Insurers Plea to Health Secretary: Call Off April 1 MSP Deadline: *Top* [02/08/10]

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A trio of insurance industry trade groups are pressing the Secretary of Health and Human Services to put off an April 1 start date for mandatory reporting of Medicare Secondary Payer (MSP) information, a program designed to reduce the likelihood of medical costs being shifted to the federal government.

"Despite our best efforts and those of the senior decision makers within the Centers for Medicare and Medicaid Services (CMS), the agency has yet to demonstrate that the new reporting system will properly function," states a letter written Friday to Secretary Kathleen Sebelius signed by the American Insurance Association, the National Association of Mutual Insurance Companies and the Self-Insurance Institute of America.

"Failure to comply with the reporting requirements as of April 1, 2010, will expose insurers and self-insureds to substantial financial penalties; we believe that a more realistic implementation date is not only appropriate but also imperative," continues the letter.

Carriers had a Dec. 31, 2009, deadline to register with CMS to conform with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. This is part of the Medicare secondary payer process that permits CMS to track medical claims payments to determine whether a person receiving treatment may also be receiving Medicare or is eligible for Medicare.

This section requires data to be submitted for group health plans, liability insurance including self-insurance, no-fault insurance, and workers' compensation. The penalty for failure to report is potentially $1,000 per day per claim, although CMS officials have stressed the agency is more concerned with ensuring the new system is working properly than fining violators.

CMS is currently testing its data reporting system and has set an April 1 date to begin full operation. The insurance industry letter to Sebelius seeks a delay for reasons that include concerns about data security, confidentiality, a lack of firm rules on portions of the process and having too little time to test the system.

Because CMS just began in January to allow insurers to submit electronic test files to its coordination of benefits contractor, the volume of tests delivered by more than 24,000 responsible reporting entities (RREs) has caused delays. "The time contemplated for testing the system is insufficient to guarantee a successful implementation on April 1," the letter maintains.

Insurers also have serious concerns, according to the letter, with a CMS mandate to submit Social Security numbers and health insurance claim numbers as part of the data submitted.

"Unlike group health insurers, this information is not readily available to property-casualty insurers, as most claims are resolved over the telephone," the letter states. "Under the pending Section 111 requirements, insurers and others will have to telephone beneficiaries asking for sensitive information that CMS, on its own website (http://www.stopmedicarefraud.gov/) advises individuals to guard as they would a credit card number."

The letter suggests CMS "is not properly using the highest-level security and encryption technology to ensure the privacy of personally identifiable information." For example, in January a reporting agent submitted 100 test files and received thousands of unrelated files in return that contained personal information of CMS beneficiaries, and a similar instance occurred in December, although the agency assured insurers that the problem had been corrected.

CMS has also been slow to provide final guidance on some technical issues, such as which RRE must report when, due to risk-sharing arrangements, more than one reporting entity has a share of a settlement. As recently as a Jan. 28 "town hall" style teleconference, CMS officials said, "guidance was still being reviewed and could not yet be released," according to the insurance group's letter.

The industry has waited since last fall for CMS to produce the third version of its user guide, which should provide clarity on such details as exactly what information is required for numerous data fields.

"They're experiencing some difficulty and that produces a ripple effect for compliance," Katie A. Fox, who co-chairs the Medicare Advocacy Recovery Coalition (MARC), said in an interview Friday. "The challenge is the deadline is looming and we need to move ahead in smoothing out these wrinkles."

MARC is a group formed in 2008 that includes insurers, self-insureds, third-party administrators and independent adjusting associations.

In its letter, MARC suggested last month that CMS extend its testing period through 2010 and begin formal implementation of mandatory reporting next year. MARC also suggests CMS alter its policy to allow all reportable data from 2010 to be submitted for up to one year from its due date.

Fox, who works as compliance and resolution unit manager for MedInsights Inc., a managed care subsidiary of GAB Robins Group, said coalition members have complained of substantial delays when attempting to submit test files. "When data is provided to the agency, those who submitted are waiting several days or several weeks to receive confirmation that it was received," she said.

These technical glitches must be frustrating to CMS as well, said Keith Bateman, vice president of workers' compensation for the Property Casualty Insurers Association of America (PCI).

"We think neither Congress nor CMS anticipated how difficult the process would be," Bateman said. "Reporting entities are having problems in getting access, being able to submit data and there are still lots of technical issues and glitches to work out."

PCI has suggested "it may be advisable" for CMS to further extend its implementation date because of the ongoing problems, according to Bateman.

The industry letter to Health Secretary Sebelius appeals for a moratorium on penalties in the early days of the new program, because an initial report, "will be the largest in terms of the volume of data submitted, as it will encompass legacy claim data from Jan. 1, 2009, to the present."

Additionally, the letter states CMS has said reporting can only be done once a quarter, "so errors and glitches inherent in a new reporting system cannot be addressed for 90 days. So, as currently envisioned by CMS, failure to report properly a $2,500 automobile medical payment to a beneficiary could subject the reporting entity to a $90,000 fine."

Peter Ashkenaz, CMS deputy director of media affairs, stated in an e-mail most government offices were shut Friday because a massive snow storm hit the east coast.

In an earlier interview, however, Ashkenaz said the first non-compliance penalties under Section 111 are unlikely to be assessed before July, because it will take several months of experience with a reporting entity to establish a track record.

"I really want to make the point that we are really focusing on getting people ready to submit and exchange data," Ashkenaz said. "We're not trying to scare folks into doing it by pushing the penalties."

To review the insurers' letter to Sebelius, go here:
http://www.aiadc.org/aiadotnet/docHandler.aspx?DocID

To read transcripts from CMS "town hall" teleconferences about the issue, go here:
http://www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp