Verisk™

Medicare 2024 Watch List

Tune-Up Your Compliance Practices to Address CMS's Evolving Changes

By Mark Popolizio, J.D. | VP MSP Compliance

Table of contents

As we enter 2024, insurers face an increasingly complex and changing Medicare Secondary Payer (MSP) compliance landscape. Reevaluating your MSP compliance protocols will be critical in the new year to meet the growing challenges and stay compliant. Understanding how recent updates from the Centers for Medicare and Medicaid Services (CMS) have changed MSP compliance, and what may be ahead in 2024, is an important first step.

Toward this objective, our 2024 Watch List report presents an interesting mix between recent CMS updates which should be on your compliance radar, along with items to watch going forward. As the new year settles in, there is certainly no shortage of CMS updates to consider. For example, on the Section 111 front, insurers will need to navigate CMS's recently released Section 111 civil money penalties to avoid potential fines. There are also new CMS updates regarding the on-going responsibility for medicals (ORM) reporting trigger, while CMS's new Unsolicited Response File is underway. Also, the industry awaits more information regarding CMS's plans to use Section 111 reporting to collect WCMSA data. In other areas, CMS conditional payment recovery claims and Treasury actions continue to increase, while Medicare Advantage enrollment has now topped 50% nationally. In addition, recent changes to CMS's Amended Review process could help insurers reduce workers' compensation Medicare set-aside allocations in the coming year. Meanwhile, a new bill in Congress proposes to repeal the private cause of action ("double damages") provision for non-group health plans.

Our latest Watch List report outlines the above items (and more) for consideration in the new year.

1. Navigating Section 111 penalties—staying compliant and avoiding fines

Perhaps the biggest news on the Medicare Secondary Payer (MSP) front in 2023 was CMS's release of its long awaited Section 111 civil money penalties (CMPs). CMS's final rule was released in the Federal Register in October 2023 at Fed. Reg. Vol. 88, No. 195, at 70363-70373 (October 11, 2023). In addition to the final rule document, CMS released an Alert (dated October 10, 2023) and a FAQ resource (dated November 2, 2023) regarding Section 111 CMPs. Further, CMS held its first CMPs webinar on January 18, 2024.

CMS's final rule constitutes the agency's official regulations to enforce Section 111's "up to a $1,000 per day, per claim" penalty provision under the MSP statute.[1] Adjusted annually for inflation, the current daily CMPs amount is now $1,428.[2] The final rule adds regulatory provisions codified at 42 CFR Part 402 (Civil Money Penalties, Assessments and Exclusions) and 42 CFR Part 405 (Adjustment of Civil Money Penalties for Inflation). The final rule applies to both non-group health plans (NGHP) and group health plans (GHPs). This report focuses on the CMPs only from the NGHP context.

Heading into 2024, it is critical for insurers to understand CMS's Section 111 penalties, how they will impact Section 111 compliance, and some of the key items to monitor in the new year. Toward these objectives, the following general overview is provided:

CMS did not finalize two CMPs proposals

We start off with some good news for insurers – CMS decided not to finalize two initially proposed CMPs in the final rule. Specifically, CMS did not finalize its initial proposal to penalize NGHP Responsible Reporting Entities (RREs) in situations when the RRE's response to CMS recovery efforts contradicts the RRE's Section 111 reporting and instances where the RRE's Section 111 reporting exceeds a proposed 20% error tolerance threshold in any four out of eight consecutive reporting periods.[3] In eliminating these two proposals, CMS notes, in part, that "[t]he final rule removes all references in the proposed rule to 'contradictory reporting' or 'exceeding error tolerance' as a reason to impose a CMP. Specifically, any references to an applicable plan providing contradictory reporting, and any CMPs imposed as a result, which were proposed … are removed and are not being finalized."[4] Thus, these two initial proposals are no longer potential bases for Section 111 penalties.

RREs may be penalized for untimely TPOC and ORM reporting

Under the final rule, CMS may impose a CMP for untimely TPOC and ORM reporting. Specifically, per 42 CFR § 402.1(22)(i), CMS may impose CMPs when the RRE "[f]ails to report any beneficiary record within 1 year from the date of the settlement, judgment, award, or other payment, or the effective date where on-going payment responsibility for medical care has been assumed by the entity." Id.

CMS has provided important commentary regarding how it plans to measure non-compliance with respect to this regulation. First, CMS states that "[n]oncompliance is defined as any time CMS identifies a new beneficiary record that was not reported to CMS timely. Timeliness is defined as reporting to CMS within 1 year of the date a settlement, judgment, award, or other payment determination was made (or the funding of a settlement, judgment, award, or other payment, if delayed), or the date when an entity's [ORM] became effective."[5] Second, CMS notes that "[t]he record must be accepted by CMS, and not rejected due to error, to be considered successfully reported" and that 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."[6]

Regarding timely TPOC reporting, CMS will compare the date of an RRE's file submission with one of two potential dates submitted as a part of the RRE's TPOC report.[7] The first of those dates is simply the TPOC Date. The second of those dates, when applicable, would be the Funding Delayed Beyond TPOC Start Date ("the funding of a settlement, judgment, award, or other payment, if delayed").[8] Per CMS, the Funding Delayed Beyond TPOC Start Date is only required to be reported in scenarios when full distribution/disbursement of funds from the TPOC are delayed more than 30 days subsequent to the TPOC Date.[9] In such a scenario, the Funding Delayed Beyond TPOC Start Date should represent the date as of which the TPOC has or will be fully funded.[10]

In situations where only a TPOC Date is reported by the RRE, CMS indicates that it will compare the RRE's file submission date with the TPOC Date and, in the event that the TPOC date is greater than 1 year prior to the file submission date, the TPOC report in question may be subject to the assessment of a penalty due to the RRE's failure to report in a timely fashion.[11] In the event that a Funding Delayed Beyond TPOC Start Date is also reported, CMS states that it will utilize that date ("the funding of a settlement, judgment, award, or other payment, if delayed"), as opposed to the TPOC Date, to assess the timeliness of the report. If the Funding Delayed Beyond TPOC Start Date is found to be more than 1 year prior to the RRE's file submission date, the TPOC report in question may be subject to the assessment of a penalty.[12]

Regarding timely ORM reporting, CMS will look to compare the date of the RRE's file submission with the date upon which the RRE assumed ORM.[13] Interestingly, while CMS indicates it will measure CMPs from the date the RRE "assumes" ORM, at present, CMS only collects the Date of Incident via the Section 111 process. On its webinar, CMS stated that it will calculate timeliness of ORM reporting by comparing the Date of Incident with the date of the RRE's initial successful ORM submission, and if the Date of Incident is found to be more than one year prior to the date of the initial successful report, the RRE would be considered non-compliant and potentially subject to a penalty.[14] CMS also noted that in situations where there is a delay in an RRE's initial report of ORM, the RRE should present mitigating evidence to CMS as part of the informal notice process in support of the reason(s) for the delayed report.[15]

Penalty Calculation

In a nutshell, the longer an RRE is delayed in successfully submitting a required report, the steeper the CMPs amount. Specifically, CMS will calculate CMPs using the following three-tiered approach: **Tier 1:** $357 (adjusted annually for inflation) for each calendar day of noncompliance, where the record was reported 1 year or more, but less than 2 years after, the required reporting date; **Tier 2:** $714 (adjusted annually for inflation) for each calendar day of noncompliance, where the record was reported 2 years or more, but less than 3 years after, the required reporting date; and **Tier 3:** $1,428, (adjusted annually for inflation) for each calendar day of noncompliance, where the record was reported 3 years or more after the required reporting date.[16] Further, the maximum penalty for any single instance of non-compliance will not exceed $365,000 (also to be adjusted annually for inflation).[17] Click here to view the full text of how CMS's penalty amount will be calculated regarding NGHP RREs per 42 CFR § 402.105(b)(3).

Records Review/Audit Process

In what was perhaps a surprise to many, CMS in the final rule notes that it will review only a total of 1,000 coverage records per calendar year (250 coverage records per quarter), to include both GHP and NGHP submissions.[18] This figure will be divided proportionally based on the total volume of GHP and NGHP coverage records reported during the calendar quarter being evaluated at the time.[19]

CMS will use a "randomized sample of recently added beneficiary records" as part of its audit process.[20] In addition, CMS, as part of its FAQ resource, indicates that its random sampling will also include reported records from sources other than Section 111 reporting stating that "*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." (author's emphasis).[21] CMS, as part of its January 18, 2024 webinar, referenced "self-reports" (coverage records created manually based on phone calls to the Benefits Coordination & Recovery Center, written correspondence, or via case reporting through the Medicare Secondary Payer Recovery Portal) as examples of non-Section 111 records which may be used as part of the audit process.[22]

CMS's intentions to also use sources outside of Section 111 reporting (which, by way of note, is not referenced in the actual final rule) raises several interesting questions for consideration. For example, how will CMS know that the information being used from other sources is accurate? On this point, CMS will take a self-report of coverage information from a variety of sources even though some of these sources may not have appropriate understanding necessary guidelines and processes to provide reliably accurate information. This, in turn, could create scenarios where CMS relies on other less reliable sources versus the information the NGHP RRE provides. Further, how would CMS expect to reconcile discrepancies where there may be conflicting information coming from those different sources? Is this something that CMS would expect to be able to sort out via the informal notice process?

Additional questions include: How will CMS accurately identify the NGHP RRE to which the supposed missing report should have been connected from data received from a source other than the Section 111 NGHP RRE? In this regard, sometimes insurer names provided by an alternate source may be slightly, or even significantly, different than that which is actually utilized by the NGHP RRE via their Section 111 reporting. Many NGHP RREs also have numerous RRE IDs, so how would CMS make a connection to the appropriate RRE ID? Further, if a self-report has been made prior to settlement occurring, which is common to obtain a conditional payment amount, could the record created via the self-report be used as a means to attempt to penalize an RRE for a failure to report if a TPOC is not subsequently submitted via the Section 111 process? If so, that is not necessarily a reliable way to identify a failure to report as situations will occur where a potential settlement may be pending, for which a conditional payment amount could legitimately be sought, but where the settlement may ultimately fail to be reached. Scenarios involving settlement/TPOC reporting could be particularly tricky here.

Unfortunately, CMS did not discuss any of these questions as part of its January 18, 2024 webinar. Going forward, we will need to monitor whether CMS addresses these questions as part of future guidance documents and/or webinars.

When CMPs will NOT be imposed

As part of the final rule, CMS also outlined when CMPs will not be imposed. In general, under the final rule's regulatory provisions, CMPs will not be imposed in situations where (i) the RRE has met its "good faith" compliance safe harbor,[23] (ii) has otherwise complied with existing thresholds or other exclusion apply,[24] and (iii) in certain limited instances where there has been a new CMS policy or procedural changes.[25] In addition to the above, CMS as part of its commentary in the final rule, also indicates that time delays caused by CMS or its contractors will not result in CMPs. On this point, CMS states that "we also wish to convey that time delays caused by CMS or its contractors in the reporting process will not trigger penalties related to timeliness, RREs must adhere to all applicable timelines, but any delay encountered when following CMS's policies and procedures will not be held against the RRE (for example, time delays related to processing by CMS contractors will not trigger any penalty)."[26]

"Good Faith" compliance safe harbor

As a refresher, in general, under CMS's good faith compliance safe harbor CMS will not impose CMPs against NGHP RREs in situations where an RRE is unable to obtain certain identifying information from the claimant to determine Medicare status and Section 111 reporting obligations. It is important to note that CMS made slight changes to its "good faith" compliance safe harbor in the final rule.

Regarding these changes, CMS states: "In the final rule, we are expanding this exemption. Specifically, as proposed in the proposed rule, NGHPs must make a total of three attempts to obtain the required information. At least two attempts to obtain the required information from the individual and his or her attorney must be by mail or electronic mail, but the final rule permits that the third attempt may be via telephone, electronic mail, or some other reasonable method."[27] Further, CMS notes that under its updated criteria "should an individual or their attorney or representative clearly and unambiguously decline to provide the information requested, no further attempts by the RRE to obtain the required information would be required."[28]

With this background noted, CMS's updated and finalized good faith compliance safe harbor criteria is outlined in 42 CFR § 402.1(c)(ii)(A). Under this regulation, CMS will not impose a CMP in situations where a NGHP RRE "fails to report required information as a result of [the NGHP RRE's] inability to obtain an individual's last name, first name, date of birth, gender, Medicare Beneficiary Identifier (MBI), Social Security Number (SSN), or the last 5 digits of the SSN, and [the NGHP RRE] has made a good faith effort to obtain this information"[29] by complying with the specific criteria per 42 CFR 402.1(c)(ii)(A), stated in full, as follows:

(1) Has communicated the need for this information to the individual and his or her attorney, or other representative, if applicable, or both.[30]

(2) Has requested the information from the individual and his or her attorney, or other representative (if applicable), at least three times— (i) Once in writing (including electronic mail); (ii) Then at least once more by mail; and (iii) At least once more by phone or other means of contact in the absence of a response to the mailings.[31]

(3) Has not received a response or has received a written response clearly indicating that the individual refuses to provide the needed information. Should the applicable plan receive a written response from the individual or their attorney or representative that clearly and unambiguously declines or refuses to provide any portion of the information specified herein, no additional communications with the individual or their attorney or other representative are required.[32]

(4) Has documented its efforts to obtain the MBI or SSN (or the last 5 digits of the SSN). This documentation, including any written rejection correspondence, must be retained for a minimum of 5 years.

As part of its January 18th webinar, CMS discussed the above in general terms, referencing the requirement of three attempts and noting that the RRE can stop requesting this information if they receive a written response that "clearly and unambiguously" reflects that this information will not be provided. Of note, CMS did not undertake an exacting review of the regulatory language or address some specific points which have raised concerns with some RREs. For example, CMS did not comment on the regulatory language requiring the RRE to request the information from both the claimant and his or her attorney, or other representative which, from the author's experience, has raised concerns with some RREs about contacting a represented claimant. As another example, CMS did not make comments regarding whether the three attempt methods referenced in the regulation had to be made in a specific order, which is another question the author has received from RREs.

