341 N. Maitland Ave., Suite 130
Maitland, FL 32751
(407) 647-8839
Fax: (407) 629-2502
www.namsap.org

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NAMSAP

National Alliance of Medicare Set-Aside Professionals

COMMENTS IN RESPONSE TO THE CMS SUPPORTING STATEMENT FOR THE MEDICARE SECONDARY PAYER MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111 OF THE MEDICARE MEDICAID, AND SCHIP EXTENSION ACT OF 2007 (MMSEA)

The following comments are submitted on behalf of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), by its Board of Directors.

NAMSAP is a non-profit organization devoted to the improvement of the Medicare Set-Aside (MSA) practice and to facilitating compliance with Medicare conditional payment recovery. Our organization has approximately 600 members including attorneys, nurses, structured settlement brokers, insurance carriers, and professional administrators. Our members are responsible for the vast majority of MSA submissions received by CMS and are also intricately involved in conditional payment issues on behalf of their clients, who include major insurance companies and self-insureds.

1. Verifying claimant entitlement to Medicare.

A major unresolved issue is the threshold step of identifying Medicare-eligible claimants. With the increasing volume of inquiries to verify SSDI status by the Social Security Administration and the likely backlog in SSDI determinations, additional resources and more responsive systems will be needed in order to verify status on a timely basis. A copy of a Medicare card should be adequate proof of Medicare entitlement, but without such proof self-attestation is notoriously undependable, as many of our members can attest. Reporting entities ought to be provided with assurances that if they attempt to confirm beneficiary status with the claimant and the Social Security Administration, and incomplete or inaccurate information is provided, they will not be penalized for failing to timely report payment to CMS.

Furthermore, since most claims do not result in litigation, there is no mechanism to force the claimant to make this disclosure. CMS should work with NAMSAP, industry groups and liability, no fault and workers' compensation insurers and self-insurers to adopt the appropriate procedures to allow compliance with the MMSEA.

2. Date of Injury.

Attachment D, Item 34 indicates that "for claims involving exposure, the DOI is the date of first exposure." This conflicts with many state accident and occupational disease laws where the Date of Injury is the Date of Disablement. The carrier on the risk is typically fixed by the state definition of Date of Injury, and it is not unusual for there to be litigation over this issue and under the "last injurious exposure" rule.

To avoid inconsistent and possibly absurd results, CMS should defer to the state WC law definition of Date of Injury in occupational disease and repetitive trauma claims. Even if one carrier was on the risk for both dates, this would also avoid the problem of that carrier having to manually change Date of Injury from what is in their claim system to what the MMSEA reporting requires.

3. Collection frequency and the duty to report.
Section C.6., page 6 of the Supporting Statement provides: "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."

a. Definitions are needed for the terms "non-contested" claim and "contested" claim.

Often a particular claim contains both "non-contested" *and* "contested" aspects. For example, a primary payer may accept responsibility for one body part (which would seemingly constitute a "non-contested" aspect of the overall claim) but deny responsibility for another alleged body part (which would seemingly constitute a "contested" aspect of the overall claim).

Clarification is also needed as to the phrase "on an ongoing basis" with respect to "non-contested" claims and also as to the specific event(s) which would give rise to the obligation to report a claimant's Medicare status.

b. Section 111 of the MMSEA [42 U.S.C. 1395(b)8(C)] states as follows:

> (C) Timing – Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability). [Emphasis added.]

A literal reading of this statutory section would seemingly indicate that the obligation of an applicable plan to place Medicare on notice would not be required until *"after"* the claim is *"resolved"* through one or more of the cited events. However, CMS' proposed guidelines regarding "non-contested" claims as contained in the Collection Frequency section (cited above) speak in terms of an "ongoing" basis *without* specific reference or direct correlation to the aforestated statutory provision.

Thus, it is unclear whether CMS' proposed guidelines regarding "non-contested" claims contemplate that an applicable plan will be required to place Medicare on notice regardless of whether or not a claim is "resolved" per 42 U.S.C. 1395(b)8(C).

With respect to "contested" claims, please define the phrase "*other payment.*"

c. Definitions are also needed as to the phrases "Situational", "Mandatory", and "Optional" on Attachment D – NGHP Data Elements. Explanations ought to be allowed as to Data Elements concerning the Data Elements related to the "Incident" [Date of Injury, Nature of Injury, Cause of Injury, ICD-9 Code, Body Part] so CMS has an understanding of the context in which the claim has been handled. From the initial collection of data, CMS should gather information as to which issues are disputed and as to the bases for compromise of claims. Opportunities for parties to inform CMS as to disputed matters and reasons for compromise based upon State laws should be preserved as Medicare's potential right to reimbursement is no stronger than the claim for recovery is under State law.

4. Conflict resolution.

Given the severity of the $1,000 per claimant, per day fine under Section 111, some sort of due process should be provided for applicable plans to be heard with respect to an alleged failure to report, before final imposition of the fine. Such procedure could well avoid more expensive and time consuming formal litigation.

5. Record retention period.

Section C.7., page 6 of the Supporting Statement recommends a "record retention period of ten years for MSP related information." Is this newly defined record retention period *prospective?*

6. Liability Self-Insurance and the risk of double reporting.

The CMS definition of "Liability Self-Insurance" on p. 13 and the risk of "double reporting" on page 14 need clarification and coordination with insurance industry usage. Deductibles and Self Insured Retentions (SIR's) are insurance terms of art and are not the same. Input from the insurance and self-insurance industries should be sought here to avoid a misunderstanding and possible double reporting.

We appreciate this opportunity to comment and would be pleased to provide additional information with respect to any of the above.

Respectfully submitted,

The Board of Directors of the National Alliance of Medicare Set-Aside Professionals

Robert T. Lewis, Esq.
Crowe Paradis Services Corporation

John Williams
Gould & Lamb, LLC

Mark Popolizio, Esq.
NuQuest/Bridge Pointe

Michael Westcott
Ringler Associates

Patty Meifert
NuQuest/Bridge Pointe

Fran Provenzano
MSA Specialists, Inc.

Jill Gradwohl Schroeder
Baylor, Evnen, Curtiss, Grimit & Witt, LLP

William Van Wambeke
M Hayes & Associates, LLC

PARHAM, WILLIAM N. (CMS/OSORA)

From: Brown, Kevin [Kevin_Brown@CalPERS.CA.GOV]
Sent: Tuesday, September 30, 2008 4:38 PM
To: CMS PL110-173SEC111-Comments
Cc: West, Christina
Subject: #155 [NGHP-ssn, software, multiple RREs submitting same person] Questions for Section 111

Dear Sir or Madam,

We look forward to dialing into the conference call tomorrow and hearing more about the Section 111 reporting. Here are just a few questions we have today. We look forward to a response at the conference call or shortly following.

- While reviewing the Section 111 proposed changes to the Query layouts, it appears that the Query functionality is changing in such a way that the Query Only HEW (HIPAA Eligibility Wrapper) software is no longer needed. Can you confirm that the Section 111 Query Only Input File (ANSI 270/271 Entitlement Query Flat File Format) will not require the HEW software?
- Are there any limitations on the number of queries that can be sent on the Query Only Input File?
- Are there any plans to work with the Social Security Administration (SSA) to assist the industry in obtaining missing SSN's?
- How does CMS plan to accommodate and reconcile two Responsible Reporting Entities (RRE's) submitting data on the same individual?

Thank You!

Kevin A. Brown, PMP, CPHIT, CPEHR
Technical Project Manager
CalPERS Contact # (916) 795-2307

MEDICARE SECONDARY PAYER MANDATORY INSURER REPORTING REQUIREMENT – COMMENTS – NON-GROUP HEALTH PLAN

SUBMITTED BY THE HARTFORD FIRE INSURANCE COMPANY

I. General Comments

1. The data element list is too long and unduly burdensome. In order to compile and comply with the current data element list, it will cause, in contrast to Medicare's statements, insurers to incur very high expenses. The expenses will be both for an intensive information technology project to build a data element reporting "feed" and for possible claim adjuster manual entry of certain data elements that are not currently captured or that require judgment calls. In order to be able to report electronically and efficiently, the data elements should be common ones that are typically captured in the claims process. The goal of this project should be boiled down to its essence, which is to aid Medicare and CMS in the collection of its liens from claimants who have resolved claims with liability insurers. Accordingly, the most important and elementary data that CMS needs from insurers is the claim resolution amount and the contact information for the claimant and their attorney, if applicable. This simple information would allow CMS to prioritize its collection efforts by amount and provide the means to contact the responsible parties.

   A process that is unnecessarily complex and expensive will only serve to drive up the cost of doing business and may possibly result in higher costs to consumers. Further, the data element list as currently constructed may only serve to inundate CMS with a lot of information that it really doesn't need and that may not even be all that useful in its subrogation efforts. For example, Data Elements 23 and 24 seek information about "No Fault Policy Limit" and whether the No Fault Policy Limit has been exhausted. It is not clear why this information may be necessary to assist CMS in determining whether it is entitled to reimbursement for payments made.

2. There is, however, a practical solution that would alleviate insurer expense concerns and also provide some relief regarding the potential for a large scale information technology project. If the data element list could, as described above, be narrowed down to the absolutely essential items and be restricted to the common elements that ISO already captures, then ISO could be a reporting source for many insurers. As also already stated, a shorter list of elements would still protect CMS because the main function of the reporting requirement is to notify CMS of claimants that owe CMS reimbursement payments. Using ISO reporting would also ensure a consistent feed of information from insurers. Also, in the event the Data Elements needed to be updated, the updates would be more efficiently performed with a consistent reporting tool.

3. CMS should also consider an optional program in which it would provide "lien settlement" agents who could furnish to the parties a final lien resolution amount before the parties settled the claim. For example, in a complex, litigated claim with extensive medical bills for past treatment, it would likely be far easier to settle the case if both parties knew with certainty that the Medicare lien could be resolved for an exact dollar figure. Attempting to settle the case with that issue remaining in doubt would only make it that much harder to determine the proper settlement amount. Accordingly, if the parties could provide a CMS agent with the medical bills at issue and other relevant information, such as, for example, plaintiff's comparative negligence, CMS could provide the lien resolution number and the case could settle. This optional plan would also prevent post-settlement disputes concerning whether certain Medicare payments were causally related to the accident at issue in the claim. These types of routine lien negotiations could be resolved pre-settlement and thereby reduce uncertainty in the settlement negotiations.

