Centers for Medicare and Medicaid Services (CMS) Rules Update

June 23, 2021 | 2:00-3:00 p.m. ET

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Presenter

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Associate General Counsel

Lavonya Chapman is Optum Settlement Solutions' Medicare Secondary Payer (MSP) Compliance Counsel and a member of the management team responsible for strategic planning and product development with legal, regulatory, and compliance oversight of all services provided to include MSP settlement language, Mandatory Insurer Reporting, ICD injury code reporting, Conditional Payment Resolution, Medicare Set-Aside Allocations (MSA), CMS approval, and professional administration of MSAs.

Lavonya joined Optum Settlement Solutions in 2014 with more than 25 years of experience as an attorney, claim director, and registered nurse. Her casualty insurance experience began as a medical case manager at USF&G insurance.

As an attorney, Lavonya has litigated medical malpractice, premises, and auto liability claims, as well as workers' compensation cases. As a registered nurse and pharmacology instructor at the University of Alabama at Birmingham, Lavonya is an expert in utilization review and emergency medical services.

Lavonya is a frequent conference speaker and mentor on all aspects of the Medicare Secondary Payer Act as it pertains to claim compliance in the property & casualty industry. She received a Bachelor of Science degree in nursing from the Samford University and a Doctorate of Jurisprudence from Birmingham School of Law.

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Objectives

- Review the two proposed rules to be released by the Centers for Medicare and Medicaid Services (CMS) that will significantly change the landscape of Medicare Secondary Payer compliance involving workers' compensation, liability, and no-fault claims
- Review what we have been told by CMS, what we anticipate when the proposed rules are published, and what we recommend should be done while we wait for the final rules from CMS
- Discuss CMS's **"future medicals"** proposals, which would clarify existing Medicare Secondary Payer (MSP) obligations associated with future medical items and services related to all claim types including liability claims, where there is a settlement, judgment, award, or other payment
- Review how CMS proposes to enforce and calculate **Civil Money Penalties** (CMP) for failure to properly report required claim information to CMS pursuant to *Section 111* of the Medicare, Medicaid and SCHIP Extension Act of 2007 (*MMSEA*)
- Review the **PAID Act** already enacted and its claim implications

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CMS "Future Medicals" Rule Proposed

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The background on Future Medicals

- Under the Medicare Secondary Payer (MSP) Act,* when related medical treatment will be needed in the future that would otherwise be reimbursable by Medicare, CMS' interest must be considered and protected
- CMS publications state that the burden to pay post settlement should not be shifted to Medicare

The MSP Act does not mandate what specific mechanism should be used to keep the claimant from using his Medicare card post settlement to pay for related treatment into the future.

*42 U.S.C. 1395y

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CMS Method of choice

CMS believes the Medicare Set-Aside arrangement (MSA) provides the **best protection** for the Medicare program and for the claimant/beneficiary.

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On 4/19/2021, CMS produced version 3.3 of the *WCMSA Reference Guide*

- Provides guidance on how to protect Medicare's future interest when settling a WC claim

- Does not provide specific CMS guidance on how to protect Medicare's interest when settling a liability claim
  - Insurance industry takes the position that there is no MSP statutory authority that allows CMS to impose obligations on insurers or self-insureds after settlement
  - *Abate v. Wal-Mart Stores East, L.P.*, 2020 WL 7027481 (W.D. Pa. November 30, 2020, liability settlement was enforced without a letter from treating physician certifying that no future treatment was anticipated and without a Liability MSA (LMSA), while plaintiff attorneys use the need for related treatment for life in the procurement of the settlement amount
  - LMSA case law decisions are inconsistent

In light of an increase in non-submit MSAs and no guidance on **how** to protect Medicare's future interest, CMS published their intent to provide guidance and clarification in the proposed rules.

