Medicare Mayhem!

Tackling New CMS Updates to Stay Compliant, Reduce Risk, and Settle Claims

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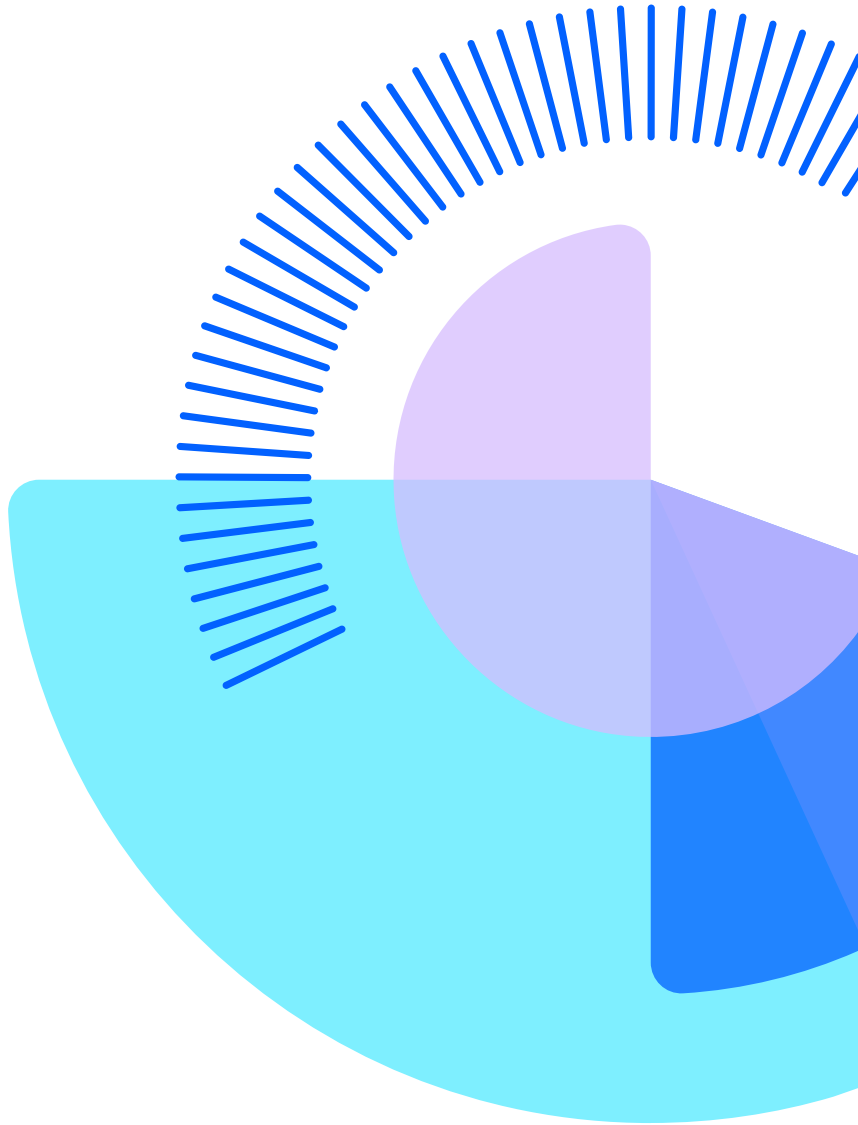

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Today's Focus Points

- Setting the stage – quick Medicare/MSP refresher
- Focus Point Topics
  - Section 111 reporting
  - TPOC/WCMSA reporting
  - $0 WCMSA
  - Medicare conditional payments (“liens”)
  - What's up in DC?
- Revising MSA best practices

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Setting the Stage

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Medicare Program Basics

Red Flags – Medicare entitlement

1. Age – 65 years (or older)
2. Social Security Disability
3. End Stage Renal Disease
4. ALS (Lou Gehrig's Disease)

Medicare Program "Parts"

A & B = Traditional Medicare (1965)

C = Medicare Advantage (1997)

D = RX Drugs (2006)

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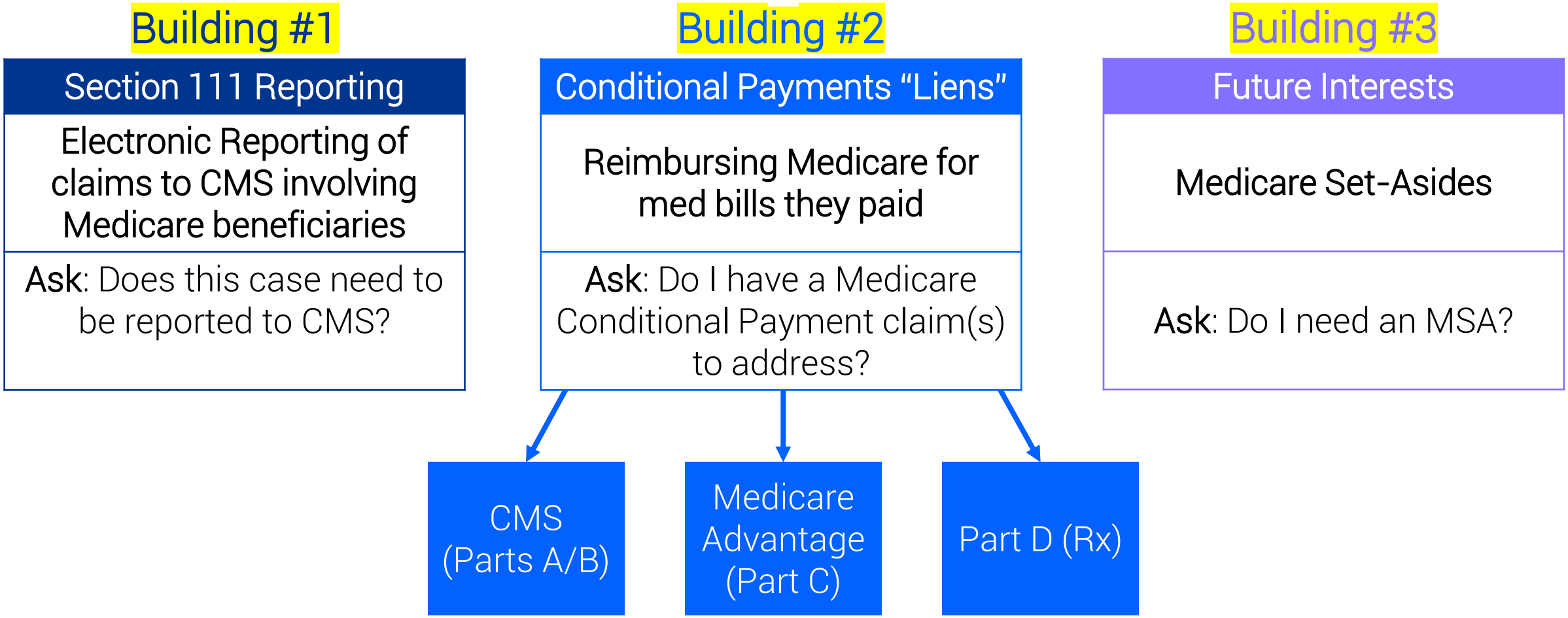
Medicare Secondary Payer – The Medicare "Campus"



