TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: AUGUST 12, 2009

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

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FTS-HHS HCFA

Moderator: John Albert
August 12, 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 at which time you may press star 1 to ask a question.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

I would now like to turn the call over to John Albert. Thank you sir, you may begin.

John Albert: Good afternoon everyone. Today is Wednesday, August 11, 2009 and this call is for Group Health Plans who are reporting under the Section 111 Mandatory Insurer Reporting Provision.

This call follows the format of the other calls that many of you have already attended and basically we will have a presentation by Ms. Pat Ambrose to go over some updated information, etcetera and we will open it up to a question and answer session.

A couple of things that I wanted to talk about very briefly before I turn it over to Pat. One of the things that CMS has seen some signs of an issue that's raising concerns for CMS is potential inappropriate use of the RRE IDs to access Medicare entitlement data through our phone system.

We've been receiving a high volume of calls soliciting Medicare entitlement information and we remind all RREs on call that whether it's they or any agents that they use, that the processes set for Section 111 are govern under the prime CX and that there are rules that as required under the data use agreement that you signed when your registered regarding the use and disclosure of that information and access to that information. So we will actually be reaching out to some of the RREs directly to confirm that the individuals being inquired about are in fact their customers or enrollees.

So please again, be sure to police yourselves and especially your agents regarding access to Medicare entitlement data through any of the processes because I, you know, this is something that CMS and any federal agency takes very seriously and if it turns out that we were having problems maintaining the confidentiality of beneficiary data because of unauthorized access to it, that would cause us to essentially shutdown access to that data and we don't obviously want to do that.

But again, it's just a friendly reminder to please make sure that, you know, your company and any agents you use are, you know, are using the Section 111 processes appropriately and for the reasons that Section 111 is here, which is to report back MSP data t us.

Other than that, you know, the GHP portion of this has been ongoing for quite awhile now. We actually have a lot of new RRE ID that have never done the data exchange with CMS like some of the old voluntary data share partners and we're happy to report that there are a number of new participants who are reporting data to us. We haven't heard a lot directly in terms of any major issues, but again that's why we have these calls to keep a line of communication open between yourselves and CMS and of contractors.

Again, I've said this in the past calls, if you have issues that you aren't getting satisfactory resolutions to regarding technical support, there is that escalation process in the User Guide that tells you basically if you don't get a response from an EDI department representative timely and about how to escalate that up the chain to make sure that you get the help that you need.

Keep in mind that the EDI department cannot answer more like policy type questions that are more the domain of CMS and those types of questions should continue to be submitted through the resource mailbox at CMS that's on the Mandatory Insurer Reporting Web page.

Again, we look at those every day and catalog them and try to use those questions or issues to improve the materials that we offer.

Also keep in mind that there are also computer based training modules out there available that you can take at any time. Processes are documented on the Mandatory Insurer Reporting Web page on how to enroll and also receive updates when new training courses or updates are made to the existing courses that are out there right now.

Other than that, that was the only thing that I had at this time and I'm going to turn it over to Pat Ambrose who is going to go over some issues that have come up recently and try to answer some questions that have come into the resource mailbox and then we will open it up to a question and only session after her presentation.

Thanks.

Pat Ambrose: Thanks John. First I'll start with some general announcements.

There have been some recent postings to the Section 111 Web site. They can be found at www.cms.hhs.gov/mandatoryinsrep. The reporting do's and don'ts, what page or section of that Web page has been updated with some additional information.

Also on that page we have temporarily posted an alert for GHP and non-GHP RREs related to providing information about your authorized representative and account manager during the registration process.

Another note, if you are developing and using a new form or process to ask a covered individual if they are a Medicare beneficiary, please be sure that includes a request for their Medicare Health Insurance Claim Number or the HICN, often times referred to as the HIC number if that is available and not just the SSN.

The HIC number is Medicare's official identifier for Medicare beneficiaries and is the preferred data element to submit on MSP input files if it's available.

John mentioned the escalation process for problems reported to your EDI representatives. The escalation process can be found in Section 12.2 of the User Guide. Please contact your EDI representative first and then allow them a reasonable amount of time for follow-up. At least a couple of days and then proceed to the escalation process if you need further assistance.

Just a reminder for those who might not have completed registration that during the new registration step on the COB Secure Web site, you must provide authorized representative information and then the account setup step which is the second step performed after you receive your Personal Identification Number or the PIN number, mailed to the authorized

representative, that account setup step must be completed by the account manager.

We've had several requests for changing the e-mail address for the authorized representative, which are actually not appropriate. The authorized representative e-mail address should reflect that individual's personal e-mail address.

We assume that these requests are an attempt to avoid having e-mails go to your authorized representatives. In the last version of the User Guide we listed the e-mails that are generated by the system and sent to the authorized reprehensive and they are quite limited, but it is important that those e-mails be delivered to that actual individual who plays the role of your authorized representative. So please make sure that that e-mail address reflects your authorized representative only.

Some notes on issues with the Section 111 COB Secure Web site. In the recent past there were some problems with files that appear to be uploaded successfully, but they were not showing then subsequently on the COB Secure Web site. These issues have been resolved.

However, if you are still experiencing problems where you submitted a file, but the Web site does not display its status of having received that file at the COBC, then please be sure to contact your EDI representative and report that.

There also was an issue with files that were still in process that had not yet completed and a response file had not yet been created were showing erroneously on the Web site with a response file date of the year 2003.

The file status for those files did show that the file was in process though. The correct response date will display once the file is actually completed and you see that the status of the file shows that that file is completed. This display problem has been corrected for any new file submissions going forward.

We are also addressing some performance issues related to the secure file transfer process and particularly with login IDs that are associated with a large number of RRE IDs.

If you experience problems timing out during the secure FTP attempt, please notify your EDI representative.

Some other notes about the HIPAA Eligibility Wrapper software or the H-E-W software often referred to as the HEW software. Please be sure to obtain the most current version of the HEW software with your - from your...

Please be sure to obtain the most current version of the HEW software there and use that with your Section 111 RRE ID. There were some problems reported with RREs who were formerly DDSA partners using the old version of the software with their new RRE ID. The best way to correct any issues that you've had or problems related to that with the HEW software is to get the most recent version of the HEW software that was developed for Section 111.

In order to obtain a copy of the HEW software, you may login to the COD Secure Web site and download the Windows (unintelligible) Server version or else you may contact your EDI representative or the general ED - CDOP EDI department number to have a copy of that software sent to you.

The mainframe software is not available as a download and you must contact an EDI representative to have the mainframe software sent to you.

If you're using the HEW software, we recommend that you do not change the .ini file, I-N-I files provided with the HEW, particularly the values used for field and record delimiters for the F12 Q70, 271 transaction set.

Another note related to the HEW software is that input files to the HEW software must be MS doc text files, not UNIX based text files at this time. We're looking to add a (unintelligible) query downloads however in the meantime a workaround is to open the file in Wordpad, not Textpad and save the file selecting the MS-DOS text as the file type.

As a follow-up to the previous GHP Town Hall conference call, when a response record is generated for a successful delete, the system does not return - does return the MSP affected and term date related to that MSP occurrence that is being deleted as well as the other Medicare coverage information for the Medicare beneficiary on the response record.

That was a question that was asked during the last conference call which we didn't have an answer to at the time.

So that delete record response record will contain the MSP effective and term dates that were applicable to the MSP occurrence that was being deleted, as well as the other Medicare coverage information on the response record.