Heading into 2024, NGHP RREs should consider reviewing their current protocols to assess if they need to be revised to comport with CMS's finalized good faith compliance safe harbor criteria as stated above.

Notice/Appeal

CMS will give NGHP RREs notice of potential CMPs, and RREs will have a right to appeal CMS penalties. CMS will first provide RREs with an informal written pre-notice of a potential CMP. This letter will be e-mailed to the RRE's Authorized Representative with a "cc" copy sent to the RRE's Account Manager.[33] Once a pre-notice is issued, RREs will then have 30 calendar days to present mitigating evidence.[34] CMS encourages RREs to submit mitigation evidence for its consideration.[35]

From there, if CMS determines a CMP should be imposed, it will send the RRE a formal written notice, via certified mail, advising what triggered the proposed CMP, the amount of the proposed CMP, and that the RRE has the right to appeal.[36] As of the time this report was drafted, CMS had not advised to whom it will send the formal notice, although it would seem logical that this notice would also go to the RRE's Authorized Representatives, with a possible copy to the Account Manager, using the physical addresses maintained in the RRE's Section 111 profile report. We will need to see if CMS provides additional information on this item going forward.

RREs will be able to appeal CMPs through the formal appeals process outlined under 42 CFR § 402.19 and 42 CFR part 1005.[37] On this point, CMS notes that "[i]n broad terms, parties subject to CMPs will receive formal written notice at the time penalty is proposed. The recipient will have the right to request a hearing with an Administrative Law Judge (ALJ) within 60 calendar days of receipt. Any party may appeal the initial decision of the ALJ to the Departmental Appeals Board (DAB) within 30 calendar days. The DAB's decision becomes binding 60 calendar days following service of the DAB's decision, absent petition for judicial review."[38]

Statute of Limitations

In the final rule CMS states that it "will apply the 5-year statute of limitations (SOL) as required by 28 U.S.C. § 2462. Under 28 U.S.C. § 2462, we may only impose a CMP within 5 years from the date when the noncompliance occurred."[39] On the webinar, CMS confirmed that it will use the 5-year SOL under 28 U.S.C. § 2462 and stated that clock begins to run when the record is actually reported, or when it obtains information that could reasonably lead to the discovery of noncompliance.[40]

Effective Date/Application Date/Scope

The Federal Register states that final rule is "effective" on December 11, 2023 (thus, the rule is now in "effect"), while October 11, 2024 is the rule's "applicability date."[41] In relation to this, CMS issued an Alert stating, in part, that "RREs are expected to be compliant with their [Section 111 reporting requirements] no later than October 10, 2024, or they may be eligible for a CMP."[42] Further, CMS in its FAQ resource notes that the "earliest a CMP may be imposed is October 2025."[43]

During its recent webinar, CMS reiterated the above dates and also provided some additional information. Specifically, CMS noted that October 11, 2024 (the rule's "applicability date") is the date the clock will begin ticking for calculating timeliness of an RRE's submissions, while October 11, 2025 is the date when it will begin its compliance review. In addition, CMS noted that April 1, 2026 is the date that quarterly randomized audits of RRE's coverage records submitted via the prior calendar quarter will commence.[44]

As noted above, CMS on the webinar stated that October 11, 2024 is the date the clock will start running in terms of calculating timeliness of submissions. In addition, CMS stated that only coverage record submissions with coverage effective dates or TPOC dates of October 11, 2024, or later would be in scope for penalties and, as such, the agency would not seek to assess penalties for submissions where the coverage effective dates or TPOC dates occurred prior to October 11, 2024.[45]

It is interesting to note that CMS' intention to use the rule's applicability date to assess timeliness, as referenced on the webinar, is information that has not been published in the Federal Register or CMS's related CMPs publications to date. Further, this information, in certain respects, appears to contradict information published in the final rule.

On this latter point, in Part II of the final rule (Provisions of the Proposed Rule and Analysis of and Responses to Public Comments), CMS indicates that it will use the rule's effective date as the basis to assess which claims may be in scope for penalties. For example, in one part of this section, CMS states that "CMPs will only be imposed on instances of noncompliance based on those settlement dates, coverage effective dates, or other operative dates that occur after the **effective date** of this regulation and as such, there will be no instances of inadvertent or de facto retroactivity of CMPs."(authors' emphasis).[46] While in another part of the same section, CMS states that "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." [author's emphasis].[47]

In both these instances, CMS's statements reference the rule's "effective" date, and not the rule's "applicability" date, as the basis to measure timeliness. From another angle, it also interesting to note that these statements would appear to lead to different results in terms of which claims may be in scope for CMPs. For example, in looking at the first passage above, this verbiage would seem to indicate that any coverages for which settlement or coverage effective dates occur prior to the 12/11/23 effective date of the rule would not be in scope for penalties. By contrast, the second excerpt above could be read to indicate that the 1-year timely reporting window would be calculated based on the latter of the rule effective date or settlement or coverage effective dates. Thus, this could be interpreted to imply that settlement or coverage effective dates occurring prior to the rule effective date are in scope for assessment of penalties but that the clock doesn't begin ticking in terms of timely reporting of those coverages until the rule effective date.

When the dust settles, this sets up an interesting situation where there may be a conflict between CMS's oral webinar statements regarding the scope question, and the actual published verbiage in the final rule. This, in turn, raises the issue of what information provided by CMS controls the question, especially given that CMS issues a disclaimer at the start of its webinars emphasizing that its published guidance takes precedence in situations where the information it provides during a webinar may conflict with what is stated in its published materials.

CMS to release additional guidance

As part of its January 18, 2024 webinar, CMS noted that it plans to issue an updated NGHP User Guide and that a new CMS.gov webpage will also be developed in the future specific to the CMPs process. CMS also noted that it plans to hold additional CMPs webinars. Going forward, it will be important to monitor this additional information to see if CMS clarifies some of the outstanding issues noted above and for any new CMS guidance, CMS may add to its final rule. In the interim, CMS directs NGHP RREs to submit questions or comments to CMS's resource mailbox: sec11cmp@cms.hhs.gov

Section 111

Penalties are now live... Are you ready?

Resource: Verisk's Section 111 CMPs resources

Verisk services: MSP Navigator® | Section 111 Audit

2. Breaking down CMS's new ORM updates and how they impact reporting

In 2023, CMS made two important changes to the on-going responsibility for medicals (ORM) reporting trigger which RREs should note as they update their compliance protocols. These updates involve (i) a key change to when ORM is considered "assumed" for reporting purposes and (ii) the ORM "termination date" in situations where RREs obtain a physician statement per CMS's Special Exception. Each of these updates are outlined in turn as follows:

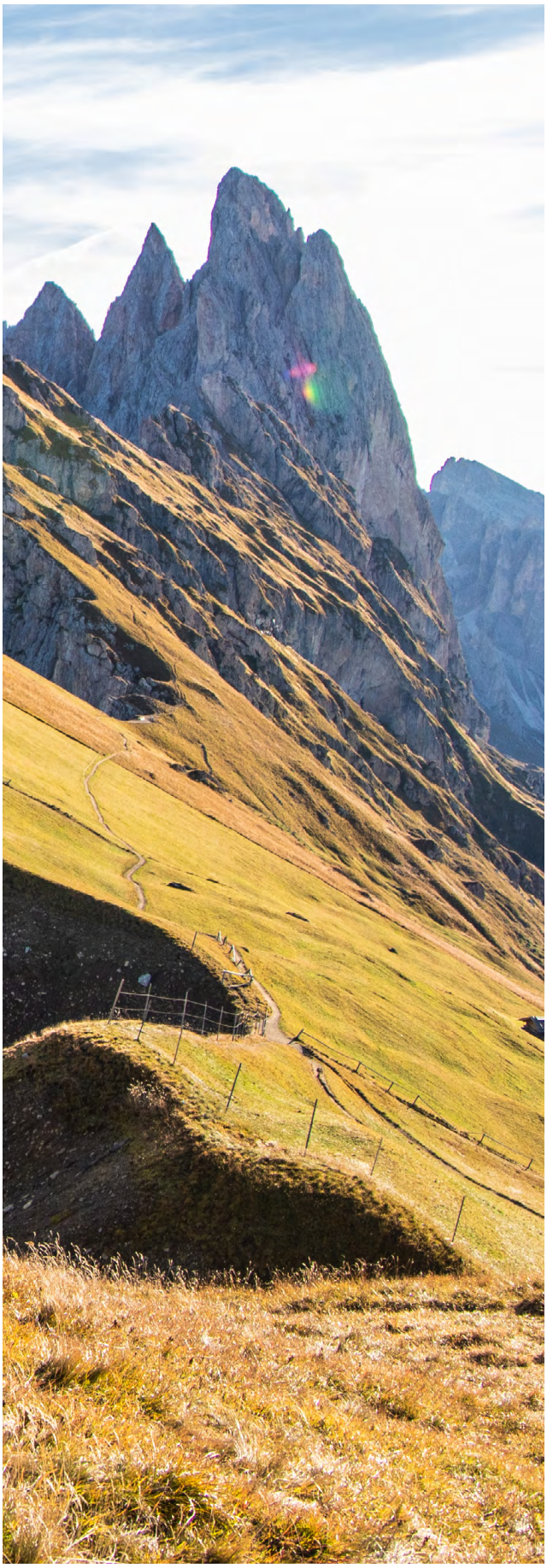
ORM reporting trigger – updates

As noted, CMS made various changes to its longstanding definition regarding when ORM is considered "assumed" for Section 111 reporting purposes last year. In June 2023, CMS initially released a short-lived update to its ORM definition as part of its Section 111 NGHP User Guide (Version 7.2, June 5, 2023) release. In August 2023, CMS then modified this change through its Section 111 NGHP User Guide (Version 7.3, August 7, 2023) update.[48]

With this background noted, CMS's current definition of ORM (as updated) per the User Guide 7.3 changes is stated, in main part, as follows:

> The trigger for reporting ORM is the determination to assume ORM by the RRE, which is when the RRE learns, through normal due diligence, that the beneficiary has received (or is receiving) medical treatment related to the injury or illness sustained. Required reporting of ORM by the RRE does not necessarily require the RRE to have made payment for Medicare-covered items or services when the RRE assumed ORM, nor does a provider or supplier necessarily have to have submitted a claim for such items or services to the RRE for the RRE to assume ORM. The effective date for ORM is the DOI, regardless of when the beneficiary receives the first medical treatment or when ORM is reported.[49] (author's emphasis).

The underlined language above is the key (and important) definitional change made by CMS to the ORM reporting trigger which RREs should note as we enter the new year. While a historical analysis into CMS's ORM reporting trigger is beyond the scope of this article, in general, the addition of the underlined verbiage basically now refines the definition of ORM assumption in a key respect. Specifically, under CMS's prior definition of ORM, an RRE was considered to have assumed ORM simply when they had made the "determination to assume ORM" or were "otherwise required to assume ORM" – regardless of whether the claimant received medical treatment. See e.g., Section 111 NGHP User Guide (Version 7.1, April 24, 2023) Chapter III, Section 6.3.[50]



However, per CMS's updated definition of ORM, an RRE's "determination to assume ORM" is now specifically defined as "*when the RRE learns, through normal due diligence, that the beneficiary has received (or is receiving) medical treatment related to the injury or illness sustained.*"[51] (author's emphasis). Thus, through this update CMS essentially eliminated the need to report ORM in scenarios where no medical treatment has been received in connection to the incident in question. Of note, CMS has not provided any further guidance as to what may be considered "through normal due diligence" as used in this context. As such, going forward, this will appear to be a judgment call for RREs to make.

It is also important to note that CMS's updated ORM definition still retains language reflecting that actual payments to do not have to be made for an RRE to have assumed ORM – which has been part of CMS's ORM reporting trigger from the start of the Section 111 reporting process. Specifically, as noted above, the updated language contains, similar to prior versions of this section, the following verbiage: "required reporting of ORM by the RRE does not necessarily require the RRE to have made payment for Medicare-covered items or services when the RRE assumed ORM, nor does a provider or supplier necessarily have to have submitted a claim for such items or services to the RRE for the RRE to assume ORM."[52]

On this point, this language (and the concept that ORM is assumed without an RRE making payment, or without a provider submitting a claim to the RRE) will likely continue to raise questions for RREs in terms of what CMS may expect from RREs to determine whether the claimant has actually received medical treatment. As noted above, the new verbiage indicates ORM is assumed, in part, "when the RRE learns, through normal due diligence, that the beneficiary has received (or is receiving) medical treatment related to the injury or illness sustained." However, as noted, CMS has not provided any further guidance as to what may constitute "through normal diligence." Thus, the question that appears to remain is, if the assumption of ORM does not require an RRE to have received a claim for items or services, or that an RRE has made payment in relation to any claim for items or services, what are CMS's expectations relating to additional efforts expected of an RRE to appropriately determine whether treatment has been received? It will be interesting to see if CMS provides further clarification on this point in the new year.

Going forward in 2024, it will be important for RREs to understand the above updates CMS has made to the ORM reporting trigger to make sure Section 111 reporting compliance protocols are up to date. Further, understanding these changes is also important from a Section 111 penalties standpoint since, as discussed above, these changes could have potential CMPs implications for RREs.

Resource: CMS's ORM trigger updates (Section 111 NGHP User Guide Version 7.3)

ORM termination – physician statement (ORM termination "date")

Another important Section 111 change is CMS's recent update to what constitutes the "ORM termination date" when an RRE terminates ORM based on a physician statement per CMS's "Special Exception." CMS introduced these recent changes in June 2023 as part of its Section 111 NGHP User Guide (Version 7.2, June 5, 2023) update.

As a quick refresher, CMS's "Special Exception" states as follows:

> There is a limited 'Special Exception' regarding reporting termination of ORM: Assumption of ORM typically occurs with respect to no-fault insurance (as defined by CMS—see Record Layout descriptor for CMS' definition) or workers' compensation. Because this may involve all levels of injury, the above rule could result in the continuation of open ORM records even where, as a practical matter, there is no possibility of associated future treatment. An example might be a relatively minor fully healed flesh wound that occurred in a State where workers' compensation requires life-time medicals. To address this situation, RREs may submit a termination date for ORM if they have a signed statement from the injured individual's treating physician that the individual will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or otherwise subject to a claim for further payment. If, in fact, there is a subsequent reopening of the claim and further ORM, the RRE must report this as an update record with zeroes or a new date in the ORM Termination Date (Field 79). Section 111 NGHP User Guide (Version 7.3), Chapter IV, Section 6.7.1. (author's emphasis).

