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VIA EMAIL

Jacquiline Cipa
Division Director
Center for Medicare and Medicaid Services
Office of Financial Management, Medicare
Secondary Payor Unit
7500 Security Boulevard
Baltimore, MD 21244

RE: MARC Coalition – MSA Reporting Procedures and EDI Representative Follow Up Calls

Dear Jacqui:

Thank you for the ongoing dialogue over the past several months regarding CMS's implementation of the new MSA Reporting requirements. As you are aware from our ongoing conversations, the MARC Coalition is concerned that the Section 111 User Guide and the WCMSA Reference Guide are incomplete and do not sufficiently address the range of situations facing reporting entities settling workers compensation cases. Further, we have recently learned that CMS is adopting new procedures when receiving reports of settlements through MMSEA Section 111 reporting that do not include approved or non-submit MSAs. This is concerning given that that MSAs have always been voluntary agreements and there is no reason that CMS or its contractors should ever be contacting reporting entities when MSAs are not reported as being part of a settlement.

In late June and early July, we are aware of at least two cases where workers compensation settlements reported with no (or $0) MSAs. In both cases the BCRC

EDI representative contacted the authorized representative at the reporting entity to inquire about the reported MSA amount.

- In the first case, the TPOC was under $35,000 was reported with a $0 MSA amount. The EDI representative contacted the RRE's authorized representative to inquire why the case was reported without an MSA. An MSA was actually being considered for the settlement and the proposal was being evaluated by the WCRC, but upon receipt of the TPOC the WCRC discontinued the review of the case without notifying the submitter or any other parties – the proposed formal MSA simply unilaterally closed the referral without the proposing party or the beneficiary being notified.

- In the second case, a TPOC of under $100,000 was reported with a $0 MSA amount. Again the EDI representative contacted the RRE's authorized representative to inquire why no MSA was created or reported. In fact, an MSA was awaiting review at the WCRC but upon reporting the WCRC terminated review (although we understand that there was information missing from the MSA submission).

CMS has never notified the regulated community that CMS will question the RRE as to why a *voluntary* MSA was not included in the final settlement. CMS also has never advised the community that pending MSAs will be terminated and that the WCRC will cease review when a TPOC is submitted with no report of an MSA. And perhaps most concerning, CMS apparently instructed its WCMSA review contractor to discontinue review of these MSA proposals without notice to the impacted parties upon receipt of a TPOC report. These apparent CMS procedures are very disruptive to the reporting community and beneficiaries.

Additionally, it appears that the WCRC has been automatically converting approved MSA data. For example, we were made aware of an instance where the WCRC converted an "approved" MSA status to a "non-approved" MSA status when the MSA amount reported with TPOC was less than the CMS approved value. Additionally, in another WCMSA the approved "Professional Administration" designation was converted to a Self-Administration status because an EIN was not reported through the Section 111 *optional* "Professional Administrator EIN" field.

We have long requested that CMS more clearly articulate its guidance in a multitude of typical workers' compensation scenarios. The above examples are predictable given the lack of guidance that the community has received.

In light of these and likely other examples, we renew our request that CMS immediately suspend MSA reporting until the Agency can explain to the community

what the policy is, what the MSA data will be used for, how it will impact those organizations that have elected in good faith to participate in the voluntary WCMSA review process, and why voluntary agreements (including private agreements that are not even submitted to the Agency) should be subject to reporting. If CMS is concerned that beneficiaries may be assessed greater repayment liability than is fair or appropriate, the solution lies with CMS revising MSP regulation and guidance rather burdening reporting entities with additional reporting requirements and uncertain policies and procedures that impair existing workflows.

We welcome further discussion about this issue, and will follow up with you to set up a time to speak. Of course, do not hesitate to reach out to me if we can answer any questions about the above information.

Sincerely,

David Farber, Counsel to MARC