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April 20, 2020

Via www.regulations.gov

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS–6061-P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: CMS-6061-P; MEDICARE SECONDARY PAYER AND CERTAIN CIVIL MONETARY PENALTIES

Dear Administrator Verma:

Tower MSA Partners is writing to share our comments on the February 18, 2020, Proposed Penalty Rule under the Section 111 reporting requirements of the Medicare Secondary Payer laws.

Tower MSA Partners is a Section 111 reporting agent for insurance carriers and self-insured entities. Further, the undersigned author of these comments has been involved with Medicare Secondary Payer compliance services for the past 17 years.

As a member of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), Tower fully endorses the comments drafted and submitted by NAMSAP which are reflected below.

Penalty Threshold for Failure to Report / Delayed Reporting - Part 402.1(c)(22)(i)

Per the proposed rule, subject to the good faith efforts provision, a penalty is imposed for an RRE who "fails to report any beneficiary record within 1 year from the date of settlement, judgment, award, or other payment." While CMS provides an error tolerance threshold for the submission of beneficiary records, no such threshold is provided for failure to report or delayed reporting over 1 year.

Tower submits that for the same reasons CMS provides for an error tolerance threshold for beneficiary records, namely a recognition that human and technical error will occur, are the same reasons why CMS should implement an error tolerance threshold for failure to report or delayed reporting. We recommend CMS implement a 10% threshold for error tolerance per RRE. The 10% would be based upon the number of TPOCs reported in the quarter (including off cycle

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reporting). For example, if 100 TPOCs are reported during a quarter, up to 10 TPOCs, which are in excess of 1 year, would be exempt from penalties for failure to report timely.

Penalties Imposed for Failure to Report / Delayed Reporting - Part 402.105(b)(3)(i)

Turning then to penalties for failure to report, the proposal states such penalties will be up to $1,000 per calendar day, adjusted for inflation, for a maximum penalty of $365,000 per calendar year. It is not clear from the proposal whether CMS will use the discretion afforded to it by the SMART Act of "up to" to impose a penalty of a less than $1,000/day. If it will use such discretion, then what are the criteria CMS will use in determining whether the penalty should be $1/day, $500/day or $1,000/day?

While we understand CMS did not write the statute, we nonetheless submit that any penalty imposed cannot violate the Eighth Amendment to the U.S. Constitution which prohibits "excessive fines." The U.S. Supreme Court decision in United States v. Bajakajian, 524 U.S. 321 (1998) sets the baseline in stating "that a punitive forfeiture violates the Excessive Fines Clause if it is grossly disproportional to the gravity of a defendant's offense." While the case dealt with a civil forfeiture, not federal civil monetary penalties, it nonetheless illustrates the principle that the penalty should be proportional to the offense.

For example, if an RRE fails to report a TPOC timely and 4 years passes. After the TPOC is reported, CMS's recovery contractors investigate and find no conditional payments were made and the Medicare Trust fund did not sustain any negative impact. Yet the RRE faces the potential penalty of about $1.5 million subject to inflation, etc. Such a penalty would cause a significant financial injury to the company and could lead to bankruptcy, layoffs, etc. We do not believe that this outcome is what Congress intended. Encouraging good faith efforts to comply with a very complex and technical reporting system should not include unnecessarily large monetary penalties such that they affect the RREs capacity to continue operating.

Tower certainly understands the need for CMS to have accurate and up-to-date data and that a penalty is appropriate when that date is not submitted timely and correctly, and financially impacts Medicare in a negative manner. That being said, the penalty itself should be proportional to the harm to CMS and the Medicare Trust Fund.

The Proposed Rule is missing sliding scale penalty factors. Congress intended a sliding scale penalty regime when in the SMART Act it modified the penalty provisions to limit penalties to "up to" specified amounts. CMS has offered no reason not to do so. We urge CMS to include in the Final Rule specific good faith provisions that address:

(1) The nature of the reporting error and the circumstances under which a report was or was not made;

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(2) The degree of culpability, history of prior offenses, and financial condition of the entity submitting the report;
(3) The resources available to the person submitting the report;
(4) Such other matters as justice may require, including the circumstances of the incident such as the period of time involved, whether a pattern of conduct is involved, the amount at issue, prior history of the reporting entity, evidence of intentionality; and
(5) Mitigating circumstances.

We believe that including these factors in the final regulation would not only correct an unfairness in the proposed rule, but would encourage the reporting policies that CMS wants to advance. For that reason, we urge CMS to explicitly incorporate the factors in 42 C.F.R. § 402.111 into the Section 111 Penalty Regulation at Section 402.105.

