Medicare Advocacy Recovery Coalition

February 21, 2014

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS–6055–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-6055-P; MEDICARE PROGRAM; RIGHT OF APPEAL FOR MEDICARE SECONDARY PAYER DETERMINATION RELATED TO LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS

Dear Administrator Tavenner:

The Medicare Advocacy Recovery Coalition (MARC or the Coalition) is pleased to provide comments on the December 27, 2013, Notice of Proposed Rulemaking addressing implementation of Title II of the Medicare IVIG and Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act), and specifically implementation of Section 202 of the Act related to establishing appeal rights for liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans (collectively non-group health plans). 78 Fed. Reg. 78802 (Dec. 27, 2013). Establishing such appeal rights is a fundamental aspect of procedural due process, and the rulemaking, whether or not mandated by the SMART Act, has been long overdue. For that reason, MARC is appreciative that the Agency is beginning to take the necessary steps to implement the SMART Act, and particularly to establish these important procedural appeal rights.

About MARC: The MARC Coalition was formed in September 2008 by a group of leading stakeholders to advocate on behalf of beneficiaries and interested stakeholders for improvement of the MSP system. MARC's membership represents virtually every sector of the regulated community affected by the secondary payer laws, including plaintiff and defense attorneys, brokers, insureds, insurers, insurance and other trade associations, self-insureds, MSP compliance vendors, and third-party administrators. MARC and its member companies are committed to achieving an efficient and effective MSP system that protects beneficiaries and the Trust Fund, while providing a rational and useable system for all stakeholders. Our members are involved with every aspect of the MSP process, and many of our members handle countless cases that involve conditional payments.

MARC's comments below reflect the membership's extensive experience with the current MSP regulations, and the impact they have on the real world settlement of payments and the return of conditional payment amounts to the Trust Fund. They also reflect the Coalition's intimate involvement in the development and enactment of the SMART Act. Most importantly, the comments reflect the Coalition Members' desire to streamline the conditional payment process so that settling parties know their obligations to the Trust Fund as timely as possible, and can repay the Trust Fund at the time of settlement consistent with the SMART Act's requirements.

I. Plan Appeals Should Not Follow the Beneficiary Adjudication System

Before addressing the technical aspects of the Proposed Rule, MARC wishes to offer a more general comment on the proposal, and the Agency's underlying assumption that non-group health plan ("NGHP" or "Plan") appeal rights should mirror those of beneficiaries under current law. As the Agency is well aware, the current appeal adjudication system serves a wide variety of stakeholders, ranging from beneficiaries to providers to insurers and others. More importantly, the system is badly overburdened, to the point that decisions are severely delayed. In a recent update from the Office of Medicare Hearing Appeals (OMHA), the Agency noted:

> Although OMHA is processing a record number of Medicare appeals, we continue to receive more requests for hearing than our Administrative Law Judges can adjudicate in a timely manner. OMHA remains committed to processing requests for hearing in the order received as quickly as possible given pending requests and adjudicatory resources. We will continue to process Part D prescription drug denial cases that qualify for expedited status within 10 days and will screen all incoming requests to ensure Medicare beneficiary issues are prioritized given that they often present emergent circumstances that must be promptly addressed. In all other circumstances, you (or your representative) will receive an Acknowledgement of Request letter when your request is docketed.
>
> Due to record receipt levels, we are currently projecting an 18 to 22 week delay in entering ("docketing") new requests into our case processing system. If 22 weeks have not lapsed since you submitted your Request for Hearing, do not resubmit your request.
>
> Based on our current workload and volume of new requests, we anticipate that assignment of your request for hearing to an Administrative Law Judge may be delayed for up to 28 months.
>
> The average processing time for appeals decided in fiscal year 2014 is 301.7 days.

