



# SCHIP Compliance Overview and Update



Updated June 3, 2009



# SCHIP: Protecting Medicare

- **Section 111 of the Medicare/Medicaid SCHIP (State Children's' Health Insurance Plan) Extension Act of 2007**
  - » **Medicare must always be the secondary payor**
    - Study identified that Medicare likely paid billions that should have been covered by the primary payor
    - Protect Medicare from paying long-term medical expenses considered the responsibility of insurance companies or self-insured employers
    - Data transfer will inform Medicare of primary insurance

# Penalties

- **\$1,000 per day per claim for late or incomplete reporting**
  - » **No maximum**
  - » **Earmarked to fund State Children's Health Insurance Fund (SCHIP)**
  - » **Claim corrections must be included with the next file transfer**

# Affected Claims

- **Workers' compensation, longshore, liability and no-fault claims for insured and self-insured programs**
  - » **Workers' compensation**
    - Existing open and new claims
    - Medicare identified as secondary to workers' compensation since inception (DOI does not affect reporting responsibilities)
    - All claims having Ongoing Responsibility for Medical (ORM) that were not closed prior to January 1, 2009 must be reported in the Responsible Reporting Entity "RREs" regular quarterly feeds beginning April 2010
  - » **Liability injuries**
    - Date of injury (DOI) on or after December 5, 1980
    - DOI as defined by Center for Medicare/Medicaid Services (CMS)
    - Claims where a medical payment is made or injury settled on or after July 1, 2009
  - » **Interim thresholds**

# New Requirements

- **Claimants who are Medicare recipients must be identified**
  - » **Every claim must be reviewed for Medicare eligibility**
  - » **Entitlement Query Function from Center for Medicare/Medicaid Services (CMS) can help determine Medicare eligibility**
  - » **Allowed one electronic data interchange (EDI) monthly per RRE for benefit status check**
- **Electronic data interchange (EDI) of all claimants who are Medicare recipients**
  - » **Provided to the CMS in a defined file format**
  - » **Sent when a partial payment, payment or settlement, judgment or award is made to a Medicare recipient**
- **Must provide the mandatory data elements timely**
  - » **Files transmitted quarterly according to CMS assigned schedule by RRE ID**

# Determining Medicare Eligibility

- RREs must review every claim to determine claimants' Medicare eligibility
- Medicare-eligible claims must be reported to CMS
- Claimants who typically qualify for Medicare:
  - » Age 65 or older
  - » Has end stage renal disease (kidney disease/dialysis patient)
  - » Has applied – or is considering applying – for Social Security Disability Insurance (SSDI)
  - » Has 104 weeks or more of disability
  - » Is receiving Permanent and Total Disability (PTD) benefits or has declared PTD status
- Entitlement Query Function from CMS can help determine Medicare eligibility
  - » Must have claimants' Social Security numbers

# Reporting Qualified Claims

- All data must be submitted electronically on a quarterly basis
  - » CMS will schedule reporting dates and times
- Reporting data is extensive
  - » More than 150 fields
  - » Some information has not previously been collected
- An RRE or its agent must continue to report a claim until it is no longer financially responsible

# Responsible Reporting Entity

- The RRE is the company funding losses
  - » The TPA is never the RRE
- Self-insured plans: The employer is the RRE
- Fully-insured plans: The insurance company is the RRE
- Insured plans with deductibles:
  - » Push from Carriers for flexibility in this – potential to change
  - » During the deductible period: The employer is the RRE
    - If the employer is funding the losses
  - » After the deductible period: The insurance company is the RRE
    - If the insurance company is funding the losses
    - The employer remains the RRE when losses continue to be funded from the employer's account

# RRE Registration

- **Registration period: May 1 – September 30, 2009\***
- **Registration Web site is currently under development**
- **Be prepared to designate:**
  - » **Authorized representative**
    - An employee of the RRE who is authorized to agree to reporting requirement and will be responsible for compliance
  - » **Account manager**
    - Will manage the daily administration
    - Can be an employee of the RRE, the TPA or a designated agent
  - » **Account designee**
    - Can be assigned by the account manager to transfer data
    - Can be an employee of the RRE, the TPA or a designated agent

