CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

Medicare Secondary Payer and Certain Civil Money Penalties

Group Health Plan (GHP) Webinar

October 15, 2024

Updated December 17, 2024:

Responses from the Question-and-Answer Session are included at the end of the Slide Deck.

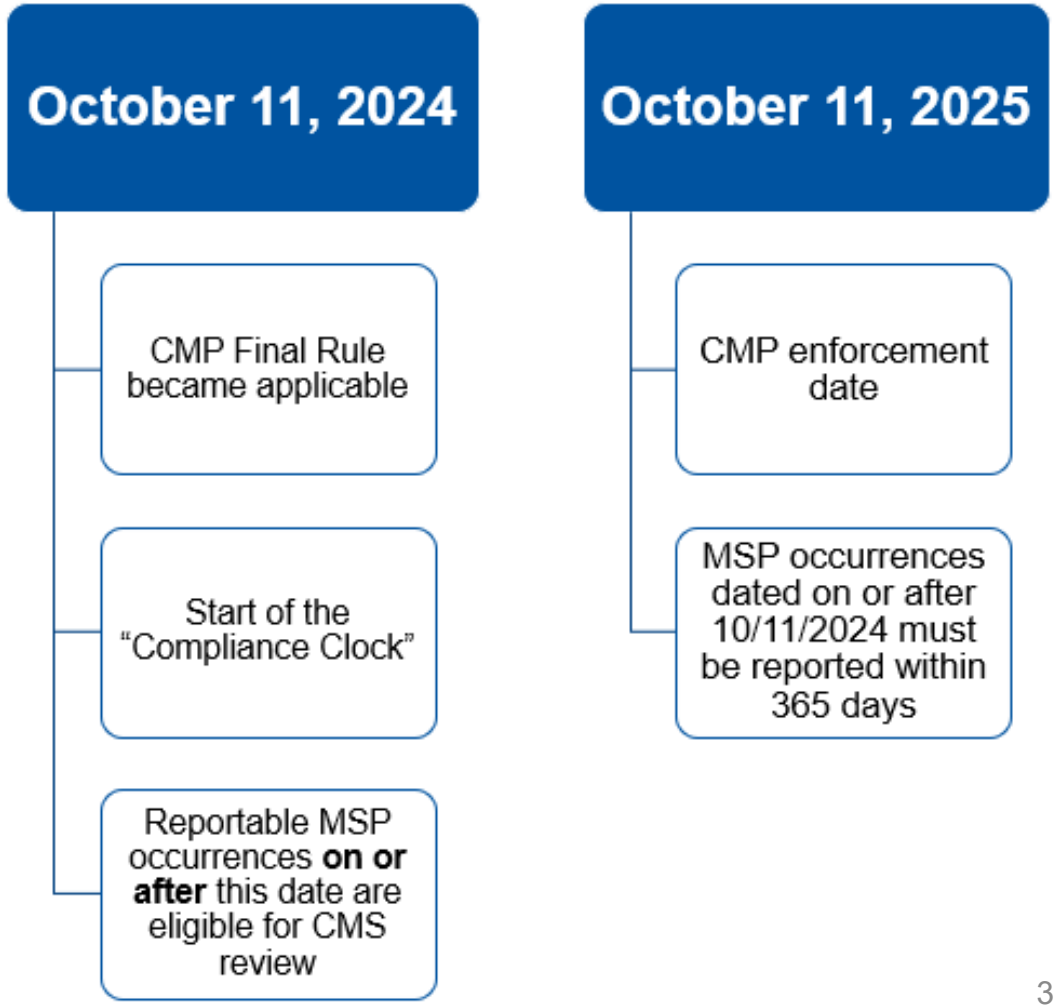
Presentation Overview

- Reminders
- Clarifying the Audit Process
- Maintaining Compliance
- CMS.gov Updates
- Questions & Answers

