PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:34 AM
To: CMS PL110-173SEC111-Comments
Subject: #33 [NGHP dta elements -- individulas vs. corporations] Business and Individual Policyholders

Policyholders may be a business or individual person. What fields are required if the policyholder is a person? How would an insurer indicate the policyholder is a person and not a business?

Shannon Sargent
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PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:35 AM
To: CMS PL110-173SEC111-Comments
Subject: #34 [NGHP --define "situational"] Nature and Cause of Injury

The "Nature of Injury" and "Cause of Injury" are situational. Define situational.

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:35 AM
To: CMS PL110-173SEC111-Comments
Subject: #35 [NGHP -- define venue] State of Venue

Is the "State of Venue" the loss state or some other state?

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:36 AM
To: CMS PL110-173SEC111-Comments
Subject: #36 [NGHP --need furtheer clarification re product liability info] Product Liability

Field required for "Product Liability" claims seem to suggest this field is reserved for claims related to defects with pharmacy products. Define the intent of these fields and if an insurer should use them for general product liability claims, such as manufacturing equipment, etc.

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:36 AM
To: CMS PL110-173SEC111-Comments
Subject: #37 [NGHP --Q "funding" data element] Funding

Is "Funding" related to whether the insurer's decision was based on the resolution of a Medicare/Medicaid lien? Are the only appropriate values for this field Yes or No?

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:37 AM
To: CMS PL110-173SEC111-Comments
Subject: #38 [NGHP --plan type Q re self-insured] Self-Insured Plan Type

Why is Self-Insured not an insurance plan type?

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Wright, Barbara J. (CMS/OFM)
Sent: Friday, September 12, 2008 3:25 PM
To: CMS PL110-173SEC111-Comments
Subject: #39 [NGHP --frequency for ongoing & reporting on prior to 7/1 ongoing] MMSEA 111 & WC & FCA Q's from Brad Cain (W Question - Here Are The Answers)

Q's that need addressed.

From: Wright, Barbara J. (CMS/OFM)
Sent: Friday, September 12, 2008 3:18 PM
To: Ashkenaz, Peter (CMS/OEA)
Cc: Mills, George G. (CMS/OFM); Wright, Barbara J. (CMS/OFM); Johnson, Frank (CMS/OFM); Vriezen, Lisa A. (CMS/CPC); Albert, John P. (CMS/OFM)
Subject: MMSEA 111 & WC & FCA Q's from Brad Cain (Workers Comp Question - Here Are The Answers)

Peter:

We assume that the two questions below are being asked in the context of the mandatory reporting requirements in Section 111 of the MMSEA. We will be addressing these issues shortly on the MMSEA 111 dedicated web page along with other similar issues. This web page, which can be found at www.cms.hhs.gov/MandatoryInsRep/ , is being used to communicate all official instructions for CMS' implementation of Section 111. A number of documents are already available for downloading. Additionally, under "Related links inside CMS" Mr. Cain can sign up to receive an automatic notification every time the web page is updated, if he would like to do so.

- Q: "What impact will this have on cases where an injured workers have received a life pension? Do carriers have to continually monitor their claims files for past recipients who become medicare eligible (i.e. they weren't eligible at the time of the settlement but become so years later and are still receiving payments/services for the workers' comp injury)?"

- Q: "If they do have to report this – is it every time they make a payment or just once after they become eligible?"

With respect to Mr. Cain's question concerning record retention -- CMS has advised for some time that third party payers may wish to keep records for at least 10 years because of the length of time allowed for the initiation of a False Claims Act action, regardless of who might initiate such an action.

From: Mills, George G. (CMS/OFM)
Sent: Thursday, September 11, 2008 7:18 PM
To: Wright, Barbara J. (CMS/OFM)
Subject: Fw: Workers Comp Question - Here Are The Answers

Sent from my BlackBerry Wireless Device

From: Ashkenaz, Peter (CMS/OEA)
To: Walters, Gerald T. (CMS/OFM); Mills, George G. (CMS/OFM)
Sent: Wed Sep 10 19:50:18 2008
Subject: Fw: Workers Comp Question - Here Are The Answers

Hi guys. More questions.

Sent using BlackBerry

From: Brad Cain - Workers' Comp Executive
To: Ashkenaz, Peter (CMS/OEA)
Sent: Wed Sep 10 19:11:55 2008
Subject: RE: Workers Comp Question - Here Are The Answers
Hey Peter,

Thanks for these responses.

In talking with a couple others in the industry, some other questions have come up.

What impact will this have on cases where an injured workers have received a life pension? Do carriers have to continually monitor their claims files for past recipients who become medicare eligible (i.e. they weren't eligible at the time of the settlement but become so years later and are still receiving payments/services for the workers' comp injury)?

If they do have to report this – is it every time they make a payment or just once after they become eligible?

And I'm hearing that people should keep the records of settlements, etc. for at least 10 years – correct (because CMS reserves the right to look back 10 years under the false claims act).

Thanks,
Brad

From: Ashkenaz, Peter (CMS/OEA) [mailto:Peter.Ashkenaz@CMS.hhs.gov]
Sent: Thursday, September 04, 2008 5:14 AM
To: bcain@provpubs.com
Subject: FW: Workers Comp Question - Here Are The Answers

Hey Brad – here are some answers:

As I mentioned I am working on the issue of Medicare set-asides in the context of workers' comp settlements. I have been hearing from both sides (defense and injured workers' reps) that these are becoming more of an issue in settling workers' comp cases – both in the time it takes to be approved and the overall amounts that have to be set aside.

What cases need CMS' approval?

- Under the Medicare statute, Medicare is a secondary payer to Workers Compensation. CMS has created a **recommended** review process for proposed Workers' Compensation Medicare Set Aside Arrangements (WCMSA) amounts that will be part of the WC settlement, judgment, and/or award. There is no statutory or regulatory requirement that WCMSAs be submitted to CMS for review. However, if a WCMSA is reviewed by CMS, and CMS did not feel that Medicare's interests were

adequately protected, and taken into account, Medicare would have an independent right of recovery against the WC insurer.

In the CMS' MSP WCMSA process, CMS reviews proposed WCMSA amounts. CMS' review and approval is limited to the proposed amounts (vs., for example, the settlement itself) although CMS makes its approval contingent upon receiving proof that the CMS-approved WCMSA amount has been fully funded as stipulated in the recommendation approval letter. Submission of a proposed WCMSA amount to CMS is not required, but it is a recommended process. Non-review by CMS because of current threshold amounts does not create a safe harbor of any type. However, CMS approval of a proposed WCMSA amount does provide the WC claimant with certainty regarding how much of the settlement, judgment, or award must be exhausted for future medical expenses on Medicare covered services and prescription drug treatment that would otherwise be reimbursable by Medicare. It is the CMS' understanding that some State WC courts are requiring CMS' review and approval of a proposed WCMSA amount before finalizing any settlement, judgment, or award. This is not a CMS requirement.

In July 2001, CMS instituted workload thresholds for review of WCMSA proposals when a WC claimant was not a Medicare beneficiary at the time of settlement. To the extent, the total WC settlement amount is greater than $250,000 and the claimant is reasonably expected to become a Medicare beneficiary within 30 months of the settlement, then a CMS-approved WCMSA would be appropriate. However, if a WC total settlement amount is $250,000 or less or where the claimant of that settlement is not reasonably expected to become a Medicare beneficiary within 30 months of the settlement date, then a CMS-approved WCMSA would not be appropriate.

In July 2005, CMS instituted a workload threshold for review of a WCMSA when a claimant was already a Medicare beneficiary at the time of settlement. The CMS would no longer review WCMSA proposals where the total settlement amount— was equal to or less than $10,000. In April 2006, CMS revised the workload threshold for claimants that were already Medicare beneficiaries at the time of settlement, and CMS would no longer review WCMSA proposals where the total settlement amount is equal to, or less than, $25,000. The CMS wishes to stress that these review thresholds are only workload thresholds and are not substantive dollar or "safe harbor" thresholds.

Is it incumbent on both sides to report the case to CMS or only the employer/insurer?

- CMS has no preference who submits the WCMSA proposal. CMS' major concern is that the amount proposed provides for all the anticipated future Medicare reimbursable services for the remaining life expectancy of the beneficiary and/or the claimant who will reasonably be expected to become a Medicare Beneficiary within 30 months of settlement. Under the mandatory reporting requirements, the payer is the entity that would report the required data under Section 111.

How many cases are you seeing and is this number changing?

- Over the last few months May through July 2008, we have reviewed and approved 1,472, 1514 and 1,565 MSA per month respectively. The total number of WCMSAs proposal submitted appears to be increasing. Since November 19, 2007 the WCRC has reviewed 12,835 cases with a MSA value of $533,695,937.

Are the set-aside amounts growing?

- There is definitely an increase in the reported "Total Settlement Amount" of workers' compensation settlements.

What impact do you expect from the new reporting penalties (the $1K/day) that take effect next year? Will the penalty apply to both sides – defense and applicant?

- CMS does not expect to assess many Civil Monetary Penalties (CMPs) under MMSEA Section 111. The CMS main objective is to receive and share quality data that both sides can use. CMS will be working with the industry on reporting under MMSEA Section 111. CMS has a dedicated webpage, www.cms.hhs.gov/MandatoryInsRep, where CMS will release information regarding the reporting requirements by Responsible Reporting Entities (RREs).

Is there a typical timeframe for getting cases approved.

- Currently our Workers' Compensation Review Contractor (WCRC) is averaging 47 days. This includes development time for additional information that was omitted from the original WCMSA submission. The majority of our Regional Offices reviews and approve the recommendations within a week. There also is a 3-5 day time from when the various letters are mailed to the appropriate parties. So, for WCMSA proposal that include all the pertinent information, where there is no need for development we are turning them around in about 60 days. As of September 1, 2008, CMS has created six Regional Centers of Excellence to develop expertise in reviewing WCMSAs and provide better customer service.

