CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
December 10, 2014
1:00 p.m. ET

Operator: Good afternoon. My name is (Peter), and I will be your conference operator today. At this time, I would like to welcome everyone to the NGHP Section 111 Town Hall Conference Call.

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, simply press star, then the number one, on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

John Albert, senior technical advisor at Centers for Medicare and Medicaid Services, you may begin your conference.

John Albert: Thank you.

Good afternoon, everyone. Just for the record, today is December 10, 2014, and this is, again, the Section 111 NGHP Town Hall teleconference. I want to let everyone know that after the call at some point to the near future, hopefully, the transcript of the call will be made available on the Section 111 NGHP page.

I also want to repeat the disclaimer I always state at the – during these calls that there – where there is a conflict of what is stated on this call and you know versus the written material, the Section 111 Web materials always take precedence over anything we say on this call.

As far as the format of this call, there will be opening remarks by myself as well as Jeremy Farquhar of the Benefit and Coordination Recovery contractor. We will then turn the call over to the operator for a Q&A session. That's – as part of that Q&A process, we would like people to please remember to provide their name and the organization they represent when asking their question just so we have that for the record.

One thing that I wanted to state – and that's only because it's been a while since we've had one of these town hall calls and there are probably a considerable number of new people on the call – I wanted to remind folks about the resource mailbox. And the purpose of that mailbox is only because we receive a lot of more general and technical question on the resource mailbox which really should be directed to your EDI representative at the BCRC. There is an escalation process and if, for some reason, you are not able to get a response or information from your immediate EDI rep within the NGHP User Guide, please use that to ensure that you get your technical questions answered as quickly as possible.

A couple of things I wanted to talk about initially before we turn it over to Jeremy – and, again, I apologize of a few things may be repeat some part of myself and Jeremy but, again, for the benefit of some of the newer folks, we thought we sometimes say it twice if necessary.

I wanted to point out that since we had the last call, there have obviously been a number of alerts posted on the Section 111 Web site and a couple of them I want to talk about. One of them are the September 10 and November 25 alerts concerning the optional use of partial SSN. This was related to the requirement of the SMART Act that requires CMS to not use the full SSN or require the full SSN for submission of data related to Section 111 reporting.

Until now, CMS matching has always required either a full HICN or, where the HICN isn't available, the full SSN, along with the name, date of birth and gender of the individual being reported. Accuracy of results using this methodology has always been quite high. In response to NGHP insurer comments regarding the sometimes difficult task of procuring HICNs or full SSNs for beneficiaries, CMS performed an in-depth analysis of many

different alternatives to see if other matching methodologies could be developed that would guarantee a high enough level of certainty to ensure a proper matching with the information being submitted.

And looking at various combinations of partial SSNs and many other matching criteria, CMS had to ensure that, one, the submitted information could be linked to beneficiaries being submitted by the RRE and, two, even more importantly, that CMS would not be creating MSP records for the wrong Medicare beneficiary. We've also referred to those as false positive matchings.

While the HICN or SSN – full SSN is always preferred, CMS did determine that the existing matching accuracy could also be maintained using just the last five digits of the SSN along with the name, date of birth and gender of the individual and still using the same three to four – three out of four matching criteria that's in the existing matching logic concerning the first name, last name, date of birth and gender.

Normally, we would allow six months to implement such a change. However, in response to high demand for some other matching option that that existing process will still remain exactly the same, meaning you can still submit a full SSN or HICN, we decided to offer this option effective January 5, 2015. If an RRE decides to submit the last five digits of the SSN, there is a possibility that CMS could find more than one match. And the only kind of change, I guess, (that was stated was that) there will be a new DP disposition code that will received, which Jeremy will provide more information on when he does his talking points.

Again, all of the detail concerning this is fully explained, we hope, in the November 25 alert. And, again, if you do have questions about that, you can contact your EDI representative.

Also, there is another alert that came out on November 10 related to an option to submit recovery agent information so that the agent can receive recovery-related correspondence. Some non-group health plans RREs use separate agents to assist with tasks related to MSP recovery demands or potential

recovery demands. However, the Section 111 (final layout) do not accommodate separate name and addresses built for this purpose.

As a temporary workaround, RREs were previously allowed to submit TP information in existing Section 111 TIN reference file fields or GDE field. As of July 13, 2015, RREs that wishes to submit recovery agent information as part of the Section 111 reporting should submit the recovery agent information in the new field designated for this purpose. And, again, Jeremy will provide more information in his talk. The main thing is that under this new process, if recovery agent information is provided, both the RRE and the recovery agent will receive recovery-related correspondence.

On October 27, there was (an alert) posted regarding a small change to the naming convention to ensure that file names are always unique. That was effective – that will be effective April 6, 2015. The length and format of the file name will remain the same. But, it's – essentially, there will be a small change to allow for it to delineate specifically between the different file types. And, again, Jeremy will talk about that as well.

The final thing I wanted to mention – and this is not related to any alerts which, again, don't exist yet. But, I did want to talk a little bit about multi-factor authentication, which is – which is another thing that's related to the SMART Act. And that is – it will be effective no later than January 1, 2016. So, again, that's January 1, 2016.

In the current MSP Recovery Portal design, users or beneficiaries are automatically authorized to access (each of the) recovery cases on the MSP Recovery Portal. This includes the ability to view the list of medical claims associated with the case and the ability to dispute any unrelated claims. All other MSP RP, or Recovery Portal users, are only allowed to manage an MSP recovery case if they have been authorized by the Medicare beneficiary via an authorization submitted through the portal. However, even those users who have been authorized by the beneficiary do not have the ability to view protected health information and other personally-identifiable information and claim-specific information.

For those that didn't know, an interim final rule is published on September 20, 2013 which lays out our approach to implementing an expanded MSP Web portal to allow other beneficiary authorized users the ability to access payment and claims detail and information they current – can't currently access. The portal functionality will be expanded to permit users to notify CMS that a specific case – specified case is approaching settlement, obtain time and date stamp and final conditional payment summary forms and amounts before reaching settlement and ensure that related disputes and other discrepancies are addressed within 11 business days of receipt of dispute documentation.

The key to implementing this change for CMS is getting the authentication process to meet federal IT security requirements under the Federal Information Security Measurement Act, which basically guides all federal agencies regarding secure – data security. So, what that means is that CMS is going to have to implement what's referred to as multi-factor authentication to allow these other entities access to the CMS data and be able to receive it.