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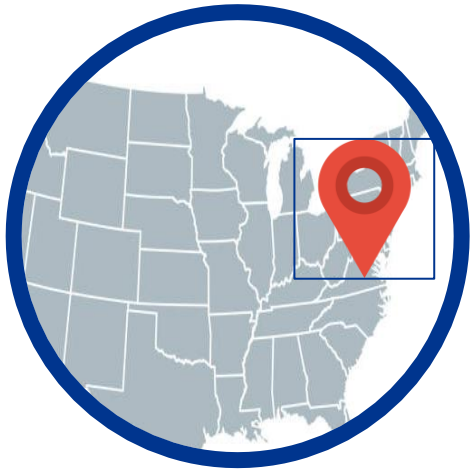
Section 111 Reporting – CMS's Capital City



Responsible Reporting Entities - RREs (insurers)

Send data to CMS via Section 111 reporting process

CMS then uses the data for MSP purposes

1. Section 111

Failure to report properly subjects RREs to civil money penalties "up to $1,512 per day, per claim)

2. Conditional Payments

CMS uses the data to initiate recovery (Part A/B)

3. WCMSA

Starting 4/4/2025, CMS now uses data to assess WCMSA practices

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CMS Query Process – Determining Medicare Status

CMS Query Process

Big 5 Data Points

1. First Name
2. Last Name
3. Gender
4. Date of Birth
5. SSN/MBI/HICN (or last five digits of SSN)

What CMS returns if there is a "hit"

- The most recent Part A and Part B entitlement dates; AND
- Part C (Medicare Advantage) and Part D (RX Drugs) (if applicable)
  - ✓ Contract name and number
  - ✓ Plan number, coordination of benefits (COB) address, and
  - ✓ Entitlement dates for the last three years (up to 12 instances) of Medicare Advantage and Part D coverage.

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Section 111 Reporting – High Level

ORM
"Ongoing Responsibility for Medicals"

- RRE reports claim to CMS when it "has made a determination to accept on-going responsibility for medicals (ORM)."
- This happens before case settles. Typically, WC, NF and med pay claims
- Insurer reports body parts, illnesses, etc. for which they are assuming responsibility

TPOC
"Total Payment obligation to the claimant"

- Settlements, judgments, awards, and other payments
- Medicals claimed, released, or the settlement has effect of releasing medicals
- $750 threshold physical trauma cases; no threshold for exposure, ingestion, and implantation
- CMS knows when claims settles etc.

Late TPOC/ORM reports can subject RRE to a penalty of "up to $1,512 per day, per claim"

What Gets Reported? (not an exhaustive list)

- Several different claim data points get reported
- Basic data points include:
  - ✓ Claimant info (Big 5 Data)
  - ✓ Claimant Rep info
  - ✓ Date of incident
  - ✓ Venue
  - ✓ Injury info – ICD codes
  - ✓ ORM/TPOC info

❖ For WC… starting 4/4/2025, CMS now also collects WCMSA data points re: Settlements with Medicare beneficiaries

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Focus Point # 1
Section 111 penalties

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Section 111 Civil Money Penalties – Snapshot

When can RREs be penalized?

- When the RRE "[f]ails to report any beneficiary record within 1 year from the date of [TPOC], or the effective date where [ORM] has been assumed by the entity."

- For TPOC –
  - ✓ CMS uses the TPOC Date submitted, unless the "Funding Delayed Beyond TPOC Start Date" is submitted.
- For ORM –
  - ✓ CMS compares the date of the RRE's file submission with the CMS's Date of Incident reflected in the ORM coverage record.

Prospective Application

- Only coverage record submissions with coverage effective dates (ORM) or TPOC dates of October 11, 2024, or later are in scope for CMPs.

- How about records that predate 10/11/24?
  - ✓ CMS cautions that accurate reporting for these records is still statutorily required and failure to properly report these records could subject RREs to other recovery actions including, but not limited to, False Claims Act suits or administrative recovery efforts.

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CMPs Penalty Calculation

CMS will use a "tiered" approach to penalize RREs as follows:

Tier 1 Over 1 year late, but less than two years	$378 for each calendar day of non-compliance
Tier 2 Over 2 years late, but less than 3 years	$756 for each calendar day of non-compliance
Tier 3 Over 3 years late or more	$1,512 for each calendar day of non-compliance

Max penalty for single instance of non-compliance will not exceed $551,880

(The above rates are based on the current adjusted inflation rates as announced in the Fed. Reg. Jan 2026. Remember, CMPs are subject to yearly inflation adjustments, so the above rates will at some point be "adjusted.")

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Section 111 Civil Money Penalties (CMPs) – Snapshot

Notice/Appeal

1. Informal Notice
   - ✓ RREs will have 30 days to submit "mitigation evidence"
   - ✓ CMS indicates this deadline will be strict
2. Formal Notice
   - ✓ If CMS believes CMPs should be imposed, they will then send the RRE "formal notice"
   - ✓ RREs will have administrative appeal rights
     - ➢ Administrative Law Judge (ALJ)
     - ➢ Departmental Appeals Board (DAB)
     - ➢ Judicial Review
   - ✓ Timely appeal filings will be critical

Notice of "Final Determination"

- Confirms that the RRE's CMP is final.
- Notice of Final Determination will be issued if the RRE:
  - ✓ does not request a hearing or appeal;
  - ✓ elects to terminate the appeals process, or
  - ✓ otherwise exhausts all available administrative appeal rights and the CMP is upheld.
- Will be sent by certified mail.
- Instructions will be provided re: how the RRE should remit payment – CMS will only accept electronic payment via Pay.gov eBill

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Focus Point # 2
TPOC/WCMSA Reporting

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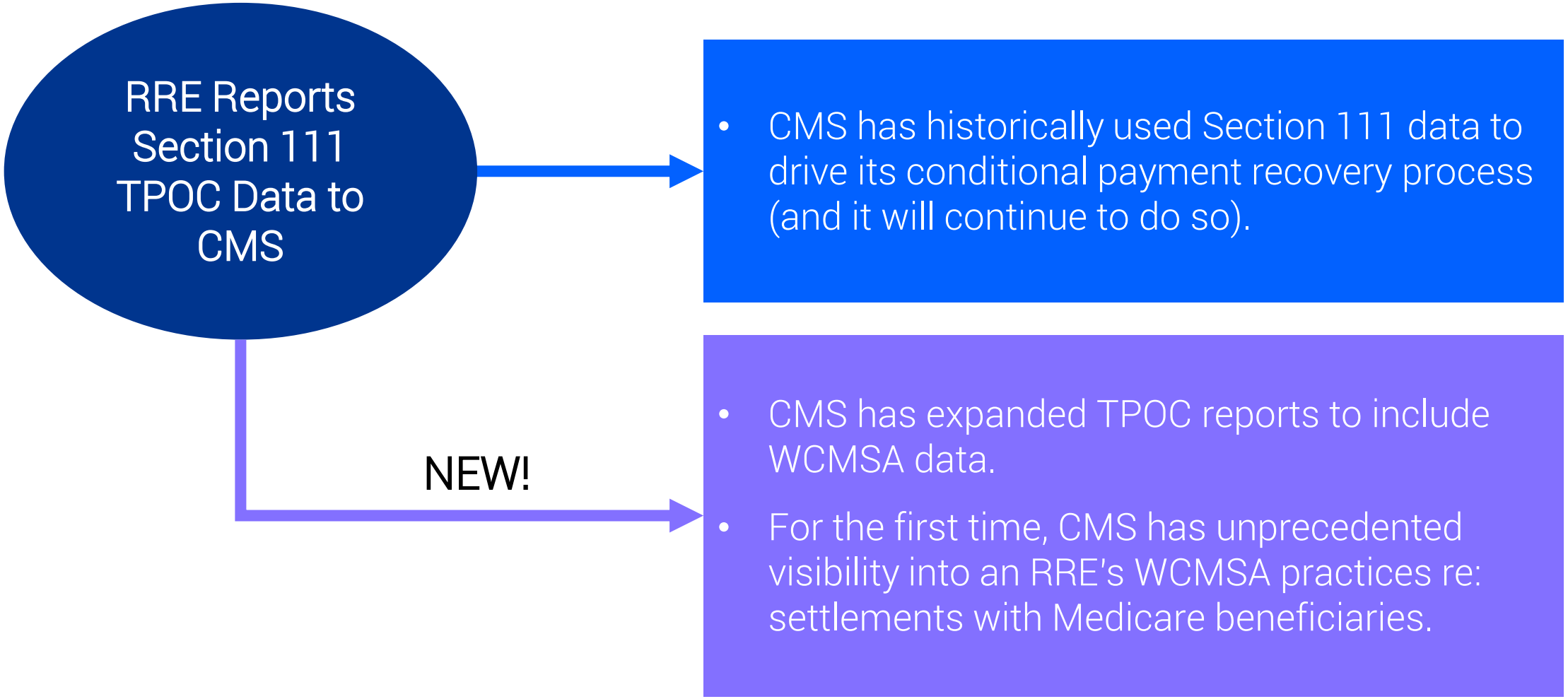
TPOC/WCMSA – Seeing the Big Picture



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TPOC/WCMSA Compliance – Practical Perspective

Effective April 4, 2025*, WC insurers must report the new TPOC/WCMSA data fields for settlements with Medicare beneficiaries as follows:

WC settlement with a Medicare beneficiary:

- Greater than $25k
- $25k or less (low dollar settlement)
- No WCMSA or $0 WCMSA (CMS reserves right to audit)

In each of these scenarios, WC carrier must report the new TPOC data points

TPOC/WCMSA Data Points
1. MSA Amount
2. MSA Period
3. Lump Sum or Structured/Annuity Payout Indicator
4. Initial Deposit
5. Anniversary (Annual Deposit)
6. Case Control Number (optional)
7. Professional Administrator EIN (optional)

*Applies to Section 111 coverage reports with TPOC dates April 4, 2025, or later.

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Compliance Impact – How CMS is using TPOC/WCMSA data

MSAs are now tracked and validated against S.111 data

- Impacts Medicare payments
- May change status of MSA approvals
- Tracks MSA spend and administration

Provides CMS a pathway to audit MSA use in WC settlements involving Medicare beneficiaries

- CMS knows which cases include MSAs
- May bring all available means to enforce program including bringing a False Claims Act claim and auditing $0 WCMSA values.