   This program would also benefit CMS because it would allow the lien to be paid immediately upon resolution of the case rather than make CMS resolve the lien with a claimant many months after CMS received notice of the settlement. Another advantage for all the parties involved would be that CMS would be guaranteed to get its lien. When cases are settled first and CMS subsequently contacts the claimant to resolve the lien, it is possible that the claimant may no longer have the settlement proceeds and may not have any other means to satisfy the lien.

   Further, the pre-settlement lien resolution process would also protect insurers that are justifiably concerned that liability for a claimant's failure to satisfy a lien may fall back onto insurers.

   In essence, CMS already has a version of this type of plan in place for worker's compensation cases that meet certain dollar thresholds because it does proactively review and comment on a Medicare Set-Aside plan before the claim settles. We are not advocating for Medicare Set-Asides for liability cases generally but only pointing out that CMS has an established process to aid parties in worker's compensation cases by getting involved prior to the settlement.

   For this optional plan to succeed, however, it would require that CMS act promptly on requests for firm lien settlement amounts so that the claim resolution did not get delayed or cause other problems with the claim such as increased litigation (as to non-litigated claims) or bad faith claims.

II. Specific Comments

1. Data Elements 10 and 15 (Social Security Number)
Certain claimants may refuse to provide this information. Will insurers be excused from reporting this information if not provided? Similarly, will insurers have formal, federal government approval to delay payment if SSN is not provided?

2. Data Element 16 (Insurance Type)
This Data Element offers the three examples of insurance types as follows: Worker's Compensation, Liability or No-Fault. The No-Fault category is confusing because it would appear that it is being offered as a replacement for an auto policy and No-Fault is a component part of an auto policy. The same auto claim may have some payments under the No-Fault component and other payments under the traditional provisions of the policy. Accordingly, it may be more clear to use "Auto" as one of the categories, instead of No-Fault or to just limit the categories to Worker's Compensation and Liability.

3. Data Elements 23 (No Fault Policy Limit) and 24 (Exhaust Information)
Why is this information needed?

4. Data Element 27 (Self-Insured)
With regard to the definition of "Liability Self Insurance" on pages 13-14 of the Supporting Statement, we take a different view of what would be considered self insurance. Accordingly, we would not view a deductible as self insurance but merely as a particular type of policy provision. On the other hand, an insured with a self insured retention (SIR) is viewed differently than one with a deductible and is treated as self insured with respect to the amount of the SIR. Accordingly, we would propose that deductible policies not be treated as self insurance.

5. Data Elements 35-36, 38-39 (Nature of Injury, Cause of Injury, ICD-9 Code and Body Part)
These are data elements that may be routinely captured as part of a worker's compensation case but are not collected or recorded with respect to other types of liability claims.

6. Data Element 37 (State of Venue)
CMS needs to provide greater clarification on what this means. For a litigated case, we assume this means the venue of the lawsuit. If the matter is not litigated, does it mean the venue of the accident, the claimant's home address, the state in which the policy was issued or something else?

7. Data Elements 40-41 (Product Liability and Product Liability Information)
This information is not captured as part of any routine claim data. Further, to the extent that it requires manual entry regarding the type of product liability case, it will be unduly burdensome.

8. Data Element 44 (Claim Resolution.)
CMS needs to provide greater clarification on what types of claims will be considered "contested" versus "non-contested." Similarly, we need further information concerning what will be considered a resolution with "no on-going responsibility" versus one with "on-going responsibility."

9. Data Element 45 (Funding).
This data element asks the question: "Was funding of the settlement, judgment, award or other payment contingent upon proof of resolution of Medicare's fee for service Medicare Secondary Payer recovery claim? Yes or No." If Medicare potentially approves of a "holdback" until claimant resolves a Medicare lien, will such "approval" protect insurers from other issues such as time limit demands, breach of contract or bad faith claims? The "holdback" plan has the benefit of ensuring that Medicare will be able to be paid (as opposed to a claimant who may spend the settlement and become judgment proof before resolving the Medicare lien) and would also alleviate concerns that an insurer may have about liability for a Medicare lien falling back onto it should the claimant fail to pay Medicare. On the other hand, insurers would likely need some specific language built into the Act or regulations that would insulate insurers from attacks on a "holdback" plan.

10. Identifying Medicare Eligible Claimants.
With respect to identifying Medicare eligibility by the category of age alone, that process may be relatively straight forward. Regarding claimants below the Medicare age eligibility requirement, however, it will be much more difficult to identify whether they may be Medicare eligible based on End Stage Renal Disease, disability or possibly another reason. CMS has indicated that Group Health Plans may currently have the ability to query CMS for aid in helping identify whether a particular claimant may be Medicare Eligible. What is the latest status of methods to help Non-GHP insurers identify and confirm Medicare Eligibility?

PARHAM, WILLIAM N. (CMS/OSORA)

From: Thompson, William D (LAW, LEG) [William.Thompson@thehartford.com]
Sent: Tuesday, September 30, 2008 5:09 PM
To: CMS PL110-173SEC111-Comments
Cc: Thompson, William D (LAW, LEG)
Subject: #157 [NGHP - several Q] Medicare Secondary Payer - Reporting Requirements - Non-GHP Comments - Hartford Fire Insurance Company [HFSG-LAW.FID104379]
Attachments: 836768_1.DOC

<<836768_1.DOC>>

To CMS - please see the attached document for Non-GHP comments from Hartford Fire Insurance Company regarding the proposed Data Elements.

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PARHAM, WILLIAM N. (CMS/OSORA)

From: dawn.stclair@choosebroadspire.com
Sent: Tuesday, September 30, 2008 5:28 PM
To: CMS PL110-173SEC111-Comments
Subject: #158 [NGHP - ICD codes, timeliness of response} QUESTIONS CMS

Importance: High

1. **With respect to liability (i.e. non-workers' compensation claims), how should a liability carrier classify injuries given that ICD-9 codes are not used for such claims?**

2. **How is CMS going to effective and timely handle, the big influx of benefits requests (w/ proper SSA-3288 signed release) that are sure to come as SCHIP goes into effect? [Local SSA offices can not timely handle requests for benefits verification now and many take weeks to reply. Frequently requires sending release / letter request more than once. SSA offices rarely answer their phones. Offices visited appear understaffed and this is a frequent complaint by SSA staff. Pre-pays very in amount from SSA office to office and range from $7.75 to $64.00 for the same written request to verify SSA vs. Medicare / Medicaid benefits. No consistency in CMS policy on pre-payments.]**

3. **Will CMS be expanding options of accomplishing this, meaning, option of on-line information site (being able to scan and submit release forms to obtain the information)?**

Dawn P. St. Clair RN, BSN, MSCC
CLCP, CDMS, CCM, QRP

Product Manager
Medicare Set-Aside & Life Care Planning Unit
Broadspire, a Crawford Company
1900 East Golf Rd., Suite 800
Schaumburg IL 60173
phone: (727) 442-2918
fax: (727) 442-2855
email: dawn.stclair@choosebroadspire.com
web: www.choosebroadspire.com

4.
5.

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Comments Regarding CMS-10265
Implementing Section III of P.L. 110-173
Submitted by: Keith Bateman, 847-553-3802, keith.bateman@picaa.net
Property Casualty Insurers Association of America
2600 South River Road
Des Plaines, IL 60018-3286
September 30, 2008

Claimant's Entitlement to Medicare

CMS is urged to clearly define what is meant by "entitled to Medicare". PCI recommends that only those actually enrolled in Medicare be considered as falling within the category of "entitled to Medicare". Such an interpretation would provide a clear standard regarding what must be reported, reduce potential disputes between RREs and CMS, and help to limit the RREs cost of compliance as well as CMS costs.

Section 111 places the burden on the non-GHP entity to make a determination as to whether the claimant is Medicare entitled without providing any tools for making it. CMS is urged to set-up an internet data base possibly in conjunction with the Social Security Administration that RREs can query whether a claimant is enrolled in Medicare (assuming that is the meaning of "entitled").

Unlike group health, the non-GHP claimant is more likely to be in an adversarial relationship with the insurer or self-insurer. Usually the claimant is not our insured, and the claimant frequently is opposed to the interest of our policyholder. Particularly in liability, we are dealing with a claimant with whom we have no on-going relationship, who has no incentive to cooperate voluntarily with insurers, whose medical costs are damages payable to him rather than doctors bills paid by insurers, and who can be compelled to provide information to us only if formal litigation is commenced. In actuality, few cases are actually tried so there is no access to the claimant's medical records and bills because discovery tools are available only in litigated cases. There are claims such as wrongful death and loss of consortium where the party suffering the injury is not the claimant so there is even less of an inclination to cooperate.

Particularly in liability, insurers usually don't have the claimant's social security number, and absent formal litigation, no tools for obtaining it. CMS has suggested that it might create a form that could be given to claimants asking for their social security and HICN numbers. While this would be better than nothing, CMS should explore whether a form could be provided to claimants that they would be compelled to complete. If not, will CMS be willing to forgo penalizing a carrier if it provides incorrect information or no social security number or HICN based on the information or lack thereof provided by the claimant? In most jurisdictions we are obligated to pay claims even if the claimant is an illegal alien or for some other reason has no social security number.

Need for Cost Benefit Analysis

There is a need for CMS to do a cost-benefit analysis to determine at what point the medical costs of claims are sufficient to warrant reporting by the primary payee and

reimbursement of CMS for payments made where CMS should have been secondary. Property/casualty insurers pay many claims with only first aid or small amounts of medical. For example, sixty-eighty percent of workers compensation claims are for medical only. The latest available information on the countrywide average medical cost involved for those claims is $627. It is likely that it would cost the workers compensation insurer more to investigate whether the claimant is Medicare entitled and for CMS to collect, store and use the information than $627. Similarly liability and auto insurers or their policyholders pay for many claims with a small medical component. In many cases, the commercial policyholder may view the payment as a "good will settlement" and not even bother reporting it to the insurer. Therefore, we urge CMS to consider some de minimus limit established so that CMS is only notified of medical claims likely to be large enough to warrant CMS' collection efforts.

