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: September 23, 2010

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

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Centers for Medicare & Medicaid Services

Moderator: John Albert
September 23, 2010
12:00 p.m. CT

Operator: Good afternoon, ladies and gentlemen. My name is (Lorrie) and I will be your conference operator today. At this time, I would like to welcome everyone to the MMSEA 111 GHP Town Hall. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

John Albert, you may begin your conference.

John Albert: Great. Thank you, operator. Good afternoon.

Today – for the record, today is Thursday, September 23. This is the Group Health Plan Open Door Teleconference for Section 111 including technical as well as policy issues, questions, answers, et cetera.

Before we begin, I wanted to again, announce the disclaimer I was doing. That is that occasionally, we do say things that contradict the official User Guide and other written materials on the Section 111 Web site where there is a conflict.

We make a mistake in terms of pronouncing policy and it's not as described in the written materials the written materials, always take precedent over anything we say at this conference call for our materials, so again, sometimes, we (inaudible) on these teleconferences. We apologize for that if that ever occurs.

We have – as we have with these calls in the past, Pat Ambrose is going to do a presentation and Bill Decker also is going to provide some feedback for HRA-specific issues and then we will launch into a Q&A session.

For the operator, we ask that they provide their name and company name they represent. And to the participants, please limit your question to one and one follow-up, and if you have more questions, please jump back in the queue. I don't think we have as many people as we have on some past calls so you should have plenty of opportunity to get all of your questions answered.

With that, I will turn it over to Pat and we'll get started.

Pat Ambrose: OK. Thanks, John.

First, on recent – relatively recent posting to the CMS Section 111 – Mandatory Insurer Reporting Web site, that Web site as you all should know is www.cms.gov/mandatoryinsrep. Version 3.1 of the Section 111 User Guide dated June 25, 2010 is on the GHP page. Also, the transcript from our last GHP call dated June 24, 2010 is on the GHP Transcripts' page.

Make a note of the reorganization that has taken place in the last few months on the Mandatory Insurer Web site and some of the different tabs that are on – or pages that are listed on the left-hand side of that page, and make sure that you're checking the appropriate pages accordingly.

On one of those tabs on the left-hand side, it refers to Computer-Based Training or CBTs, and we encourage you to register and take the CBT courses for Section 111 GHP reporting.

We have added a new Medicare Secondary Payer or MSP course curriculum on the CBT page which provides general information regarding MSP. This is not actually specific to Section 111 but you might find helpful as background material related to your Section 111 reporting.

If you've already registered for the GHP CBTs, you should already have access to those courses. If you haven't registered, there are instructions on the

CBT page on how to register and you'll be notified of course updates and new courses as they are provided.

We are working on the final touches to the updates to the Computer-Based Training courses based on Version 3.1 of the User Guide and those will be issued very soon. So the CBTs for GHP reporting that are out there right now are based on information in the User Guide Version 3.0, but we will have updates out there very shortly.

Also, it might be interesting to some of you to note that we are working on a new Computer-Based Training module or CBT geared specifically towards Health Reimbursement Arrangement reporting or HRA reporting.

The other announcement I'd like to mention is for those of you who use the BAFIS system, that's B-A-F-I-S – to do online queries, we are moving that application for all Section 111 GHP RREs to the Section 111 COB Secure Web site in January 2011.

So, that should make not only your registration for BAFIS easier but also access to it easier, the same rules about limitations of how many queries you can submit under that method still apply. So, anyway, look forward to a change to how you get into an access to BAFIS coming up in January 2011.

It will also mean that any registered user of the Section 111 COB Secure Web site, anyone registered for GHP associated to and a GHP RRE ID will have access to BAFIS without having to get a separate log in ID and use that separate dial-up method.

Another thing we're working on is a fact sheet for employers that will explain what employers must provide, what certain information they must provide to insurer and provide this information on a timely basis so that insurer and TPA RREs can report accurate coverage information on their Section 111 file.

This type of information will include things like employer size, active work status of employees, relationship codes to the subscriber, the address where the employer should receive recovery demand and employment termination dates and retirement dates.

The idea is that insurers could take the fact sheet and share it with their employer customers to improve the lines of communication between the two entities. I don't have an exact timeline for this fact sheet but it is something that we're working on.

Remember that the special GHP reporting extension for dependents expires at the end of 2010 so please review Section 7.2.8 of Version 3.1 of the User Guide. This extension was intended to give RREs more time to report dependents who's coverage started before January 1, 2009 but continued past January 1, 2009, in order to give you enough time to collect the necessary information such as Medicare Health Insurance Claim Numbers or HICNs, also referred to as HICNs as well as social security numbers as needed or required.

When you report these individuals, please provide the original effective date of the individual's coverage that was in place as of January 1, 2009 and subsequent – and then any subsequent changes as necessary.

Note that HRA coverage will be accepted on production files as of October 4, 2010. That's when we're implementing our October release for Section 111 reporting as of COBC.

Report your HRA coverage with a coverage type of R as in (Roger). The basic rules for when to make your initial report of HRA coverage are as follows. Report coverage with a plan year effective date of October 1, 2010 and later but reporting of earlier effective dates is acceptable.

Report as soon after your plan year – or your plan year renewal or effective dates as possible. Future effective dates are not accepted though.

Report during your assigned quarterly file submission period and also note that the 45-day grace period applies if you cannot include the coverage in your initial submission file.

See Section 7.2.7 and 7.2.9.6 of the User Guide for more information on that grace period. So hopefully, that will help you in determining when your HRA coverage should initially be reported.

I think I mentioned earlier but I'll say it again just to make sure. We are coming up with our developing a separate Computer-Based Training module for HRA reporting and it will also cover those guidelines for initial reporting that I've just mentioned.

Another topic that I would like to present is that we've seen some examples where Responsible Reporting Entities or RREs are reporting separate records for hospital versus medical coverage.

Please note that if the individuals have comprehensive coverage and you are the RRE required to report that comprehensive coverage – and by comprehensive, I mean both hospital and medical and it may also possibly include prescription drug coverage.

In that circumstance, you should submit one record with an insurance type that reflects the – or coverage type that reflects the comprehensive coverage such as value of A as in alpha or W as in (Wally) or four as in the number four.

In some cases, we see RREs submitting two records. One, with a J as in (John) for hospital-only and the other, with a K for medical-only, but all the other fields on the records are the same including the policy and group numbers which doesn't seem to make sense. Let's take a look at those coverage types and make sure that you're reporting appropriately.

As always, please submit your specific technical questions to your EDI representative first. Specific technical issues related to your file submission can't be addressed effectively if they are sent to the CMS resource mailbox or elsewhere.

You will get a much faster response to your specific technical issues if you contact your EDI representatives and then follow the escalation procedures in chapter or Section 12 of the User Guide as necessary.

For example, if you have a specific case where a query for which you do not received an expected response, you believed the individual to be a Medicare beneficiary but your query response came back indicating that the information you submitted on your query was not matched to a Medicare beneficiary.

In circumstances like that, please provide that information in a secured session to your EDI representatives to research the specifics. Also, your EDI representative will be able to answer those other technical reporting questions that you have and elevate those within their EDI department as necessary.

Now, I'm going to get into some of the questions submitted to the Section 111 Resource Mailbox since the last conference call.

In the – the first question that I'm covering has to do with why the individual policy number is not returned on an N record on the non-MSP response file. I have taken this under advisement and it will be considered.

The individual policy number, as you know, is returned on the D and the F record, however, in the meantime, you might consider using the Document Control Number or the DCN fields for this. Possibly, you could put your individual policy number in there for – and use that as a matching criteria when you get your response records back.

Another question asked is an employer has less than 20 employees, are they subject to Section 111 reporting and does it matter if someone in the group has end-stage renal disease?

Employer size only applies to MSP for individuals entitled to Medicare due to age or disability. Employer size is not a factor for MSP when the individual is entitled to Medicare due to ESRD or end-stage renal disease.

So, even if an employer size is less than 20, you must report those active covered individuals thought or known to have ESRD. Please see the new MSP CBTs I mentioned earlier and, of course, also the definition of active coverage individuals in the User Guide.