Multi-factor authentication is kind of what it sounds like. And that is it's an extra step above the normal two-factor authentication that you know kind of – it's an – it's an extra step, essentially, to provide the user with an additional piece of information they can provide to CMS and essentially get into the Web portal and view that information.

Until CMS implements this multi-factor authentication process, we will continue to provide beneficiaries with access to details and claims related to their pending settlements through the Web portal. This will include date of service, provider names, diagnosis codes and conditional payment.

Beneficiaries and attorneys and other representatives will continue to be able to dispute the relatedness of claims and submit a notice for settlement and other types of documentations through the Web portal. The beneficiary's attorney or other representative (in the ethical panel will) continue to be able to register through the Web portal and access conditional payment information related to a beneficiary's pending settlement. However, the access will remain limited until we implement the multi-factor authentication process as defined in and required under CMS' (additional requirements).

Once this solution has been implemented, a beneficiary's authorized attorney or other representatives or an authorized (applicable plan) that is appropriately registered to access the Web portal will have access to the beneficiary's MSP conditional payment information or specified MSP recovery case. This information will include date of service, provider names, diagnosis codes and conditional payment amounts.

Again, this change will be implemented no later than January 1, 2016. And, of course, as we finalize the requirements and get it ready for release, we'll be, of course, posting additional alerts to notify everyone about what the requirements will be as far as multi-factor authentication so that people can plan as early as possible on what they have to do to be able to utilize this new feature when it goes live, again, no later than January 1, 2016.

With that, I'm going to turn the call over to Jeremy, who's going to go over some more technical information, as well as provide some additional information that we received – more general questions received through the Section 111 resource mailbox. And, then, it will come back to me and we will go into the Q&A session.

So, Jeremy?

Jeremy Farquhar: Thanks, John.

For starters, I'd like to just begin and touch on several of the alerts that John already discussed briefly and provide a little bit of additional technical information.

For those unaware, the alerts for NGHP may be visiting CMS NGHP Mandatory Insurer Reporting page at go.cms.gov/mirnghp. Again, that's go.cms.gov/mirnghp. And, then, from that page, you can click on the NGHP Alerts link that you'll see on the left-hand side of the screen. And all of these alerts are at the bottom of the following screen in the Download section.

The first of these alerts was published on October 27 and is related to upcoming changes to the response file naming convention for files retrieved

via SFTP or HTTPS. This change will take effect as of 4/5/2016 and will impact the last four characters of the file name just prior to the.txt file extension. These characters are part of the timestamp and presently represents seconds and centiseconds. The current file naming conventions are outlined in Chapter Three of the NGHP User Guide, Section 10.3 and the aforementioned alert provides the revised naming conventions.

In a nutshell, once the change is implemented, the four characters presently representing seconds and centiseconds will be populated with a number between 0000 and 9999. And, as John mentioned, the reason for this is to prevent duplication of response file names. And that's duplication of response file names within a specific RRE's directory.

We had some occasional problems in the past where, sometimes, RREs would have multiples file submissions and response files would be generated for both of these file or the multiple transmissions at the same time. And, if so, they could be posted to the mailbox with the same timestamp, causing problems for some people's processes and their ability to download and process those files. This should rectify any problems therein. It will always be a unique file name within the specific RRE directory.

OK. The second alert, which had been published on November 10, covers upcoming changes to the TIN reference file. The changes is intended to provide RREs with the capability to provide separate recovery agent address information for the routing of recovery-related correspondence.

At present, RREs have been provided a workaround wherein they pay provide a TPA address in the standard TIN address field. In utilizing this workaround, the RRA name would be provided in the TIN office code mailing name, Field Five, and a CO or ATTN would be entered into the TIN office code mailing address line, Line Two, just Field Seven preceding the TPA's name. The other remaining address fields will be populated with the TPA's address.

Now, with the change, which would be implemented as of July 13, 2015, we'll add a second set of address fields for recovery agent information. And these fields are going to be used only to provide the name and address of the

third party who will be assisting the RRE with the recovery process. The new fields will be 16 through 22, and they'll be added at the end of the current record layout immediately following (and before an) RRE address fields.

Please note that as of 7/13/2015, the current TPA address workaround which I previously described – it will be retired and should no longer be utilized. As of the aforementioned date, the RRE name and address must be provided in Fields 5 through 11. Recovery agent information is optional. But, if an RRE is utilizing a third party for assistance with the recovery process, then that entity's information may be provided in Fields 16 through 22. If recovery agent information is provided, then copies of all recovery correspondence will be mailed to both the RRE and the recovery agent addresses. For those RREs submitting via DDE, the new recovery agent fields will also be added to the online screens.

Please note that CMS will utilize the designation of an agent and submission of that agent's name and address on the TIN reference file or DDE submission as an authorization by the RRE for the agent to resolve any recovery correspondence related to claim submissions with a matching RRE ID, TIN and office code and site ID combination. CMS will consider the RRE bound by the agent's actions on such matters.

However, the RRE still retains ultimate responsibility for adhering to the Section 111 mandatory reporting requirements and all other MSP obligations. For further details and full revised TIN reference input and response file layouts, please refer to the aforementioned 11/10/2014 alert.

Finally, the third alert published November 25 provides technical guidance relating to the upcoming change initially announced September 10, which will allow RREs to submit a five-digit partial SSN for beneficiary matching purposes within all Section 111 NGHP processes. As noted in the original 9/10/2014 alert, this change is being implemented in accordance with Section 204 of the Strengthening Medicare and Repaying Taxpayers, or SMART, Act of 2012.

Although it's still highly recommended that RREs submit either the HICN or full SSN, as of January 5, 2015, all RREs will also have the option to submit only the last five digits of the beneficiary's SSN. No other aspect of the matching process will change if the RREs utilize the last five digits of the SSN for matching purposes. If a partial five-digit SSN is submitted, that five-digit SSN must match exactly in addition to three out of four of the following fields – first initial, surname, data of birth and gender.

Partial five-digit SSNs will be accepted on the claim input and query-only files, as well as via the online DDE and beneficiary lookup screens. If an RRE wishes to submit the partial SSN on either the claim or query-only files, the pre-existing SSN fields should be utilized. The first four positions of the SSN field should be populated with spaces followed by the last five digits of the SSN.

If the five-digit SSN is provided on the claim input or query-only file submission, only the five-digit SSN will be returned on the corresponding response file. If a beneficiary match is found, the full HICN will still be returned on the response file regardless of whether a full or a partial SSN is submitted on the input file.

If an RRE wishes to submit a five-digit partial SSN via the DDE or beneficiary lookup screens on the Web site, no leading spaces will be required. The RRE may simply enter the last five digits on the SSN. The Web site will accept either five or nine digits as a valid entry.