Reporting of Claims

CMS needs to clarify which claims must be reported to CMS. Is it claims filed after July 1, 2009; dates of injury after July 1, 2009, or payments after July 1, 2009? What if the case was settled prior to July 1, 2009, but payment was not made until after July 1, 2009? What if the payment is for a claim that pre-dated passage of the applicable Medicare Secondary Payer Provision? In the non-GHP world, there are entities that may be paying claims, but are neither insurers nor self-insurers. These include residual market mechanisms, guaranty funds, uninsured employer funds, and possibly a few second injury funds or other special funds that pay the claimant directly. CMS needs to define who must report so that these entities know whether or not they have a reporting duty.

Another point needing clarification is whether the payment involved is a payment for medical or could at least arguably be said to include some medical payment.

Given the uncertainty about which claims must be reported, a few of PCI's members asked whether they could report all their claims to CMS and let CMS determine which involved medical payments or damages for medical and whether the claimant was Medicare entitled. What is CMSs' position on this? Also, some reporting entities because of their size or because they write a limited amount of medical coverage may have such a low claims volume that establishing an electronic reporting system is not warranted. CMS is urged to provide an alternative for such RREs.

Date of injury, whether it triggers the reporting obligation or is a data element should be determined according to the applicable state's statutory or common law. CMS should not create its own.

Our members are confused regarding the timing of reporting. In some places quarterly reporting is mentioned and other places on-going. CMS needs to reconcile these statements.

Property Casualty Insurers Association's Comments

CMS' Time Table Needs to Be Accelerated

CMS is focusing on the GHP entities first because it believes that they will more readily be brought into production and because the effective date for them is January 1, 2009 while it is July 1, 2009 for non-GHP entities. However, this approach does not give non-GHP entities sufficient lead time to comply. GMS needs to accelerate its time table for making material available to the non-GHP entities. Non-GHPs haven't been using the standardized HIPAA electronic transaction sets nor dealing electronically with CMS. Particularly on the liability side, insurers have done very little electronic reporting of detailed claim information. Moreover, CMS clearly does not understand the complexities of the non-GHP coverage environment, so more lead time is needed. To mutually educate each other and to allow for the needed adjustments to data systems, it is important that the data elements be finalized, record layouts published, transmission standards be released, and companion guides developed as soon as possible. Data elements not essential to putting CMS on notice of a potential secondary payer situation should be deleted.

CMS needs to begin a more detailed dialog with the non-GHP entities to understand the complexities of other coverages. Our coverages may provide for multiple deductibles and coverage limits. More than one insured may be involved in coverage. Settlements may be partial and this can vary with the coverages. Claims may involve multiple plaintiffs, multiple defendants, class actions, etc. What reporting does CMS expect when a case involves multiple plaintiffs but only one is Medicare eligible? What reporting priorities are to exist when multiple payees (insureds and self-insureds) are involved? Who reports when liability may be apportioned? In settlements, it is rare for the agreement to be broken into medical, indemnity, pain and suffering, etc.

In some cases, non-GHP entities are required to make payments even though they ultimately are found to have no liability. Also, CMS needs to understand the complexities of comparative and contributory negligence, subrogation and actions over. All these examples demonstrate that the non-GHP environment is much more complex than that of group health insurance with which CMS is most familiar. Therefore, CMS is going to have a lot more issues to grapple with than it does with group health so more lead time for learning is needed.

Records Retention

CMS is urged to drop the recommendation for a ten year period for record retention. CMS has not made the case for needing this from reporting entities. It is outside the range of normal business practice, and it will drive up costs for RREs. Also, it's not clear whether CMS intends this recommendation to be retroactive or prospective only. If a medical payment is made on a twenty-year old claim after July 1, 2009, are you expecting the carrier to maintain records going back ten years?

Appeals

We urge CMS to establish a process for an RRE to challenge the imposition of a penalty when the carrier has made a good faith effort to comply with the reporting requirements but cannot complete all required fields, such as social security number, because the claimant refused to provide the information or provided incorrect information.

Conflict with State or Other Federal Laws

Our members are concerned that the reporting requirements will result in conflicts with their obligations under state unfair claims settlement practices acts and state and federal privacy laws. CMS has verbally dismissed these as unfounded. We request that at the very least CMS provide the bases for its conclusions in writing. To protect us from lawsuits based on CMS' interpretation of these laws, we urge CMS to develop a hold-harmless agreement that it will offer to all RREs.

Resources

We urge CMS to make sure that it will have sufficient resources to timely accept and respond to the data being provided to it. We would like to be assured that we will not have a repeat of the experiences we have had with workers compensation MSAs.

CMS Cost Estimates

Several of our members believe that CMS has significantly understated the cost of implementation for data providers. This applies not only to the provider cost, but also to the aggregate cost because the number of data providers is much greater than the CMS' assumption. However, until we set more specific information from CMS regarding the data reporting requirements, it will be impossible to develop appropriate estimates.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Tiffany Yamini [Tiffany@ramoslawfirm.com]
Sent: Wednesday, October 01, 2008 8:48 AM
To: CMS PL110-173SEC111-Comments
Subject: #162 [timeline] Questions for the SCHIP Open Forum
Attachments: Tiffany Yamini.vcf

1) When will the interactive website be on-line? When can we start entering information?
2) Is reporting only mandatory for WC claims filed after the July 1, 2009, reporting deadline or must we also report claims that are already in process on that date.

Tiffany K. Yamini

Tiffany K. Yamini
Ramos Law Firm
1800 Peachtree Street, N.W., Suite 620
Atlanta, Georgia 30309
678-904-7586 (direct dial)

www.ramoslawfirm.com
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Tiffany K. Yamini

Tiffany K. Yamini
Ramos Law Firm
1800 Peachtree Street, N.W., Suite 620
Atlanta, Georgia 30309
678-904-7586 (direct dial)

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Sent: Wednesday, October 01, 2008 8:48 AM
To: CMS PL110-173SEC111-Comments
Subject: #162 [timeline] Questions for the SCHIP Open Forum
Attachments: Tiffany Yamini.vcf

1) When will the interactive website be on-line? When can we start entering information?
2) Is reporting only mandatory for WC claims filed after the July 1, 2009, reporting deadline or must we also report claims that are already in process on that date.

Tiffany K. Yamini

Tiffany K. Yamini
Ramos Law Firm
1800 Peachtree Street, N.W., Suite 620
Atlanta, Georgia 30309
678-904-7586 (direct dial)

www.ramoslawfirm.com
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PARHAM, WILLIAM N. (CMS/OSORA)

From: Matthis, Shelley B6LPA [Shelley.Hayes@CIGNA.COM]
Sent: Wednesday, October 01, 2008 8:49 AM
To: CMS PL110-173SEC111-Comments
Subject: #163 [TPA/use of agents/ssn] Mandatory Secondary Payer Reporting - Use of Agents

Can you provide further details on the use of agents for reporting purposes. We serve as a TPA for many self-insured plans for which we administer claims. Many of our customers do not want to share SSNs with us for privacy and security reasons. However, they would be willing to have their broker or other administrator report to CMS for their membership. Is this an acceptable means of reporting so that we, as claims administrator, can rely on multiple agents of the customer's choosing to submit the report on our behalf for specific customers?

Shelley Matthis
Federal Regulatory Affairs Manager
CHC National Regulatory Compliance Organization
Phone: 860.226.5372
Network: 572.5372
Fax: 860.226.1769
Email: Shelley.Hayes@cigna.com
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PARHAM, WILLIAM N. (CMS/OSORA)

From: Rich F. Crook [rich.crook@aibpa.com]
Sent: Wednesday, October 01, 2008 11:00 AM
To: CMS PL110-173SEC111-Comments
Subject: #165 [GHP active covered individuals] confusion over GHP reporting of "active covered individuals"

Your data elements notice from September 25, 2008 has a definition of an Active Covered individual that is somewhat confusing, in that it lists the requirements for Sec. 111 reporting then goes on in the next paragraph to say "an active covered individual is someone who may be Medicare eligible and currently is employed." Do you need ALL individuals covered in the GHP ages 45 through 64, or what the following paragraph says "who may be Medicare eligible."

Please clarify

Thank you.

Rich Crook
Project Coordinator
Phone 503.224.0048 ext. 1805
rich.crook@aibpa.com

Small enough to know you, big enough to serve you

A&I Benefit Plan Administrators, Inc.
1220 S.W. Morrison St, Suite 300
Portland. OR 97205-2222
Phone: (503) 224-0048
Toll-Free: (800) 547-4457
Fax: (503) 228-0149

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Robin.Taylor [Robin.Taylor@healthalliance.org]
Sent: Wednesday, October 01, 2008 11:35 AM
To: CMS PL110-173SEC111-Comments
Cc: Sandra Caro
Subject: #166 [timeline,VDSA & MIR, TIN] Questions for Open Door Forum Scheduled for 1-3 EST 10/1/08

We are an insurer who is currently not participating in VDSA nor has a current agreement in place.

Questions:

1. What are the timeframes for each file transmission or reporting piece (including timeframes for testing periods vs Production)?
2. Can you explain the difference between VDSA and Mandatory Insurer reporting requirements and what is due when for us.
3. This may be included in your answer to question 2, but in the Supporting Statement for the Medicare Secondary Payer (MSP) Mandatory Insurer Reporting Requirements of Section 111 of the Medicare Medicaid, and Schip Extension Act of 2007, page 2, paragraph one reads... Section 111 establishes separate mandatory reporting requirements for GHP and non-GHP. Is this a separate reporting requirement from that of the MSP file sharing?,
4. If we sign the VDSA, how do the timeframes apply and is there a strict deadline on when the production file must be received?
5. Is there a specific time element required for us as the Insurer to gather the TIN's for those groups that we presently don't have and would be submitting under a pseudo TIN?

Robin Taylor
Business Analyst
IT Health Alliance Medical Plans
217-383-8332

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Chapman, Gregg [GreggChapman@firsthealth.com]
Sent: Wednesday, October 01, 2008 12:22 PM
To: CMS PL110-173SEC111-Comments
Subject: #167 [NGHP-identify MDCR bene]Question for Teleconference

Will a new streamlined process be implemented that will allow an insurer to find out if a claimant is a Medicare beneficiary? The existing process involves getting a signed release and sending it to the Social Security Administration. This process currently takes weeks and could conceivably take months once all the insurers start the reporting process next year. That would be a hardship on the industry since it would delay the settlements of claims by months while everyone waited for the Medicare eligibility report to get back from the Social Security Administration.