Further, if no conditional payments were made, there should be no CMP assessed for that beneficiary's claim/claims.

Finally, the proposed regulation is not clear as to how the daily penalty will be calculated for ORM claims. Does the daily penalty even apply to ORM claims?

We propose that the same calculation method as outlined above be applied to ORM and TPOC reports.

Data Contradicts Recovery - Part 402.1(c)(22)(ii)

The rule as proposed indicates that if an RRE's response to CMS' recovery efforts "contradicts" the RRE's Section 111 reporting, the penalty would be calculated based on the number of calendar days that the entity failed to appropriately report updates to beneficiary records, as required for accurate and timely reporting under section 111 of MMSEA. The rule goes on to indicate that for an NGHP, the penalty would be up to an adjusted $1,000 per calendar day of "noncompliance" for each individual, for a maximum annual penalty of an adjusted $365,000 for each individual for which the required information should have been submitted.

We submit this is grossly unfair, and runs the risk of creating penalties of hundreds of thousands (or even millions) of dollars for claims involving small amounts of money. More specifically, under CMS's proposal, a retroactive ORM termination going back two years would result in over a million dollars of penalty. We urge CMS to withdraw this type of penalty.

Additionally, the CMS ORM policies continue to be problematic. RREs regularly "administratively close" claims files consistent with industry practice, and there are numerous instances in which the claim file will not be reopened (and cannot be reopened given the sheer volume of claims at issue) to check whether ORM is correctly reported or terminated. In sum,

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CMS has not provided the appropriate standards that would allow companies to terminate ORM when files are administratively closed.

We appreciate that some companies try to set "automated" ORM termination systems, while others have a manual process when an event occurs requiring reopening of an administratively closed file. Either way, the CMS parameters for closing ORM are inappropriately narrow. Now CMS proposes penalizing parties who appropriately look back to close ORM. We urge CMS to withdraw proposed section 402.1(c)(22)(ii).

Further, it seems the use of the word "noncompliance" in this section means something different than in the previous section dealing with failure to report beneficiary records or untimely reporting of same. How does CMS define "noncompliance," "contradict," and "failure to appropriately report updates"? Is "contradictory" information limited to situations like the example given where ORM was terminated two years prior? In the "Background" section of this proposed rule, CMS indicates that if an RRE's dispute or redetermination request "appears to directly contradict its own reporting," then CMS will issue "an informal written notice of noncompliance identifying the nature of the noncompliance and the determination of the potential amount of the CMP would be issued to the RRE. The RRE would again have 30 calendar days to respond with mitigating information before the issuance of a written notice in accordance with 42 CFR 402.7." How does "directly contradict" differ from simply "contradict?"

Additionally, do the rules proposed include contradictions provided by Beneficiaries? For example, if an RRE reports that they have open ORM because the claim occurred in a lifetime medical state but the Beneficiary tells CMS that the RRE isn't responsible for the treatment. Can the RRE be penalized for a contradictory statement made by an entity, person or representative other than the RRE themselves?

What if one of the RRE vendor partners submits contradictory information without realizing they are even doing so? For example, they include a few ICD-10 codes on a WCMSA submitted to the WCRC which contradict what RRE included on their Section 111 reporting. Does this subject the RRE to penalties?

Further, we understand that there are times in which CMS asserts recovery against RREs for conditional payments made for unrelated body parts regardless of what was submitted via Section 111 reporting. This causes a significant financial burden on the RRE. We proposed that CMS clearly identify that errors/mistakes that CMS contractors make in recovery efforts will not constitute "contradictory" reporting.

If CMS will not withdraw this section, then we again come back to proportionality of harm to the Medicare Trust Fund. In the example provided in the proposed regulation, the RRE mistakenly fails to report ORM termination which occurred two years prior. The RRE learns of this error and makes an appropriate correction to their Section 111 reporting. Per the proposed regulations, CMS

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could issue a $365,000 penalty in this case (and likely more as it is adjusted for inflation). However, the harm to Medicare is limited to administrative fees in attempting to recover against the RRE and then, perhaps additional fees in collecting against a claimant who has a Medicare Set-Aside to pay for such charges. Even if some penalty is appropriate for the alleged error in reporting, such penalty should be proportionate to the harm to Medicare.

If an RRE's response to CMS' recovery efforts "contradicts" the RRE's Section 111 reporting resulting in potentially tens of thousands of dollars in penalties, what incentive is there for the RRE to correct the reporting if the result of making the correction is thousands of dollars in penalties? For example, the cost of submitting a correction to the reporting information is going to potentially cost the RRE more in CMPs than leaving medicals open for life and just paying them even though they are not legally responsible for them. This seems to contradict the purpose and intent of the statute which is to encourage good faith efforts to comply and not to impose unnecessarily harsh penalties.

In conclusion, if penalties are to be imposed for contradicting ORM reporting, we recommend the sliding scale factors cited above be utilized to ensure proportionality between the harm to Medicare and the penalty imposed.

"Safe Harbor" for Data Collection from Beneficiaries - Part 402.1(c)(22)(A)(2)

The proposed rule includes an exemption for those situations where a beneficiary refuses to provide needed information to an RRE for reporting. We appreciate and support this proposal, but recommend that CMS not be so limiting in the specific number of actions a reporting entity must make (and how they must be made). Consumers are sensitive in supplying private and health information, even for Medicare purposes, and they will be frustrated when repeatedly asked for the same information if they have refused to provide it. This could trigger customer complaints. We request that CMS eliminate a mandatory minimum number of communications with beneficiaries, and instead simply require that the RRE make good faith efforts under the circumstances to try secure needed reporting information. CMS can explain its preferred actions in the Final Rule preamble as a helpful guide to what the Agency will be looking for when attempting to collect the needed information.

If CMS will not eliminate the requirement of a mandatory minimum attempts to request the MBI or SSN information, then we request CMS not require two attempts by mail (we assume U.S. Mail) and one by phone, but rather allow more expansive forms of communication, U.S. mail, phone, e-mail or fax. Further, once the individual or attorney responds that he or she will not provide the SSN or MBI, then there should be no further requirement to contact the individual or attorney to request the information.

Informal Notice – D. Summary of Public Comments #8

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CMS advises that its informal notice process will provide the RRE 30 calendar days to respond with any mitigating information prior to the issuance of a notice of proposed determination in accordance with 42 CFR 402.7. We submit that 30 days is too short of a time in some cases for the RRE to investigate and respond to the informal notice. This is currently exemplified by the conditional payment process where the 30-day timeframe is often insufficient for the RRE to respond to a Conditional Payment Notice. This might work in the GHP realm, but an investigation where there is an "appearance of directly contradictory information" will take more time and effort in the NGHP realm where the claim may very well involve the adverse parties and their attorneys, attorneys for the RRE, the RRE itself, a third-party administrator, and vendors for Section 111 reporting and recovery.

We propose that the RRE be provided with 120 calendar days post-receipt of the informal notice to respond.

Further, we propose that when making CMP Demands, that CMS make billing information and medical record information available to the RRE if a conditional payment recovery is going to be asserted as well. This will allow the RRE to effectively determine if the debt was actually related to the claim. Currently, that is nearly impossible on lifetime ORM claims because the reason for treatment is completely unknown to the RRE and might not be related to the original accident/claim.

Prospective Application - D. Summary of Public Comments #6

Please provide a more extensive definition of prospective application. For example, will CMS be considering penalties for TPOCs which should have been reported prior to the implementation date of the penalties regulation? Also, will CMS impose penalties for correction to diagnosis codes in response to conditional payment recovery when such codes were reported prior to the implementation date of the penalties regulation?

Further, if an RRE reports ORM termination dates after the final regulation is implemented, but the ORM termination date pre-dates the date the rules become active, will this claim be subject to daily penalties? If so, what is the benefit to an RRE for reporting ORM claims that have already terminated in the past but were never reported? Additionally, if an RRE reports a TPOC that occurred prior to the date of the final regulations, but was reported "late", will the RRE be penalized daily for the late report? If so, the rule appears to be supporting that CMS does not want RREs to continue to make good faith efforts to correct old data and get claims that may have been missed reporting. In fact, the rule suggests that RREs will be penalized for their good faith efforts.

It is illogical for CMS to think that claims will not be missed and need to be caught and corrected at a later date. We propose that this should not be penalized. In the alternative, we propose that

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CMS consider providing RREs that internally audit and correct their own reporting (thus saving CMS money from having to do their own audit) a reduction in overall CMPs.

For example, if an RRE can prove that it hired an independent auditor to perform a compliance audit and they implemented a plan to correct all of their missed claims/bad data, CMS should waive the double damage penalty provided above and only charge interest and the cost of the recovery effort by CMS. This provides the RREs with an incentive to clean up their own data, it will allow CMS to recover their conditional payments on a much more efficient and effective basis, it will save CMS money in audit recovery spend, and it is an overall win for all parties involved, including the beneficiaries.