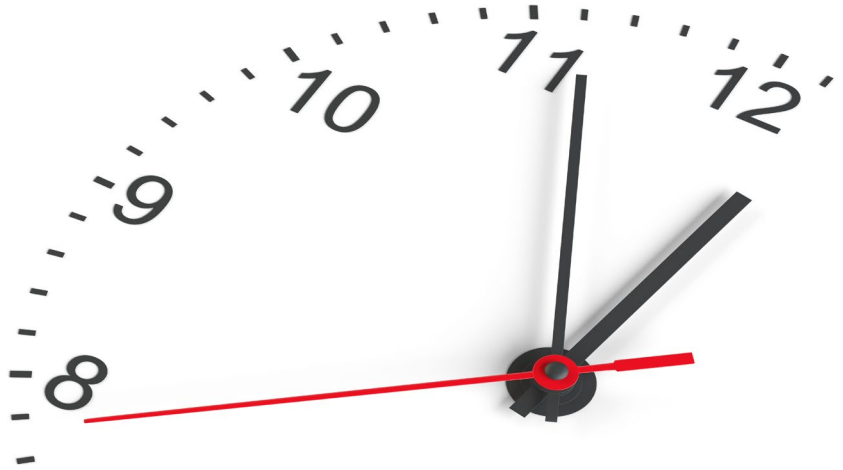
Reminders: Important Dates

<u>Note</u>: There are no additional changes to:

- Reporting requirements
- Designated reporting periods
- EDI Representatives



Reminders:
The Timeliness Requirement



- Final Rule requires that records are submitted in a timely manner.
- An RRE is considered to have reported timely, or is compliant with the Section 111 reporting requirements, if their record is reported within 365 days of:
  - The effective date of the coverage, *OR*
  - The date the individual became a Medicare beneficiary, whichever is later.
- It is not the reporting agent's responsibility to ensure Section 111 records are submitted to CMS in a timely manner, if such a service is being used.

Reminders: Updating RRE Information

CMP correspondence will be mailed to the RRE's Account Representative (AR) on record.

- Copies will be mailed to Account Manager (AM).
- Reporting Agents **will not** receive CMP correspondence.

It is the RRE's responsibility to ensure all contact information is up to date.

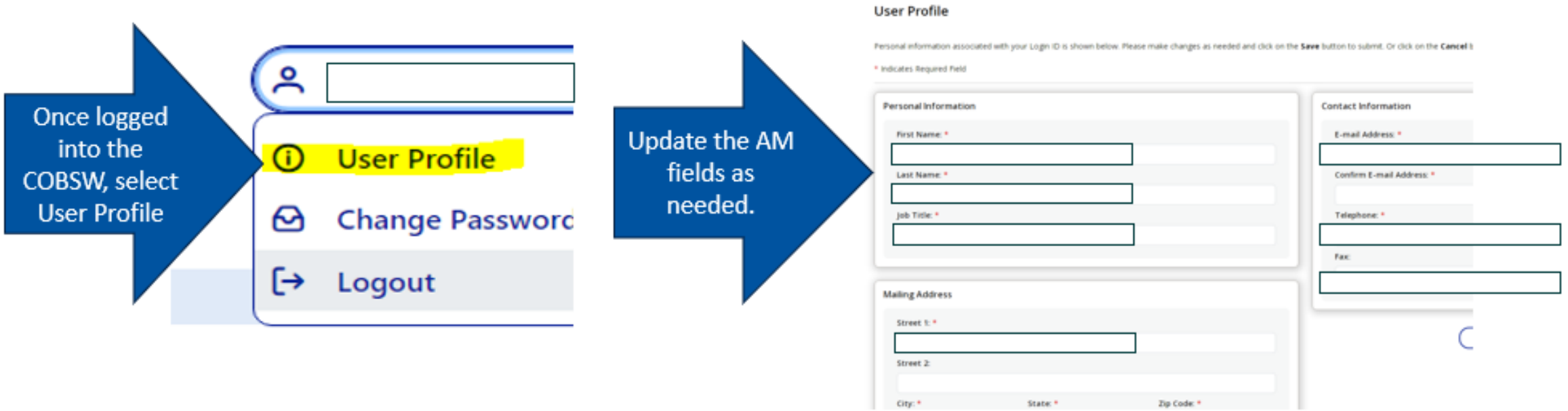
- RREs will still be held accountable should any CMP correspondence be missed due to inaccurate, outdated contact information.

Your assigned EDI Representative should be contacted if :

- The named AR requires replacement and/or associated contact information requires updating.

Updating the AM Contact Information

- If the named AM requires replacement, please contact your assigned EDI Representative.
- If the AM contact information and the RRE's account information (e.g., address, phone, etc.) requires updating, the AM can complete this action via the COBSW.