PARHAM, WILLIAM N. (CMS/OSORA)

From: tafflaw@earthlink.net
Sent: Tuesday, September 16, 2008 12:56 PM
To: CMS PL110-173SEC111-Comments
Subject: #41 [Section 111 unjustiifed] My Comments to CMS.

I wish to comment -- and adversely -- on the new reporting requirements to be imposed upon liability insurers and self-insurers in the case of third party personal injury claims. There is simply no need for this. You can show no necessity for this additional requirement. Need and necessity must be shown before governmental regulations are imposed in any field of private endeavor. The extra work for taxpayers will far outweigh any monetary benefit to Medicare.

Medicare recipients are already advised and warned about reporting this sort of thing. You are about to double-load and double-burden all of us in this field of work. Please do not impose these regulations! The economy can bear only so much extra, unnecessary work in connection with processing personal injury claims.

FRANK D. TAFF, J.D.
www.TAFFLAW.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Donna Mize [DMize@healthadvocatesinc.com]
Sent: Thursday, September 18, 2008 2:24 PM
To: CMS PL110-173SEC111-Comments
Cc: Brenda Smith
Subject: #44 [NGHP -- govt. should bear entitlement verification burden] Comments from PMSI MSA Services regarding MMSEA reporting requirements

Importance: High

As a leader in the MSA industry we, PMSI MSA Services, would appreciate your consideration of the following:

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 on cases where the claimant is a Medicare beneficiary. The legislation also includes penalties of $1,000.00 per day per claim for Medicare-entitled cases that are not reported in accordance with the Secretary of Health and Human Services instructions.

The first step in the process of compliance with the MMSEA is for the primary payer to verify the claimant's Medicare status. If the claimant is a Medicare beneficiary, the primary payer must report the case to Medicare.

Currently, verification of Social Security and Medicare status is done by obtaining a signed SSA-3288 release form which is then sent to the appropriate Social Security Office for a response. This process can take several weeks to several months, depending on the Social Security office that is contacted.

Please note, primary payers are dependent on claimants to sign a consent form in order to obtain this information. There are no penalties assessed against the claimant for refusing to cooperate with this process (i.e. sign a release and/or disclose the proper Medicare entitlement information to the primary payer). However, even if the claimant remains uncooperative, the primary payer is still held liable under the current proposed reporting requirements with a significant fine for non-compliance.

Insurance carriers and third party claims administrators (primary payers) have expressed their concern with the extended turn around time of current paper process of obtaining Medicare entitlement information. The lack of timely responses from the Social Security Administration (SSA) will inhibit the primary payers from reporting promptly under the MMSEA. It is of the utmost importance that primary payers have adequate access to this information in light of the significant $1,000.00 per day per claim fines that can be imposed as of July 1, 2009. It is also anticipated that with the implementation of the MMSEA, the respective SSA offices will receive more requests for SS verification than in the past which may increase the turn around times from the SSA.

It is imperative for the Federal Government to give consideration to implementing an electronic verification process for Medicare entitlement status rather than the current paper based process. The paper process of verification does not allow a swift enough turn around time and could jeopardize the timeliness of the affirmative legal obligation of the SCHIP Act reporting.

Since the MMSEA mandates insurer reporting which is absolutely dependent on first obtaining information from the SSA, it seems reasonable that CMS should work hand in hand with the SSA to implement a process for the primary payers to obtain the necessary information quickly and easily. The best way for this to occur would be to create an electronic format for which this information can be obtained by the primary payers.

In view of the statutory imposition of the SCHIP Act claim reporting requirements, CMS should consider the concerns of the industry (primary payers) in regard to this issue. If the first step in the process (Medicare entitlement verification) can not be expedited, the ramifications to the primary payers in regard to potential fines for non-compliance are great.

Accordingly, we suggest the following steps:
1) Support the establishment of an electronic inquiry process where primary payers and their representatives may seek clarification of claimants' Medicare status.

2) The inquiry should be based on social security number.

3) Inquiries should be allowed by any primary payer or their representatives (i.e. direct or third party).

4) The information sought is strictly the Medicare entitlement status of the claimants, so there should be encryption protection preventing any further information from a claimant's file from being transmitted.

5) The electronic "bridge" allowing Medicare status inquiry will allow all primary payers the opportunity to proactively and timely generate the mandatory claim reporting requirements under the MMSEA. It will also result in a collateral benefit; primary payers will be more likely to protect Medicare as a secondary payer when settling claims, thus assisting with maintaining Medicare's fiscal health.

Donna Mize
Director of Quality Control & Training
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Single-Source Solution for Workers' Compensation

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Friday, September 19, 2008 1:30 PM
To: CMS PL110-173SEC111-Comments
Subject: #48 [GHP -- SEE, rename some elements, etc.] Required Data Elements: "Employer" and Multiemployer Plans

Most Taft-Hartley multiemployer plans cover employees of multiple contributing employers. Participants may work for different contributing employers at different times, and may simultaneously work part-time for two or more contributing employers. A participant may have active coverage while not actively working for any contributing employer, because current active eligibility is almost always based on past work. Another participant may be working for Employer A at a time when his or her active eligibility was earned (and paid for) by Employer B in the recent past. This is especially common among certain construction trades.

Therefore, it is often impractical, or at best arbitrary, to identify a participant's employer at any given time.

In addition, when an individual is covered under a multiemployer plan, the plan (not the employer) is responsible for claims. Therefore, CMS should direct Medicare reimbursement demands to the plan, not the employer. The employer would forward them to the plan administrator anyway, so the matter would be resolved faster if the demand were sent directly to the plan administrator.

I recommend that the "Employer" EIN field be relabeled or redefined to mean Plan Sponsor, and that the multiemployer plan's EIN and address be reported to CMS.

Also, please clarify how "Employer Size" and "Small Employer MSP Exception" apply when the individual is covered under a multiemployer plan.

David Pittman
Manager, Compliance | National Support | Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210 | Columbia MD 21044
410-884-1416 (direct) | **410-884-1424** (fax) | **141416** (VOIP)

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Friday, September 19, 2008 2:09 PM
To: CMS PL110-173SEC111-Comments
Subject: #50 [GHP data element Q from Attachment C] Required Data Elements: Insurance terminology

The list of **Required Data Elements** in **Attachment C** refers to insurers and policies, making it difficult to interpret these requirements in the context of a self-insured plan, whether administered by a TPA or self-administered. **Attachment A** defines "Insurer" as meaning a commercial insurance carrier. Please clarify the following:

7. Document Control Number (Assigned by the insurer)
Who assigns the Document Control Number when there is no insurer?

13. Policy Holder's First Name
14. Policy Holder's Last Name
15. Policy Holder's Social Security Number
*Self-insured plans do not have Policy Holders. (HIPAA Implementation Guides refer to **Subscribers**.)*

18. Group Policy Number
What does "policy" mean with reference to a self-insured health plan?

19. Individual Policy Number
What does "individual policy" mean in the context of any group plan, insured or self-insured? Should this be "subscriber number"?

20. Employee Coverage Election (Who the policy covers)
What does "policy" mean with reference to a self-insured health plan?

23. Insurer EIN and Business Address
What does this mean with reference to a self-insured plan?

24. Rx Insured ID Number
Does this mean Subscriber ID?

29. Person Code (Assigned by Insurer)
Who assigns the Person Code to participants in a self-insured plan?

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PARHAM, WILLIAM N. (CMS/OSORA)

From: ljeanp59 [ljeanp59@netzero.net]
Sent: Saturday, September 20, 2008 11:58 AM
To: CMS PL110-173SEC111-Comments
Subject: #52 [SSN complaint] QUESTIONS:

I would like to find out why: almost all seniors and disabled adults end up living in the slums; also, how many times have the SS department, governement, CMS, and everybody says "NEVER GIVE ANYONE ONE YOU SOCIAL SECURITY NUMBER" but in fact everybody see's it when you use your insurance cards (medicare, medicad, regular, discount) it doesn't matter which one you use your SS# is always there, you have said don't put SS# on drivers license, don't use for ID, can not be used for writting checks but all in all every insurance card has your social security number on it?
Please can anyone there answer any or all of these questions.

Thank You
Loretta Jean Plymale
ljeanp59@netzero.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Kelley, Joan (GIC) [Joan.Kelley@state.ma.us]
Sent: Monday, September 22, 2008 3:27 PM
To: CMS PL110-173SEC111-Comments
Subject: #53 [GHP specific Qs from MA GIC which has a VDSA?]

Dear Madam or Sir:

We are trying to determine whether the proposed amendment requiring additional mandatory quarterly reporting to Medicare Secondary Payer, 42 U.S.C. 1395y(b)(7) and (b)(8), Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 applies to the Massachusetts Group Insurance Commission (GIC), which is the group health insurer for state, county and some municipal employees.

From what I have read of the proposed statute and other materials on the CMS website, I believe it does apply to the GIC because the GIC falls within the definition of "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 or self-administered, a plan administrator or fiduciary." I believe we are a plan administrator for a group health plan that is self-insured or self-administered. Can you please tell me if this interpretation is correct as you understand the law?

Also, the GIC has been a Voluntary Data Sharing Agreement entity. Does this new law change voluntary reporting to mandatory quarterly reporting?

Additionally, the new law will require the use of SSNs for insureds in addition to just EINs. I am optimistically thinking this change may ease some of the problems the GIC has had in the past with MSPRC, due to the confusion generated by solely using EINs. Do you agree?