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TPOC/WCMSA – Protocol Considerations

WC settlement with a Medicare beneficiary

Settlement Greater than $25K "Threshold Settlement"	Settlement $25K or Less "Non-Threshold Settlement"	No WCMSA or $0 Dollar WCMSA
• Settlement meets CMS' voluntary WCMSA "review threshold"	• Settlement does <u>NOT</u> meet CMS's WCMSA review threshold	• "$0" MSA value must be submitted
• Submit to CMS?	• What are you doing here?	• CMS reserves the right to audit $0 MSA value
• Do not submit? ✓ Non submit ✓ Evidence based medicine MSA (EBMSA) ✓ WCMSA Ref. Guide Section 4.3	• Remember, CMS's review threshold are <u>not</u> safe harbors, and CMS states its interests still need to be considered. WCMSA Ref. Guide Section 8.1	

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Does TPOC/WCMSA reporting apply?

Case #1

- WC claim.
- CL is not a Medicare beneficiary.
- Total settlement amount (as defined by CMS) = $580,000.

Case #2

- WC claim.
- CL = Medicare.
- Parties settling out indemnity but keeping medicals open.

Case #3

- WC claim.
- CL = Medicare beneficiary.
- Total settlement amount (as defined by CMS) = $75,000.

Case #4

- WC claim
- CL = Medicare beneficiary.
- Total settlement amount (as defined by CMS) = $19,000

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Focus Point #3
CMS's new $0 WCMSA Policy

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CMS has waived goodbye to reviewing $0 WCMSAs!!

CMS no longer reviews $0 WCMSAs effective 7/17/25

Let's break down CMS's new $0 WCMSA policy effective 7/17/25

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CMS's New Zero MSA Guidelines (Section 4.2, WCMSA Ref. Guide)

$0 WCMSAs are still appropriate if Medicare's interests are protected in the following scenarios:

1. Medical Basis	2. Denied Claim and No Payments	3. Court Determination	4. Denied claim and payments made within pay without prejudice period
• Treating Physician Note. • Physician indicates: To a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury.	• Denied claim under law. • No payments medical or indemnity, unless investigating. • Medical and indemnity not actively paid.	• Ruling on the merits that no benefits are owed. • Medical and indemnity not actively paid.	• Denied claim under law • Payments made without prejudice within rules of WC law • Medical and indemnity not actively paid

In all 4 scenarios CMS emphasizes that a $0 WCMSA is appropriate when the settlement agreement does not allocate certain amounts for specific future or past medical or pharmacy services as a condition of settlement.
*** Insurers must maintain supporting documentation in their file ***

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Focus Point # 4
CMS (Parts A/B) Conditional Payment Claims

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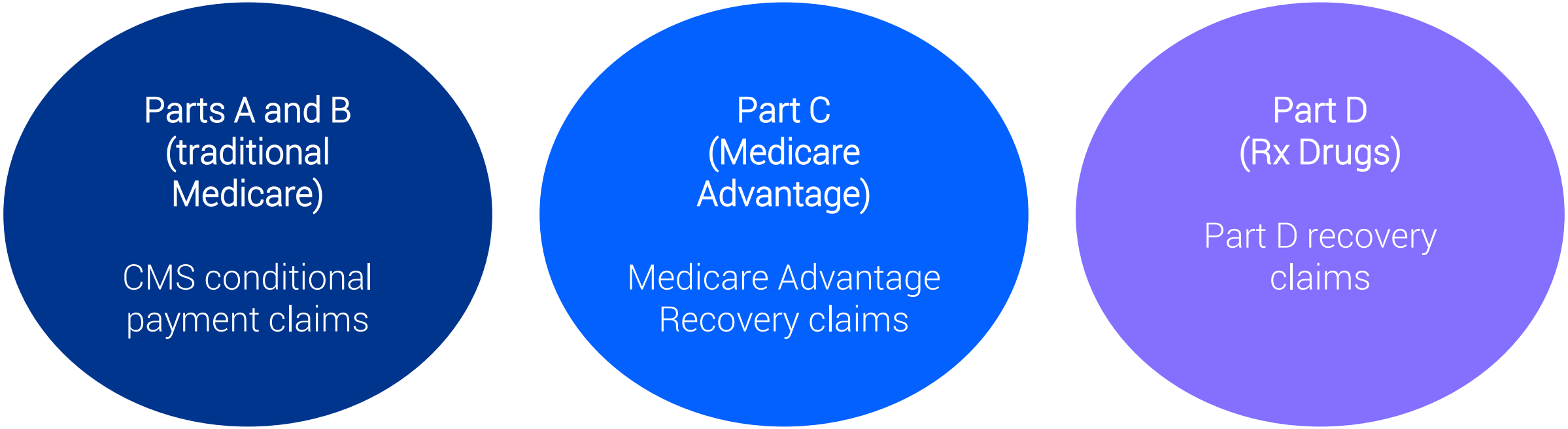
Types of Medicare Recovery Claims



Knowing which Medicare "part" the claimant is/was enrolled is important – this helps determine what type of Medicare recovery claim(s) you may have!
Let's break them down…

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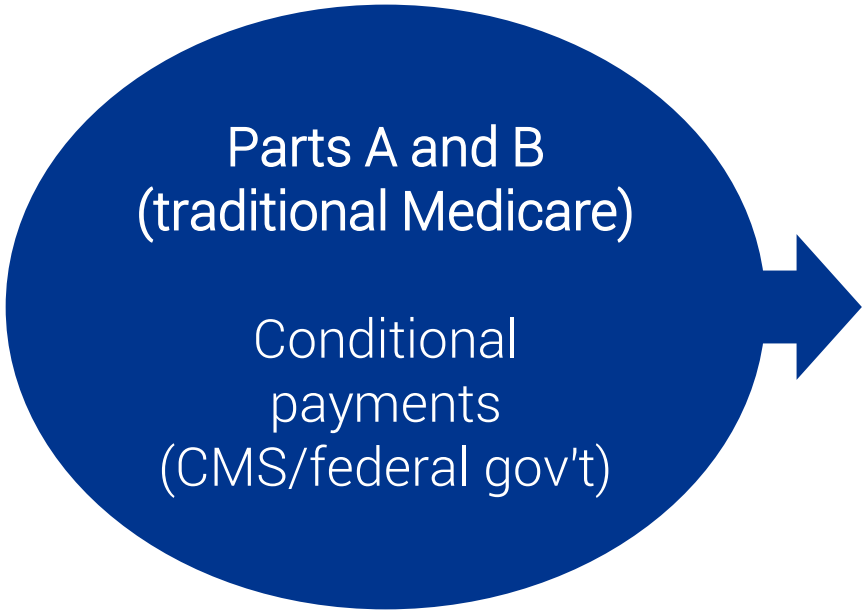
Medicare Parts A and B – CMS Conditional Payment Recovery



CMS – Highlights
• CMS (federal gov't) has strong rights ✓ Can pursue insurer, claimant, and/or claimant attorney ✓ Interest accrual ✓ Treasury claims (including offset) ✓ Double Damages ✓ Department of Justice
• CMS uses two contractors: ✓ BCRC – Benefits Coordination and Recovery Center ✓ CRC – Commercial Repayment Center
• Challenging/Disputing Conditional Payment claims (5 levels appeal process

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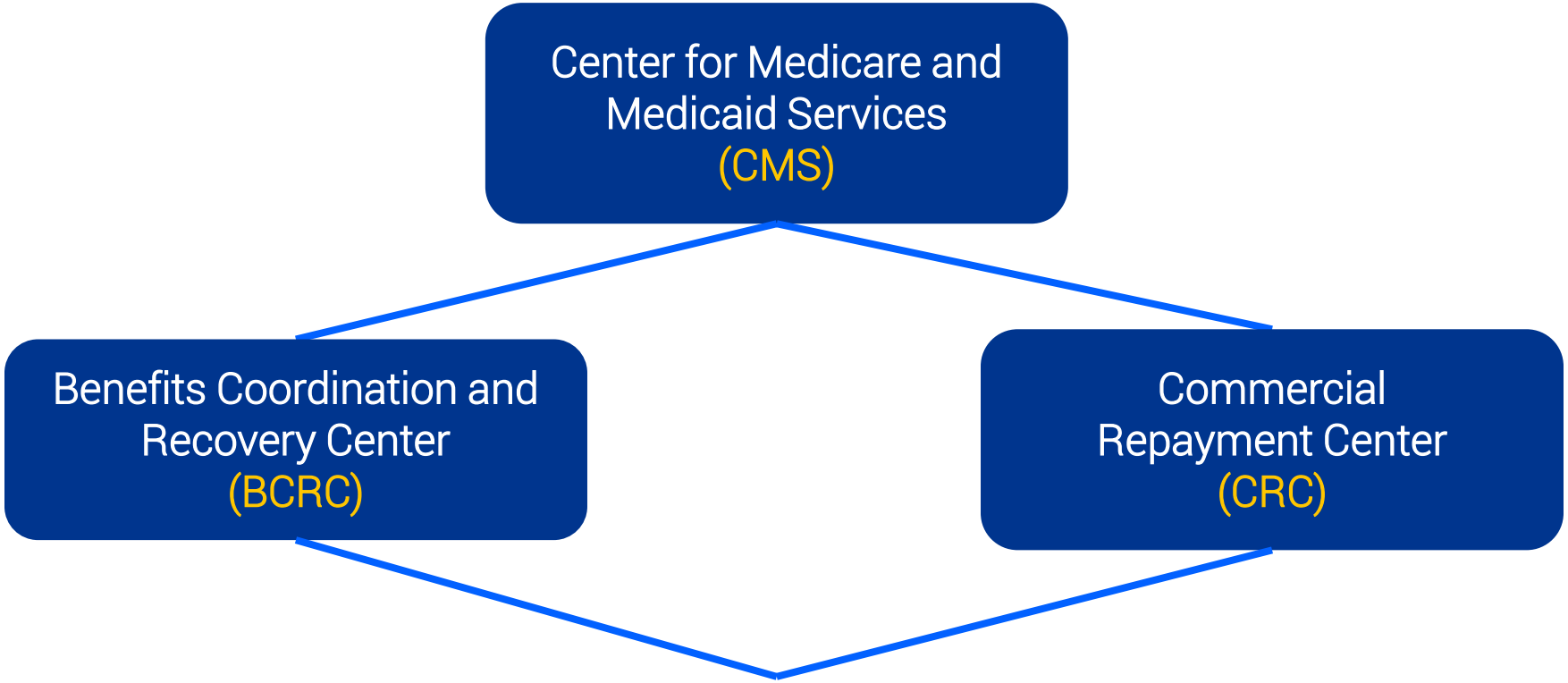
Medicare Parts A & B: Who's Who?



These are the contractors that help CMS with its conditional payment recovery activities.

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Parts A & B: Which Contractor Does CMS Use and When?

ORM
On-going responsibility for medicals

CMS uses CRC

CRC Recovery

- ✓ CRC pursues WC/NF/Med-Pay/ PIP when ORM = YES
- ✓ Debtor = Carrier/Self-Insured
- Authorization Required = Letter of Authority (LOA)
- CRC Correspondence is time sensitive
- Deadlines must be adhered to
- Demands are made prior to settlement
- Rolling recovery = Multiple recovery cases and multiple lien demands

TPOC
Settlement judgment award or other payment

CMS uses BCRC

BCRC Recovery

- ✓ BCRC pursues Liability Settlements and Post-TPOC WC claims
- ✓ Debtor = Plaintiff/ Medicare Beneficiary/Claimant – but remember, insurer remains ultimately liable per 42 CFR 411.24
- Authorization Required = Proof of Representation (POR)
- Post TPOC WC Claims - debtor switches to claimant/POR is required
- Demand is made post settlement

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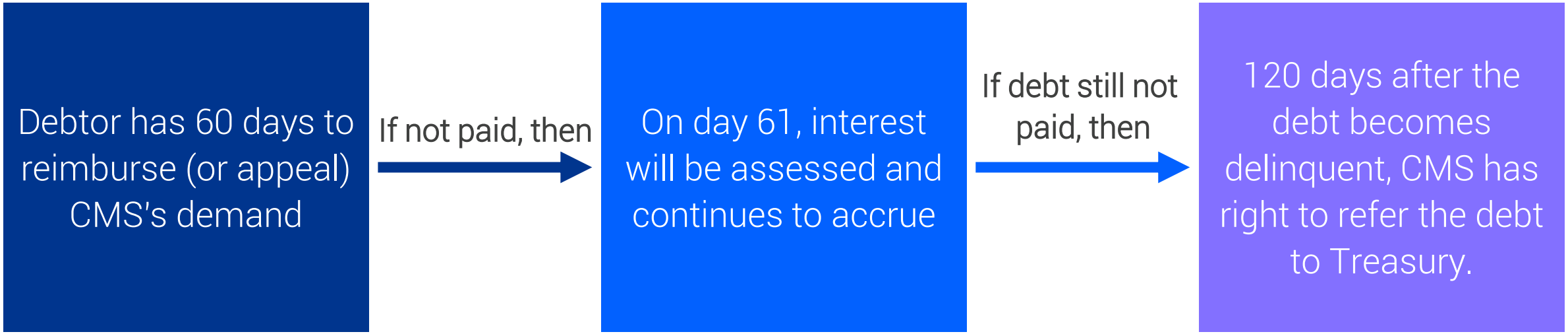
Treasury Claims: Demand to Collection

- If CMSs demand is not reimbursed timely, then they will refer the debt to the Treasury Department.
- Here is how a claim gets to the Treasury:



Treasury uses the Treasury Offset Program and a panel of Private Collection Agencies to collect debts

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Challenging Conditional Payment Claims

Challenging/Appealing CMS Claims
1. Redetermination
2. Reconsideration (Qualified Independent Contractor (QIC)
3. Administrative Law Judge (ALJ)
4. Medicare Appeals Council (MAC)
5. Federal Court

NOTE: Courts are strict about adhering to the filing timelines and exhausting administrative remedies before the court has jurisdiction

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Focus Point # 6

Medicare Advantage Plans (MAPs) and Part D Conditional Payments

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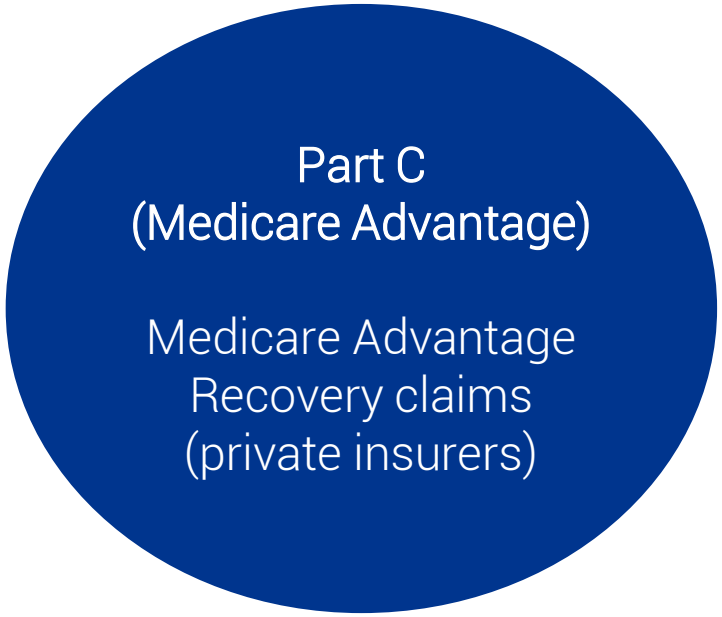
Medicare Advantage (Part C) Recovery Claims – Nutshell



Medicare Advantage Plans (MAPs) – Highlights
• Medicare plans provided by private insurers (not CMS)
• Approx. 33 million people are enrolled in a MAP – 51% of all Medicare beneficiaries – close to 3,500 plans nationally
• Top three MAP providers = United Healthcare (29%), Humana (17%), and BC/BS (11%)
MAPs have recovery rights ✓ Medicare Advantage statutes and regulations ✓ Alert: the courts in some jurisdictions have also allowed MAPs to sue for "double damages" ✓ CMS, BCRC, and CRC are <u>NOT</u> involved in the recovery process – you must deal directly with the MAP (or its recovery company)

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Do MAPs have recovery rights?

MAP Stats/
Regulations?

Yes – MAPs may "bill"
or "charge"

Double Damages under
the MSP?

Depends on Jurisdiction

Let's take a look...