Now, I'll go to some of the questions that were submitted to the CMS Section 111 resource mailbox.

There were numerous questions submitted again related to collection of the SSN and HIC number for covered individuals and what to do when an SSN

cannot be or a HIC number cannot be obtained. What to do if an individual - a covered individual does not have an SSN at all.

Please refer to the Section 111 Mandatory Reporting Web site on the URL which I gave earlier and on the What's New page of that Web site you will see on May 26, 2009 Compliance Guidance document regarding the collection of SSN and HIC numbers and the model language that CMS has produced on - for use in that collection.

On the GHP page of the Mandatory Insurance Reporting Web site or Section 111 Web site, you'll also see a compliance document for GHP responsible reporting entities dated December 16, 2008, which gives you some information about what to do or what steps to take in addition while you're trying to collect the SSN and HIC numbers.

Please note that if no SSN or HIC number is available for a covered individual, do not send the record. It will only be rejected with an error code and no record of that submission is retained by the COBC.

If an individual and so what you need to do is obtain the SSN and/or HIC number and submit that record when those data elements are available.

If an individual does not have an SSN at all, they cannot be a Medicare beneficiary and therefore reporting of that individual is not required, RREs are only required to report Medicare beneficiaries on the MSP input file.

Also not the definition of an active covered individual and the age threshold in that definition that's in the User Guide.

Another note related to the SSN and HIC number collection. Please also see Section 7.2.8, the Special GHP Reporting Extension for Dependents regarding when reporting is required for certain dependents whose coverage was affected prior to 1-1-2009 and also note that there is no CMS requirements to terminate a members coverage if they refuse to provide an SSN or HIC number.

Again, the documents on the What's New page provide instruction on what to do in that circumstance.

There were some questions related to the Employer TIN and the use of a Plan Sponsor TIN in the Employer TIN field. We discussed some of these issues during the July 8, 2009 Town Hall meeting. Please note that the current version, Version 2.3 of the GHP User Guide in Section 7.2.2 space, a Plan Sponsor TIN may be used in place of an Employer TIN in the case of a multiple employer/multi-employer plan that uses an hours bank arrangement.

The Plan Sponsor TIN should be entered in Field 21, which is the Employer TIN Field on each of the applicable MSP input file detail record and affected with files processed July 1, 2009 and subsequent corresponding TIN reference file detail records should be submitted with a value of F in the TIN Indicator Field 8.

With the TIN name and address of the plan sponsor provided in Fields 1 through 7 of that TIN reference file.

Several issues related to the use of the Plan Sponsor TIN in the Employer TIN Field still under review at CMS include whether the use of the Plan Sponsor TIN will be expanded to a broader set of multi-employer or multiple employer plans. That has not been determined, so currently the User Guide states that

it's only to use in the case of a multiple employer/multi-employer plan that uses an hours bank arrangement frequently at Taft-Hartley type of arrangement.

Another issue that is still under consideration is whether the Plan Sponsor TIN must be used in those cases or whether that's actually an option.

And then lastly, the situation - a situation that's under review is where an individual common law employer is different than the employer whom the individual receives health benefits. For example the individual who works for Employer A, which is a (unintelligible) Employer B and Employer B provides the GHP coverage.

So again, those issues are still under review at CMS and will provide information or updates on those as soon as possible.

A question was submitted related to the 45-day grace period. Particularly this questioner was stating that they planned to use the finder file or query only file method to first determine active covered individual Medicare status and then subsequently those who are matched Medicare beneficiaries report them on the MSP input file and there was a concern about during the course of that quarter, individuals that become newly enrolled in the plan after the finder file has been submitted and processed, but before the MSP input file has been submitted and processed.

I recommend that you take a look again at Section 7.2.9.6, the Late Submission and Compliance section of the User Guide and also review the applicable CBT, Computer Based Training module related to this.

Probably another way to look at the late submission calculation and this 45-day grace period is to consider that a record is marked late if the effective date submitted on the Add record is more than 135 days older than the start date of the current file submission time frame.

So in an example where perhaps your MSP input file is due on the first day of the first month of each quarter, July 1, October 1 and so on and a members effective date of July1, but you submit that information in your October 1 file, that would less than 135 days prior to the current file submission timeframe and that record would not be flagged as late because July 1 is not 135 days prior to October 1.

So again, please review that section in the User Guide in the CBT and perhaps that will reassure you that you do have adequate time to add these new enrollees in your next quarter file submission without having that record be marked as late.

Another question was asked about what individuals could be included on the query only file, particularly, possibly individuals whose coverage was terminated in the plan. Please note that RREs may include any, any of their covered individuals on the query only file and on the query records in the P file regardless of their actual coverage date and regardless of the reasons for their coverage, whether it's due to current employment or not.

So you may include other individuals aside from those defined as active covered individuals on your query only file and on the query reference of a non-MSP file if you're a expanded submitter.

Another question was submitted related to the compliance flags for the insurer and Employer TIN submitted. If you received a compliance flag for an insurer

employer TIN submitted on the MSP input file in your TIN reference file, but believe that TIN is actually valid, please contact your EDI representative. You will be asked to provide documentation that will demonstrate or prove that the TIN is indeed valid and it will then be added to the COBC database with valid TIN's after that verification has been done.

For COBC only validates the TIN's submitted on the MSP input file. It does not try to match the associated name and address that you provide on your TIN reference file to the sources of TIN validation since that address particularly that you're providing on your TIN reference file should be the address where communications related to Section 111 and coordination of benefits and subsequent recovery efforts should be directed and that address is not necessarily the address associated to the TIN by the IRS.

So during the processing of your MSP input files and TIN reference files, the TIN's are only the actual TIN field is being validated.

Some additional questions were submitted related to MSP occurrences that are or rather GHP coverage that reflect a period of time of less than 30 days. As we stated in the User Guide, we are not able to post MSP occurrences to the common working file, Medicare's CW Web file that are less than 30 days.

If you send an ad or an update record that reflects a period of time less 30 days, you will receive an SP32 error code back and the record will actually be rejected.

This is a CWS edit that can't be controlled by the COBC and because the CWS will not accept MSP occurrences of less than 30 days. That record will actually be rejected.

The question goes on to ask if a new member gains and loses coverage in a span of time that's less than 30 days, should we not even bother to send an Add record for individuals and that is actually a correct action to take if you know that the effective and end dates of the GHP coverage are less than 30 days apart, do not send the record since we are not able to process that record.

Another related question went on to ask what to do in the case that the coverage - the GHP coverage changes in less than 30 days, but coverage continues, you must send one update record. So what should we do if coverage does not continue?

So in this example, they were saying the month to month member previously accepted by the COBC and CMS and the record was returned with (unintelligible) but then there were changes from family to single GHP coverage type, but then also at the same time at the end of that same month they termed their coverage, what is the expect transaction?

You have no choice but to delete the record if it was previously accepted with an open ended term date or a term date that reflected more than 30 days prior, but now your update would reflect less than 30 days and if indeed that coverage has been terminated there's not real choice other than actually deleting that record.

There were some discussion on the last GHP conference call about foreign employer addresses, particularly in one scenario Canadian employers who employee US citizens that work in the US, who have coverage under a US based group health plan insurer. CMS, this issue is still under review by CMS. There are several things that we are trying to work out related to what address should be submitted for the employer and also the various scenarios about what situations are actually reportable in those cases.

So again, that's something that is still under review and we'll get back to you as soon as possible with information regarding that.

