SETTLING PERSONAL INJURY CLAIMS: SECTION 111 AND CIVIL MONETARY PENALTIES - IS YOUR CLIENT COMPLIANT?

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As we work through the new realm of "normal" in light of Covid-19, many things about our practices have changed. Several legal requirements, especially in the health care industry, have been relaxed. Most trials have been continued and most deadlines extended. However, at least one thing remains constant: The Medicare Secondary Payer Act and Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA" or "Section 111"). The rules on reimbursing Medicare (and Medicare Advantage Organizations) and submitting timely Section 111 reports have not changed. In fact, the Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule which addresses when and under what conditions it will issue Civil Monetary Penalties (CMPs) for failure to comply with the MMSEA. This article addresses the types of Section 111 reports, when Section 111 reports are required and who is authorized to submit Section 111 reports. This article also provides an introduction to the CMS' Notice of Proposed Rulemaking on Civil Monetary Penalties. Part II of this article (which will also be published during the Covid-19 crisis) will focus on potential reporting gaps and oversights in Section 111 reporting and common misconceptions about Section 111 reporting.

What is a Section 111 Report and When is it Required

Section 111 reports are electronic reports, submitted to the CMS though the CMS Section 111 Reporting Portal.[1] The report may only be submitted by a Responsible Reporting Entity (RRE) (usually a defendant and/or its insurer) who has registered with the CMS to Section 111 report or by an entity or person designated as a reporting agent by the RRE (in its Section 111 Mandatory Reporting Profile Report). The purpose of Section 111 reporting is to ensure that Medicare properly coordinates benefits.[2]

There are two types of Section 111 reports: Total Payment Obligation to the Claimant (referred to as a "TPOC") and Ongoing Responsibility for Medicals ("ORM"). Most defense lawyers are familiar with the requirement to Section 111 report a TPOC. Many lawyers may never have a reason to address Section 111 reporting of ORM, but all defense lawyers, claims managers and in-house counsel should be familiar with the concept. In some cases reporting of both a TPOC and ORM is required.

The obligation to Section 111 report a TPOC is triggered when there is a payment to (or on behalf of) a Medicare eligible claimant who pled and/or released medical expenses.[3] TPOCs usually arise as a result

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[1] *https://www.cob.cms.hhs.gov/Section111/LoginWarning.action*

[2] This article addresses Section 111 reporting for Non Group Health Plans (NGHPs) (such as liability, workers' compensation and no fault insurers, including self-insureds). Section 111 reporting is also required by Group Health Plans (GHPs).

[3] CMS NGHP User Guide, Chapter III: Policy Guidance, Chapter 6: Responsible Reporting

of a settlement or judgment. Risk management write-offs, gifts and vouchers also trigger a Section 111 reporting obligation when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a result of the underlying incident. The CMS User Guide has detailed guidance on the definition of a TPOC, the types of action that triggers reporting of a TPOC, and monetary reporting thresholds. Those details are not addressed in this article.[4]

Reporting ORM is required by the RRE where the claimant is Medicare eligible and the RRE (or its insurer who *may* be responsible for reporting) assumes ORM or is required to assume ORM. For those of you pondering: "What exactly does this mean," think about workers' compensation claims where the employer sometimes assumes liability (based upon a no fault system) and pays incident-related ongoing medicals expenses (thus the term ORM). As mentioned, the trigger for the Section 111 report is when the RRE assumes, or is responsible for assuming, ORM. This date is usually earlier than a TPOC. Reporting ORM requires some level of detail about the claim including a description of the injuries (for which the employer will pay associated medicals). However, a dollar amount is not required. The RRE indicates (in the portal) that it has assumed ORM. If (and when) ORM may be terminated, the employer is required to enter an ORM termination date. Reporting ORM and reporting the termination of ORM also assist CMS with coordinating benefits. There are limited exceptions to the requirement to report ORM. Those exceptions and additional details on reporting ORM are not addressed in this article.

CMS also considers mandatory medical payment ("Med Pay") and/or personal injury protection ("PIP") coverage as no fault coverage. Defense counsel, claims managers and in-house counsel should review applicable insurance policies for Med Pay and PIP provisions. When those provisions are triggered, an evaluation on whether (and when) a Section 111 report of ORM is required is prudent.

Entities, Section 6.5.1: What Claims Are Reportable? When Are Such Claims Reportable? The term "CMS NGHP User Guide" refers to the CMS MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No Fault Insurance, and Workers' Compensation User Guide. CMS routinely updates the CMS NGHP User Guide. See *https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-user-guide/nghp-user-guide.html* (last visited April 27, 2020). CMS uses the term "injured party" broadly.