Gregg Chapman, Esq.
Coventry Workers' Comp Services
21300 Victory Blvd. 12th Floor
Woodland Hills, CA 91367
Office: (818) 737-8516 Direct
Cell: (818) 825-7887
Fax: (818) 737-8544
greggchapman@cvty.com

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Cooper, Ellen Anselm [eacooper@bcm.tmc.edu]
Sent: Wednesday, October 01, 2008 12:22 PM
To: CMS PL110-173SEC111-Comments
Subject: #168 [NGHP-non-citizens]Question for teleconference

We have a number of Foreign non-citizens, how do we handle these people.

Ellen Anselm Cooper
Baylor College of Medicine
Benefits Administrator for Health, Welfare, and ERISA Compliance
eacooper@bcm.edu
One Baylor Plaza BCM207
Houston, Texas 77030
713.798.9087

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Debbie Johnston [djohnston@hchadmin.com]
Sent: Wednesday, October 01, 2008 12:25 PM
To: CMS PL110-173SEC111-Comments
Subject: #169 [NGHP - who does it apply to/ssn]Teleconference

1. Please confirm this applies to self-funded group health plans maintained by a single employer.

2. Does this apply to:
   - municipal group employer plans?
   - school plans?
   - church plans?

3. We have several client group health plans that refuse to provide the plan participants' social security numbers. Can we tell them the information is required by law?
   - If either the employer or employee refuses to provide the SSN, can the plan deny coverage?

Thank you.
~Debbie Johnston

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Sheehan, Carol [csheehan@highpointins.com]
Sent: Wednesday, October 01, 2008 12:19 PM
To: CMS PL110-173SEC111-Comments
Subject: #171 [NGHP - interface]questions for today's teleconference

1. We need an interface built so that carriers can easily determine which claimants are Medicare eligible. Is anyone considering this? And if yes, what is the time frame? Will it be ready for 7/1/09?
2. If not, are you going to at least give us a phone number to call to get an answer to our question. Requiring every liability carrier in the country to submit forms to Medicare will be too cumbersome for Medicare to respond to.

Carol Sheehan
Casualty Supervisor, Northern Claims Office
Office 973-434-2436
Fax: 888-433-3023
csheehan@highpointins.com
www.highpointins.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Bob_Harrald@gbtpa.com
Sent: Wednesday, October 01, 2008 1:05 PM
To: CMS PL110-173SEC111-Comments
Subject: #176[data file exchange]CMS questions

Can a data file of eligible claimant information be sent to the CMS?

Also, is there a record layout available?

Bob Harrald
Gallagher Bassett Services, Inc.
Data Compliance
(630) 285-3731

PARHAM, WILLIAM N. (CMS/OSORA)

From: Allen, Colleen [callen@hselaw.com]
Sent: Wednesday, October 01, 2008 1:06 PM
To: CMS PL110-173SEC111-Comments
Subject: #177[NGHP - RRE]MMSEA111 Questions

Please clarify who is the party responsible for reporting (RRE) in the following situations:

(a) self-insured group health plan where third party administrator makes all claim decisions, including final decisions on appeals of denied claims.

(b) self-insured group health plan where third party administrator makes initial claim decisions and plan administrator or other fiduciary (not the third party administrator) makes final decisions on appeals of denied claims.

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Arthur Chapman [achapman@cornerstonesettlements.com]
Sent: Wednesday, October 01, 2008 1:18 PM
To: CMS PL110-173SEC111-Comments
Subject: #178 [NGHP - setasidequestion for conference call

As a settlement advisor in personal injury liability cases, I am attempting to give good advice to my plaintiff attorney clients.

Case in point. In a current case involving a 74 year old man, severely injured in a motor vehicle accident, the casualty insurance company is demanding that we provide funding for a Medicare Set Aside allocation and that we submit it to CMS for approval. This is not a worker's comp claim.

Is it mandatory that we do this?
Is the casualty company required to report this claim and settlement to CMS?
If we do not do this, is the claimant going to continue to be covered by Medicare for medical treatment for injuries received in the accident?
If he continues to receive coverage by Medicaid, can Medicare come back at a future date and recover the money paid on behalf of the claimant for treatment of injuries as a result of the accident?

Thank you,

Cornerstone
SETTLEMENT SERVICES
Arthur Chapman
5575 Poplar Avenue, Bldg. C, Ste. 617
Memphis, TN 38119
Ph: (901)766-0166
Fax: (901)766-0806
Cell: (901)262-7498

PARHAM, WILLIAM N. (CMS/OSORA)

From: Allen, Colleen [callen@hselaw.com]
Sent: Wednesday, October 01, 2008 1:23 PM
To: CMS PL110-173SEC111-Comments
Subject: #179 [NGHP - RRE requirements]

Can you please addresss the following:

When a third party administrator of a self-insured group health plan is the RRE, does the third party administrator complete the section of the registration document which requires RRE Information with its own compnay name and EIN or should the sponsoring employer's information be entered?

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Brad Jones [BJones@fslins.com]
Sent: Wednesday, October 01, 2008 1:32 PM
To: CMS PL110-173SEC111-Comments
Subject: #180 [GHP-reporting requirements]Question- Reporting requirements

1. If a group health plan has primary payor responsibility in all instances, does the insurance company or its TPA have reporting requirements? If so, why?

2. Who is NOT to be reported?

Bradford R. Jones
Assistant Counsel
Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, Missouri 64111-2406
Phone: (816) 756-1060
Fax: (816) 968-0657

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Brad Jones [BJones@fslins.com]
Sent: Wednesday, October 01, 2008 1:50 PM
To: CMS PL110-173SEC111-Comments
Subject: #184 [GHP - scope]RE: Scope of Medicare Reporting

What is the scope of "Group Health Plan" for reporting requirements?

Bradford R. Jones
Assistant Counsel
Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, Missouri 64111-2406
Phone: (816) 756-1060
Fax: (816) 968-0657

From: Brad Jones
Sent: Wednesday, October 01, 2008 12:38 PM
To: 'PL110-173SEC111-comments@cms.hhs.gov'
Subject: Scope of Medicare Reporting

Would employer ERISA plans that include stand-alone prescription, vision, GAP, etc. be excluded, or included in the definition of Group Health Plan for purposes of the Medicare reporting?

Bradford R. Jones
Assistant Counsel
Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, Missouri 64111-2406
Phone: (816) 756-1060
Fax: (816) 968-0657

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Steve Elliott [SElliott@fslins.com]
Sent: Wednesday, October 01, 2008 2:32 PM
To: CMS PL110-173SEC111-Comments
Subject: #186[GHP - exemptions]Mandatory Reporting Section 111 Group Health Plans

Are there any types to group health policies issued to employers that would be exempt from the data reporting under Section 111? Examples of employer group health policies might include the following:

- Stand-alone Dental
- Stand-alone vision exam/glasses
- Stand-alone outpatient prescription drug
- Stand-alone supplemental coverage that reimburses the employee for deductible and coinsurance not otherwise covered under an Employer's primary major medical plan.
- Stand-alone fixed hospital indemnity and other limited benefit fixed indemnity plans.

Thank you for your response.

Stephen A. Elliott, JD, CLU, FLMI, AIRC
Senior Counsel
Fidelity Security Life Insurance Company
800-648-8624 X1543

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Schroeder, Pam [pschroeder@spokanecity.org]
Sent: Wednesday, October 01, 2008 2:44 PM
To: CMS PL110-173SEC111-Comments
Subject: #187[NGHP - use a similar file/RRE]Duplication of Reporting Files

We recently completed an electronic data interchange project in the state of Washington (SIEDRS). Is there any way we can "piggyback" on that file and add any additional elements you would require?

I'm still unclear about our responsibilities under a self-insured liability program. We are self insured, but have a TPA that administers our claims in their computer system. They bill us back for costs. Do we have a responsibility to report, or is that their responsibility?

Thank you.

Pam Schroeder
Director, Risk Management
City of Spokane
808 W. Spokane Falls Blvd.
Spokane, WA 99201-3327
509.625.6220

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Tito Melara [Tito.Melara@safeway.com]
Sent: Wednesday, October 01, 2008 2:57 PM
To: CMS PL110-173SEC111-Comments
Cc: Tito Melara; Roy Franco
Subject: #188[NGHP - multiple reportings]Questions

Importance: High

To CMS:

How will CMS avoid multiple reporting for the same loss when there are multiple RRE's? And then, what happens if each RRE reports different ICD9 codes for the same loss? Also what happens if the parties stipulate to a judgment signed off by the court....will CMS accept the allocation?

Thank you

Tito Melara, LPCS
Corporate Casualty Claims Manager
Safeway Risk Management
O (925) 226-5343
C (925) 353-0778
F (925) 226-5738
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PARHAM, WILLIAM N. (CMS/OSORA)

From: Kaija Blalock [Kaija@1strehab.com]
Sent: Wednesday, October 01, 2008 3:38 PM
To: CMS PL110-173SEC111-Comments
Subject: #190[NGHP - 1st file submission]initial reporting of ongoing claims

Thank you for today's forum. One question I was not able to ask. When an RRE submits a **first** production file after 7/1/09, that file should include **all active** claims involving Medicare entitled individuals for whom the RRE has assumed responsibility and for whom that responsibility has not terminated, even if the responsibility was assumed prior to 7/1/09?

Kaija Blalock

Kaija Blalock, R.N., B.S.N. RN-WCCM, JD
Medical Case Management Supervisor

First Rehabilitation Resources, Inc.
14504 Greenview Drive, Suite 508
Laurel, Maryland 20708
Telephone: (410) 792-0506 or (301) 369-3401 or (888) 252-0368
Facsimile: (301) 206-7650
E-mail: kaija@1strehab.com
www.1strehab.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Kaija Blalock [Kaija@1strehab.com]
Sent: Wednesday, October 01, 2008 3:43 PM
To: CMS PL110-173SEC111-Comments
Subject: #192[NGHP - RRE's and Agents]RREs and agents

Question: The company I work for provides case management and consulting services for workers' compensation and liability carriers. Currently we take over some state reporting requirements for some Insurers. Would we be able to report in lieu of any of our Insurers/RRE? If so, how would we register and would we be assigned an EDI?