A question was asked about test files that are submitted by various RREs that happen to have the same SSN's or HIC numbers submitted on them. I think the conditions here might be a case where there is several TPA's involved with group health plans for particular employees or TPA's that are being used by an insurer.

To answer the specific question, saying that is there a problem if multiple RREs submit test files with the same SSN or HIC numbers. There is no issue with test files being submitted by different RREs that happen to have the same Social Security Numbers or HIC numbers.

Do make sure that in this scenario you have determined accurately who are the RREs and who should report in these cases. Technically there should be no overlap of reporting of the same GHP coverage, but it is conceivable that people have multiple- are covered under multiple plans and will be reported by multiple RREs and that's a perfectly acceptable situation in both test and production.

A question was submitted about how future changes to Section 111 reporting, both technical requirements and policy changes, how those will continued to be communicated.

They will continue to be communicated in the way that they are done now. All Section 111 updates will be published on the CMS Section 111 Mandatory Insurance Reporting Web page and as you know that provides an automatic notification if you sign up for that, you will get an e-mail when that Web site,

anything that has been posted to that Web site and information is also posted on the What's New page. Even though you do get notification, we encourage you to go out to that Web site in the What's New page on a frequent basis looking for updates.

RREs will receive at least 90 days notice, but usually 180 days notice or six months of any significant changes that would affect your coding per Section 111 Reporting.

So, don't expect any, you know, sudden changes of which you would need to comply in less than six months usually six months.

Someone pointed out that the registration application on Section 111 COB Secure Web site only allows for a four digit telephone extension and many people have five digit telephone extensions. These are optional fields and so don't bother filling out the phone extension if it's more than four digits and you are not able to submit that information on the Web page.

A question was asked about an employer that has both employees in the US and employees overseas and would the overseas employees count toward the total employee count and yes, see the User Guide Section 7.2.7 which states employers size must be based on the size of the entire company or corporation, not just the subsidiary and when calculating the number of employees, RREs should use the total number of employees in an organizational structure of the parent subsidiaries and siblings rather than just the number of employees in a particular subsidiary being reported on. It goes on to say that subsidiaries of foreign companies must count the number of employees of the organization worldwide.

So again, that document is in Section 7.2.7.

There was a question submitted about a group health plan that covers inmates that are being transferred but get hurt between facilities. The questioner stated that there is no employer/employee relationship. These individuals are not covered due to current employment status, so they are not considered active covered individuals and therefore are not to be recorded on your MSP input file.

I personally can't state whether that plan would be defined by CMS as an actual GHP, but I - we can state that those individuals would not be active covered individuals.

John Albert: Those individuals - the injuries would not be covered the Medicare because they would be considered in custody which is an exclusion under 1862A.

Pat Ambrose: Okay. There you have it.

Another question came in stating that an RRE has an employer group that gave them a tax exempt code and not the employer group TIN and can we accept a tax exempt code, which is not formatted like a tax identification number and the answer to that is that no we can only accept actual IRS assigned tax identification numbers in the employer TIN field.

John Albert: If there's an issue between a non-taxable entity and an employer EIN give us the EIN.

Pat Ambrose: Okay. There was a question submitted related to changes in the Relationship Code field which is Field 12 on the MSP input file and as you know this is defined as a key field for MSP occurrences.

The particular RRE is not currently - does not currently capture the date of the relationship code actually changes and so the question went on to ask how to submit these changes.

You really need to start capturing the date of the change to the relationship code in order MSP occurrences to be created accurately and result in proper payment by the GHP and Medicare since that's a key field in determining MSP in most cases.

Just sending a delete record followed by an add record with the new information would result in simply a complete replacement of the original MSP occurrences and again could result in improper claim payments. Sending an update record with the new value without deleting the original record would just create a overlapping or duplicate, not really duplicate, but would create a new MSP occurrences since it's a key field and so there would be two overlapping occurrences with different patient relationship and that is not accurate either.

So the only recommendation I have is that the RRE make a change to their system to start capturing that date that the relationship (unintelligible).

Another question was submitted about a situation related to scenarios given in the event table, but does not seem to be exactly covered and this has to do with gap, recorded gaps in coverage.

So in this example, a covered individual is covered by the GHP for January and February and then not covered for March and April, but then becomes covered again in May, June and July and this could happen in those hours bank and Taft-Hartley scenarios.

Then, so the RRE has submitted two records. One for the January through February, an effective date of January 1 and a termination date of February 28 and then submitted a second record with an effective date of May 1 and a termination date of July 31.

Then prior to creating their next quarterly file submission they discover that the individual actually was covered during that gap of March and April and they were asking what the proper approach would be to take.

So currently we have two MSP occurrences with different dates and that gap in between them, but really what the scenario is, is that the individual is covered from January through July continuously.

So assuming that the coverage is exactly the same, for all these time periods, the RRE should submit an update for the first period that was beginning in January and extend that occurrence through to termination date. So send a new termination date and that original first record will become then January through July 31 and then send a delete for the coverage that has started on May 1.

And so again, what you're trying to do is end up with just one MSP occurrence for this individual reflecting January through July. So update the first one for July through - January through July and delete the second one as that just shows a duplicate time period.

Again, that assumes that the coverage is actually the same.

Another question was submitted related to an employer that has a self administered executive medical reimbursement plan that covers very few employees and no dependents. And the question is really whether they need to

register as an RRE and report if none of these individuals are Medicare beneficiaries.

The question included a possibility of using the finder file approach, however in order to use the finder file or the query only file, you must register in order to obtain an RRE ID in order to submit that file.

So, that said, you have - if you go ahead and register as an RRE and use the finder file, then of course we're going to expect a quarterly file submission even if you have nothing to report and you'll be submitting that empty file over and over again.

However, if you can confirm that the covered individuals are not Medicare beneficiaries by some means other than the finder file, then the RRE does not need to register until they expect to have something to report. Note that you need to continue to monitor those covered individuals and their Medicare status.

See the a note at the end of Section 7.1.6.1 of the User Guide, which talks about RREs that may have nothing to report and therefore have no need to register until such time they do.

Another question, I'm going to read this one. It says sometimes we are not aware that a group number is disabled and eligible for Medicare until several months or years after the fact. What date should we use as the effective date in this situation, should the effective date be recorded as the date we discovered the member is Medicare eligible or the date the member is actually - the member actually became eligible for Medicare.

I want to be sure to stress that the date you submit on the MSP input file is the effective date of the actual GHP coverage. When you are submitting your MSP input files, you are not submitting Medicare entitlement or eligibility date, you are submitting a GHP effective and termination dates on that MSP input file.

So, RREs do not report on Medicare effective dates, they report on the GHP coverage effective dates. The COBC will determine when the individual became covered by Medicare and it will use your GHP effective and termination dates as well as Medicare coverage dates to determine the effective date for any application MSP occurrences.

Another question goes on to ask about some possible duplication of reporting and it's a case that we have talked about on previous calls and is documented in the User Guide, where you have a GHP and an RRE who is going to report that main medical (unintelligible) GHP coverage, but there are certain PPA's that process claims for particular specific coverage's sometimes referred to as carve out coverage's including dental, vision, mental health, chiropractic services.

Again, this was covered on previous calls. The PPA providing claim services for dental, vision, mental health, chiropractic services that are not covered by Medicare, does not register and report as a separate RRE. So, there should be theoretically no duplication of reporting. Please see the note at the end of Section 7.1.6.1 and notes on this in Section 7.2.7 of the User Guide.

