

The New Medicare Reporting Requirements



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Historical Perspective



**HISTORICALLY MEDICARE WAS PRIMARY PAYER FOR
CARE RESULTING FROM NEGLIGENCE**

Medicare as Primary Payer



- Pre 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation.

Medicare as Secondary Payer



- Post 1980, Medicare is **secondary payer** to certain group health plans and is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation

Problem



- **Since 1980 efforts have been directed at recouping money expended for tort claims. The collection rate has been low.**

New Amendments



- **On June 1, 2008 Congress passed law requiring mandated reporting of payments by insurers to Medicare recipients.**
- **This law adds new mandatory reporting requirements for group health plan (GHP) arrangements and for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation.**

New Amendments



- **The law is Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173). 42 U.S.C. 1395y(b)(7) & (8).**

Purpose of New Amendments



The purpose of the Section 111 MMSEA is to enable CMS to pay appropriately for services by determining primary versus secondary payer responsibility AND avoiding payment when others are responsible.

In this session:



- Generally who/what/when reporting should occur. A primer for risk officers and attorneys.
- This is not a training session – if you are RRE see CMS website for training modules.

I. Who reports?



REQUIRED REPORTING ENTITIES (RRE)

Group Health Plans

Non Group Health Plans

Group Health Plans



- **(GHP) Arrangements (42 U.S.C. 1395y(b)(7)) – Insurer-** an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments.

Insurers vs. Third Party Administrator (TPA)



- In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

GHP versus NGHP



- **The Centers for Medicare and Medicaid Services (CMS) experience with Voluntary Data Sharing Agreements (VDŠA) has made the implementation of Section 111, Mandatory Insurer Reporting (MIR) for Group Health Plan (GHP) reasonably stable and smooth.**

Non Group Health Plans



CMS does not have the advantage of leveraging an existing reporting system like the VDSA for reporting liability, no-fault and workers' compensation (Non-GHP). They recently updated the NGHP reporting format and there will likely be changes ahead.

Non Group Health Plans



- 1. Liability Insurers**
- 2. Self Insurers (Hospitals, Health Care Facilities, Clinics)**
- 3. No Fault Insurers**
- 4. Workers' Compensation**

Liability Insurers



- **Liability insurance (including self-insurance) is coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction which results in injury or illness to an individual or damage to property.**

Examples of Liability Insurers :



- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

No-fault insurance



- **Insurance that pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who is at fault for causing the accident.**

Responsible Reporting Entities (RRE) and Use of Agents



- **An applicable RRE may contract with an entity to act as an agent for reporting purposes.**
- **Agents may include, but are not limited to, data service companies, consulting companies or similar entities that can create and submit Section 111 files to the COBC on behalf of the RRE.**

II. How Reported



ELECTRONICALLY

First Register as RRE



- If you are an RRE you must register to electronically submit information to CMS.
- To register go to www.swetion11.cms.hhs.gov. Refer to section 8 of the MMSEA User Guide for additional information.

Note: RRE Registration Deadlines have Passed



- We are still in the “Testing Period” An RRE must test data exchange before submitting Claims Files.
- This is a technical not a substantive issue.

Electronic Submission



- RREs will submit information electronically.
- ▶ The actual data submission process will take place between the RREs and the CMS Coordination of Benefits Contractor (the COBC).
- ▶ The COBC will manage the technical aspects of the Section 111 data submission process for all Section 111 RREs.

Method of Reporting



- **Reporting entities should already have software and hardware in place to electronically submit the information.**

What is Reported?



DATA DATA DATA DATA DATA DATA
DATA DATA DATA DATA DATA DATA
BLAH BLAH BLAH BLAH BLAH BLAH

Settled/Released Claims



- **Where the injured party is a Medicare beneficiary and medicals are claimed and/or released Or the settlement, judgment, award, or other payment has the effect of releasing medicals**

Format of Data: Electronic Data Files



- **The Claim Input File is the data set transmitted from an RRE to the COBC that is used to report information.**

File Formats



- **Claim Input File**
- **Claim Response File**
- **TIN Reference File**
- **Query Input File**
- **Query Response File**

Claim Input File **(45 Data Fields)**

- **Injured Party Name**
- **SSN**
- **HICN (Medicare Claim Number)**
- **Gender**
- **DOB**
- **Client**
- **RRE**
- **Litigation Information (Attorney/Representative)**
- **Ongoing responsibility for Medical Payment**
- **Injury/Incident/Illness information (ICD-9 code)**
- **Insurer Information**
- **Additional Claimant information in Death Case**

Initial/Ongoing Claims



- ▶ **Claims for which ongoing responsibility for medical payments exists as of **January 1, 2010 and subsequent, regardless of the date of an initial acceptance of payment responsibility must be reported.****

▶ **Ongoing Claims**



- ▶ Claim information is reported after ongoing responsible medicals (ORM) has been assumed by the RRE or after a Total Payment Obligation to Claimant (TPOC) settlement, judgment, award or other payment has occurred.

When to report?



JANUARY 1, 2010 FORWARD.

Enforcement dates



- Any settlement, judgment, award or other payment made **January 1, 2010**, or after which meet the reporting thresholds.
- **Reports will occur on a quarterly basis**

Ongoing Reporting Dates



- RREs must report new claims for Medicare beneficiaries that received settlements, judgments, awards or medical payments during the quarterly period. TPOC claims are only reported once.