Clarifying the Audit Process

Note: The statutory requirements are not waived due to another entity or individual reporting the information an RRE is required to report.

- CMS' 1st audit will include records from the 4th Quarter of 2025.
  - The "compliance clock" began 10/11/2024 and eligible MSP occurrences must be reported within 365 days.

- Random sample of 250 new, accepted records per quarter which proportionately represent GHP and NGHP records.
  - Records received through both Section 111 (including records submitted through DDE) and non-Section 111 submissions will be sampled.
    - Non-Section 111 records will be matched to a Section 111 record, which will be evaluated for compliance.
    - If a non-Section 111 record cannot be matched to a Section 111 record, that suggests potential non-compliance.
  - Sample is across "entire universe" of a quarter's records, not per RRE, and include DDE records.

Maintaining Compliance:
Obtaining Required Beneficiary Information

- General expectation: GHP RREs have already obtained required beneficiary information needed to report as part of enrollment, or soon after.
- RREs should maintain records of any communication attempts (including dates and type of communication effort made) which can be provided as mitigating evidence to CMS, if necessary.
- Reminder: *The MBI/SSN Collection- GHP Model Language* is available for download on CMS.gov.

Maintaining Compliance: Employer Health Plan Coverage

RRE is required to report within 365 days of:

- The employee's Medicare entitlement date.
- The beneficiary enrolling in new employer health care plan.
- The beneficiary enrolling in a new prescription drug plan.

Reminder:

- Employees that are not eligible for Medicare should not be reported via Section 111.
- **Note:** Query functionality and COBSW beneficiary lookup action are available for RREs to use to determine if an individual is entitled to Medicare.

Employer Health Plan Coverage: Example

- A beneficiary is enrolled in their employer's health care coverage plan, which was previously reported by the RRE via Section 111.
- The beneficiary later enrolls in a new prescription drug plan with a new coverage effective date.
- The RRE is required to report the beneficiary's new prescription drug coverage within 365 days of the effective date of coverage.

Maintaining Compliance:

Rejected Records

It is the RRE's Responsibility to:

- Contact the assigned EDI Representative,
- Determine the cause of the error, **and**
- Resubmit a corrected record within 365 days of the MSP occurrence.

Helpful Resources

- 9/10/2024 - GHP Reporting Webinar slides presentation
- GHP User Guide

Changes in MSP Applicability

- There may be instances where the circumstances of a beneficiary's Medicare enrollment may impact the applicability of the MSP rules, including the RRE's reporting obligations.

- The RRE is required to stay abreast of members' Medicare eligibility and enrollment, and report accordingly.

Failure to Submit via Section 111 after a Non-Section 111 Record was Reported

As a reminder, both Section 111 and non-Section 111 submissions (e.g., VDSA, self-report, provider report, etc.) will be sampled, potentially resulting in the discovery of the failure to report.

Example:

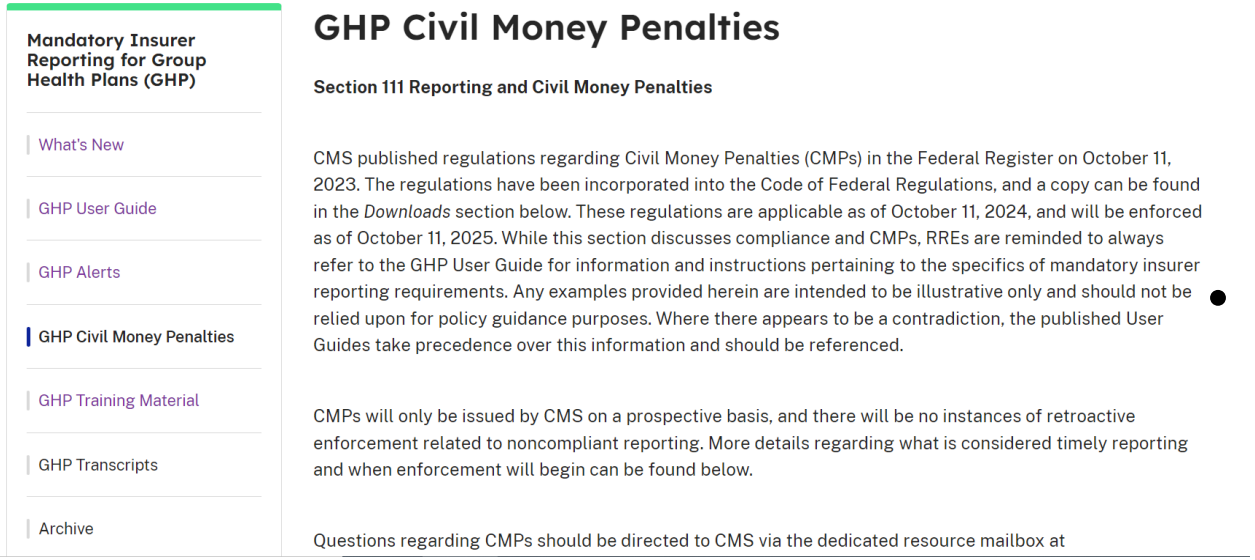
- A record was received with an effective date of 2/5/2025 through an employer's VDSA.
- On 4/1/2026, the employer's VDSA record is randomly selected for CMS' audit, and a corresponding Section 111 record from the RRE cannot be found.