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Future Medicals clarification and update hints resumed on 12/18/2018

- Medicare does not provide beneficiaries with guidance to make appropriate choices on how to pay related future medical expenses post settlement.
- To date, CMS has not released its “future medicals” proposal
- CMS has stated they will eventually take steps to codify future medicals expenses in WC, liability and no-fault claims

Notice of Proposed Rulemaking (NPRM) to be published in Code of Federal Regulations (CFR) pushed to:

September 2019
THEN
October 2019
THEN
February 2020
THEN
August 2020
THEN
March 2021
THEN
October 2021

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Spring 2021 proposed rule abstract of “future medicals”

from Office of Information and Regulatory Affairs (OIRA)

- Health and Human Services-Centers for Medicare and Medicaid Services (HHS/CMS)
- Title: Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047)
- Includes proposed rules for liability, no-fault and workers’ compensation claims
- Clarifies how an *individual claimant/Medicare beneficiary* must satisfy Medicare’s interest with respect to future medical items and services
- Removes obsolete regulations

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Pending MSA proposed rulemaking

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HHS/CMS **RIN:** 0938-AT85 **Publication ID:** Spring 2021

Title: Medicare Secondary Payer and Future Medicals (CMS-6047)

Abstract:

This proposed rule would clarify existing Medicare Secondary Payer (MSP) obligations associated with future medical items services related to liability insurance (including self-insurance), no fault insurance, and worker's compensation settlements, judgments, awards, or other payments. Specifically, this rule would clarify that an individual or Medicare beneficiary must satisfy Medicare's interest with respect to future medical items and services related to such settlements, judgments, awards, or other payments. This proposed rule would also remove obsolete regulations.

Agency: Department of Health and Human Services(HHS)
RIN Status: Previously published in the Unified Agenda
Major: Yes
CFR Citation: 42 CFR 405 42 CFR 411
Legal Authority: 42 U.S.C. 1395y(b)
Legal Deadline: None

Priority: Economically Significant
Agenda Stage of Rulemaking: Proposed Rule Stage
Unfunded Mandates: No

Timetable:

Action	Date	FR Cite
NPRM	10/00/2021	

Regulatory Flexibility Analysis Required: No
Federalism: No
Included in the Regulatory Plan: No
RIN Data Printed in the FR: No
Related RINs: Related to 0938-AR43

Government Levels Affected: None

Agency Contact:
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What we know from CMS

- CMS does not recognize Non-Submit or Evidence-Based MSAs that are not CMS approved
- CMS cannot measure and coordinate benefits if they are unaware of the existence of a Non-Submit MSA

Obsolete = "no longer useful"

- Does obsolete mean that it will remove the "voluntary" CMS review of MSAs?
- Does removing "obsolete" regulations imply that something new will **replace** the "obsolete" regulation?
  - Making CMS' Coordination of Benefits contractor aware of all MSA funding
  - Offering LMSA "voluntary" CMS reviews not usually available for liability claims due to staffing constraints
  - Disclosing the existence of a Non-Submit MSA to CMS by submitting a copy to the Coordination of Benefits contractor and/or merely adding a Section 111 reporting field acknowledging its existence
  - Requiring more accountability with the CMS' annual MSA attestations when any MSA is self-administered or professionally administered
  - Providers have been instructed to bill any MSA disclosed by the patient on the patient questionnaire

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Best practices while we wait

- All types of settlements should consider Medicare's future interest when related future treatment is anticipated
- Use the WCMSA Reference Guide until we get other CMS guidance
- Protect the Medicare Trust Fund by using either an MSA or a portion of the settlement funds, to pay providers/prescribers for related post settlement care

> Notwithstanding liability policy limits, comparative/contributory negligence, statutory caps on damages, or judicial decisions, and ensuring that a Medicare card is not used

- Equitably apportioned LMSAs using case law calculations can be used until CMS rules are published in the CFR
- Section 111 reporting data is being used to:
  - Enforce MSP compliance
  - Coordinate benefits with traditional Medicare
    (Soon to add Medicare Advantage plans (MAP) and prescription Part D plans (PDP))

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Civil Money Penalties (CMP)

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Section 111 MIR Civil Money Penalties (CMP)

On February 18, 2020, CMS released its Section 111 CMP proposed rule for non-group health plans (NGHP) who are noncompliant in reporting to CMS, Federal Register at 85 Fed. Reg. 8793.

Potential CMP Amounts:

- Imposed penalties per claimant are calculated up to $1,000 per calendar day of noncompliance (Up to a maximum penalty of $365,000 per year)
- Similar to strict liability

It is the RRE, the insurer, or self-insured entity who is responsible for paying CMPs. However, TPAs are often the ones who report the Section 111 data.

