CMS Suspends the Data Match Program

Contact: UBAmember@fisherphillips.com

What was the Data Match Program?

Medicare Secondary Payer (MSP) rules determine when Medicare must pay primary or secondary to another coverage provider. Congress enacted the Omnibus Budget Reconciliation Act of 1989 to provide the Centers For Medicare & Medicaid Services (CMS) more robust information about Medicare beneficiaries' group health plan (GHP) coverage, in part, to prevent Medicare from paying primary when it should pay secondary. The law required the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information about whether Medicare beneficiaries or their spouses were working, and therefore, potentially covered by an employer-sponsored GHP that Medicare should be secondary to under its coordination of benefits requirements. More specifically the SSA would provide the IRS Social Security numbers (SSN) of Medicare beneficiaries, and the IRS would then match the SSNs to Medicare beneficiaries' tax returns. The IRS would provide this information to CMS, and if CMS determined that the Medicare beneficiary or their spouse may be employed, it would send a Data Match Questionnaire to employers.

Employers were required to respond to these Questionnaires electronically within 30 days or face civil penalties. These Questionnaires asked, among other things, whether the individual was employed, and if so, whether the individual was eligible for an employer-sponsored GHP. As of July 1, 2018, this portion of the MSP rules was suspended. When the Data Match Program was suspended, employers who had outstanding Questionnaires were encouraged to complete the Questionnaire as requested.

What are the current reporting obligations?

CMS still requires mandatory insurer Section 111 reporting for GHPs. Section 111 reporting is also part of the MSP rules. It was designed to help Medicare correctly pay for the health insurance benefits of Medicare beneficiaries by determining whether Medicare should pay primary versus secondary.

Section 111 authorizes CMS and a GHP's responsible reporting entity (RRE) to exchange health insurance benefit entitlement information electronically. The insurer or third party administrator (TPA) will fulfill this reporting requirement for fully-insured GHPs. For self-insured GHPs that are also self-administered, the RRE is the plan administrator or fiduciary. If there is a TPA for a self-insured plan, it is likely that it will be the RRE.

Section 111 reporting requires RREs to submit information electronically on a quarterly basis about employees and dependents who are Medicare beneficiaries with employer-provided GHP coverage that may be primary to Medicare. CMS then provides the RRE with Medicare entitlement and enrollment information for individuals enrolled in the GHP that can be identified as Medicare beneficiaries. This mutual data exchange ensures that claims will be paid by the appropriate organization at first billing instead of Medicare having to request additional payments from the GHP at a later date. The Section 111 GHP reporting process also includes an optional exchange of prescription drug coverage information for Medicare Part D purposes.

Voluntary Data Sharing Arrangements (VDSA)

Throughout the existence of the Data Sharing Program, CMS has encouraged employers to engage in VSDAs. Even though the Program is suspended, it continues to permit employers to establish these arrangements. VDSAs do not operate that differently from Section 111 reporting, except that it is an employer rather than the insurer reporting this information. If employers establish a VDSA, they must agree to electronically provide the GHPs available Medicare entitlement information to CMS quarterly, and CMS will provide the employer with its Medicare entitlement information for those individuals. Similar to Section 111 reporting, this process is aimed to ensure that Medicare does not pay primary when it does not have to.

There are a number of advantages to establishing a VDSA. Ideally, if this process is accomplished properly, Medicare will not overpay erroneously, and it should prevent errors and delays which could impact Medicare entitled participants and beneficiaries. This is beneficial to employers because CMS has the statutory right to recover amounts that they overpaid. By participating in a VDSA, the employer can avoid repayment demands as well as their negotiations or potential penalties for late or non-payments with CMS.

Whether an employer should sign a VDSA is an important question since it creates obligations for employers that would not otherwise exist. As such, it may be useful for employers contemplating entering into a VDSA to seek legal counsel.