We propose that CMS consider other ways to encourage RREs to implement internal audits and to soften penalties on RREs for finding and correcting their own data without CMS's auditors intervention.

Again, we urge CMS to clarify whether the prospective in nature application mean that the rule will only apply to dates of injury that occur on/after the date of the final regulation? Or does the prospective in nature application mean that the rule will only apply to TPOCs and ORMs submitted on or after the date of the final promulgation of the regulation? If the answer to the later question is yes, this appears to defeat the overall goal of obtaining correct information on a timely basis so that the Medicare system can be administered accordingly.

Five Year Statute of Limitations - D. Summary of Public Comments #7

In its supporting summary, CMS takes care to outline that these penalties would be imposed within the existing CMP five year statute of limitations. That limitations period is triggered when the agency identifies the non-compliant action. In addition, the supporting statement indicates that penalties will be assessed prospectively and not retroactively.

CMS states that per 28 U.S.C. 2462 the statute of limitations starts running when CMS "identifies" the noncompliance. The statute does not use such terminology but instead states "when the claim first accrued."

Accordingly, the statute of limitations for CMPs should start running when the claim first accrued, in other words, when the TPOC or ORM should have been reported per CMS requirements, not when the noncompliance was identified by CMS. Any other interpretation would defeat the very reason that a statute of limitations is in place, namely, to require timely resolution of the claim while the facts surrounding the claim are still relatively fresh and available. CMS's identification standard arguably allows CMS to impose penalties many years to decades after the noncompliance occurred.

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With that said, we submit that 28 U.S.C.2462 is the inappropriate statute of limitations to apply to the penalties provision of the MSP Act. The applicable statute of limitations, should be three years, as memorialized by Congress through the SMART Act. 42 U.S.C. § 1395y(b)(2)(B)(3).

ALJ and Departmental Appeals Board Backlog Concerns - D. Summary of Public Comments #5

Under the proposed rule, CMS expects the final rule would comport with the appeals process as prescribed by 42 CFR 402.19 and set forth under 42 CFR part 1005. In broad terms, parties subject to CMP would receive formal written notice at the time penalty is proposed. The recipient would 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.

The average processing time of ALJ cases in 2009 was 94.9 days, so just outside of the 90 day requirement. By 2017, it took an average of 1,142 days for a case to be processed, or just over three years. The average for the first three quarters of 2018 was 1,187 days, so the trend is creeping ever closer to 3.25 years. Some have called this an "extreme backlog." The U.S. Department of Health and Human Services (HHS) has provided some insight into the issues faced by OMHA in its "HHS Primer: The Medicare Appeals Process:" "OMHA was receiving more than a year's worth of appeals every 18 weeks at the end of FY 2015. As of the end of FY 2015, the pending workload at OMHA exceeded 880,000 appeals while annual adjudication capacity was approximately 75,000 appeals." Under the resources available to OMHA at that time AND assuming no additional appeals, HHS estimated it would take OMHA eleven years to process its backlog. In 2018 OMHA had 5.4 times as many appeals pending than could be decided in 2018. The outlook isn't any better for 2020 and beyond. The proposed rule will only add to that backlog. And as it stands now, recovery contactors do not stay recovery enforcement actions while an ALJ or DAB appeal is pending. This results in Treasury offset or payment under protest by RREs. Accordingly, we submit the following questions:

- Are penalties subject to the Treasury offset program?
- If so, will they be stayed pending an appeal?
- Does interest accrue on penalties?
- Does the RRE have the option of paying the penalties during the pendency of the appeal and if the appeal is partially or fully successful having CMS reimburse the RRE for the payment?
- What is the expected timeframe for an RRE appealing a CMP to obtain a hearing before an ALJ?

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Implementation of Final Rule

As a result of response to the coronavirus pandemic, some RREs have reported diverting staff resources away from Section 111 reporting to more critical and immediate needs. Other RREs have unfortunately had to furlough or layoff staff. While we hope this is short-term, this is nonetheless the present situation. RREs, of course, still have an obligation to properly report pursuant to the MSP Act. Nonetheless, during what we hope is a recovery period for both private and public entities through the balance of 2020, we request no final rule be implemented until at least 1/1/2021.

Tower MSA Partners appreciates the opportunity to share its thoughts and comments in response to CMS' proposed rule on Medicare Secondary Payer civil monetary penalties. Tower hopes that the comments and information provided are helpful to the agency in further evaluating this matter. Please do not hesitate to contact us if you have any question or would like additional information.

Sincerely,

Daniel M. Anders, Esq.
Chief Compliance Officer
Tower MSA Partners