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CMS Releases Advance Notice of Proposed Rulemaking in "Future Medical" Situations

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On May 3, 2012, the Centers for Medicare & Medicaid Services (CMS) provided early notice that it would be publishing proposed rules regarding Medicare Secondary Payer (MSP) compliance obligations in relation to "future medicals."

On June 15, 2012, CMS released its proposed rules and related information in the form of a *"draft" advance notice of proposed rule-making,* referred to by CMS as the "ANPRM."

These proposed rules are published in the Federal Register, Volume 77, No. 116 (June 15, 2012). The ANPRM proposes amendments to 42 C.F.R. Parts 405 and 411. A copy of the ANPRM proposals can be obtained here.

Currently, the regulations pertaining to the Medicare Secondary Payer (MSP) statute do not contain a specific mandate requiring CMS review and approval of future medical allocations, nor do they contain any provisions addressing specific options to address Medicare's "future interests." However, the ANPRM's proposals will now in all likelihood set in motion the establishment of formal legal regulations and provisions regarding post-settlement MSP obligations with respect to Medicare's future interests. In this regard, the ANPRM is unprecedented in MSP compliance, as historically all post-settlement MSP compliance activities regarding Medicare's future interests have been voluntary up to this point.

In terms of how the ANPRM is set up, the document contains a general statement regarding background and objectives, which is then followed by a series of proposed options to consider Medicare's "future interests" pertaining to non-Group Health Plan (NGHP) settlements. Through the ANPRM, CMS solicits comment on how individuals can meet MSP compliance obligations with respect to NGHP settlements.

All parties interested in submitting comments must do so by August 14, 2012. During this period, CMS will solicit comments regarding (**a**) the nature of the proposed rules, (**b**) the proposed guidelines set forth herein, and (**c**) the methodology for reviewing future medical amounts.[1]

In general, the key points for consideration regarding the ANPRM can be outlined as follows:

Proposed General Rule

The ANPRM sets forth the following general rule surrounding future medicals:

> If an *individual or Medicare beneficiary* obtains a 'settlement' and *has received, reasonably anticipates receiving, or should have reasonably anticipated receiving* Medicare covered or otherwise reimbursable items and services after the date of 'settlement,' he or she is required to satisfy Medicare's interest with respect to 'future medicals' related to his or her 'settlement' using any one of the following options outlined later in this ANPRM. (Emphasis Added).[2]

In examining the above text, it is noted that the rule conceivably contemplates inclusion of a larger number of claims as qualifying for MSP "future interests" consideration than currently exists under CMS' policies.

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For example, the proposed general rule provides that *"individual[s] or Medicare beneficiar[ies]"* must "satisfy Medicare's interest." CMS' reference to an *"individual"* being obligated to "satisfy" Medicare's interests, without including any other qualifying criteria, raises interesting considerations when contrasted with CMS' current policy related to non-Medicare beneficiaries. Specifically, under current CMS policy, individuals who are non-Medicare beneficiaries, but have a *"reasonable expectation of Medicare enrollment within 30 months of the settlement date,"* have a policy-driven obligation to consider, and potentially protect, Medicare's interest in certain situations. (See e.g., CMS' 4/22/03 WC MSA Policy memo). Under current policy, the agency has listed five specific factors in terms of determining whether a non-Medicare beneficiary is considered to have a *"reasonable expectation of Medicare enrollment."*[3]

By contrast, the ANPRM does not contain any qualifying criteria or other factors in relation to non-Medicare beneficiaries; it simply references "individuals" as potentially having an obligation to "satisfy" Medicare's interest "with respect to future medicals" if that individual *"has received, reasonably anticipates receiving, or should have reasonably anticipated receiving Medicare covered or otherwise reimbursable items and services after the date of 'settlement[.]'"*[4]

Proposed Options to Address Medicare's "Future Interests"

The ANPRM proposes seven (7) different options for individuals whose settlements fall within the scope of the above general rule. These options are outlined below.

In reviewing the proposed options below, it is important to note that Options 1-4 apply to *both* Medicare beneficiaries and non-Medicare beneficiaries; while Options 5-7 apply *only* to Medicare beneficiaries.

