# PUBLICATION

## CMS Seeks Comments on Establishment of CMPs Related to MSP Reporting [Ober|Kaler]

**January 23, 2014**

CMS recently solicited comments for the development of methodologies and criteria to be used in evaluating whether or not to impose civil money penalties (CMPs) on arrangements of certain group health plans (GHPs) and non-group health plans (non-GHPs) that are noncompliant with Medicare Secondary Payer (MSP) reporting requirements. The notice of proposed rulemaking [PDF] was published in the Federal Register on December 11, 2013, and **comments are due by February 10, 2014**.

Provisions of the Social Security Act (the Act) define when Medicare is the secondary payer to certain primary plans. Act § 1862(b). Generally, Medicare is prohibited from making payment if payment can be expected to be made by certain types of primary plans, where certain conditions are met. Those primary plans include group health plans, workers' compensation plans, liability insurance, and no-fault insurance.

In 2007, Congress added mandatory reporting requirements for GHP and non-GHP arrangements, such as liability insurance, no-fault insurance, and workers' compensation. Act §§ 1862(b)(7), (b)(8). GHPs and non-GHPs must report to CMS when they pay a claim on behalf of a Medicare beneficiary. Such reporting facilitates CMS's determinations of when other insurance coverage is primary to Medicare. CMS uses the information reported to prevent improper payments, and to seek repayment when Medicare paid but a different payer was primary to Medicare.

CMS has the authority to impose CMPs against GHPs and non-GHPS for noncompliance with the reporting requirements. Congress originally authorized the Secretary of the Department of Health and Human Services (DHHS) to assess CMPs against health care facilities, practitioners, and suppliers for noncompliance with Medicare and Medicaid rules in 1981. Since that time, DHHS has implemented CMPs as an alternative enforcement tool for agencies working to ensure compliance with statutory and regulatory mandates. The MSP provisions were also revised over time, and now the non-GHPs *may* be subject to a CMP of up to $1,000 per day for failure to comply with the reporting requirements. This penalty is discretionary and, consequentially, CMS is working to establish methodologies and criteria for determining when to implement CMPs.

Through its notice of proposed rulemaking, CMS solicited comments regarding the specification of practices for which CMPs would or would not be imposed in accordance with sections 1862(b)(7) and (b)(8) (42 U.S.C. 1395y(b)(7)(B) and (8)(E)). Specifically, CMS is interested in:

1. defining “noncompliance” in the context of the phrase “for each day of noncompliance with respect to each claimant…” in sections 1862(b)(7) and (b)(8) of the Act;
2. establishing particular mechanisms and criteria that could be used to evaluate whether a CMP would be imposed;
3. devising methods to determine the dollar amount of a CMP that would be levied for each day that a non-GHP is the responsible reporting entity and is noncompliant under section 1862(b)(8) of the Act; and
4. developing methods and criteria to determine which actions would constitute a “good faith effort” taken by an entity to identify a Medicare beneficiary for the purposes of reporting under section 1862(b)(8) of the Act.

## Ober|Kaler's Comments

CMS's notice of proposed rulemaking seeks to develop a systematic approach to implementing CMPs against noncompliant GHPs and non-GHPs. Changes to the processes that have been used up to this point are clearly on their way. Industry entities should take note of this proposed rulemaking because this is the industry's opportunity to play a role in the creation of methodologies and criteria that will be used to evaluate their own actions in the future. Comments are due by February 10, 2014.