Joan E. Kelley
Associate General Counsel
Group Insurance Commission
19 Staniford Street
Boston MA 02114
(617) 727-2310 x 7022
fax: (617) 227-5181

PARHAM, WILLIAM N. (CMS/OSORA)

From: Brenda Smith [BSmith@healthadvocatesinc.com]
Sent: Tuesday, September 23, 2008 7:39 AM
To: Wright, Barbara J. (CMS/OFM)
Cc: Donna Mize
Subject: #56 [duplicate of #44, different PMSI empoyee] Question

Barbara-

I have left you a couple of messages in regard to some questions our company (and the MSA industry in general) has regarding the new mandatory insurer reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) which mandates group health plan (GHP) arrangements, liability insurance (including self-insurance), no-fault insurance, and workers' compensation report cases where the claimant is a Medicare beneficiary. The legislation includes penalties of $1,000.00 per day per claim for Medicare-entitled cases that are not reported in accordance with the Secretary of Health and Human Services instructions. Please note the comments from our company below. Could you please advise whether CMS has considered the issue noted below and what steps can be taken in this regard? If you are not the correct person to address this issue, could you please forward this e-mail to the proper person? These comments have also been sent to CMS via the e-mail address posted on the web site.

The first step in the process of compliance with the MMSEA is for the primary payer to verify the claimant's Medicare status. If the claimant is a Medicare beneficiary, the primary payer must report the case to Medicare.

Currently, verification of Social Security and Medicare status is done by obtaining a signed SSA-3288 release form which is then sent to the appropriate Social Security Office for a response. This process can take several weeks to several months, depending on the Social Security office that is contacted.

Please note, primary payers are dependent on claimants to sign a consent form in order to obtain this information. There are no penalties assessed against the claimant for refusing to cooperate with this process (i.e. sign a release and/or disclose the proper Medicare entitlement information to the primary payer). However, even if the claimant remains uncooperative, the primary payer is still held liable under the current proposed reporting requirements with a significant fine for non-compliance.

Insurance carriers and third party claims administrators (primary payers) have expressed their concern with the extended turn around time of current paper process of obtaining Medicare entitlement information. The lack of timely responses from the Social Security Administration (SSA) will inhibit the primary payers from reporting promptly under the MMSEA. It is of the utmost importance that primary payers have adequate access to this information in light of the significant $1,000.00 per day per claim fines that can be imposed as of July 1, 2009. It is also anticipated that with the implementation of the MMSEA, the respective SSA offices will receive more requests for SS verification than in the past which may increase the turn around times from the SSA.

It is imperative that the Federal Government gives consideration to implementing an electronic verification process for Medicare entitlement status rather than the current paper based process. The paper process of

verification does not allow a swift enough turn around time and could jeopardize the timeliness of the affirmative legal obligation of the SCHIP Act reporting.

Since the MMSEA mandates insurer reporting which is absolutely dependent on first obtaining information from the SSA, it seems reasonable that CMS should work hand in hand with the SSA to implement a process for the primary payers to obtain the necessary information quickly and easily. The best way for this to occur would be to create an electronic format for which this information can be obtained by the primary payers.

In view of the statutory imposition of the SCHIP Act claim reporting requirements, CMS should consider the concerns of the industry (primary payers) in regard to this issue. If the first step in the process (Medicare entitlement verification) can not be expedited, the ramifications to the primary payers in regard to potential fines for non-compliance are great.

Accordingly, we suggest the following steps:

1) Support the establishment of an electronic inquiry process where primary payers and their representatives may seek clarification of claimants' Medicare status.

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4) The information sought is strictly the Medicare entitlement status of the claimants, so there should be encryption protection preventing any further information from a claimant's file from being transmitted.

5) The electronic "bridge" allowing Medicare status inquiry will allow all primary payers the opportunity to proactively and timely generate the mandatory claim reporting requirements under the MMSEA. It will also result in a collateral benefit; primary payers will be more likely to protect Medicare as a secondary payer when settling claims, thus assisting with maintaining Medicare's fiscal health.

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Single-Source Solution for Workers' Compensation

PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:40 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #57 [can RRE report more frequently than required - NGHP] Comments/Questions

Is a non-GHP insurer prohibited from reporting data to CMS more frequently than required?

Susan Maynard
Claim Consultant
State Farm Insurance

(309) 766-5997

PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:47 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #61 [COBSW capacity] Comments

Will there be a limit to the number of people with access to the COBSW to make entries? If so, what will be the criteria?

Susan Maynard
Claim Consultant
State Farm Insurance
(309) 766-5997

PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:48 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #62 [who/how many can register for each RRE] Comments

How many people will be allowed to register for each RREs?

Susan Maynard
Claim Consultant
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(309) 766-5997

PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:51 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #64 [definition of "claim" for NGHP] Comments

In the health insurance industry the term "claim" is defined as a single medical bill. Property and Casualty (non) carriers typically define a "claim" as the occurrence of an event that may trigger coverage under an insurance policy. A non-GHP "claim" includes reimbursement for all medical bills relating to treatment for injuries caused by the covered event. For reporting purposes, it is our suggestion that non-GHP insurers report based on the accident/occurrence definition of "claim", not on a single medical bill definition of "claim."

Susan Maynard
Claim Consultant
State Farm Insurance
(309) 766-5997

PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:52 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #65 [NGHP wants access to bene eligibility files] Comments

It is our suggestion that non-GHP insurers be permitted to obtain the Medicare-eligibility status of a claimant by checking with CMS through Medicare Beneficiary Eligibility Inquiries (270/271 HIPAA eligibility transaction system injuries).

Susan Maynard
Claim Consultant
State Farm Insurance
(309) 766-5997

PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:53 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #66 [NGHP wants to mix payer type (liablity/NF/WC) in single report] Comments

It is our suggestion that non-GHP insurers report all eligible claims, (i.e. liability settlements, no-fault, medical payments, and workers compensation) together at one time on a quarterly basis so that only four reports are submitted to CMS each year.

Susan Maynard
Claim Consultant
State Farm Insurance
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PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:51 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #67 [NGHP no report if no payment?] Comments

If a Medicare-eligible beneficiary submits a claim including medical expense benefits under a Property and Casualty insurance policy but the insurer makes no payment (e.g., as the result of a coverage exclusion), it is our suggestion that the non-GHP insurer not be required to report claimant information to CMS.

Susan Maynard
Claim Consultant
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PARHAM, WILLIAM N. (CMS/OSORA)

From: Susan Maynard [susan.maynard.bh2m@statefarm.com]
Sent: Tuesday, September 23, 2008 9:53 AM
To: CMS PL110-173SEC111-Comments
Cc: Susan Maynard
Subject: #68 [NGHP -- termination of reports w/ exhaustion, no multiple reports for ongoing] Comments

Once liability, no-fault, or medical payments coverage benefits have been fully exhausted, it is our suggestion that the non-GHP insurer provide a one-time notice in the next quarterly report to CMS rather than provide CMS with extra, multiple, or sequential notices.

Susan Maynard
Claim Consultant
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PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Tuesday, September 23, 2008 11:41 AM
To: CMS PL110-173SEC111-Comments
Subject: #69 [GHP -SAG/Teamster fund type issues; SEE] Required Data Elements: "Employer" and Multiemployer Plans (Part 2)

I read the guidance dated September 22 regarding employer size, which was useful but it didn't fully address the issues that multiemployer plans may face when complying with the MIR requirements. I have additional comments regarding multiemployer plans.

Many multiemployer plans in the construction trades have Money-Follows-the-Man Reciprocity Agreements, under which employer contributions received by one Trust are automatically transferred to another Trust in order to maintain the worker's benefits in his or her "home" benefits plan. There is no agreement or other direct relationship between the employer and the plan that is providing the benefits.

For example, a carpenter who lives in Minnesota might spend the winter working in Texas. His Texas-based employer sends contributions to the Texas Carpenters Welfare Trust, which then sends money and data (hours worked) to the Minnesota Carpenters Welfare Trust, so that the worker's benefits provided by the Minnesota Carpenters would continue.

In such situations, the Trust that provides the benefits will most likely not receive any information regarding the worker's employer in the other Trust's jurisdiction.

This complexity is on top of the eligibility "lag" that is ubiquitous in such plans. For example, under a plan with quarterly eligibility rules, hours worked in the December-January-February work quarter might buy eligibility in the April-May-June eligibility quarter. Therefore, in the example above, the worker's employment in Minnesota would earn his coverage while he is working in Texas, and he may have left Texas and returned to Minnesota before the hours worked in Texas are used to earn eligibility. So at any given time the employer for whom he currently works may not have any relationship to the employer who paid for his benefits.

Administrators of multiemployer plans will need further guidance regarding both of these topics: money-follows-the-man reciprocity and eligibility lag rules.

From: David Pittman [mailto:dpittman@zenithadmin.com]
Sent: Friday, September 19, 2008 1:30 PM
To: 'PL110-173SEC111-comments@cms.hhs.gov'
Subject: Required Data Elements: "Employer" and Multiemployer Plans

Most Taft-Hartley multiemployer plans cover employees of multiple contributing employers. Participants may work for different contributing employers at different times, and may simultaneously work part-time for two or more contributing employers. A participant may have active coverage while not actively working for any contributing employer, because current active eligibility is almost always based on past work. Another participant may be working for Employer A at a time when his or her active eligibility was earned (and paid for) by Employer B in the recent past. This is especially common among certain construction trades.

Therefore, it is often impractical, or at best arbitrary, to identify a participant's employer at any given time.

In addition, when an individual is covered under a multiemployer plan, the plan (not the employer) is responsible for claims. Therefore, CMS should direct Medicare reimbursement demands to the plan, not the employer. The employer would forward them to the plan administrator anyway, so the matter would be resolved faster if the demand were sent directly to the plan administrator.

I recommend that the "Employer" EIN field be relabeled or redefined to mean Plan Sponsor, and that the multiemployer plan's EIN and address be reported to CMS.

Also, please clarify how "Employer Size" and "Small Employer MSP Exception" apply when the individual is covered under a multiemployer plan.