Office of Medicare Hearing Appeals, Important Notice of Adjudication Timeframes (2013).[1] It is not appropriate to utilize a system that is projected to take five months to even docket an appeal, and almost two and a half years to assign a case to an Administrative Law Judge ("ALJ"). While we appreciate that, for historical reasons, beneficiary MSP appeals are today relegated to this system, there is no reason to replicate a broken process simply because it already exists.

[1] Available at http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html

Instead, we propose that the Agency create a designated team of several MSP Claims experts, who would function as Independent Review Entities (IREs), but who would have exclusive jurisdiction over MSP appeals (NGHP appeals for now, although the process could quickly be expanded to beneficiary appeals as well), and who would have "fast track" authority to process claims short of the full adjudicatory hearing process that CMS has embodied in regulation today. By way of example, CMS has adopted such types or review processes in the past. *See generally* 42 C.F.R.§ 422.626 (fast-track appeal process in Medicare Advantage setting); *id.* at 422.624(b)(2)(iii) (addressing IREs). A similar alternative appeal process should be adopted here. Further, to improve the adjudication system, we recommend that CMS utilize reviewers with a minimum of five years' expertise in MSP claims administration, and such reviewers should be dedicated to MSP claims review only.

Beyond the IRE process, appealing parties should also be given the option of utilizing the existing process with its extensive and developed procedural protections, *or* to opt for the "fast lane" MSP adjudication system. The fast lane system could include basic procedural protections, such as limited discovery rights, limited written filings of up to 20 pages, truncated hearings of thirty minute presentations per side, and a very brief time period for issuance of ALJ decisions. We also urge the Agency to designate one ALJ to exclusively handle MSP appeals for purposes of the fast lane process, allowing the adjudicator to develop expertise in MSP claims resolution, and permitting expedited adjudications without interference from other types of claims. By adopting such an alternative "fast lane" process for NGHP appeals, with the possibility of expanding the system to beneficiary appeals if it proves effective, the Agency has the opportunity to not only innovate beyond the existing broken system, but return funds that are the subject of appeals to the Trust Fund faster than the current appeal process would allow.

The remainder of the comments below will respond directly to the Proposed Rule.

II. Permit NGHPs to Appeal Earlier in the Process

The Proposed Rule indicates that the Agency will only permit a Plan to appeal following a "final determination" that the Plan is liable for a conditional payment. While MARC appreciates the need for a final agency action to trigger an appeal, the realities of the MSP process suggest that it is often late in the process before the Agency reaches a final determination as to a Plan – particularly when compared to the date upon which CMS reaches a final determination as to a beneficiary's liability. Given that Plans are often far more sophisticated than beneficiaries about the complexities related to conditional payment and ongoing responsibility for medical determinations, and the Plans can play an important and moderating role in the negotiation of the proper recovery amount, we urge the Agency to permit Plans to engage in the process upon a final determination related *either* to the beneficiary or to the Plan, whichever comes first.

The timing of appeal rights is particularly important in the case of large, multi-party and multi-plaintiff cases, such as class action matters and mass tort cases. There are often multiple Responsible Reporting Entities (RREs) implicated in such cases, and the determination of which may (or may not) be the actual responsible entity is often reached before a "final determination" is reached as to all RREs in the matter. Even outside the mass-tort situation, however, the Agency's understanding of the MSP laws to create joint and several liability between both the

RRE and the beneficiary for repayment supports permitting earlier appeal participation for RREs. Simply stated, it is critical to allow all parties with an interest in the conditional payment to participate in the appeal, whether or not a "final determination" has been reached as to any particular entity. We recommend that Plan appeal rights be triggered upon a "final determination related to a claim," rather than upon the final determination as to an individual responsible for the claim when it is legally possible that numerous entities may be responsible for repayment.

Recommendation: Appeal rights should begin upon any final determination related to the claim – not based upon a final determination as to any particular liable party in situations where multiple parties could be found to be liable.

III. Plan and Beneficiary Appeals Must be Permitted to be Consolidated

CMS has also proposed that beneficiaries and Plans have separate appeals, which would involve separate dockets and separate adjudication timetables. MARC respectfully urges the Agency to permit Plan and beneficiary appeals to be consolidated.

