

MMSEA, Section 111

Frequently Asked Questions

What is MMSEA Section 111?

Section 111 of The Medicare, Medicaid and SCHIP Extension Act of 2007 institutes mandatory reporting requirements for group health, liability (including self insurance), no-fault insurers and workers' compensation insurers/plans. Insurers are to report certain prescribed claims information in regard to Medicare beneficiaries to the Secretary of Health and Human Services.

What are the major responsibilities for insurance carriers and other primary payers?

Determine Medicare entitlement status of the claimant.
Submit entitled claims to Medicare on a quarterly basis.

What are the penalties for non-compliance?

Failure to comply may result in a \$1,000.00 fine per day, per claim, and possible civil penalties. Fines can go into effect as early as January 1, 2011.

Who is Responsible for Reporting?

The Responsible Reporting Entity (RRE) would be the insurer or self insured plan, please refer to the July 12, 2010 "User Guide" for definitions of RRE, insurer and self insured plan). This document can be viewed at CMS dedicated MMSEA web page <https://www.cms.hhs.gov/MandatoryInsRep/>

Third-party administrators (TPA) are never RREs. CMS has confirmed that TPAs of any type have no reporting responsibilities for liability insurance (including self-insurance), no-fault insurance or workers' compensation. (Unless the TPA is a Self Insured Entity of its own)

Can an RRE assign MMSEA Reporting Requirements to their TPA or a vendor?

CMS will allow the use of agents for MMSEA Section 111 reporting. However, if an agent is designated, the RRE remains responsible and accountable for compliance. Where an entity reports on behalf of another entity required to report, it is doing so as an agent of the second entity. Therefore, if a TPA will report on behalf of the insurance carrier, they would be considered an agent. If that TPA who has been designated to report on behalf of an RRE would like to use an agent, CMS will allow this and has set up their system accordingly.

How will the RRE submit data to CMS?

The data submission process will take place electronically with the Coordination of Benefits Contractor (COBC).

When do RREs need to register?

The registration Period is 5/1/09 – 12/30/10. RREs must register on their own behalf. If an agent will be used for reporting they should be designated at the time of registration. Please review Section 8 Account Registration and Set Up Process in the NGHP User Guide Version 3.1 July 12, 2010

How will the Registration Process work?

At registration an **Authorized Representative** (AR) will be assigned. This should be a person who can legally bind the RRE to the requirements of MMSEA Section 111 reporting. This person will not be a user on the COBC secure web site, but will sign the data use agreement as well as designate and sign off on the **Account Manager** (AM). At the time of registration, the AR will decide how many RRE ID numbers are needed (there is no limit to the number of RRE IDs which can be set up). The number of IDs needed will depend on how the RRE wants to set up the reporting process. If the RRE works with multiple TPAs and would like each individual TPA to be responsible for reporting they will register for an RRE ID for each TPA. If an RRE has 2 different claims systems (i.e. WC versus Liability) they should set up two RRE IDs so claims can be reported separately. If an RRE has several subsidiaries and wants to report those cases separately, they will register for multiple RRE IDs. Each RRE ID can send one data submission file per quarter and one query file per month. The **Account Manager** (AM) will manage the day to day processing of the data transfer. The AM can be an employee of the RRE, a representative of the TPA or a representative of an agent. **Account Designees** (AD) are people who will be designated by the AM and will have the ability to upload, monitor and transfer files. If an RRE wants to use their TPA to report, but the TPA wants to contract out to an agent to handle the reporting, CMS will allow this. The RRE will have an AR from their company designated. The TPA can be marked as the AM and the TPA will then name the agent they would like to use for reporting purposes. The TPA can then designate people from the agent to be ADs.

How will RREs verify whether a claimant is a Medicare beneficiary for MMSEA Section 111 reporting purposes?

