November 19, 2013

Via Overnight Delivery
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS–6054–IFC
Mail Stop C4–26–05
7500 Security Boulevard, Baltimore, MD
21244–1850

Re: CMS-6054-IFC; MEDICARE PROGRAM; OBTAINING FINAL MEDICARE SECONDARY PAYER CONDITIONAL PAYMENT AMOUNTS VIA WEB PORTAL

Dear Sir or Madam:

DRI – *The Voice of the Defense Bar*, greatly appreciates the opportunity to provide comments and feedback to the Interim Final Rule with comment ("IFR") with respect to obtaining final Medicare Secondary Payer Conditional Payment amounts via the Web Portal under the Medicare Secondary Payer ("MSP") Act. As background, DRI is an international organization of defense attorneys and corporate counsel that is recognized as a thought leader and an advocate for the defense bar at the national and state level, as well as in Europe. With more than 22,000 members, DRI provides members and their clients with access to world-class education, legal resources and numerous marketing and networking opportunities that facilitate career and law firm growth. For more information, log on to www.dri.org.

DRI specifically created an MSP Task Force to help educate its members and their clients on all MSP issues, with the goal of ensuring that the Medicare Trust Funds are reimbursed the appropriate amount. The MSP Task Force has been active in handling matters involving MSP issues and educating the legal community on these issues. Below, we provide our experiences, observations, comments and feedback to the IFR.

Threshold Considerations.

There is a long-standing strong judicial policy in favor of settlements over trials. Further, the sooner a claim is resolved the sooner money will be returned to the Medicare Trust Funds. Accordingly, the promotion of settlement must be a primary focus of CMS' Rules. To encourage settlement CMS' Rules must provide both predictability and finality, and to do so within a reasonable timeframe. Absent these certainties, parties will be discouraged from settlement, resulting in Medicare beneficiaries being treated differently from non-Medicare beneficiaries. That will place Medicare beneficiaries at a significant disadvantage. Lawyers will not agree to represent them because of the uncertainty and the cost of handling their claims. Further, Medicare beneficiaries will be discouraged from bringing claims, resulting in a more rapid depletion of the Medicare Trust Funds. Finally, defendants and insurers will not agree to settle a claim involving a Medicare beneficiary because they will not possess the peace of mind required for them to close their files with finality and satisfy insurance and accounting requirements.

In order to adhere to long-standing judicial policies, the Rules CMS promulgates must recognize that liability claims, unlike workers compensation and no-fault insurance claims,

are inherently a compromise of the claims by all parties. In both workers compensation and no-fault claims, once responsibility is accepted, claims for medical expenses are paid in full which drives the value of settlement. Further, there is no recovery for non-economic based damages. Whereas in the liability context, there are a number of factors that drive value of the case; medical expenses is just one factor. Other factors include the likelihood of prevailing at trial, other economic and non-economic losses such as lost wages, lost earning capacity, pain and suffering, and/or loss of consortium. Nevertheless, it is crucial for a plaintiff to know the precise amount he or she must reimburse Medicare out of the settlement amount in order to understand how much he or she is personally recovering as part of the net proceeds ultimately received. Medicare beneficiaries cannot make an informed decision absent such critical data.

Further, because liability settlements often happen on short notice, the 120 days established by Congress is the maximum amount of time parties should have to wait to learn the final amount Medicare needs to be reimbursed. Accordingly, provision of prompt and accurate Final Conditional Payment amount is crucial to the success of settlement of a claim and thereby prompt return of monies to the Medicare Trust Fund. For these reasons, CMS should carefully consider the significant differences between liability claims and worker's compensation or no-fault insurance claims in honoring Congress' direction and intent in enacting the SMART Act.

Many Medicare beneficiaries pursue claims for reimbursement without using counsel. There are many important societal reasons why informal claims resolution without counsel should be encouraged. CMS should be careful in its rulemaking to avoid either assuming that all Medicare beneficiaries pursuing claims are represented by counsel or building into its rules a *de facto* requirement of counsel.

Upon review and consideration, we would be pleased to elaborate on any comments or suggested feedback provided.

The Interim Final Rule.