While, statistically, the matching percentages for the full SSN and the partial five-digit SSN are extremely close, reporting of the five-digit may introduce a slight chance that more than one possible match may be found given the information provided by the RRE. In the somewhat unlikely event that more than one beneficiary may match, utilizing the personally-identifying characteristics submitted along with the partial SSN, a new duplicate disposition code, as John had reference previously – DP – will be returned on the claim and query-only response files.

If duplicate matches are found via the online DDE or beneficiary lookup processes, a message indicating as such will be displayed on the beneficiary (knockdown) page. This new duplication disposition or online message should not be interpreted the same as the pre-existing 51 or "Beneficiary not found" disposition or online message.

In the event that the DP disposition or online duplicate match message is received, the RRE should first double check that all matching criteria have been entered correctly and then, if possible, resubmit with the full SSN or HICN in place of the partial five-digit SSN. If a distinct match is still not found, the RRE may contact the BCRC call center at 855-798-2627. That's – again, that's 855-798-2627. And the information may be reported to the call center representative as a self-report over the phone.

Please note, RREs utilizing the HEW software for the query-only file process who intend to submit partial SSNs will need to download the revised version 3.1.0 of the software, which will accommodate the new changes. The PC version of HEW 3.1.0 will be available for download via the Reference Materials menu on the Section 111 secure Web site upon logging in as of January 5.

Again, you'll have to log in to the Web site before you'll see that software option. If you're in the login screen and you go to Reference Materials, that menu is visible before you log in. You will not see the download link. You have to log in first. Once you've logged in, you should then see the link to download the software within that Reference Materials menu.

RREs who will not be submitted partial SSNs may continue using the current HEW 3.0.0 software. RREs utilizing their X12 translator who intend to submit partial SSNs must obtain the revised version of the X12 270/271 Companion Guide in order to accommodate changes to the input and response file layouts. If an RRE does not intend to submit partial SSNs, they shouldn't need the revised Companion Guide as no changes would be necessary to the current format. The revised Companion Guide is available for download at present, and the direct link to the document is provided within the 11/25 alert.

Moving on, since our last town hall call, we've received numerous e-mails via the CMS resource mailbox concerning general practices related to the collection of SSNs for Section 111 reporting purposes. While we've already discussed this via the town hall forum repeatedly in the past, the volume of e-mails still being received on this topic would seem to warrant it being mentioned again.

First off, please note that we've always indicated that the Medicare HICN is our preferred identifier. If you're able to obtain the Medicare beneficiary's HICN, there is no need to collect the SSN. However, if you do not have the HICN and are uncertain whether an individual is entitled to Medicare, then you may utilize the SSN and query the individual's Medicare entitlement status and obtain the HICN if entitlement exists.

As noted previously, as of January 5, it will also be possible to query entitlement utilizing just the last five digits of the SSN. Those entities looking for documentation regarding the collection of HICNs and/or SSNS may wish to refer to the alert dated August 24, 2009 entitled "Compliance and Guidance Regarding Obtaining" – excuse me – "Individual HICNs and/or SSNs for Non-Group Health Plan Reporting."

This alert can be found posted on the main CMS NGHP Mandatory Insurer Reporting page for which the URL is go.cms.gov/mirnghp. Please note that alert is on the main page. It is not on the NGHP alerts page. So, that's go.cms.gov/mirnghp. If you scroll down to the bottom of the page, the alert is available within the Download section.

Also available here is the HICN, SSN collection, NGHP model language document, which may be utilized in your efforts to obtain the HICN or the SSN. If the individual from whom you are attempting to collect the information is unwilling to provide their HICN or SSN, they may sign the form indicating as such and you may retain a copy of the form to document your efforts.

Please note – and this may really go without saying – but having a beneficiary sign the model language form indicating that they refuse your personal – their

personal information should not be a first resort. You must make every effort to obtain the information required in order to report successfully.

Please note, a number of the e-mails received via the resource mailbox pertain to situations where RREs are indicating that a claimant must first provide a valid SSN before they will make any payments for medicals and before they will issue any settlement judgment award or other payment. In some cases, the insurer seems to be indicating that this is due to the fact that if a valid SSN is not provided, they cannot comply with CMS' mandatory reporting requirements. Situations being referenced in a number of these e-mails involve individuals who do not have SSNs.

Those in question may include, but are not limited to, individuals who are non-citizens, those with legal residency status only, individual with alien authorized work status, those with undocumented status, individuals with expired and/or pending status et cetera. These individuals would not be eligible for Medicare and there should be no need to report on them via the Section 111 process. It's important to remember that the Section 111 mandatory insurer reporting only requires RREs to report data on individuals who are presently or have previously been entitled to Medicare.

As a general rule, if an individual does not have an SSN, they aren't typically going to be eligible for Medicare. If there is no reasonable that an individual may be entitled to Medicare, then attempting to report their information via Section 111 should be unnecessary.

Another trend we've been noticing via the CMS resource mailbox as of late – and John mentioned this at the start of the call – is that the mailbox is frequently being utilized for matters which are not directly related to the Section 111 reporting process. The resource mailbox e-mail – and for those who don't – who aren't familiar, it's pl110-173sec111-comments@cms.hhs.gov. It's intended strictly for use related to – related directly to the Section 111 reporting process.

In particular, we've noticed a high volume of e-mails relate to the recovery process being sent to this mailbox. Recovery-related correspondence should

not be routed to that Section 111 CMS resource mailbox. If you have an NGHP recovery-related with which you require assistance, please contact the BCRC call center directly. That number for the BCRC call center, again, 855-798-2627.

Also, the recovery mailing address for NGHP inquiries and checks, should any of you need that, is NGHP at P.O. Box 138832. That's in Oklahoma City, Oklahoma, ZIP 73113. And I'll repeat that. NGHP at P.O. Box 138832 in Oklahoma City, Oklahoma, ZIP 73113. And that's for inquiries and checks for the recovery process.

In addition to the – excuse me. In addition to the significant volume of recovery-related e-mails, there have also been numerous notes regarding basic technical issues for which the BCRC should be responsible for providing assistance. In some cases, individuals have written into the mailbox indicating that they have had difficulty contacting their assigned EDI rep of that they do not know who is presented assigned as their EDI rep.

Please note that there is a documented escalation process, as John had also mentioned, which should be followed for matters of this nature. That escalation process is clearly outlined within Chapter Two, Section 7.2 of the current NGHP User Guide. Again, that's Chapter Two, Section 7.2. I am actually the first point of contact within that escalation process, and my complete contact information is provided within the aforementioned section of the user guides.