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CMPs may be imposed…

1 When an RRE Fails to report or **fails** to report a reportable event involving a Medicare beneficiary such as TPOC or ORM termination date that exceeds a one (1) year timeframe

- CMPs accessed and calculated daily based on the number of individual Medicare beneficiary claim records that the RRE submitted late.
- Penalty per claimant up to $1,000 per calendar day of noncompliance for which the required data should have been submitted via Section 111 reporting.
  (One year maximum penalty of $365,000 per individual per year pursuant to *42 CFR part 102)*
- Late reporting begins the day after the last day of the RRE's prescribed reporting cycle when the data should have been submitted to CMS and ends the day that CMS receives the information.

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CMPs may be imposed…

2 When an RRE exceeds CMS' ***error tolerance thresholds*** established by the Health & Human Services (HHS) Secretary in any 4 out of 8 (or less) quarterly reporting periods

CMS proposes the initial and maximum *error tolerance threshold* would be 20%.

- Errors reported by the RRE involve ≥20% of the beneficiary claim records in a given reporting period.
- Those beneficiary claim records were prevented from being accepted and processed by CMS.
- Significant errors that prevent a file or individual beneficiary from processing include missing claimant data such as a last name or date of birth or the failure to provide a matching Tax Identification Number (TIN).

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CMPs may be imposed…

3 When an RRE contradicts RRE's Section 111 Reporting data in their responses to CMS recovery efforts

- ICD codes, ORM termination dates included in recovery disputes and appeals are inconsistent with the Section 111 data fields
- Penalty calculated based on the number of calendar days that the RRE failed to appropriately report updates to the beneficiary records as required for accurate and timely reporting.
- Penalty per claimant up to $1,000 per calendar day of noncompliance for which the required data should have been submitted via Section 111 reporting.
  (One year maximum penalty of $365,000 per individual per year pursuant to *42 CFR part 102)*
- CMS acknowledges that it does not yet have systems in place to monitor when RREs or their recovery agents contradict their Section 111 data reported.

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CMPs will be prospective and NOT imposed if…

- A NGHP RRE reports required data within one year of the date of settlement
- A NGHP RRE's data submission compliance does not exceed the error tolerance threshold in any of the four out of eight consecutive quarterly reporting periods

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CMP safe harbor and good faith efforts to properly report

- CMS does not plan to impose CMPs for good faith efforts to identify claimants who are Medicare beneficiaries
- The NGHP RRE must show their good faith efforts used to obtain necessary information for Section 111 reporting, to query and obtain the claimant's Medicare beneficiary status
- The claim file must be retained for five years as mitigating evidence should CMS contemplate imposing CMPs.
  - At least two communications by U.S. mail, once by email or phone to the individual claimant and claimant's attorney
  - The NGHP RRE certifies that it has not received a response in writing with the Medicare Beneficiary Identifier or Social Security number
  - The NGHP RRE received a letter whereby the claimant and claimant's attorney refused to produce requested the Medicare Beneficiary Identifier or Social Security number
  - The NGHP RRE claim and legal records illustrate good faith efforts and reasons for failure to collect required information

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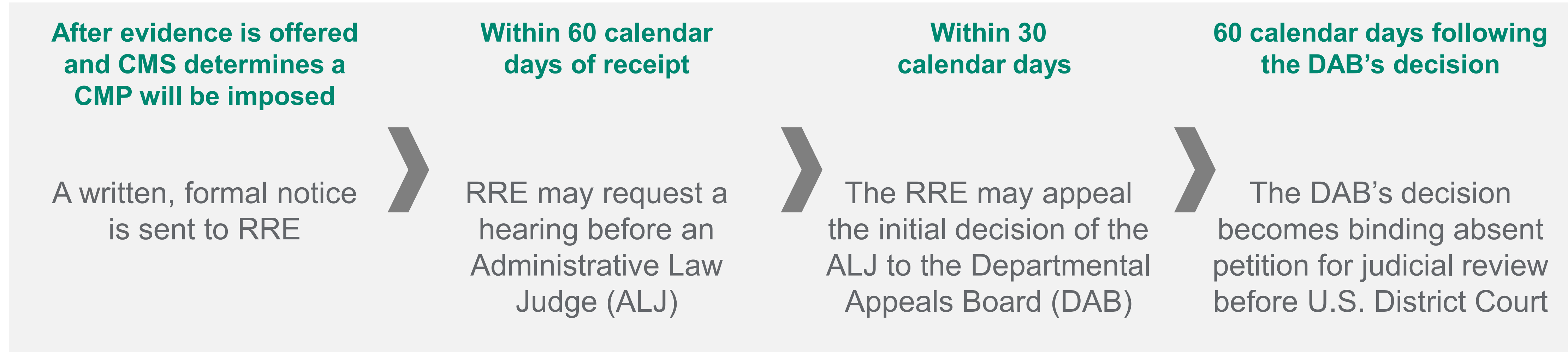
Notice and appeals of CMPs owed