First, existing regulation permits beneficiaries to appoint plans as "appointed representatives" (42 C.F.R. § 405.910) or to "assign" appeal rights to third parties (although MARC acknowledges that such assignment may be to an entity *other* than a plan. 42 C.F.R. § 405.912). Given that plans could today serve as appointed representatives of the beneficiary, and that third parties with no relationship to the claim could serve as beneficiary assignees, it follows that Plans should be allowed to participate in beneficiary appeals (and, of course, vice versa). *See, e.g.* 42 C.F.R.§ 422.574 (permitting physicians and providers to participate as parties in beneficiary appeals of Medicare Advantage appeals).

Second, permitting such appeals would eliminate duplication in already overburdened ALJ proceedings. Indeed, since the very same claim – the question of the conditional payment associated with the injury or illness -- is necessarily in dispute in either case, consolidating the two cases and permitting beneficiaries and Plans to participate in the same appeal would make sense as a matter of administrative and judicial economy.

Third, permitting joint appeals would avoid complexities related to conflicting decisions in the same matter. Stated differently, by requiring separate appeals, CMS creates the likelihood that a beneficiary and a Plan could appeal a proposed repayment and each receives a different decision from an Administrative Law Judge. Conversely, the ALJs would be placed in difficult positions if there were non-binding, but pre-existing, decisions related to the same underlying facts. Although principles of *res judicata* and *collateral estoppel* clearly would not apply when two related parties are barred by regulation from participating in each other's appeal, the result would still be confusing and cumbersome for all involved. Thus, we urge CMS to revisit its proposal that Plans be barred from participating in beneficiary appeals. Rather, we urge CMS to explicitly permit such consolidated action, and amend 42 C.F.R. § 405.912 to allow beneficiaries to assign their appeal rights to Plans.

Finally, and whatever appeal rights Plans are permitted, Plans should have explicit rights to designate third parties (such as their agents) as appointed representatives for the purpose of the appeal, and otherwise to assign appeal rights to third parties. As the Agency is aware, virtually all RREs have designated agents responsible for Section 111 reporting and compliance. Plans

should thus be permitted to designate those agents, or any other entities that they wish, as their authorized representatives. Similarly, Plans should be permitted to assign the right of appeal to their agents or other third parties.

Recommendation: Revise the Proposed Rule to Permit Plans to Appeal Alongside Beneficiaries, and amend 42 C.F.R. § 405.912 to permit beneficiaries to assign their rights of appeal to their Plans; and to permit Plans to designate appointed representatives or to otherwise assign their rights of appeal to third parties.

IV. Interest and Penalties

Finally, although not addressed in the Proposed Rule, we urge CMS to adopt an explicit regulation that penalties and interest will be tolled during a good faith appeal of a conditional payment dispute. In the alternative, given that delays in the appeal process are caused by the OMHA backlog, rather than the failure of appealing parties to pursue their appeals, any interest should be limited to 90-days – the normal time through which an appeal should move through the appeal process. It is unfair to assess interest and penalties for prolonged periods caused by the Department's backlog in the appellate process.

Recommendation: Adopt A Regulation Tolling Penalties and Interest During the Pendency of a Good Faith Appeals.

* * *

V. Conclusion

The Proposed Rule is a positive step in implementing the SMART Act. We urge CMS to give serious consideration to creating a fast track process given the historic and existing backlogs in the ALJ system. We also urge the Agency to improve the proposed rule, and permit more ready and open access to appeal rights to all involved parties.

We appreciate the Agency's consideration of these comments, and we welcome any further questions that the Agency may have related to the SMART Act and its implementation. Please contact David Farber, counsel to the Coalition, at 202.626.2941 or dfarber@kslaw.com if you have any questions or request any further information regarding these comments.

Respectfully submitted,

Michele L. Adams, Chair
Medicare Advocacy Recovery Coalition (MARC)