David Pittman
Manager, Compliance | National Support | Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210 | Columbia MD 21044
410-884-1416 (direct) | **410-884-1424** (fax) | **141416** (VOIP)

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Tuesday, September 23, 2008 1:23 PM
To: CMS PL110-173SEC111-Comments
Subject: #70 [NGHP --electronic reporting parameters] MIR Web Reporting

Will a non-GHP insurer have the option to submit reports through direct data entry on a CMS/COBC website? If so, are there a minimum/maximum number of claimants and/or entries an insurer can make if this is the reporting mechanism?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Decker, William F. (CMS/OFM)
Sent: Thursday, September 25, 2008 4:02 PM
To: CMS PL110-173SEC111-Comments
Subject: #77 GHP data elements

Bill Decker
CMS
410-786-0125

From: David Pittman [mailto:dpittman@zenithadmin.com]
Sent: Thursday, September 25, 2008 10:41 AM
To: Decker, William F. (CMS/OFM)
Subject: MIR: GHP data elements

Bill,
The list of data elements in Attachment C of the "Supporting Statement" does not by itself provide much information about the contents of those fields. For example, it doesn't indicate what values would be valid for "Relationship Code", "Employer Size", "Small Employer MSP Exception", "Employee Coverage Election", or "Employee Status".

In contrast, the "Transitioning into Section 111" document for current VDSA partners provides extensive information about the valid values for each field.

Is it safe for us to assume that the data elements in the alternative method(s) for complying with Section 111 will have the same characteristics that are described under "Data Type" and Description" in the "Transitioning" document? For example, will alternative methods of reporting use the same four values for "Relationship Code" and the same three values for "Employer Size"?

Also, the "VDSA User Guide" describes a separate "TIN Reference File", which seems quite different from the Employer and Insurer data elements listed in Attachment C. For example, the "Reference File" includes a name for each entity, while the GHP Data Elements do not include the name of the entity. Can you shed any light on how non-VDSA reporting entities will identify the Employer and Insurer? Will there be a separate "Reference File" or will that information be included in every individual record? I'm not asking for exact details (assuming you don't know all of the details yet), but I'm hoping for an overview.

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Decker, William F. (CMS/OFM)
Sent: Thursday, September 25, 2008 4:43 PM
To: CMS PL110-173SEC111-Comments
Subject: #79 [GHP -- SSN issue] Medicare Mandatory Insurer Reporting (MIR)

Bill Decker
CMS
410-786-0125

From: David Pittman [mailto:dpittman@zenithadmin.com]
Sent: Monday, September 15, 2008 3:20 PM
To: Decker, William F. (CMS/OFM)
Subject: FW: Medicare Mandatory Insurer Reporting (MIR)

Bill,
The implication of the message below is that CMS will require the SSN and other information of ***every*** individual covered under each plan. If that is true, when and where will CMS clearly and unequivocally document this requirement?

(Please don't refer me to the statutory language. Congress authorized the collection of information that is for the purpose of administering the MSP rules. Congress did not specify what information is necessary.)

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From: Anne Lennan [mailto:anne@spbatpa.com]
Sent: Wednesday, August 13, 2008 11:07 AM
To: David Pittman
Subject: Re: Medicare Mandatory Insurer Reporting (MIR)

David,

I spoke to John Albert of CMS this morning. He says that VDSA partners are currently asked to provide SSNs on all people covered under the plan, including dependents. Given this, John says the MIR data requirements will not be any different, either than some minor changes for insurers. Since the VDSA is voluntary, CMS does not demand all the data elements. However, the MIR is required by Congress, so CMS will be more strict.

John says a User Guide will be posted on the CMS website for the MIR. He could not give me an estimated date as to when that would be. He did say that there would be a 15-month grace period for obtaining the data elements, as well as a good faith standard, along with standardized forms for entities to use.

Anne

PARHAM, WILLIAM N. (CMS/OSORA)

From: Evan Swingle [EvanSw@VSP.com]
Sent: Thursday, September 25, 2008 6:13 PM
To: CMS PL110-173SEC111-Comments
Subject: #80 ["limited scope insureres?] Reporting requirements

The proposed amendment to the reporting rules in 42 U.S.C. 1395y(b) are applicable Group Health Plans, as defined in 26 USCS § 5000. Can CMS clarify whether these new reporting requirements will pertain to limited scope insurers that do not provide coverage for major medical conditions payable under Medicare?

Thank you,

Evan Swingle
Regulatory Compliance Specialist | VSP Vision Care | Office of the General Counsel | 3333 Quality Drive, Rancho Cordova, CA 95670 | Mail Stop 163 | vsp.com P: 916.851.5181 or 800.852.7600 x 5181 | F: 916.851.4851

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Friday, September 26, 2008 12:02 PM
To: CMS PL110-173SEC111-Comments
Subject: #83 [GHP - trust, hours bank type Qs] RE: Required Data Elements: "Employer" and Multiemployer Plans (Part 3)

The last sentence in the new preliminary guidance document **MMSEA111GHPWhoMustBeReported092508** reads:

"RREs must have employer size information for all of the employers in the multiple/multi-employer GHP."

Please note that this does not address my concern about construction workers who are working outside their multiemployer GHP's geographical jurisdiction but whose employer contributions are forwarded to their GHP from another GHP in accordance with a reciprocity agreement between the two Trusts. In this situation, there is no direct relationship between the participant's GHP and his employer. His/her employer is not "in the multiple/multi-employer GHP".

Also, please note that administrators of multiemployer plans in the construction trades often do not know who a participant is currently working for. If a participant started working for a new employer on September 29th, his multiemployer plan might not receive any record of that employment until late November. Nevertheless, the participant may have continuous coverage throughout those months due to hours worked for a prior employer.

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410-884-1416 (direct) | **410-884-1424** (fax) | **141416** (VOIP)

From: David Pittman [mailto:dpittman@zenithadmin.com]
Sent: Tuesday, September 23, 2008 11:41 AM
To: 'PL110-173SEC111-comments@cms.hhs.gov'
Subject: RE: Required Data Elements: "Employer" and Multiemployer Plans (Part 2)

I read the guidance dated September 22 regarding employer size, which was useful but it didn't fully address the issues that multiemployer plans may face when complying with the MIR requirements. I have additional comments regarding multiemployer plans.

Many multiemployer plans in the construction trades have Money-Follows-the-Man Reciprocity Agreements, under which employer contributions received by one Trust are automatically transferred to another Trust in order to maintain the worker's benefits in his or her "home" benefits plan. There is no agreement or other direct relationship between the employer and the plan that is providing the benefits.

For example, a carpenter who lives in Minnesota might spend the winter working in Texas. His Texas-based employer sends contributions to the Texas Carpenters Welfare Trust, which then sends money and data (hours worked) to the Minnesota Carpenters Welfare Trust, so that the worker's benefits provided by the Minnesota Carpenters would continue.

In such situations, the Trust that provides the benefits will most likely not receive any information regarding the worker's employer in the other Trust's jurisdiction.

This complexity is on top of the eligibility "lag" that is ubiquitous in such plans. For example, under a plan with quarterly eligibility rules, hours worked in the December-January-February work quarter might buy eligibility in the April-May-June eligibility quarter. Therefore, in the example above, the worker's employment in Minnesota would earn his coverage while he is working in Texas, and he may have left Texas and returned to Minnesota before the hours worked in Texas are used to earn eligibility. So at any given time the employer for whom he currently works may not have any relationship to the employer who paid for his benefits.

Administrators of multiemployer plans will need further guidance regarding both of these topics: money-follows-the-man reciprocity and eligibility lag rules.

From: David Pittman [mailto:dpittman@zenithadmin.com]
Sent: Friday, September 19, 2008 1:30 PM
To: 'PL110-173SEC111-comments@cms.hhs.gov'
Subject: Required Data Elements: "Employer" and Multiemployer Plans

Most Taft-Hartley multiemployer plans cover employees of multiple contributing employers. Participants may work for different contributing employers at different times, and may simultaneously work part-time for two or more contributing employers. A participant may have active coverage while not actively working for any contributing employer, because current active eligibility is almost always based on past work. Another participant may be working for Employer A at a time when his or her active eligibility was earned (and paid for) by Employer B in the recent past. This is especially common among certain construction trades.

Therefore, it is often impractical, or at best arbitrary, to identify a participant's employer at any given time.

In addition, when an individual is covered under a multiemployer plan, the plan (not the employer) is responsible for claims. Therefore, CMS should direct Medicare reimbursement demands to the plan, not the employer. The employer would forward them to the plan administrator anyway, so the matter would be resolved faster if the demand were sent directly to the plan administrator.

I recommend that the "Employer" EIN field be relabeled or redefined to mean Plan Sponsor, and that the multiemployer plan's EIN and address be reported to CMS.

Also, please clarify how "Employer Size" and "Small Employer MSP Exception" apply when the individual is covered under a multiemployer plan.

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September 26, 2008

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
Attention: Identifier Control No. CMS-10265
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Sirs:

Please accept this letter and the enclosed "Comments in Response to the Mandatory Reporting Requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 as proposed by the Centers for Medicare & Medicaid Services (CMS)" in response to the Agency Information Collection Activities: Proposed Collection; Comment Request published in the Federal Register on August 1, 2008.

UWC is a member organization located in Washington DC originally established in 1933 to serve as the voice of business with respect to issues related to workers' compensation and unemployment insurance. The organization currently serves as the coordinator of a broad based coalition of employers, attorneys, self-insurers, injured worker representatives, and Medicare set-aside professionals seeking to improve Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) processes and procedures.

We welcome this opportunity to provide comments to assist CMS in implementation of the new mandatory reporting requirements and hope to establish a dialogue to discuss methods by which to improve the processes and procedures.

Sincerely,

Douglas J. Holmes
President

Comments in Response to the Mandatory Insurer Reporting Requirements of Section 111 of the Medicare Medicaid, and SCHIP Extension Act of 2007 as proposed by the Centers for Medicare & Medicaid Services (CMS)

Introduction

On August 1, 2008, the US Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) published Agency Information Collection Activities for comment in compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995. Subsequent to initial publication, on September 15, 2009, CMS published a proposed Implementation Timeline on its web site. An overview and Description of the Registration Process for Responsible Reporting Entities was released on September 24, 2008.

The comments below are in response to the collection activities as proposed on August 1st and as updated by CMS on September 15, 2008 and September 24, 2008.