- CMS anticipates using an informal written “pre-notice” process to allow the RRE to present mitigating evidence before the imposition of a CMP
- The RRE would have 30 calendar days to respond and provide mitigating evidence before the issuance of a written notice



- CMS intends to apply a five-year *statute of limitations*.

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Preparation for CMPs

- The earliest effective date could be any day now or as late as February 2023
- CMS presumes that all stakeholders are making an effort to be compliant now
- Insurers/Responsible Reporting Entities (RRE) are already evaluating Section 111 compliance practices in light of CMP's proposed rulemaking
  - Open dialogue early on in a case to communicate the need to obtain an SSN to comply with MIR requirements
  - SSN Collection Model Language Form created by CMS as of 3/10/2021

    https://www.cms.gov/files/document/mmsea-111-mbi-ssn-collection-nghp-model-language.pdf

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Indications that CMS is preparing for CMP enforcement

- CMS is looking at some Section 111 anomalies such as TPOC amounts of less than $500 when ORM is not open
- No-Fault claims with ORM open but no policy limits reported
- CMS recovery and coordination of benefits contractors are closely watching *contradictions* such as ICDs connected to open ORM inadvertently left open post settlement (TPOC) and are denying Medicare claims for claimant/beneficiaries

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Next steps…

Workers' Compensation, No-Fault and Liability Insurers and TPAs

- Review and determine if Section 111 errors need to be corrected
- Isolate and review data that has been or is rejected and marked as an error in your Section 111 monthly and quarterly reports from CMS or your reporting agent
- Try to get Section 111 reporting right the first time, ensuring that no claims are left unreported and CMPs are not imposed for a failure to report.
- Have a proactive team that is constantly monitoring the monthly Medicare Query results and quarterly CMS error or disposition codes returned by CMS or your Section 111 Reporting Agent – take action to promptly correct the error codes.

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Preparation for CMPs

Since CMPs will be *prospective*, key decision makers (rather than individual adjusters) must weigh the downstream consequences as to when valid SSN or other Section 111 data errors are corrected. .

After the Medicare entitlement date? *After the CMP effective date?*

***Retroactive corrections* can:**

- Create a trigger for Medicare conditional payment recovery from the claimant as debtor on very old claims that were resolved long ago or from the RRE as debtor if the SSN is associated with open ORM
- Trigger a massive amount of CMPs for failure to or late TPOC reporting if corrected errors over a year old are transmitted to CMS after the CMP effective date

- If retroactive corrections are needed to avoid CMPs, know how they will impact Medicare conditional payment recovery efforts against the debtor, whether the claimant or the RRE/insurer
- Weigh the risks and benefits of retrospective Section 111 data corrections. While the CMPs are stated to be prospective, correcting old errors may cause Medicare conditional payment recovery to become retroactive

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Provide Accurate Information Directly (PAID) Act

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The Problem

- CMS mandates that both traditional Medicare, as well as Medicare Advantage plans (Part C) and prescription Part D plans (PDP) recover any payments they made for treatment of injuries/illnesses claimed to be related to:
  - Workers' compensation (WC) claims
  - No-fault claims-premises med pay, auto med pay or personal injury protection (PIP)
  - Liability claims
- Claim handlers have no easy way to determine whether claimant's use or providers/prescribers bill a patient's Medicare Advantage plan (MAP) card or their prescription Part D plan card to pay for related items, services, or prescriptions

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The Problem

- MAPs seek recovery and if reimbursement is not prompt by filing private causes of action (PCOA) for double damages rather collecting from the Department of Treasury; very expensive to defend these lawsuits
- PDP are becoming aggressive and persistent in seeking recovery as well
- On 9/4/2020 an 11th Circuit judicial decision expanded MAP recovery rights to not just MAPs/PDP but also to “downstream actors”. All may now also file PCOAs against insurers/RREs

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The Problem – Enrollment in MAPs is growing

MAP PLANS IN 2020

24.1M Beneficiaries Enrolled

36% of all Medicare beneficiaries

> 59M **Medicare beneficiaries** are enrolled in Part D plans
(72% of all Medicare beneficiaries)

- Current CMS recovery contractors (BCRC and CRC) and the Medicare Secondary Payer recovery portal only have information about Medicare conditional payments paid by traditional Medicare.
- More claimant/Medicare beneficiaries don't have traditional Medicare but instead enroll in MAP and PDPs.
- After settlement, when the claim file has been closed, it has to be reopened to address MAP and PDP recovery efforts against insurers and self-insured entities.