Kaija Blalock

Kaija Blalock, R.N., B.S.N., RN-WCCM, JD
Medical Case Management Supervisor

First Rehabilitation Resources, Inc.
14504 Greenview Drive, Suite 508
Laurel, Maryland 20708
Telephone: (410) 792-0506 or (301) 369-3401 or (888) 252-0368
Facsimile: (301) 206-7650
E-mail: kaija@1strehab.com
www.1strehab.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Crites, Candi [CCrites@spokanecounty.org]
Sent: Wednesday, October 01, 2008 3:49 PM
To: CMS PL110-173SEC111-Comments
Subject: #194 [NGHP - DOL data reporting system]DLI SIEDRS compliance program

Sensitivity: Confidential

Good afternoon,
In this mornings tele con you had requested that I send you information about the Department of Labor & Industries Self-Insured Electronic Data Reporting System. As of July 1, 2008 all self-insured employers were required to submit all claim information (we submit weekly updates some do monthly) for every workers comp claim filed by Spokane County employees. Which was my question; will we be able to integrate the two reporting requirements into one (SIEDRS & CMS) or are we going to have to purchase another complete program to be complaint with your reporting requirements?

Also, I have two questions of clarification regarding this reporting requirement.

1. Are you seeking solely for monetary awards issued or are you also looking for injury information?

2. Are you solely seeking settlement information for individuals actually receiving medicare benefits at the time of opening and or closing?

Thank you,

Candi Crites, WWCP
WC Claim Adjudicator
Risk Management
477-6106

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Nancy_Thomas@ajg.com
Sent: Thursday, October 02, 2008 8:33 AM
To: CMS PL110-173SEC111-Comments
Subject: #198[Medicare malpractice payments]Medical Malpractice Payments

Does this requirement extend to insurance companies who issue medical malpractice payments to a claimant on behalf of a physician or hospital? If so, what is the process? Thank you.

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Nancy Thomas-Hahn
9821 Katy Freeway, Suite 600
Houston, TX 77024
Phone: 713.935.8868
Fax: 713.935.2479
nancy_thomas@ajg.com

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From: Kim Bushek [kbushek@benefitsourceinc.com]
Sent: Thursday, October 02, 2008 2:47 PM
To: CMS PL110-173SEC111-Comments
Cc: Sharon Mason; Holly Miletti
Subject: #200[NGHP - RRE vs Agent]RRE vs. Agent

CMS,

We are a TPA, doing self funded ERISA GHP's for small to medium size companies. We are confused on if we are the RRE or is our clients. The teleconference had us thinking the client was the RRE. However, we referred to Attachment A, which left us thinking we are the RRE?
If the client is the RRE, do they need to register, with us as the reporting agent? If we are the RRE, do we have to report each client separately or can we report all of them at one time?

Sincerely,
--
Kim Bushek
Report Specialist
BenefitSourceInc.
Monroe Office
Direct Line: (734)384-8526
Email: kbushek@benefitsourceinc.com
FAX: (734)242-4437

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From: Kristy Gibson [kgibson525@aol.com]
Sent: Friday, October 03, 2008 8:24 AM
To: CMS PL110-173SEC111-Comments
Subject: #201 [NGHP - confirmation of MDCR entitlement]Entitlement Information

I sat in on the 10/1/08 conference call where it was reported that CMS is looking into a process by which entities can confirm entitlement information. I think this is absolutely necessary. I am a MSA Allocator and one of the most difficult parts of my job is to confirm SSDI and/or Medicare coverage. This is because it is next to impossible to get the Social Security Administration to respond to requests for information, even when a release is submitted. I advise my clients to request a copy of the beneficiary's Medicare card, however, even when a copy of the Medicare card is requested, it is frequently never received. Since this amendment mandates that Medicare coverage be investigated on every claim, I think it will be absolutely necessary for CMS to develop an efficient means by which this can be accomplished.

Kristy Gibson, RN

Set Aside Specialists, LLC
Kristy L. Gibson, RN
PO Box 523
Statesville, NC 28687
Phone: (704) 876-3232
Fax: (704) 876-3202
Mobile: (704) 402-5247
Email: kgibson525@aol.com

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Toni McMurry [tmcmurry@keenan.com]
Sent: Friday, October 03, 2008 12:01 PM
To: CMS PL110-173SEC111-Comments
Cc: Walter Pregizer; Savannah Greene; Carmella Claridy; Cheryl Disheroon; Lisa Krafick
Subject: #202[NGHP - ssn & reporting requirements]Non GHP Data Procurement and Reporting Requirements

Importance: High

1. Is CMS partner with authorized agents for report such as ISO Claim Search, Gould and Lamb, etc? Want to confirm that we, the TPA, Keenan can electronically report to CMS? Will the TPA have to pay a fee to report claims to CMS?
2. Can you verify if the SSN will be mandatory for liability claims since we currently cannot require a claimant to provide one? Will there be an optional identification number for liability claims in addition to the SSN? If a claimant/attorney refuses to provide the SSN what is the TPA's obligation to show compliance/due diligence in obtaining it?
3. The query service for looking up SSN numbers that was mentioned in the teleconference, will that be located on the CMS website to use so that we do not have to use an outside vendor to obtain this information?
4. When claimants refuse to sign a release for information to determine Medicare status, what is the recourse for the TPA to assist in enforcing?

Toni McMurry
Manager, TPA Operations
Keenan & Associates
(310) 212-0363 ext. 3318
mcmurry@Keenan.com
License#0451271

PARHAM, WILLIAM N. (CMS/OSORA)

From: Toni McMurry [tmcmurry@keenan.com]
Sent: Friday, October 03, 2008 12:03 PM
To: CMS PL110-173SEC111-Comments
Cc: Walter Pregizer; Savannah Greene; Carmella Claridy; Cheryl Disheroon; Lisa Krafick; Amy Donovan; Helen Thomas
Subject: #203[GHP - reporting requirements]GHP Data Procurement Question and RRE Determination

1. Beyond submitting the required file within the required timelines, what is needed for the Responsible Reporting Entity to be in compliance in obtaining the information from the individual member? If we have a Medicare eligible member who does not submit the information to us or the employer what are we expected to do or show as reasonable proof that we tried to obtain the information and be within compliance guidelines?
2. We are the TPA for several self insured groups. In the past when completing and submitting Medicare Payment Demands we were required to obtain authorization from our clients to act on their behalf. Does this mean we will be considered an agent vs. the actual RRE?

Toni McMurry
Manager, TPA Operations
Keenan & Associates
(310) 212-0363 ext. 3318
mcmurry@Keenan.com
License#0451271

PARHAM, WILLIAM N. (CMS/OSORA)

From: Wind, Donald C [Donald.Wind@bnsf.com]
Sent: Wednesday, October 08, 2008 6:00 PM
To: CMS PL110-173SEC111-Comments
Subject: #214 [NGHP- RRE for liability] Who is the RRE when liability is shared?

Sometimes we share liability with another like entity (another railroad in this case), including splitting the payment at settlement time. Who is the RRE in an instance like this? Is the RRE the entity who carries the highest percentage of the risk? For instance, if "we" fund 40% of the liability and "they" fund 60% of the liability, are "they" the RRE? Do we both have to report? Can the parties sharing the liability just make a decision, as long as someone accepts responsibility as the RRE?

Does CMS' answer change if one of the two parties involved is an insurance company? Examples include 1) an injury with a subrogation claim or 2) a contractor on our property who has their own insurance, where the contractor's insurance policy bears part of the risk. In both examples, it seems that if the insurance carrier pays the highest percentage of the liability, they would be the only RRE of the liability???

Thanks for your consideration of this issue.

Don Wind

BNSF Railway

817-352-2331

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PARHAM, WILLIAM N. (CMS/OSORA)

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PARHAM, WILLIAM N. (CMS/OSORA)

From: CMS PL110-173SEC111-Comments
Sent: Wednesday, October 01, 2008 11:37 AM
To: PARHAM, WILLIAM N. (CMS/OSORA)
Subject: FW: #146 NGHP -- PRA from MARC] Opportunity to Comment on CMS Section 111 of the Medicare...Extension Act of 2007 (MMSEA)
Attachments: Response to CMS Request for Comments Section 111 MMSEA.doc; Addendum A - Response to CMS Request for Comments Section 111 MMSEA.doc

Importance: High

Note that the track changes on the one document were on the incoming

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From: Tito Melara [mailto:Tito.Melara@safeway.com]
Sent: Tuesday, September 30, 2008 1:40 PM
To: CMS PL110-173SEC111-Comments
Cc: Roy Franco; Seana@SBThomasLaw.com; David S. Rosenbaum
Subject: #146 NGHP -- PRA from MARC] Opportunity to Comment on CMS Section 111 of the Medicare...Extension Act of 2007 (MMSEA)
Importance: High

To CMS:

The attached comments are being posted by the Medicare Advocacy Recovery Coalition (MARC) – a group of concerned, insurance carriers, self insured entities, trade associations and attorneys.

Thank you

Tito Melara, LPCS
Corporate Casualty Claims Manager
Safeway Risk Management
O (925) 226-5343
C (925) 353-0778
F (925) 226-5738
World-Class Service Starts With A Safe Team

"Email Firewall" made the following annotations.

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Response to Request for Comment Re Mandatory Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (CMS-10265)

By Roy A. Franco, JD
Seana B. Thomas, Esq.
David S. Rosenbaum, Esq.
For the Medicare Action Recovery Coalition (MARC)

~~(ROY TO ADD~~ MARC Medicare Advocacy Recovery Coalition ~~MARC LOGO HERE)~~

Roy Franco, J.D.

Director Risk Management Strategy
Safeway Company
4410 Rosewood Drive
Pleasanton, CA 94588-3492

Seana B. Thomas, Esq.
Law Office Seana B. Thomas
15 W. Carrillo St. Ste 219
Santa Barbara, CA 93101
T: 805.879.7553/805.705.7303
F: 805.962.0722
seana@sbthomaslaw.com

David S. Rosenbaum, Esq.
McDowall Cotter, APC
2070 Pioneer Court
San Mateo, CA 94403
T: 650.572.7933
F: 650.582.0834
Drosenbaum@mcdlawyers.net

1. INTRODUCTION

The CMS, via Document CMS-10265 (the "Agency Information Collection Activities: Proposed Collections; Comment Request"), has requested comment regarding the information collection provisions of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (42 USC 1395(b)(7)(8), as to the necessity and utility of the collection provisions for the performance of the agency's functions, the accuracy of the estimated burden of the collection and reporting provisions, ways to enhance the quality, utility and clarity of the information collection, and the use of automated collections techniques and other forms of information gathering to minimize the information collection burden.