1. **Definitions and standards are needed with respect to the basis upon which a reporting entity is to determine whether a claimant is entitled to Medicare.**

   Definitions and standards should be developed by CMS in collaboration with reporting entities to determine the circumstances in which a reporting entity is required to report the identity and applicable information about an individual who receives a payment, judgment, award or settlement and these standards should be uniformly followed. Without clear guidance, reporting entities are likely to over report in order to minimize potential liability, imposing unnecessary administrative costs for the reporting entities and CMS. Must all payments made to individuals 65 and older be reported? Is there a guideline to be used to determine whether individuals receiving SSDI are to be reported? May reporting entities, absent other indications of Medicare entitlement, rely on self reporting by individuals?

   A model questionnaire which may be used by reporting entities to gather information necessary to determine Medicare entitlement for reporting purposes could be helpful. A copy of a Medicare card, for example, would be adequate proof of Medicare entitlement, but self-attestation may or may not be. With the increasing volume of inquiries to verify SSDI status by the Social Security Administration and the backlog in SSDI determinations, additional resources and more responsive systems will be needed in order to verify status on a timely basis.

2. **The "Date of Injury" data element should be revised.**

   Attachment D would require that reporting entities report a "date of injury" defined for claims involving exposure as the "date of first exposure". This conflicts with many state occupational disease laws where the Date of Injury is the "Date of Disablement". Insurance carriers affix risk by the state definition of Date of Injury.

Liability under the Longshore and Harbor Workers' Compensation Act is determined based on the last "injurious exposure" whilst employed in a maritime setting. Self insurers and insurance carriers in the LHWCA sector do not track dates of first exposure. They track dates of last injurious exposure in maritime employment.

To avoid inconsistency and to avoid absurd results for employers and insurers, if the intent of this data element is to identify the point at which there may be liability for a primary payer, then CMS should defer to the state WC, LHWCA or applicable definition for this data element

3. **The requirement that all reporting be electronic by July 1, 2009 for non-group health plans should provide for acceptance of reports through other methods during a reasonable transition period.**

We appreciate the efforts to date by CMS to establish an implementation timeline as set forth on the CMS web site on September 15, 2008, and to address paper reporting for GHP reporting entities. The extended period for development, registration and testing before final implementation as of January 1, 2010 will provide additional time in which to assess differences in the record lay-out, definitions of terms, and capability of reporting entities to reasonably comply with the new requirements. It should be recognized, however, that there will continue to be a need to address those circumstances under which reporting entities may be constrained by systems issues and/or resources from fully reporting electronically within the time frames established and plans should be developed to work with the entities reasonably seeking to comply without imposing penalties available to the agency under statute.

Attachment D of the Supporting Statement for the MSP Mandatory Reporting Requirements provides a listing of data elements, however the actual data format and record lay outs are also needed as soon as possible for reporting entities to assess whether the information requested is in a format that is compatible with information already maintained and/or to assess the cost of obtaining and maintaining the information in the required format. Without this additional information, start-up burden associated with implementation of the new reports cannot be accurately estimated.

For example, a self-insurer may maintain payroll and workers compensation payment records with a limitation on the number of characters available for the first, middle and/or last name of an individual that does not align with the proposed data element format. To comply with the new reporting requirements such an entity would need to gather the information again from each individual for key stroke entry into the CMS system and/or modify its existing system to maintain the information to be reported.

4. **CMS should provide guidance with respect to the circumstances under which it would accept reports as "substantially complying" to include those instances in which all of the information requested is not available and/or is not available in the form requested and/or for good cause may not be provided within the time provided for response.**

Information requested in Attachment D may not be available in the form or within the time requested or because the individual to whom a workers' compensation payment is being made may have refused to provide the information due to security, confidentiality or legal prohibitions. In such cases there should be a recognition that the reporting entity is not refusing to report as required but is not able to report all of the information requested for reasons beyond its control. In such cases the reports should be accepted as substantially complying and supplemented with the required information as soon as it is available to the reporting entity.

5. **The elimination and/or curtailing of Coordination of Benefit Contractor data collection processes such as the IRS/SSA/CMS Data Match should be planned in conjunction with the implementation of the new reporting requirements to minimize overlapping reports and avoid confusion and unnecessary reporting.**

6. **The confidentiality and security of information reported must meet the terms of all applicable federal and state law in addition to the provisions of HIPAA and the reporting requirements should avoid conflicts with other applicable federal and state law.**

   Confidentiality and security of the terms of settlements (e.g. defense base act; private agreements) must be maintained even if access to the data might be permissible under HIPAA, and HIPAA authorization/permission requirements should not be imposed on information that otherwise could be disclosed for workers' compensation purposes.

   The substantive confidentiality and/or security requirements of the applicable state or federal law applying to the information as it was initially obtained and maintained under workers' compensation laws and plans continue in effect as the information is reported to CMS, and are not preempted by CMS administrative reporting requirements. There should be immunity or safeguards from suit from claimants or other interested parties for self insurers/carriers who release information to CMS in accordance with its requirements.

7. **Clarification is needed in defining collection frequency and the point at which the duty to report arises.**

   The draft requirements indicate that collection will be on no more than a quarterly basis, but then indicate that Non-GHP data will be on an ongoing basis for no-fault insurance and workers' compensation for non-contested claims and on a one time basis for contested cases where there is a single settlement, judgment, award, or other payment.

   Is the quarterly report a minimum requirement with additional on-going reporting required for non-contested cases? What is meant by reporting on a one-time basis when the terms of settlements, judgments and awards may require payments over multiple quarterly periods?

   The "Resolution" section of Attachment D indicates that situational reporting is only applicable when a contested claim has been resolved. The "Settlement Date" is required to be reported as

the Date of Settlement, Judgment, Award or Other Payment. What is meant by "other payment"?

Must cases in which a claim is resolved but no payment is made be reported? Must a payment be reported even if the claim has not been resolved in its entirety?

Reporting entities should be permitted to exclude from reporting payments of minor amounts and/or for short term injuries where Medicare's interest is diminimus (e.g. slip and fall medical only injuries that do not result in significant lost time from work or disability awards). In such cases the costs of administration by CMS exceeds the potential recovery by CMS. A review of effective reporting practices already in place with the US Department of Labor and state administrative agencies responsible for receiving workers' compensation reports under current law could be helpful in determining appropriate guidance.

Consistency in the time periods for reporting by group health plans and non-group health plans to the extent possible could reduce reporting burden, particularly for entities with both responsibilities.

8. **The record retention periods currently being used as a matter of sound business practice should be accepted, and any modifications should be narrowly drawn with a reasonable transition period in which to implement changes in order to minimize burden. The processes for retention should be addressed in collaboration with reporting entities before setting standards.**

It is unclear whether the proposal to "recommend" that the retention period for "MSP related information" be 10 years is effectively a requirement or a suggestion. The 10 year retention period is longer than is generally accepted business practice, and the effective imposition of a 10 year period may unnecessarily impose a significant burden on many reporting entities. Also, it is unclear what is meant by "MSP related information"? Does this refer only to the data to be provided on quarterly reports or is it much more broadly defined? The reporting requirements of Section 111(a)(8) pertain only to information with respect to individuals who have been determined by the plan administrator to be entitled to Medicare benefits and are required to be reported under the new requirements on or after July 1, 2009. If there is a need to access information in order to bring a False Claim Act action or to provide for an administrative offset, then analysis of the data needed and options for longer term electronic storage and retrieval should be developed by CMS in conjunction with the entities maintaining the records.

It is also not clear whether the suggested 10 year retention period is retroactive or prospective only. The scope of the new reporting requirements is limited to reports due on and after July 1, 2009. Retention requirements associated with this requirement should take effect on or after July 1, 2009 and be limited to the information provided in the applicable reports.

Reporting entities should be encouraged and enabled at minimal cost to provide the information needed by CMS. The statement in the requirements that "Absence of related

information does not constitute a valid defense against an MSP recovery action." is unnecessary and is not helpful in clarifying the requirements of Section 111.

9. **The burden estimates for Non-GHPs significantly understate the burden associated with implementation of Section 111.**

   The hourly cost of staff to make determinations of Medicare entitlement, the status and legal effect of settlements, judgments and awards is significantly more than $12.00 per hour

   The number of hours required to review and understand the instructions, search for and compile the information to be provided, and complete the reports is significantly under estimated. It is clear from a review of Attachment D that a number of the items required may not be readily available in existing systems maintained by reporting entities and additional time and effort will be required to determine whether the information is available and whether it may be disclosed before entering it by key stroke into the CMS system.

   In addition, the determination of those individuals who are Medicare entitled is likely to require the request of additional information from individuals that is not already maintained by the entity, access to information from SSA, and training in legal analysis with respect to whether the report is required.

   The number of non-GHP entities reporting is drastically underestimated. CMS has estimated the number of non-GHP reporting entities on a national basis to be only 400. An initial review of information available from the National Association of Insurance Commissioners identifies over 700 property and casualty insurers who directly write Workers' Compensation Insurance. The California Self-insurers Association alone lists approximately 100 employers as members. Approximately 650 insurance carriers report within 485 carrier groups to NCCI. There are more than 360 authorized insurers and 200 authorized self-insurers/groups listed just for the Longshore and Harbor Workers' Compensation Act by the US DOL Office of Workers' Compensation Programs. In addition to all of these are state workers' compensation jurisdictions that may be required to report secondary or special fund payments, state funds, and self- insurers in other states. Although some of these carrier and self-insurance entities may be reporting to more than one of these offices or associations, the number is clearly greater than 400, and this is only the workers' compensation part of the non-GHP group.

   Capital costs and the costs of office space, equipment, hardware, software, staff training, and personal benefits should be added to the cost burden analysis.

10. **The cost to the Federal Government of implementing these requirements greatly exceeds $8 million per year.**

    Given the significant underestimate of the number of reporting entities and the complexity of the reports, CMS will incur significant costs in order to properly receive and maintain the data provided in the newly required reports. CMS will incur significant up front systems design,

software and hardware development costs. In addition, costs associated with proper communication and consultation with the reporting entities will be substantial. CMS should reevaluate projected costs based on the more complete review of the new requirements which will show that the number of reporting entities and the complexity of proper administration is much greater than was initially expected.