Note: The RRE is noncompliant with Section 111 reporting because it failed to submit a corresponding Section 111 record to the 2/5/2025 non-Section 111 record.

Period of Noncompliance: 02/06/2026-04/01/2026 (The date of CMS audit)

CMP Calculation: $1,000 x 37 (days of noncompliance) = $37,000 (as adjusted for inflation)

CMS.gov Updates



Mandatory Insurer Reporting for Group Health Plans (GHP)

- What's New
- GHP User Guide
- GHP Alerts
- GHP Civil Money Penalties
- GHP Training Material
- GHP Transcripts
- Archive

GHP Civil Money Penalties

Section 111 Reporting and Civil Money Penalties

CMS published regulations regarding Civil Money Penalties (CMPs) in the Federal Register on October 11, 2023. The regulations have been incorporated into the Code of Federal Regulations, and a copy can be found in the *Downloads* section below. These regulations are applicable as of October 11, 2024, and will be enforced as of October 11, 2025. While this section discusses compliance and CMPs, RREs are reminded to always refer to the GHP User Guide for information and instructions pertaining to the specifics of mandatory insurer reporting requirements. Any examples provided herein are intended to be illustrative only and should not be relied upon for policy guidance purposes. Where there appears to be a contradiction, the published User Guides take precedence over this information and should be referenced.

CMPs will only be issued by CMS on a prospective basis, and there will be no instances of retroactive enforcement related to noncompliant reporting. More details regarding what is considered timely reporting and when enforcement will begin can be found below.