CMS's recent update relates to the underlined verbiage of the Special Exception by outlining the ORM termination date to be used by an RRE when it can obtain a "physician statement" (in accordance with the above stated requirements) outlined by CMS as follows:

- Where the physician's statement specifies a date as to when no further treatment was required, that date should be the reported ORM termination date;
- Where the physician's statement does not specify a date when no further treatment was required, the date of the statement should be the reported ORM termination date;
- Where the physician's statement does not specify a date when no further treatment was required, nor is the statement dated, the last date of the related treatment should be used as the ORM termination date.[53]

Headed into 2024, this is another important ORM-related change which RREs should note to make sure they are using the appropriate ORM termination date in situations where they have a basis to terminate ORM under CMS's Special Exception as outlined above.

CMS's new

ORM updates should be on the map in the new year.

Resource: CMS's ORM termination updates (Section 111 NGHP User Guide Version 7.2)

Verisk services: MSP Navigator® | Section 111 Audit

3. Getting ready for CMS's new TPOC/WCMSA reporting process

An important 2024 watch list item is CMS's upcoming plans to collect workers' compensation Medicare set-aside (WCMSA) data through its Section 111 total payment obligation to the claimant (TPOC) reporting trigger.[54] This new process, which will only pertain to certain workers' compensation (WC) cases, is scheduled to begin on April 4, 2025. CMS's plans could have a significant impact on Section 111 reporting and WCMSA compliance, including the use of non-submit and Evidence based Medicare (EBMSA) set-aside arrangements. On November 13, 2023, CMS held an initial webinar (November webinar) to discuss its forthcoming plans. It is anticipated that CMS will release additional information in the new year.

To help prepare for this new change, the below provides a general overview of the information discussed by CMS on its November webinar as follows:

Applicability/Scope

Under this upcoming process, WC Responsible Reporting Entities (WC RREs) will be required to report certain WCMSA data points (outlined below) for claims involving Medicare beneficiaries where a reported TPOC (settlement, judgment, award, other payment) includes a WCMSA arrangement. This new process will not apply to non-Medicare beneficiaries until/unless the claimant is determined to be Medicare eligible. Importantly, WC RREs will need to report the required data points for WCMSAs submitted to CMS for review, as well as for other MSA arrangements or (EBMSAs) which are not submitted to CMS for review. Likewise, CMS has advised that reporting will also be required in situations where ongoing responsibility for medicals (ORM) continues for some injuries associated with the claim, but not others. While CMS's WCMSA submission process will remain optional, CMS has advised that reporting of the required WCMSA data points will not be optional.

In addition, CMS notes that WC RREs will be required to report the applicable data points regardless of whether the settlement meets CMS's current $25,000 WCMSA review threshold (which is a threshold CMS uses separately to evaluate whether it will review a WCMSA proposal). Thus, in other words, the current $25,000 WCMSA review threshold CMS uses for review purposes will not apply to the forthcoming Section 111 WCMSA reporting requirements. Rather, as CMS explained, under its upcoming process the WCMSA data points will need to be reported, regardless of whether CMS's $25,000 WCMSA review threshold is met and whether a WCMSA is submitted to CMS for review. However, as clarified by CMS during the Questions and Answers segment of its November webinar, changes related to the new Section 111 WCMSA reporting requirements will not nullify the agency's longstanding $750 workers' compensation "low dollar" TPOC reporting threshold for physical trauma-based claims. As such, the new requirements will apply only to those claims required to be reported under CMS's Section 111 TPOC reporting threshold guidelines.

WCMSA data points to be reported

CMS has advised that WC RREs will be required to report the following data elements via the Section 111 Claim Input File layout:

- **MSA Amount**
  This will be the total MSA amount and will be required when reporting a workers' compensation TPOC where there has been an associated WCMSA established.

- **MSA Period**
  This will represent the period of coverage, in years, and will be required in any scenario where the MSA amount is greater than $0.

- **Lump/Annuity Indicator**
  This data element will indicate whether the settlement is being paid out via a lump sum or as a part of a structured annuity and will be required in any scenario where the MSA amount is greater than $0.

- **Initial Deposit Amount**
  This data element will only be required for those scenarios in which the settlement is being funded via a structured annuity.

- **Anniversary (Annual) Deposit Amount**
  This data element will be required only in scenarios involving a structured annuity. As part of the Q&A session, CMS indicated that in situations where there is a structured settlement/annuity, the Anniversary (Annual) Deposit Amount is expected to be submitted one time with the initial TPOC report and not on an annual basis.

- **Case Control Number**
  A case control number is created by CMS when they establish a WCMSA within their internal processes. If a WCMSA has been established via the voluntary review process, prior to the Section 111 report having occurred, the RRE will have the ability to submit the associated Case Control Number via the Section 111 report. While this is an optional field, CMS encourages RREs to report it when it may be available as it would be helpful for them in making the connection to the pre-existing WCMSA.

- **Professional Administrator EIN**
  This would be the tax ID of the professional administrator in scenarios where a professional administrator is being utilized after the establishment of the WCMSA. This will also be an optional field, but CMS encourages submission of this information, if possible, when applicable.

Of note, while CMS plans to collect the above data points through the Claim Input File, no changes are planned regarding the Claim Response File layout. However, new Section 111 errors (both hard and soft edits) will be introduced and returned in relation to issues identified with the newly added WCMSA fields. CMS plans to release an updated file layout and additional information on new error codes in early 2024.

CMS also discussed how it will use the information collected. In this regard, CMS noted that a WCMSA record will be posted to the Common Working File (CWF) database which will prevent Medicare from making primary payments in relation to any ICD codes connected to the WCMSA. Also, CMS indicated that notification of the WCMSA would be sent to the beneficiary specifying the process for attestation and exhaustion. CMS also noted that it will continue to facilitate the longstanding voluntary WCMSA process, as they have in the past, while the data collected via Section 111 will serve to supplement that existing process. Further, CMS noted that it has no plans for special or required testing, although RREs interested in testing will be able to do so via the standard predefined Section 111 testing process. CMS will notify RREs when testing becomes available (currently estimated for Fall 2024, though this is subject to change) and encourages RREs to coordinate any testing with their assigned BCRC EDI representative.

Projected implementation timelines

CMS has provided the following high-level estimates regarding its anticipated roll-out of the above changes:

- **Early 2024** – CMS will provide RREs with the updated file layout and newly introduced error codes.
- **October 7, 2024** – The ability to test the new changes will be made available.
- **April 4, 2025** – Final implementation of the new changes/requirements.

Big picture considerations

CMS's plans to capture WCMSA data points as part of TPOC reporting can be viewed as a significant expansion of its Section 111 reporting process. From a Section 111 reporting standpoint, the technical changes to the reporting process as outlined thus far by CMS are significant in nature, although they are relatively straight forward. As discussed above, CMS plans to expand the Claim Input File and will introduce new reporting errors as part of its upcoming changes.

From a WCMSA perspective, it is important to note that CMS's plans to capture WCMSA data points will apply to all WCMSAs – including non-approved MSAs and Evidence based MSAs. As such, CMS will now have better - and unprecedented - visibility into the use of WCMSA arrangements as part of WC settlements. Up until this point, CMS has lacked the ability to know about and track non-CMS approved MSAs or Evidence based MSAs. However, under CMS's planned changes, the agency will now have, for the first time, greater knowledge about, and visibility into, the use of non-CMS approved WCMSA arrangements. Accordingly, going forward, it will be interesting to see how CMS, armed with this new WCMSA information, will use this data to scrutinize or question WCMSA arrangements established outside of its review process and, if this could raise potential issues for claimants (and potentially other parties) per Section 4.3 of CMS's WCMSA Reference Guide.[55] While CMS did not specifically reference such plans as part of this webinar, this will certainly be one of the areas to watch as this new process unfolds and eventually gets implemented.

Looking ahead to 2024, it will be important to closely monitor CMS's plans to capture WCMSA data through the Section 111 process and how these updates will change Section 111 reporting and WCMSA compliance practices. In particular, as noted above, it remains to be seen how CMS may plan to use this information in the WCMSA context, especially in relation to the use of non-CMS approved WCMSAs, and how that could potentially impact continued use of these arrangements going forward.

CMS's upcoming

TPOC/WCMSA data collection process will impact Section 111 and WCMSA compliance.

Latest Updates: CMS's New TPOC/WCMSA Alert

Verisk services: MSP Navigator® | Section 111 Audit

4. Assessing CMS's new Section 111 NGHP Unsolicited Response File "opt-in" process

CMS implemented a new Section 111 feature last year referred to as the **Section 111 NGHP Unsolicited Response File "opt-in" process.** Per CMS, this optional process, which started in July 2023, will "alert [RREs] to [Section 111] records they submitted that were updated by another entity other than the RRE over the last month."[56] Information regarding this process can be found, in main part, as part of CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter IV, Section 7.5 and Chapter V, Appendix F. In addition, CMS held a webinar on June 6, 2023 webinar ("June 2023 webinar") to discuss this process. This new process is only available for file submitters and is not being offered to Direct Data Entry (DDE) reporters.[57]

As part of this process, only beneficiaries or their authorized representative may update a RRE's ORM termination date.[58] These parties may only update the ORM termination date and are not allowed to terminate the ORM coverage record.[59] On this latter point, CMS has advised that if the beneficiary or their authorized representative request to update anything other than the ORM termination date, they will be referred to the RRE for the RRE to evaluate whether the requested update is appropriate.[60] CMS also mentioned that RREs may contact the BCRC Call Center to request off-cycle updates between their Section 111 file submissions and that these updates will also be reflected within the new Unsolicited Response File.[61]

In terms of processing, CMS uses the BCRC Call Center to accept the permitted updates to the Section 111 ORM record from the beneficiary or their authorized representative.[62] On this point, CMS in User Guide Chapter V, Section 7.5 states that the "only entity other than the RRE who can update these records is a BCRC CSR/Analyst on behalf of the (verified) beneficiary, for an access to care issue. ORM is not terminated due to entitlement. Updates made by a BCRC Call Center representative based on a call from the RRE will also be noted in this file."[63] As part of this process, CMS explained that the BCRC Call Center representative will ask the caller a series of questions to determine if the criteria to apply such an update has been appropriately met.[64] Per CMS, these questions include, in part, the following: Is the beneficiary still being treated for their injuries? Is the coverage/case still ongoing? Has the coverage been exhausted? Does the beneficiary have a release from their treating physician?[65] Per CMS, based on the answers to these questions, the BCRC Call Center representative, if deemed appropriate, will apply an ORM Termination Date to the Section 111 ORM coverage record.[66]

For those RREs who have opted into this process, the Unsolicited Response File is available to them on the 2nd Sunday of each calendar month with files returned via the same transmission method already utilized for each RRE's other response files.[67] Regarding the information returned, CMS notes that the "file will cover applied records submitted by the RRE in the last 12 months, and will include the following information: key matching fields, including the last DCN submitted by the RRE; current values for identifying portions of the records in question; the most recent beneficiary entitlement information (though changes to this information will not trigger the NGHP Unsolicited Response File); the source of the update; the reason for the update; [and] the date the record was last changed."[68] RREs can view a more detailed listing of the specific data elements returned as outlined more fully by CMS in Chapter V, Appendix F. In addition, CMS notes certain "fields of interest," along with Tables outlining Modifier Type Code and Modifier, and Change Reason Descriptions as part of Chapter IV, Section 7.5. Further, CMS notes that "if there are no changes to existing records for the most recent reporting period, the file will still be sent but will be empty (header and trailer records only). It will appear in the claim response file folder."[69]

Importantly, CMS has advised RREs that they should review the Unsolicited Response File upon receipt to verify the accuracy of the updated information and, if the update is inaccurate, the RRE should submit a correction on their next Section 111 file.[70] Also, during the June 2023 webinar, CMS received numerous questions about expectations from RREs when erroneous ORM termination dates are identified via the Unsolicited Response File and whether an update should be submitted via Section 111 to correct the erroneous update. Further, CMS was asked if, even in scenarios where the prior Section 111 report was correct, if RREs were expected to send an update even though their reported data had not changed, and if a Section 111 update would be required if the RRE contacted the BCRC Call Center to request the correction of an erroneous ORM termination date. In response to these questions, CMS indicated that an RRE would be expected to submit an update via the Section 111 process in all the above scenarios.[71] In addition, CMS advised that there is not a specific mechanism to prevent flip-flopping of data in scenarios where an ORM termination date is applied erroneously based on a beneficiary/beneficiary representative call where the RRE subsequently corrects the erroneous update.[72] In this situation, BCRC protocol instructs their Call Center Representatives to escalate to a supervisor if such scenarios are noted, but there is nothing to technically prevent flip-flopping of data and the repeated application of the erroneous ORM termination date.[73]

As noted above, this new process is only available for file submitters – and is not being offered to Direct Data Entry (DDE) reporters.[74] Further CMS notes that this process must be performed individually for each participating RRE ID and that it will not allow a large group of RRE IDs to opt into the process en-masse.[75]

CMS outlined the following steps for those eligible RREs interested in opting into this new process:

For new RRE ID registrations – For RREs registering for a new RRE ID, the ability to opt in will be added to the Account Setup portion of the registration process via CMS's Section 111 COBSW.[76] When completing the Account Setup process for a new RRE ID registrants will see a newly added question asking, "Would you like to receive Unsolicited Alerts?" followed by the statement, "Check here to receive Unsolicited Alerts" coupled with a radio button which may be selected by the registrant to opt in.[77]

For existing RRE accounts – These RREs can also opt in via the Section 111 COBSW. In these instances, also beginning in July 2023, RREs will have the ability to opt into the process via the RRE ID Profile Information screen where they will see a new radio button, similar to that outlined above, which may be selected to participate in the new process.[78] Further, CMS advised that the RRE's Account Manager (AM) is the party who should opt an RRE into the Unsolicited Response File process. CMS also noted that there would be a new version of CMS's Section 111 COBSW User Guide, posted within the Reference Materials file menu of the Section 111 COBSW, which will contain more explicit details regarding the opt in process.[79]

From a larger compliance perspective, CMS has advised that the updates made to a RRE's ORM coverage record as part of this process will not directly impact conditional payment recovery cases or CMS's existing recovery processes.[80] Per CMS, only the ORM coverage record which would affect access to care and coordination of benefits would be impacted.[81] In addition, CMS advised that the Unsolicited Response File will not replace the letters that the BCRC currently mails out to RREs when an ORM Termination Date has been reported by a beneficiary or their authorized representative.[82] This longstanding practice will continue.

