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CMS Issues Final Rule Implementing Appeal Provisions of the SMART Act - Commentary

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On Thursday, February 26, the Centers for Medicare and Medicaid Services published a final rule implementing provisions of the Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2012 regarding the appeals process for liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans when Medicare pursues a Medicare Secondary Payer (MSP) recovery claim directly from those entities (here).

Until the passage of the Act on January 10, 2013, there had been no mechanism by which an insurer could formally appeal a claim from Medicare seeking reimbursement for medical treatment provided on behalf of an individual beneficiary that was properly the responsibility of the insurer or "primary payer" or "applicable plan." The only appeals process that existed prior to passage was reserved to the beneficiary alone. Pursuant to Subpart I, Code of Federal Regulation, §405, a multilevel appeals process was available requiring a redetermination by the contractor issuing the recovery demand, and, failing that, a reconsideration by a Qualified Independent Contractor (QIC). If a dispute continued, the case could be heard by Administrative Law Judge (ALJ). Following ALJ adjudication, the case could continue to a review by the Departmental Appeals Board's (DAB) Medicare Appeals Council (MAC). Federal judicial review was the final step in the process.

Despite multiple public comments requesting that the new rule take into account the lack of efficiency of the process and the inordinate time required even to docket a hearing before an Administrative Law Judge (which some had pointed out, took over one year to schedule), CMS has determined that the most appropriate process for all parties is the current beneficiary appeals process as the issues in controversy are virtually the same as if the recovery action were directed at the beneficiary. No determination or comment was made regarding judicial economy or time frames.

Significantly, CMS has determined that the "initial determination" as to whom to pursue for recovery is not appealable. In its initial proposed rule, CMS reasoned that §405, subpart I should establish that initial determinations are not appealable as Medicare has the right to pursue recovery from any entity that it believes is the appropriate party. Clearly, this may be argued to be contrary to the SMART Act's intent, but CMS has seemingly couched its explanation for the rule using the rationale that Medicare's powers are broad enough under the Medicare Secondary Payer Act to make a threshold determination of primary payer responsibility. The only question in these matters, it suggests, is the amount in controversy rather than the party against whom recovery is sought.

The final rule also clarifies CMS' position regarding beneficiary responsibility. Many public comments had indicated that the first target for recovery action should be the beneficiary and/or that actions should be limited to the beneficiary or whomever the parties agreed should be responsible. Again, CMS used the broad provisions of the Medicare Secondary Payer Act to justify the use of its discretion in the targeting of appropriate parties for recovery.

Additionally, CMS clarified their position that even where multiple applicable plans existed, the CMS determination of responsibility is not appealable. Further, the rule does not allow an applicable plan or beneficiary to participate in the appeal of the other party, does not require CMS to inform an applicable plan regarding a recovery effort against a beneficiary nor can beneficiaries assign their appeal rights to applicable plans. Regarding notice of a recovery action, the rule will allow both the beneficiary and the applicable plan to receive the initial determination which includes appeal rights language. In its discussion regarding applicability of the process to all parts of Medicare, CMS determined that the appeal rights established by the SMART Act do not extend to Medicare Part C or D organizations but only to Medicare Parts A and B which was specifically called for in the Act. Given the current activity on behalf of Medicare Advantage Organizations in pursuing their rights under the Medicare Secondary Payer Act, this may be the subject of some debate and interpretation in the coming days.

Many public comments were determined to be outside the scope of the rule making process including notice for purposes of the statute of limitations, the process by which an identified debtor is determined, access by applicable plans to beneficiary medical records and the tolling of civil monetary penalties during the pendency of an appeal. The rule does not address appeals related to the determination of a proposed workers' Compensation Medicare Set-Aside Arrangement (WCMSA).

The final rule is little changed from the proposed rule that CMS had previously issued. While some comments directed at issues of notice and administrative efficiencies were accepted and will be implemented, many larger Medicare Secondary Payer issues prompting the passage of the Act were not, nor were the ongoing debate as to the rights of Medicare Parts C and D plans. Presumably, as CMS only addressed the appeals process, these issues will be addressed in subsequent policy memoranda or in final rules required by the remainder of SMART Act implementation. Interested stakeholders continue to await CMS guidance on the remainder of SMART Act implementation and on many other issues.

As CMS amends the final rule to include its responses to public comments, it will be published in the Federal Register. Sixty days after publication, the rule will become effective. ECS will monitor the publishing of the Rule and will comment on all newly incorporated provisions when it is published.