WHAT YOU NEED TO KNOW ABOUT MSP REPORTING FAILURES

By Alston & Bird, LLP Health Benefits Practice

In October, the Centers for Medicare & Medicaid Services ("CMS") issued its final rule for civil money penalties on Medicare Secondary Payer ("MSP") reporting failures. Although penalty calculation rules might not seem to be of much interest to anyone who works hard to be compliant and never expects a penalty, third-party administrators and insurers should consider self-auditing current compliance due to the severity of the potential penalties. Under the rule, a single failure to report could result in a penalty of $1,000 per day (typically increased annually) up to a maximum of $365,000 (also typically increased annually) for each failure. The rule also announces that CMS will begin random MSP reporting audits.

RECAP: MSP REPORTING REQUIREMENTS (MMSEA SECTION 111)

Beginning in 2009, Section 111 of the Medicare, Medicaid, and SCHIP Extension Action of 2007 required reporting by group health plans and non-group health plans (for example, liability insurance, no-fault insurance, and workers' compensation). The intent of these reporting

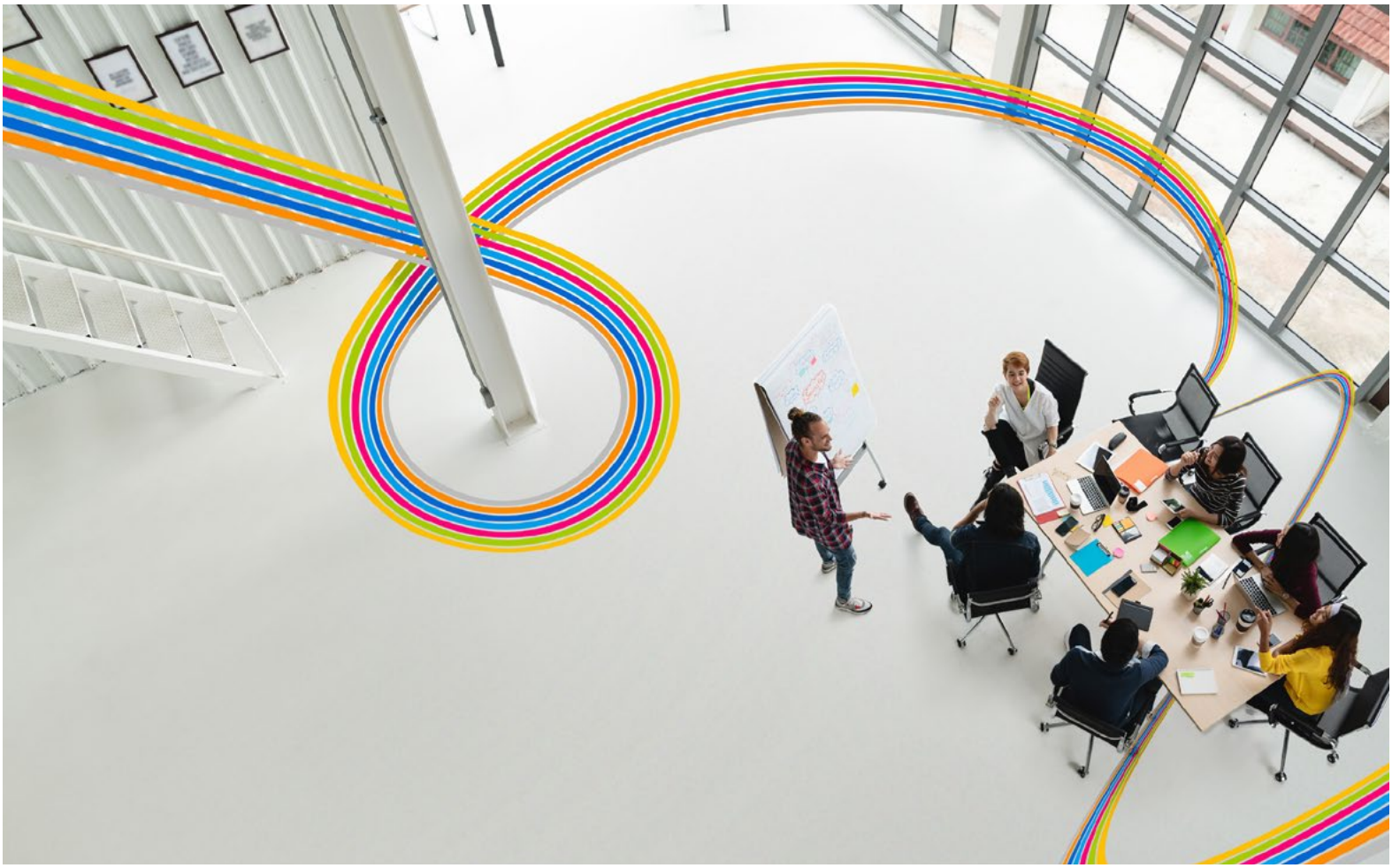
requirements is to reduce the instances where Medicare mistakenly pays primary. Although the goal of reporting is similar, the requirements and liability for group health plans ("GHPs") and non-group health plans ("non-GHPs") are different as CMS' final rule and separate detailed guidance make clear. CMS' reporting guidance is voluminous (see https://www.cms.gov/medicare/coordination-benefits-recovery/mandatory-insurer-reporting-group-health-plans), so only a very high-level overview of the reporting requirements is possible here.

