Medicare Advocacy Recovery Coalition

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
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 Administrator Tavenner:

The Medicare Advocacy Recovery Coalition (MARC or the Coalition) is pleased to provide comments on the September 20, 2013, Interim Final Rule 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 201 of the Act related to the final conditional payment web portal. MARC is appreciative that the Agency is beginning to take the necessary steps to implement the SMART Act. The Coalition, however, is disappointed that the Agency failed to promulgate rulemaking through regular notice and comment, and instead chose to issue an "Interim Final Rule" (IFR). Further, the Coalition is concerned that the Agency has failed to comply with the clear statutory requirements to implement a final conditional payment process by October 2013, and that the process it has chosen to implement in the interim rule allows for over twice the statutory 120-day period to obtain a final payment amount.

The IFR does not comply with Section 201 of the SMART Act; both in the details of the proposed implementation, as well as in the timeframe in which the Agency proposes to actually implement the Section 201 portal procedure. For these reasons, as well as the additional reasons set forth below, MARC urges CMS to withdraw its IFR, and to re-issue, within 120 days, a new proposed rulemaking implementing the web portal for prompt and expeditious resolution of the final Medicare secondary payer conditional payment amounts.

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. Timing of Portal Process (120 days v. 245 days)

The IFR is in direct violation of Section 201, which explicitly required CMS to develop a portal process that, from beginning to end, took 120 days. The statutory language could not be more clear: "In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment." The language of Section 201 is unambiguous; the entire process – from beginning to end – is to take 120 days, which is triggered by the notice, and which includes the 65 day response period *within the 120 day period* in which the Secretary is to provide the final number. In contrast, however, the Agency proposes a new regulation, 42 C.F.R. 411.39(c)(1)(i), which states that the ". . . beneficiary, his or her attorney or other representative, or an applicable plan, provides initial notice of a pending liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlement, judgment, award, or other payment to the appropriate Medicare contractor at least **185 days** before the anticipated date of settlement, judgment, award, or other payment." (emphasis added) Subsection (c)(1)(iii) is to the same effect. Nothing in the statute allows the Agency to create such a "pre-settlement" notification – or to turn 120 days into 185 days.[1]

The IFR is also vague as to when the so-called "initial notice" is supposed to occur. For example, the Agency states that the beneficiary must: "provide initial notice of pending liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlements, judgments, awards, or other payment to the appropriate Medicare contractor at least 185 days before the anticipated date of settlement." 78 Fed. Reg. 57801 col. 3. However, the settling parties only know of such a prospect when they reach a conceptual agreement to the settlement at the start of the 120-day period. Stated differently, no such date even exists half a year before settlement – rendering the entire process an impossibility.

[1] In fact, the 185 day period is really 245 days. CMS can extend the process by an additional 30 days, and then, after the final amount is printed out three days before settlement, another 30-day period is required by the Interim Final Rule to allow for CMS to calculate any reduction for plaintiffs' attorney fees. This is truly unacceptable, and in direct violation of Congress' direction.

There is no reasonable way CMS can interpret the statute to require any notice beyond 120 days. In fact, the Agency's proposal is identical to what CMS claims that it offers settling parties today and what the Agency contended it provided to setting parties throughout the period when Congress considered the SMART Act. Congress surely did not enact legislation to codify existing agency process – instead, Congress found that the Agency's policies and procedures were ineffective in providing settling parties with a timely statement *before* settlement of what the *final* obligation was. Congress stated in no uncertain terms that the period is to begin and end within 120 days.[2] Given that CMS's proposal fails to comply with the plain text of the statute, the proposal must be withdrawn and CMS should reissue a new proposed rule.

We appreciate that the Agency's intent may have been to broaden the "protected period" to the full 120 day time frame, which in turn would allow parties to settle and repay the Trust Fund as soon as they received the requisite conditional payment amount from the Agency (in 65 days, or hopefully even less time). However, the regulation states that the "initial notice" must be provided "at least 185 days before the anticipated date of settlement, judgment award or other payment," (emphasis added) which thereby requires a 185-day period to pass between the "notice of claim" and the settlement. In contrast "Diagram 1" at 78 Fed. Reg. 57803 suggests that there is no need to extend the settlement period to 185 days, but that settlement can occur immediately following receipt of the conditional payment amount (subject to refresh prior to 2016). Unfortunately, "Diagram 1" is contained in the Preamble and not in the Rule itself, and the Rule's use of the phrase "at least" conveys a different impression to all stakeholders. **We specifically recommend that CMS replace the phrase "at least" with the phrase "at any time up to" which more properly conveys the impression left in Diagram 1 which we believe may have been the Agency's intent.** Along the same lines, the Agency has not clarified whether the "three day" period to print the final amount is three calendar or three business days. **We recommend CMS clarify that all periods less than ten days are "business days" rather than calendar days.**