11. **The burden estimate of the statement of requirements should include an expiration date in recognition of the likelihood that additional information with respect to cost burden will change estimates.**

    As CMS has already recognized with its September implementation timeline announcement, that the complexity and administrative burden of the reports in an environment in which there have not been national reporting standards will require a phased in approach with flexibility to make adjustments as more information becomes available.

    The announcement by CMS that it will review comments submitted by September 30, 2008 and provide for a second public comment period is a good first step in recognizing that the burden estimate should be revisited after an extended comment period.

12. **A review of the existing reporting requirements for related federal agencies is needed to determine whether much of the data identified to be reported in Attachment D is already reported by employers and insurers and whether existing data files may be shared to reduce the reporting burden. The reporting requirements for Group Health Plans and Non-Group Health Plans should be coordinated to the extent possible so as to eliminate the burden of overlapping and/or inconsistent definitions and reporting requirements, particularly for entities with reporting requirements for both.**

    Employers and Insurers are called upon to submit an array of reports to a number of federal and state agencies, many of which have overlapping requirements and slightly different data elements.

    Individual identifying information is already available through federal data bases maintained by the IRS, SSA, USDOL, HHS, and Homeland Security. The reporting of the social security number alone should enable HHS to obtain a number of the other data elements without having them manually entered again by key stroke.

    For example, the US Department of Labor Office of Workers' Compensation Programs requires that each self insurer/carrier provide a listing of all payments made in conjunction with lost time claims on an annual basis. This report, the LS-513, includes each claimant's name, social security number, date of incident, and amount paid in both compensation and medical payments during the course of the calendar year. This report should be reviewed to determine whether it already provides the information needed by CMS to meet the reporting requirements of Section 111.

The draft Overview and Description of the Registration Process indicates that a Section 111 reporting profile for each reporting entity, including estimates of the volume and type of data to be exchanged for planning purposes will be required as part of the registration process. How will reporting entities responsible for reporting settlements, judgments, awards and payments for multiple Non-GHP and GHP reports be handled? Must a volume and type of data to be exchanged be developed for each reporting entity type with consideration for each state and/or federal WC plan or state law separately identified? Such a requirement would be extremely burdensome and add unnecessary costs for reporting entities and CMS.

A review of Attachment C Data Elements and Attachment D Data Elements likewise with entities preparing both reports should also be conducted and plans developed to minimize duplication of effort.

13. CMS should establish a conflict resolution policy and procedure

The provisions of Section 111 provide for the imposition of a $1,000 fine per day for failure to report to CMS as required. Although the implementation timeline announced by CMS on September 15th is a welcome indication of flexibility in administration of the new requirement, there is still an ongoing need to provide for a process and procedure through which reporting entities would have an opportunity to be heard with respect to reasons for failure to report and given an opportunity to cure reporting failure before imposition of the fine. The Overview and Description of the registration process released on September 24th provides that CMS will certify whether a registrant is a "valid" RRE for Section 111. On what basis will CMS determine whether the registrant is a valid reporting entity? Is the determination appealable?

A process for conflict resolution would assure employers and insurers of an opportunity to be heard and avoid the arbitrary imposition of unnecessary fines.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Becky Dannenberg [bdannenberg@simmonscooper.com]
Sent: Friday, September 26, 2008 3:06 PM
To: CMS PL110-173SEC111-Comments
Cc: Becky Dannenberg; Gloria Colon
Subject: #85 Liability Insurance-Set aside requirements

This response is written on behalf of SimmonsCooper LLC and their clients in response to your Invitation for Public Comments on the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), in which you solicited comments from other agencies on the Mandatory Insurer Reporting Requirements of MMSEA Section 111.

Situation: The Medicare Secondary Payer Act (MSPA) clearly supports the idea that the requirement for "set asides" is not limited to workers' compensation cases. The MSP makes it clear that Medicare is always the secondary payer to workers' compensation and liability insurance. The new reporting requirements will make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties. The government could use this information to decide to pursue aggressive enforcement of the set aside requirement outside of worker's compensation settlements.

Comments: Unlike workers' compensation settlements that allocate for future medical expenses, nearly all of our settlements do not differentiate between damages and the future medical expenses. Settlements in asbestos cases are not for full compensation of the injury. It is, therefore, difficult to allocate an exact amount to future medical expenses. The new law does not provide guidance in the event the CMS decides to use the reported information to pursue set asides in a liability settlement.

Question: Will the information reported by the liability insurance be used to pursue set asides in liability settlements?

Recommendation: With respect to your question concerning "the necessity and utility of the proposed information collection for the proper performance of the agency's functions," we, as a firm with a strong program to protect Medicare's liens, believe to function properly, the new law should provide clear guidance on how CMS plans to use the reported information in to pursue liability settlements in cases such as asbestos cases where it is difficult to assign an exact amount for future medical expenses.

On behalf of SimmonsCooper LLC and their clients we submit these comments in the interest of providing clarity and efficiency to the process. Fair, fast and certain resolutions with clear guidelines are in the interest of all parties.

SimmonsCooper, LLC
Gloria Colon
gcolon@simmonscooper.com

Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

Thank you.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Becky Dannenberg [bdannenberg@simmonscooper.com]
Sent: Friday, September 26, 2008 3:10 PM
To: CMS PL110-173SEC111-Comments
Cc: Gloria Colon; Becky Dannenberg
Subject: #86 [no post 12/4/80 exposure] Liability Insurance-No Post 1980 Exposure

This response is written on behalf of SimmonsCooper LLC and their clients in response to your Invitation for Public Comments on the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), in which you solicited comments from other agencies on the Mandatory Insurer Reporting Requirements of MMSEA Section 111.

Situation: Because of Medicare's policy to not pursue recoveries in asbestos cases in these instances, we do not send such cases through the Medicare resolution process. Instead, we simply ensure that there is, in fact, no post-1980 exposure and keep the cases on file in case we are ever called to prove the no post-1980 exposure. The new law requires liability insurance, no-fault insurance, and workers' compensation to report all Medicare beneficiaries who have received a settlement, judgment, award, or other payment.

Comments: The new law does not provide guidance on how to handle cases without post-1980 asbestos exposure.

Questions: If a SimmonsCooper client has received a settlement but was not sent through the Medicare resolution process due to no post-1980 exposure – and liability insurance reports that client – what evidence, if any, will the liability insurance or Medicare require SimmonsCooper to provide as proof of no post-1980 exposure? What will Medicare consider acceptable evidence of no post-1980 exposure? What system will Medicare introduce to ensure plaintiff's attorneys properly validate entitlement? How will this process affect the release of our client's money upon determination of no-post 1980 exposure?

Recommendation: We believe that it is vital for the proper functioning of the new rules that the guidelines address provide clarity on the above questions. A bright line using no post 1980 exposure provides a firm date in which to make these determinations.

On behalf of SimmonsCooper LLC and their clients we submit these comments in the interest of providing clarity and efficiency to the process. Fair, fast and certain resolutions with clear guidelines are in the interest of all parties.

SimmonsCooper, LLC
Gloria Colon
gcolon@simmonscooper.com

transaction or matter addressed herein.

Thank you.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Becky Dannenberg [bdannenberg@simmonscooper.com]
Sent: Friday, September 26, 2008 3:13 PM
To: CMS PL110-173SEC111-Comments
Cc: Gloria Colon; Becky Dannenberg
Subject: #87 Liability Insurance-Settlements involving multiple defendants

This response is written on behalf of SimmonsCooper LLC and their clients in response to your Invitation for Public Comments on the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), in which you solicited comments from other agencies on the Mandatory Insurer Reporting Requirements of MMSEA Section 111.

Situation: Because a plaintiff may have been exposed to asbestos through many different companies, there are often multiple defendants in an asbestos case. Under SimmonsCooper's lien resolution program, we offer to resolve the Medicare lien immediately after we receive enough money to cover the conditional payment from Medicare. This is done regardless of whether all defendants have paid their settlement. When we submit the settlement statement, we provide all settlements paid as of the date that we sent the final demand. The new law requires liability insurance, no-fault insurance, and workers' compensation to report all Medicare beneficiaries who received a settlement, judgment, award, or other payments.

Comments: The new law does not provide guidance on how to address settlements involving multiple defendants.

Questions: In the case where a Medicare lien has already been resolved by SimmonsCooper based on the settlement money provided by some – but not all – defendants, what will Medicare do with those defendants that report settlements in the case but who were not included in our settlement statement that resolved the lien? What if the settlement does not involve payment for medical expenses related to the personal injury? Will the liability insurance still be required to report this settlement? How will this process affect the release of our client's money upon resolution of the Medicare lien?

Recommendation: We believe the rules should be clear on these issues.

On behalf of SimmonsCooper LLC and their clients we submit these comments in the interest of providing clarity and efficiency to the process. Fair, fast and certain resolutions with clear guidelines are in the interest of all parties.

SimmonsCooper, LLC
Gloria Colon
gcolon@simmonscooper.com

Thank you.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Becky Dannenberg [bdannenberg@simmonscooper.com]
Sent: Friday, September 26, 2008 3:16 PM
To: CMS PL110-173SEC111-Comments
Cc: Gloria Colon; Becky Dannenberg
Subject: #88 Liability Insurance-Conflict of Information Between Liabilty Insurance and Plaintiff Attorneys

This response is written on behalf of SimmonsCooper LLC and their clients in response to your Invitation for Public Comments on the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), in which you solicited comments from other agencies on the Mandatory Insurer Reporting Requirements of MMSEA Section 111.

Situation: The Medicare Prescription Drug Improvement and Modernization Act of December 2003 make verifying and resolving conditional Medicare payments an affirmative duty of plaintiff's attorneys (among other entities). Plaintiff's attorneys are further required to report information to Medicare when they represent a Medicare eligible plaintiff in a personal injury case. A plaintiff's attorney that fails to follow these instructions may face an independent cause of action from the government in an amount equal to double the damages.