There's also an Appendix I in the User Guide that covers how to calculate employer size. It's not just as simple as the count of employees on the date that you happen to be making your report of GHP coverage. So please review that. There's a CBT on employer size as well. There are lots of information out there regarding that topic.

Barbara Wright: You should also remember that for employer size, if an employer is in a multiple – multi-employer Group Health Plan then the rules apply if any employer within the group is the requisite size. So even if you have less than 20 and we're dealing with working ages, you could be subject to the MSP rules.

Pat Ambrose: Thank you, Barbara. Another question asked if an employer group is not responsive with providing the required information, had we, the RRE, note that on our file that we will need to transmit for Section 111 reporting?

There is no means for you to report that on Section 111 files. Obviously, you need to obtain that information from the employer group as soon as possible. And as I've mentioned earlier, we're working on a fact sheet that can help you possibly improve the lines of communication.

John Albert: The message that we'll repeat is that it's very important that you document your processes where you are having difficulty getting information. And I guess I'll jump in to add onto Pat's discussion about the employer outreach that we're attempting to do.

We are very interested hearing from folks on the call regarding any processes or communications that they've used and would be willing to share with CMS that we could share with the rest of the community out there regarding outreach type of materials that you've provided or whatever to employers.

We want to build that on our end as well but at the same time we're interested to see if there are any best practices that you all have identified as being very successful and would be willing to share that with everyone. So, again, please communicate that, if you would like, to the CMS Resource Mailbox.

Pat Ambrose: Good. Thank you, John.

The next question asked, is there a mandated date of when a 270 query will be required to be sent in? And they went to ask, is it possible to send them at this time and get a 270 response?

I refer you to the User Guide that we mentioned previously, the Section 111 GHP User Guide Version 3.1 on the Web site. The query file is optional and will remain so in the foreseeable future. Most certainly, queries may be sent at this time and in the X12 270, 271 format or transaction set, and again, I refer you to the User Guide where this process is explained.

Another suggestion here would be to contact your EDI representative or the main EDI Department number. I'll give that number now and we'll also provide it again. But if you do not have an EDI representative contact, you may go to the Section 111 COB Secure Web site which is www.section111.cms.hhs.gov and you will find on one of the menu options across the top of the page a Contact Us menu option where this number is listed, but the main EDI Department number is 646-458-6740.

A question came up regarding registration where certain information is requested during the account setup step where the account manager is inputting information about themselves and the RRE ID account.

And this question asked about reporting agents and – versus the RRE company. I'll read the question to make sure that I'm making myself clear here. Reporting agent requested on the account manager registration, is this item left blank? If we, as the TPA, do all the reporting for our HRA clients ourselves and don't use a reporting agent or do we put our RRE or account manager information here?

If you are as the claims paying TPA, the RRE, and you are doing your own reporting, you would obviously be putting in your information as the RRE name and company information and then you would leave the reporting agent information blank if you are not using a reporting agent.

The reporting agent during registration has to do with are you using another company aside from yourself to help you transmit files to and from the COBC

for Section 111 reporting. It's not intended to mean, are you a TPA or third party administrator.

I can't comment though on who is the RRE in your particular situation so please make sure you've reviewed Section 7.1.1 of the User Guide for that information.

Another question regarding the profile report and the company information section. Again, these individuals submitting the question indicates that they are the RRE, a third party administrator for an HRA group and asking, should the name of the client be listed in the company info or themselves as the third party administrator?

Again, remember, if you're kind of confused, you may – and you don't have an EDI representative, you could submit this question via calling the EDI Department main number and also see that Content menu options on the COB Secure Web site that I mentioned earlier. However, the RRE's information should be entered during registration as the RRE and company name as well as the tax identification number or the TIN of the RRE.

This question also went on to ask about whether HRA reporting, whether you can report HRA information using the basic reporting option. If you are reporting under the basic option, generally, you just report hospital and medical coverage. And if you're reporting HRA coverage, you use coverage code of R as in (Roger).

And again, as I've mentioned earlier, we'll be posting a CBT on HRA reporting soon so that might help answer some of your additional questions related to that.

The next question asked, how does a GHP that is in multiple or multi-employer plan coordinate benefits with Medicare? I'm sure others here at CMS will want to chime in but first, you need to determine who is the Responsible Reporting Entity against the Section 7.1.1 of the User Guide for information on who must report and who is defined as the Responsible Reporting Entity or RRE.

In the case of a multiple employer plan or multi-employer plan, it is generally the claims paying TPA or the plan sponsors such as a union.

Bill Decker: I would interject that the RRE is the claim processing TPA but I believed and John can confirm this that our User Guide says that in those specific circumstances, the multiple employer plan that the plan sponsor information is put in the employer field in lieu of the employer information.

Pat Ambrose: Yes. I'm getting to that, as a matter of fact.

So once you've determined who is the appropriate – the plan sponsor might be the RRE – and correct me if I'm wrong, but might be the RRE if they do their own claims administration and don't use the services of the third party administrator.

OK. So, you've figured out who the RRE is then the RRE submits the MSP input files as described in the User Guide. When you're submitting those files, you would put the RRE or the TPA or plan sponsor as the case may be but put the RRE's TIN in the insurer TPA TIN Field 22 on the MSP input file detail record and submit then a TIN reference file record with a TIN indicator of I, as for Insurer, on the TIN reference file.

You would put the plan sponsor's TIN in the employer TIN field in the employer TIN field of Field 21 and then correspondingly submit a TIN reference file record for that plan sponsor TIN on your TIN reference file detail record with a TIN indicator of S which indicates that that TIN reflects the plan sponsor.

Another question asked about testing and it sounds like it comes from an RRE who has already completed the testing process for at least one RRE ID. I'm not sure whether this individual had additional RRE IDs or not and whether they are just adding additional plan to report under one single RRE ID or if they might be setting up separate RRE IDs.

But they were asking if I already completed testing, do I need to test again, if I've already previously tested for Group Health Plans and I've already began

reporting for those and I assume they're adding additional Group Health Plans to their reporting mechanism.

So you must go through the testing process for each RRE ID registered. So it depends really on how you're reporting as to whether you need to test again. You could report all plans under one RRE ID or you could be setting up multiple RRE IDs depending on your structure and your claim system and have you set up reporting. So see section eight of the User Guide for more information on that.

So if you do have multiple RRE IDs, you must complete testing for each RRE ID. But if you've already tested successfully and your RRE ID has been turned to a production status and you're just adding more GHP plan reporting underneath and you're going to include them on the RRE ID that's already in the production status, that's perfectly fine and you don't need to retest as far as we are concerned. You might want to retest for your own purposes if you're taking data from a different source to supply to us.

And note that while you're submitting production files under an RRE ID, you may still submit test files as well under that same RRE ID. They're kept and tracked completely separately. So you may continue your production reporting under the RRE ID and also at the same time test other changes as you see fit with that same RRE ID.

The next question indicates that the RRE has a policy that provides coverage for replacement of lost or damaged hearing aids and the like and they asked whether this was reportable under Section 111.

This is covered in the User Guide in Section 7.2.7. It's in the fifth paragraph from the end of that section. If you did a search for hearing aid, you can probably find that section as well but we have covered that information before.

The next email first was indicating that it was difficult to find the email address for submitting questions to CMS. It's the email address that we referred to as the Section 111 Resource Mailbox.

If you go to www.cms.gov/mandatoryinsrep, our Section 111 Mandatory
Insurer Reporting Web site, on the What's New tab, you will see the email
address published there. It's in other various places on the Web site but it is
on the What's New page. I will add it to the User Guides in the next version
as well.

Now, that said, again, remember to submit particular technical questions that
you have. This individual had some questions about the secure FTP process
and I need to refer you to your EDI representative or the main EDI
Department number and follow the escalation procedures that are described in
the Section 12 of the User Guide as well.

The next question was submitted by Blue Cross Blue Shield that does not
currently utilize the query method to identify records report. You'll see in the
User Guide, you have two options. The query files are optional.

So if you're not using the query as sort of a finder file to determine whether
active covered individuals are Medicare beneficiaries prior to reporting them
or including them on your MSP input file, you can instead use the definition
of an active covered individual and submit based on the age thresholds, other
information according to that definition of an active covered individual. You
may submit them all on your MSP input file without querying first.

