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LITIGATION UPDATE

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MMSEA Section 111 Mandatory Reporting: A Guide to the User Guide

The Centers for Medicare and Medicaid Services (CMS) have issued multiple versions of a User Guide designed to shed light on the complex reporting requirements mandated by the Medicare, Medicaid and SCHIP Extension Act, better known as MMSEA. The MMSEA aims to ensure that Medicare is reimbursed for conditional payments on behalf of Medicare beneficiaries when their injuries are caused by a Responsible Reporting Entity (RRE).

Unfortunately, the User Guide has created more confusion than clarity. The uncertainty surrounding implementation of the MMSEA is troubling—particularly when considering the $1,000 per day penalty for each day of noncompliance. This Alert provides an overview of the MMSEA Section 111 reporting requirements and highlights several key compliance issues. We also have a Best Practices guide to MMSEA reporting available on request.

MMSEA Section 111 Overview

Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation or in which another government entity was responsible. With the addition of the Medicare Secondary Payer (MSP) provisions in 1980, Medicare became a secondary payer to group health plan coverage in certain situations and is always a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation. The MSP provisions have been amended several times, including by the passage of the MMSEA in 2007.

Section 111 of the MMSEA imposed new, mandatory reporting requirements with respect to settlements, judgments and other payments made on behalf of Medicare beneficiaries. The MMSEA bridged the funding gap created by escalating Medicare costs by enabling Medicare to recover conditional payments made on behalf of beneficiaries in situations where another party or entity has assumed primary responsibility for those payments. While Medicare has always had the ability to pursue recovery claims where appropriate, the MMSEA has shifted the burden of identifying these potential claims to various Responsible Reporting Entities, including insurance companies, pharmaceutical companies and product manufacturers.

The mandatory reporting requirements apply to Medicare beneficiaries who have coverage under group health plan arrangements and to those who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance or workers' compensation. The new reporting provisions are being implemented by CMS, a federal agency which is part of the Department of Health and Human Services. The data collected under Section 111 reporting will be used by CMS in processing claims billed to Medicare for reimbursement for items and services furnished to Medicare beneficiaries and for MSP recovery efforts.

Whom should I contact for more information?

Our team has prepared a Best Practices guide to navigating the MMSEA. To receive this guide, or request further information on any of the topics discussed here, we welcome you to contact the partners listed below:

Siobhan A. Handley
New York, NY
212-506-3757
shandley@orrick.com

Robert P. Reznick
Washington, D.C.
202-339-8409
rreznick@orrick.com

Does Section 111 replace or eliminate existing obligations?

Mandatory reporting under Section 111 is an additional method for CMS to obtain information regarding situations where Medicare is appropriately a secondary payer. Section 111 does not replace or eliminate any existing obligations under the MSP provisions for any entity. For example, Medicare beneficiaries who receive a liability settlement, judgment, award or other payment still have an obligation to refund associated conditional payments to Medicare within 60 days of receipt. 42 C.F.R. § 411.24(h). Similarly, Section 111 reporting requirements do not eliminate Medicare's existing processes, including those followed by the Medicare Secondary Payer Recovery Contractor for MSP recoveries. While demands involving liability insurance recoveries against a settlement, judgment, award or other payment are routinely issued to the Medicare beneficiary, Medicare may initiate recovery proceedings against a third-party payer for reimbursement if Medicare is not reimbursed by the beneficiary within 60 days of receipt of the third-party payment. 42 C.F.R. § 411.24(i).

Who must report?

An entity's reporting obligation—i.e., whether it is a Responsible Reporting Entity—hinges on the entity's risk retention plan. According to the MMSEA Section 111 statutory language, an RRE is any "applicable plan," including, but not limited to, liability insurance (including self-insurance), no-fault insurance and workers' compensation plans. 42 U.S.C. § 13957(b)(8)(F). Liability insurers are those that, in return for the receipt of a premium, assume the obligation to pay claims described in an insurance contract and assume the financial risk associated with such payments. An entity that engages in a business, trade or profession is deemed to have a self-insured plan if it carries its own risk—whether by a failure to obtain insurance or otherwise—in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award or other payment to satisfy an alleged claim (including any deductible payment or co-payment on a liability insurance plan) for a business, trade or profession.

An RRE may not by contract or otherwise shift its reporting responsibility, although it may contract with a third-party administrator to act as an agent for reporting purposes. Agents may include data service companies, consulting companies or other similar entities that can create and submit Section 111 claim files to the CMS Coordination of Benefits Contractor (COBC) on behalf of the RRE. The RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of the data submitted. In addition, registration for reporting and file submission with the COBC must be completed by the RRE.

What must be reported?

RREs are required to submit claim files containing information for all claims involving a Medicare beneficiary as the injured party where medical expenses were claimed and/or released and were addressed or resolved through a settlement or other payment. CMS recently issued an Alert which extended by one year—but only for certain claims—the date that triggers a reporting obligation. No-fault insurance, workers' compensation and liability insurance (including self-insurance) claims for which the RRE has assumed ongoing responsibility for medicals (ORM) must be reported if the payment obligation accrued on or after October 1, 2010. Liability insurance (including self-insurance) claims for which the RRE has not assumed ORM must be reported if the payment obligation accrued on or after October 1, 2011.

If the injured party is deceased, the RRE has a reporting obligation if the decedent was a Medicare beneficiary at any time from the date of incident (alternatively defined by CMS as the date of incident, date of first exposure, date of first ingestion and/or date of implant) until the date of death. Registered RREs may submit a query to the COBC to determine the Medicare status of an injured party before submitting claim information.

The data required for Section 111 reporting includes:

- The injured party's Social Security Number and/or Medicare Health Insurance Claim, full name, gender and date of birth
- The venue whose state law controls the resolution of the claim
- The date of incident as defined by CMS (e.g., date of incident, date of first exposure, date of first ingestion)
- The diagnosis and alleged cause of the injury/illness/incident

- The date a payment obligation was established, the total payment amount and the estimated date of funding (if payment has been or will be delayed)

- Information about the injured party's representative (e.g., attorney, guardian/conservator, power of attorney), including his or her first and last name, firm name (if applicable), Federal Tax Identification Number, mailing address and phone number

- Information about the claimant (if the claimant is not the injured party/Medicare beneficiary, as in wrongful death cases), including his or her full name, Federal Tax Identification Number, mailing address, phone number and relationship to the injured party

In addition to the above claim-specific information, the RRE must report information regarding the type of insurance coverage provided, including the Federal Tax Identification Number of the applicable plan, the plan policy number and the relevant claim number(s).

What is the current implementation timeline?

On November 9, 2010, CMS issued an Alert announcing that the implementation date for submission of initial claim reports had been changed from the first calendar quarter of 2011 to the first calendar quarter of 2012 for all reportable liability insurance (including self-insurance) claims where the RRE has not assumed ongoing responsibility for medicals (ORM). Liability insurance (including self-insurance) ORM reporting, as well as reporting of no-fault and workers' compensation claims, is not subject to this delay—i.e., initial claim reports must be submitted during the first calendar quarter of 2011.

What are the penalties for noncompliance?

RREs that fail to comply with Section 111 mandatory reporting requirements shall be subject to a penalty of $1,000 for each day of noncompliance for each individual for which information should have been submitted.