If you have an issue regarding anything related to technical Section 111 reporting process, you should first attempt to reach out to your assigned EDI representative. As documented, please allow 48 hours for your assigned representative to reply. If you have trouble obtaining a reply from your assigned EDI rep, then you should utilize the aforementioned escalation process. If there is any confusion regarding who your currently assigned EDI rep may be, then following the escalation process is the best way to obtain that information.

Finally, there seems to have been a bit of confusion regarding changes to the liability TPOC threshold which took effect as of 10/1/2014, and the following is an attempt to provide clarification and, hopefully, eliminate any remaining confusion.

Initially, in February 2014, an alert had been published indicating a change to the previously-outlined liability TPOC threshold timeline. Prior to the aforementioned alert, the liability TPOC threshold was slated to change from $2,000 to $300 as of 10/1/2014. However, in February, the timelines was updated and the future slated threshold amount was changed from $300 to $1,000.

October 1 has come and gone and those changes have taken effect as planned. Presently, liability TPOC amounts for TPOC dates 10/1/2014 and later which are greater than $1,000 must be reported no later than the first quarter of 2015.

Subsequent to the February alert, an additional alert had been published on June 4, 2014. The purpose of this alert was to provide information regarding changes to the CJ07 error code, which (already coincide within the new) liability TPOC threshold. The CJ07 error is triggered when the combined submitted TPOC amount is less than the minimum accepted TPOC value for the corresponding TPOC timeframe.

The liability TPOC dates between 10/1/2012 and 9/30/2014 – all TPOCs greater than $2,000 are required to be reported. For that same timeframe, liability values greater than $300 up to $1,000 are accepted, although those reports are not technically required. Liability TPOC amounts of $300 or less for TPOC occurring between 10/1/2012 and 9/30/2014 will be rejected with a CJ07 error.

Now, for all liability TPOCs taking place on or after 10/1/2014, the mandatory reporting threshold has been lowered to $1,000 and the minimum reportable value has also been raised to $1,000, effectively eliminating the difference with the minimum and the mandatory threshold. It’s just a one threshold that’s $1,000.

Therefore, as previously noted, all liability TPOC values greater than $1,000 for TPOCs on or after 10/1/2014 must be reported. At the same time, any liability TPOCs of $1,000 or less for TPOC dates on or after 10/1/2014 will be rejected with a CJ07 error.

However, please note that the update to the CJ07 threshold error in order (to recheck) values of $1,000 or less for dates 10/1/2014 and subsequent is not scheduled to be applied until the beginning of January. At present – at the present moment, it would technically still be possible to report any value greater than $300 without generating a CJ07. That will change as of January 5.

Also, please be aware that the information regarding the changes to the CJ07 error from the June 4 alert were not incorporated into the October 6 NGHP User Guide update. Our apologies for that. This was an oversight, and the changes referenced in the June alert are still applicable. A new version of the NGHP User Guide with an appropriately-revised liability TPOC threshold timeline is slated to be published in June.

And that's it for me. I'll hand it back to you, John.

John Albert: All right. Thanks, Jeremy.

I guess now we're ready to move into the Q&A session, operator. And, again, as I stated before, just to allow for everyone a change at the microphone, please limit yourself to one question and one follow up and then allow for others and just jump back in the queue in case we do have a lot of questions. Also, again, please provide your name and the company you represent prior to asking your question.

Operator, we can start the Q&A session.

Operator: At this time, I'd like to remind everyone, in order to ask a question, please press star, then the number one, on your telephone keypad.

Your first question comes from the line of Lisa Maynard.

Your line is open.

Lisa Maynard: Hi. Thank you. This is Lisa Maynard with Hamlin & Burton Liability Management. And we have – we actually have a couple of policy questions, but it's on one topic. So, I hope you'll allow me to ask these questions.

As we understand it, if no loss of consortium claim is actually filed in a claim or a lawsuit but a family member signs a relief which releases any and all claims which has the effect of releasing an unclaimed loss of consortium claim, we should be reporting the signing family member as a separate record. That's our understanding, and we have a question related to that.

In what – in a case where no loss of consortium claim is claimed and a family member is only signing a release in his capacity as a legal representative of the injured party and not signing and releasing any loss of consortium claim for himself, are we exempt from reporting the signing family member as a separate record in that circumstance?

Barbara Wright: If someone is signing a document only in their capacity as a represented and you don't have any release specifically for them, there would be nothing to report for that representative as an individual.

Lisa Maynard: OK. And, then, the second question we have is in a case where a loss of consortium claim cannot be legally brought by a family member because a loss of consortium claim is prohibited by law in that state and we have a release signed by a family member that releases any and all claims which, again, has the effect of releasing a loss of consortium claim, are we also exempt from reporting a loss of – reporting a separate record for that family member in that circumstance?

Barbara Wright: Whether or not it's loss of consortium, the fact that a particular type of claim would not be legally successful is not in any way determinative of whether or not any settlement judgment award or other payment is reportable. Otherwise, every single claim that an appellant knew would be unsuccessful in a court of law wouldn't be reportable. If the – if there is a settlement judgment award or other payment, it doesn't matter whether the underlying claim is legal. If

there is – you know if it's been settled, then you're into the reporting (concept).

Lisa Maynard: OK. So, it doesn't matter if – for releasing a loss of consortium claim, even if you can't bring one in that state, then we should – we should go ahead and report it as a separate record.

Barbara Wright: Yes.

Lisa Maynard: OK. Will there be a memo published regarding reporting requirements on loss of consortium claims?

Barbara Wright: It's under consideration. But, we don't have one that's near or final at this point.

Lisa Maynard: And we – and we have a clear understanding that release – we're understanding correctly that releases of loss of consortium claims that are not brought or claimed – those do have to be reported as a separate record, right?

Barbara Wright: What you're looking at is who – if the party that's being release is a Medicare beneficiary or was a Medicare beneficiary.

Lisa Maynard: Exactly. The person is a Medicare beneficiary but they're signing – they're signing a release – or a family member signing a release and that releases any and all claims for that person, then we report a separate record. Is that correct?

Barbara Wright: Yes.

Lisa Maynard: OK. Thank you very much.

John Albert: And for the record, that was Barbara Wright speaking for CMS.

Lisa Maynard: Thank you.

Operator: Your next question comes from the line of (Anne Armstrong).

Your line is open.

