DEPARTMENT OF HEALTH & HUMAN SERVICES
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ALERT

Medicare Secondary Payer and Certain Civil Money Penalties: Frequently Asked Questions

CMS has finalized its rule specifying how and when CMS will calculate and impose civil money penalties (CMPs) when group health plan (GHP) and non-group health plan (NGHP) responsible reporting entities (RREs) fail to meet their Medicare Secondary Payer (MSP) reporting obligations. The text of the final rule can be found and reviewed in its entirety in the Federal Register, which can be found at https://www.federalregister.gov/documents/2023/10/11/2023-22282/medicare-program-medicare-secondary-payer-and-certain-civil-money-penalties. To help RREs prepare for potential CMPs, CMS is addressing some frequently asked questions. CMS will also be hosting webinars in January 2024 to begin to share additional information about CMPs.

Q. How does this rule affect my Section 111 reporting obligations?

A. This rule does **not** alter the Section 111 reporting requirements in any way, and RREs should report as required. For example, a Total Payment Obligation to Claimant (TPOC) must be reported only it is related to an incident that occurred on or after December 5, 1980, *and* releases medicals, *and* meets any other specifications outlined in the User Guide (e.g., TPOC amount thresholds). Please review the Section 111 User Guides if you are uncertain whether a record should be reported.

Q: What are the key dates associated with this rule?

A: As noted in the published rule, the key dates are:

- October 11, 2023- Publication of the rule in the Federal Register.
- December 11, 2023- The rule is effective and integrated into the Code of Federal Regulations.
- October 11, 2024- The rule is applicable. From this date forward, Responsible Reporting Entities (RREs) will be held accountable for ensuring that all records are reported timely.

Q. When will CMS issue the first penalties under this rule?

A. The earliest a CMP may be imposed is October 2025. The 1-year period to report the required information before CMPs would potentially be imposed would begin on the latter of the rule effective date or the settlement or coverage effective dates which an RRE is required to report in accordance with sections 1862(b)(7) and (b)(8) of the Act. There will be no "look back" period and all penalties will be prospective in nature.

Q. What is subject to a penalty?

A. A CMP may be imposed when CMS identifies an instance where a TPOC or Ongoing Responsibility for Medicals (ORM) or coverage under a GHP has not been reported timely, as defined in the rule. The record must be accepted by CMS, and not rejected due to error, to be considered successfully reported. As a reminder, CMS considers ORM and TPOCs to be separate reporting obligations, and CMS will evaluate the timeliness of the ORM and TPOC reporting separately for the purposes of determining compliance.

Q. How will CMS identify instances of non-compliance?

A. CMS will audit a random sample of 250 records that were added on a quarterly basis from across all reported records for a total of 1,000 records to be reviewed annually. This sample will reflect a proportionate number of GHP and NGHP records and may shift each quarter as GHP and NGHP record volumes vary.

When a sampled record is from a source other than Section 111 reporting, CMS will identify and review the associated Section 111 record for compliance. If the Section 111 record has not been successfully reported at the time of review, noncompliance will be determined based on the information supplied in the other record (e.g., the date of settlement).

Q. Will there be any limits on how many records could be audited for a particular RRE?

A. Because the sampling process will be entirely random, it is possible that one RRE could have multiple records selected for review in any quarter. To ensure the sample is truly random, there will be no limits to which RREs are selected, or how many times an individual RRE's records may be selected.

Q. What if the individual became entitled to Medicare after ORM was assumed or GHP coverage became effective?

A. In these circumstances, the timeliness of reporting is based on the individual's eligibility for or entitlement to Medicare.

Q. What if settlement occurs, but the specific TPOC amount is determined later?

A. CMS will use the "TPOC Date" to determine reporting timeliness, unless the "Funding Delayed Beyond TPOC Date" on the record is populated. In those situations, the "Funding Delayed Beyond TPOC Date" will be used.

Q. What if RREs have additional questions about their Section 111 Mandatory Insurer Reporting?

A. RREs that have additional questions about the reporting process should contact their EDI representative. If you have questions or comments specific to CMPs, please send them to the Section 111 CMP mailbox at Sec111CMP@cms.hhs.gov.