Comment: The new MMSEA law does not render the already established MMA law obsolete. The new law does not provide guidance on how conflicts of information will be resolved between information provided by the insurers and information provided by the plaintiff's attorney at the beginning of the case.

Question: If there is conflicting information between the two reporting entities, how will Medicare clarify or investigate the disparities? How will this process and, consequentially, the resolution of the conflicting information affect the release of our client's money?

Recommendation: We believe we should be clear on these issues. Resolved Medicare liens should allow future settlements to be completed without further renewed resolution. A letter or confirmation of resolution should be issued and suffice for a completed process.

On behalf of SimmonsCooper LLC and their clients we submit these comments in the interest of providing clarity and efficiency to the process. Fair, fast and certain resolutions with clear guidelines are in the interest of all parties.

SimmonsCooper, LLC
Gloria Colon
gcolon@simmonscooper.com

transaction or matter addressed herein.

Thank you.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Becky Dannenberg [bdannenberg@simmonscooper.com]
Sent: Friday, September 26, 2008 3:19 PM
To: CMS PL110-173SEC111-Comments
Cc: Gloria Colon; Becky Dannenberg
Subject: #89 Liability Insurance-Record Retention Policy

This response is written on behalf of SimmonsCooper LLC and their clients in response to your Invitation for Public Comments on the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), in which you solicited comments from other agencies on the Mandatory Insurer Reporting Requirements of MMSEA Section 111.

Situation: Liability insurers will want to adhere to the same retention policy as the MSP.

Comment: Because of the shared liability between the parties (insurers, plaintiff's attorneys, and claimant/plaintiff), all records created in resolving a Medicare lien would be needed to prove that a settlement was reached with Medicare's interests in mind. The new law does not provide guidance about the recommended record retention policy for all parties involved in the resolution of a Medicare lien in a personal injury case.

Questions: Will the plaintiff's attorney in a personal injury case be required to retain records related to Medicare lien resolutions for ten years? What will be the triggering date for the retention? The date of the lien resolution or the date of the last settlement in the case?

Recommendation: We believe a trigger date for the ten years of records retention should be from the date the lawsuit was filed.

On behalf of SimmonsCooper LLC and their clients we submit these comments in the interest of providing clarity and efficiency to the process. Fair, fast and certain resolutions with clear guidelines are in the interest of all parties.

SimmonsCooper, LLC
Gloria Colon
gcolon@simmonscooper.com

Thank you.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Poland, Ann [apoland@coresource.com]
Sent: Friday, September 26, 2008 3:41 PM
To: CMS PL110-173SEC111-Comments
Subject: #92 [refusal to furnish SSN] Social Security Numbers

Dear Sir/Madam:

With a group health plan, what happens if a participant refuses to provide us with their Social Security Number, regardless of any legal obligation?

Thank you.

Ann Poland
Director of Legislative Research
CoreSource, Inc.
9775 Crosspoint Boulevard, Suite 118
800-345-0555 ext 13
Fax: 317-578-3543
apoland@coresource.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Deanna P. Laidler [laidled@odscompanies.com]
Sent: Friday, September 26, 2008 3:51 PM
To: CMS PL110-173SEC111-Comments
Subject: #94 [GHP -- suggested exemption, frequency, etc.] Medicare Mandatory Insurer Reporting Requirements

Thank you for affording us the opportunity to comment on the impact of the Mandatory Insurer Reporting Requirements of the MMSEA. We would like to take this opportunity to confirm what we perceive to be the reporting obligations of Group Health Plans and to request clarification as to some of the requirements set forth in the guidance provided to date.

In a memorandum issued on September 25, 2008 by the CMS Office of Financial Management/Financial Services Group, it appears that the initial quarterly file submission from group health plans is essentially to be a report of all group health plan members age 45 and above, those who receive kidney dialysis or who have received a kidney transplant, those individuals known by the group health plan to be entitled to Medicare. Upon receiving the data, it is our understanding that the COBC will identify those individuals who are Medicare beneficiaries and will notify the group health plan of the same. In subsequent quarters, the group health plan reports will contain only new or changed coverage information.

We would like to suggest that group health plans be required to submit information only on plan participant who have actually submitted claims within the calendar year or other reporting period. The obligations relating to liability insurance clearly indicate that reporting extends only to individuals for whom a claim has been filed. With the intent of the law being to ensure that Medicare pays appropriately, absent a claim, there is no corresponding payment obligation. There are a number of members within any group health population that do not submit a single claim within a calendar year. With respect to that population, we feel it is burdensome to track and report on these individuals. Therefore, we request that the reporting obligation be limited to those individuals who have had a claim within the relevant reporting period.

We would also like to suggest that the frequency of the reporting periods be reduced to no more than once or twice per year. For the majority of the individuals that have Medicare as secondary coverage, this will remain fairly static, with a small list of additions or deletions.

Thank you for your consideration of these comments.

Deanna Laidler
Government Programs Compliance Officer
The ODS Companies
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PARHAM, WILLIAM N. (CMS/OSORA)

From: Roy Franco [Roy.Franco@safeway.com]
Sent: Sunday, September 28, 2008 12:15 PM
To: CMS PL110-173SEC111-Comments
Subject: #103 [NGHP -- multiple issues] Open Door Forum Teleconference CMS 10/1/2008 (Questions)

Thank you for providing this Open Door Forum. I recently joined a coalition to improve the collection activities for Medicare. It is a concerned group of self insureds, insurance carriers, trade associations, defense attorneys and plaintiff attorneys worried that the implementation of MMSEA provisions as currently constructed will challenge the ability to settle claims with Medicare beneficiaries. The Medicare Advocacy Recovery Coalition (MARC) wants to bring about efficiencies to this collection process without impeding the liability resolution process and create a situation where Medicare beneficiaries (primarily our senior citizens) are being disenfranchised from legal representation and the prompt delivery of benefits. The questions raised below are brought forth to encourage dialogue to improve the reporting process. I will be participating in the call on 10/1/2008 and look forward to your responses.

1. There are significant structure differences between Group Health Plans, Workers' Compensation and Liability Insurance – Will CMS hold an Open Door Forum Conference to discuss Mandatory Reporting issues for Liability Insurance (including self-insurance) only?
2. CMS has provided estimates that Liability Insurance (including self-insurance) process about 44 million claims each year, does CMS recognize that the majority of those claims are done so without the benefit of litigation?
3. If CMS answer to the previous question is in the affirmative, what legal mechanism does a Liability Insurance (including self-insurance) carrier employ to obtain the social security number from the Claimant when there is no litigation?
4. If there is no legal mechanism that is available to require the Claimant to disclose his or her social security number and the Claimant refuses to cooperate and provide it what consequences (i.e., reporting penalties under the MMSEA or double recovery claims under the MSP) does the Liability Insurance (including self-insurance) carrier face from CMS if it later turns out that the Claimant is indeed a Medicare Beneficiary?
5. How does CMS propose that a liability insurance (including self-insurance) carrier go about selecting which of the 44 million claims it may or may not obtain a social security number from?
6. If there is no methodology that CMS can provide for the liability insurance (including self-insurance) carrier in the previous question, will CMS recognize this as an added financial burden when it calculated the costs for the industry in its recent request for comment? If so, will CMS update its burden estimates?

7. Will CMS require the liability insurance (including self-insurance) carrier to pay Medicare directly the reimbursement amount or will it allow for the settlement, award, judgment or other payment to be made directly to the Claimant?
8. How does CMS plan to avoid duplication of reporting where parties to a liability claim seek to obtain interim conditional payment information that is necessary to assist in the resolution of the claim? Doesn't this create a working file upon reporting? Is another working file opened when the liability insurance (including self-insurance) reports the settlement, award, judgment or other payment? Please explain how this reporting process will be reconciled?
9. CMS is able to code up to five ICD-9 codes, what occurs if another liability insurance (including self-insurance carrier) reports additional ICD-9 codes, is another working file created that needs to be resolved?
10. Will CMS provide a release to the liability insurance (including self-insurance) carrier for any final demand payment it may make to Medicare?
11. How does CMS propose that a liability insurance (including self-insurance) obtain procurement costs information that may violate the attorney-client privilege if it is required to pay the reimbursement amount directly to Medicare? Will a method be allowed for the Claimant and their attorney to seek a credit for such procurement costs? Will this cost CMS money to process? Is that calculation taken into consideration by CMS?
12. How should reporting be handled in a class action? Will the court plan take precedence over CMS reporting requirements? Will the defendants be protected from MMSEA reporting requirements if the court plan provides for a contrary reporting scheme as the class members may not be entirely identified?
13. Finally, will CMS consider providing a reporting hierarchy to avoid multiple liability insurance (including self-insurance) carriers reporting that may arise in a single claim? Let's take the following accident: An employee of a vendor delivers product to a retail facility and is injured on the premises due to a leaking refrigeration unit that was maintained by another vendor – the potential parties to the case are: Claimant, Claimant's employer, premises owner, premises occupier, vendor that maintained refrigeration unit and potentially the supplier of the maintenance unit and possibly the property manager of the subject property. Does CMS want all of these insurance carriers reporting the same incident? How does CMS propose to avoid duplication? Again, what happens if each carrier reports the injury using slightly different ICD-9 codes?

There are other questions that go beyond the context of this call that we would like to discuss with CMS. However the above questions demonstrate potentially the confusion with regard to the implementation of the MMSEA that will more than likely delay CMS from receiving the $1.1B in benefits it estimates. MARC would like the opportunity to discuss these issues face to face and possibly improve all of our understanding so that a system can be implemented that will be efficient and not drive unintended consequences.

Roy A. Franco
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World-Class Service Starts With A Safe Team.

"Email Firewall" made the following annotations.