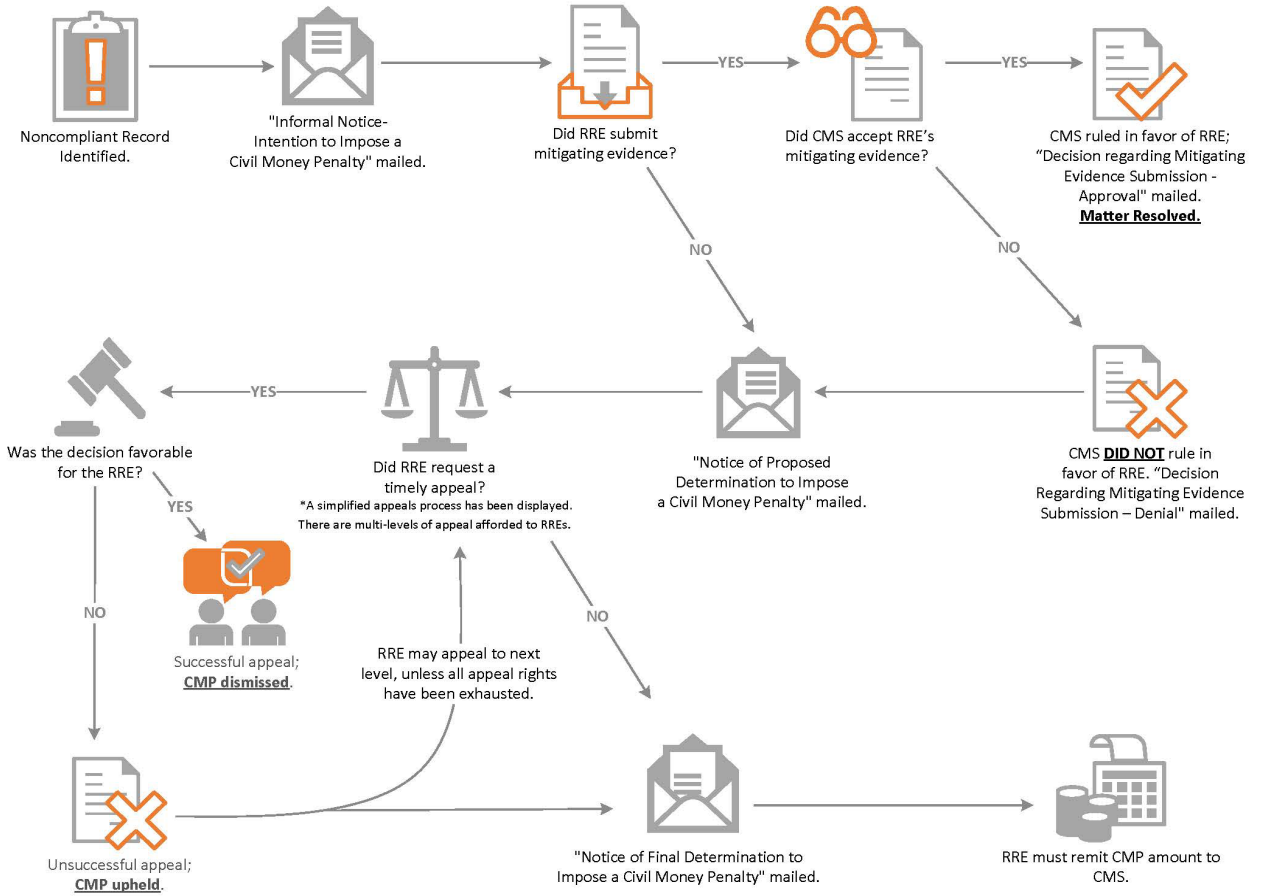
Questions regarding CMPs should be directed to CMS via the dedicated resource mailbox at

- The “GHP Civil Money Penalties” page is now live and available under the existing Mandatory Insurer Reporting page of CMS.gov.
- The letters and appeals process described on the website will be discussed in more detail at a future webinar.
  - Additional downloads, such as the letter samples, will be published as they become available.

CMS.gov Updates: Continued

- The “CMP Workflow” download is intended to visually represent the process an RRE can expect to follow if a noncompliant record is found during a quarterly audit.
  - **Note**: The process has been simplified, specifically related to the appeals process.

- If an RRE’s record is selected during the quarterly audit and it is determined to be **compliant:**
  - CMS **will not** contact the RRE. (Workflow does not apply)



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Question and Answer Session

- The following slides contain consolidated questions and answers discussed during the 10/15/2024 GHP webinar.
  - Questions and comments specific to CMPs should be directed to the CMS resource mailbox: sec111cmp@cms.hhs.gov
  - Continue to monitor CMS.gov for updated outreach and education materials.

Medicare Eligibility

Q: Other than age, how does an RRE stay abreast of a member's Medicare eligibility?

A: There is a general expectation that GHP RREs will monitor members' potential entitlement and eligibility as a part of the regular coordination of benefits activities and course of business. If a member is potentially eligible or entitled to Medicare, RREs are encouraged to utilize the Section 111Query Only Input File to identify whether or not a member is actually entitled and enrolled in Medicare.

More information of the Query functionality can be found in the GHP User Guide. RREs may also contact their assigned EDI Representative for additional assistance.

SSN Collection

Q: If an RRE does not have a member's MBI or SSN, how can the RRE obtain the information?

A: To assist RRE's in collecting the MBI or SSN information, CMS has provided the **MBI/SSN Collection – GHP Model Language** available in the Downloads section of https://go.cms.gov/mirghp.

Correcting File Errors

Q: What happens if an RRE reports timely, however a source that is higher on the Hierarchy changes incorrectly changes the record and it does not get accepted? How would this impact the RRE if the original record was submitted timely, but the resubmission to correct the hierarchy error is late?

A: If an RRE receives a hierarchy error and notices on their unsolicited file that the information is incorrect, they are encouraged to submit a corrected record on their next quarterly file submission. Anytime an RRE receives an error, whether it's hierarchy or another SP error, and the original information was correct, the RRE should submit a correction on the next quarterly file, using the hierarchy bypass (“HB”) override code.