CMS has confirmed that they will provide a Query function to Non-GHP RREs to verify Medicare beneficiary status. The Query function will be an electronic file exchange process:

- **Each RRE ID can submit one query file per month.** The COBC will return a response file to the entity which submitted the file (either the agent or the RRE).
- The information required for the Query will be SSN (or HICN), name, DOB and gender.
- The SSN is **REQUIRED** to run the Query. If there is a match (*claimant is currently on Medicare or was on Medicare at some time*) with the above data, CMS will send back the HICN for that person.
- Query Response files will be returned within 14 days.
- If the CMS response file indicates there is no match that does not mean the claimant is not on Medicare. It just means there was no match based on the data provided (some data could be incorrect). The Query function is only as good as the data submitted.
- Social Security entitlement information **WILL NOT** be provided through the Query function.
- The Query function should be used to filter claims to determine which cases should be reported as CMS only wants data on Medicare beneficiaries. CMS discourages "data dumping" (sending all claims without verifying Medicare status) and recommends that the Query function is utilized.
- CMS confirmed that it is acceptable to report ALL cases where the claimant is age 65 or older rather than doing a Query on these files. This will not be considered "data dumping."

Will CMS advise the RRE if a SSN is incorrect?

CMS indicated that the Query function will not identify if a SSN is incorrect. CMS has made the decision that the only information that will be returned on the Query file is the claimant's Medicare status. Verification of Social Security status through the Social Security Administration will still be required for MSP compliance purposes to determine the need for an MSA allocation since CMS has no plans to offer any information other than Medicare entitlement status.

When will the data transfer process be tested?

The voluntary testing Period ends 12/31/2010. However if testing is completed before January 2010, RRE's can begin submitting live data files in the last quarter of 2010. All users associated with the RRE's account will be able to submit test files. The Query function will also be tested at the same time as the data transfer. CMS encourages all RREs to register and begin testing within the above noted timeframes. Live data is not required for testing- the RRE should still go through the testing process even if they do not yet have all the required data. The mandatory testing period begins January 1, 2010 through December, 31, 2010.

When will an RRE be required to submit live data to CMS?

Live Reporting will begin in the first quarter of 2011 and each RRE will receive a designated quarterly submission timeframe assigned by the COBC.

What if multiple RREs are involved in the same case?

Multiple RREs involved in the same settlement are all responsible for their own reporting under each individual policy. This would apply when there is a workers' compensation (WC) case which involves a WC carrier as well as a third party liability carrier. This would also apply when there is no-fault and liability coverage on a case. The reporting process is claimant specific as well as policy specific.

Which claims need to be reported?

- All claims involving a Medicare beneficiary where a settlement, judgment, award or other payment is made as of October 1, 2010 or later.
- All claims involving a Medicare beneficiary where ongoing responsibility for medical payments exists as of January 1, 2010 regardless of the date of the initial acceptance of payment responsibility.

What if a claimant is not a Medicare beneficiary at the time ongoing responsibility for medicals (ORM) is assumed? Does that claim need to be reported?

If an individual is not a Medicare beneficiary at the time responsibility for ongoing medicals is assumed, the RRE must monitor the status of that individual and report the case when the individual becomes a Medicare beneficiary. This would be done by continuing to Query the claimant on the RREs monthly Query file.

Exception: Responsibility for ongoing medicals has terminated before individual becomes a Medicare beneficiary.

What about claims that are closed and/or inactive?

For ORM assumed prior to January 1, 2010, if the claim was actively closed or removed from current claims records prior to January 1, 2010, the RRE is not required to identify and report that ORM under the requirement for reporting ORM assumed prior to January 1, 2010. If such a claim is later subject to reopening with further ORM, it must be reported with full information, including the original DOI (as defined by CMS). **What does this mean...?** If a claim is closed and/or inactive prior to 1/1/2010, the RRE does NOT need to report it unless a subsequent payment is made causing the file to be reopened.

What about reporting thresholds?

CMS issued an alert dated 3/20/2009:

http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSupp_NGHP.pdf

For **workers' compensation** ORM, claims meeting the **all** of following criteria are excluded from reporting:

- a. "Medicals only."
- b. "Lost time" of no more than 7 calendar days.
- c. All payment(s) has/have been made directly to the medical provider.
- d. Total payment does not exceed \$750.00.

