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Legislative Rulemakings Seeking Greater Enforcement of Medicare Secondary Payer Compliance Are Set to Arrive in 2019

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In December 2018, two (2) notices were posted on the Office of Management and Budget (OMB) website signaling that the Department of Health & Human Services (DHHS)/Centers for Medicare & Medicaid Services (CMS) plans to move forward with Notice of Proposed Rulemakings (NPRMs) which would ramp up CMS' enforcement of the Medicare Secondary Payer (MSP) Act in 2019. The first rulemaking is titled, "Miscellaneous Medicare Secondary Payer Clarifications and Updates," and the second rulemaking is titled, "Civil Money Penalties and Medicare Secondary Payer Reporting Requirements." Both rulemakings are scheduled to be released by September 2019.

The first rulemaking through its description intends to set out parameters around how parties can protect Medicare's interests regarding future medical obligations in the settlement of liability, no-fault, and workers' compensation claims. However, because a review process already exists for Workers' Compensation Medicare Set-Asides (WCMSAs) and typically no-fault claims do not have a future medical obligation, the industry has interpreted this notice to provide that CMS intends to create a process to review Liability Medicare Set-Asides (LMSAs).

The abstract of the rule provides the following language:

> *"This proposed rule would ensure that beneficiaries are making the best health care choices possible by providing them and their representatives with the opportunity to select an option for meeting future medical obligations that fits their individual circumstances, while also protecting the Medicare Trust Fund. Currently, Medicare does not provide its beneficiaries with guidance to help them make choices regarding their future medical care expenses when they receive automobile and liability insurance (including self-insurance), no fault insurance, and workers' compensation settlements, judgments, awards, or payments, and need to satisfy their Medicare Secondary Payer (MSP) obligations."*

It is noteworthy that the proposed rules states that the priority level for this initiative will be "Economically Significant" to the Department of Health and Human Services (HHS). A Government Accountability Office (GAO) study issued in March of 2012 found that additional clarity around future medical obligations in liability claims needed to be provided to the industry by CMS. Specifically, the GAO noted that the Acting Administrator of CMS shall "develop guidance regarding liability and no-fault set-aside arrangements." Logically, the NPRM is a long-awaited action item from the GAO study that CMS needs to check off its to-do list.

Further, aside from the GAO study, the NPRM does not come as a surprise as CMS has been recently indicating over the past several years that it will move forward with a voluntary LMSA and No-Fault Medicare Set-Aside (NFMSA) review program. Additionally, the current Workers' Compensation Review Contractor's (WCRC) Request for Proposal (RFP), which was awarded to Capitol Bridge LLC, had also indicated that the contractor for the first time ever would also have the task of reviewing LMSAs and NFMSAs in addition to WCMSAs. As such, the current WCRC is contractually bound to take on this task once CMS issues parameters around LMSA and NFMSA review.

Numerous questions remain around a proposed voluntary LMSA program: How will CMS view comparative fault/negligence situations? What about liability settlements which are nuisance value? What if the Medicare beneficiary will not cooperate in utilizing an LMSA; What exposures will a primary payer have in that situation? Will Medicare interrupt benefits where it determines that parties did not protect Medicare's interests in the liability settlement?

While the industry awaits formal guidance from CMS relative to the submission of LMSAs, it would be prudent for primary payers to ensure that they are enforcing best practices applicable to addressing future medical care in Medicare settlements within their respective organizations. For large dollar settlements, an LMSA should be secured and incorporated into the settlement process. By stating specifically what the anticipated future medical cost will be, CMS will be limited should they seek to collect all or part of the settlement from the claimant post-settlement. Primary payers should establish a settlement threshold for LMSAs. However, in scenarios involving small settlement amounts with Medicare beneficiaries, a formal LMSA may not be necessary although detailed protective settlement language should be employed on every file.

The second NPRM on Civil Monetary Penalties (CMPs) and Medicare Secondary Payer Requirements intends to set out parameters around the amount and criteria in which CMPs would be imposed upon Responsible Reporting Entities (RREs) for noncompliance with MSP Reporting requirements.

The abstract of the rule provides the following language:

> *"Section 516 of the Medicare Access and CHIP Reauthorization Act of 2015 amended the Social Security Act (the Act) by repealing certain duplicative Medicare Secondary Payer reporting requirements. This rule would propose to remove obsolete Civil Money Penalty (CMP) regulations associated with this repeal. The rule would also propose to replace those obsolete regulations by soliciting public comment on proposed criteria and practices for which CMPs would and would not be imposed under the Act, as amended by Section 203 of the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act)."*

The industry has anticipated this NPRM because under the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act), CMS is required to establish criteria and practices in which CMPs would be imposed under the Act. Through the SMART Act, specifically Section 42 USC 1395y(b)(8), the regulatory language surrounding CMPs of $1000 per day per claim for noncompliant RREs was modified to provide that such CMPs/penalties would be "up to $1000 each day of noncompliance with respect to each claimant."

In other words, the SMART Act allowed for CMPs to be discretionary rather than mandatory. In order to set parameters around CMS' discretion on safe harbors from such CMPs, Medicare would need to lay out such safe harbors for RREs to determine when CMPs should be issued and the monetary amount of such CMP. Back in 2013, CMS issued an Advanced Notice of Proposed Rulemaking (ANPRM) regarding these safe harbors, but for the past five years has taken no further regulatory action until now.

If Medicare begins auditing RREs through their Recovery Audit Contractors (RAC Audits) or other methods, NGHP entities would be wise to revisit the efficiency and accuracy of their current Medicare (Section 111) Reporting platform and process. While it may take a couple of years for regulations to pass and RAC Audits to begin, IT initiatives of this scale are slow moving. Cleaning up late and/or under reporting of claims from over 8 years of historical claim data can no doubt be a tedious process. The industry can be certain that once the NPRM is complete and comments are collected from the industry, CMS will eventually issue a final rulemaking which will then allow for civil monetary penalties against noncompliant RREs.

Regarding the criteria and practices in which CMS can issue a CMP, it is anticipated that the NPRM will include safe harbors for RREs which can evidence good faith efforts to report or report properly. However, in scenarios where RREs have failed to either register as an RRE or report reportable claims, or scenarios in which there is improper termination of Ongoing Responsibility for Medical (ORM), the RRE will likely be subject to CMPs.

Since reporting has been ongoing in earnest since 2011, it is anticipated that compliant organizations will have taken the necessary steps to manage all aspects of Mandatory Insurer Reporting. This would include coordinating the proper RRE registration for all primary payers, and capturing the Big 5 data elements so applicable bodily injury claims can be queried by CMS to determine Medicare eligibility. To ensure all applicable reporting triggers are in place for ORM and Total Payment Obligation to Claimant (TPOC) events, claims should be systematically or manually screened. Claims that qualify for necessary coding must be examined for correct ICD coding. Response files from CMS that contain errors should be addressed immediately.

In conclusion, both NPRMs on Section 111 CMPs and LMSAs are sure to permanently change the landscape of MSP compliance in 2019. Primary payers of workers' compensation, no-fault, and liability insurance should begin preparing comments and feedback to CMS when the NPRMs are issued and additionally align best practices now to ensure MSP compliance.