CMS also has proposed that the 30-day "extension" period, which it may invoke beyond the 65-day response period also accrue before the 120 day period begins. Proposed 42 C.F.R. 411.29(c)(2)(A). Counting the 30-day extension period before the 120-day protected period is contrary to the SMART Act. Congress allowed CMS one 30-day extension, but that extension is within, not before, the 120-day period. Thus, the regulation must be withdrawn and corrected.

CMS' proposal must be conformed to the requirements of the SMART Act, needs to work within the context of how settlements actually occur, and should promote timely resolution of claims. In actual practice, claims often settle quickly, and in order to conclude a settlement all parties to an agreement – plaintiffs/beneficiary/claimant and defendants – have an interest in closing the file on the matter and timely paying the claimant. While the IFR has nicely accommodated the

[2] The Agency appears to suggest that since the 120-day period is defined by the SMART Act as the "protected period," that the 65 day calculation of the conditional payment amount is in addition to, rather than within, the 120 days. 78 Fed. Reg. 57801 col. 3. There is neither textual basis or legislative history to support that construction, and it is in direct violation of the plain statutory text and Congressional intent.

Agency's needs, it completely fails to meet the realities of settling non-group health plan (NGHP) cases. For example,

- The practical realities of settling cases suggest that a 185-day period to settle an uncertain and contingent MSP obligation in addition to the settlement itself will result in settlements falling apart; settling parties are unwilling (and should not have to) wait half a year to conclude their settlement for MSP purposes. Indeed, if CMS retains this time period, it will delay, if not destroy, many settlements, causing a loss to the Trust Fund of otherwise recoverable dollars;

- In both litigated and non-litigated cases, there is often a short window to settle early in the case – a half year delay in concluding the settlement will eliminate the ability to settle within that early window – increasing costs for all, and reducing recoveries for the Trust Fund;

- Many cases that settle before a lawsuit is commenced require concluding the settlement before the statute of limitations expires; again, a half of a year could be the difference between settlement or litigation and a loss to the Trust Fund;

- Even for those cases where the settlements are achieved during litigation, both state and federal courts are not tolerant of keeping dockets open for a half year pending resolution of MSP claims, and cases will often get forced to hearing or trial during that period[3];

- Many states workers compensation and general liability statutes contain specific settlement payment requirements that require payment of settlement amounts within a proscribed period of time. For example, a recent Illinois statute, SB 1912, requires settlements to be expedited within 30 days of delivery of the executed settlement document. Other state laws have similar requirements. *See also* NY Prompt Payment of Settlement law, CPLR 5003-a; Ohio Claims Practices Act, OAC 390101054. Similarly, insurers could be subject to bad faith or unfair claims handling practices claims. While MARC appreciates that MSP laws supersede state law, the MSP regulations do not change, or supersede, state prompt payment settlement statutes or similar laws, or state court docket requirements. Thus, to the extent that the SMART Act regulations interfere with those state laws, cases cannot and will not be settled, and the Trust Fund will lose the ability to timely collect conditional payment recoveries.

As indicated from the points above, it is already a stretch to demand that Medicare beneficiaries' settlements be delayed 120 days to resolve MSP obligations; the 120-day period tests the limits

[3] The most heavily litigated MSP issue, as reflected in published federal court opinions, are Motions to Enforce Settlements. Such motions will decrease dramatically if CMS does not implement the SMART Act correctly.

of keeping a settlement together at all. Unfortunately, the longer the time the greater the chance that the settlement will not occur, forcing a claimant either to abandon the matter or force the matter to trial. And if either happens, beneficiaries are delayed in receiving payments that would otherwise be due to them, and the Trust Fund is delayed in recovering funds due to it. These complexities can be resolved, however, if CMS complies with the law and adopts the 120-day period. Stated differently, the CMS proposal, requiring beneficiaries to wait over half a year for their settlement payments, creates a lose-lose-lose for all stakeholders and the Trust Fund. The goals and intent of the SMART Act require CMS to revise its interim final regulations.

Recommendation: CMS must change its IFR to ensure that the 65-day notice period, and the 30-day extension period, are *within* the 120-day window set by the SMART Act; the Agency must also eliminate any other "notice" obligations *before* the 120-day period.