One last question was submitted about whether the COBC or CMS notifies a Medicare beneficiary that a GHP MSP occurrence has been posted and the answer to that is no. We do post those MSP occurrences and begin basing

Medicare claims payments on those looking for Medicare to pay secondary to the GHP coverage reflected in the MSP occurrences.

(Unintelligible) that information ultimately goes back to the provider and the Medicare beneficiary under explanation of benefits statements that claims that there is primary insurance and the claim needs to be submitted to that first and Medicare would pay secondary and so on. If a Medicare beneficiary has an issue with the MSP occurrence and the primacy payment by Medicare versus the GHP, they very frequently contact the COBC, who then handles that situation directly with the Medicare beneficiary and may need to follow up with the RRE.

So with that I will turn it over to John again and we'll proceed to the question and answer session.

John Albert: Thanks Pat. Just a couple of more points I thought of while Pat was speaking and that is I just wanted to let everyone know that you probably noticed from time to time that documents - you will get notifications via the list service regarding new documents and there are on occasion where the documents aren't necessarily where you would expect them to be and that is because of ongoing issues we have regarding limitations with Internet postings through he CMS Web service.

You know, the main thing is, is continue to check the What's New page in particular, as well as the GHP tab. There are occasions where we will have to put a document temporarily under one and then eventually move it hopefully to the GHP tab itself if it's truly related to GHP reporting.

So, again when you receive that notice, we recognize that it's sometimes difficult to determine where that new document or update was initially, but

that is - we want to get the information out as quickly as possible and then basically move it to the appropriate tabs as we can.

But please have patience on that respect. That's something the unfortunately that is out of our control and with there being so much new information going out to that Web page for both the GHP as well as the (unintelligible) health plan tabs, we sometimes have to shuffle stuff around just to get it out there as quickly as possible.

But either way, if you're getting a notification on the list server, that means there is something that's been posted. Occasionally the notice, the notice about the new document may actually beat the document itself.

They go into a large queue and occasionally the list server will talk about a new thing and the document might be delayed by a day or two. We've seen that happen a couple of times. So if you don't find it, just check back in, in a day or two and look for it. But again, that notification is what you should be looking for to determine whether something is new out there or should be out there shortly.

Some questions still continue to come in and I'll just make again a general statement that I made in the past regarding questions about compliance and I will stress that, you know, CMS doesn't haven't, you know, much out on the Web page right now regarding compliance other than the at risk.

But the main at risk document - what the main thing is, is to follow the procedures in the User Guide and report timely. If you demonstrate that you are making that effort, that's what CMS is looking for. We're much more interested in working with you to improve the process and get everybody up

and running on the reporting as well as receiving the response information from CMS than we are in CMP's.

So, just because I know someone will ask the question, we don't have any additional materials at this time regarding compliance. The main thing again is concentrate on improving your data exchange process with CMS and that's what we're looking for in terms of compliance.

So, I wouldn't even bother asking about those other questions because we don't have an answer for you on that because we are also focused primarily on building and getting the data exchange up and running.

And other than that operator, I guess we could turn it over for Q&A's. We'll probably address a couple of questions that were submitted as well, will probably come up by (unintelligible).

Operator?

Coordinator: As a reminder, if you do have a question please press star 1 at this time. Again that's star 1 for any questions and we do have a couple of questions that queued up earlier.

Our first question will come (Carol Leachman). Your line is open.

(Carol Leachman): Thank you.

On the Invalid TIN error, you said that we would need to prove that it was a valid TIN, how are we going to do that?

Pat Ambrose: I forget the actual document off the top of my head. There is an IRS tax related document that could be submitted if you have access to that. Other than that, I'm not sure. I don't think that it's anything to burdensome, but you know obviously we need something that would demonstrate that that is a valid TIN rather than just some number or that it wasn't mis-keyed.

But I'm afraid I don't have it in front of me as to what they will ask for, but we can follow up and get back to you on that.

(Carol Leachman): Okay and if it is an IRS document that we have to obtain from our employer group to prove that we need to have that put in the User Guide so that we can go to the employer group and say this is the document and here's the proof that you've got to give us this document.

Pat Ambrose: Yes. Understood.

(Carol Leachman): Thank you.

Coordinator: Our next question will come from John Downey. Your line is open.

John Downey: Good afternoon. Thank you.

I'm going to press the envelope here. I have two questions and a request for a clarification.

The most recent do's and don'ts list as posted had a three bullet point code for deletion, effective date, insurance coverage type and patient relationship. The GHP User Guide 2.3, page 51 also includes HICN and SSN. Which is correct?

Pat Ambrose: The HICN and SSN are part of the key and you would use a delete/add in that case of changing the HICN and SSN. But the change to the HICN SSN really only has to do with you've reported the wrong person entirely.

John Downey: Okay.

Pat Ambrose: And essentially you're deleting that record because you should never have reported that person and then if there is another person that you should have reported instead or in lieu of that person, then you're sending an add. So we'll take a look at that again and see if we can add further clarification to it.

John Downey: Thanks Pat. Now then for my two questions, getting a request from some of our marketing folks and sales folks, are there any instances in which the RRE would not be primary over Medicare for working-(ageds) for those employers and/or associations that have greater than 20 employees.

John Albert: Not that I'm aware of.

John Downey: Thank you, thank you. And can individual employers participating in associations, and I know our guidance is still with CMS on this, use individual employer size other than any method posted in filing a (SEE)?

John Albert: The statute is very clear that it is -- and I'm assuming you're talking about working aged?

John Downey: Yes.

John Albert: If any employer in the group has TIN to multiple or multi-employer plan has at least 20 employees, Medicare is secondary until and unless a small employer exception request has been submitted and approved by the COBC.

So you need to report it -- and I don't have the user guide in front of me -- unless there's a (SEE) I would report it as everybody's got over 20.

John Downey: Got you. I hear you loud and clear. And we'll pass that up the line. Thank you for your attention.

John Albert: Thank you.

Coordinator: Our next question will come from (Katherine Keifer). Your line is open.

(Katherine Keifer): Hi. I have a question regarding (basis). We sent in the application for that I believe is was on June 8 and have not received anything back yet. I have spoken a number of times to my EDI rep and he said that it goes through some sort of review process before you get your packet of information. How long is that taking?

John Albert: I assume that you've registered for Section 111 reporting and you're just following up with the (basis) request?

(Katherine Keifer): That's correct.

John Albert: All right. We're going to have to -- who is your -- what's your RRE ID?

(Katherine Keifer): 10509.

John Albert: 10509. And are you listed as a contact?

(Katherine Keifer): I'm the account manager.

John Albert: Okay. 10509. Okay, we'll check on that. It's one the things that we're trying to add to, you know, like maybe on the next version of the user guide or some of those type of expectation timeframes so that, you know -- you should have received something by now for sure.

But one thing that we're trying to do as a result of some questions that have come in is to put out more timeframes to like set expectations in terms of what turnaround should be for certain steps of the process. But in the meantime we will follow up on this one.

And hopefully the contractor is actually on the call and heard that contract number and can look into it as we speak. So thank you for bringing that to our attention. Did you bump it up to the next levels when you were -- when you didn't get what you were looking for?

(Katherine Keifer): No because I didn't consider that EDI.

John Albert: Okay. Okay.

(Katherine Keifer): I certainly can send an email up the line if you'd like me to.