Also, the ANPRM proposes detailed definitions of several key terms which must be considered when evaluating the below options. These terms are: *chronic illness/condition; date of care completion; future medical care ("future medicals"), physical trauma and major trauma*. These terms are defined as part of the endnote to this sentence for the reader's reference and should be consulted in reviewing the below options.[5]

Option 1:

The individual/beneficiary pays for all related future medical care until his/her settlement is exhausted and he/she documents it accordingly.

Under this option, the individual *uses the entire settlement amount* for future claim related medical needs. It is noted that CMS would not review documentation in conjunction with this option, but reserves the right to "occasionally" request documentation from beneficiaries "at random" as part of Medicare's "program integrity efforts."

Option 2:

Medicare would not pursue "future medicals" in certain liability settlements if the individual/beneficiary's case fits <u>all</u> of the conditions under either of the following headings:

Scenario A: The amount of liability (including self-insurance) settlement is a defined amount (to be later determined) or less and all of the following are met:

- The accident, incident, illness, or injury occurred one year or more before the date of settlement;
- The underlying claim did not involve a chronic illness/condition or major trauma;
- The beneficiary does not receive additional "settlements;" and
- There is no corresponding WC or No-Fault claim.

Scenario B: The amount of liability insurance (including self-insurance) settlement is a defined amount (to be later determined) or less and all of the following criteria are met:

- The individual is not a beneficiary as of the date of settlement;

- The individual does not "expect to become a beneficiary" within 30 months of the date of settlement;
- The underlying claim did not involve a "chronic" illness/condition or major trauma;
- The beneficiary does not receive additional "settlements;" and
- There is no corresponding WC or No-Fault claim.

Option 3:

The individual/beneficiary acquires/provides an attestation regarding the "Date of Care Completion" from his/her treating physician.

The "Date of Care Completion" can be obtained either before or after settlement.

If the Date of Care Completion is obtained *prior* to settlement, the rule proposes that Medicare's recovery claim would be limited to conditional payments *"it made for Medicare covered and otherwise reimbursable items and services provided from the Date of Incident through and including the Date of Care Completion."* In this regard, the rule proposes that *"[a]s a result, Medicare's interests with respect to 'future medicals' would be satisfied."* Importantly, the physician must attest to the Date of Care Completion and attest that *"that the individual would not require additional care related to his or 'settlement.'"*

If the Date of Care Completion is obtained *after* settlement, the rule proposes that Medicare would pursue recovery for related conditional payments *"it made from the date of incident through and including the date of 'settlement.'"* With respect to future medicals, Medicare's interest *"would be limited to Medicare covered and otherwise reimbursable items and/or services provided from the date of 'settlement' through and including the Date of Care Completion."* As with a pre-settlement procurement, the physician must attest to the Date of Care Completion and attest that *"that the individual would not require additional care related to his or 'settlement.'"*

Option 4:

The individual/beneficiary submits a proposed MSA to CMS for the agency's review and obtains agency approval.

CMS is using the ANPRM to solicit comments on methodology for reviewing liability MSAs. However, the ANPRM does not distinguish between liability and workers' compensation for the purposes of this option.

Option 5:

The beneficiary participates in one of Medicare's new conditional payment recovery options pertaining to certain liability cases.

CMS recently released the following three new policies related to conditional payment recovery: *$300 Threshold, Fixed Percentage Option*, and *Self Calculation Conditional Payment Option.* These new policies pertain only to certain physical liability trauma claims and there are several conditions which must be met under each policy.[6] CMS states that *"when a beneficiary participates in any one of these recovery options, [he/she] has also met his/her obligations with respect to future medicals."* (Remember: this option would only apply to Medicare beneficiaries).

Option 6:

The beneficiary makes an "up front" payment to Medicare in conjunction with the settlement.

CMS is exploring bifurcated programs to allow for upfront payment to CMS in both workers' compensation and liability situations. In both such situations, Medicare would have to review and approve the pre-payment amount. (Remember: this option only applies to Medicare beneficiaries)

Option 7: **The beneficiary obtains a compromise or waiver of recovery.**

CMS will have discretion *not* to pursue future medicals related to a specific settlement in situations where the beneficiary obtained either a compromise or waiver of Medicare's recovery claim. (Remember: this option only applies to Medicare beneficiaries)

What's Next?