II. CMS Must Eliminate the Pre-Registration Requirement Upon Beneficiaries

The IFR at 42 C.F.R. 411.39(b)(1)(i) requires that to initiate use of the portal a beneficiary must ". . .create[] an account to access his or her Medicare information through the CMS Web site." Again, while this proposal will surely be administratively convenient for CMS, it is unworkable for beneficiaries and the regulated community. While beneficiaries today already have access to their claims information through the MyMedicare.gov website, and already believe that they are "registered" with Medicare, even requiring further registration on Mymedicare.gov may prove too much for some. Further, the vast majority of beneficiary settlements with non-group health plans involve claims in which there is no attorney representing a party, and no person available to assist a beneficiary in "registering" for a federal program in which they are already registered. Simply put, by adding another administrative hurdle into the process, CMS may render the process unusable. The fact is that beneficiaries technically challenged or already confused and uniformed about the MSP laws simply will not register.

Under existing laws, beneficiaries are already obligated to "cooperate" with CMS in navigating the MSP laws. 42 C.F.R. 411.23. There is no reason that this regulation cannot deem beneficiary consent and participation in the portal process for the purpose of facilitating expedited settlements leading to quicker and more efficient payments to both the Trust Fund and the beneficiaries themselves.[4] With all due respect to the Agency, the MSP Section 111 process, and other Medicare registration processes launched over the past three years have proven vulnerable to breakdown, IT failures, and the like, and the simpler the process, the better for all. Moreover, the plethora of such computer "registrations" will serve only to confuse beneficiaries – especially since beneficiaries rarely bring more than one claim in their life and thus will have no need to use the system more than once or twice in their entire lives.

[4] CMS already allows "inferred" consent in workers compensation and no-fault cases and automatically (without beneficiary consent) provides primary plans with a copy of Conditional Payment Letters. **We recommend that CMS consider modifying 42 C.F.R. 411.23 to include liability plans,** which will save time and confusion and more accurately reflect the realities of claim settlement and application of the Privacy Act of 1974 with regard to MSP claims.

During the legislative debate over the SMART Act, it was CMS who urged Congress to turn the entire expedited final conditional payment notification process into an electronic procedure using a web portal. At no time did CMS ever inform the Congress, or any other stakeholders, that using an electronic process would delay, rather than expedite, the navigation of the final conditional payment procedure by requiring beneficiaries to pre-register into yet another "system." Congress agreed to the Agency's recommendation to use a web portal, but not at the price of creating additional complexities requiring that beneficiaries create accounts on an internet portal.

Finally, and to the extent that CMS maintains the registration requirement, we request that the Agency clarify that the registration at issue is on the mymedicare.gov site.

Recommendation: The Agency should eliminate the requirement that beneficiaries create "accounts" on the web portal or otherwise "register" with Medicare.

III. CMS Must Revise the "Post-Settlement" 30-Day Fee Resolution Window

Similar to its erroneous proposal that beneficiaries need to register to allow settling parties to access the web portal, the Interim Final Rule includes another unnecessary procedural hurdle, after the settlement has occurred. Specifically, the regulations require that within 30 days following settlement the settling parties must re-submit the settlement information again, this time to calculate offsets for attorneys' fee reductions. The preamble states:

> Within 30 days of securing the settlement, the beneficiary or his or her attorney or other representative must submit through the Web portal ''settlement'' information specified by the Secretary. We expect that the amount and type of ''settlement'' information required will be the same information that CMS typically collects to calculate its final demand amount. This information will include, but is not limited to: The date of ''settlement'', the total ''settlement'' amount, the attorney fee amount or percentage, and additional costs borne by the beneficiary to obtain his or her ''settlement''. We will require that this information is provided within 30 days of the date of settlement. Otherwise, the final conditional payment amount obtained through the Web portal will expire. Once settlement information is received, we will apply a pro rata reduction to the final conditional payment amount in accordance with 42 C.F.R. 411.37 and issue a final MSP recovery demand letter. We understand that providing settlement information within 30 days of the date of settlement may be challenging at times, but we would like to encourage beneficiaries and their attorneys or other representatives to assist us in providing swift resolutions to these matters and promote timely recoveries for Medicare. We expect to incorporate a method into the Web portal that will allow settlement information to be entered directly through the Web portal and/or uploaded directly through the Web portal.