And this particular RRE asked if they need to continue to send records on the
file until a match is found. Let's say the member just turned 45 years old,
they are – they fit the definition therefore of an active covered individual,
they've sent them on an MSP input file, the MSP response file indicated that
they are not matched to a Medicare beneficiary and they wanted to know if
they should continue to submit that individual.

And the answer is yes, you are to continue to send these members if you're
not using the query method on your subsequent quarterly MSP input files until
such time that individual is not an active covered individual any longer.

The other option is, of course, to implement the query method at some point.
When you're ready, that might – you might find that easier. It would be less

data to transmit and it's probably recommended but, of course, it's not required.

The next question asked is as I continue to resubmit record on my MSP input file for this individual who is an active covered individual but not yet a Medicare beneficiary, what coverage information should I continue to send?

So you should send records that reflect the coverage of the person at the point that they became an active covered individual with the effective date that reflects that when that coverage began.

So for example, if the person had only medical coverage from January 1, 2009 through December 31, 2009, and then had comprehensive hospital and medical coverage from, say, January 1, 2010 going forward and they became an active covered individual on February 15, 2010, so they did not become an active covered individual and were not reportable until after they had already changed their coverage to both hospital and medical then start sending this individual on your file with an effective date of the latest coverage – the hospital/medical coverage of January 1, 2010, you don't have to go back to January 1, 2009 and the coverage that they might have had in place at that time.

Each time this individual's coverage changes, you may then send only one record for them with that new coverage and the effective date of that coverage. You don't have to report all their old coverage records since by virtue of sending them on one of those quarterly files and getting the 51 response back, you determine that they weren't a Medicare beneficiary at the time, you know, under that former or previous coverage.

If their coverage has been the same all along, you just keep sending the same record with the original effective date which might have been in 1995. The system will set the MSP effective date to the date that the person first becomes entitled to Medicare.

And if you're sending your record with – in open-ended termination date as you should be if the coverage continues then you wouldn't get the SP 31 and the SP 32 errors when the individual becomes entitled.

So this individual also asked about the SP 99 error. The only time you will get an SP 99 is when that individual is under 45 and you do not include a Medicare Health Insurance Claim Number or HICN. So hopefully, I've answered that.

Again, there is information on the Reporting options under the GHP CBT Curriculum. Now, when you sign up – I encourage you then again to sign up for the CBTs, and I don't know the name of the course off the top of my head but I think that it has something to do with submission methods or – I can't remember, but you'll see it and recognize it – in the course curriculum, I apologize for that. But it's a very good course that explains the difference between the query or finder file method versus reporting using the active covered individual definition. When you sign up to the CBTs, you don't have to take all of them. So you can jump right to that course and take only the ones that most interest you.

Another question indicated that a Medicare query was returned with an individual – not matching an individual to a Medicare beneficiary but the RRE believes that individual to be over age 65.

You know, it is possible for someone over 65 not to be entitled to Medicare yet, however, this is an example where you should provide that information in a secured fashion to your EDI representative to research. So if you get unexpected response back on your query file, you most likely would want to question your EDI rep if you believe that that information was incorrect.

The next question asked whether – Section 111 reporting, whether it applies to all TPA groups regardless of size or only those with 20 or more employees. I think I'd covered that one adequately before.

Section 111 reporting applies, you know, basically to all GHPs. There are certain MSP rules based on employer's size. So again, take a look at Appendix I of the User Guide, the MSP CBTs and the GHP User Guide CBTs and the definition of active covered individuals in the User Guide.

Next question had to do with do we have any provisions for RREs to register after June 30, 2010. And we most certainly do. Registration will remain open forever for Section 111 as new RREs may form and develop or you may want to change your reporting methodology and create a new RRE ID. So, you may go to the Section 111 COB Secure Web site at anytime and start a new registration to obtain a new RRE ID.

Another question came in asking do I have to report HRAs with 20 or more employees or 100 or more employees, and I've seen both numbers and we'd like to have confirmation? And, you know, I'm sorry to keep repeating myself, but obviously, there's a lot of confusion out there especially with the new reporters who are getting geared up to report their HRA information.

There's a lot of information out there, again, in Appendix I of the User Guide Section 7.1.2 of the User Guide. You basically must consider reporting all active covered individuals regardless of the employer size if any particularly if any active covered individual might be entitled due to ESRD.

The next question had to do with what coverage type should be used when HRA coverage is reported. And the question, you know, in particular was saying, "You know, we're making reimbursements, we might not know whether it was due to hospital or medical coverage." For HRA reporting, you should be using coverage type R as in (Roger).

The next example also was – or the next question, rather, submitted has to do with an RRE who has received late submission flags on their response file that they don't necessarily think are correct or accurate and wanted to know what to do in those circumstances.

In one case, it looks like the individual had just become an active covered individual who had just turned 65, and when they made their report, they got a late submission flag for that individual even though, of course, they might have reported an effective date of the coverage date earlier than their subsequent birthday, et cetera.

First off, in those examples of receiving a late submission flag that you believed to be incorrect, please report those examples to your EDI

representative. You could also indicate your EDI representative that they could forward issues related to that to their supervisor or even to myself, Pat Ambrose. We'll take a look at them and see what might be happening.

I believed that we might have a system issue where we might not be appropriately checking the age of the active covered individual or the Medicare beneficiary. I'm not entirely sure of that but we'll look into it further.

There was – the question went on to also state that they have received a late submission flag on some Medicare beneficiaries who's Medicare entitlement was retroactive. And that is something that I know we haven't accounted for and you may receive a late submission flag on that, and I think in that circumstance, you're just going to have to ignore that late submission flag.

You know, what I want to reiterate what we've said on previous calls is that the late submission flag is a warning back to the RRE for you to make sure that you check that you are reporting in a timely fashion, there is no automatic penalty that is incurred as a result of receiving that flag.

The late submission flag and the compliance flag are for your information, and obviously we're paying attention to them too, but they're for your information so that you can react appropriately and follow up.

OK. One last question. This question was again asking about HRA reporting and whether or not coverage type R should be used since the User Guide didn't specifically state that coverage type of R is allowable for the basic reporting option, so the RRE's confusion has to do with the basic option versus the expanded option.

And again, if you're reporting HRA coverage, you should use coverage type R regardless of whether you're reporting under the basic or expanded but I would assume that you're reporting under the basic option in that case.

You can also refer to your EDI representative with further questions about that. It should be noted that basically, all the requirements in the User Guide related to GHP Section 111 reporting and your MSP input file, all those

requirements apply to HRA reporting as they apply to hospital, medical and other coverage reporting for Section 111. So there's not really a different set of requirements for HRA other than those that are specifically satisfied or pointed out in Section 7.2.7.

OK. So with that, I am finish and I think I'm turning it over to Bill Decker for some additional information.

Bill Decker: Thank you, Pat, very much. Hi, everybody. My name is Bill Decker. I am with CMS in Baltimore and I'm going to cover a couple of subject areas.

First is social security numbers, one of my favorite areas. Between our last Group Health Plan call and this call, we've got a number of questions about social security numbers and the questions were all exactly the same essentially.

The question was somebody doesn't want to give a social security number, what can I do, somebody doesn't want to give me a social security number, can I deny coverage, someone doesn't want to give me a social security number security number, how should I handle that?

And our answer to that is that we can't tell you what you should do. Can you hang on for a second?

Pat Ambrose: Hold on just one moment.

Barbara Wright: Let's just tell everybody that…

Bill Decker: Operator?

Operator: Yes, sir?

Bill Decker: We have – this is for everyone else who's on the call, we're going to actually have to get off the call for a couple of minutes and dial back in.

Operator: OK.

Bill Decker: We apologize to everyone on the call but there appears to be some room conflicts here with the facilities so we are going to do that. So we're going to sign off.

John Albert: Give us five minutes.

Bill Decker: Give us about five minutes everyone.

John Albert: Yes. And we'll be right back to you.

Bill Decker: OK, operator?

Operator: Did you want music hold back on?

Bill Decker: Well, can you let the participants know if they can't hear me right now that we need to suspend this call for five minutes and come back in?