This Response is submitted by the Medicare Advocacy Recovery Coalition (MARC), an organization of representatives of and counsel for self-insured entities, insurance carriers, retail trade associations, risk management associations and third party administrators affected by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Through its members, MARC has extensive experience with insurance, claims administration and settlement, litigation, and reimbursement to Medicare and other plans in all Federal and State jurisdictions. MARC has carefully reviewed and analyzed the MMSEA in light of existing legal authority and the collective experience of its members.

There are aspects of MMSEA procedures and provisions which, although well-intentioned, present significant, inequitable, and ultimately unworkable burdens upon the affected plans, upon senior citizen beneficiaries, and upon CMS itself. The unintended adverse impacts of the MMSEA will impede, rather than facilitate, the government's goal of increasing collection of Medicare reimbursement from the affected plans.

2. BACKGROUND

In order to best understand the difficulties posed by the MMSEA, it is helpful to understand how and why General Liability Settlements (GLS) are reached, how reimbursement has worked in the past to allow for the finality and certainty of such settlements in

the context of self-insured entities and general liability carriers, and why that finality is crucial to the ability of the affected plans to conduct business.

Group Health Plans (GHP) and Worker's Compensation Carriers have legal relationships with health care providers and are able to quickly assess their responsibility for the cost and payment of medical services. These plans pay health care providers directly for services rendered to subscribers/injured workers, without regard to fault. These plans generally process/pay bills for medical services as they are incurred and consequently do not ordinarily become involved in reimbursing Medicare for past medical expenses. More importantly, these plans have the cooperation of their insureds/claimants in obtain information which might otherwise be privileged or private as a result of their contractual relationship with the plan or other statutory basis. The ready access these plans have to this information adds greatly to the plans' ability to efficiently process claims for medical services.

In contrast, General Liability Carriers (GLC) and Self-Insured Plans (SIP) do not have relationships with health care providers rendering treatment to the Medicare beneficiary or potential Medicare beneficiary. The GLC or SIP must rely on the beneficiary to provide information about eligibility, coverage and medical services rendered. The preferred method is to obtain a records release from the beneficiary so the GLC or SIP may secure this information directly. However, even assuming the beneficiary cooperates (often not the case in an adversarial claims situation), obtaining records takes time, as does evaluation of the issues presented by these claims, including liability, causation, and the extent of injury and medical treatment alleged to be related to the claim.

The mere fact that a GLC or SIP requests medical records from a beneficiary does not automatically mean that it will pay for the loss (or receive all of the applicable medical records). It is the responsibility of the GLC or SIP to pay only after an investigation into the facts of the loss, analysis of the nature and extent of injury/illness, evaluation of the applicable law as it affects a determination of liability and defenses thereto, and the assessment of exposure based upon liability, injuries and jurisdictional nuances. Once that analysis has

taken place, the GLC or SIP commences negotiation with the beneficiary to resolve a loss. This negotiation includes the exchange of information and analyses by each side as to liability, past and future medical expenses, lost wages, other miscellaneous incurred expenses, and pain and suffering.

This system of claims handling, negotiation and settlement has worked extremely well for many years, resulting in a decrease in the burden on our trial courts. Indeed, it appears from many knowledgeable sources that *more than 90% of all claims settle before trial.*

The long-standing system under which liability settlements have been reached has also generally involved the agreement between the parties that reimbursement to Medicare and other health care providers would be the responsibility of the beneficiary and/or his/her counsel. It was left to the beneficiary and counsel to negotiate with Medicare as to the amount of reimbursement to be received by Medicare from the beneficiary's settlement proceeds. This system allowed the settling plan to know exactly what its loss was, put at end to that loss, and formulate business decisions accordingly. These matters are of great significance in the ability of the affected plans to set appropriate reserves and address other budgetary matters required to conduct business.

Given this background, it may be seen that a GLC or SIP cannot reasonably be expected to make payment for medical services until its evaluation of a claim is complete, and that it requires significant information, including privileged medical information, in order to do so. (It does happen on occasion that the liability of an insured third party will be sufficiently clear that some medical payments may be made during the evaluation process. However, this is uncommon and, as a general rule, payment by the plan does not and cannot occur until evaluation is complete and an offer to resolve the entire claim can knowledgeably be made.)

With this historical background in mind, the difficulties presented by the MMSEA become apparent.

3. ISSUES PRESENTED BY MMSEA PROVISIONS

A. Medicare Eligibility:

"The reporting of Social Security Numbers (SSNs) or associated Medicare Health Insurance Claim Numbers (HICNs) is critical for the coordination of benefits".[1] MARC agrees with this concept, but under the present reimbursement scheme and the MMSEA, Non-GHP entities cannot compel a beneficiary to provide Medicare eligibility information absent a lawsuit. Most claims do not result in litigation and hence there is no mechanism to require this disclosure. The Non-GHP faces a legal impossibility to comply with the MMSEA should the beneficiary not cooperate. In order to remedy this so that the affected plans can in fact comply with the new ~~regulations,~~ regulations; CMS should provide a "safe harbor" for the affected plans by designing regulations that shift the obligation to report to the Medicare beneficiary. Appropriate reporting standards should include a method by which plans can report non-cooperation by beneficiaries which makes compliance with the reporting requirements, perhaps a mechanism by which plans can "disable" or be excused from completing otherwise mandatory reporting fields such as SSN and date of birth, ~~or~~, or by which plans can otherwise provide CMS with sufficient information so CMS can compel cooperation by the beneficiary. In addition, CMS should work with Non-GHP to develop the appropriate definitions, standards and procedures to be followed for protection of the plans in the event of beneficiary non-cooperation.

Voluntary Data Sharing Agreements (VDSA) could provide a safe harbor for discovering Medicare eligibility. However, the present VDSA form is not designed for Non-GHP entities, and contains verbiage that is applicable only to GHP entities. The VDSA should be reformed to rectify this oversight, and CMS should seek comment from Non-GHP

[1] Supporting Statement for the Medicare Secondary Payer (MSP Mandatory Insurer Reporting Requirements of Section 111 of the Medicare Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) at p. 16

entities as to the form of that document and necessary revisions. CMS will need to take into consideration the role of gents for Non-GHP entities, such as Third Party Administrators (TPA), which may need to be signatories to the VDSA. In some cases, the TPA will own the Claims Management Information System (CMIS) and will thus be in the best position to provide electronic data to CMS. The owner of the CMIS is the entity which should be responsible for complying with the VDSA. —The owner of the CMIS would be the proper legal entity to execute the VDSA as an agent for the insurance carrier or self insured.

The VDSA process may need modification as well. Given state and Federal privacy concerns, CMS should work with Non-GHP entities to identify the "minimum necessary" data elements to be swept from the CMIS, to be compared against the IRS/SSA/CMS data match process. CMS should not record any non-matched data, and should destroy it properly and securely. These standards need to be adopted by the VDSA, and legal responsibility for any data breach should be set forth clearly therein.

___A physical form to be signed by the beneficiary (or non-be
___beneficiary) attesting to his/her beneficiary status, such as is
___suggested by CMS with a picture of a HICN card be used to
___provide a "safe harbor" to the plans. Execution of this form by a
___beneficiary (or non-beneficiary) under penalty of perjury should
___have legal force to excuse a plan from mistaken identification of
___a beneficiary, or failure to identify a beneficiary, when the plan
___is relying on the sworn affidavit of a claimant. CMS should
___adopt standards related to this form, including timelines for its
___use in relation to when the settlement, award, judgment or other
___payment is made. CMS may wish to consider adding a data
___element to the reporting scheme to require disclosure as to
___whether this form was obtained from the claimant. MARC
___believes discussions should take place regarding the effect of a
___negative attestation from a claimant, and the impact of a denial
___of el igibility, u nder p enalty o f p erjury, b y a c laimant o n t he
___reporting entity. Under such a circumstance, MARC believes
___the burden and penalties for non-reporting or incorrect reporting
___should shift to the Medicare beneficiary, if it is later determined

___the beneficiary's attestation was erroneous In a related matter, ___MARC believes CMS should engage in discussion with the ___affected plans about appropriate document retention rules. ___(*See below)*

B. Impact of Notice:

MARC expects that CMS does not intend the MMSEA to disrupt the process already in place to obtain the Initial Conditional Payment Information (ICPI) statement. CMS recognizes the ICPI is important in assisting the resolution of a l iability c laim. However, t he es tablished I CPI p rocess, following implementation of with the MMSEA, will create unintended duplication and a resultant increase in record-keeping for all involved parties, since the same claim will be reported at least twice – once to obtained the ICPI and then a second time when a settlement is reached. There is no provision in the new revisions to simply append an already reported liability claim. CMS should meet with Non-GHP entities to discuss how to avoid this potential duplication of effort. It may make sense for CMS to assign a record identifier number that can be provided to the Non-GHP entities so that later reports can be appended to already existing reports. It may also make sense to have abbreviated reporting requirements for those liability cases with a pre-existing record identifier number.

Furthermore, the continuing need for information collection, so that Medicare makes payment in the proper order and takes recovery actions as appropriate, should not result in a delay of Medicare benefits to the beneficiary. CMS should adopt rules that avoid penalizing the beneficiary when a Non-GHP claim is being investigated. This investigation will include reporting the loss to the Coordination of Benefits Office and requesting, assuming consent of the beneficiary, the Initial Conditional Payment Information (ICPI) statement for analysis. CMS should not implement the mandated 120-day waiting period during the investigation process. This waiting period disrupts claim resolution, and reduces

opportunity for CMS to collect its "mistaken" (that is, conditional) payments.

Finally, under the MMSEA, any person or entity may report a claim to the Coordination of Benefits Office Contractor (COBC). This may lead to unnecessary and duplicative claims. CMS should develop clear regulations as to who is able to or must report. Should health care providers be allowed to report? If so, how will CMS avoid duplicative reporting of the same claim? It may be best to limit reporting to the Medicare Beneficiary, his/her agent, the insurance carrier or self-insured.

C. Mandatory Insurer Reporting (MIR):

MIR will involve CMS contractors. To be approved for reporting on-line, an application must be submitted. However, there is no application currently available. The Non-GHP entity is required to register on-line via a secure website, but that website is still being built. The MMSEA requires reporting, but it is difficult to assess the administrative burden on the affected plans to report in view of these uncertainties. CMS should extend this Request for Comment to allow for a fair review of the process when it is available.

