



Beacon Industry Update

Medicare Section 111 mandatory reporting update

So, there's a new "stimulus" in town, and it's backed by the fines from CMS for failure to file eligibility reports.

As you know, section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("Section 111") added some mandatory reporting requirements for group health plans ("GHPs")--let's not forget about the "stimulus" for compliance--\$1,000 fines PER PERSON PER DAY for failure to report qualifying individuals.

By the way, the timetable says that GHP's should be registered to begin testing already.

This is all about Coordination of Benefits ("COB"). The Feds want to be sure that if any other entity is on the hook for reducing Medicare's costs on claims for individuals for which you manage coverage, you're on the hot spot. Furthermore, they're requiring online reports, at least quarterly.

If your legacy vendor still hasn't given you Medicare COBA crossover claims yet, they'll never meet the deadline. Getting these claims directly from the federal contractor makes the COB process in your office much easier, and **MUCH MORE ACCURATE** than waiting for the COB info from the Provider and typing it into your legacy system.

If you already get COBA files directly, you can bet that your legacy vendor will charge a hefty premium for adding the new Section 111 reports, even though the formats for reporting Section 111 eligibility are very similar to the eligibility submission requirements for COBA.

Either way, you owe it to yourself to look at SpyGlass. COBA claims information is "live" and built-in. We're testing the Section 111 requirement directly with CMS now. SpyGlass is a claim system that was made for HIPAA, is fully web-based, and designed to support the market needs of today. It's a true "Google era" application.

Fact Sheet based on the overview at <http://www.cms.hhs.gov/mandatoryinsrep/>

Medicare Secondary Payer Mandatory Reporting

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), adds new mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. See 42 U.S.C. 1395y(b)(7) & (8). The information below includes a section addressing the Centers for Medicare &



Medicaid Services' (CMS) implementation plans as of June 1, 2008, as well as a brief overview of the provisions of the law.

Implementation, General

* January 1, 2009, implementation date for GHP * July 1, 2009, implementation date for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. * A Paperwork Reduction Act (PRA) Notice was published in the Federal Register, August 1, 2008, (Volume 73, Number 149) with a link for associated documents. * Implementation may be "by program instruction or otherwise." * All instructions for implementation will appear at this site (www.cms.hhs.gov/MandatoryInsRep), through a link to this site, or as a document which may be downloaded from this site or an associated link. The materials will include both draft (when possible) and final documents, including information on how interested parties may comment on the documents and/or CMS' implementation of MMSEA section 111.

The types of planned documents include, but are not limited to:

- Statutory provisions.
- August 1, 2008 Paperwork Reduction Act Federal Register as a link or download.
- Supporting statement (with Attachments) for the August 1, 2008 Federal Register PRA notice.
- Data elements for reporting related to GHP arrangements and data elements for reporting related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation (part of the PRA supporting statement/Attachments).
- Definitions and Reporting Responsibilities (provides details which will assist individuals/entities in determining if they are responsible reporting entities; part of the PRA supporting statement/Attachments).
- "ALERT" regarding collecting Social Security Numbers (SSNs), Medicare Health Insurance Claim Numbers (HICNs), and Employer Identification Numbers (EINs), (may be helpful if a responsible reporting entity receives questions about the collection of SSNs and/or HICNs).
- "Opportunity for Public Comment" (provides information on submitting comments to CMS through a dedicated e-mail address).
- Record layouts.
- Registration process for reporting.
- Time-frames/timelines (provides details on when registration for reporting must be completed, when reporting will start, time-frames for testing, etc.).
- "User Guides" for the submission of data
- A suggested model form for the collection of Medicare beneficiary information.



- What Medicare claims processing contractors need to know about Section 111.

The new provisions for GHP arrangements found at 42 U.S.C. 1395y(b)(7):

* Add reporting rules; do not eliminate any existing statutory provisions or regulations. * Include penalties for noncompliance. * Contain provisions for the Secretary to share information on Part A entitlement and enrollment under Part B. * Who must report: "an entity serving as an insurer or third party administrator for a group health plan...and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary." * What must be reported: data elements determined by the Secretary. * A voluntary GHP insurer reporting process is already in place. The mandatory reporting process will build upon the existing voluntary process. * When/how reporting must be done:

- In a form and manner, including frequency, specified by the Secretary.
- GHP reporting will likely be no more than quarterly.
- Submissions will be in an electronic format.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8):

* Add reporting rules; do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment. * Include penalties for noncompliance. * Who must report: "an applicable plan." "...[T]he term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement: (i) Liability insurance (including self-insurance). (ii) No fault insurance. (iii) Workers' compensation laws or plans." * What must be reported: the identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim. * When/how reporting must be done:

- In a form and manner, including frequency, specified by the Secretary.
- Information shall be submitted within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).
- Submissions will be in an electronic format.

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