Operator: They can hear you right now.

Bill Decker: OK.

Operator: All right.

John Albert: All right. We'll call back in. Bye.

Operator: OK.

Barbara Wright: OK.

They're waiting (right now).

John Albert: Operator?

Operator: Yes, sir?

John Albert: Oh, is this (Lorrie)?

Operator: Yes, it is.

John Albert: Oh, hi. We're back. We're ready to continue.

Operator: OK. You're in the main conference. You may go ahead.

John Albert: OK. Thank you. So, we apologize, everyone, on the call that we had a conflict with the room and we had to change location so we are back and I think Bill Decker was getting ready to speak so here he is.

Bill Decker: Once again, hi, everybody. This is Bill Decker. I am with CMS in Baltimore. We're hoping that you can hear us OK. We had to change phones, change rooms as you've heard.

I was about to launch into an explanation of some of the questions we've got between the last call and this call regarding the collection of social security numbers and the questions were all, as I've said earlier, exactly the same. The questions were that people didn't want to provide an RRE or an employer or both with a social security number.

Generally speaking, it was the social security number for the dependent of a covered individual, and we've got a number of questions about what should be done about that. Is it permissible, we were asked to deny the insurance coverage, is it permissible to not report, is it permissible to do – to take actions like that?

Our answers to all those questions is basically the same and that is that we can't tell you what it is that you should do or can do or cannot do regarding your rules about coverage but as long as it's not Medicare coverage, those are our rules but further, on private insurance rules, those are your rules, not ours.

We ask you to tell us – and for Section 11 reporting – about people who are Medicare beneficiaries. We say this constantly over and over again and we need you to tell us about people who are Medicare beneficiaries because that's your responsibility.

Yes, you know, that a Medicare beneficiary's primary identification number is the Medicare Health Insurance Claim Number also known as the Medicare HICN or the Medicare ID number.

That's the number that we insist upon receiving from you when you correspond with us electronically during the course of the Section 111 reporting. That is our primary identifier for our own patient population.

You also know that we can seek to find out if an individual maybe a Medicare beneficiary if we have that individual social security number plus some other personal identifying information.

If you are curious to know if someone is a Medicare beneficiary and wish you ask us if that individual is, if you can provide us what the social security number and the other personal identifying information and we will check our own database to see if that person is, in fact, a Medicare beneficiary.

If we can find that person, we will let you know we found that person and provide the Health Insurance Claim Number. That's as much as we can tell you about what you should do if people – if you ask for social security numbers and people don't give them to you.

We do tell you that you can request people to fill out a form that we have on our Web site. If they don't want to supply with an SSN and you keep a copy of the form that they have completed in your own records, and that is Rule B if it ever comes to that, information that will be sufficient for us to know that you tried to get the social security number from someone who you wished to find out was a Medicare beneficiary or not.

But that's just as much as we can say about what you should do about social security numbers in trying to collect them. We do have a form on our Web site that you can use, to ask – to give to someone to see if they're a – to see if they will give you the social security number that you're asking for.

If they do, fine. We can then check if they don't. You keep a copy of the form in which the person has, in writing, declined to provide the SSN and that is sufficient for our purposes to show that you have attempted to discover the SSN for someone.

Yes, one, we have – I've just received request to go offline briefly. We'll be right back.

OK. Everybody, we're back. We just had a little discussion among ourselves about what we really wanted to – if we want to get into anything else, and we don't, so no social security number question in any case, so I'm finished with that part of the presentation.

I want to go over some information about Health Reimbursement Arrangements – HRAs. Pat has already given you a lot of information in her presentation about HRAs. I'm going to give you some more and then – but I'm not going to go into great depth on any of the questions that we've got because they were all essentially questions about what is an HRA, what is the structure of HRA reporting and do I have to report? We did get a number of questions but what I really want to do here is go over very quickly, but I hope completely, with an overview of the HRA reporting process.

First of all, I want to mention that between the last call and this call, we eliminated any distinction between what we have been calling an embedded HRA versus a standalone HRA. There is no distinction really between the two and so we dropped the distinction in our written materials.

Anybody who asks questions asking for clarification about the difference between an embedded and a standalone HRA, that's the answer. There isn't any distinction so we don't need to actually answer that question.

In general, a Health Reimbursement Arrangement is a Group Health Plan insurance product. And those of you who know how to report Group Health Plan insurance products under Section 111 should know how to report an HRA. It's the same way you would report at Blue Cross Blue Shield plan coverage like any other group health insurance plan coverage type under Section 111.

There really isn't a great mystery to what an HRA is. It's Group Health Plan insurance and that's why it's reportable under Section 111. Remember that in Section 111 reporting in general, you are reporting the coverage not what the coverage may be used to pay for or may, in fact, be paying for. They're telling us that you are providing group health insurance plan coverage to

active covered individuals and that also applies to Group Health Plan coverage.

But we've got a number of questions about, do – if this then that on coverage questions and essentially, if you're providing HRA coverage, it's Group Health Plan insurance coverage and that's what you're reporting. That's what we need to check against.

You tell us you're providing the insurance coverage and we know what we are being asked to pay for and we can crosscheck to see if that's a responsibility of yours or if it's a primary responsibility of ours.

Deductible and copays are health insurance care cost there reimbursable through Health Reimbursement Arrangements, that's true, but they are basically paying for – they are basically paying for reimbursement for medical care costs plus your HRA is being used to pay for being used as a health insurance product when it's only paying copays or deductibles or other interior insurance products.

And as a consequence, that's reportable. That's when if you're just paying part of an insurance premium or if your covered individuals are just paying parts of an insurance premium through an HRA, that HRA is reportable through us because it's GHP and it is reimbursing for healthcare cost.

We've got a number of other questions which I think though are – I've covered in general there. More specifically, everything you need to know about HRA coverage is in Section 7.2.7 called the MSP Input File Detailed Requirements that's in the MMSEA Section 111 MSP Mandatory Reporting GHP User Guide Version 3.1 dated June 25, 2010, and the specific information about HRA reporting starts on Page 65 of that User Guide.

I'm going to defer answering any of the other questions we've got because I believe that if anybody needs to have – I think we've answered in general what all the general questions were. And if you have specific questions, when we open it open up to questioning, you can ask more specific questions.

But HRA, these HRA questions now, and I'm actually happy about this, are beginning to drill down to the point where it's not just process but it's also process and policy involvement.

And I'd like to open it up when we do get to the opening up portion of this call to anybody who has a question. And I'm asking now around the table, if anyone else has any presentations to make…

Female: No.

Bill Decker: I'm getting head turning no and so, operator, we are ready to open it up. Once again, remember, we are asking you to ask one question and then we will let you ask one follow-up question but if you have more information to ask us, please drop off the queue and come in again at the back end so we can get in as many questions as we can.

And anything else before we turn it over? OK, operator, we will take questions now at this point.

Operator: Excuse me. At this time, I would like to remind everyone, if you would like to ask a question, star one on your telephone keypad.

Your first question comes from the line of (Tanya Lee) from Blue Cross Blue Shield. Your line is open.

(Tanya Walker): Hi. This is (Tanya Walker) from Blue Cross Blue Shield of Alabama. This is a question concerning the HRA reporting and the effective and termination dates that we are supposed to report to you.

If a member dropped their HRA election from $1,000 to say about $500, do we report the termination date at that time or do we leave it open for the entire calendar year or covered year?

Bill Decker: Again, remember that HRA insurance coverage is essentially GHP coverage. You would handle it just the way you would handle any other GHP coverage.

If they have – if they're still being covered in the current coverage period, even though they have dropped their reimbursement amount, you'd still be reporting. You still leave that open coverage.

And if it was above $1,000, you would – on an annual basis, you'd still have to report it. Again, it's not what the amount of the money of the HRA is. It doesn't dictate whether or not you report it. It's whether it's open coverage and whether it's a $1,000 or more during that period of open coverage.

Barbara Wright: Think of it as the equivalent of exhausting part of the coverage. The record stays open because it's a continuing coverage but they've exhausted the amount for that year. So you leave the record open.

(Tanya Walker): Well, but we are to report two different records – one, the regular (MSPD) kind of record and an additional record reflecting the HRA coverage.