# Key Dates to Note

- **May 1 – September 30, 2009\* : Required Reporting Entities (RREs) registration**
  - » **May 7, 2009 Broadspire WebEx for registration questions**
  - » **May 12, 2009 CMS teleconference for registration issues**
  - » **May 14, 2009 Broadspire WebEx for registration questions**
  - » **June 3, 2009 Broadspire WebEx for registration questions\***
  - » **June 15, 2009 Broadspire registration QA WebEx\***
- **July 1, 2009: SCHIP becomes effective for open claims\***
- **January 1, 2010 – March 31, 2010\* : Test file submissions**
- **January 1 – March 31, 2010: Production EDI**
  - » **Initial quarter includes new claim and settlement data as of July 1, 2009**
  - » **July 1, 2010: Report date for claims with medical responsibility assumed prior to July 1, 2009 that had missing data elements (i.e. Social Security number)**

# Broadspire's Solution

- **Data capture and management**
  - » New warehouse facility for data elements
  - » Gather and edit data as required for completeness/accuracy
  - » Accept data return from other agents
- **Electronic Data Interchange**
  - » Medicare eligibility check (Social Security number, date of birth, name, gender)
  - » Error processing
  - » Supply data to CMS, RREs or selected agents according to schedule

# Broadspire's Agent Reporting Solution

- Employers with self-insured plans and insurance companies may designate agents to provide mandatory insurance reporting (MIR) services
- Contract addendum required
- Broadspire's preferred vendor, PMSI \*, is available to deliver CMS-required services
  - » Medicare eligibility checks
  - » Submit information to Medicare's COBC as required
  - » Broadspire will coordinate with the vendor to supply required information

# Our Vendor's Role

- Error management (aging, reporting)
- Manage complex RRE scheduling
  - » Medicare beneficiary file monthly by RRE
  - » CMS claim submission on RRE-assigned quarterly schedule
- MSA services
  - » Identify claims needing an MSA
  - » Conditional payment identification
  - » Lien negotiations

# Steps to Take

- **Determine RRE status**
  - » **Contact carriers and prior TPAs**
    - Registration required for run-off
  - » **Determine number of RRE IDs needed**
    - Insured, self insured, SIR, deductibles
- **Register beginning May 1, 2009**
  - » **Broadspire's account executives will communicate information required for registration**
  - » **Provide registration information to Broadspire (Web-based and account executives)**
- **Assist in data gathering**
  - » **Changes to TelePlus effective March 6, 2009**
    - Social Security number mandatory for liability
  - » **Respond to requests for missing Social Security number, date of birth, etc.**

# Alternative Agents

- **Clients who use our systems and choose agents other than Broadspire's Agent Reporting Solution**
  - » **Broadspire will deliver the necessary data in the CMS required format to your agent**
  - » **Your RRE or its agent will be responsible for:**
    - Performing the Medicare beneficiary check
    - Providing the Medicare beneficiary information to Broadspire in the CMS response file
    - Notify Broadspire about any reporting errors CMS response file
  - » **Contract addendum required**
- **Clients who do not use our systems are responsible for:**
  - » **Adding the necessary fields to applications**
  - » **Performing the necessary data transmissions**
  - » **Managing any errors**

# What Has Not Changed

- **Medicare Set-Aside (MSA)**
  - » **An allocation used to protect Medicare's future interests in workers' compensation claims**
    - MSA currently recommended for workers' compensation claims
  - » **Procedures not changing for MSAs**
    - Separate from the mandatory reporting requirements
  - » **Liability claims**
- **Lien rules**
  - » **CMS has six years from the date of its knowledge to pursue a lien**
    - Coordination of Benefits Contractor (COBC) hired by Medicare to recover payments that should not have been made by Medicare, sends lien letters

# Terms and Acronyms

<b>AGENT</b>	Entity who will be reporting on an RRE's behalf
<b>CMS</b>	Center for Medicaid and Medicare Services
<b>COBC</b>	Coordination of Benefits Contractor
<b>MIR</b>	Mandatory insurer reporting
<b>MMSEA</b>	Medicare, Medicaid and SCHIP Extension Act of 2007
<b>MSA</b>	Medicare set-aside
<b>MSPA</b>	Medicare Secondary Payer Act (1980 established MSA in WC)
<b>MSPRC</b>	Medicare secondary payer recovery contractor
<b>Non-GHP</b>	Non group health plan
<b>ORM</b>	Ongoing responsibility for medical
<b>RRE</b>	Responsible reporting entity
<b>RRE ID</b>	Code assigned by CMS to the RRE for identification purposes must go on claim records