Looking ahead to 2024, CMS's Unsolicited Response File process will enter its first full year of operation. RREs will need to assess this new process as they reevaluate their compliance practices and decide whether they would like to opt-in to monitor if updates are made to its ORM filings by the beneficiary or their authorized representative. From the author's general observations, many RREs have been slow to opt-in to this process thus far, while many of the RREs who are participating in this process report little to no activity being reported through the Unsolicited Response File. It will be interesting to see if more RREs decide to opt into this process in the new year, and if CMS makes any changes to this process.

CMS's Unsolicited Response File

Provides RREs with information on ORM updates made by the claimant or their representative.

Resource: CMS's Unsolicited Response File – Q&A and CMS's Webinar (June 2023)

Verisk services: MSP Navigator® | Section 111 Audit

5. Staying on top of rising CMS recovery claims and Treasury actions

Similar to last year, CMS (Medicare Part A and B) conditional payment recovery claims should remain an important focus point in the new year. Along these lines, in April 2023, CMS released its annual report, titled The Medicare Secondary Payer Commercial Repayment Center (CRC) in Fiscal Year 2022, which, once again, indicates that CRC conditional payment recoveries increased.[83]

Specifically, CMS's updated report reflects that CMS (through the CRC's efforts) returned $253.17 million dollars in net collections to the Medicare Trust Fund in FY 2022, up from $246.44 million for FY 2021.[84] Of the $253.17 million returned back to Medicare, CMS notes that "[a] total of $263.94 million of these payments were direct payments (that is, payment received directly from debtors)."[85] CMS further indicated that "[a] total of $83.16 million of these payments were collections made by the Department of Treasury on delinquent debts and processed by the CRC during FY 2022."[86] Further, CMS reports that $48.15 million in excess collections were identified and refunded to the identified debtors (excess collections can occur when the debtor fails to respond in a timely manner.)[87] CMS's agency administrative costs are noted as $45.77 million (including contingency fees paid to the CRC).[88]

As for other findings, CRC nominal net collections increased by 4% in FY 2022 compared to FY 2021.[89] In addition, demand volume increased by 21% in FY 2022, although demand amount decreased by 24% in FY 2022.[90] The report does not provide information regarding potential reasons behind the noted decrease in demand amounts. Further, the study notes that the CRC issued 91,178 demand letters relating to 101,240 individual beneficiaries, representing $793.51 million in potential mistaken and conditional payments made by Medicare during the FY 2022.[91] Of this amount, CRC validated $441.71 million "as correctly identified mistaken and conditional payments to be recovered" for both GHP and NGHP ORM claims.[92] Regarding these latter figures, there continues to be a significant difference between amounts identified and validated. This was also the case in FY 2021 where CRC identified more than $1.04 billion in potential conditional payments but validated only $539.87 million of that amount.[93] It remains unclear if the continued difference between identified versus validated amounts is attributable to issues with the CRC's grouper algorithm or the accuracy of an RRE's reported Section 111 data. Regardless, there seems to be room for improvement in this area (once again) as we enter the new year.

In assessing the new data, CRC recoveries, as noted above, increased in FY 2022 over FY 2021 ($253 million vs. $248 million). Further, while Treasury collections only increased slightly in FY 2022 in comparison to FY 2021 ($83 million vs. $82 million), it is important to keep in mind that overall Treasury collections increased a striking 47% from FY 2020 to FY 2021.[94] Thus, although Treasury collection increased only slightly in FY 2022, the upward trend continues, especially when considering that Treasury collections were $55 million in FY 2020.[95] This continuing trend coincides with our general experience of increasing Treasury collection actions (including Treasury offsets) over the past few years.

Looking ahead to 2024, it will be important for insurers to reassess current CMS conditional payment protocols to make sure CMS recovery claims are addressed and resolved in a timely manner. In this regard, keep in mind that CMS and its contractors, based on our experience, continue to strictly adhere to applicable deadlines to dispute and appeal CMS recovery claims. Thus, it is critical that insurers have practices in place to ensure that these timelines are met, as failure to respond timely to CMS recovery claims could impair, or extinguish, an insurer's ability to challenge or appeal a CMS recovery claim. Further, not adhering to CMS's deadlines could also result in Treasury collection actions, including Treasury offsets.

Proactive practices are

Key to stay compliant, reduce costs, and avoid Treasury claims.

Verisk services: CP Link® | Conditional Payment Services | Treasury Services

6. Medicare Advantage recovery claims — avoiding "double damages"

Headed into 2024, Medicare Advantage Plans (MAPs) is another topic which should be on the radar again this year as this program's popularity continues to rapidly grow and insurers face increasing MAP recovery actions (including claims for "double damages").

Of significance, updated data reflects that Medicare Advantage enrollment has now eclipsed traditional Medicare enrollment for the first time in program history. **Specifically, nearly 31 million Medicare beneficiaries (or roughly 51% of all Medicare beneficiaries nationwide) are now enrolled in a MAP.**[96] In the big picture, the fact that more Medicare beneficiaries are now enrolled in a MAP versus traditional Medicare falls in line with a steady increase in MAP growth over the past 15 years or so. For example, in 2007, only 19% of all Medicare beneficiaries were enrolled in a MAP.[97] However, ten years later this figure had increased to 38%, while by 2022 MAP enrollment hit 48%.[98] Of note, virtually all Medicare beneficiaries (99.7%) now have access to a MAP as an alternative to traditional Medicare.[99]

Looking at MAP enrollment by state, three states, Alabama, Hawaii, and Michigan, now have MAP enrollment rates of 60%, while 94% of all Medicare beneficiaries in Puerto Rico are enrolled in a MAP.[100] Meanwhile, 26 states have MAP enrollment rates of at least 50%,[101] including California (55%), Florida (58%), New York (54%), and Texas (55%).[102] In terms of plan availability, in 2024 there are 3,959 MAPs available nationwide for individual enrollment, which is actually a 1% decrease (39 fewer plans) than offered in 2023.[103] Overall, the average Medicare beneficiary will have access to 43 MAPs in 2024.[104] While this figure is the same as 2023, it is still more than double the number of MAP plans offered in 2018.[105] It is also reported that three companies (Champion Health Plan, Peak Health, and Verda Health Plan of Texas) have entered the MAP market for the first time in 2024, while thirteen firms exited the market.[106] Overall, MAP enrollment continues to be concentrated in two main providers -- UnitedHealthcare and Humana. For example, UnitedHealthcare and Humana accounted for nearly half (47%) of all MAP enrollees in 2023, broken down as follows: UnitedHealthcare had 8.9 million enrollees (or 29%) and Humana had 5.5 enrollees (or 18%) in 2023.[107] Meanwhile, Blue Cross/Blue Shield had 4.4 million enrollees (or 14%) in 2023.[108]

Turning to MAP compliance considerations, it will be important to monitor the courts to see if any additional courts issue rulings allowing MAPs to sue insurers for "double damages" under the MSP's private cause of action (PCA) statute in the new year.[109] On this front, it is significant to note that three United States Circuit Court of Appeals have ruled that the MSP's PCA statute applies to MAPs. Specifically, the Third, Eleventh, and Second Circuits have ruled that MAPs can sue insurers for "double damages" under the PCA statute in In re Avandia, 685 F.3d 353 (3rd Cir. 2012), Humana v. Western Heritage Insurance Co., 832 F.3d 1229 (11th Cir. 2016), and Aetna Life Insurance Company v. Big Y Foods, Inc., 52 F.4th (2nd Cir. 2022), respectively.[110] Of note, the 11th and 2nd Circuit Courts also levied "double damages" against the insurers

as part of their rulings. In addition to the U.S. Circuit Courts noted above, several United States District Courts have also ruled that MAPs can bring PCA claims against insurers.[111]

As the ability of MAPs to sue under the PCA statute takes hold in a growing number of jurisdictions, the courts are being called upon to address related questions which also warrant monitoring in the new year. For example, in 2023 several courts addressed whether an insurer's Section 111 reporting provides a MAP with standing to sue under the PCA statute. While a complete review of standing in relation to the PCA statute is beyond this report's scope, very generally, several courts in 2023 ruled, in part, that an insurer's Section 111 reporting alone was insufficient to establish standing under the PCA statute.[112] See, MSP Recovery Claims, Series LLC v. Hereford Insurance Co., 2023 WL 2993857 (2nd Cir. April 19, 2023); MSP Recovery Claims Series 44, LLC v. Arbella Mutual Insurance Company, 2023 WL 3481496 (D. Mass. May 16, 2023); MSP Recovery Claims, Series LLC v. Safeco Insurance Company of America, et. al., 2023 WL 3481586 (D. Mass., May 16, 2023); and MSP Recovery Claims, Series LLC v Travelers, 2023 WL 4744753 (D. Connecticut, July 6, 2023);[113] but see, MSP Recovery Claims Series 44, LLC v. Bunker Hill Insurance Company, 2023 WL 4744739 (D. Massachusetts, July 25, 2023) (finding that a MAP's assignee had standing to sue in that case since the complaint alleged facts in addition to an insurer's Section 111 reporting).[114]

Another interesting question that is arising regards which statute of limitations (SOL) applies to MAP recovery claims brought under the PCA statute. While a complete examination into this complex area is beyond the scope of this report, in general, the core question is whether the SMART Act's three-year SOL governs claims brought by MAPs (or their assignees) under the MSP's PCA statute, or whether another SOL provision applies.[115] In a nutshell, the courts, in general, have rendered different opinions regarding this question. For example, some courts have found that the SMART Act's three-year SOL applies to MAP claims brought under the PCA statute.[116] See e.g., Collins v. Wellcare Healthcare Plans, Inc., 73 F.Supp 3d 653 (E.D. La. 2014); MSP Recovery Claims, Series LLC v. Nationwide Mut. Ins. Co, 2022 WL 3572439 (S.D. Ohio July 25, 2022), and MAO-MSO Recovery II, LLC v. Farmers Ins. Exchange, 2022 WL 1690151 (C.D. Cal. May 25, 2022). However, other courts have disagreed. By way of examples, in MSPA Claims 1, LLC v. Tower Hill Prime Insurance Co., 2022 WL 3223801 (11th Cir. August 10, 2022) and MSP Recovery Claims Series 44, LLC v. Bunker Hill Insurance Company, 2023 WL 4744739 (D. Mass. July 25, 2023) the courts in these cases rejected the argument that the SMART Act's SOL applies, ruling, in part, that the SMART Act's limitations period only applies to claims brought by the government, and not private actors suing under the PCA statute. Instead, these courts found that the four-year "catch-all" limitations period contained in 28 U.S.C. § 1658 (a) governs MAP claims under the PCA statute. While these two courts agreed that the four-year SOL under § 1658 (a) applied, it is interesting to note that they differed in terms of how the four-year period was to be measured.[117]

From a practical claims perspective, insurers should review their current MAP compliance protocols to assess if they need to be revised given the current trending. As part of this, it is important to note which jurisdictions have court rulings allowing MAPs to sue insurers for double damages and to watch for possible new rulings from other jurisdictions expanding these rights to MAPs. It is also important to keep in mind that CMS provides critical information regarding a claimant's Medicare Advantage status through the Section 111 Query Process as part of the PAID Act.[118] Specifically, CMS provides Non-Group Health Plan (NGHP) Responsible Reporting Entities (RREs) with important information regarding a claimant's Medicare enrollment status through the Section 111 Query Process, including: the **(1)** contract number, contract name, plan number, coordination of benefits (COB) address, and entitlement dates for the past three years (up to 12 instances) of Part C (Medicare Advantage) and Part D coverage; and **(2)** the most recent Part A and Part B entitlement dates.[119]

Of note, the PAID Act does not require CMS to provide information on potential MAP recovery claims. However, insurers can use the above data, if they elect, to contact the Plans to proactively address potential Medicare Advantage recovery claims. On this point, it is important to remember the PAID Act was prompted in large part by the wave of recent actions filed by MAPs (or suits filed on their behalf by assignee entities) asserting recovery rights, including claims for "double damages," and the insurer's inability to proactively identify claimants who were MAP (or Part D) enrollees. While the PAID Act contains no specific requirements regarding data handling or how the data is to be used, from a practical standpoint, insurers can use this information, if they so elect, to address potential MAP recovery claims to avoid potential double damages lawsuits.

Over

50% of all Medicare beneficiaries are now enrolled in a MAP — is it time to revisit your MAP protocols?

Verisk services: CP Link Paid Act Component | Medicare Advantage Resolution Services

7. Revisiting Medicare Part D recovery

In the bigger MSP compliance picture, Medicare Part D (Medicare's prescription drug program) is often overshadowed by the seemingly endless flurry of activity in the other MSP compliance contexts. Further, comparatively speaking, things have remained relatively quiet on the Part D compliance front. Notwithstanding, insurers may wish to revisit Part D in the new year to make sure they are touching all the MSP bases as they re-evaluate their compliance practices.

