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The PAID Act is Coming to Medicare-Are You Ready?

July 7, 2021
13 MIN READ

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In December 2020, an act was signed into law, which will change the way some reporting entities coordinate Medicare benefits. This PAID Act will go into effect before year's end, but CMS is busy preparing for the change. In today’s podcast, Deborah Robinson-Stewart, joins us to explain.

Tom Kerr (TK): Deborah, to kick things off, what is the PAID Act and how does it impact our industry?

Deborah Robinson-Stewart (DRS): It is the Provide Accurate Information Directly Act and it was enacted back on Dec. 11, 2020. It's an act that is a means to help nongroup health plans such as workers' compensation, insurance carriers, and Responsible Reporting Entities, that are otherwise known as carriers and insurers, better coordinate the benefits that are provided to Medicare beneficiaries, particularly Part C and Part D Medicare enrollment information.

Currently, the carriers and insurers only have access to what is known as traditional Medicare and that's your Part A and Part B Medicare benefit information when they do a Section 111 query. So, for those that may not know, Section 111 is the Mandatory Insurer Reporting. So, carriers and insurers have an obligation to report all of their open claims to Medicare so that Medicare can coordinate benefits and determine if there is a beneficiary with an open claim that is part of the workers' compensation claim process or liability claim process.

When they report to Medicare, usually through an electronic database, Medicare will send back to the carrier/insurer all of the individuals that are identified through that process as a Medicare beneficiary. And it's the responsibility of the carrier or insurer to ensure that Medicare does not make any payments for accident-related care that are otherwise the responsibility of the carrier or insurer. So, that's where we get the Section 111 reporting process and that's where we get to this PAID Act and the coordination of benefits.

So, on Dec. 11, 2021, CMS will begin to provide these carriers and insurers when they do this query process with up to three years of beneficiary enrollment data for the Part C and Part D plans. So, Part C is your Medicare Advantage plan and Part D is your Medicare Prescription Drug plans. This change is very significant because prior to this, finding out this information was like a seek-and-find puzzle. There's no central repository for this information because Part C and Part D plans are largely run by private health care insurers like Aetna, Humana, UnitedHealthcare. And so, in each state, there could be numerous plans. So, if the Medicare beneficiary refuses to provide the plan information, or you only have the plan name and the state that the plan is in, it could take weeks to never to get this information. So, this is why this PAID Act is very significant for carriers and insurers.

TK: What's the current state of its implementation?

DRS: So, currently we're in the information phase. As I said, the PAID Act was enacted back on Dec. 11, 2020, and it'll go in effect Dec. 11 this year. The other day, CMS held a town hall webinar where they answered questions from the community regarding the upcoming coming changes and they addressed what's next. So, the next phase will be the testing phase.

The addition of the Part C and Part D information to the query response file will add a large number of new fields. So, the software that CMS uses is going to be updated to account for the increase in the size of the data, and CMS is planning to hold a testing webinar to further discuss what's going to go on during the testing phase and that will be held on Sept. 9. After that period, there will be a testing phase where the carriers and insurers, who are also known as Responsible Reporting Entities, will be able to test the new software and this testing phase will start on Sept. 13 and go until Dec. 11.

The testing is not required, but CMS does highly recommend it. And, during this time, the carriers and insurers will be able to conduct the testing in the new version of the CMS software without interfering with the current version of the software, but it's a good opportunity for them to be able to flush any errors that might occur.

Again, this is going to mark a very increased change in the size and the amount of data because we're now reporting fields from Part C, which would include all of that Medicare Advantage plan information, and then Part D plans information. So, it's going to increase the query response file significantly.

TK: So, to confirm, the go-live date is Dec.11. So, the goal is that the testing will begin in September and roll right up to that date that right?

DRS: That is correct. The current plan is to test, during that time and roll right up until the date that it goes live, essentially. So, on the 11th the testing site will go from being a testing site to becoming the live site.

TK: So, hopefully, everything will go well and on schedule.

DRS: Indeed.