Enforcement by CMS



- **Centers for Medicare/Medicare CMS has the authority to Coordinate Benefits (COBC)**
- **MSPRC – Medicare Secondary Payer Recovery Contractor**

Penalties for Non Compliance:



- **\$1000 per day per unreported claim**

What will CMS do with the Data?



- **Share the data to other Medicare divisions.**
- **Provide the data to contractors who determine whether Medicare is primary or secondary**
- **Provide a response to RRE.**

What Risk Officers and Providers Need to Know:



- **Determine if claimant is a Medicare beneficiary.**
- **Gather information for Claims Input File (see appendix).**
- **Report settlement, judgment, award or payment the RRE.**

What attorneys need to know:



- **Reporting is required whether, or not, there has been an admission or determination of liability.**

Payment may be demonstrated by



- a judgment,
- a payment conditioned upon the recipient's compromise,
- waiver,
- Release of payment for items or services included in a claim against the primary plan or the primary plan's insured,
- or by other means.

Plaintiffs' Attorneys



- This new statute, does not relieve an attorney's obligation to report cases to the Coordinator Of Benefits Contractor (COBC) and it is in the best interest of the attorney to report.

Plaintiffs' Attorneys:



- Medicare will demand the funds it paid for injury-related medical payments, whether, or not, the attorney reported the case.
- If you do not consider Medicare's interest when litigating the case, the final settlement to your client will be lower than anticipated and you may face prosecution for failure to comply or malpractice.

Ignorance is Not Bliss



- In the past, Medicare learned of settlements through claimants or their attorneys when they reported the case to the Coordinator Of Benefits Contractor.
- With the implementation of Section 111, Mandatory Insurer Reporting (MIR), Medicare will discover settlements through insurers.

Defense Attorneys



- **Need to assist clients in compliance.**
- **Prepare interrogatories at the outset to determine Medicare eligibility and the data elements.**
- **Be aware of Medicare Lien and that no release is forthcoming until settlement is consummated.**

Settlement Agreements



- **Consider specific language referencing Medicare Liens.**

Possible Impact to the attorney community:



- **Settlement may be delayed until Medicare's interests have been considered.**
- **Attorneys may be sued for failure to comply with COBC.**
- **Attorneys may have to provide insurers additional information to support their reporting requirements.**

Myth: Workers Compensation Cases Must have Medicare Set-Asides



- **MSAs are not required in order to close a Workers' Compensation case.**
- **Insurers do not have to go back and "close" each case through a structured settlement or MSA.**

Myth: Medicare will seek reimbursement from Insurers who fail to Comply



- **Medicare does not seek recovery directly from Insurers.**
- The Medicare Secondary Payer Recovery Contractor (MSPRC) is responsible for recovering "overpayments" "conditional payments" or "liens."
- The MSPRC recovers mistaken payments (GHP) from employers and conditional payments (NGHP) from beneficiaries. Medicare follows the money.

See US. v. Harris



- **Misleading case law (U.S. vs Harris) has been quoted as evidence that Medicare will recover from Insurers. The quoted case was a suit against an attorney for challenging Medicare's right to recovery. Although not part of the MSP recovery process, the statutes do allow recovery from the Insurer through the civil courts.**

Myth: Claimants must Set Aside Liability Funds.



- Medicare does not require nor encourage Liability Set-Asides as part of MIR or MSP. Medicare's requirement is that funds allocated for "future medicals" must be properly expended.

Myth: Reporting Agents Must Perform MSA



- **A Reporting Agent does not have to perform MSAs** in order to act on your behalf.
- Medicare's GHP and NGHP User guides explicitly state that Agents may report on behalf of Responsible Reporting Entities without caveat.

Myth: MSPRC will not be able to keep up



- **The Medicare Secondary Payer Recovery Contractor (MSPRC)** combined 38 separate contractors and consolidated management from the Regional Offices to the Central Office.
- The MSPRC closed 800,000 pieces of open correspondence inherited from the 38 contractors and met contractual performance goals by mid-year 2008. Medicare is heavily investing in manpower and new computing systems to ensure that the MSPRC will meet the demand.

Myth: You have to report potential beneficiaries



- You only have to report payment, judgment or awards to enrolled Medicare beneficiaries -- Medicare does not require you to report Medicare "eligible" claimants.
- They require you to report enrolled Medicare Beneficiaries that received a one-time payment if they received the payment when they were enrolled.
- If you have assumed responsibility for ongoing payments and that individual enrolls in Medicare at a later date -- then you report that individual at that time.

Myth: Medicare will seek more than the settlement



- **Medicare will not seek to recover more than the settlement amount.**
- If for instance, the Insurer settles the claim for \$2,000, but the Medicare conditional payments (lien) exceed that amount, Medicare only seeks recovery for the settlement amount minus any procurement costs (e.g., attorney fees).
- General rule is 1/3 third of settlement.

Questions?



Important Note:

To comment or make inquiry regarding a Mandatory Insurer Reporting document and/or posting, please utilize the designated mailbox only. PL110-173SEC111-comments@cms.hhs.gov.