Time is running out. Non-GHP entities need to plan for implementation with their respective IT departments. Delays in finalizing the MIR will place additional strain on limited IT resources and budgets. CMS should consider an interim implementation plan that may allow for paper reporting to allow Non-GHPs sufficient time to properly plan for compliance within their IT budget cycle. Other questions are presented by the MIR: How is the VDSA related to this? Is the VDSA required in order to report directly to CMS? An Index Bureau may not be a proper vehicle for some companies, and direct reporting may, in such cases, ~~be~~ be required. What are a company's options if it is not approved for direct reporting and the index bureau is not an option?

Index Bureaus take information and share it with other members. Some members are self-insured and considered hybrid entities for HIPAA purposes. Self-insureds may refrain from reporting certain losses in order to protect Personal Health Information (PHI). The index bureau would therefore not capture PHI from these entities and reporting to CMS would be incomplete. In order to be compliant with HIPAA rules, these hybrid entities will need to report directly to CMS. CMS should meet with Non-GHP entities that are also hybrid entities to ensure proper processes are in place to allow them to report directly to CMS.

D. CMS Contractor Recovery Activities:

Will reporting under the MMSEA require Non-GHP entities to pay the mistaken payments directly to the CMS Contractor? (*See 42 C.F.R. §411.22*) Is there any circumstance where the Non-GHP entities can distribute the entire funds for a Settlement, Award, Judgment or other payment? If not, how are state rules and laws reconciled with regard to state court Satisfaction of J udgment procedures or obligations under State Fair Claims Administration Acts? The MMSEA exposes the Non-GHP entity to unnecessary liability if it ignores state law. CMS should work with Non-GHP entities to establish rules to avoid unnecessary penalties, fines or additional legal exposure to the Non-GHP entity. This will promote resolution of claims and increase collection for mistaken payments.

CMS_of course recognizes that Federal law preempts state law, and therefore Non-GHP entities are protected from any perceived violation of state laws in this area. However, Federal regulations currently in place do not clearly define how funds are to be distributed at time of a settlement, award, judgment or other payment. This ambiguity provides an argument that the proceeds of settlement, award, judgment or other payment should have been disbursed to the Medicare beneficiary in accordance with State Fair Claims Practices laws. CMS needs to provide clear regulations regarding distribution of funds and remove the

ambiguities currently in place so plans may feel confident they are making distributions without arguable violation of State law.

If it is CMS's intention that funds be paid directly by the insurance carrier or self-insured to_a beneficiary after a settlement, award, judgment or other payment, how then does CMS propose the plans handle the deduction for "procurement costs". The insurance carrier or self-insured is not a client of the Medicare beneficiary's lawyer, and is not legally entitled to information as to procurement costs under the attorney-client privilege. Does the Medicare beneficiary have to apply for a credit so the Medicare/CMS claim for reimbursement is reduced to account for procurement costs? Will doing so add cost to the process for CMS, and delaying resolution of the matter? It would appear to make more sense for the Medicare beneficiary to deal directly with CMS on the reimbursement/deduction for procurement costs issues Regulations should be written to remove any requirement that the insurance carrier or self-insured reimburse CMS if the Medicare beneficiary fails to comply with the law. CMS should discuss these issues with Non-GHP ent ities, as t hose ent ities c ould p otentially as sist in avoiding delay in the process for reimbursement if the regulations mandate that CMS deal directly with beneficiaries and/or their counsel in this regard.

There will be Non-GHP claims that involve multiple insurance carriers for a single liability defendant. To reduce over-reporting and unnecessary administrative costs, the insurance carriers should be able to enter into an agreement to allow for a single report to be filed by one on behalf of all. Compliance with that agreement would provide a "safe harbor" from any penalties under the MMSEA.

There are Non-GHP claims that will involve multiple liability defendants and their insurance carriers. To reduce confusion and duplicative reporting, CMS should consider assigning a record identifier number for each claim reported and p rovide t hat inf ormation t o t he Non-GHP ent ity. As

other parties are identified, the CMS record number would be shared with them to allow for easier consolidation of reporting information with the CMS contractor.

How will reporting be handled for multi-party class actions? CMS should work with Non-GHP entities to create appropriate rules and procedures for the MMSEA to be properly implemented. Class Actions pose unique problems, since class members, while identifiable, are difficult to manage. Non-GHP entity costs will increase if an entity is not allowed to submit the entire claim proceeds in accordance with the approved Court plan. CMS should make provision for the recognition of state law, as doing so would greatly improve the certainty of the reimbursement process.

Other questions are posed as well: For example, there does not appear to be consideration in the present statutes and regulation for liability claims handled by a foreign insurance carrier or self insured. If a domestic self insured or insurance carrier successfully tenders the loss to a responsible entity that is foreign, is the domestic insurance carrier or self insured still responsible to report a settlement, award, judgment or other payment to CMS? If so, how is the domestic entity to do so? Under the present system, it does not appear there is a mechanism to allow a domestic entity to compel provision of this information either.

What about those situations where a liability claim is tendered to a responsible party that is a domestic insurance carrier or self insured? Is the original party (the foreign entity) to the claim responsible for the reporting of the settlement, award, judgment or other payment?

E. Small Business Impact:

For purposes of the new regulations, what is the CMS definition of a small business? It is challenging for the affected plans to properly respond to even this request for

comment without a common reference and definition to draw upon.

Notwithstanding, MARC disagrees with the CMS assessment that only a handful of small businesses will be impacted by this legislation. Complex Non-GHP claims are non-discriminatory – impacting a business of any size. Methodologies need to be employed by CMS to protect a small company being overburden on reporting requirements such as class action, by way of example.

F. Collection Frequency:

CMS requests demands two reporting types – ongoing and one time basis. In regard to ongoing reporting, does CMS contemplate under the MMSEA that data for each Non-GHP claim will be appended or cumulative? Knowing what CMS intends in this regard would be helpful to affected plans in determining the requirements for data extraction.

Under the MMSEA, there is no requirement to report liability claims on an ongoing basis. In case of a structured settlement, how is the affected plan to know what the settlement "amount" is for reporting purposes? Is the settlement "amount" the periodic benefit, or is it the value of the structure, as a whole, over time? There needs to be discussion between CMS and Non-GHP entities to establish the criteria so affected plans know how to report structured settlements.

Is the quarterly reporting requirement of the MMSEA a maximum or minimum requirement? Does CMS expect both ongoing and one-time payments to be reported at the same frequency? Consistent application of the rules will make for easier programming by the affected plans and, in turn, CMS.

In addition, and quite significantly, there must be clarification and discussion as to what type of format the requested data is to be provided in.

G. Special Circumstances:

CMS and Non-GHP entities should discuss what documents are *necessary* to be retained for 10 years. It is expensive for all entities, including CMS, to maintain records, and CMS has effectively doubled that cost with its recommendation regarding document retention under the MMSEA (if CMS in fact actually intends to require that *all documents* related to the Non-GHP claim must be retained). If appropriate methods are adopted to ensure proper determination of Medicare eligibility status, then it may make sense to preserve *only* information concerning eligibility determination. Would it be satisfactory if Non-GHP entities preserved the information transmitted via the MIR for the recommended period of time as well? It is difficult to assess the special circumstances which may arise when it is unclear what CMS's need is for the described, very-extensive, document retention. Is CMS concerned there might be non-reporting of Medicare Eligible claims that involve a settlement, award, judgment or other payment? If so, the information required to be maintained to address this concern may not be as burdensome, since the information necessary to be retained would likely be limited to the data contained within the electronic transmission.

H. Listening/Outreach Sessions:

MARC was formed to fill a void because there is no liability "industry", yet rules, regulations and laws are being created as if there were such an industry. MARC would therefore like to be included in future sessions regarding revisions to the MMSEA or related legislation in order to avoid unintended consequences of the MMSEA and similar legislation. MARC's members are made up of claim professionals, trade associations, risk managers, insurance companies, ~~TPAs~~TPA's and attorneys who could provide appropriate insight to improve CMS collection activity, without jeopardizing the manner in which liability claims are processed and resolved without the necessity of trial.

The implementation of the MMSEA, taken together with the MSP law and previously enacted/amended regulations, will result in a reduction in CMS collection activities and more than importantly hurt our Senior Citizens. Appropriate action is necessary to avoid this unintended consequence before the MMSEA goes into effect. We would welcome the opportunity to explain this further and participate in efforts to avoid these undesirable adverse effects. (*See Addendum "A"*)

I. Confidentiality

We respect the application of the Health Insurance Portability Accountability Act (HIPAA) and agree that privacy of Personal Health Information (PHI) must be protected. We must look to that statute for guidance in its application. It is to be noted that HIPAA does not apply to Worker's Compensation cases. Designing reporting requirements that are HIPAA-compliant increases costs and enforces a standard that does not exist. CMS and Non-GHP Worker's Compensation Entities should meet and discuss definitions and standards to ensure the efficient transfer of information while appropriately safeguarding privacy.

HIPAA is applicable to the Non-GHP liability entities. However, this fact does not justify a "one size fits all" approach to HIPAA confidentiality that will impose laws which are not applicable in Worker's Compensation cases upon Non-GHP liability entities. CMS and Non-GHP Liability Entities will need to meet to discuss methods to ensure HIPAA protections remain in place, such as making a determination as to the "minimum necessary" data to be transmitted. The Act should be revised to reflect that, as information is maintained within the requirements of the Act, it may be transmitted without violation of HIPAA and other privacy protections.

Non-GHP entities may include hybrid entities as described under HIPAA. CMS should meet with representatives of these groups to ensure that the

methodologies mandated ~~by thisby~~ by this reporting requirement do not create disclosures that may trigger additional reporting responsibilities under HIPAA.

The Privacy Act of 1974 requires consent from the Medicare beneficiary before CMS can release information to an insurance carrier or self insured. CMS and Non-GHP Entities should meet and discuss whether any regulations may be promulgated to in effect imply consent by a beneficiary to release of otherwise privileged information, when a claim is made, as is the case in a litigated matter. Although the claim may not result in litigation, in fact a beneficiary has put his/her condition at issue by filing a liability or worker's compensation claim. The Non-GHP entity is required to report the claim under the MMSEA, but is barred from receiving the very information that might help *resolve* the c laim, absent t he consent of the beneficiary. Because a liability claim is an adversarial situation, beneficiaries are often contentious and reluctant to sign any documents, for fear by doing so they may give up a perceived right to compensation. This reluctance impedes the claims-resolution process and will result in lesser, rather than greater, improvement in CMS collection of conditional payments.