(Anne Armstrong): Thank you. So, just to give you some context, this would be – this is just an example. But, the RRE is a healthcare system that owns several facilities and employs multiple providers. But, a question has come up.

So, for example, one of the hospitals has a CT scanner that's down for maintenance or some other issue or otherwise unavailable and a Medicare beneficiary patient is ordered to have a CT scan. In that situation, we arranged for private ambulance transport to another facility where the CT scan can be conducted and return transport. And the hospital whose scanner is down would like to pay the ambulance bill on behalf of the beneficiary.

So, as long as there is a careful analysis as to – and there is a determination that no untoward effect resulted from the transport itself or from any additional time it took to complete the scan – so, there is no – there is no additional expenses that could arise out of it that the patient wouldn't have otherwise required, does the hospital who sends and then pays the bill need to report that ambulance bill as a TPOC?

Barbara Wright: OK. This is Barbara again. It sounds like you took the long way around to talk about what's more of a billing question. There is nothing you gave me in that scenario that indicate you were doing – arranging for this because of a risk management issue. You were arranging for it because the scan needed done and it was you know – and not available at your facility.

In terms of the billing aspect of that, if – because the hospital that sent them there wanted to pay for it, you would need to talk to your Medicare administrative contractor in terms of whether or not you had the bill of claim that showed it was fully paid et cetera. But, as I said, you haven't indicated that you had a risk management situation.

(Anne Armstrong): Right. There is no risk management issue. There is no – there is no liability issue. And …

Barbara Wright: OK. Well …

(Anne Armstrong): … the ambulance. Sorry.

Barbara Wright: Well, I mean (inaudible).

(Anne Armstrong): I was going to say the ambulance is a separate company. And, so, they would actually – so, we would pay the bill. But, we have no way through the billing process to alert Medicare that we've paid this bill because the – it's the ambulance as a separate entity's bill.

Barbara Wright: If the – OK. So, if it's the ambulance that's billing Medicare, it's up to the ambulance to indicate that someone else has already paid in full. I mean …

(Anne Armstrong): OK.

Barbara Wright: But, it is – the way you described it, you seem to be talking about purely a billing issue. And if – and if the ambulance has any questions about how to bill that, they should be talking to their Medicare administrative contractor about the proper procedures.

(Anne Armstrong): OK. Thank you.

Barbara Wright: OK.

Operator: Your next question comes from the line of (Bonnie Mastardi).

Your line is open.

(Bonnie Mastardi): Thanks. This is (Bonnie Mastardi) with Farmers Insurance. And I had a question regarding the model language. For a period of time, the model language was not posted on the Web site. And, then, with the new five digits, you posted it with that as an indicator.

If a company is currently going to be using the five-digit option, for example, because of programming updates et cetera (and that and that), is it – question number one, is it acceptable to use the old model language format so we don't have confusion (inaudible) five digits?

John Albert: Yes.

Barbara Wright: Yes.

(Bonnie Mastardi): All right. And the question, again, is couldn't that old language document be added back to the Web site so that there is confirmation that it is still acceptable for …

John Albert: Yes. That's – you – there – it's basically the same model language. It's just that one little in there that you can remove related to the five-digit SSN. So you know you can – again, it's model language that – you know again, it can be modified. And you know if you're not collecting the five – the five digits and you just want to keep it as a – you just remove that little piece of language from it.

(Bill Decker): And this is (Bill Decker). Are you also saying that you can't find the model language on the Web site anymore?

Male: (Inaudible).

(Bonnie Mastardi): (Inaudible) saying (inaudible) point in time (inaudible) probably you were taking it down to update it for the five digits. But, there was a point in time where it (inaudible).

John Albert: We seem to have lost you.

(Bonnie Mastardi): (Inaudible).

Barbara Wright: We are still hearing only an occasional syllable.

(Bonnie Mastardi): (Sorry about here). (Inaudible).

John Albert: All right. Operator, can we take the next question?

Operator: Yes. Your next question comes from the line of (Emily Campbell).

Your line is open.

(Emily Campbell): Hi. This is (Emily Campbell) from (Bigory, Bigory, Daniels). And I've got a couple of questions regarding certain benefits that are provided in connection with short-term travel, hospital confinement and accident-only

policies and whether those benefits would meet the definition of no-fault insurance, either the definition set forth in the user guide or in the regulation such that they would trigger a Section 111 reporting obligation. And I've sent these questions to the Section 111 mailbox but haven't seen any guidance issues in response. So, I was hoping for some additional information regarding these benefits today.

And the first of the benefit types is accidental death benefit. And an example would be where there is an accidental death benefit that's paid pursuant to a set schedule of benefits – for example, $50,000 for the accidental death of the insured paid in one lump sum where that lump sum is not required to be used or otherwise designated as benefits for the payment of healthcare services and is paid regardless of whether any Medical expenses are actually incurred. And in that situation, I was just hoping for some guidance as to whether or not those types of benefits would be reportable for Section 111 purposes.

Barbara Wright: When it's – this is Barbara again. When it's accidental benefits, there are specific designated sum that's separate from in addition to any medical expenses that may or may not be paid. The accidental death benefit amount does not need reporting.

(Emily Campbell): OK. That's really helpful. And sort of along similar lines, with respect to hospital confinement, benefits – those would be issues sort of pursuant to a hospital confinement policy where it would be, again, the benefit is payable pursuant to a set schedule of benefits – for example, $200 per day for each day of hospital confinement payable upon receipt (approve of loss) but not required to be used for or designated for the payment of healthcare services and payable regardless of whether new medical expenses are actually incurred by the insurer. Again, would these types of benefits be subject to Section 111 reporting?

Barbara Wright: For your question both for hospital confinement and permanent total disability benefits, the argument you presented was along the same lines that it didn't have to be used for medical et cetera. And whether or not they are actually used by the recipient for medical isn't determinative of how we classify it for both the permanent total disability and the hospital confinement. At this

point, we see no reason that you're exempt from reporting. I mean, those benefits – particularly confinement – people – if you're confined to the hospital, you clearly are having some medical cost no matter who is paying them.

So, the accidental death benefit – there may not even be any medical associated with that depending on how it happened. And it is specifically only for the death and separate from medical. These other two could easily be for medical as well. And, so, we would say you do need to report them.

(Emily Campbell): OK. So, just to be clear, the accidental death one-time lump indemnity benefits would not be reportable for Section 111 purposes. But, the hospital confinement and permanent total disability benefits would be reportable.

Barbara Wright: Yes.

(Emily Campbell): OK. All right. Thanks very much.