The IFR fails to comply with the SMART Act's requirements to such a degree that it would be most efficacious for the Agency to withdraw the IFR and issue a new notice of proposed rulemaking with proposed rules that implement the requirements of the SMART Act. When compared to the charge of Section 201 of the SMART Act, the IFR fails to meet the SMART Act's mandate.

Of primary concern to DRI is the Agency's failure to meet the requirements of the SMART Act to streamline the conditional payment process such that parties attempting to settle a claim can know what their obligations to the Medicare Trust Funds are within 120 days of an anticipated settlement, thereby facilitating settlements, and facilitating quicker repayment to the Medicare Trust Funds. Section 201 of the SMART Act calls for an individual, representative or plan to provide 120 days' notice of a potential settlement, judgment, award or other payment – not 185 days' notice as in the Rule. Thus, the SMART Act specifically set out that a final conditional payment amount would be provided within 120 days before an anticipated settlement. The 65 days that the Agency has to respond is supposed to fall within the 120 days, not to precede the 120 days as proposed by the Agency in the IFR.

This misinterpretation is highlighted in the Agency's proposal that the "initial notice of a pending liability… settlement" must be made "at least 185 days before the anticipated date of settlement." See 42 C.F.R. § 411.39(c)(1)(i). This 185 day period has no basis in the SMART Act. See 42 U.S.C. § 1395y(b)(2)(B)(vii)(I). In fact, this proposal is contrary to the SMART Act's direction that the entire process complete within 120 days.

Another concern is that the proposed 30 day extension period that the Agency can request beyond the 65 day period, as contemplated by the SMART Act, is to fall within the 120 period as well. It is not as the

Agency proposes to be added on before the 120 day period begins to run. As discussed above, it is unacceptable for the Agency to attempt to expand the 120 day period specified by the SMART Act.

Even 120 days, in many cases, is longer than most parties take to settle a claim. Thus, for many parties, even the SMART Act does not do enough to provide them with finality in reaching settlement. For parties to finalize a settlement, they must know the final amount Medicare requires to be reimbursed.

Another significant concern for DRI is that the IFR does not meet the SMART Act requirement that Plans must have access to conditional payment information. Section 201 (II) of the SMART Act requires that the Secretary provide a website that allows individuals who receive items and services, their representatives **and** the Plans to utilize the website to determine the final conditional payment amount. In regard to resolution of conditional payments, the SMART Act does not distinguish between actions or access of a Plan as opposed to an individual or representative. Therefore, DRI asks the Agency to reconsider the procedure set out in the IFR.

First, the IFR indicates that Plans will not have access to un-redacted information about conditional payments until 2016, which contradicts the intent of the SMART Act. Further, in order for Plans to have access to this information the IFR provides that Plans not only have to register under the multifactorial authentication process, but they will also have to obtain and provide at least two different consent forms. It is undisputed that a beneficiary's privacy must be protected; however, in making a claim, the beneficiary implicitly waives privacy as to the conditional payments related to that claim. For a Plan to reimburse those conditional payments, it needs access to the beneficiary's conditional payment data. If a Plan cannot access this data it is patently unfair to hold the Plan legally liable for any failure to make a repayment.

Further, workers compensation and no fault insurers routinely have access to claim information without the need to obtain even one, much less two, different consent forms from beneficiaries, thus there is no reason why this cannot also be the situation for liability insurers and self-insureds. Finally, when a beneficiary is not represented by counsel it is often the case they will not sign a consent form. Requiring that they sign two different consent forms is essentially an insurmountable barrier to settlement in many cases. Lack of access as required by the SMART Act may hinder a Plan from addressing conditional payments where a beneficiary does not have a representative.

Another concern to DRI is the Agency's proposed regulation at 42 C.F.R. § 411.39(b)(1)(i) which requires the beneficiary to create an account in order to use the portal. This requirement creates an insurmountable obstacle for many beneficiaries and plans. The vast majority of Medicare beneficiaries lack the technology knowledge to manage all the Agency's proposed rule requires, especially on top of the complicated obligations under the MSP Act. Further, in most claim situations a Medicare beneficiary is not represented by counsel, thus they cannot rely on the assistance of their counsel or representative to help. The Agency should eliminate this requirement in its entirety, but if it does not, then at a minimum this requirement must be modified to make it less cumbersome to address the fact that the beneficiary population is generally not computer savvy and thus will face challenges with this process.