J. Burden Estimate (hours and wages)

CMS uses as an example 42 C.F.R. 411.25 to establish its position that there has been a "longstanding obligation" (since 1994) to determine the correct order of payment and pay correctly. However, MARC submits the regulation was unclear as originally drafted, in that it required a primary payer to place Medicare on "notice" when it "learned" that Medicare had made a payment which the primary payer either made itself or should have made. The "learned" standard was far from clear and resulted in Medicare not being advised of all possible sources of reimbursement.

In actuality, the regulation was only amended *this year* (2/22/2008) to make clear that a primary payer's

responsibility includes a judgment, or a payment conditioned upon a recipient's compromise, waiver and release (whether there is a determination or admission of liability of payment) in a claim against the primary plan. (*See 73 Fed. Reg. at 9683(2/22/2008)).* Therefore, there has not been a "longstanding obligation" to make this determination; in fact, that "obligation" has only been in place approximately six months. Thus, primary plans such as Non-GHP entities are only now attempting to understand how to implement procedures compliant with this regulation.

MARC respectfully submits CMS has underestimated the burden to implement the MMSEA reporting requirements in several respects: 1) The calculation includes assumptions based on applications and processes that are still being developed; 2) The hourly cost associated is not realistic, given the IT and claims personnel that will be required review the rules, build the business requirements and program CMIS and data transfer protocols; 3) No cost is included for software or hardware upgrades that will be necessary to properly deliver the information so it is appropriate and secure; and 4) Insufficient time is allotted (5 minutes) to secure the Social Security Number of a beneficiary where there is no legal requirement by the beneficiary to provide this information.

As noted above, the Non-GHP liability entity may be a "primary plan", but that status does not provide the affected plan with a legal relationship with the Medicare beneficiary sufficient to allow the plan to obtain a Social Security Number or other necessary information, absent litigation. A request for this information may draw a legal response, resulting in proceedings that will delay CMS recovery of its mistaken payments. CMS and the Non-GHP liability entities should sit down and discuss methods to ensure the collection process is less adversarial. Perhaps CMS would entertain a letter or policy memorandum that explains *why* the Non-GHP liability entity is seeking personal information. Such a letter might alleviate beneficiary fears and avoid conflict with their legal counsel.

Additional obstacles are presented in the Non-GHP mandatory data fields:

Address, Date of Birth, Social Security # or HICN#: There is no legal requirement to compel a Non-GHP claimant to provide information *short of legal proceedings*. This will take significant time and expense for all parties, including CMS.

Policy #: A Self-insured may not have policy numbers. Will the data field accept "not applicable" or "none"? What if there is more than one applicable policy #? Is it possible to append more than one policy to a reported claim to avoid duplication issues?

Claim #: Self-insureds may not have claim numbers. Will the data filed accept "not applicable" or "none"?

Date of Injury: CMS has decided that "for claims involving exposure, the date of injury is the date of the first exposure." This definition may lead to unintended consequences as to the applicability of insurance coverage under state law for liability cases and in the worker's compensation arena may conflict with disease laws where the date of injury is the Date of Disablement. To avoid inconsistent and possibly absurd results, CMS should defer to the applicable state law.

MARC respectfully suggests CMS has not properly estimated the cost to Non-GHP entities. For purposes of this analysis, it is assumed that the CMS cost per hour and time estimates are. However, CMS calculations fail in determining the number of claims to be processed. CMS estimates the number of claims at 2,926,100, but this assumes these "Medicare eligible" claims are identifiable. In fact, as explained above, many of these claims are not readily identifiable. Therefore, the Non-GHP entity will be required to develop a process to identify the "Medicare eligible" claim and collect SSN and other information on every claim, many (if not most) times without any legal

mechanism for requiring the beneficiary to disclose that information.

After collection of the SSN (a potentially impossible task for the plan, which CMS estimates will take only 5 minutes), some must be spent for the plans to run the claim against a SSN database to determine "Medicare eligible" status. It is anticipated that for most of the 400 Non-GHP reporting entities, the VDSA query process would be utilized. If we assume the VDSA process will only take a single minute, we see quickly that there will be a significant cost for Non-GHP entities, far in excess to what is estimated by CMS.

MARC believes a more realistic calculation of the time and cost involved would be:

SSN Collection: 5 minutes x 44,000,000 = 3,666,667 hours x $12/hour = $44,000,000 (compared to $2,926,092). This is a significant reporting burden which must be considered by CMS, as well as methods be adopted to alleviate this unwarranted expense.

Furthermore, estimates by CMS for the time and cost involved in implementation of combined system & administrative processes are equally flawed. Under the MMSEA, $35M is budgeted for implementation of the reporting requirements, but CMS estimates it will take all of the Non-GHP reporting entities less than $10M to implement. This estimate is, respectfully, completely unrealistic. In order to comply with these requirements, technology must be developed and/or updated by the affected plans. IT system development requires planning, budget and resources. The mandated changes will require analysis to take into account system and software architecture and development time to permit the flow of information from the plan to CMS and to the plans from CMS. Additionally, information fields will need to be added to the system. Arguably, CMS estimates have taken into consideration the time required for, but not the capital improvements required by, the software systems needed in

order for plans to be in compliance. These costs need to be identified and included into the CMS burden estimate.

K. Capital Costs:

There will be capital costs to upgrade CMIS systems to meet reporting requirements under the MMSEA. An interface will need to be built; before this is done, an IT business analyst will need to conduct a requirements analysis. Assuming the data fields are structured similarly and there is no need to reformat the data before transmission each time and then restructure any response that is being sent back to be uploaded, the major costs to be incurred by the affected plans will be adding CMIS fields to handle the new data requirements.

L. Costs to the Federal Government:

A $35M budget was authorized under the MMSEA to implement the reporting requirements. That cost should be *added to* the estimated annual cost to reflect the full cost of the project. The estimated annual cost appears low. CMS is allotting $2.76 to process each of the estimated 2.9M claims to be reported annually. At $12 an hour, that is less than 14 minutes per claim, or 18.5 seconds per field.

CMS has not taken into consideration the significant number of inquires that will be presented to CMS and its contractors by Non-GHP entities attempting to confirm whether a Claimant is "Medicare eligible". The only fail-safe method to confirm whether someone is "Medicare eligible" is to query the CMS database and therefore CMS can expect to receive roughly 44M inquiries for this confirmation. This also requires the plans to be granted necessary access to the database, something which is not certain under the statutes and regulations and presently framed, and which may be barred by present privacy regulations, including HIPAA, unless exceptions are provided for. Assuming CMS is correct that it may take CMS as little as ten seconds to process this information, even that very optimistic time

estimate would result in CMS incurring 122,222 hours each year for this element of the proposed plan alone, costing at least $1.46M.

In addition, it does not appear CMS has estimated the costs to other branches of the Federal Government. For example, the Judicial Branch will be required to process claims that were not previously subject of Federal Jurisdiction. Due to unclear rules, a Non-GHP entity may be forced into litigation in order to resolve the numerous questions posed by the new statutes and revisions thereto. If a settlement, award, judgment or other payment is reached, the Non-GHP entity may be required to consider an Interpleader Action filed in Federal Court to have its rights declared, with certainty and finality, so that the judiciary may determine how to distribute the funds the plan is willing to pay in settlement, or must pay as a result of verdict or judgment. The Federal Court would therefore be involved with greatly increased frequency in actions w hich w ere c ustomarily w ithin t he p urview o f t he state court system, or, much more commonly and efficiently, handled without any judicial intervention at all. If this occurs, it is readily seen that the costs to the Government- as well as to the plans and the beneficiaries - will increase, and payment to the senior citizen beneficiaries will be greatly delayed. It is manifest, of course, that this group of beneficiaries – senior citizens – in most cases will be inconvenienced if not actually harmed by significant delay in their receipt of funds from settlement or verdict/judgment, a delay which could readily be avoid with revision to the proposed regulations and requirements. CMS should promptly recognize these important issues and seek dialogue with the Judicial Branch to remedy these issues before significant impediments to claim resolution arise, to the detriment of all parties and greatly increased burdens on our trial courts.

M. Program Changes/Changes in Burden

There may very well be a reduction in CMS data collection processes such as the IRS/SSA/CMS Data Match following

implementation of the MMSEA; however those reductions may be eclipsed by multiple reporting of an estimated 2.9M cases, as well as other issues discussed in *Appendix "A"* to this Response.

N. Publication and Tabulation:

There was an indication by CMS at the 3/25/2008 meeting that CMS would share data with the industry. An example was given of a Worker's Compensation case, where the individuals presenting claims do not exist. Information as to fraud, waste and abuse should be shared by CMS with liability representatives, to prompt appropriate SIU inquiries at the state level. Will CMS share back the reported data?

O. Expiration Date:

There will be a change in burden estimates given that certain aspects of the MIR are still being constructed. An expiration date should be set for the current burden estimates, so they may be reevaluated if construction of the MIR takes longer than anticipated.

P. Deductibles or Co-Payments:

CMS and the Non-GHP entities should meet and agree on definitions. Insurance terms of art are being used by CMS and a common understanding of the terms is necessary to arrive at the outcome desired by all parties, including CMS. The term "deductible" is an insurance term of art. The insurance carrier "owns" the paper on which the policy form is written, and responsibility to report a claim under a policy lies appropriately with that entity. Self Insured Retention (SIR) is also an insurance term of art. CMS describes a situation where multiple reporting may occur; MARC anticipates m ultiple r eporting is m ore l ikely t o t ake p lace where an SIR is involved. The partially self-insured entity is responsible for payments up to the self-insured retention before the insurance carrier pays. The self-insured more than likely should be the reporting entity in that situation.

Notwithstanding, to avoid duplicate reports, it may make sense for CMS to consider assigning a record identifier number which could be shared between parties, so multiple records may be aggregated after reporting.

CONCLUSION

MARC is prepared to move forward productively to work with CMS, its contractors and the Legislature to effect necessary changes in the pending legislation which will meet the government's goal of increasing Medicare reimbursement, while avoiding the unintended adverse consequences set forth herein and in Appendix "A".

Respectfully submitted,

Medicare Advocacy
Recovery Coalition (MARC)

Bbyy Roy A. Franco, J.D.
——— Seana B. Thomas, Esq.