[4] CMS NGHP User Guide. *https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-user-guide/nghp-user-guide.html* (last visited April 27, 2020).

Civil Monetary Penalties

As of today, the CMS has not accessed an NGHP RRE with CMPs. The CMS is currently authorized to impose Civil Monetary Penalties up to $1,000 per day, per plaintiff for failure to Section 111 report. However, CMS has issued a Notice of Proposed Rulemaking which defines circumstances when CMPs may or may not be imposed.[5] The proposed rule indicates that CMPs will not be limited to cases where an RRE simply failed to Section 111 report. CMS may levy CMPs in several circumstances including where an RRE submits reports in good faith but exceeds a CMS error threshold. The deadline for offering public comments has passed. The following is a summary of the proposed rule.

Failure to report

Failure to submit a Section 111 report may subject the RRE to a CMP of $1,000 for each day of non-compliance, per each individual who should have been reported. The proposed rule provides for a maximum of $365,000 per year, per each individual who should have been reported.

As mentioned above, RREs are required to report ORM and a termination date for ORM, where appropriate. If an RRE fails to report an ORM termination date the proposed CMP is up to $1,000 per day (adjusted annually for inflation) for each day of noncompliance (per individual) for a maximum annual penalty of $365,000 per year. The penalty on ORM termination is retroactive if ORM is not property terminated.

Inaccurate Reports

Defense counsel, claims managers and in-house counsel should be mindful of the requirement to reimburse Medicare and the information that has been submitted to CMS in connection with CMS' recovery of conditional payments. Where the information submitted to CMS in response to its recovery efforts contradicts Section 111 reports, the NGHP would be subject to a CMP based upon the number of days the entity failed to properly report. The proposed penalty is $1,000 per day of noncompliance, with a maximum penalty of $365,000 per individual.

Poor quality of reports

CMS will also track errors in Section 111 reports, and the proposed rule suggests that errors in excess of a 20% threshold (for any four out of eight consecutive reporting periods) will result in CMPs. Penalties for NGHPs would be tiered with an initial $250 per day of noncompliance, per individual. The penalty would increase with each subsequent quarter of noncompliance by $250 per day (to a maximum of $1,000 a day). The maximum proposed penalty would be up to $90,000 per individual per reporting period.[6]

Situations where CMPs would not be imposed

Submission of a TPOC: The proposed rule suggests there will be no CMP if the NGHP

[5] The proposed rule can be found at *https://www.federalregister.gov/documents/2020/02/18/2020-03069/medicare-program-medicare-secondary-payer-and-certain-civil-money-penalties.* The CMS Fact Sheet can be found at *https://www.cms.gov/newsroom/fact-sheets/cms-proposes-methods-calculate-civil-monetary-penalties-group-non-group-plans* (last visited April 27, 2020). Note that the proposed rule also pertains to Group Health Plans.

[6] Most NGHP RREs are registered to report on a quarterly basis.

submits Section 111 reporting of a TPOC within a year of a settlement.[7]

Good faith effort to obtain required Section 111 reporting information: There are occasions where a claimant will not cooperate in providing information needed for a Section 111 report. An example is where the claimant refuses to provide a social security number. The proposed rule suggests no penalty will be imposed if the RRE is unable to obtain required information and documents good faith efforts to do so. The proposed rule includes specific details on the documentation that should be maintained and how long that documentation should be maintained (5 years).

Procedural Issues: The proposed rule provides that the CMPs will be prospective (except for the ORM example provided above). What is not clear is whether the existing CMPs (allowing for penalties up to $1,000 per day) will remain in place. RREs who do not agree with a proposed penalty will have an opportunity to appeal. The proposed rule includes a statute of limitations of 5 years from the date when then non-compliance was identified by CMS.

Stay tuned for Part II of this article which will address potential gaps in Section 111 reporting and common misconceptions about Section 111 reporting.

Along with monitoring developments on the Medicare Secondary Payer Act, Taylor Porter attorneys continue to follow the legal developments and regulations pertaining to COVID-19. For the latest legal news and developments, please visit the Taylor Porter *Coronavirus – Legal News and Business Resources* (*http://www.taylorporter.com/blog/cat/30/coronavirus*) section of our Firm's website.

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[7] Note that the deadline for submitting Section 111 reports, at this time, is a shorter time frame and depends upon the manner in which the RRE is registered to Section 111 report.