Decker: ...for that information. That would be where you would be looking for law. And that would be certainly well out of the range of anything that the Medicare program would be doing under MSP reporting.

((Crosstalk))

John Albert: But the employer is bound by the MSP statute just like the insurer is to properly coordinate benefits with Medicare.

Barbara Wright: So the MSP statute would be the place to refer the employer.

Man: Right. Yes.

Bill Decker: Yes. Right. The employer does have obligations under MSP to report that information to CMS.

John Albert: They do under the IRS data match right now.

Bill Decker: So that is right. So the employer has the obligation to do. And what they are doing - what we are doing essentially is giving you the information that they would have to report directly to us instead.

Barbara Wright: And what is fair to say here is that the quicker we get more complete information including that employer information, the more likely we are to be able to sunset the data match provisions which will let employers off the hook for having to separately complete the data match.

It is in their interest to give you the information so that we can ultimately eliminate the data match process.

Jane Lindsay: On that IRS data match process, does that questionnaire only go to employer groups identified as having Medicare individuals?

John Albert: Yes. I mean it is either the workers themselves are beneficiaries or we identify the spouse of a worker who has Medicare.

Jane Lindsay: Okay. Thank you.

John Albert: And those are filtered by employer size, number of W-2s things like that. But yes, I mean basically any employer that would have MSP data, you know, that we would like to be able to eliminate the IRS data match for employers.

Again, the employer has an interest in this financially as well because the sooner we have the data, the sooner we can stop making mistakes in payments and the employer is the primary debtor identified on our systems in terms of any MSP payments. So...

Jane Lindsay: Right.

John Albert: ...they have a self interest in doing this. This is a way for them to apply...

Jane Lindsay: But that only applies to those employers who have these members. More of our group do not have working ages. So it really, you know, they are finding it hard times to understand why they would need to report this.

Barbara Wright: If they have ESRD there is no group size.

John Albert: Well they may not have working age, but they may have - the person again may have a spouse who is a beneficiary and Medicare is secondary. It is not just the worker, it is the spouse of the worker.

Bill Decker: And other dependent.

John Albert: Yes. And other dependents. And that is where more than half of them have seen information actually reside. It is not with the worker's themselves it is with the covered spouses and dependents.

One thing I can take from just the call today is that, you know, as we move along to finalizing and getting the reporting aspect of this nailed down is that, you know, (those also) give us an opportunity for, you know, some more employer outreach directly through, you know, the Section 111 Web site, possibly providing information to answer employer questions just like we want to do with beneficiaries.

So we hear these comments loud and clear and we want to help through that process. So we appreciate that.

Coordinator: I show no further questions.

John Albert: Okay. I guess that will do it about ten of three. And did you do the claimer Bill?

Bill Decker: Yes. I did it at...

((Crosstalk))

John Albert: Okay. Okay. All right. Well since there are no more questions I am going to...

Coordinator: Excuse me.

John Albert: Yes.

Coordinator: One question just came through.

John Albert: Okay.

Coordinator: One moment please. (Albert Tolson) your line is now open.

(Albert Tolson): Thank you. See, last but not least. I have a question about the quarterly reporting. The next reporting - I reported my first (live) file in this month of October. So I am assuming that my quarterly file will be January. Is that correct?

Pat Ambrose: Well actually your first file should have been reported in the last quarter, the third quarter, so July, August or September of 2009. So, perhaps though you submitted your first file a little bit late due to, you know, issues with testing and the like.

(Albert Tolson): Yes.

Pat Ambrose: You are current then. You are to submit a file for the fourth quarter 2009 - October, November, December.

(Albert Tolson): Okay.

Pat Ambrose: And that would be during your assigned file submission timeframe that shows on your profile report. That also shows when you log onto the COB Secure Web site.

(Albert Tolson): Okay.

Pat Ambrose: So, and, you know, what we ask you to do is just work towards getting on schedule.

(Albert Tolson): Okay.

Pat Ambrose: And so, you know, look at your file submission period, attempt to send another file during that time or send it late if, you know, it is already passed, and then hopefully in the first quarter of 2010 you will be on time with and submitting during that assigned quarterly.

(Albert Tolson): Okay. That is not a problem. So then my follow up question to that is we are tracking by year now for the ages 55 and over. So, anyone that did not make the first batch would make the second batch as long as they become 55 between the period of October and December. Is that correct?

Pat Ambrose: Yes. Yes. You could - yes.

(Albert Tolson): Okay now. If a person within that age range or 55 and over terminates between your first file and your next quarterly file, do you submit that person in that next file as a termination?

Bill Decker: If they have never been Medicare, then they have never been accepted as Medicare.

(Albert Tolson): Excuse me.

Pat Ambrose: So if you have not reported this person before?

(Albert Tolson): No. You have reported them before.

Pat Ambrose: Oh. And now...

(Albert Tolson): And now they have terminated between the first time you reported them and the second time you are sending your file.

((Crosstalk))

Bill Decker: Oh they met their beneficiary?

Barbara Wright: Was there record accepted the first time?

(Albert Tolson): Excuse me?

Barbara Wright: Was the record accepted as a Medicare beneficiary...

(Albert Tolson): yes.

Barbara Wright: ...the first you submitted it.

(Albert Tolson): Right.

Barbara Wright: So they are a Medicare beneficiary and they have open coverage which terminates between two of your reports. Correct?

(Albert Tolson): Yes.

Pat Ambrose: Then you need to send an update record with the GHP terminate date...

(Albert Tolson): Oh okay. That is it.

Pam Ambrose: ...and then that will be the last time that you need to report them unless you cover them again at a later date.

(Albert Tolson): Okay. Okay. And then the last thing is I was listening to where there was a group that had a complaint of their EDI. What do you do when you have a compliment for your EDI rep...

Pat Ambrose: Well...

(Albert Tolson): ...turn it around and make it positive?

Pat Ambrose: Yes. I would like to reach out and give you hug right now. You know, you could also use the escalation process and send that compliment up the chain to the supervisor listed in that escalation process to say that you had a good experience with your EDI rep.

(Albert Tolson): Okay. Start with the es...

John Albert: Or you can send it to the resource mailbox as well. And we appreciate that.

(Albert Tolson): Okay. We will - okay resource mailbox or the escalation process.

Pat Ambrose: That is great. Thank you.

(Albert Tolson): Okay. That is all I have. Thank you very much.

Coordinator: I show no further questions.

Bill Decker: All right. Thanks very much (Diana). We are I think done here and thank you everybody who was on the call. With five minutes to go, we are going to take all of your comments and questions back and be talking with you again in a month or so.

All of us here at CMS thank you very much for participating and we hope that our information as is as - has been as good as your questions were. So thank you very much and we will talk to you again in a month.

And Operator could you stay on the line just a second?

Coordinator: That can concludes today's conference. Thank you for participating. You may disconnect at this time.

Bill Decker: When you get a chance Operator, can you give us...

END