There are multiple problems with this requirement. First, there is no reason to re-submit settlement information a second time into the portal – it is not only duplicative, but it creates further risk in delaying the process. Second, the submission process defeats the 120-day period

set by Congress to resolve the conditional payment obligation. Indeed, settling parties should be able to repay the Trust Fund at the settlement table – settlements should not be left open because CMS has not yet provided a "final" payment amount. Third, the Agency does not set any time period by which, even if the settlement information was reloaded into the system, it is obligated to provide the settling parties with the "final" conditional payment amount.

Finally, this process, to the extent needed, should be optional or subject to self-calculation. The sole reason that settling parties' final conditional payment amount might deviate from what was printed off the portal three days prior to settlement would be due to an attorneys' fees and costs reduction consistent with 42 C.F.R. 411.37. However, as noted above, the vast majority of beneficiary settlements never involve a lawyer, and thus there would be no reason for any reduction calculation. For such beneficiaries, there is simply no reason to interpose an additional delay, and additional procedural hurdles, following settlement. Moreover, unless there is a true final conditional payment amount *at the time of settlement,* in many cases there will be no settlement.

Even if a conditional payment obligation is subject to reduction for attorneys' fees, that calculation is mandated by regulation, and is formulaic. 42 C.F.R. 411.37 (referenced in the regulations). Thus, for beneficiaries who exercise the option to seek a repayment reduction, they should be permitted to "self-calculate" the reduction and submit their calculation, and their reduced conditional repayment, along with the basis of the self-calculation, to CMS.

Recommendation: The vast majority of beneficiary settlements involve beneficiaries not represented by counsel, and who do not need reductions in reimbursement for attorneys' fees. The post-settlement 30-day portal update should be optional for those beneficiaries. The portal process should include a "check-off" if the beneficiary is not represented by counsel or wishes to waive their fee reduction option. Further, the final conditional payment obtained three days before settlement should be the maximum owed, and to the extent any reduction is allowed the Agency should provide the "final" amount (with fee reduction) within 10 days following beneficiary reduction request.

IV. The Requirement that Settling Parties "Refresh" the Portal 10 or More Days Before Settlement Is Not Needed or Permitted.

The IFR also contains a new requirement, not contemplated by the SMART Act, that the settling parties must obtain a "claim refresh" at least ten days before the settlement date. For example, IFR section (c)(1)(iii)(A) requires: "On or before December 31, 2015, the beneficiary, or his or her attorney, or other representative must request an update of claim and payment information (hereafter referred to as a claims refresh) via the Web portal and await confirmation that the claims refresh has been completed. CMS provides confirmation of the claims refresh completion through the Web portal no later than 5 business days after the electronic request is initiated." A similar "refresh" process is required after January 2016. However, the refresh process is both unnecessary, and improper. Settling parties should be able to conclude their settlement within three days of settlement as soon as they receive the conditional payment amount from CMS within 65 days of their request. Stated differently, given that every day that CMS does not

produce a final conditional payment amount is a day a beneficiary is denied access to settlement funds and thereby the settlement is at risk of collapsing, the parties should be able to settle in full within three days of getting the conditional payment amount from CMS and printing it off the website. The interim "claim refresh" procedure serves no purpose, and instead interposes an additional multi-day delay into the settlement process.

Recommendation: The "claim refresh" requirement should be eliminated from the final conditional payment process.

V. The IFR Build out of the Portal Until January 2016 Violates the SMART Act

The IFR also indicates that CMS will delay implementation of the interactive web portal until January 1, 2016. This is in stark violation of the direction provided by the Congress that the portal needed to be operational within nine months of the enactment of the law, or by October 10, 2013. The SMART Act could not be more clear: the "clause" was to be "effective . . . not later than nine months after the date of enactment of this clause." CMS has failed to meet this statutory deadline, which in turn has harmed beneficiaries and cost the Trust Fund considerable money already.

It appears that the Agency has construed the law to only require it to promulgate final regulations within nine months. Even if that were a proper construction, the Agency has failed to meet that mandate, as the "Interim Final Rule" is not a "Final Rule," but one subject to notice and comment. The Agency has simply missed the deadline, and in turn, by failing to timely pursue notice and comment rulemaking, has proposed a flawed concept in violation of the letter and intent of the SMART Act.

Even more serious is the Agency's indication that the actual portal will not be operational until January 1, 2016. This three-year delay is far beyond what Congress ever contemplated, and is in violation of the legislative direction. Again, Congress did not memorialize the existing portal into law – it mandated that the Agency accelerate the process and build a new system (and an electronic portal system at the Agency's request) as timely as possible, but within months, not years.