Bill Decker: Yes, yes, there are two coverages.

(Tanya Walker): OK. And so if they were to change their HRA election coverage, we are to report – I submitted several questions to the EDI rep about the add update process and this was one he couldn't answer whether or not we were to terminate just that HRA occurrence.

Bill Decker: No. Hang out a second. We're going to go offline just a brief moment here and come right back to you.

Bill Decker: The answer, we think, you're looking for – or the answer we think will be most useful to you anyway, is that the HRA coverage that you have which you're separately reporting, that's true, stays in effect until it's terminated. It's not terminated simply because it's – there isn't any more money left in that account at this period.

As long as it rolls over into another coverage period, it's going to stay active coverage. And if it is funded below the $1,000 limit in the next coverage period, you wouldn't necessarily report it although you could. There isn't any provision against that. But you wouldn't terminate it. You wouldn't send us,

for example, a termination notice of the coverage unless in fact the coverage was terminated.

John Albert: If the employer dropped the HRA.

Bill Decker: Right.

(Tanya Walker): I think I understand what you're saying but I guess what I'm looking for is if they, say, only set up in HRA contract for six months and they, you know, set it up for the $1,000 annual benefit, and then after six months, they changed it to only – to a $500 annual benefit. At that point, would we send you basically a cancelled?

Bill Decker: You will. Would the $500 benefit run through the rest of the coverage period for that HRA?

(Tanya Walker): Possibly, yes.

Bill Decker: Then I don't think you'd send us anything. I think it's just the change in the coverage in that.

(Tanya Walker): OK.

John Albert: Which we…

Bill Decker: That's right, which we don't collect.

(Tanya Walker): OK. Thank you.

John Albert: This is essentially the same coverage that would just stay open. The value of the coverage is not something that we're asking you to report.

Bill Decker: It started as reportable coverage. It dropped. That's going to happen to a lot of HRAs that are used during the course of a coverage period for an HRA.

We're not asking anyone to tell us when that initial – more than $1,000 annual coverage limit drops below because we're assuming that as long as HRA

coverage remains available to the active covered individual, it could go back up above $1,000 coverage limit.

John Albert: If you – once you report HRA coverage, you can leave it open until such time as the employer terminates the HRA contract period.

(Tanya Walker): OK. Thank you.

John Albert: Yes. I mean if it's a different HRA then – you know, a different coverage then yes, you would terminate the old one and open the new one but…

Barbara Wright: Because they're not exactly…

John Albert: Yes.

Bill Decker: That's right, yes.

John Albert: So the same ones, one continue as (Roger).

Bill Decker: Does that help you?

(Tanya Walker): Yes. Thank you.

Male: OK. Thank you.

Operator: Your next question comes from the line of (Scott Sheldon) of (EBS RMF FIL). Your line is open.

(Scott Sheldon): Hi. Thank you. First, it's important to note that for HRAs, we don't currently track a lot of the information required to complete reporting or even to complete the query-only files.

So really, my question comes down to if we haven't yet received the information from an individual and failed to report on someone at the first possible opportunity to report them but we do intend to report them at the first possible opportunity after we received the required information, is that compliant or are we out of compliance to that point?

John Albert: Yes. I mean technically, the requirement required to report the data when it's due, you know.

Barbara Wright: And we did give significant advanced notice…

John Albert: Yes.

Barbara Wright: …in terms of reporting for HRAs just because we had heard from the industry that you wouldn't necessarily have collected this information. The original start date for the rest of GHP was January 1, 2009.

Bill Decker: And this is GHP coverage. The bottom line for us is always that we want good data reported to us. We want you to be able to send us good data and we want to work with you to get you to the point where you are sending us good data – useful data to us and data keeps you in compliance with the Section 111 requirement.

                 As long as we understand that you're working actively to do that, we will continue working with you to get you into the best reporting mode that we can get you into. After cooperating with, you know, Section 111 requirements, you have registered, you're working with the COBC, you're talking to us, that appears to us that you are going forward with your reporting requirements and we will encourage you to keep going forward with them.

(Scott Sheldon): All right. But I mean along those same lines, I mean as we're understanding it and as you pretty much express this data in this teleconference, I mean there's no re-precaution to a person who just doesn't reply to us when we send out the – and trying to collect the information. But we're faced with half the penalties when they passively refuse to supply the information to us by just never replying. Am I understanding that correctly?

Barbara Wright: You need to document your process that you use to attempt to get the information. We – as Bill Decker said, we have model language on the Web site to use. That shouldn't be your first and only approach to get information.

                 But if you've attempted to get information and you don't get it through your standard process and you proceed to the model language, you need to

document what your normal process is that you've followed all the steps and that's what we would be looking at when we eventually reach compliance issues.

But we can't say that just because you haven't routinely collected this information as a path, does that automatically gives you a path right now? You need to document your process and what you're doing.

(Scott Sheldon):   All right. Thank you.

Operator: Your next question comes from the line of (Geraldine Hawkins) of WEA Insurance. Your line is open.

Pat Ambrose: Yes, thanks.

(Rick):   OK. I'm sorry. We had our phone muted. This is (Rick).

On page eight of the current User Guide at the bottom, it says, starting July 17, RREs must submit either Field 15 or Field 18 on all MSP input file detailed record. Field 15 was previously required. RREs are encouraged to use Field 18 instead of Field 15.

Our dilemma is that you don't give a due date or a deadline date for this and we're trying to prioritize all our corporate objective for 2011. So, do you have any guideline or future realistic date that we should shoot for to convert this so we can help prioritize this for our corporation?

Pat Ambrose: OK. So this is the fields having to do with the subscriber's SSN or policy holder's SSN versus the individual policy number.

(Rick):   Correct.

Pat Ambrose: And you may continue indefinitely using the – or submitting the policy holder's SSN. We have no deadline for you to make that switch so, you know, you really have to use your own judgment as to when you want to prioritize that change in your own system.

(Rick):   OK.

Pat Ambrose: We made the change right away to make it an either/or, you know, and take either fields because it has been pointed out to us that while we were saying we don't require SSN for Section 111 reporting, we, in fact, were by requiring it – the policy holder's SSN in Field 15. So we made the change right away to rectify that as to when you make the change on your end, it's really your call.

(Rick):   OK. I just was concerned that you may just all of a sudden mandate it. You've got 90 days and I'll start using Field 18 and that wouldn't give us enough time.

Pat Ambrose: No. There is no – nothing like that happening in the foreseeable future. And a change like that, you would be given advance notice.

(Rick):   OK. That answers our question.

Male: One more question, is that really an either/or situation or could we populate both fields?

Pat Ambrose: You could populate both fields. That's perfectly acceptable.

Male: Thank you.

Operator: Your next question comes from the line of Tracy Butler from Hill Country Bible Church. Your line is open.

Tracy Butler: Hello. I have a very basic – pardon me for going back to the basics of this – but my question is more around – what we have here is third party administrators for all of our benefits except for our HRA. We self-administer our HRA. We just become aware that we have to do this reporting.

                 We've gone so far as to register as an RRE at this point but my question is really basic and that, if we only have two employees that are over age 65 but they do not take Medicare coverage at this time, do we still need to report?

Bill Decker: That is by the definition.

Pat Ambrose: If they're active covered – if they are Medicare beneficiaries over age 65 who are employed, have an active employment status, they need the definition of an active covered individual and are reportable.

Bill Decker: Yes. The check off is, are they Medicare beneficiaries? If they are, yes. Are they actively employed Medicare beneficiaries or are they the dependents of an actively employed worker for you, folks?

Tracy Butler: OK. So they did not – they have not applied for Medicare so they are not beneficiaries of Medicare.

Barbara Wright: If they're not Medicare beneficiaries, they're not reportable.

Bill Decker: Right.

John Albert: Yes.

Barbara Wright: But do remember there are some instances where you will have potentially people under 65 who are beneficiaries.

John Albert: And make sure that you don't just rely and say, "Have you reapplied for Medicare?" and they say, no, and in essence, signed up for B but not applied – signed up for A but not sought B.

Bill Decker: Right.

Barbara Wright: Yes.