John Albert: Yes, I mean, you don't need to do it now but I just -- in the future that if you're not able to get that response or, you know, because you have to get a response and if you don't, and this is anyone on the call, you know, it's one thing that, you know, maybe it's the response you don't want to hear, but if you basically just are not getting an answer, please refer that up the line in the future. But we'll take this and we'll be in touch with you very shortly.

(Katherine Keifer): Thank you so much.

John Albert: All right. Thank you.

Coordinator: Our next question will come from (Sharon Clayton). Your line is open.

(Sharon Clayton): Hi. I have a couple questions for you. The first one is in regards to the group health plan effective dates that we're sending on the MSP file. We were actually electing to use the MSP effective and term dates just for the fact that if we were using our group health plan effective date we could actually sometimes be sending you dates when there wasn't an MSP occurrence. Is that a problem?

John Albert: Well what do you mean there was not MSP occurrence?

(Sharon Clayton): They may be -- maybe there was a situation that should have actually been, and I know it doesn't happen often, but maybe Med was prime at that point. Yes, like in your ESRD situation. So we don't really want to send our group health plan effective date because that could maybe give you wrong information. So what we're actually doing is giving you the first date that the MSP is effective.

John Albert: Okay. Can you hold on for just a second?

(Sharon Clayton): Sure.

John Albert: Hi. We're back. I mean the straight answer is that it really -- you should be reporting the date when they were an active covered individual essentially. You know, there's a lot of different scenarios where Medicare is primary versus secondary or changes. But in those cases those would probably be separate records being submitted anyway.

(Sharon Clayton): You know...

John Albert: The risk obviously is if you're trying to make a determination as to when Medicare is secondary, you may be wrong because you don't have all the complete information.

If you provide unique records of coverage to CMS as defined, you know, what an active covered individual is, that will be enough information for CMS to determine based on the various reasons for entitlement as well as the data provided such as employer size, et cetera, when there is an MSP period. So we ask that you submit, you know, the coverage beginning as when they were defined as an active covered individual.

(Sharon Clayton): How would that work then in a case where an employer changes its size. So his group...

John Albert: You would report a separate record. Because if the employer's size changed and they were 20 or more, that would be the first record. And then maybe -- but maybe they're not found as entitled due to age, it's because of disability but when, you know, the 100 or more rule kicks in, you would report then. And then we would build a coverage record based on when that 100 or more threshold was met.

(Sharon Clayton): And that's going by the fact that they're large for each scenario. But if that scenario was where they're going from a large employer where it is actually Med secondary to a Med prime or vise versa, you know, they went from the small to a large, if I send you my group health plan effective date, I'm going to be showing...

John Albert: But you would report that record when they actually achieve that -- you know, and I won't get into the legal aspects but when that 20 or more rule kicked into effect that would be the start date of the coverage.

(Sharon Clayton): Okay. And then that's where I was questioning because...

((Crosstalk))

(Sharon Clayton): ...is our group health plan is truly effective for years.

John Albert: Yes. I think I know -- we think we know what you're getting at and we understand but that's why we have that level of detail at the record level because obviously the employer's size is, you know, one of the fields that we look at to determine whether or not there is MSP or not. And depending on why they're entitled to Medicare will determine whether there is MSP is not as well as any of the other, you know...

(Bill Davoyna): Pardon me. Remember you have to use the regulatory counting rules. For example, there's 20 employees for at least 20 weeks in this calendar year, toward the end of the year the employer size drops to 15 and remains 15 in 2010, you would not report a drop below 20 until the effective date of January 1, 2011 because of the way the regulations and statue is structured.

John Albert: And we did receive a number of questions on employer size and I think that as a result of that we're going to try to provide more pointers to information that will help you with that.

But I mean the size rule for working age has been around since long before I started in CMS and it hasn't changed and the legislation doesn't change the MSP statue at all. But we'll see if we can, just based on the number of

questions we received, if we can put together or find some better information out there to point you to -- to help you with making that determination.

Pat Ambrose: I'd also like to point you to the event table that was added to the last version of the user guide and the scenarios of where you're making updates or changes to key field information and also below that to changing other fields that are critical to determination of MSP including that employer size and the instructions that it's giving you in terms of sending update and add records to reflect that change.

But I'll take it as an action to then try to add further clarification in the user guide related to, you know, the effective date and exactly what should be reported in that effective date.

John Albert: Just keep in mind that the user guide is not intended to be an MSP policy document. It is there for purposes of setting up the reporting process for Section 111.

So we would not make, you know, the user guide a primary source of, you know, MSP policy information but we will try to provide, you know, updates or clarifications where we can without overstepping that boundary because again, we don't want this document to be construed as some type of official payments policy document relating to MSP itself.

(Sharon Clayton): Okay. So just one clarification then. If I have a member who has been enrolled with our company and the same employer since January of 2000, has had Medicare since January of 2000, their group did not become large until this past year. You're saying that if I send to you from January of 2000 until the time that they became a large group, you're not going to put that as a Medicare secondary record?

Pat Ambrose: That's correct if you provide the proper information in the employer size field.

John Albert: If they were less than 20 and the reason that we determine they were entitled was due to age, then we would not build an MSP record for that individual if the entitlement was solely due to age.

(Sharon Clayton): Okay.

John Albert: Then you would submit a separate record for when they actually did exceed that threshold.

Pat Ambrose: The user guide also does state that, you know, for cases of less than 20 and, you know, don't quote me here. I know I'm being transcribed. But, you know, it does talk about when reporting is required and not in that -- in the case of an employer with less than 20 employees.

But the system is -- the COB system will take that employer size field into account and while it's determining whether an MSP occurrence should be created. So if you provide the proper information in that employer size field and the appropriate effective and termination dates for changes in that employer size field, you should be good to go.

John Albert: And remember where it's a multi-employer group health plan, you use the size of the largest employer in the group when reporting.

(Sharon Clayton): Right. And I know our issue is just that we will get too many error codes coming back on our files. And that has happened with a couple of other plans. Because when we're doing that, then you get an error back for that record that's not truly MSP and then you're hitting your threshold limit.

John Albert: Well, that's okay. I mean those thresholds are not meant to be some type of penalty. They're just meant to be a check for us and for you to help us identify potential issues. That's all. Don't read anything for into it.

That threshold is merely a safety valve for CMS to reach out to participants to make sure that they're doing it correctly and obviously there are going to be times when the thresholds would be legitimately exceeded.

But, you know, it's just a way to kind of check over time, like if you see the same group over and over again submitting certain errors at a high level, it's an opportunity for us to reach out and make sure that, you know, they don't have some issues that we could help them with.

Sometimes they're legitimate but that's all. They're not meant to be any type of threat or anything like that. They're mainly tools to help us monitor the process and to help you as well.

(Sharon Clayton): Okay. Thank you.

Coordinator: Our next question in queue will come from (Seenet Tonvy). Your line is open.

(Seenet Tonvy): Hi. I have a couple of questions. I've been trying -- I went online and tried to look for the HEW wrapper application, the download for that. Can you provide me with that direct link?

Pat Ambrose: Yes. You need to go to www.section111.cms.hhs.gov. That's the Section 111 COB secure Web site.

(Seenet Tonvy): I'm sorry. Section 11.cms....

Pat Ambrose: hhs.gov

(Seenet Tonvy): hhs.gov. Okay.

Pat Ambrose: Yes. Now you need to have registered and be a user.

(Seenet Tonvy): Right. We are.

Pat Ambrose: Okay. And so a user needs to log in to the Web site and then on the menu options once you've logged in, you'll see how to go about downloading it.