The Agency suggests that it will take years to create a "multi-factorial authentication" process and implement it into an interactive web portal. Respectfully, and as the Agency well knows, the multi-factorial process is not needed, as even today in certain aspects of the MSP conditional payment process employer representatives are allowed full access to beneficiary information because CMS sends the information, including extensive personal health information, directly to the employers and insurers without any verification or authentication of their relationship to the beneficiary, much less a request for confidentiality around that information. It is thus somewhat surprising that CMS, itself routinely sending personal health information through the mail, would be so guarded in developing a web-based service. (As the Agency knows, it also allows electronic access through the existing portal for employers and insurers in many cases). The Coalition respectfully suggests that the Agency is capable of building out a secure and interactive web portal in several months, rather than several years.

Recommendation: The Agency should not await development of an unnecessary multifactorial verification process or otherwise delay build out of the portal. Congress was clear the system should be operational in nine months. The Agency should immediately commit to standing-up the interactive portal system by February 2014 using existing security features functioning in the "Section 111" Reporting process and the existing portal.

On a related note, we identify for CMS the fact that the Agency has failed to properly accommodate the regulated community in its creation of the "Medicare Secondary Payer Recovery Portal (MSPRP), and we call upon CMS to correct its deficiencies and carry forward those changes in the SMART Act portal process as well. Specifically, CMS has limited the number of users per employer or insured. Originally, the limit was set at 20, but it was subsequently raised to 100. CMS did not recognize the difference between data reporting and the claims settlement process, and the reality that data reporting tends to be more centralized while claims adjusting occurs in many locations and involves a large number of adjusters and other personnel settling thousands of claims. The nature of claims adjusting requires that multiple individuals within the regulated organizations be able to promptly access these two portals in order to settle claims and appropriately protect Medicare's interest. Thus, CMS should also ensure that multiple (and unlimited) personnel across any insurer or self-insured organization of third party administrator be able to access and use the interactive portal.

VI. The IFR "Dispute" Process Is Confusing and Unclear

The Coalition appreciates that CMS has announced regulations around the expedited dispute process. Yet, the Agency's regulation is flawed in two respects: first, the Agency's decision that the dispute process is available to a beneficiary of applicable plan only once is without basis in law, and fails any measure of procedural due process. Second, the regulations are unclear as to how the dispute process links to the final conditional payment process, and whether the dispute process tolls the running of the 120-day period. Each issue is explored below.

First, there is no basis in the law for the dispute process to only be available once. Such a limitation fails fundamental procedural due process considerations. For example, if CMS includes erroneous claims not attributable to an accident or injury in a conditional payment claim (for example, cancer treatment payments on a claim for a broken leg arising from a slip and fall event), and the claims are disputed, if CMS upon reconsideration includes other erroneous claims on the file (for example, wellness visits or cardiac care) there is no opportunity for the beneficiary or plan to dispute these claims. The goal of the dispute process is to ensure the claims are correct, so that the right conditional payments can be repaid to the Trust Fund as soon as possible. It serves no purpose to limit the dispute process to one dispute, when the Agency has the opportunity to change the claims subject to its reports anytime up to three days before settlement. The Agency should eliminate the artificial limit of one dispute per claim.

Second, the regulations do not clarify how the dispute process affects the 120-day settlement notice period, and whether or not the period is tolled during the dispute process. Moreover, Parties may be interested in settling, and are unable to do so simply because they mutually

disagree with the health care payments included on the CMS conditional payment statement. Although the SMART Act limits settling parties to using the expedited interactive portal once per case, the regulations should make clear that the limitation should only apply to "clean cases" where the settling parties have no dispute with CMS as to the payment includable within the conditional payment amounts. Stated differently, conditional payment amounts that include disputed claims should not count against the one claim limit in the Act.

Recommendation: CMS should clarify that beneficiaries and plans have the ability to negotiate more than once regarding disputed claims, and that cases in which disputes cannot be resolved should not count against the one time limitation on using the expedited portal procedure.