TK: So, how does the PAID Act impact payers?

DRS: It will provide them with an opportunity to better coordinate benefits. So, we always talk about coordination of benefits in MSP compliance So, Medicare Secondary Payer compliance entails potentially doing an MSA but also checking for conditional payments. As I said before, when Medicare has made payments for any kind of accident- or incident-related treatment, they expect to be repaid because, in Medicare's role, they were set up not to be a primary payer, but to be a secondary payer.

So, the impact is to help the payers or the Responsible Reporting Entities better coordinate the benefits so that they would not be held on the hook or, before they settle, be able to have the information of where they need to make payments in terms of reimbursing Medicare.

So, right now, when you do a query inquiry through the Section 111 process, you're only going to uncover Part A and Part B Medicare beneficiary information. It's the same if you were to do a conditional payment search with Medicare, it is only going to cover for Part A and Part B benefit information. With the enhancements Medicare will make through the PAID Act, this will automatically give the payers, or the Responsible Reporting Entities, any kind of Part D and Part C enrollment information. This will then allow them to make contact with those Medicare entities to determine if they also have made any payments in relation to accident or incident treatment for that particular Medicare beneficiary.

TK: Got it. And what do payers need to know about the new law?

DRS: I think the top thing is to know that they will have to access this new information through the query process. Again, they're going to get the plan contractor's name, their contact number, their address. Again, before this information was not readily available and it was like a seek-and-find, like I said, and this is going to be for the previous three years for that Medicare beneficiary.

So, the standard query process would be that you would do a query, you would get the Medicare information back from the query and it was typically traditional Medicare only. So, with this enhanced query process, you're going to get the Medicare beneficiary information back, you're going to get traditional Medicare, and you're going to get the Part C and Part D plan, but you're also going to get Part C and Part D information for the previous three years.

So, if I were to do a query on Dec. 11 when this goes live, I would get information for three years prior to that. This is significant because Medicare beneficiaries can change plans each year during annual enrollment. So, if you had somebody who was not participating in traditional Medicare through the A and B plan but elected to use a Medicare Advantage plan through a private health insurer and say, in 2019, they used UnitedHealthcare, didn't like that and then, in 2020, when open enrollment came, they changed to Humana, now, through this query process, you're going to be able to see all of the plans that the Medicare beneficiary used for the preceding three years. And then you would be able to reach out to them to coordinate benefits and ensure they had not made any

payments in relation to an accident or injury.

And, as we know, sometimes in the workers' compensation realm, some of these claims can be open for years. I had a case that I worked on recently where the injury was in 2007, and here we are in 2021. And so, sometimes you have these cases that go on forever. At least you would be able to look back for the preceding three years to determine if there were any Medicare payments that were made under these Part C and Part D plans.

TK: So, what can payers do now to best prepare for meeting the requirements of the law?

DRS: The number one thing that payers can do is to stay abreast of the changes. One of the other things is to ensure that you update your Section 111 capabilities in accordance with the CMS directives. The size of the query file is going to be changing to accommodate all these new fields. CMS uses software called HEW (HIPAA Eligibility Wrapper) and a new version of this is going to be released just in time for the testing period that we talked about.

So, payers and Responsible Reporting Entity want to make sure they're going to be utilizing this newer software, because my understanding is that the older version is not going to be able to accept all of the fields that are going to come along with these changes with this Part C and Part D information.

So, that's the first thing, to make sure that your software is up to date because you're going to want to have all of this additional information. The second thing is to participate in the testing period. The testing is not required, but it's recommended, and it does span over two months in timeframe right up until this goes live. So, it's not required, but if there are issues identified during the testing phase you'll have an opportunity to address them with CMS and get them corrected so that when this does go live, you're not missing out on any information.

TK: And let's say that a payer doesn't get involved in the testing process. What could happen if they're unprepared when the PAID Act goes live?

DRS: So, it really just goes back to your systems. If you're still trying to utilize the old software for the query response then your system is not going to align and you're not going to be able to absorb the new fields. So, you're not going to get all of the information.