Operator: Your next question comes from the line of Jay Lichtman.

Your line is open.

Jay Lichtman: Hi. I had a – this is Jay Lichtman from CorVel Corporation. I had a question that might be more policy-related. But, for long-term security of Social Security numbers, with the modifications that does allow us to send in just the last five digits of a Social Security number, it's ironic that we will still get back at HICN that, in the most – you know in most cases, still includes the full Social Security number. Is there any plan for the very long term to use an alternate identifier for HICN that does not include a Social Security number?

John Albert: That's not that we can really comment on because I'm – you know I – you know that discussion has been ongoing for a long time, I'm sure, as you're aware of it. There is nothing that's been released accordingly. So …

Jay Lichtman: Sure. OK. Just – I was wondering if any of the partial Social Security number acceptance was making any inroads in that direction. But, it sounds like it's certainly a separate conversation entirely.

John Albert: That was specifically related to the requirements of SMART Act, the (inaudible).

Jay Lichtman: Sure.

John Albert: Or last five digits.

Jay Lichtman: All right. Thank you very much.

Operator: Your next question comes from the line of (Kyle Brennan).

Your line is open.

(Kyle Brennan): Hi. My name is (Kyle), as just mentioned, and I'm a developer at the (Hardford). And I have a question regarding whether – so we transfer files via SFTP – both query and claim files. And I was curious to know when we can start testing the submission of those files for partial SSNs.

Jeremy Farquhar: Unfortunately, there is – there will be no advanced testing prior to January 5. You can send us test files as of January. But, we won't be prepared to take in the five-digit SSNs until that date.

(Kyle Brennan): Understood. Thank you very much.

Operator: Your next question comes from the line of Gerry Coryell.

Your line is open.

Gerry Coryell: Good afternoon. My name is Gerry Coryell. I'm with the Louisiana Insurance Guarantee Association. My question concerns the December 4, 1980 cutoff of asbestos-related claims or toxic tort claims. My understanding is that the August 19 update says – indicates that if a suit is filed that does not allege exposure to asbestos beyond 12/4/1980, that that is not a reportable loss to CMS.

Now, if the initial suit alleges exposure beyond that date – let's just say 1983 – and the plaintiff counsel subsequently amends the petition or suit to limit exposure to 1979, as we have seen on numerous occasion over the past several

months, that – it's our understanding that that would not be a reportable loss to CMS. Is our understanding correct?

Barbara Wright: Can you hang on for a second?

Gerry Coryell: Surely.

(Jen Mattis): Hi. This is – this is (Jen Mattis). I'm another one of the policy analysts here. Your understanding is generally correct. The most recent alert that we published reflect that we're willing to rely upon the most recently-amended complaint as long as the amended – you know as long as you are not amending the complaint for the sole purpose of excluding Medicare from pursuing recovery and as long as there is no specific release associated with that type of exposure. So, if what you have is an amended complaint reflecting that exposure did, in fact, end prior to December 5, 1980 and you have a general release, then that's acceptable for the purpose of the December 5, 1980 alert.

Gerry Coryell: Thank you. I appreciate your answer.

Operator: Your next question comes from the line of (Marcine Rubenstein).

Your line is open.

(Marcine Rubenstein): Hi. My name is (Marcine Rubenstein) and I'm from the (Nielsen) Law Firm. I wanted to know if we report a claimants information in error and CMS rejects our report, does the rejection void our entire report?

Jeremy Farquhar: Well, the rejection basically indicates that we did nothing with the information that you submitted to us. So, if you send something to us in error and you received a rejection on the response file or on the onscreen that's being entered via DDE, then there is – there is no further action necessary on your part. So, if it was erroneous, that information didn't go anywhere, you don't have to follow up any further.

(Marcine Rubenstein): So, the rest of our report is fine. I will just take the one claimant who shouldn't have been reported and delete that from our submission, but the rest of our submission is fine?

(Marcine Rubenstein): We – I wouldn't think of it as deleting it from your submission. You might do better to think of it as it was never posted on Medicare's side of the house. So, we never – if you receive a rejection code, whatever that may be, whether it'd be a 51 for a beneficiary not found or an SP disposition with a correlating error code, that means that Medicare did not apply your data and it's for only the records that you received that rejection, whether it'd be not found or an error code.

For those any of those records receiving the error or the rejection, I would indicate that we've done nothing with your data. No further follow up for those particular records is necessary if you determine that that information should not have been submitted in the first place. No need to send a delete transaction or anything of that nature. Sometimes, people do get confused about that, and that's not necessary. We're telling you that we never posted the record in the first place. So, you're safe.

(Marcine Rubenstein): OK.

John Albert: And we assume you are talking about a record-level error, not a file error because the – I guess, you're talking about the rest of them. Again, every …

(Marcine Rubenstein): Right. I'm talking about a file error. So, I'm saying if we submit …

John Albert: (A file error). OK.

(Marcine Rubenstein): Right. If we submit information – I'll make it simple. We submit information on two claimants. We receive back a file, a Section 111 submission. We received back an error code. Do we need to resubmit a corrected report or will the report we submitted just not take action on the one claimant and post the other claimants, if you want to call it that?

Jeremy Farquhar: So, it's still unclear. You're saying it's a file level error. But you don't receive errors back on a file level. So, let's just clarify that. When you – if you're receiving errors back for specific individuals, that is not a file-level error. That is a record-level error. So, if you …

(Marcine Rubenstein): OK.

Jeremy Farquhar: If you would submit – so, there's two possible scenarios. If you submit a file and that entire file is rejected for whatever reason, it generates a severe error or it triggers threshold and the BCRC follows up with you and we do not actually process that file …

(Marcine Rubenstein): Yes.

Jeremy Farquhar: … and, say, you had records on the file. One of them, you realized, was erroneous, well, then, if we didn't process that file, you could turn around and then resubmit the file, removing the one erroneous record within the file and then submitting the other record that you feel is valid. If you …

(Marcine Rubenstein): Can that be submitted immediately or do you have to wait until the next reporting period?

Jeremy Farquhar: No. You can – you can resend immediately. We've moved to support early reporting restrictions sometime back. So, as long as your prior file is completed processing, if there is no other file in process at present, no other claim file processing at present, you can go ahead and resend as soon as you're prepared to do so.

(Marcine Rubenstein): Great. Thank you so much.

Operator: Again, if you would like to ask a question, press star and then the number one on your telephone keypad.

Your next question comes from the line of (Steve Stevridius).

Your line is open.