VII. The Agency Has Not Proposed to Provide Plans With Appropriate Access to Conditional Payment Information

The Coalition also urges the Agency to revisit its proposal for allowing NGHP Plans access to conditional payment information. For example, the Agency indicates that until 2016 Plans will not have access to un-redacted information about conditional payments for which the Agency seeks recovery. Similarly, the proposal indicates that to access the un-redacted information in the system after 2016, Plans will have to obtain at least two different consent forms, as well as register under the multifactorial authentication process. While the Coalition is deeply respectful of beneficiary privacy concerns, it notes that the sole reason that applicable plans (insurers and self-insureds) need to ever access that data is because the Agency insists on repayment for those claims. It is patently unfair for the Agency to demand payment for claims it deems as conditional payments, but at the same time refuse to provide the data upon which it seeks payment on privacy grounds.

At the same time, it is further unfair for the Agency to bar Plans from access to data. First, the Agency routinely sends unsolicited detailed private health information about beneficiaries to plans seeking reimbursement; many of these notices are sent to wrong parties. The Agency purports to cloak the process in the IFR within privacy when it routinely violates those same privacy concerns in current operations. Second, and more specific to the portal process, workers compensation and no fault insurers currently have unobstructed access to claim information without the need to obtain one, much less two, different consent forms from beneficiaries. (As an aside, MARC notes that the many beneficiaries who are not represented by counsel are distinctly uncomfortable signing waiver forms, and thus the two different consent forms pose a material barrier to settlement resolution for these unrepresented individuals.) To MARC's knowledge CMS has never received a beneficiary complaint about this access. There is no basis for constructing a complex and multi-layered process in the name of privacy when there is no privacy concern today. Rather, the Agency should revise its proposal to expand the existing access for workers compensation and no fault carriers to all applicable Plans.

Recommendation: CMS should revise the regulations to simplify Plan access to the portal data, eliminating multiple consent forms and simplifying the IFR's authentication process.

VIII. The CMS Regulation Has Failed to Provide Needed Information

As noted above, the MARC Coalition is disappointed that CMS has failed to proceed through regular notice and comment rulemaking, and instead has opted to avoid seeking stakeholder comment and moved forward through an interim rule. The Coalition disagrees with the Agency's justification for proceeding by IFR rather than regular rulemaking. As a result, the rule is missing several areas where regulation is needed. Among those are regulations addressing the following issues:

- What information must the settling parties report to trigger the 120-day protected period (and to the extent that CMS retains the 65 day notice before the 120-day period, to which MARC strongly objects, whether that notice is through the portal or through some other process);

- What is the process by which parties to a dispute may withdraw from the final demand process in the event that the settlement is not consummated following notice to CMS; and

- What is the process by which parties can repay the final conditional payment demand at the time of settlement.

The Coalition also recommends that CMS clarify in its rulemaking that: (a) participation in the expedited final conditional payment demand process be optional, and not required of settling parties; and (b) 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.

We understand that the Agency may be contemplating that settling parties, to begin the portal process, report the same information as is required to be reported to the COBC today to initiate calculation of the conditional payment amount process. We further believe, but ask the Agency to verify, that the information needed to be reported is contained in the MSP Manual, Chapter III, paragraph 202.2.1. If that is the Agency's intention, we request that the Agency clarify in a Final Rule that the information needed to be reported to initiate the portal process is that contained in the Manual.

Finally, MARC calls to the Agency's attention the fact that regulations are needed to implement the formal Appeal process set forth in Section 201. The Coalition agrees with CMS that this formal appeal process is distinct 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.

Recommendation: CMS should reissue the regulations to address missing information and propose regulations setting out the formal appeals process.

IX. CMS Should Eliminate IFR 42 C.F.R. 411.39(d) Addressing Future Medicals

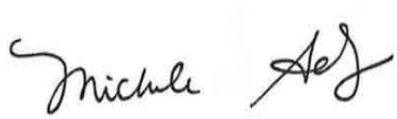
The MARC Coalition also urges CMS to withdraw IFR 411.39(d), addressing future medical costs. As the Agency is well aware, during the legislative debate over the SMART Act, it proposed to include legislative text similar to the regulation. Congress specifically rejected such language in the statute. As such, it is inappropriate for CMS to reserve claims for so-called "future medicals" when Congress previously rejected including it in the statute. Such a regulation, not addressed anywhere in the preamble, is inappropriate as it defeats the very finality that the final conditional payment process is designed to achieve.

Recommendation: CMS should delete IFR 42 C.F.R. 411.39(d).

Conclusion: As demonstrated above, the IFR is flawed in that it sets forth a process in direct contradiction to Congress' clear instruction, exceeds and misconstrues the SMART Act, and fails to address needed regulatory issues. For all the reasons set forth above, the MARC Coalition urges CMS to withdraw the IFR and reissue a proposed rule upon which all stakeholders can comment.

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)