(Seenet Tonvy): Okay.

Pat Ambrose: So yes, it's on the COB secure Web site rather than on the CMS's Web site with the mandatory insurer reporting information for Section 111.

John Albert: And just to make sure, you said it's Section 111 not 11.

(Seenet Tonvy): Right. 111. Okay. And the second question has to do with the Query File 270, 271. In (Loop) 2000Z in the name segment, CMS is requesting that we send the RRE. But according the HIPAA guidelines that field was used on NPI.

So our Level 1, Level 2 validation on our system it will fail if we send the file using the RRE. So my question is how -- is that the value that CMS is expecting? And how are other -- what are other companies doing to bypass that validation?

Pat Ambrose: Were you saying the NPI, National Provider Identifier?

(Seenet Tonvy): Right.

Pat Ambrose: You know, we don't actual collect the National Provider Identifier in our X12 270, 271 transaction set.

John Albert: I think they're just using that as a way to put that RRE ID because there's nothing in the transaction set called RRE ID?

(Seenet Tonvy): Right. But in the HIPAA guideline what it's saying is those fields are used for like the value on NM108 that's -- the value is PI for provider information, but what -- according the HIPAA standard it's supposed to be XX for NPI and the value below that, the 109 is supposed to be the NPI and not no other value. It's supposed to be a ten-digit NPI number.

Pat Ambrose: We don't really have the appropriate people in the room here to get down into that level of detail. So could you please report that issue through your EDI representative and we'll take a look at it.

(Seenet Tonvy): Okay.

John Albert: What's your RRE ID?

(Seenet Tonvy): It's 11357, with four leading 0s.

Pat Ambrose: Okay. Thank you.

(Seenet Tonvy): Thank you.

Coordinator: Our next question in queue comes from (Rich Walker). Your line is open.

(Rich Walker): I can't see even if they want to do...

((Crosstalk))

Coordinator: Excuse me, (Rich Walker), your line is now open.

(Rich Walker): Yes, I got actually one question with two parts that may seem disconnected. But employer size, need clarification. You may have touched on this in your intro comments but we have a handful of clients, I'm sure other PPAs do as well that have several affiliated companies and they all come together under one plan and we administrate that plan. And we've handled that a couple different ways in our system.

The one client in particular is -- we cover Companies A and B and Company B is a joint venture between Company A and Company C. We do nothing with Company C. Company A is responsible for providing medical benefits for Company B as the joint venture.

Per MSP rules, how should these be reported in the TIN reference file? These Companies A and B both have separate TINs. Company A is 6 employees; Company B is 66. What category on the employer size should they be listed?

(Bill Davoyna): You said one's got 6 and one's got 66 or something?

(Rich Walker): Yes, sir.

(Bill Davoyna): Okay. They have clearly more than 20. I would say that the employees in C are affiliated with A in an ongoing business relationship, so they have current employment status with A. And you said A is the one that's providing the

group health plan coverage, so you would add together the two and use the TIN for A.

(Rich Walker): Okay. That's what we've been doing. But I'm glad to hear that. Okay. Another question. And I think you did touch on this earlier but in the TIN reference file, we're providing the address for the employer group, the description on the field is that you'll use that address for correspondence, et cetera. It seems like you said in a previous call that correspondence will be sent both to the employer and the payer, is that correct?

(Bill Davoyna): I think the (demand) is addressed to the employer and a copy is sent to the claims processor.

(Rich Walker): Okay. An exact copy?

(Bill Davoyna): When you say you're reporting not the employer's address but the address of the plan?

(Rich Walker): No, we're reporting the employer's address under the employer's row and we're reporting our address under our row for the payer.

(Bill Davoyna): That's fine. That's correct.

(Rich Walker): Okay. Well that will do it. Thank you.

Coordinator: Our next question will come from (Barbara Main). Your line is open.

(Barbara Main): Hi. I was just had my question on the query-only response file. And we were wondering if at some point down the road that people filing under the basic reporting option would be getting any Part D information.

John Albert: No. We are bound to only release information where applicable. And if you're only reporting hospital medical coverage, we can't release any Part D entitlement data because it's outside the scope of your reporting. If you report -- sign up for the expanded report prescription drug data, we'll provide Part D information.

Pat Ambrose: I need to add a minor clarification. Currently for both basic and expanded, the query-only response file does not provide Part D information and we are working to add that at a later date. So for expanded reporters to submit the non-MSP file, they will get back Part D enrollment entitlement information.

(Barbara Main): Okay.

Pat Ambrose: Okay.

(Barbara Main): Thank you very much.

Coordinator: Our next question in queue will be from (Bo Erbansfa). Your line is open

(Jim Erbansfa): Hi. Actually it's (Jim). Pat and John, we're at GHP as the result of a collectively bargained (unintelligible) trust fund. And we're primary for our working-aged individuals. But often times we get a request for Medicare to be primary.

And the CMS Web site indicates that Medicare beneficiaries are free to reject the employer plan coverage. I'm verifying that information and asking what documentation will we need other than a participant's letter requesting to be dropped from coverage?

John Albert: If they're dropped from coverage, you're not providing coverage at all, correct? You cannot provide coverage that's supplemental to Medicare.

(Jim Erbansfa): No.

John Albert: You'll in essence be providing no coverage.

(Jim Erbansfa): Correct.

John Albert: So you would not have a reporting requirement under Section 111.

(Jim Erbansfa): But under the collective bargaining agreement, the contributing employer would still be required to pay on that individual. Does that matter at all?

John Albert: That gets to me a rather interesting complicating factor. It could be argued that that's taking Medicare into account which it's another set of issues. Send an email to the Section 111 report indicating that it was a policy-related issue and I'll ask the monitor to forward that to me.

(Jim Erbansfa): Thanks.

John Albert: Yes, just mention today's call in like the subject line and include your contact information.

(Jim Erbansfa): Okay. Thank you.

Coordinator: Our next question in queue will come from (Denise Stillwell). Your line is open.

(Denise Stillwell): Yes, I'd like some clarification on the employer group size changes when we report on that. I guess I'm a little bit confused on the actual effective date we need to send.

So if we have a group that originally has 25 employees so they fall above the less than 20 threshold, but they fall below, let's say they fall below, they have 15 employees. So do we report -- say they get 15 employees starting 1/1/2010 but our plan would remain primary for the remainder of 2010 and 2011, would that be correct?

John Albert: Okay. When -- now you said they had less than 20 on January 1, 2010.

(Denise Stillwell): Right.

John Albert: That means they had more than 20 in 2009.

(Denise Stillwell): Right.

((Crosstalk))

John Albert: ...be primary for 2009 and 2010 not for 2011.

(Denise Stillwell): Okay. So if...

John Albert: It (unintelligible) preceding year.

(Denise Stillwell): Okay. So the effective date we would send to you saying that you guys, that we're secondary would be...

John Albert: Well no, you're not reporting to use when they're secondary. You wouldn't be re -- in that case if they had never been above, you wouldn't report them. But in this case the effective date on this example where they had more than 20 in 2009 and say their coverage started in January 2009, that would be the effective date of the MSP coverage or the effective date...

((Crosstalk))

(Bill Davoyna): Now if they started with you January 1, 2010, but they had the 20 in 2009 but in 2010 had the fewer than 20, you would still need to report it as more than 20 under the counting rules.

John Albert: Yes.

(Denise Stillwell): Okay. So if it was -- if they had 20 in 2009 and then in 2010 it was below...