John Albert: I've seen that many times, people are misinterpreting the differences between Part A and Part B.

Barbara Wright: Yes. I believe unless things have changed over recent years, when someone goes in and applies for social security retirement benefits, if they apply at age 62, part of the application is technically an application for at least the Part A benefits. They will automatically get those at age 65 if they're receiving the retirement benefits.

And I believe they're also technically (oust) at that time, whether they will want Part B. So if they're getting social security benefits and they're age 65, for sure, I would expect them to be Medicare beneficiaries as well.

So be – like the other Bill here, just said, "Oh, I've warned you, you need to not just ask them did they apply." It's possible that he will have it because they had already applied for cash benefits sometime ago.

Tracy Butler: All right.

Barbara Wright: Same thing happens when someone receives social security benefits because of disability. They automatically get Medicare started a certain period of time after that.

John Albert: Without an additional application.

Bill Decker: Right.

Tracy Butler: Is there a way for me to submit the social security numbers to find out for sure if they're reportable – if this is a reportable person or not?

Pat Ambrose: Yes, there is. There are several ways. One is file submission – the query-only file. There is software available – the HIPAA eligibility wrapper or the HEW software that you can either download from the Web site or get from your EDI representative.

And it sits on a PC platform so it's pretty easy to use and you could create a query file and upload it on the COB Secure Web site and then to get a response file back that you load back into this application and it would transform it into a more readable file and you could tell whether, you know, you use that process. So in the User Guide, it's referred to as the query-only file.

Tracy Butler: OK.

Pat Ambrose: Another option is BAFIS – B-A-F-I-S. You can apply – there's a form to fill out to get a user ID and apply for access to that. Right now, that is – and

that's in the User Guide in one of the appendices, and, you know, work with your EDI representative to get access to BAFIS.

You may get – or right now, BAFIS is a dial-up type of process and starting in January, we're putting it on the COB Secure Web site. So that's another option, especially since you have very few individuals that you might have to report. That would be another option to check on their Medicare status.

Tracy Butler: Thanks. Therefore, their spouses as well. So I would need to submit this for any employee or spouse at age 65 or older.

Pat Ambrose: Dependent, you know, their…

John Albert: I think they're covered by that coverage, yes.

Tracy Butler: OK.

Pat Ambrose: Yes. Take a look at the definition of active covered individuals in the User Guide to help you decide who you need to query and check on.

Bill Decker: Did you say you've already received your RRE ID?

Tracy Butler: Yes.

Bill Decker: And you already know who your EDI rep is?

Tracy Butler: Yes.

Bill Decker: Good, good. Your rep can help you with pretty much any of these kinds of questions also.

Tracy Butler: OK. Thank you.

Bill Decker: Sure.

Operator: Your next question comes from the line of (Mary Overton) of Wal-Mart Blue Cross. Your line is open.

(Craig Wolf):   Yes. This is (Craig Wolf), and I am just wondering if CMS has given any thought to moving the inquiry file to a quarterly file, I believe in 2011, and if we could potentially look at keeping that as a monthly file?

It's very beneficial for us, I think, and our members related to being able to reduce the number of demand letters and making sure that we're getting proper benefit payments on an ongoing basis.

And then with your changes that you're having, I think, in 2001, to BAFIS which you've alluded to, will that process allow us to have an increased number of hits on that or are you going to still minimize and have a certain number of hits?

Pat Ambrose: Well, as far as I know, BAFIS will have the same limitation of the number of queries that you can perform within a month but I honestly need to double check on that requirement.

I'll let Bill Decker respond to the monthly versus quarterly…

Bill Decker: Deferring to CMS to talk about that change, and I will actually defer to John Albert.

John Albert: Yes. I mean, you know, the issues has come about is basically very heavy usage of that process which unfortunately there are some uses out there that use it way more than most and it's forced us to kind of rational.

But we don't want to get to that point but the capacity of the system is being outpaced by some of extremely heavy volumes of repetitive queries being made to it so we're kind of like – you know, we would like to expand any of these processes when we can but there are going to be times such as now because of the very heavy usage that we would have to restrict it.

So, well, we apologize for that but again, we – you know, if we can get – if the volume can, you know, subside to what we feel is a more reasonable level, you know, we would hope to be able to open that up again but I guess that with this process being relatively new and everybody jumping on, once it's probably higher than expected volume of queries and if we get to the point

where the system can't handle it, you know, and nobody gets responsive, that's a much bigger problem than rationalizing it so that's what we had to do.

(Craig Wolf):   All right. Thanks.

John Albert: I mean, you know, for entities that are extremely large and large volumes, some of them have multiple RRE IDs which means they can kind of space their queries out and things like that.

There is a code that the EDI Department has worked directly with some of the heavy volume users to try to spread some of that workload across the quarter but unfortunately, it's got to the point that, you know, between the system and the volume, it's just can't handle it so we're at risk of not being able to handle it so…

Operator: Your next question comes from the line of (Brigitte Einstein) from (Siridium). Your line is open.

(Brigitte Einstein):   Hi. My question is regarding specifically when the HRA funds are exhausted, when does the Medicare process pick up to start becoming the primary payer?

Bill Decker: Medicare technically remains the secondary payer but our system would indicate that the primary payer is making no payment under particular claim and that's acceptable to us.

(Brigitte Einstein):   OK.

Pat Ambrose: So the claim – Bill, if I understand what you're saying, the claim goes to the HRA first is essentially…

Bill Decker: If the provider or supplier who is responsible for submitting the claim to Medicare, for either primary or secondary payments, has evidence that the HRA benefits have been exhausted for the period.

There is a code that they put on their electronic frame – I can't remember what the number is but it came up a few days ago – which indicates that the primary payment benefits for that particular insurer have been exhausted for

the period and then Medicare will use that information to process the claim assuming a zero payment from their primary plan.

(Brigitte Einstein): OK. Fabulous. Follow-up would be, what is the normal turnaround time after – within that process for Medicare to pay out that claim?

Bill Decker: Whatever the normal claim processing rules are assuming the claim was submitted correctly.

(Brigitte Einstein): OK. Thank you.

John Albert: Yes. So, no different from a claim for payment against of a GHP.

Bill Decker: Any other GHP.

John Albert: Any other GHP benefit, yes.

Bill Decker: Right, yes,

John Albert: And you need to understand that if a claim is not submitted with all the appropriate codes, it may be either A, denied or B, or what we call RTTs, return to provider for additional information. So it's incumbent upon the provider or supplier properly filling out the electronic claim submission.

(Brigitte Einstein): And I understand that. I simply wanted the high-level overview so that we can explain it as a TPA.

Bill Decker: OK. Good. Thank you.

(Brigitte Einstein): Thank you.

Operator: Your next question comes from the line of (Michelle Mitten) of Health Plan Services. Your line is open.

(Michelle Matten): Thank you for taking my call. My question is we are an RRE for a Group Health Plan that we have a Medicare Expense Reimbursement plan associated with the high deductible plans only.

We paid the claims for the high deductible plan but the portion of the MER plan; we send a letter to the employer letting them know how much we applied to the deductible. We don't process the MER plan ourselves. Would this be reportable as an HRA?

Male: Reportable by whoever it is described – what you're calling the MER plan and making the same – if that's the employer then it's the employer.

(Michelle Matten): OK, then great. Thank you so much.

Operator: Your next question comes from the line of (Martha Sanchez) of Peter C. Foy & Associates. Your line is open.

(Martha Sanchez): Hi. I have a question in regards to the effective dates of when they need to be reported. For example, we have a couple of clients where their HRAs wouldn't start until 01/01 or wouldn't renew again until 01/01. Do we report that on the first quarter of 2011 or do we need to start reporting on the fourth quarter of this year?

Bill Decker: When do you report and when do you renew again?

(Martha Sanchez): When they renew…

Bill Decker: …already in process…

(Martha Sanchez): What about if their effective dates are like 08/01 and 07/01?

Bill Decker: That's right. You report – you wouldn't need to – you are not required to make any reporting until 01/012011. You may report earlier if you wish.

(Martha Sanchez): Oh, OK. So we already did all the registration of the accounting, everything, and we're in the testing phase. Is there a timeframe for the testing phase since some of these wouldn't be reported until 2011?