As noted, the period for comment submission ends on August 14th. CMS will then consider the comments and decide whether and how to implement both the general rule and the proposed solutions. From there, it is likely that new MSP compliance requirements will develop. CPSC will be closely monitoring all events regarding the ANPRM and will keep the industry apprised accordingly.

For More Information …

For further information regarding CMS' ANPRM proposals, please contact Vice President of Strategic Services, Martin Cassavoy (mcassavoy@cpscmsa.com) or Sr. Section 111 Legal Counsel, Mark Popolizio (mpopolizio@cpscmsa.com).

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Endnotes

[1] The ANPRM sets forth several different options for the public to submit comments, including electronic submission, regular mail, express/overnight mail, and delivery by hand or courier. These options, and the technical requirements relating to each, can be found at ANPRM, 77 Fed. Reg. 116, at 35918 (June 15, 2012).

[2] *Id*. at 35919.

[3] Under CMS' 4/22/03 WC-MSA policy, the agency defines *"reasonable expectation of Medicare enrollment"* to include, but not being necessarily limited to, situations in which the claimant (a) has applied for social security disability (SSD); (b) has been denied SSD but anticipates appealing that decision; (c) is in the process of appealing or re-filing for SSD; (d) is 62.5 years or older; or (e) has End Stage Renal Disease but does not yet qualify for Medicare based upon this condition. See, Thomas L. Grissom, *CMS Memorandum to All Regional Administrators*, April 22, 2003.

[4] ANPRM, 77 Fed. Reg. 116, at 35918 (June 15, 2012).

[5] These terms are defined under the ANPRM as follows:

> **Chronic Illness/Condition**: means that the illness/condition persists over a long period of time. The term is generally applied when the course of a disease or condition last for more than 3 months. If the individual/beneficiary alleges an injury that is a chronic illness/condition, it is presumed that future medical care will be required. Examples of chronic diseases include, but are not limited to: Chronic airflow limitation, including asthma and chronic bronchitis; cancer, diabetes; quadriplegia; and nephrogenic systemic fibrosis.

> **Date of Care Completion**: means the date the individual/beneficiary completed treatment related to his or "settlement." The individual/beneficiary's treating physician must be able to attest that the individual/beneficiary has completed treatment and that no further medical care related to the "settlement" will be required.

Future Medical Care ("future medicals"): means Medicare covered and other otherwise reimbursable items and services that the individual/beneficiary received after the Date of "Settlement." This definition specifically applies to items and services related to an individual/beneficiary's settlement, judgment, award, or other payment.

Physical Trauma: refers to an injury (as a wound) to living tissue caused by an extrinsic agent. This also includes blunt trauma, which refers to an injury caused by a blunt object or collision with a blunt surface (as in a vehicle accident or fall from a building).

Major Trauma: major trauma means serious injury to two or more Injury Severity Score (ISS) body regions or an ISS greater than 15. The ISS body regions include the following:

- Head or neck.
- Face.
- Chest.
- Abdomen.
- Extremities.
- External.

ANPRM, 77 Fed. Reg. 116, at 35919 (June 15, 2012).

[6] The ANPRM provides a brief description of these options at 77 Fed. Reg. 116, at 35920 (June 15, 2012). However, this description does not outline or discuss all the detailed and technical qualifying information. Accordingly, the authors strongly encourage the reader to review all the criteria related to these new policies as can be found at www.msprc.info.

With that said, these policies, very generally, can be summarized as follows: Under CMS' new $300 liability threshold policy, the agency will waive its conditional payment claim with respect to certain physical liability settlements of $300 or less. Under CMS' new *Self Calculation Method,* a plaintiff in certain physical trauma liability settlements of $25,000 or less may submit a proposal to CMS to satisfy conditional payments *prior* to settlement. CMS' new *Fixed Calculation Method* permits a plaintiff in certain physical trauma liability settlements of $5,000 or less to pay 25% of the gross settlement to satisfy conditional payment obligations upon CMS approval. Again, each of these new options contains several detailed and technical criterion which must be met (including CMS approval), and which limits their potential applicability. For more information see, www.msprc.info.