To get started, it may be helpful to briefly review key aspects of the Part D program. Very generally, Medicare Part D is a voluntary outpatient prescription drug benefit available to Medicare beneficiaries provided through private plans that contract with the federal government.[120] Beneficiaries can choose to enroll in either a stand-alone prescription drug plan ("PDP") to supplement traditional Medicare, or a Medicare Advantage plan that provides all Medicare-covered benefits, including prescription drugs ("MA-PD").[121]

By the numbers, 50.5 million of the 66 million (90%) of all Medicare beneficiaries were enrolled in a Part D plan in 2023.[122] Of this figure, 56% were enrolled in MA-PDs, while 44% were enrolled in stand-alone PDPs.[123] In 2024, there is a total 709 stand-alone PDPs offered by 11 firms available, which is actually the lowest number of PDPs and firms since the Part D program started in 2006.[124] However, the average Medicare beneficiary still has a choice of close to 60 options for Part D coverage in 2024, including 21 PDPs and 36 MA-PDs.[125] It is also noted that since 2020, the number of PDPs available to the average traditional Medicare beneficiary has decreased by 25% while the number of MA-PDs has increased by 57%.[126]

In 2023, the top three Part D providers were UnitedHealth, CVS Health, and Humana, which covered close to 6 in 10 of all Medicare beneficiaries enrolled in Part D.[127]

In terms of Part D recovery, certain federal statutes and regulations indicate that Part D plans have the same recovery rights as Medicare Advantage Plans (MAPs). For example, 42 U.S.C. § 1395w-102(4) states, in part, that the recovery rights afforded to MAPs "apply in the same manner" to Part D. Likewise, 42 CFR § 423.462 provides that the same "Medicare secondary payer procedures" that apply to Medicare Advantage Plans under § 422.108 also apply to Part D plans. Further, under § 422.108, MAPs may seek reimbursement from claims payers and other parties in workers' compensation, liability, and no-fault cases. This regulation further gives MAPs the same recovery rights as traditional Medicare under the MSP.

In addition to the above, CMS has also released information referencing Part D recovery rights. By way of example, in 2011, CMS issued a policy memo which stated, in part, that Part D plans "have the same MSP rights and responsibilities as Medicare Advantage Plans, including collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities."[128] In 2018, CMS added language to existing provisions contained in its Medicare Prescription Drug Benefit Manual regarding Part D recovery. On this point, CMS added, in part, the following guidance to Part D providers: "Part D sponsors are responsible for identifying and recovering any Coordination of Benefits (e.g. where a Part D sponsor paid for a claim and another payer should have paid), MSP related mistaken payments and submitting associated adjustments to CMS.

Recovery of payments when the sponsor determines no payment at all should have been made or the amount paid was more than it should have been should be sought from the responsible other party. Sponsors should implement processes to handle payment resolution in these situations directly with the primary payer or in limited cases with the beneficiary … [a] claim for a drug that should be paid as MSP may not be submitted or paid as a primary claim by the Medicare plan."[129] Of note, this updated language supplemented existing manual provisions regarding Part D secondary payer concepts which stated, in part, that "Part D sponsors will have the same responsibilities under MSP requirements as [Medicare Advantage] plans, including collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities; and the relationship between MSP rules and State laws. Part D sponsors must properly apply MSP requirements and regulations to their payments (e.g. working aged, worker's compensation)."[130]

Overall, the above authority suggests that Part D providers have recovery rights, although, in the author's experience, these plans have not been as active in asserting these rights in comparison to MAPs. Further, unlike the MAP context, we have not seen the type of litigation and judicial activity (at least thus far) regarding Part D recovery issues. In this regard, an interesting question to consider is whether the courts would find that Part D plans also have the right to sue for "double damages" under the MSP's private cause of action (similar to what their MAP counterparts have been arguing and prevailing upon in certain jurisdictions over the past few years). To the authors knowledge, this precise issue has not yet been directly litigated in relation to a Part D recovery action. However, it is noted that the 3rd Circuit as part of its ruling in Avandia, in which the 3rd Circuit ruled that MAPs could sue insurers for double damages under the MSP's private cause of action statute, also indicated that its ruling would apply to Part D recovery claims. Specifically, the court in Avandia, in an endnote, stated that "… our holding on the meaning of the private cause of action will apply equally to private entities that provide prescription drug benefits pursuant to Medicare Part D."[131]

As we head into 2024, it will be interesting to see if Part D providers will start to pursue recovery claims more aggressively against insurers and other parties. In the interim, it is important to keep Part D in mind when re-evaluating MSP compliance obligations to determine how potential Part D recovery claims should be addressed. In this regard, as outlined more fully in the MAP section above, remember that CMS provides information regarding a claimant's Part D enrollment status through the Section 111 Query process, including, in pertinent part, the contract number, contract name, plan number, coordination of benefits (COB) address, and entitlement dates for the past three years (up to 12 instances) of Part D coverage.[132] Thus, checking the Query results is a good first step to determine a claimant's Part D beneficiary status. From there, insurers can use this data, if they elect, to contact the identified Part D plan(s) to proactively address potential Part D recovery claims, or otherwise determine how potential Part D recovery claims should be addressed and resolved.

Touching all the bases –

Reassessing Medicare Part D recovery.

Verisk services: CP Link Paid Act Component | Medicare Advantage and Part D Resolution Services

8. CMS's Amended Review process can help reduce WCMSAs

In an important development on the workers' compensation Medicare set-aside (WCMSA) front, CMS has removed the maximum time limit for Amended Review submissions.[133] This new (and significant) change should be on the radar as it can potentially provide additional opportunities to reduce prior CMS approved WCMSAs for qualifying cases and get claims settled.

By way of brief background, CMS introduced its Amended Review process in 2017. Generally, Amended Review allows parties a one-time request to submit new medical documentation to adjust a prior WCMSA approval for cases meeting the Amended Review requirements.[134] Prior to CMS's update, CMS limited the time period to file an Amended Submission to six years. However, as noted above, CMS has now removed this time limitation for qualifying cases.[135]

Based on this update, CMS's current Amended Review criteria is as follows: "(i) CMS has issued a conditional approval/approved amount at least 12 months prior; (ii) the case has not yet settled as of the date of the request for re-review; and (iii) projected care has changed so much that the submitter's new proposed amount would result in a 10% or $10,000 change (whichever is greater) in CMS' previously approved amount."[136] If this criterion is met, CMS states that it "will permit a one-time request for re-review in the form of a submission of a new cover letter, all medical documentation related to the settling injury(s)/body part(s) since the previous submission date, the most recent six months of pharmacy records, a consent to release information, and a summary of expected future care."[137] If CMS approves the Amended Review request, "the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased."[138]

While a complete examination into all the potential bases for an Amended Review filing is beyond the scope of this report, in general, reductions in treatment costs or changes in the claimant's treatment regimen may provide a basis to file a new WCMSA using the Amended Review process. In this regard, typical examples include situations where surgeries or procedures for implanted devices have occurred after the original WCMSA approval, the claimant's treatment has stabilized or reduce, changes or reductions in medication resulting in less monthly spend, and reduction in reserves over time. It is important to note, however, that CMS states that "the approval of a new generic version of a medication by the Food and Drug Administration does *not* constitute a reason to request an amended review for supposed changes in projected pricing." (author's emphasis).[139]

From a practical compliance standpoint, CMS's removal of the time limit for Amended Reviews is a significant change that potentially opens new opportunities to settle out claims where a CMS approval or counter-higher prevented claim settlement. Heading into 2024, workers' compensation insurers and other stakeholders should consider reviewing their claims inventory to see if they have any claims that would qualify for Amended Review either on a case by case basis, or perhaps as part of a targeted settlement project.

CMS's Amended Review process can

Open doors to reduce WCMSAs and settle claims.

Resource: CMS's WCMSA Reference Guide (Version 3.9, May 15, 2023)

Verisk services: MSA | MSA 2nd Look | Provider Outreach

9. Will CMS revisit LMSAs in the new year?

All was quiet on the Liability Medicare set-aside (LMSA) front in 2023 following CMS's withdrawal of its future medicals proposals in October 2022. In the big picture, over the past decade, CMS has made what can be considered two significant attempts to establish formal future medicals rules for liability settlements, before ultimately withdrawing its proposals both times.

By way of brief overview, CMS in 2012 issued an Advanced Notice of Proposed Rulemaking (ANPRM) which was the agency's first attempt to establish formal rules regulating future medicals for liability claims.[140] Very generally, CMS's 2012 ANPRM was a complex set of proposed rules governing when and how CMS' future medical interests were to be addressed as part of liability settlements, which included possible plans for a formal LMSA review process.[141] In September 2013, CMS announced plans to release a Notice of Proposed Rulemaking (NPRM) as its next step.[142] However, for unknown reasons, CMS withdrew these proposals in the fall of 2014.[143]

The issue then fell silent until late 2018 at which time the Office of Information and Regulatory Affairs (OIRA) issued a notice advising that CMS was aiming to release a NPRM by September 2019.[144] This projected NPRM release date was then pushed back several times to October 2019, February 2020, August 2020, March 2021, October 2021, and then February 2022.[145]

In terms of CMS's focus, OIRA's Fall 2021 notice (which at the time pushed back the projected NPRM back until February 2022) stated, in part, as follows: "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. This proposed rule would also remove obsolete regulations."[146] Of note, while OIRA's Fall 2021 notice (and some other, but not all, of OIRA's other notices) also referenced no-fault and workers' compensation cases, it was anticipated that CMS's proposals would focus primarily on liability settlements.[147]

In March 2022, OIRA issued another notice this time indicating that CMS had completed its future medicals proposals and had sent them to OIRA for review.[148] However, in October 2022, OIRA released an updated notice advising that CMS's proposals were withdrawn, without explanation and without CMS ever releasing its proposals to the public.[149]

Thus, as we enter the new year, all remains quiet on the LMSA front and it is unknown whether CMS will revisit the issue in 2024. In the meantime, for liability insurers (and other liability stakeholders), it is back to square one, or perhaps more accurately, everything remains at square one, regarding the vexing questions of whether CMS has the right to regulate future medicals as part of liability settlements and, if so, when a LMSA (or some other form of future medicals mechanism) should be included, and how this should be done. Expanding on this latter point, if CMS decides to revisit the future medicals issue, it is important to note that several critical (and nagging) questions remain – just as they have since CMS began talking about regulating future medicals in liability settlements over a decade ago. One such question likely to be raised by many (which surfaced in some of the commentary responses filed regarding CMS's 2012 proposals), involves the extent to which CMS has (or does not have) authority to regulate future medicals for liability claims in the first instance.[150] On this point, it is interesting to note that there have been several recent case decisions calling into question whether the MSP or current federal regulations require LMSAs. See e.g., Silva v. Burwell, 2017 WL 5891753 (D. N.M. 2017); Sipler v. Trans Am Trucking, Inc., 881 F.Supp. 2d 635 (D. N.J. 2012); Bruton v. Carnival Corporation, 2012 WL 1627729 (S.D. Fla. 2012); Abate v. Wal-Mart Stores East, L.P., 530 F.Supp.3d 257 (W.D. Pa. November 30, 2020); and Stillwell v. State Farm, et. al., 563 F.Supp.3d 1195(M.D. Fla., September 27, 2021). Whether CMS will consider these cases and the various points raised by the courts therein going forward is unknown.

From a more practical perspective, several important questions remain. For example, which party should be responsible for complying with any implemented regulations? Which claims should be included (and excluded)? Should there be monetary thresholds? How will CMS account for specific liability claims realities – such as comparative fault, policy limits, caps, and discounted settlements? Will no-fault or med-pay claims be at play? Will there be penalties or other forms of potential liability for improper compliance? Other key questions regarding "how" it would all work also remain, such as whether there would be some form of review/approval process? Would CMS set rules around the calculation of future medical allocations? Would there be rules regarding funding and administration?

Against this backdrop, insurers (and other liability stakeholders) will need to consider how best to consider and address the issue given this unsettled (and unusual) landscape as we wait for CMS's next move.

LMSAs –

Waiting for CMS's next steps.

Resource: LMSAs – back to the drawing board

Verisk services: Liability Claim Tool Kit

10. What's up in D.C.? Keeping an eye on the RAMP Act

An item to watch in Congress this year is the **Repair Abuses of MSP Payments (RAMP) Act.** In May 2023, the RAMP Act was re-introduced into the U.S. House of Representatives as H.R. 3388 and the U.S. Senate as S. 1607 as part of the current Congressional session (118th Congress). The RAMP Act was introduced into the House by Brad Schneider (D-IL) and Gus Bilirakis (R-FL), and the Senate by Senators Tim Scott (R-SC) and Maggie Hassan (D-NH).[151] As outlined below, the RAMP Act proposes to modify the Medicare Secondary Payer (MSP) Act's private cause of action (PCA) statute, codified at 42 U.S.C. § 1395y(b)(3)(A), by eliminating non-group health plans from its application, and limiting its scope to group health plans.

Currently, the MSP's PCA provision reads as follows:

> (3) Enforcement (A) Private cause of action - There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A). 42 U.S.C. § 1395y(b)(3)(A).

The RAMP Act proposes to modify the current version of the PCA statute stated above as follows:

> SEC. 2. PRIVATE CAUSE OF ACTION FOR DAMAGES IN THE CASE OF A GROUP HEALTH PLAN WHICH FAILS TO PROVIDE FOR PRIMARY PAYMENT OR APPROPRIATE REIMBURSEMENT. Section 1862(b)(3)(A) of the Social Security Act (42 6 U.S.C. 1395y(b)(3)(A)) is amended by striking "primary plan" and inserting "group health plan (as defined in 8 paragraph (1)(A)(v))"[152]

The RAMP Act effort is being led, in main part, by the Medicare Advocacy Recovery (MARC) Coalition which, as many will recall, is the same group which was instrumental in securing passage of the Strengthening Medicare and Repaying Taxpayers Act (SMART Act) (P.L. No: 112-242) back in 2012 and, more recently, the Provide Accurate Information Directly Act (PAID Act) (P.L. No. 116-215) in 2021.