(Bill Davoyna): You would still report it as over 20 for 2010.

(Denise Stillwell): Okay.

(Bill Davoyna): Because remember the rule is at least 20 employees for 20 or more calendar weeks in the current or preceding year.

(Denise Stillwell): Okay, right. Okay. So then I guess where I'm confused is if the change occurs on the first of the year, do we send like a 1/1/2010 date or do we send -- do we calculate it out and send 1/1/2011.

(Bill Davoyna): I'm not...

(Denise Stillwell): Do you understand where I'm...

(Bill Davoyna): I know what you're saying. I don't remember exactly how the non-group health -- the group health plan guide says to report numbers. But bottom line is you're primary through 2010.

(Denise Stillwell): Right.

Pat Ambrose: You can't report a future effective date.

(Denise Stillwell): Okay.

((Crosstalk))

Pat Ambrose: You may report a future term date but you cannot report a future effective date. So you would have to wait until that effective date rolls around for the change and report it.

(Bill Davoyna): Right. And I wouldn't try to report the 2011 term date because they could go back up above 20 for 20 weeks in 2010.

(Denise Stillwell): Right. Okay. I'm still confused but I'll figure it out. Thank you.

(Bill Davoyna): If you could, send a detailed example to the mailbox.

(Denise Stillwell): Okay.

Pat Ambrose: And we'll take it under advisement to add some examples to the user guide and the CBTs.

(Denise Stillwell): Okay. Thank you very much.

Coordinator: I currently have just one more question in queue. Again as a reminder that is star 1 for any questions. Our last question currently in queue comes from (Steven Ross). Your line is open.

(Peter Massina): Actually this is (Peter Massina). I just wanted to just offer just an answer to one of the questions that came up earlier on a 270, 271 question. Inside of that (ANOM) 108 field there's actually two values. One of them I believe is (add vac) for NPI and the other one is VZ, which is universal qualifier.

You can use that for all non-PCP provider requests stated in the front of the book. It's kind of buried depending on your version. So it does let you submit that and it will pass compliance through our general (mat) managers pretty much.

Pat Ambrose: Thank you very, very much for that.

(Peter Massina): Yes.

Coordinator: And we do have a couple more questions that queued up. Our next question will come from (Paul Smith). Your line is open.

(Paul Smith): Yes, I just wanted to have a follow-up question with the HEW software. We too have experienced running the 270 through our (30-I) which is our compliancy checker and it does fail for other reasons. And so again just follow up in terms of compliancy from HIPAA we do see some issues that are coming up and would like to get some guidance around that.

Pat Ambrose: Okay. Those have -- I did see that you submitted I believe that question to the resource mailbox. What we need you to do is provide the details of what fails

and what, you know, appears to be non-compliant. We haven't had this report as of yet.

And what would be most expedient is if you could send those to your EDI representative and we'll handle it through that channel although you're welcome to send it to the resource mailbox as well. But I think that would be to your EDI representative with exactly what you believe is not compliant and we'll take care of it.

(Paul Smith): Okay. So, based on your comment then, it sounds like the objective is that these transactions would be compliant.

Pat Ambrose: As far as I know, yes.

(Paul Smith): Okay, thank you.

John Albert: Do you mind giving us your RRE ID?

Woman: We don't have it handy but we'll submit another question.

John Albert: Yes, just send it to your EDI rep.

Woman: We did actually submit a question to our EDI rep about this and we haven't heard anything back. It's about a week, week and a half ago. So we'll submit another one. Thanks.

Coordinator: Our last question currently in queue comes from (Cassandra Olson). Your line is open.

(Cassandra Olson): Hi Pat and John. (Cassandra Olson) with Blue Cross Blue Shield of Florida. Just looking for some clarification. First when will the transcript for this call come out? Do you know?

Pat Ambrose: It takes approximately two weeks.

(Cassandra Olson): Okay.

Pat Ambrose: And that gets posted to the Section -- CMS Web site, Section 111 page.

(Cassandra Olson): Right. And unfortunately I dropped out of shorthand in high school so I missed a couple of things. The report -- who reports the Medicare dates? Is that done by the COBC?

Pat Ambrose: I'm not quite sure I understand your question.

(Cassandra Olson): Earlier in the call there was a question about...

Pat Ambrose: Are you referring to what effective date you should be submitting?

(Cassandra Olson): Well we don't report Medicare effective dates...

((Crosstalk))

Pat Ambrose: That's right. That's right. It's up to the COBC and CMS to determine the dates of Medicare coverage.

(Cassandra Olson): Right.

Pat Ambrose: You are to report your GHP coverage effective dates. And the discussion went on to talk about changes to certain key information such as employer size.

(Cassandra Olson): Right.

Pat Ambrose: And so you might report an original GHP coverage effective date and then the employer size changes and according to all those rules about when that change becomes effective, you would report a termination date for the original record and an add record...

(Cassandra Olson): Right.

Pat Ambrose: ...with a perspective date of when that change is to take place.

(Cassandra Olson): Right. I got all that. I just didn't know if it was the COBC or Medicare who actually reported the Medicare dates and...

((Crosstalk))

Pat Ambrose: Yes, we have the Medicare dates on file.

(Cassandra Olson): Okay.

Pat Ambrose: So when you report an individual we match that individual to our database of Medicare beneficiaries and that includes, you know, we have then the information as to when they are actually covered by Medicare.

(Cassandra Olson): Okay. And you guys said that there were no known circumstances when the RRE would be primary if under 20 employees unless there was an (SEE)?

Pat Ambrose: I think there is -- the individual has to be working-aged.

((Crosstalk))

(Bill Davoyna): ...employer with -- if it's a multi or multiple employer group health plan Medicare is secondary for everyone who does not have an (SEE) if any participating employer has at least 20 employees.

I believe the other question was, is there any circumstance where an employer with more than 20 employees that is not -- for which an (SEE) has not been granted and -- or in a single employer plan doesn't have to comply with the MSP rules? And the answer was we're not aware of any circumstance where they would be of exempt.

John Albert: So for example if you had a multi-employer group health plan where one of them had 25 and there was another that had 6 and there was someone in that 6 who was a working-age beneficiary meaning, you know, they were over 65 and had coverage, there would be MSP for age because they are part of that multi-employer group health plan.

(Bill Davoyna): Unless a small employer exception has been requested an approved.

John Albert: So, yes, there are many instances where someone can have fewer than 20 but because of their relationship with other employers in that group multi-employer group health plan, Medicare is secondary.

(Bill Davoyna): And remember that the rule is slightly different with respect to the situation where any participating employer has at least 100 employees, then the disability rules are applicable to everyone regardless of size and there is no exception granted.

(Cassandra Olson): Okay. All right. And in one of the questions I believe that Pat was answering earlier from last time's conference call or from the mailbox. The changes to the relationship code, that there wasn't a date field to capture the code changes. And I just wanted to clarify you're asking that we capture the date and get it to the COBC how?

Pat Ambrose: Yes, you in your internal system need to know when changes are made to an individual's coverage that effect -- that may affect MSP. And...

(Cassandra Olson): Okay. So we...

Pat Ambrose: And again see that event table in the user guide as to reporting that change. Normally, you know, this was patient relationship. If you already have a record out there that's been accepted with an 01, you would be -- in the patient relationship changes, you would need to terminate that record, you know, not delete but add a -- update the record with a termination date and send an add record for the date of the change of that key field or other field that is critical to MSP determination.

(Cassandra Olson): Okay, great. Thank you so much.