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Medicare Advantage Plans (MAP) and Prescription Part D Plans (PDP) are…

- Private insurers who must be approved by CMS to participate in the Medicare program.
- Considered to be non-compliant by CMS when they do not recover the money they paid for treatment involving the underlying claim, out of the settlement proceeds

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The Solution – Provide Accurate Information Directly (PAID) Act

- Significant aspect of Medicare Secondary Payer (MSP) claim compliance
- Signed into law on 12/11/2020 and will be fully effective by the end of 2021
- PAID Act will make it easier to…
  - Identify potential primary payers who have accepted ORM for MAPs and PDPs to seek reimbursement from as required by CMS
  - Know when claimant/beneficiary has agreed to reimburse MAP/PDP out of settlement proceeds when related treatment is released upon settlement (TPOC)

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Three actions prompted by the PAID Act

The PAID Act requires CMS to provide information through the payers/insurers/RREs Section 111 query process and requires action from:

1 **CMS**

The insurer/RRE's Section 111 query response file will received information from CMS

2 **Insurer / Payer / RRE**

Insurers/RREs must act and reach out to the name and address CMS is required to provide them

3 **Applicable MAP or PDP**

The applicable MAP or PDP who will respond to a request to verify whether payment have been made for related treatment

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Multiple parties impacted by the PAID Act

Insurers, self-insured entities, and responsible reporting entities (RRE)	Claim handlers and Third-Party Administrators (TPA)	Claimant's who are Medicare entitled and are enrolled in a MAP and/or PDP
Claimant attorney's who must assist their client to comply	Medicare Advantage Plans (MAP) Part C	Prescription Part D Plans (PDP) whether stand alone plan or within a MAP

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The MAP/PDP Reimbursement is due…

Liability claims or other denied claims that eventually settle

The conditional payment debt is due upon settlement, judgment, award, or other payment

Workers' compensation claims

Reimbursement may be due when the claim is deemed compensable, medical benefits are paid, and when ongoing responsibility for medicals (ORM) is reported to CMS via Section 111 mandatory insurer reporting (MIR) upon Medicare entitlement

Premises med pay, auto med pay and/or auto personal injury protection (PIP) claims

Reimbursement may be due when the insurer receives notice of the claim that is a covered event under the no-fault portion of the policy

- CMS expects insurers to report ORM and the exhaust limits as a no-fault claim with or without a companion liability claim and with or without actual payment of related medical expenses, when the claimant is Medicare eligible

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Preparation and next steps

All settling parties are impacted by the PAID Act and must:

- Confer, ask questions and improve compliance processes well before settlement
- Look to see if a MAP/PDP name(s) and address(es) returned on the query response file
- Rule out whether claimant/beneficiary's injuries/illnesses were paid for by a MAP and PDP
- Once a MAP/PDP name and address is known, CMS expects the insurer/RRE/TPA to reach out and verify whether conditional payments exists much like is done for traditional Medicare
- If insurers/TPAs/RRE's don't act upon the query response file, then expect MAPs and PDPs to eventually begin their recovery efforts based upon ORM and TPOC reporting much like the traditional Medicare recovery contractors do. The traditional Medicare recovery contractors:
  - Commercial Repayment Center (CRC) –ORM for WC and No-Fault claims
  - Benefits Coordination & Recovery Center (BCRC) for liability or denied claims that settle

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Optum Workers’ Comp and Auto No-fault Solutions collaborates with clients to lower costs while improving health outcomes for the claimants we serve. Our comprehensive pharmacy, ancillary and managed care services, including settlement solutions, combine data, analytics, and extensive clinical expertise with innovative technology to ensure claimants receive safe, efficacious and cost-effective care throughout the lifecycle of a claim. For more information, email us at expectmore@optum.com.

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