So, imagine you getting to the settlement table, and you're ready to settle your file. You have a number, and you're still working off of the traditional Medicare Part A and Part B query that told you that Medicare hasn't made any payments. Most of our customers have a Section 111 reporting partner and they will determine that the person is a Medicare beneficiary. We then will go to Medicare and ask to see if they made any payments. That's the traditional Medicare.

So, imagine that you haven't updated your system so that you're getting these query responses, including the Part C and Part D information. You get to the settlement table, and then you find out "hey, this person's not using traditional Medicare, they're using a Medicare Advantage plan." And "hey, they also have a Part D plan," but you don't know this because you haven't updated your systems and you have not then reached out to these plans to determine if Medicare has made any payments in relation to the accident or injury that you're about to settle. Well, that could potentially delay or derail your settlement because you don't have all of the information.

So, that's why it's important that you stay on board and update your systems. Medicare makes it easy for you. In the *Non-Group Health Plan User's Guide*, there is a link that will take you right to the page so you can access the software. Medicare provides the software, you just have to download it to your systems. I don't believe that you have to purchase it. So, they do make it quite easy for you.

TK: Great. And what are some of things you or Genex are doing to help payers meet the requirements of the system or prepare for this change?

DRS: So, the first thing is education and awareness. So, right now, because this is very fresh, I'm working on a news alert to go out to our customers so that we keep this issue on the forefront and they know what's coming down the pike. So, periodically we'll send out news alerts that deal with MSAs, Medicare Secondary Payer Section 111, those things. So, this is going to go out in relation to the PAID Act. It will discuss what occurred in the town hall that was held the other day and the CMS timeline for implementation and testing.

The other thing is encouraging the payers to establish best practices for query process to ensure that no information is missed. So, we just talked about the potential for derailing a settlement. When you haven't updated your systems, and you're only looking at Medicare from a traditional Medicare standpoint, and you don't have all of the information, you're not gleaning the Part C and Part D information. The other thing is that when you query through the Section 111 process, oftentimes, you may not get a hit that comes back telling you that somebody is a Medicare beneficiary.

And, if you have a case that has been open for a long period of time, you may not want to just query that particular claim one time. You may put into place a best practice where you query on an annual basis or you query on a quarterly basis. If somebody is close to being of Medicare age, which is 65, and you're starting to query at 63 and you're not getting anything, you may continue to do the query. If you know that the claimant is a recipient of Social Security Disability benefits, you may continue to query because you have the understanding that individuals with a strong work history that have been adjudicated disabled and are receiving Social Security Disability benefits for 24 consecutive months will become entitled to Part A Medicare benefits after that 24 months, thus making them a Medicare beneficiary. So, encouraging and establishing the best practices for a query process is something that would help a payer or Responsible Reporting Entity meet the requirements.

The other thing is MSP compliance requirements. So, there's MSAs, there's conditional payments, we talked about Part A and Part B Medicare being traditional Medicare and the query that goes along with that, but also reminding individuals that we work with that you also need to be on the lookout for Part C and Part D.

And sometimes what happens is a lot of the Part C and Part D entities have recovery agents. So, what that means is that rather than a plan like a Humana sending you a letter or UnitedHealthcare sending you a letter saying that they've made payments in relation to an accident or injury the insurer has a claim for, they hire a recovery agent. There's the Rawlings group that might send you a letter saying, "hey we represent UnitedHealthcare, we understand that there's an open claim that we may have made payments for."

So, those are the things that we like to remind people of as well. There's a full circle of MSP compliance that you need to be aware of, and sometimes you might not get a letter directly from the Advantage Plan or the Part D plan that the Medicare beneficiary is a part of, but you may get it from a recovery agent. And, you don't want to just put them in your file and ignore those because again, those are the types of things that come up at the settlement table and can derail or delay a settlement.

TK: Thanks, Deborah. We'll be sure to keep an eye on the Paid Act's progression over the next few months. Until then, thanks for listening.

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