WHAT PLANS ARE GHPS?

MMSEA Section 111 borrows from an Internal Revenue Code ("Code") definition of group health plan to define GHPs subject to mandatory reporting. However, it does not include that definition's exception for plans sponsored by government employers, which are also subject to mandatory reporting. Generally, a GHP is:

> "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide healthcare (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families."
>
> 26 U.S.C. § 5000(b)(1).

Although this definition is broad, CMS recognizes some exceptions to this definition and the reporting requirement, including:



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- Health FSAs
- HSAs (if Medicare beneficiaries are not allowed to make current-year contributions or did not contribute to an HSA at any time they were a Medicare beneficiary)
- Stand-Alone Dental, Vision, Behavioral, and Mental Health Coverage (including EAPs)
- "Small-Dollar" HRAs – The definition of HRA for MSP mandatory reporting purposes is broader than the definition of HRA under the Code. It includes not only the alphabet soup of HRAs like ICHRAs, EBHRAs, and QSEHRAs, but also employer-funded medical reimbursement accounts that are not typically defined as HRAs because unused amounts are forfeited at the end of each year without any carryover (e.g., MERPs). Although the MSP definition of HRA is broader than the Code's, CMS provides an exception to reporting for HRAs with an annual benefit of less than $5,000 at the beginning of the year. Amounts carried over from prior years must be included when determining if the current year benefit is less than $5,000. HRAs embedded with medical coverage must be reported separately and in addition to the medical coverage.

WHO IS RESPONSIBLE FOR REPORTING?

Responsible reporting entities ("RREs") must report the GHP's active covered individuals. The RRE is typically the insurer or third-party administrator. The employer is not the RRE except when it is the plan administrator or a fiduciary of a GHP that is both self-insured and self-administered, which is rare. In short, a TPA or insurer should generally assume it must fulfill the MSP reporting requirements for the GHPs they administer or insure, respectively, and likely cannot punt ultimate responsibility and liability back to the employer or plan.

WHEN CAN CMS IMPOSE A CIVIL MONEY PENALTY ON A RRE FOR A GHP REPORTING FAILURE?

The civil money penalty applies when a GHP does not report a GHP's coverage of a Medicare beneficiary within the later of 365 days from the Medicare beneficiary's (a) GHP coverage effective date or (b) Medicare entitlement date.

WHAT IS THE PENALTY AMOUNT?

For GHPs, the penalty is $1,000 for each day after the 365-day deadline above for reporting an individual, as adjusted annually by statute ($1,325 as of June 8, 2023). The penalty begins accruing after the 365-day period to report coverage. The maximum penalty per individual is $365,000, as adjusted annually. Notably, CMS said for non-GHPs, it will assess "up to" $1,000 per day, which gives CMS discretion to negotiate the penalty amount. However, CMS decided that the statute does not give CMS the same discretion when assessing the penalty for violations by GHPs.

HOW DOES CMS INTEND TO ENFORCE THESE REQUIREMENTS?

CMS will audit a randomized sample of new beneficiary records received each quarter. CMS says it will not undertake an automated review of all records submitted, as it initially proposed.

HOW WILL CMS NOTIFY RRES OF PENALTIES?

CMS says it will communicate informally with RREs before issuing a formal notice assessing the penalty (the "pre-notice process"). CMS says that this pre-notice process will allow the RRE "to clarify, mitigate, or explain any errors that were the result of a technical issue or due to an error or system issue caused by CMS or its contractors." CMS declined to regulate or specify the mitigating information that RREs

can provide, as doing so "would be impractical and counter to the spirit of the informal notice process[.]" Instead, "any mitigating factors or circumstances are welcomed, and a dialogue is encouraged in an attempt to find solutions that are short of imposing a CMP." RREs that do not resolve penalties favorably during the pre-notice process must request a hearing before an administrative law judge if they wish to appeal an assessment. As a result, RREs should not ignore any notices for CMS, especially the initial informal notice, as the pre-notice process could prove to be one of the most effective and affordable methods of eliminating or reducing a penalty. As discussed above, the statute limits CMS' ability to negotiate the penalty amount for GHPs if assessed.

Is it too late and are we doomed if we are an RRE that might have current or past reporting compliance failures?

Not at all, but you're in the 11th hour and you need to make reporting compliance a priority now. Although the rule is effective on December 11, 2023, it does not become applicable until October 10, 2024. Accordingly, CMS expects RREs to be compliant with the reporting requirements no later than October 10, 2024. Any RREs that are not compliant by then may be penalized. ■

Attorneys John R. Hickman, Ashley Gillihan, Steven Mindy, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. John is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley and Steven are partners in the practice, and Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to John at john.hickman@alston.com