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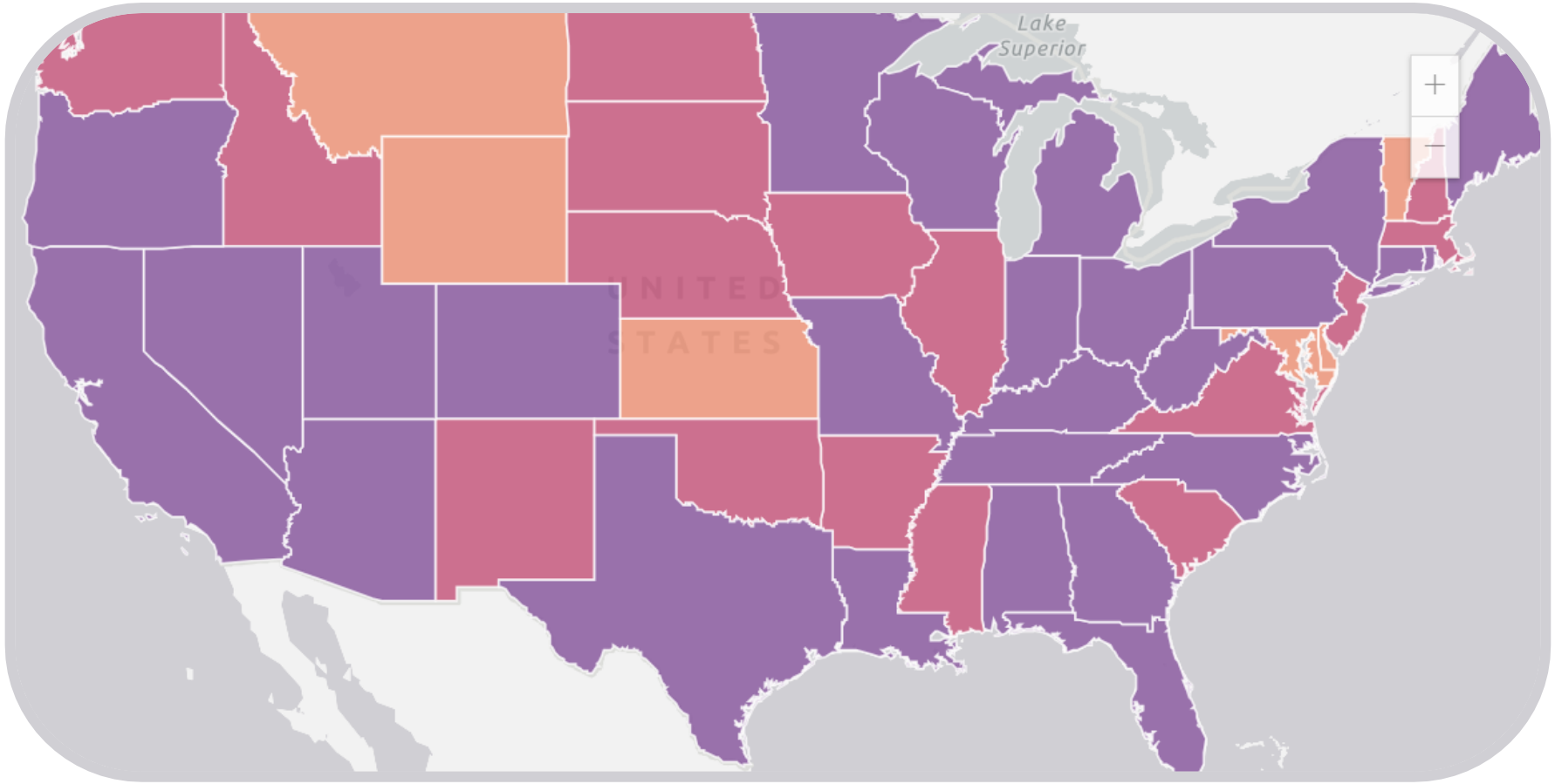
Medicare Advantage: Enrollment Rates (CMS Data)



Source: CMS, Data.CMS.gov, Medicare Enrollment Dashboard | CMS Data (September 2025); retrieved 1/14/26

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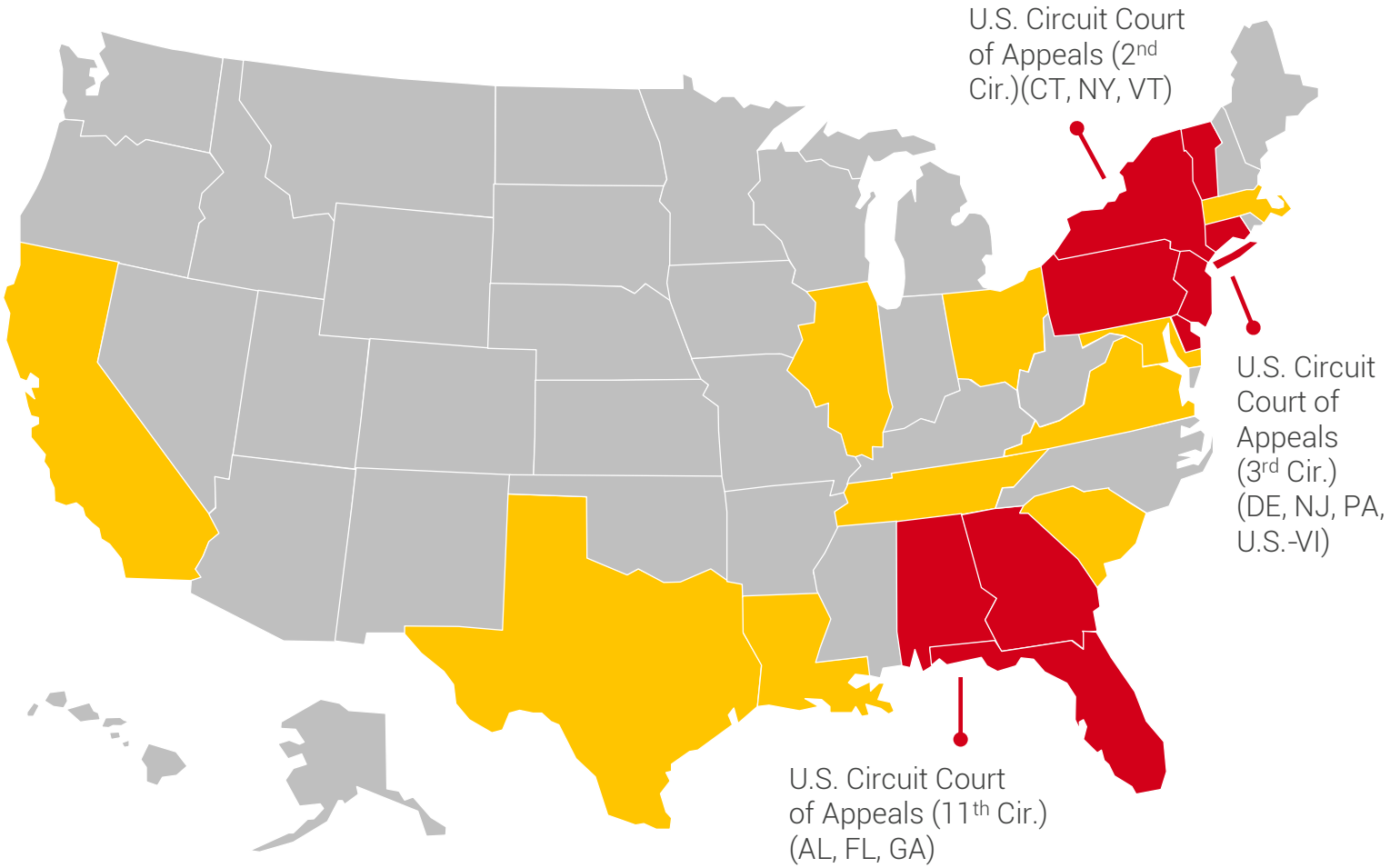
Medicare Advantage Plans: "Double Damages" Issue