Pat Ambrose: You're welcome. Other questions?

Coordinator: Our next question in queue comes from (Nava Reels). Your line is open.

(Nyda Reels): Hi. It's (Nyda). Just a question about the (SEE). As an RRE how would we become informed that it's been approved? In looking at the guide I think it's on that response file we would see the recognition that the application has

been accepted or approved, is that true? And would we get also the time span when that exemption has been granted?

I understand it's a year but I assume it's a year from the date when you've gotten it and approved it. So would we get all of that on that response file back? That's what we thought looking at the implementation guide.

Pat Ambrose: Go ahead.

(Bill Davoyna): I mean if you send an MSP record and you indicate that there is a (SEE) and provide that (SEE) HICN...

(Nyda Reels): No, no, I'm not talking -- we're looking for you to tell us it's been granted because it's individual employers that are submitting to you the application. So we would have no knowledge of that.

(Bill Davoyna): Number 1, it's not the employers that are submitting the information. It is the plan that was requesting information and provides information from the employers with respect to size.

The response goes back to the plan and it is the plan's obligation to notify the employer and the affected individuals that it's been granted. The communication is between the multiple or multi-employer plan and the COBC, not the individual employer.

(Nyda Reels): And I guess that's what -- I guess it's just the terminology that plan is not the RRE. I'm the RRE in this situation so I...

((Crosstalk))

(Bill Davoyna): ....the insurer.

(Nyda Reels): Yes, I'm the insurance company and we have an association of many small employers and within that group they have individual small employers that will be filing for this exemption.

(Bill Davoyna): Okay, Number 1, it is not the individual employers that would be filing for the exemption. It is the association plan. Now also the association plan, if you look at the cms.hhs.gov Web site under employer services and under that small employer exception, you'll see that there are circumstances where the multi or multiple employer group health plan can designate the insurer to make their request for them with the appropriate documentation and to have the communication going to and from them.

So it's going to be either the association plan itself or you acting as the agent for the association plan that would be communicating with COBC.

(Nyda Reels): So and what you explain that we have this association that's thousands of possible members, so they're filing this application on behalf of their entire population?

(Bill Davoyna): No.

(Nyda Reels): I didn't understand.

(Bill Davoyna): The association -- I would suggest that -- it's pretty explained in considerable detail on the CMS Web site. So I would think -- I would suggest that you go to the CMS Web site and review exactly what it says. I think that will answer the questions that you're raising.

(Nyda Reels): And who is talking because I myself have looked and it's not really clear, an employer has looked, so perhaps we need to look again but if we have follow-up questions, is there someone we can contact?

(Bill Davoyna): Send your question to the Section 111 mailbox and if necessary, they'll forward it to me.

(Nyda Reels): And who's the me that's talking?

(Bill Davoyna): It's (Bill Davoyna).

Pat Ambrose: If you take a look at Section 7.2.4 the small employer exception section of the user guide, at the bottom of that section there's a link on the CMS Web site, www.cms.hhs.gov/employerservices/05_smallemployerexception.asp. That's the location of the information that (Bill) is referring to on the CMS Web site.

(Bill Davoyna): And there are also some downloads on that that you may want to look at as well.

Pat Ambrose: And then just to be clear, in order for when you get to reporting on your Section 111 files, in order for the COBC to consider the small employer exception, you have to submit that (SEE) HICN field. And then the system will take that record and match it up against the small employer exception database and find out whether the GHP coverage that you're reporting -- you know, how it compares to that -- the exception period.

((Crosstalk))

Pat Ambrose: And what you receive back from the CMS or from COBC on your Section 111 files is just how we process the record against the small employer

exception. But through Section 111 we don't actually notify you of the approval of a (SEE).

As (Bill) said earlier, that's done outside of Section 111 reporting and that process is described on the link on the CMS Web site that we talked about before.

(Nyda Reels): Okay.

Coordinator: Our next question will come from (Gerrilynn Hawkins). Your line is open.

(Erica Wagner): Hi. Actually this is (Erica Wagner). I have a question regarding late submission indicator. Our initial file we submitted I believe at the end of May or early June and we received a number of late submission flags on that file when we received a response.

The question is if these people have never been submitted before, why is there a criteria on late submission when it was our first time reporting them?

Pat Ambrose: That should not have happened. There should have been logic in the system to account for the fact that you were reporting your initial file. So if you believe that one of the flags was set erroneously, we need you to report that to your EDI representative if you haven't done so already.

(Erica Wagner): Okay. Yes, another interesting thing is that we had received the same -- we had reported the same information for a subscriber and a spouse and we received a late submission flag for one but not the other. But we reported the same date, so that was a little unusual as well.

Pat Ambrose: Okay. Could I put you on mute just for a second? We have some -- an internal discussion we need to...

(Erica Wagner): Okay.

Man: If you get answers to all your questions, let me know.

Pat Ambrose: Okay. Someone just informed me that there was an issue with the late submission flag back in the May timeframe and that it has been addressed.

(Erica Wagner): Okay.

Pat Ambrose: If you see that occur again -- now also note that nothing -- you know, there's no fine automatically imposed by the system as John has said earlier. So if you believe that since that May submission if you believe that the late submission flag has been erroneously set, then we -- that is something that needs to be reported to an EDI representative and we'll take it from there.

(Erica Wagner): Okay. And then just to confirm one other thing, since we are reporting individuals' coverage back to the beginning or since they enrolled with us which some -- in some situations it could go back to the 1980s, if somebody had maybe met the reporting criteria before but maybe they were 44 and now they turned 45, when we submit that record and if we -- for coverage back to, you know, '98, that should not result in a late submission flag, is that correct?

Pat Ambrose: That's correct. The system is supposed to be looking at the age of the individual.

(Erica Wagner): Okay. All right. I just wanted to double check.

Pat Ambrose: Okay.

(Erica Wagner): Thank you.

Coordinator: Our last question currently in queue comes from (Rich Walker). Your line is open.

(Rich Walker): It's me again. Can we -- can I have further clarification -- what are the determining factors in, you know, if we have a company that has several affiliates together under the plan and maybe they do have separate TINs but depending on their business relationship maybe they all fall under the same TIN, what determines whether or not we put them together to get the employer size? And what determines whether or not we put them all under the same TIN?

(Bill Davoyna): Generally speaking you aggregate the parent with all of the subsidiaries. And in one of the cases that was mentioned, there was a joint venture.

(Rich Walker): Right.

(Bill Davoyna): One of the employers in the venture was providing the coverage to those individuals to whom the coverage was being provided and the minimum would be associated in an ongoing business relationship. They may or may not have been employees depending on the unique circumstance of the joint venture. So if you've got specific questions about a specific example, I would suggest you send all the facts to the mailbox.

(Rich Walker): Okay. Thank you.

Coordinator: And I am currently showing no further questions from the phone lines.

John Albert: Okay. Well I guess that's good. Does anyone else here -- okay. Well let's -- I guess we get to end a few minutes early. So I'd like to thank everyone for their participation. We have a couple action items on our end that we're going to follow up on as well as a couple specific RREs that -- some issues that were brought up.

We thank you for your participation. Please continue to submit questions or comments to the CMS resource mailbox and also as well work with your EDI rep. Again we want the dialogue to continue here at CMS to continue to improve the process. With that we will say good afternoon. Thank you. And operator if you could tell me how many had signed up.

Coordinator: Absolutely.

That does conclude today's conference. You may all disconnect at this time.

END