CMS recommends that you maintain records that reflect an RRE’s attempt to report. If the record was randomly selected for CMS’ quarterly audit, the RRE would have the opportunity to submit mitigating evidence to CMS for review. The RRE could provide information as to the events transpiring with the record in question, including actions outside of the RRE’s control which prevented timely reporting.

Correcting File Errors Continued

Q: Do RREs need to start using a hierarchy bypass (HB) override on all SPH0 errors, even if the RRE has confirmed, via phone call, that their records match CMS'?

A: Utilizing the HB override is recommended if the RRE receives an SPH0 error when the record on the file was correct. If the RRE determines that an update/delete must be applied, the RRE should submit the transaction again in the next quarterly file submission with a value of HB in the Override Code (Field 33) of the MSP Input File Detail Record.

As a reminder, hierarchy rules also apply to Part D primary and supplemental drug records. The Override Code (Field 28) on the Non-MSP Input File Detail Record is used for supplemental drug coverage occurrences.

CMS' Quarterly Audit

Q: Could CMS clarify the sampling of records? Is it 250 records per RRE, or only 250 records are being audited across all GHP and NGHP RREs?

A: CMS will audit 250 records, per quarter, across all submitted records for both GHP and NGHP RREs. The division of the 250 selected records between GHP and NGHP will be proportionate to on the total number of GHP and NGHP records submitted in that quarter. The proportion of GHP and NGHP records will likely vary each quarter, depending upon the total number of records received. Audited records will be manually reviewed by a CMS staff member.

CMS' Quarterly Audit Continued

Q: Would the quarterly submission timeline be taken into account when calculating the CMP? Are RREs able to report more regularly than once a quarter to ensure the records are received timely?

A: An RRE's reporting period is not a factor in calculating a CMP, rather, it is 365 days from the reportable event or when the beneficiary's Medicare coverage began, whichever is later. If there is a rational explanation as to why the RRE was unable to report the record within 365 days of the reportable event, the RRE may submit that explanation and supporting documentation as mitigating evidence to CMS.

RREs should continue reporting during their assigned reporting period, and not at a greater frequency.

CMS' Quarterly Audit Continued 2

Q: Can CMS confirm the statement about "new accepted records per quarter." Does this mean that only input records from the previous quarter are examined?

A: When CMS performs a quarterly audit, the audited records will be those that were reported, or should have been reported, in the immediately preceding quarter.

Hypothetical Example: The records for an audit will range from January 1, 2026 – March 31, 2026. CMS will perform the random quarterly audit on May 15, 2026, allowing 45 days from the last day of the reporting period (March 31, 2026, in this example) to ensure all records from the submission period have been processed.

Q: If an audited record is found to be non-compliant does that trigger an expanded audit on that RRE?

A: No. Only the individual records that are randomly selected for the quarterly audit will be reviewed for compliance by CMS.

CMP Notices (Letters)

Q: Will notification of non-compliance or other notices be mailed via USPS or emailed? Previous communications indicated some letters will be emailed.

A: Due to concerns about emailing CMP notices that contain Protected Health Information (PHI), all CMP correspondence will be sent through the United States Postal Service (USPS) to the RRE's Account Representative (AR); the Account Manager (AM) will receive a copy. Certain correspondence, such as the "Notice of Proposed Determination to Impose a CMP," will be sent via Certified Mail.

Please ensure the AR and AM contacts, and associated addresses, are updated prior to January 2026.

CMP Notices (Letters) Continued

Q: If the letter is mailed and an RRE is only allotted 30 days to submit mitigating factors, when does the timeline begin? Why is it presumed that the letter has been received within 5 days?

A: The 30-day timeline begins on the date of the CMS letter, and CMS presumes that the letter was received within 5 days of mailing, barring evidence of mail processing delays. CMS will process the response based on the date it was received in CMS' mailroom or the postmark date, whichever is most advantageous to the sender.

CMS allows 5 days mailing time, which is a standard that CMS applies to issued MSP Recovery correspondence. It is presumed the RRE will receive the CMP notice 5 days from the date the CMP notice was mailed. If, in the event of a natural disaster, for example, which would prevent mail from being received, CMS would take such an event into consideration.