For **liability insurance (including self-insurance) and workers' compensation TPOCs**, the following dollar thresholds apply:

- a. For TPOCs dates of After 10/1/2010, TPOC amounts of **\$0.00 - \$5,000.00** are exempt from reporting except.
- b. For TPOCs dates of January 1, 2011, through December 31, 2011, TPOC amounts of **\$0.00 - \$5,000.00** are exempt from reporting.
- c. For TPOCs dates of January 1, 2012 through December 31, 2012, TPOC amounts of **\$0.00 - \$600.00** are exempt from reporting.

When and how will CMS fine for non-compliance?

CMS has continually stated on conference calls that they are more interested in good quality data rather than passing out fines. CMS is expecting all RREs to register and test data according to the current timeline in place. Real data is not required for testing, so the RRE should register and begin testing as soon as possible. CMS has indicated in the past that the first step in compliance with Section 111 is to follow the timeline. If RREs want to be in compliance, they need to register and test within the appointed timeframes and be prepared to do live reporting in the first quarter of 2011. If the RRE is having any issues with being ready to report, they need to discuss their issues with the assigned EDI Representative.

Can an agent servicing multiple RREs request the same quarterly reporting timeframe?

CMS has indicated that they will attempt to accommodate specific requests by RREs or agents. This may include requesting the same reporting dates for multiple RREs or requesting one EDI Representative for multiple RREs for which an agent must report.

Does MMSEA Section 111 have an impact on or change the Medicare Set Aside Process?

No. CMS has made it clear that MMSEA Section 111 does not change or alter any legal obligation/requirements under the Medicare Secondary payer statute (MSP). The MMSEA does not have a direct impact on the MSP. Therefore, insurers are still responsible for protecting Medicare's interest still need to be considered for both past (conditional payments/liens) and future (MSA) payments. MMSEA Section 111 does impose new claim reporting requirements on claims handlers, which are in addition to the necessity of protecting Medicare as a secondary payer under the MSP. The indirect impact is that CMS will now have a report outlining every case where Medicare should be protected as a secondary payer. **At any time in the future, CMS can select cases to audit for MSP compliance.**

How should a case involving deductibles or co-payments be reported?

Please see the CMS Alert dated May 26, 2010 for the revised definition of Who Must Report. www.cms.gov/MandatoryInsRep/Downloads/AlertWhoMustReportrev052610.pdf

How does MMSEA Section 111 reporting affect claims handlers?

Adjusters may need to adapt to system changes which will be necessary to capture all the data required for Section 111 reporting. Additional information may need to be obtained from claimants to comply with the data elements CMS requires to be reported. Expedited Medicare status will be important (through the Query function) to ensure timely reporting. Section 111 reporting brings a heightened awareness to Medicare conditional payments (liens). Adjuster should address potential Medicare conditional payments early in the claims process.

Who do I contact @ CMS if I have problem?

If there is a program or technical problem involving Section 111 data exchange, the first person to contact is your assigned EDI Representative at the COBC. If an EDI Representative is not yet assigned, call the **COBC EDI Department at 646-458-6740.**

If after working with the EDI Representative, the problem still requires assistance at a higher level, please contact **Jeremy Farquhar, at 646-458-6614 or JFarquhar@ghimedicare.com.** If further escalation is necessary, contact the **COBC EDI Manager, Bill Ford, at 646-458-6613 or WFord@ghimedicare.com.** The **COBC Project Director, with overall responsibility for the COBC EDI Department, is Jim Brady.** Mr. Brady can be reached at **646-458-6682 or JBrady@ghimedicare.com.**

See how MedAllocators can help you prepare for MMSEA readiness. To discuss MMSEA requirements, contact your Account Executive or Harold Brooks at 678-993-3312 hbrooks@medallocators.com MedAllocators Reporter Specialist.