DRI is also concerned with the Agency's proposed rule requiring the beneficiary or his or her representative to submit settlement information within thirty days after the settlement to allow the Agency to then calculate a pro rata reduction to the final conditional payment amount reflecting attorney's fees and costs and then issue a final demand letter. This additional step does not make sense for the many claimants who are not represented by counsel and thus would not qualify for any such reduction. Thus, this requirement should be optional, not mandatory. The beneficiary should have an option to not pursue this reduction so that the amount provided by the Agency is in fact the final demand amount. Further, the proposed rule does not specify the time by which the Agency must respond to the submission. Again,

finality is of crucial importance to resolution of claims and prompt payment to the Medicare Trust Funds. Thus, a definite time frame should be established for the Agency to respond and identify the amount by which a reimbursement amount is reduced to account for legal fees and costs.

Next, 42 C.F.R. § 411.39 (c)(1)(vii)(B) allows up to 90 days to report a settlement before voiding the final demand amount. This 90-day time period conflicts with the 60-day period for repayment set forth in the MSP Act itself at 42 U.S.C. § 1395y(b)(2)(B)(ii), causing confusion between statutory and regulatory requirement and thus further increasing the potential delay for reimbursement.

Another concern for DRI is the "dispute" process set forth in the IFR. There is no legal basis for the Agency to limit a beneficiary to a single opportunity to dispute a conditional payment. It is relatively common that the conditional payment amounts identified by the Agency include payments that are not related to the claim at issue. So, once a claim is disputed, while the Agency may conceded that specific payment is not related, it is not uncommon that in that interim period the Agency may add other payments that are similarly not related up to three days before settlement. Thus, a beneficiary or plan should have the opportunity to dispute these claims as well. The goal should be to have an accurate list of payments made that are related to the claims so the Medicare Trust Funds can be reimbursed as soon as possible.

In addition, the IFR does not provide whether or how the dispute process relates to the final conditional payment process or whether the dispute process tolls the 120-day period. The fact that unrelated payments are included by the Agency as conditional payments should not trigger the limitation on the parties to use the portal one time per case.

Finally, DRI notes the Agency failed to propose regulations necessary to implement the formal Appeal process set forth in Section 201. DRI agrees that this formal appeal process is different from the "claim dispute" process addressed in the regulations, and urges the Agency to promulgate the requisite rules for the formal appeals process as soon as practicable. Because a Plan may not have the related medical records, it has its hands tied in negotiating as to related medical costs, both in regard to the individual and in regard to a demand potentially made upon the Plan. This is contrary to the Act that requires in Section 201(VII) that "[t]he Secretary shall promulgate regulations establishing a right of appeal and appeals process … for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan… that is a primary plan." Also, the Agency failed to identify what information the settling parties must report in order to trigger the 120-day protected period and how the report is to be made (through the portal or some other process). In addition, the Agency failed to describe how parties may withdraw from the final demand process if a settlement is not reached after notice to CMS. Finally, the Agency failed to describe how the final conditional payment demand amount can be paid at the time of settlement.

In conclusion, DRI recommends that CMS withdraw the IFR and, instead, reissue a proposed regulation operationalizing Section 201 of the SMART Act in the form of a notice of proposed rulemaking. In the alternative, DRI recommends that CMS provide a number of clarifications. First, DRI recommends that CMS clarify in its rulemaking that parties are not required to participate in the expedited final conditional payment demand process, and that, in fact, 42 C.F.R. § 411.39 represents a second and alternative path of conditional payment reimbursement under the MSP Act. Thus, participation is optional as opposed to required. DRI also recommends that CMS, in its rulemaking, clarify that if CMS fails to provide a conditional payment final demand within 95 days (the initial 65 day period, plus the 30-day extension period) then the Agency is deemed to have waived its right to recovery for any amounts related to the underlying claim as specified in the SMART Act.

DRI thanks the Agency for its consideration of the above issues, including the request that the Agency withdraw the IFR and issue a new notice of proposed rulemaking. DRI again invites the Agency to

follow up with any questions it has. We look forward to collaborating with the Agency on this and other MSP-related issues in the future.

Our best,

J. Michael Weston
President, DRI – *The Voice of the Defense Bar*