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PARHAM, WILLIAM N. (CMS/OSORA)

From: David Chetcuti [chetcuti1@yahoo.com]
Sent: Sunday, September 28, 2008 4:51 PM
To: CMS PL110-173SEC111-Comments
Cc: Bennett Pugh; David Chetcuti
Subject: #104 [NGHP reporting parameters & mix-up with IEQ] rMMSEA Questions for 10/1/08 Teleconference

Dear CMS:

I have three (3) questions concerning the definition of disputed claims for IEQ reporting requirements when some medical bills have been paid. What I am looking for is whether or not an IEQ must be immediately filed or if filing can wait until the claim is resolved in situations where:

1. a claim is in dispute with medical "treatment" not being paid, what are the IEQ reporting requirements if the defendant schedules and pays for a one-time, defense medical "evaluation?"
2. a claim is in dispute with no medical treatment being provided, except for one bill which was accidentally paid, what are the IEQ reporting requirements?
3. under California work comp the law requires that medical bills be paid while an insurance company investigates whether or not to accept or deny liability. If the company later disputes liability and stops paying medical benefits, what are the IEQ reporting requirements?

Thank you.
David Chetcuti

PARHAM, WILLIAM N. (CMS/OSORA)

From: Eckert, Dawn [Dawn.Eckert@BCNEPA.Com]
Sent: Monday, September 29, 2008 11:26 AM
To: CMS PL110-173SEC111-Comments; Decker, William F. (CMS/OFM)
Cc: Miller, Cheryl; Telech, Walter
Subject: #108 [VDSA partner -- who must be reported] CMS Conference Call - Section 111 VDEA

As a follow up to the conference call on Thursday September 25, 2008, I would like to verify that we understand the following.

We at Blue Cross of Northeastern PA currently participate in a VDEA and submit all members who are Medicare secondary. The "Transitioning into Section 111 Reporting document" states the following under the "Differences Between the Current VDSA/VDEA Files and the new Section 111 Files" section:

On the MSP Input File, the age threshold for reporting individuals not otherwise known to be Medicare beneficiaries is now 45 years of age and older. This has been lowered from the age threshold of 55 years of age used in the VDSA and VDEA program. In addition, with Section 111 reporting, adherence to this reporting age threshold is a requirement.

* We currently report all actively employed members or dependents who (as determined by employer size and the Medicare entitlement reason) are Medicare Secondary regardless of the age. I understand that this will suffice since you are not interested in creating a file for members who are not Medicare Secondary? Can you confirm?

It was stated that if we insure a Multiple Employer Plan that we would need to identify each employer TIN and each employer size.

* We currently insure two Multiple Employee Welfare Associations (MEWA) that have at least one employer with over 20 employees but none with over 100. We contract directly with the MEWA and not with each individual employer.

* We require all of our contract holders to verify annually the employer size. Our MEWA contract holders respond for all the employers under their association. All of our MSP information is on the Contract Holder level and since we do not contract with the individual employers in an association, we have never captured the list of employers enrolled through the MEWA or the individual TIN number for the employers involved.

* On the MSP input file layout (field 16), we have the information to respond to the employer size rule:
  Employer Size Rule: Enter '1' if the employer has fewer than 20 full or part-time employees but is part of a multi-employer plan and another employer in that plan has 20 or more employees. Enter '2' if employer has fewer than 100 full or part-time employees but is part of a multi-employer plan where another employer in that plan has 100 or more employees.

* Is Blue Cross responsible for obtaining all of the EIN/TIN and employees size for all employers enrolled in the MEWA or is it the responsibility of the MEWA to obtain and report the information? Since we only contract with the MEWA are we OK just submitting all MEWA members under the MEWA TIN and following the employer size rule?

* We have one MEWA that has filed and received a small employer exception. The MEWA has provided documentation and we have flagged that enrollment on our system. The MEWA has the responsibility to update the enrollment and maintain the exception with CMS. Again, is this sufficient?

Also, am I correct that as long as we sign the new VDEA and begin our programming we will be in compliance with Section 111 even if the programming is not completed by January 2009?

Thanks,

Dawn M. Eckert
Contract Administration Department
Blue Cross of Northeastern Pennsylvania
Voice (570)200-6547 Fax (570)200-6650
E-mail Dawn.Eckert@Bcnepa.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Raterink, Dennis [RaterinkD@michigan.gov]
Sent: Monday, September 29, 2008 11:59 AM
To: CMS PL110-173SEC111-Comments
Subject: #110 [WC definitions]

I represent he State of Michigan Funds Administration, which administers a group of State Workers Compensation Funds. The majority of these Funds provide reimbursement to the employer or the employer's insurer under certain conditions.

The question has been raised whether these Funds will be considered an "applicable plan." While the definition indicates that "for workers' compensation information this would be the Federal Agency, State Agency, or self-insured employer or the employer's insurer."

Does the fact that the majority of the Funds do not provide direct payment to the claimant, but reimbursement to the employer/insurance carrier, take the Funds out of the definition of "applicable plan"?

Next, if one of the Funds does provide direct payment to a WC claimant, does it then qualify as a "State Agency" under the definition of "applicable plan"?

Dennis J. Raterink

Assistant Attorney General

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Lansing, MI 48909

(517) 373-1176

PARHAM, WILLIAM N. (CMS/OSORA)

From: Cochrane, Mike [Mike.Cochrane@lfg.com]
Sent: Monday, September 29, 2008 12:05 PM
To: CMS PL110-173SEC111-Comments
Cc: Pirsch, Patrice
Subject: #111 [GHP - stand alone ltd scope dental plan] Question for October 1 Teleconference

Are stand-alone, limited-scope dental plans subject to the reporting requirements?

Mike Cochrane
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Zurich North American Insurance Comments in Response to the CMS Document Entitled: Supporting Statement for the Medicare Secondary Payer—published 8/01/08 on the CMS Website

1. In Section 13, CMS alleges that there will be no capital costs to comply with the SCHIP reporting requirements. Our initial estimate to make changes to our current computer system to ensure reporting compliance is very substantial. The employees or contractors who we will need to engage in programming the system make substantially more than $12 per hour.

2. In Section 12, CMS estimates that it will take only 5 minutes for an employee making $12/hr to collect social security numbers. Based on the public's being advised to never give out your social security number, we believe that the 5 minute estimate is too optimistic. Further, with benefits and wages, our administrative support employees' average pay is significantly higher than $12/hour.

3. There are 45 proposed "data fields" listed in Attachment D which are either "Mandatory, Situational or Optional". If situational applies, does it now become a "Mandatory" reporting requirement? What is the definition of "situational"?

4. Is the only way to ensure compliance with the reporting requirements and avoid the $1000/day fine, to notify CMS of all Workers Compensation, No Fault and Liability claims? Is CMS prepared to handle the data submission of almost every Workers Compensation, No Fault and Liability claim being made countrywide? Please note that our pending of all open, existing claims for the applicable lines of business is in excess of 1,000,000.

5. On cases involving exposure to harmful contaminants, there are often multiple carriers making payment to the same claimant. If all carriers must report their portion of the settlement, do they put in Data Field #43, the amount of their contribution, or the full amount of settlement?

6. If Zurich writes business under several trade names, all under the Zurich umbrella, must separate reports be provided for each name or can they all be combined?

7. What is the trigger for when the claim must be reported? Is it only when a payment is made?

8. If an injured claimant has both a liability claim and a med pay claim, must both be reported?

9. Must the same claim be reported every quarter, as long as it remains open, or does it only need to be reported once? And, if the claim has to be reported each quarter but a carrier inadvertently misses one quarter, will it still be subject to a fine even though it has satisfied the reporting requirement in the other quarters?

10. When will additional "listening sessions" be scheduled?

11. For data field #19 "TIN", is that the TIN for the policyholder or for the insurance company?

12. The ICD 9 code, data field #38 is not currently collected on Liability and No Fault claims. In workers compensation, there may be multiple ICD9 codes on various medical bills. Which code are you asking for? Will the body part code suffice for Workers Compensation? If so, our system is set up to report one code only and not multiple codes. Will one code be enough? If the body part is reported under data field #38, what must be reported under data field #39? What is required with respect to Liability claims, where the ICD9 code is not currently collected?

13. For data field #44, if we are reporting an open claim which has not yet been resolved, what must be completed in that data field?

14. For liability claims, there are situations where the claimant will not provide their social security number. They are not required by law to provide their social security number to file and pursue a claim. If we are not able to obtain their social security number, what information would suffice, if any, for reporting purposes to Medicare?

15. Please note that some of the data fields you have listed are not currently collected as part of our routine claim handling. Those fields include:
Data field #19 – TIN of insured
Data field # 38 for liability and no fault claims
Data field #41 – product liability information
Data field #44 – claim resolution
Data field #45 – Funding

16. For data field #9, Gender, our claim system has an "unknown" code as well as "M and "F". Will the "unknown" code be accepted?

17. For claims involving exposure, what if the state law imposes liability on the date of last exposure, not the date of first exposure, so that carriers typically use the date of last exposure for the date of injury? Shouldn't the injury date vary depending upon what date the jurisdiction uses as workers' compensation carriers in Pennsylvania, for example, which goes by date of last exposure, will have no ability to easily locate and provide the date of first exposure?

18. Regarding the data element that requires that we identify the "product" in a products liability claim, please note that most product liability claims are caused by machines, manufactured products, etc. and not by prescription medications. We do not currently have a data field in our claim system that identifies the product which can be easily transmitted via EDI. A data field would have to be added and built into our claim system.

19. In fatality claims, the name of the claimant that is entered into our system is the decedent and not the widow or children. There are currently no data fields in which to enter the widow's and children's' names. Such data fields, if required, would have to be added and built into our claim system. Please note that in a death case, only one claim is established for all dependents. There are not individual claims established for each dependent. To establish additional claim numbers would impact our customer's frequency and loss ratios, resulting in an unnecessary negative premium impact.

20. Will the SSA form "Consent to Release" (OMB #0960-0566) still be required to verify social security and Medicare status of an injured worker or third party claimant? Is there a violation of privacy laws if the signed release is no longer required?