MARC's website contains a post titled "MARC celebrates bicameral and bipartisan introduction of the RAMP Act in Congress" which, in support of the RAMP Act, states, in part, as follows: "While the initial MSP laws were created to ensure Medicare doesn't pay when another entity is responsible for paying a beneficiary's claim, the private cause of action never achieved that purpose and has been rendered obsolete by more recent law changes. Since 2007, the MSP statute ensures that every judgment, settlement, and award is reported to Medicare, Medicare Advantage and Part D plans. As such, the private cause of action is no longer necessary. Unfortunately, the private cause of action is preventing beneficiaries from resolving claims, ironically making Medicare the primary payer in cases it should not be."[153]

As noted above, the RAMP Act would eliminate non-group health plans (i.e., workers' compensation, liability, no-fault, and other plans) from the MSP's PCA provision. While a complete examination into all the various types of PCA actions that have arisen recently in the NGHP context is beyond the scope of this report, one area that has seen noted activity involves Medicare Advantage recovery claims. Specifically, as outlined in the Medicare Advantage section of this report, over the past several areas, certain Medicare Advantage Plans (MAPs), or assignees of these plans, have brought several lawsuits against NGHPs seeking "double damages" under the MSP's PCA statute for the NGHP's alleged failure to properly reimburse MAP payments. To date, the United States Circuit Courts of Appeals for the Second, Third, and Eleventh Circuits, in Aetna Life Insurance Company v. Big Y Foods, Inc., 52 F.4th 66 (2nd Cir. October 26, 2022), In re Avandia, 685 F.3d 353 (3rd Cir. 2012), and Humana v. Western Heritage Insurance Co., 832 F.3d 1229 (11th Cir. 2016), respectively, have ruled that the MSP's PCA statute applies to MAPs allowing them to use this provision to sue insurers for double damages. In addition, several U.S. District Courts[154] have similarly ruled that the PCA statute applies to MAP recovery claims. Of note, the court in two cases thus far have awarded "double damages" against the defendant insurer.[155] Outside of the MAP context, the PCA has raised other issues regarding application and scope as discussed, in general, in the endnote to this sentence.[156]

Heading into 2024, it will be interesting to see if the RAMP Act garners additional co-sponsors and support as it moves through Congress, and whether the proposal ultimately has any chance of becoming law as part of the current Congressional session. As of this time, H.R. 3388 has been referred to the House Committee on Ways and Means, and the House Committee on Energy.[157] In the Senate, S. 1607 has been referred to the Senate Finance Committee.[158]

Will the private cause of action be

Repealed for non-group health plans?

11. Going forward—2024

In assessing the various topics discussed in this report, it is evident that MSP compliance issues will continue to require attention as we enter the new year. In this regard, it is indeed an interesting landscape of mixed compliance considerations. In some areas, there are new CMS requirements and processes, such as Section 111 CMPs and the agency's upcoming TPOC/WCMSA data collection process. Meanwhile, on other fronts, insurers will continue to face longstanding compliance challenges, like increased CMS recovery demands and rising WCMSA costs. As MSP compliance expands and becomes increasingly complex, it is important that insurers stay abreast of CMS's updates, understand how these changes impact MSP compliance, and reevaluate their MSP compliance practices to make the necessary adjustments to stay compliant and reduce risk. Toward this goal, the author hopes this report is helpful as part of this process. Of course, please not hesitate to reach out to me if you have any questions.

A note from your Verisk Compliance Solutions team

We are very proud to serve our customers in the Medicare compliance space – and beyond. That is why you will notice on this report and all of our communications moving forward that we are moving toward using the Verisk name to identify who we are. This shift in perspective means that you will be able to navigate the full spectrum of our solutions for insurers, self-insureds, and TPAs more easily.
We look forward to supporting your success in 2024 with enhanced product integrations, expanded solution sets, and much more, all under the Verisk name.

Find out more

For more information about our Medicare compliance suite of solutions, please contact:
CasualtySolutions@verisk.com
1-866-630-2772

verisk.com/medicare-compliance

ABOUT THE AUTHOR

Mark Popolizio, J.D.,
is the Vice President of MSP Compliance for Verisk Casualty Solutions. He is a nationally recognized authority in Medicare Secondary Payer (MSP) compliance. Mark practiced insurance defense litigation for ten years concentrating in the areas of workers' compensation and general liability. As of 2006, Mark has dedicated his focus exclusively to MSP compliance working with carriers, self-insureds, TPAs and other claims professionals in addressing MSP compliance issues. Since 2001, Mark has been a regularly featured presenter on MSP issues at national seminars and other industry events – and has authored numerous national articles addressing several topics related to MSP matters In addition, Mark has released several articles on Third-Party Litigation Funding issues. Mark is also active with several industry groups.

Mark graduated Summa Cum Laude from Quinnipiac University in Hamden, Connecticut with Bachelor of Science degrees in Legal Studies and Sociology. He relocated to South Florida in 1992 to attend law school at Nova Southeastern University School of Law in Ft. Lauderdale, Florida. While at law school, Mark served as a Judicial Clerk to the late Honorable John D. Wessel (15th Judicial Circuit, Palm Beach County, Florida) and was a research assistant for Professor Leslie Larkin Cooney. Mark graduated from Nova in 1995 and is licensed to practice law in Florida and Connecticut.

You can contact Mark at mpopolizio@verisk.com

Notes

1. CMS's right to impose CMPs stems from 42 U.S.C. § 1395y(b)(8)(E)(i) which states as follows: "An applicable plan that fails to comply with the [Section 111 reporting] requirements … may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant …A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare Secondary Payer claim under this subchapter with respect to an individual." (Emphasis Added) To effectuate this provision, CMS is tasked with "specifying practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information." 42 U.S.C. § 1395y(b)(8)(I). It is from these provisions upon which CMS's CMPs are based.

2. Fed. Reg. Vol. 88, No. 226, at 82786-82787 (November 27, 2023). Per 42 CFR Part 102, the Section 111 CMP amount will be adjusted annually for inflation. See, Fed. Reg. Vol. 88, No. 195, at 70373 (October 11, 2023).

3. These two initial proposals are outlined as part of CMS's initial proposals at 85 Fed. Reg., No. 32, 8797-8799, (February 18, 2020).

4. Fed. Reg. Vol. 88, No. 195, at 70369 (October 11, 2023).

5. Fed. Reg. Vol. 88, No. 195, at 70370 (October 11, 2023).

6. CMS Alert: Medicare Secondary Payer and Certain Civil Money Penalties: Frequently Asked Questions (November 2, 2023).

7. Fed. Reg. Vol. 88, No. 195, at 70370 (October 11, 2023). Of note, CMS defines timeliness of reporting under the final rule as follows: "Timeliness is defined as reporting to CMS within 1 year of the date GHP coverage became effective, **the date a settlement, judgment, award, or other payment determination was made (or the funding of a settlement, judgment, award, or other payment, if delayed)**, or the date when an entity's Ongoing Responsibility for Medicals (ORM) became effective. Failure to report timely prevents CMS from promptly and accurately determining the proper primary payer and taking the appropriate actions."(author's emphasis). In relation to timely reporting of TPOC information (bolded segment above), CMS refers to both "the date a settlement, judgment, award or other payment determination was made" but also include "(or the funding of a settlement, judgment, award, or other payment, if delayed)". Where the authors of this article note above that "CMS indicates that it will compare the date of an RRE's file submission with one of two potential dates submitted as a part of the RRE's TPOC report" it is in order to distinguish that CMS uses two separate and distinct date fields within their Section 111 Claim Input File, as outlined in the agency's NGHP Section 111 User Guide, in order to identify "the date a settlement, judgment, award, or other payment determination was made" which is CMS's "TPOC Date" as well as "the funding of a settlement, judgment, award, or other payment, if delayed" which is CMS's "Funding Delayed Beyond TPOC Start Date field. Both of these date fields will be utilized by CMS to determine timeliness of reporting; See, CMS's Section 111 NGHP User Guide, (Version 7.3, August 7, 2023), Chapter III, Section 6.5.1.2.

8. See n. 7 above.

9. See, CMS's Section 111 NGHP User Guide, (Version 7.3, August 7, 2023), Chapter III, Section 6.5.1.2. Of note, within the agency's NGHP User Guide, CMS outline "Timeliness of Reporting" and the way that the "Funding Delayed Beyond TPOC Start Date" is used to determine timeliness, in conjunction with the "TPOC Date", as follows: "6.5.1.2 Timeliness of Reporting. NGHP TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met: • The alleged injured/harmed individual to or on whose behalf payment will be made has been identified. • The TPOC amount (the amount of the settlement, judgement, award, or other payment) for that individual has been determined. • The RRE knows when the TPOC will be funded or disbursed to the individual or their representative(s). RREs should retain documentation establishing when these criteria were or will be met. RREs should not report the TPOC until the RRE establishes when the TPOC will be funded or disbursed. In some situations, funding or disbursement of the TPOC may not occur until well after the TPOC Date. RREs may submit the date the TPOC will be funded or disbursed in the corresponding Funding Delayed Beyond TPOC Start Date field when they report the TPOC Date and TPOC Amount, but must do so if the TPOC Date and date of the funding of the TPOC are 30 days or more apart. Timeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the latter of the TPOC Date and the Funding Delayed Beyond TPOC Start Date." Id.

10. See n. 9 above.

11. Fed. Reg. Vol. 88, No. 195, at 70372 (October 11, 2023).

12. Fed. Reg. Vol. 88, No. 195, at 70370 and 70372 (October 11, 2023).

13. Fed. Reg. Vol. 88, No. 195, at 70372 (October 11, 2023).

14. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

15. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

16. Fed. Reg. Vol. 88, No. 195, at 70370 (October 11, 2023).

17. Fed. Reg. Vol. 88, No. 195, at 70370 (October 11, 2023).

18. Fed. Reg. Vol. 88, No. 195, at 70369 (October 11, 2023).

19. Fed. Reg. Vol. 88, No. 195, at 70369 (October 11, 2023). To illustrate via an example, CMS has provided the following: "For example, if over the calendar quarter being evaluated, CMS received 600,000 GHP records and 400,000 NGHP records for a total of 1,000,000 recently added beneficiary records, then 60 percent of the 250 records audited for that quarter would be GHP records, and 40 percent would be NGHP records." Fed. Reg. Vol. 88, No. 195, at 70369-70 (October 11, 2023).

20. Fed. Reg. Vol. 88, No. 195, at 70366 (October 11, 2023).

21. CMS Alert: Medicare Secondary Payer and Certain Civil Money Penalties: Frequently Asked Questions (November 2, 2023).

22. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

23. 42 CFR § 402.1(c)(ii)(A).

24. 42 CFR § 402.1(c)(ii)(B)

25. 42 CFR § 402.1(c)(ii)(C). On this point, CMS states when "[t]he incident of noncompliance is associated with a specific reporting policy or procedural on the part of CMS that has been effective for less than 6 months following the implementation of that policy or procedural change (or for 12 months, should CMS be unable to provide a minimum of 6 months' notice prior to implementing such changes)." See, 42 CFR 402.1(c)(ii)(C).

26. Fed. Reg. Vol. 88, No. 195, at 70367 (October 11, 2023).

27. Fed. Reg. Vol. 88, No. 195, at 70370 (October 11, 2023).

28. Fed. Reg. Vol. 88, No. 195, at 70370 (October 11, 2023).

29. 42 CFR § 402.1(c)(ii)(A)(1).

30. 42 CFR § 402.1(c)(ii)(A)(2).

31. 42 CFR § 402.1(c)(ii)(A)(3).

32. 42 CFR § 402.1(c)(ii)(A)(4).

33. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

34. Fed. Reg. Vol. 88, No. 195, at 70367(October 11, 2023).

35. On this point, CMS states that "any mitigating factors or circumstances are welcomed, and a dialogue is encouraged in an attempt to find solutions that are short of imposing a CMP. We believe it is in the best interests of all RREs to leave the informal notice process open to any reasonable submission of mitigating factors so that we are free to entertain all such documentation without strict limits on what is, or is not, acceptable." Fed. Reg. Vol. 88, No. 195, at 70367 (October 11, 2023).

36. Fed. Reg. Vol. 88, No. 195, at 70367 (October 11, 2023) and CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

37. Fed. Reg. Vol. 88, No. 195, at 70367 (October 11, 2023).

38. Fed. Reg. Vol. 88, No. 195, at 70367 (October 11, 2023).

39. Fed. Reg. Vol. 88, No. 195, at 70367-68 (October 11, 2023). Regarding potential application of the five-year limitations period, CMS provides the following example in the final rule: "An explanation and example of how this 5-year statute of limitations will apply is as follows: For failure to initially report the date of settlement or effective date of coverage timely (where applicable), noncompliance occurs on every day of non-reporting after the required timeframe for reporting has elapsed. For example, if the date of settlement is January 1, 2025, then the RRE will have 1 year from that date to report the coverage before being potentially subject to a CMP (that is, January 1, 2026). If the settlement date was January 1, 2025, but the RRE did not report it to CMS until October 15, 2026, the RRE will be considered noncompliant for the period of January 2, 2026, through October 15, 2026. If CMS does not act until after October 15, 2031, then the statute of limitations has elapsed and no CMP may be imposed." Id.

40. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

41. Fed. Reg. Vol. 88, No. 195, at 70363 (October 11, 2023).

42. See, CMS's alert.

43. See CMS's Section 111 CMPs FAQ document (November 2, 2023), Medicare Secondary Payer and Certain Civil Money Penalties: Frequently Asked Questions CMS's FAQ on this point reads, in full, as follows: 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.

44. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

45. CMS's NGHP Section 111 CMPs Webinar (January 18, 2024).

46. Fed. Reg. Vol. 88, No. 195, at 70368 (October 11, 2023).

47. Fed. Reg. Vol. 88, No. 195, at 70368 (October 11, 2023).

48. By way of background, CMS initially updated the definition of ORM as part of CMS's Section 111 NGHP User Guide (Version 7.2, June 5, 2023) to read as follows: "The trigger for reporting ORM is the assumption of ORM by the RRE, which is when the RRE has made a determination to assume responsibility for ORM and when the beneficiary receives medical treatment related to the injury or illness. Medical payments do not actually have to be paid, nor does a claim need to be submitted, for ORM reporting to be required. The effective date for ORM is the DOI, regardless of when the beneficiary receives the first medical treatment or when ORM is reported." CMS's Section 111 NGHP User Guide (Version 7.2, June 5, 2023), Chapter III, Section 6.3. This update was short-lived and was ultimately replaced by CMS's changes made in User Guide (Version 7.3) as further discussed in this section. See our prior article for more information on CMS's short-lived update to the ORM reporting trigger contained in User Guide Version 7.2

49. CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter III, Section 6.3.

50. For comparative purposes, User Guide (Version 7.1), Chapter III, Section 6.3 read, in pertinent part, as follows: "The trigger for reporting ORM is the assumption of ORM by the RRE—when the RRE has made a determination to assume responsibility for ORM, or is otherwise required to assume ORM— not when (or after) the first payment for medicals under ORM has actually been made. Medical payments do not actually have to be paid for ORM reporting to be required." Id.

51. CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter III, Section 6.3.

52. Id.

53. CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter III, Section 6.3.2.

54. Very generally, under CMS's TPOC reporting trigger, reporting is required upon claim resolution (or partial resolution) through a settlement, judgment, award, or other payment for cases in which the claimant is/was a Medicare beneficiary as of the TPOC date and where medicals were claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals. Under CMS's current thresholds, WC settlements greater than $750 are required to be reported under the Section 111 reporting process. See generally, CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter III, Section 6.4. and CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter III, Section 6.4.4.1.

55. As discussed in Verisk's recent article, in general, CMS as part of Section 4.3 addressed the use of EBMSAs and Non-Submit MSAs. Specifically, CMS, while acknowledging its WCMSA review and approval process is voluntary, stated that it viewed "the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement." See, CMS's WCMSA Reference Guide, Version 3.9 (May 15, 2023), Section 4.3. As such, CMS stated it "may at its sole discretion deny payment for medical services related to the WC injuries or illness, requiring attestation of appropriate exhaustion equal to the total settlement as defined in Section 10.5.3 of this reference guide, less procurement costs and paid conditional payments, before CMS will resume primary payment obligation for settled injuries or illnesses, unless it is shown, at the time of exhaustion of the MSA funds, that both the initial funding of the MSA was sufficient, and utilization of MSA funds was appropriate." Id. While CMS did clarify that it may consider and accept evidence that an EBMSA or a Non-Submit MSA funding was sufficient, it has not provided any metrics or guidance regarding how that would be evaluated. Id.

56. See, CMS's Section 111 NGHP User Guide, (Version 7.2, June 5, 2023), Chapter IV, Section 7.5 and CMS's Section 111 NGHP User Guide (Version 7.2, June 5, 2023), Chapter V, Appendix N. In the big picture, this new "opt-in" feature incorporates a trend that has been occurring over the past several years where CMS has been allowing another party – other than the actual RRE – to make changes to the Section 111 ORM records. In this regard, this trend has deviated from CMS's historical practices. On this point, historically, from the author's experience, at the

beginning of the Section 111 reporting process, CMS had instructed its contractors not to apply updates to Section 111 ORM records based on information received from sources other than the RRE. In those situations, CMS would typically direct the individual/entity providing the contradictory information back to the RRE to discuss any appropriate corrections to the Section 111 ORM record as submitted by the RRE. In situations involving a request for ORM termination, CMS would also typically send a letter to the RRE informing them of the receipt of that contradictory information. The RRE would be instructed that they could submit an update, if appropriate, via the Section 111 process or that they could reach out to the BCRC to request and/or provide additional clarifying details. In those scenarios, if the RRE did not reach out directly or submit an update via the Section 111 process, the Section 111 record would remain as previously reported by the RRE. However, from the authors' experiences, CMS's approach as outlined above, has started to change over the past few years in that it has become more common for CMS to permit the BCRC to allow and apply updates to the Section 111 ORM record based on information received by a party other than the RRE. Most of time, it is the beneficiary who provides information leading to a change in the Section 111 ORM record. In these situations, CMS, unlike prior practice, makes the change without notifying the RRE. One partial exception to this regards ORM termination. In this scenario, the authors find that CMS continues to send letters to the RRE. However, contrary to prior practice, CMS has typically already applied the change to the RRE's Section 111 ORM record. Thus, RREs may need to follow up with the BCRC to ensure that their Section 111 ORM record was not updated inappropriately.

57. Information provided by CMS as part of the agency's June 6, 2023 webinar.

58. Id.

59. Id.

60. Id.

61. Id.

62. Id.

63. CMS's Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter V, Section 7.5.

64. Information provided by CMS as part of the agency's June 6, 2023 webinar.

65. Id.

66. Id.

67. See, Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter V, Appendix F and information provided by CMS as part of the agency's June 6, 2023 webinar.

68. Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter IV, Section 7.5.

69. Section 111 NGHP User Guide (Version 7.3, August 7, 2023), Chapter IV, Section 7.5.

70. Information provided by CMS as part of the agency's June 6, 2023 webinar.

71. Id.

72. Id.

73. Id.

74. Id.

75. Id.

76. Id.

77. Id.

78. Id.

79. Id.

80. Id.

81. Id.

82. Id.

83. This report provides updated information regarding conditional payment recoveries processed through its Commercial Repayment Center (CRC) contractor for group health plans (GHPs) and CRC's non-group health plans (liability insurance, no-fault insurance, or workers' compensation plans) ORM recovery program. CMS notes this is its annual report to Congress as required by Section 1893(h) of the Social Security Act. The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2021 (October 2022), title page. This report provides information regarding CRC collection activities from October 1, 2021, through September 30, 2022. The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2022 (April 12, 2023). By way of background, the CRC assumed handling of GHP recovery cases from the MSPRC in May 2013. CMS then expanded CRC's activities into the NGHP arena in FY 2016 to help identify and recover Medicare conditional payments when an NGHP applicable plan has, or had, ORM. The CRC coordinates with the Benefits Coordination and Recovery Center (BCRC) to review and update NGHP records to identify conditional payments made by Medicare. As part of this process, the CRC identifies conditional payments, and where an NGHP plan has ORM, the CRC initiates recovery.

84. The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2022 (April 12, 2023), at 5. In this regard, this report at page 5 contains the following mathematical breakdown of CRC's collection activities and the ultimate reported as returned to the Medicare Trust Fund in FY 2022:

    Direct Collections $263,935,715.73

    + Treasury Collections: .....$ 83,169,911.86

    (-) Excess Collections Refunded: .....$ 48,154,971.57

    (-) CMS Administrative Costs: ..... $ 45,771,175.02

    Amt Returned to the Medicare Trust Fund: $253,170,481.00

85. The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2022 (April 12, 2023), at 5.

86. Id. at 5.

87. Id.

88. Id.

89. Id.

90. Id.

91. Id.

92. Id.

93. The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2021 (October 2022), Section 4.1, p.7.

94. The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2021 (October 2022)

95. The 2020 figure is taken from CMS's "Report to Congress Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2020," p. 8.

96. Meredith Freed, Anthony Damico, Jeannie Fuglesten Biniek, and Tricia Neuman, Medicare Advantage 2024 Spotlight: First Look, KFF (November 15, 2023). Author's Note: Per this organization's website, "KFF" was formerly known as The Henry J. Kaiser Family Foundation or the Kaiser Family Foundation. As outlined more fully on KFF's website, this organization has rebranded to simply "KFF" which is now referenced as this entity's "operating business name." See, https://www.kff.org/about-us/#kff-name for more information.

97. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023), Figure 1. As part of their analysis, the authors of this piece attributed the rise in MAP enrollment to certain policy changes designed to encourage greater insurer participation in the program. On this point, these authors state as follows: "Medicare Advantage enrollment has been on a steady climb for the past two decades following changes in policy designed to encourage a robust role for private plan options in Medicare. After a period of some instability in terms of plan participation and enrollment, The Medicare Modernization Act of 2003 created stronger financial incentives for plans to participate in the program throughout the country and renamed private Medicare plans Medicare Advantage." Id.

98. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023).

99. Meredith Freed, Anthony Damico, Jeannie Fuglesten Biniek, and Tricia Neuman, Medicare Advantage 2024 Spotlight: First Look, KFF (November 15, 2023).

100. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023), Figure 6.

101. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023), Figure 6.

102. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023), Figure 6.

103. Meredith Freed, Anthony Damico, Jeannie Fuglesten Biniek, and Tricia Neuman, Medicare Advantage 2024 Spotlight: First Look, KFF (November 15, 2023), Figure 2.

104. Meredith Freed, Anthony Damico, Jeannie Fuglesten Biniek, and Tricia Neuman, Medicare Advantage 2024 Spotlight: First Look, KFF (November 15, 2023).

105. Meredith Freed, Anthony Damico, Jeannie Fuglesten Biniek, and Tricia Neuman, Medicare Advantage 2024 Spotlight: First Look, KFF (November 15, 2023).

106. Meredith Freed, Anthony Damico, Jeannie Fuglesten Biniek, and Tricia Neuman, Medicare Advantage 2024 Spotlight: First Look, KFF (November 15, 2023).

107. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023), Figure 6.

108. Nancy Orchieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (August 9, 2023), Figure 6.

109. The MSP's private cause of action statute is codified at 42 U.S.C. 1395y(b)(3)(A) which states, in full, as follows: "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." Id.

110. By way of note, the 3rd Circuit has jurisdiction over federal cases originating in Delaware, New Jersey, Pennsylvania, and the U.S. Virgin Islands; the 11th Circuit has jurisdiction over federal cases originating in Alabama, Florida, and Georgia; while the Second Circuit has jurisdiction over federal cases originating in Connecticut, New York, and Vermont.

111. On this point, the following United States District courts have ruled that MAPs can sue claims payers for double damages: MAO-MSO Recovery II, LLC v. Mercury Insurance, 2018 WL 3357493 (C.D. Calif. May 23, 2018); MAO-MSO Recovery II, LLC v. Farmers Insurance Exchange, 2018 WL 2106467 (C.D. Calif. May 7, 2018); Aetna v. Guerrera, 300 F.Supp.3d 367 (D. Conn. March 13,2018); MAO-MSO Recovery II, LLC v. State Farm, 2018 WL 340021 (C.D. Ill. January 9, 2018); MSP Recovery Claims, Series 44 v. Zurich, 2023 WL 5227396 (N.D. Illinois, August 15, 2023); Collins v. Wellcare Healthcare Plans, Inc., 73 F. Supp.3d 653 (E.D. La. 2014); MSP Recovery Claims Series LLC v. Plymouth Rock Assurance Corporation, 404 F.Supp.3d 470 (D. Massachusetts, July 18, 2019); MSP Recovery Claims, Series LLC v. Phoenix Insurance Company, 426 F.Supp. 3d 458 (N.D. Ohio, December 12, 2019); MSP Recovery Claims, Series LLC v. Grange Insurance Company, 2019 WL 6770729 (N.D. Ohio, December 12, 2019); MSP Recovery Claims, Series LLC v. Progressive Corporation, 2019 WL 5448356 (N.D. Ohio, September 17, 2019); Humana Ins. Co. v. Bi-Lo, LLC, 2019 WL 4643582 (D. South Carolina, September 24, 2019); Cariten Health Plan, Inc. v. Mid-Century Ins. Co., No.: 2015 WL 5449221(E.D. Tenn. 2015); Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co., 95 F.Supp.3d 983 (W.D. Tex. 2014); Humana v. Shrader, 584 B.R. 658 (S.D. Tex. March 16, 2018); and Humana Ins. Co. v. Paris Blank LLP, 187 F. Supp.3d 676 (E.D. Va. 2016).

112. Very generally, "standing" is defined in one source as follows: "Standing, or locus standi, is capacity of a party to bring suit in court." See, https://www.law.cornell.edu/wex/standing Expanding on this definition, the court in MSP Recovery Claims, Series LLC v. Hereford Insurance Co., 2023 WL 2993857, *1 (2nd Cir. April 19, 2023), explained "standing," in part, as follows: "[c]onstitutional standing has three elements: (1) injury-in-fact, i.e., 'an invasion of a legally protected interest [that] is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical,' (2) causation, i.e., 'a causal connection between the injury and the conduct complained of,' and (3) redressability, i.e., 'it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.'" (court's emphasis) MSP Recovery Claims, Series LLC v. Hereford Insurance Co., 2023 WL 2993857, *5 (2nd Cir. April 19, 2023), citing Lujan v. Defs. Of Wildfire, 504 U.S. 555, 560-561 (1992). The court noted further that the "party invoking federal jurisdiction – here MSP – bears the burden of establishing all three elements." MSP Recovery Claims, Series LLC v. Hereford Insurance Co., 2023 WL 2993857, *5 (2nd Cir. April 19, 2023).

113. See the author's articles for a more in-depth review of these decisions:

Second Circuit dismisses Medicare Advantage "double damages" lawsuit on

standing grounds – rules the insurer's Section 111 reporting did not establish liability

The United States District Court for Massachusetts dismisses a Medicare Advantage claim for "double damages" – rules that insurer's Section 111 reporting does not establish standing to sue

The United States District Court for Connecticut dismisses a Medicare Advantage claim for "double damages" – rules that insurer's Section 111 reporting not sufficient to establish standing

114. See the author's article for a more in-depth review of this decision:

The United States District Court for Massachusetts rules that a MAP assignee has standing to assert a private cause of action (PCA) claim and that a four-year statute of limitations governs PCA actions

115. The "SMART Act" is the abbreviation for the Strengthening Medicare and Repaying Taxpayers Act of 2012 (P.L. No. 112-242, 126 Stat. 2374) which was enacted into law on January 10, 2013. One of the several provisions contained in the SMART Act was a statute of limitations provision which is codified at 42 U.S.C. § 1395y(b)(2)(B)(iii). This section, in pertinent part, states as follows: "an action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed." Id.

116. 28 U.S.C. § 1658, this statute states in full as follows: Time limitations on the commencement of civil actions arising under Acts of Congress. (a) Except as otherwise provided by law, a civil action arising under an Act of Congress enacted after the date of the enactment of this section may not be commenced later than 4 years after the cause of action accrues. (b) Notwithstanding subsection (a), a private right of action that involves a claim of fraud, deceit, manipulation, or contrivance in contravention of a regulatory requirement concerning the securities laws, as defined in section 3(a)(47) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(47)), may be brought not later than the earlier of (1) 2 years after the discovery of the facts constituting the violation; or (2) 5 years after such violation. Id. (Author's emphasis).