Bill Decker: The testing phase should be finished as quickly as you can so that both you and the COBC – the Coordination of Benefits Contractor – are comfortable that when you start reporting, you will be able to do so with no problems or issues.

(Martha Sanchez): OK, got it. Oh, OK. All right. Great. Thank you so much.

Operator: Your next question comes from (Walter Smith) of Blue Cross Blue Shield. Your line is open.

(Rose Tazis): Hi. This is (Rose Tazis). I just want to know on Section 111 with $1,000 receipt, there's an indication of a (Med B) or Part D contractor number. For example, the H numbers, the S numbers, the R numbers. I wanted to know where could we get a list of who those contractors are.

John Albert: Are they asking for a list of the Part B plans based on the numbers? And I didn't know if GHI had that list or not. We're going to have to get back to you on that. Did you submit that question on the Resource Mailbox?

(Rose Tazis): No, I have not.

John Albert: OK. If you wouldn't mind doing so and leaving us your contact information. We're just not sure at this point in time where that information is housed. I mean it is available and I thought that we might be able to – once we get – make that available to you all, we should be able to, you know.

Bill Decker: Medicare is a very large insurance and there are different divisions inside this insurance company and that's going to be in a different division.

John Albert: Yes. So we'll take that up and try to make sure if that is made available to those that need it…

Bill Decker: Right.

John Albert: …via like, you know, your EDI Department or something like that because I'm pretty sure that we had a list, as the contractor, but I don't know if it's been updated or not. Obviously, we make changes quite rapidly so we'll take that up. Thank you.

(Rose Tazis): OK. And then I have one question – it's a different subject. On the multiple employer plan sponsor, we are a TPA, so therefore, just to clarify what I've heard you said earlier – I think, Bill stated that – we should be putting the plan

sponsor's TIN number on the record and on the TIN file or is it the actual multiple employer to type that identification number that will go in that field.

Pat Ambrose: In the employer TIN on the – which is Field 21 of your MSP input file; you would put the plan sponsor's TIN. And Field 22 is you would put your TIN as the TPA – insurer TPA as the RRE.

And then on the TIN reference file, you submit two records, one for each of those TINs, one for the plan sponsor and corresponding information and one for the TPA – RRE TPA. Does that answer your question?

(Rose Tazis): Yes.

Pat Ambrose: OK.

(Rose Tazis): Finally, the last question I have is on the coverage plan. If we have changes where – and this kind of relates to the retro fee service, if we understand that, let's say, six months ago, this particular (approach in 1B) and this TIN number and they had a particular coverage type, and now, today, they are the different ones so on that date of reporting period, we will be sending you a record for the most current coverage type. Is that correct? We should not be sending you a record to change the coverage type that the member had six months ago?

Pat Ambrose: Have you already reported the previous coverage and have that record accepted?

(Rose Tazis): Right.

Pat Ambrose: In that case, you would send an update record to term – with a termination date to end the previous record and then send an add record with the effective date of the new coverage and an open-ended termination date with the new coverage type.

Barbara Wright: Now, I want to make sure you're talking about a new type of GHP coverage because I thought I heard you say a new type of MSP coverage.

(Rose Tazis):   No. I'm saying the person was an MSP member the initial time we looked forth in the person. So they were MSP members with – for example, let's say, their coverage type was W. And now, they're still MSP member but the coverage type just changed to a J. What is that?

Barbara Wright: Yes. And so you would send an update record for the prior record with the termination dates and then send it – and add record with the new effective date of the new coverage and an open-ended termination date.

(Rose Tazis):   OK. So the only time that we would do something different, Barbara Wright, at your point is if we initially transmitted that member to MSP and let's say today, we find out that this person should have actually been a non-MSP.

Barbara Wright: Yes. That is true. I mean if you initially reported that coverage and the person is actually not actively employed, there are retiree, and you've got an old one back on your MSP input file and an MSP occurrence has been created but never should have been created because that person was a retiree throughout that coverage period then in that case, you will send to delete and – so that you delete that coverage…

(Rose Tazis):   OK. All right.

Barbara Wright: …or that MSP occurrence.

(Rose Tazis):   OK. All right.

Barbara Wright: And we are doing it. That is just one of the things.

(Rose Tazis):   OK. Thank you.

Operator: Your next question comes from the line of (Karen Maverick) from (Electricians) Health and Welfare Plan. Your line is open.

(Janet):   Hi. My name is actually (Janet) and my question is on HRA. I'm writing no retroactive reporting as required for HRA coverage. Only coverage was an effective date of 10/01/10 and subsequent must be reported.

On our HRA, it started in 2007. The people who remained active whether they have a balance or not, their effective date remains January 1 of '07. Are those reportable?

Pat Ambrose: Yes.

Bill Decker: Yes. It's coverage that is open-ended as of.

(Janet): OK. And my next question is the new year allowable is only $792. So if that's all they had, it wouldn't be reported but if they have a carryover, only the ones that have carryovers that are over $1,000…

Barbara Wright: The carryover plus the new amount is $1,000 or more…

Bill Decker: Right, right.

Pat Ambrose: Yes.

Bill Decker: If at any time during the current coverage period, the amount in any individual's HRA exceeds a $1,000 then it's reportable.

(Janet): OK.

Barbara Wright: And then once you report them even if the amount drops, you do not terminate it if their coverage remains open.

Bill Decker: Right.

(Janet): OK. So the ones with zero balance, now, when they get $792, they're not reportable.

Bill Decker: Not at this time.

(Janet): OK. All right. Thank you.

Operator: Your next question comes from the line of (Roger Arnold) of Group Health Corporation. Your line is open.

(Roger Arnold):   Hi. I've got a question about the query-only file again. I understand that for
                    2011, it will be quarterly as opposed to monthly. If we have two different
                    RREs, could we submit one of them? And basically, could each RRE that we
                    have submitted on the quarterly basis?

Barbara Wright: Yes. The quarterly limitation is by RRE ID.

(Roger Arnold):   OK. That's what I thought I heard. I just want to clarify. Thank you much.

Bill Decker: It's important to remember that again, you can't mix people from one RRE
                    with another RRE so individuals associated with an RRE cannot be submitted
                    at another RRE's file.

(Roger Arnold):   Good clarification. Thank you very much.

Operator: Your next question comes from the line of (Cynthia Martin) of HealthScope
                    Benefits. Your line is open.

(Cynthia Martin):   Yes, hi. I have a question about HRA. It may have actually just got answered
                    but we had some plans that on January 1, then full-year only fund is $800 of
                    the HRA but during the year, the employee may complete an activity and
                    aren't additional HRA dollars which could put them over the $1,000. So my
                    understanding now is that at that point, we would need to report that as an
                    HRA.

Bill Decker: Correct.

(Cynthia Martin):   OK. Thank you very much.

Operator: Your last question comes from (Jenny Lee) of USW Benefit Funds.

(Jenny Lee):   Hello. Thanks for taking my call. My question is about actively employed
                    individual. And we have such case that a participant who is about 40 years
                    old and left the company, so not actually employed, but his remaining balance
                    is over $20,000, but he's now retired. So in this case, do we have to report
                    this participant?

Barbara Wright: Is he a Medicare beneficiary?

(Jenny Lee):   Excuse me?

Barbara Wright: Is he a Medicare beneficiary is your first question.

(Jenny Lee):   Sometimes or sometimes not. He's 40 and some people do have HICN
                    Number but some people do not.

Barbara Wright: Normally, to have Medicare coverage below 65, you've got two choices.

(Jenny Lee):   OK.

Barbara Wright: So they're getting social security disability benefits or they have ESRD.

(Jenny Lee):   Right.

Barbara Wright: One other relatively recent exception is there are people mainly out in the area
                    of – I forgot the exact county but it's out in the area of – it's in Montana. I
                    think it's linked in Montana.

(Jenny Lee):   OK.

Barbara Wright: Some people there have Medicare coverage based on asbestos exposure.

(Jenny Lee):   OK.

Barbara Wright: And so…

Bill Decker: But…

Barbara Wright: That wouldn't affect most of you in this universe.