(Steve Stevridius): Yes. Good afternoon. (Steve Stevridius) speaking. My question has to do with the responsibility a liability carrier will have in the cases where it discovers past potential fraudulent use of Social Security numbers. For example, let's say you have a situation where someone claims that they are undocumented and were never issues Social Security numbers. But, in the course of litigating the file, we find that the plaintiff has a license which would indicate that he had, at some point, have a Social Security number to get that license. Another situation is one where we find evidence of multiple use of Social Security numbers.

How far do we have to go to get to the bottom of it? Or, is there some place that we have a special reporting line where we can get further assistance with something like this?

John Albert: Yes. Unfortunately, none of us here are really sure how to respond to that. I mean, there is – I mean, Medicare has a fraud line available. But, I'm not really sure.

Barbara Wright: And so does the Office of Inspector General.

John Albert: Yes.

Female: And I think you're talking about (inaudible) Section 111 reporting.

John Albert: Yes. I mean, there is – that's kind of like – I mean – yes. That's separate and distinct from Section 111 reporting. I mean, that's – there is no responsibility under the Section 111 process.

Barbara Wright: Under Section 111, what you'd want to make sure is whether you've convinced yourself one way or the other whether the person has an actual Social Security number.

(Steve Stevridius): Right. Well, I get – in many cases, if we have like a driver's license, we know that there is a Social Security number associated with the person because, otherwise, the license were never issued. But, on the other hand, when we requested formally, we get a response that the plaintiff came to this country undocumented and, therefore, doesn't have one; it was never issued one.

So, let's say, in that specific case, do we have to take it a step further and, say, insist on – you know present them with the driver's license information and – you know this happens on one or two occasions. So, we don't know what to do in that case as far as what our responsibilities are to get to the bottom of whether this person has a Social Security number so that we could check to see if they are, therefore, on Medicare.

John Albert: All right. Well, we were discussing here as well. I mean, I guess that the answer we would give you is to utilize that model language. And if you aren't able to get what you need, then just document it accordingly. Obviously, if you see something that – you know there is some potential misuse or fraudulent activity occurring, we aren't really sure who to report that to. But, obviously you know the inspector general or whatever would probably want to know that information.

(Steve Stevridius): Yes. So, if we get like for our – I'm sorry. For Section 111 reporting purposes, if we would get an affidavit saying that they don't have a Social Security number, would that be sufficient, at least to the extent of fulfilling our reporting obligations?

John Albert: Yes.

(Steve Stevridius): Yes. OK. One other thing along those lines. Is there any place that we can go to request a person's Social Security number, of course, with the proper authorizations? Would that be the Social Security Administration? Do you know of anything where we could go to get to the bottom of someone's Social Security number status if it need – if it comes to that?

Barbara Wright: Well, I mean, my question would be if the person hasn't given you a number and (have been) – why would they give you an authorization? You know I can't see someone who is not going to give you his number giving you an authorization to go to Social Security.

John Albert: You would never be able to talk to Social Security about somebody's SSN (inaudible). That's between the owner of that number and the Social Security Administration.

Barbara Wright: But, if there was person who had lost their Social Security number (or something) …

John Albert: Yes.

Barbara Wright: Maybe it was a lot of information and a lot of (people) who are representing him. But, the type of situation you were describing earlier is that when you really don't have it. I don't see that person giving you an authorization.

(Steve Stevridius): OK. Thanks very much for your help.

Operator: Your next question comes from the line of (Bonnie Mastardi).

Your line is open.

(Bonnie Mastardi): Thank you. Hopefully, you can hear me this time. I actually have another question. It's regarding Medicare Advantage holders. When we submit a query to Medicare through the process – the query process, if that – if that individual holding that Social Security number is a Medicare Advantage individual, will we get a positive response back?

Jeremy Farquhar: Yes, you will.

Barbara Wright: Yes. Anyone who has Medicare Advantage or Part C has to have both Part A and B. During the time of their Medicare Part C Advantage membership, they receive their benefits through a Part C organization. But, they have to have both Part A and B to even sign up for a Medicare Advantage organization.

(Bonnie Mastardi): OK. And my second question related to that on the Medicare Advantage – if we report someone that is, indeed, a Medicare Advantage holder, will that information that we've reported to you be shared with that Medicare Advantage company?

Barbara Wright: Is the information we receive shared with the MA (inaudible)?

Male: (Inaudible). I guess, for – (inaudible).

Barbara Wright: (Inaudible) whether you're reporting – ORM or a TPOC whether or not the Medicare Advantage may or may not have access to that information. But, in either case, there is an obligation under the – for both Part C and Part D for those beneficiaries who receive liability or no-fault or workers' compensation to deal with their Medicare Advantage or Part D plan in determining whether or not they have any recovery responsibility for any settlements, judgments or (for other payments).

John Albert: Yes. I mean, where there is – where there is overlap with regular fee-for-service and Part C, generally, they would receive that information. But, we try to only provide information to that side of Medicare when it's necessary. So, (inaudible).

(Bonnie Mastardi): So, they – so, if we – if we submit a report and the individual has a Medicare Advantage plan, it sounds to me like what you're saying is in some cases, you're going to share the information with the MA plan and, in some cases, you're not. (Is that) (inaudible)?

Barbara Wright: It's not a matter of we create a report and send it out or don't send it out. If they have access to certain types of information through our various systems, then they may or may not have access to the information for Section 111 reporting. But, they are – the obligation is if there is a settlement judgment award that still exists with respect to Part C and Part D. And, also, anytime that you are reporting to us, remember there are many people – even if they have Part C and Part D, they didn't necessarily have it during all the time that's relevant for the settlement judgment award or payment at issue. So, they might – we might have a recovery claim for fee-for-service Part A and B and they might be separate recovery claims for Part C or Part D from any entities that they were involved with.

(Bonnie Mastardi): OK. Thank you.

Operator: Your next question comes from the line of (David Christiansen).

Your line is open.

(David Christiansen): Good afternoon. I have a question regarding the obligation of U.S. RREs involved in litigation in foreign countries where some of the recipients of judgment or settlement could be expatriates from the U.S. and thus could be Medicare beneficiaries.

Barbara Wright: And the question is?

(David Christiansen): Well, the question is if so and if there is a difficulty with the foreign jurisdiction in obtaining the data points to report, what is the responsibility of the RRE?

Barbara Wright: I mean, at this point, we've said that anything that involved the Medicare benefit – someone who is or was a Medicare beneficiary needs to report it. If it's liability, no-fault or workers' compensation, any benefit that occurs in a foreign country – and we do get many such reports.