117. For example, the United States Circuit Court of Appeals for the 11th Circuit in MSPA Claims 1, LLC v. Tower Hill Prime Insurance Co. found that the four-year period is to be measured by the "occurrence rule"— which begins the limitations period on the date that the violation of the plaintiff's legal right occurred. See, MSPA Claims 1, LLC, 2022 WL 3223801 (11th Cir. August 10, 2022), at *5, citing SCA Hygiene Prods. Aktiebolag v. First Quality Baby Prods., LLC, 580 U.S. 328, 137 S. Ct. 954, 962, 197 L.Ed.2d 292 (2017). However, the United States District Court for Massachusetts in MSP Recovery Claims Series 44, LLC v. Bunker Hill Insurance Company, while agreeing with the 11th Circuit that the four-year SOL applied, disagreed that the limitations period should be measured under the "occurrence rule" stating, in part, that "[t]his Court disagrees with a rule that provides that the cause of action accrues when the MAO pays the medical fees and becomes entitled to reimbursement. At that moment the MAO would have no reason to know that it was entitled to any reimbursement and that it had a claim against a responsible primary payer." MSP Recovery Claims Series 44, LLC v. Bunker Hill Insurance Company, 2023 WL 4744739, at *8 (D. Massachusetts, July 25, 2023). Instead, the District Court for Massachusetts found that the "discovery rule" applies noting, in part, that the four-year SOL "'commences the limitations period on the date the plaintiff discovered or should have discovered the cause of action.'" MSP Recovery Claims Series 44, LLC v. Bunker Hill Insurance Company, 2023 WL 4744739, at *7 (D. Massachusetts, July 25, 2023), citing MSPA Claims 1, LLC v. Tower Hill Prime Ins. Co., 43 F.4th 1259, 1265 (11th Cir. 2022), and SCA Hygiene Prods. Aktiebolag v. First Quality Baby Prods., LLC, 580 U.S. 328, 137 (2017).

118. The "PAID Act" is the abbreviation for the Provide Accurate Information Directly (PAID) Act (P.L. No. 116-215) which was enacted into law on December 11, 2022. By way of brief background, President Trump signed the PAID Act into law on December 11, 2020, as part of H.R. 8900, titled the Further Continuing Appropriations Act 2021 and Other Extensions Act. H.R. 8900, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Title III, Offsets, Sec. 1301, (ii), Transparency of Medicare Secondary Payer Reporting Information. The PAID Act amended 42 U.S.C. § 1395y(b)(8)(G). In pertinent part, the text of the PAID Act reads as follows: (ii) SPECIFIED INFORMATION.— In responding to any query made on or after the date that is 1 year after the date of the enactment of this clause from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan— (I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this title on any basis; and (II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period." H.R. 8900, Further Continuing Appropriations Act, 2021, and Other Extensions Act, Title III, Offsets, Sec. 1301, (ii), Transparency of Medicare Secondary Payer Reporting Information.

119. See CMS's Section 111 NGHP User Guide, Chapter V, Appendix E (Version 7.3, August 7, 2023).

120. An Overview of the Medicare Part D Prescription Drug Benefit, KFF (October 17, 2023). Author's Note: Per this organization's website, "KFF" was formerly known as The Henry J. Kaiser Family Foundation or the Kaiser Family Foundation. As outlined more fully on KFF's website, this organization has rebranded to simply "KFF" which is now referenced as this entity's "operating business name." See, https://www.kff.org/about-us/#kff-name for more information.

121. An Overview of the Medicare Part D Prescription Drug Benefit, KFF (October 17, 2023).

122. Juliette Cubanski and Anthony Damico, KFF, Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing, KFF (November 8, 2023).

123. Juliette Cubanski and Anthony Damico, KFF, Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing, KFF (November 8, 2023).

124. Juliette Cubanski and Anthony Damico, KFF, Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing, KFF (November 8, 2023).

125. Juliette Cubanski and Anthony Damico, KFF, Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing, KFF (November 8, 2023).

126. Juliette Cubanski and Anthony Damico, KFF, Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing, KFF (November 8, 2023).

127. Juliette Cubanski and Anthony Damico, Key Facts About Medicare Part D Enrollment and Costs in 2023, KFF (July 26, 2023), Figure2.

128. See, CMS memo, Medicare Secondary Payment Subrogation Rights, Medicare Advantage Organizations and Prescription Drug Plan Sponsors (December 5, 2011).

129. See, CMS's Prescription Drug Manual, Chapter 14, Coordination of Benefits (Revised, September 17, 2018).

130. See, CMS's Prescription Drug Manual, Chapter 14, Coordination of Benefits (Revised, September 17, 2018).

131. See, In re Avandia, 685 F.3d 353, at n.20. The court in this endnote stated "Our decision here unquestionably results in cost savings for the Medicare Trust Fund because our holding on the meaning of the private cause of action will apply equally to private entities that provide prescription drug benefits pursuant to Medicare Part D. See 42 U.S.C § 1395w-151(b) (requiring that provisions

relating to the MA program and MAOs be read to include part D plans). Because Part D prescription drug plans explicitly share gains and losses with the federal government, 42 U.S.C. § 1395w-115(e), the Medicare Trust Fund unquestionably loses money if these private entities recover less from primary payers." Id.

132. See CMS's Section 111 NGHP User Guide, Chapter V, Appendix E (Version 7.3, August 7, 2023). In addition, CMS also provides the contract number, contract name, plan number, coordination of benefits (COB) address, and entitlement dates for the past three years (up to 12 instances) of Part C (Medicare Advantage) and the most recent Part A and Part B entitlement dates. Id.

133. CMS made this change as part of its Workers' Compensation Medicare Set-Aside (WCMSA) Reference Guide (Version 3.9, May 15, 2023) update. CMS outlines its Amended Review process in Chapter 16.3 of the WCMSA Reference Guide.

134. Workers' Compensation Medicare Set-Aside (WCMSA) Reference Guide (Version 3.9, May 15, 2023), Chapter 16.3.

135. Id..

136. Id.

137. Id.

138. Id.

139. Id.

140. See, Centers for Medicare and Medicaid Services, Medicare Secondary Payer and "Future Medicals," CMS-6047-ANRPM, 77 F.R. 35917 (June 15, 2012).

141. Id. at p, 35919-35921.

142. This notice was entitled *Miscellaneous Secondary Payer Classifications and Updates (CMS-6047-P) (Fall 2018)* and stated, in main part, as follows: "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."

143. Medicare Secondary Payer and "Future Medicals" (CMS-6047-P) (Fall 2018)

144. This notice was entitled *Miscellaneous Secondary Payer Classifications and Updates (CMS-6047-P)* (Fall 2018) and stated in main part, as follows: "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." Id.

145. The following outlines each of these OIRA notices:

Miscellaneous Secondary Payer Classifications and Updates (CMS-6047-P) (Spring 2019)

This notice pushed back the projected release date to October 2019. This notice stated, in main part, as follows: "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." Id.

Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047) (Fall 2019)

This notice pushed back the release date to February 2020. This notice stated, in main part, as follows: "This proposed rule would ensure that beneficiaries are making the best healthcare 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." Id.

Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047) (Spring 2020)

This notice pushed back the release date to August 2020. The notice stated, in main part, as follows: "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." Id.

Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047) (Fall 2020)

This notice pushed back the release date to March 2021. This notice stated, in main part, as follows: "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 regulation." Id.

Medicare Secondary Payer and Future Medicals (CMS-6047) (Fall 2021)

This notice pushed back the projected release date to February 2022. This notice stated, in main part, as follows: "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. This proposed rule would also remove obsolete regulations." Id.

146. Medicare Secondary Payer and Future Medicals (CMS-6047) (Fall 2021)

147. On this point, compare the verbiage contained in the various OIRA notices as outlined in n. 145 above.

148. See our March 2022 article: https://www.verisk.com/insurance/visualize/cms-on-the-move--final-section-111-civil-money-penalties-rules-and-future-medicals-proposals-are-pending-review-for-release/

149. Medicare Secondary Payer and Future Medicals (CMS-6047) (March 1, 2022) See also, our October 2022 article: CMS's future medicals proposals have been withdrawn

150. While a deeper dive into this question is outside this report's scope, very generally, as part of its 2012 ANPRM proposals, CMS proceeded, in part, from the position that Medicare was prohibited from making payment under the MSP statute when payment has been made via settlement and that Medicare remained the secondary payer until the settlement was exhausted. Centers for Medicare and Medicaid Services, Medicare Secondary Payer and "Future Medicals," CMS-6047-ANRPM, 77 F.R. at 3918. Further, CMS stated, in part, that it was entitled to recover conditional payments related to settlements "regardless of when the items and services are provided." Id.

151. Of note, the version of the RAMP Act introduced in the 118th Congress as H.R. 3388 and S. 1607 differs from the version of the RAMP Act introduced in the last Congressional term (117th Congress) in that the prior version proposed to eliminate the PCA statute in its entirety. The prior version of the RAMP Act can be viewed here.

152. See, H.R. 3308, Sec. 2 and S. 1607, Sec. 2.

153. https://marccoalition.com/2023/05/17/marc-celebrates-bicameral-and-bipartisan-introduction-of-the-ramp-act-in-congress/

154. See, MAO-MSO Recovery II, LLC v. Mercury Insurance, 2018 WL 3357493 (C.D. Calif. May 23, 2018); MAO-MSO Recovery II, LLC v. Farmers Insurance Exchange, 2018 WL 2106467 (C.D. Calif. May 7, 2018); Aetna v. Guerrera, 300 F.Supp.3d 367 (D. Conn. March 13,2018); MAO-MSO Recovery II, LLC v. State Farm, 2018 WL 340021 (C.D. Ill. January 9, 2018); Collins v. Wellcare Healthcare Plans, Inc., 73 F.Supp.3d 653 (E.D. La. 2014); MSP Recovery Claims Series LLC v. Plymouth Rock Assurance Corporation, 2019 WL 3239277 (D. Massachusetts, July 18, 2019); MSP Recovery Claims, Series LLC v. Phoenix Insurance Company, 2019 WL 6770981 (N.D. Ohio, December 12, 2019); MSP Recovery Claims, Series LLC v. Grange Insurance Company, 2019 WL 6770729 (N.D. Ohio, December 12, 2019); MSP Recovery Claims, Series LLC v. Progressive Corporation, 2019 WL 5448356 (N.D. Ohio, September 17, 2019); Humana Ins. Co. v. Bi-Lo, LLC, 2019 WL 4643582 (D. South Carolina, September 24, 2019); Cariten Health Plan, Inc. v. Mid-Century Ins. Co., No.: 2015 WL 5449221(E.D. Tenn. 2015); Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co., 95 F.Supp.3d 983 (W.D. Tex. 2014); Humana v. Shrader, 584 B.R. 658 (S.D. Tex. March 16, 2018); Humana Ins. Co. v. Paris Blank LLP, 187 F. Supp.3d 676 (E.D. Va. 2016).

155. See, Aetna Life Insurance Company v. Big Y Foods, Inc., 52 F.4th 66 (2nd Cir. October 26, 2022) and Humana v. Western Heritage Insurance Co., 832 F.3d 1229 (11th Cir. 2016).

156. On this point, one issue that has resulted in considerable litigation over the years is exactly "who" can sue under the PCA statute given that the text of the PCA is silent on this point. While the federal government is granted the express right to bring a claim under the PCA through another MSP provision (42 U.S.C. § 1395y(b)(2)(B)(iii)) the PCA statute itself provides no indication as to who may bring suit under its provisions. While a complete review of the full collection of cases addressing this question is beyond the scope of this article, it is noted that several courts have ruled that the PCA provision is not a qui tam statute. A qui tam action has been described as an action where "a private plaintiff, known as a "relator," brings suit on behalf of the government to recover a remedy for a harm done to the government." See, Wood v. Empire Health Choice, Inc., 574 F.3d 92, 97 (2d Cir. 2009). In this regard, as one court commented, "[n]ot just anyone can wander in off the street and avail themselves of the MSP Act's private cause of action." Netro v. Greater Baltimore Medical Center, Inc., 891 F.3d 522, 528 (4th Cir. June 4, 2018). Rather, as another court explained, "the PCA statute merely enables a private party to bring an action to recover from a private insurer only where that private party has itself suffered an injury because a primary plan has failed to make a required payment to or on behalf of it" (authors' emphasis). Woods v. Empire Health Choice, Inc., 574 F.3d 92, 101 (2d Cir. 2009). See also., In re Avandia Marketing, Sales Practices & Products Liability Litig., 685 F.3d 353 (3d Cir. 2012); ; Stalley ex rel. United States v. Orlando Regional Healthcare Sys., Inc., 524 F.3d 1229 (11th Cir. 2008); Stalley v. Methodist Healthcare, 517 F.3d 911 (6th Cir. 2008); Stalley v. Catholic Health Initiatives, 509 F.3d 517 (8th Cir. 2007); United Seniors Ass'n v. Philip Morris USA, 500 F.3d 19 (1st Cir. 2007); Netro v. Greater Baltimore Medical Center, Inc., 891 F.3d 522 (4th Cir. 2018); and O'Connor v. Mayor and City of Baltimore, 494 F.Supp.2d 372 (D. Maryland, July 19, 2007). Similarly, another court found that "the private right of action provided by 42 U.S.C. § 1395y(b)(3)(A) is not a qui tam statute, and [a plaintiff], who is a volunteer and who lacks any injury in fact, does not have standing to pursue such an action" and, thus, the MSP "allows a private plaintiff to assert his own rights, not those of the government." Stalley v. Catholic Health Initiatives, 509 F.3d 517, 527 (8th Cir. 2007). In terms of which parties the PCA statute does apply, it is noted that, in general, courts have found that Medicare beneficiaries can sue under the PCA, See e.g., Estate of McDonald v. Indemnity Insurance, 46 F.Supp.3d 712 (W.D. Ky. 2014) and O'Connor v. Mayor and City of Baltimore, 494 F. Supp. 2d 372 (D. Maryland, July 19, 2007), as well as medical providers, see e.g., Michigan Spine and Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co., 758 F.3d 787 (6th Cir. 2013).

157. https://www.congress.gov/bill/118th-congress/house-bill/3388?s=1&r=6

158. https://www.congress.gov/bill/118th-congress/senate-bill/1607