Bill Decker: Right. Your first cut is, is he a Medicare beneficiary, does the individual have
                    a Medicare Health Insurance Claim Number…

(Jenny Lee):   OK.

Bill Decker: …and if that individual does and fits the other active covered individual
                    reporting parameters then yes, you would be reporting.

(Jenny Lee):   OK. And my second question is we get retiree information from employers, so they send us when somebody was retired. And is that enough to exclude one from the reporting list if we have the retired, because after retire, sometimes they get another job but which we don't know?

Bill Decker: Well, yes, if they are officially retired from the coverage that they had when they were employed…

(Jenny Lee):   OK.

Bill Decker: …by the auto industry firm, I presumed is what you deal with, then they're retired from that coverage that they had. If they get new coverage, we would inspect the new insurer…

(Jenny Lee):   Oh, OK.

Bill Decker: …to report that new coverage. If they stayed retired, that new insurer does not have to report that new coverage.

(Jenny Lee):   Oh, OK. So you would know from out there.

Bill Decker: …the definition of active covered individual.

(Jenny Lee):   OK.

John Albert: Also, see the discussion in our regulations on re-employed….

(Jenny Lee):   OK, OK. Thank you.

Operator: There is one last question in the queue from (Francine Rufo) from Horizon BCBSNJ. Your line is open.

(Francine Rufo): Hi. Thank you for taking my question. Where are we receiving on the (add)? Actually, it's a non-MSP response but I guess it probably, in fact, the MSP response as well.

Incorrect or missing Medicare entitlement information. I had an example where a person has Part B as of February 1, 2010 but on the last non-MSP response file, she came up blank as having no Part B.

We received an inquiry from the member who said, "Yes, I do have Part B," which prompted us to call the COBC who said no, they don't. But then we asked them to check CWS and they did and they say, yes, he does have Part B as of February 1, 2010. My question is are you aware of this situation and is it being investigated?

Pat Ambrose: We're most certainly aware since you appropriately reported it to your EDI representative. I personally don't have any information about it but we'll follow up and…

Bill Decker: When did you do the query? Because we actually just completed a very significant rethink with…

(Francine Rufo): It was just yesterday, as a matter of fact. But I've been hearing it from my girls every once on a while. They'll tell me that when they query basis or they call GHI, they're telling them they don't have Medicare but then when they asked them to check CWS, it's there.

Pat Ambrose: Well…

(Francine Rufo): I don't know.

Pat Ambrose: No, CWS is the system of record…

(Francine Rufo): Exactly.

Pat Ambrose: …for it well. They are system of record for Medicare Secondary Payer, MSP information related to GHP. However, they are not the system of record for Medicare entitlement.

(Francine Rufo): Oh, really. I thought they were.

Pat Ambrose: And we actually – now, of course, they have to have a record of Medicare entitlement so does the COBC but there is a third source that Medicare

beneficiary database, but honestly, I think the official system of record is probably social security.

(Francine Rufo): All right.

Pat Ambrose: So, both COBC and the CWS are getting Medicare entitlement information from the Medicare Beneficiary Database – MBD – and, you know, sometimes, some things can happen but some people reported us. It will be investigated and will get to the bottom of where this out of sync situation could have occurred. But with 45 plus million beneficiaries, you know, there is…

Bill Decker: Forty seven.

Pat Ambrose: Forty seven.

Bill Decker: All right.

Pat Ambrose: There are going to be some discrepancies and…

(Francine Rufo): Yes. I understand that also but I just didn't – I was really was wondering if we were the only one finding it or if there are other insurers that were finding this.

John Albert: This has always been an ongoing issue and, you know, we depend on people pointing this out to us to see what happened because there can be changes that occurred to the CMS data system but have impacts, you know, to COB and other. I mean we basically are supposed to be taking a snapshot of that data (inaudible) in our systems but…

Bill Decker: The updates in there that are real-time.

John Albert: Yes. I mean, you know, the updates aren't always timely. There's just any number of issues. So again, we appreciate when people do discover these situations and, you know, get that to us because we use that to keep on top of what's happening or not happening. And as I've mentioned, we just kind of to do a fairly significant rethink but again, (don't think of) 100 percent correct either so…

Barbara Wright: And there are also situations where the actual processing as the Medicare entitlement claim takes you beyond the effective dates…

(Francine Rufo): Correct, yes, yes.

Barbara Wright: So you've got a little bit of retroactivity showing.

(Francine Rufo): Right, right. OK. All right. Thank you very much.

Bill Decker: Thank you.

John Albert: Thanks for your vigilance.

Operator: And you have another question in the queue from (Martha Sanchez) from Peter C. Foy & Associates. Your line is open.

(Martha Sanchez): Hi. Yes. I have one final question. When we report the active covered employees and their dependents, I guess our initial file, should it only be the ones that are Medicare beneficiaries or should we report all of them and then the CMS will tell us who is Medicare beneficiary?

Pat Ambrose: Well, you have your choice. Are you using the finder file method? Are you using the query file?

(Martha Sanchez): We're not sure yet. I mean I guess it would mean depending on what the answer is. I was told that for the query file, I guess, we couldn't use it but I don't remember the reason why we couldn't use it.

Pat Ambrose: OK. Well, you're not required to use a query file. If you're using the MSP input file, we recommend that to – or you are to submit any one who fits the definition of an active covered individual including, you know, those who might have ESRD, et cetera. And so check out the definition of that.

I mean technically, you're not required to report anyone unless they are Medicare beneficiary but in order to find out, you either have to query or submit them on the MSP input file.

(Martha Sanchez): OK. So regardless, we can either just submit it at the initial file and then CMS will tell who is on – who is Medicare beneficiary?

Pat Ambrose: Yes. On your…

(Martha Sanchez): …or we can do the submission file in the query?

Pat Ambrose: Yes. I mean either way, we check the Medicare status of the individual that you're reporting. We attempt to match them to a Medicare beneficiary whether you're submitting them on a query file or submitting them on the MSP input file.

(Martha Sanchez): OK. So then after we've determined who is Medicare beneficiary, on the next file, do we only submit those individuals or do we still have to submit everything else?

Bill Decker: Well, someone else – someone who could have become a beneficiary in the…

Pat Ambrose: Yes. If you're not using the query method, you really have to send all your active covered individuals…

(Martha Sanchez): Got it.

Pat Ambrose: …every time.

(Martha Sanchez): Every time, OK.

Pat Ambrose: And make sure that you realized that if you send someone under age 45, that, you know, you're sending them because you know them to be a Medicare beneficiary and you need to include their Medicare Health Insurance Claim Number, the HIC Number, on that or else, you'll get an SP 99 back.

And I highly encourage you to take a look at the Computer-Based Training modules in addition to the User Guide on this topic because it will step you through this type of question and give you, you know, good information to answer it to.

(Martha Sanchez): Is this all in the Web site?

Pat Ambrose: Yes. Go out to the Web site. It's the Mandatory Insurer Reporting Web site. You know that URL, www.cms.hhs – I mean cms.gov/mandatoryinsrep. And when you get there, there'll be a series of additional pages or tabs on the left-hand side, and one of those is entitled, "Computer-Based Training" or CBT in parenthesis. And when you go there, you can see how to register for the CBTs and then subsequently, be able to take those CBTS.

Bill Decker: Those CBTs are interactive. They're Web-based and they're free.

(Martha Sanchez): OK.

Pat Ambrose: One note of caution in what you were saying before, when you submit information on someone, what we do is not tell you whether or not they are definitively a Medicare beneficiary. We attempt to match them against our record so our answer is whether or not they've matched against the beneficiary's file. So it's dependent upon the quality of your data.

If you have reason to believe that someone is a Medicare beneficiary and you get an answer of no then you need to be double checking your data. As you've heard during this call, several people have identified an instance where someone actually was a beneficiary and for whatever reason, they weren't getting the correct reply.

Bill Decker: From us.

(Martha Sanchez): OK.

Operator: And there are no more questions in the queue at this time.

John Albert: OK. On behalf of the CMS, we'd like to thank everyone for participating, for good questions. We will try to follow up and respond where we owe people something in terms of additional materials on the Web site.

Please keep attuned to that for future conference calls.

And with that, operator, we'd like to sign off.

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