(David Christiansen): OK. So, if you're unable to obtain the data points to query the individual for beneficiary status, then you would follow your normal process for documenting your efforts. Correct?

Barbara Wright: Yes.

John Albert: Yes.

(David Christiansen): OK. Thank you.

Operator: Your next question comes from the line of (Lisa Riley).

Your line is open.

(Lisa Riley): Hi. My name is (Lisa Riley) with (CCMI). I had a question regarding the new requirement where you only have to submit the last five digits of a Social Security number. One of those is that you submit the surname. So, how many spaces are you allowing for that because, right now, (with a query), we only give the first six letters of the last name?

Jeremy Farquhar: On the query files, it's still just the first six characters of the last.

(Lisa Riley): OK.

Jeremy Farquhar: You know that's how we perform our matching – using the six characters. The claim input file will allow you to provide the full six. But, if you send that full – or, I mean – excuse me. The claim input file will allow you to submit the full surname. But, when we do the matching on the back end, it just uses the first characters of that last name anyhow.

(Lisa Riley): OK. So, there is no need for us to reprogram spaces in there or anything? The six will be as sufficient?

Jeremy Farquhar: You don't.

(Lisa Riley): OK. Great. Thank you.

Jeremy Farquhar: Six (inaudible). Yes.

Operator: Your next question comes from the line of Nicholas Alberts.

Your line is open.

Nicholas Alberts: Good afternoon. This is Nicholas Alberts from Zurich Insurance. I'm – I have a question about the settlement of asbestos and other toxic tort matters. We routinely find that a plaintiff's attorney will refuse to give us certain data points that are required to report a settlement. And they do so relying on a letter from CMS indicating that there is no Medicare lien or some letter that might relate to a lien but not really fully stated that a lien (is to be satisfied). And, so, my question is what, if any, effect does such a letter have on an RRE's reporting obligations of an otherwise reportable settlement?

Barbara Wright: I'm not sure. Personally, I'm not sure exactly which letter you're talking about. There have been some instances where we've specifically given plaintiffs and defendants letters that certain individuals do not have to be reported with respect to asbestos settlements and some other settlements. I mean, that has to do with various work that we are doing here in central office.

If it's – if it's one where it specifically is a CMS letter and it says no reporting is necessary, then I would just give a copy of the letter. But, it's really hard to tell exactly what letter you're talking about.

Nicholas Alberts: So, the text of the letter is – and I apologize I'm not familiar with exactly what form it is. But, the text of the letter usually says something like there is – there is no existing Medicare lien. There is – that there are no paid amount for which a lien applies.

Barbara Wright: Are you talking about a traditional payment letter or something (inaudible) (reported). Yes. This – what you just read does not sound like it's anything that technically relieves reporting or anything. It may even and only have been a condition payment letter or a conditional payment notice which, in fact, only gives what the contractor has looked at to date. It doesn't necessarily give it through the date of settlement. So, the fact that they have an interim letter or anything that's saying that there hasn't been any – that there isn't any conditional payment at this moment doesn't mean there won't be by the time there is a settlement et cetera.

Nicholas Alberts: Thank you.

Female: Do they ever – do they ever with copies of those letters?

Nicholas Alberts: They do periodically. And, usually, there is a – in a way, they are trying to avoid providing some piece of information.

Female: OK. I mean, I think – I think, for the most part, we would – we would go back to our model language reference if – you know if you've made attempts and you were able to document your attempts. If you're able to obtain copies of those letters, those letters usually do – it sounds like you know folks are actually redacting them. But, those letters usually do contain case IDs and other information that CMS can usually use or the BCRC can use to identify a particular person you know if you're – if you're up for going that far. But, I think, our default would be the model language again.

Nicholas Alberts: Great. Thank you.

Your next question comes from the line of (Monica Kovasi).

Your line is open.

(Monica Kovasi): Hi. I have a question about the obligation of RREs to pay and satisfy a Medicare lien when there is a settlement or a judgment in favor of the beneficiary. So, Section 111 requires reporting whenever there is a settlement or some sort of a judgment to a beneficiary. But, I was wondering whether the RREs also had an obligation to ensure that the Medicare lien is satisfied and paid to CMS or is there simply a reporting requirement.

So, to be more specific, following a trial verdict, if there is a judgment in favor of the plaintiff Medicare beneficiary, can the defendant RRE pay the full judgment amount to the plaintiff beneficiary? Or, do we have any obligation to directly pay and satisfy the Medicare lien and then just pay the remainder to the beneficiary?

Barbara Wright: The Medicare Secondary Payer provisions, including the reporting provisions, are found at 42 United States Code 1395y(b). That's where the whole – the MSP provisions are. And one of the provisions says that we have a right to recovery against the primary payer and any individual or entity that has the money – who received the money in their hands at any point.

So, the simple fact that you arrive at a settlement and paid the beneficiary does not technically take you completely off the hook. There are a lot of insurers that are making sure that the money is paid back to CMS. That's why they are asking for a final conditional payment amount or information before they are doing funding et cetera. We can't advise how that needs to be done. But, yes, the statutory provisions do put the primary payer on the hook as well as the beneficiary.

(Monica Kovasi): That's very helpful. Thank you so much.

Operator: Your next question comes from the line of (Timothy Shaffer).

Your line is open.

(Jason Dream): This is (Jason Dream) with Auto-Owners Insurance. This question is in regards to the 8/24/09 alert concerning the collection of HICN and Social Security numbers. With to the requirement that the model language be resigned and dated every 12 months in cases where there is ORM, does that apply when the file has been closed?

Barbara Wright: It depends why you closed the file. If you closed it because you no longer have legal responsibility, then no, you don't need to have it resigned because you would have terminated the ORM or wouldn't be reporting it past the certain date. But, if it's a situation where it is still legally open and you would like to close it for administrative convenience, then closing it for administrative convenience does not relieve you of any obligations associated with Section 111.

(Jason Dream): Thank you.

Operator: We have no further questions at this time. I turn the call back over to the presenters.

John Albert: OK. Well, with that, I'd like to thank everyone for their participation today. Again, be on the lookout for transcripts from the call. Again, there will be more alerts forthcoming regarding some of the processes that we talked about earlier during this presentation. Stay in touch also with the Web site for additional updates to other materials, as well as announcements of any future teleconference calls that we'll be hosting. With that, I'd like to thank everyone.

And, operator, if you could keep the CMS folks in the room when you sign everyone else, we'd appreciate it. Thank you.

Operator: This concludes today's conference call. You may now disconnect.

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