Can Medicare Advantage Plans sue for double damages?

- U.S. Circuit Courts of Appeals = Yes
- U.S. District Court(s) = Yes
- Not yet addressed

Question: How about D Plans?

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Medicare Part D (RX Drugs) Recovery Claims – Nutshell

Part D
(Rx Drugs)

Part D recovery claims
(private insurers)

Part D – Highlights
• Outpatient prescription drug plans provided by private insurers
• Stand alone prescription drug plans PDPs (Parts/AB) • Medicare Advantage prescription drug plans MA-PDs
• 56 million Medicare beneficiaries are enrolled in Part D (approx. 80% of all Medicare enrollees) • Main Part D providers: UnitedHealth, Humana, CVS Health, Centene, CIGNA (cover 75% of all Part D enrollees).
✓ Part D plans have recovery rights ✓ Federal stats/regs – Part D plans have the same recovery rights as MAPs ✓ Double Damages too? ✓ CMS, BCRC, and CRC are <u>NOT</u> involved in the recovery process – you must deal directly with the Part D plan (or its recovery company)

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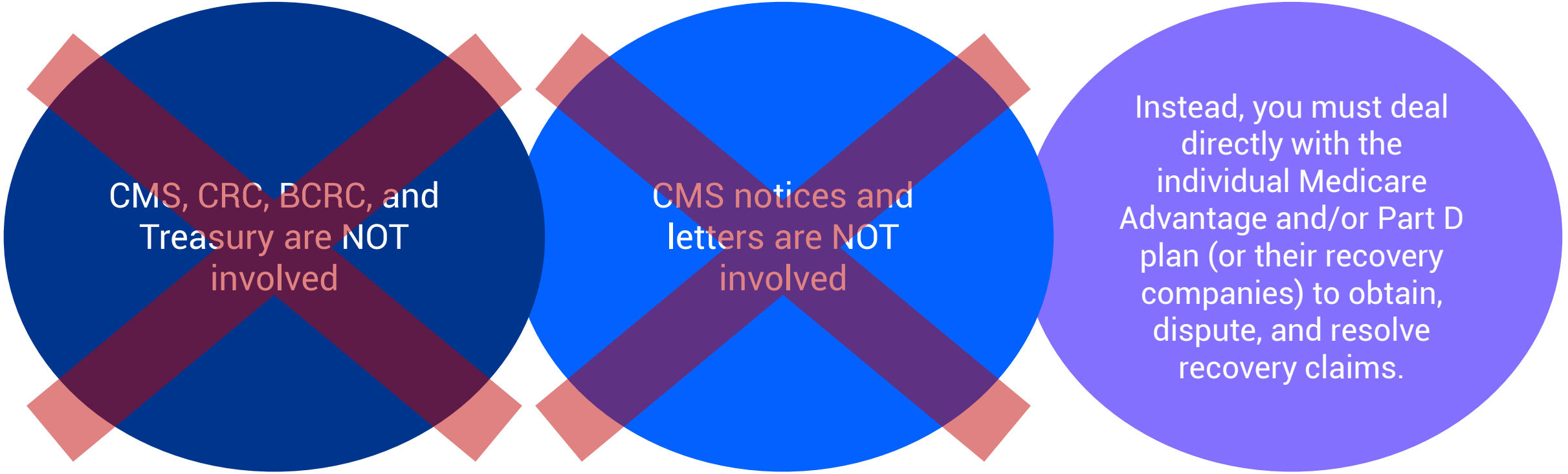
MAP and Part D Recovery Process (it is different from CMS's process)



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Medicare Recovery – True / False

1. The Section 111 Query is helpful as it provides information regarding the claimant's Medicare plan type.
2. The Section 111 Query provides you with Medicare recovery ("lien") amounts.
3. Settlement language where the claimant agrees to be responsible for resolving Medicare liens protects the carrier from Medicare.
4. You can get Medicare's final demand amount prior to settlement.
5. Medicare doesn't negotiate their lien amounts.
6. There may be multiple Medicare liens from a single settlement.
7. You can request MAP and Part D lien amounts from the BCRC.

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Focus Point # 7
What's up in DC?
RAMP Act

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What's up in D.C.? RAMP Act

Repair Abuses of MSP Payments (RAMP) Act

- **Proposal**: If passed into law, the RAMP Act would eliminate non-group health plans from the MSP's private cause of action provision, which is the provision of the statute that allows for "double damages" recovery against insurers (and potentially other parties) in certain circumstances.
- **Potential Claims Impact:**
  - Medicare Advantage "double damages" actions.
  - Other MSP related issues

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Questions?

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