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VIA EMAIL

Kimberly Brandt
Deputy Administrator
Center for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: MARC Coalition – Medicare Secondary Payer Reporting Issues – Request for Meeting

Dear Kim:

On behalf of the MARC Coalition, I am writing to request a meeting with you to address how the Medicare Secondary Payer (MSP) program could be improved to enhance beneficiary protections and streamline administrative efficiencies. As you know, MARC is the only multi-stakeholder coalition advocating to improve the MSP program on behalf of beneficiaries, affected companies, and other stakeholders. Our efforts on the SMART Act and PAID Act, and our ongoing collaboration with CMS, speak to that work, and it is in that spirit that we reach out to you.

The Administration, starting with Executive Order 14192 ("Unleashing Prosperity Through Deregulation") and continuing through Dr. Oz's leadership, has worked hard to significantly reduce the private expenditure required to comply with Federal regulations and to increase beneficiary access to care without adding cost. To further those goals, we are asking for a call with you to address three MSP improvements which would further the Administration's policies: (1) reform the MSP "Ongoing Responsibility for Medicals" reporting process which is directly causing hundreds of thousands of beneficiaries each year to be improperly denied care;

(2) withdraw a recent Office of Financial Management (OFM) reporting change that is unnecessary, will cause the reporting of erroneous data, and which many cannot implement; and (3) restructure how OFM implements changes to the Reporting User Guide. Each is addressed below:

ORM Issues: We are asking that you and your team work with OFM to modify how "ORM" is terminated, and that you bring the beneficiary care perspective into the policy analysis. In brief, workers' compensation and no fault (auto) insurance commonly includes an obligation that the insurer covers future treatments arising from an accident or injury until such time as policy limits are exhausted or an applicable statute of limitations expires. Many states, however, do not have a statute of limitations on so-called "ORM." In such states, insurers (and self-insureds) exercise their professional judgment and close claims based upon no expectation of future medical care. For example, if an individual suffered a cut to their arm requiring an emergency room visit, the insurer closes the claim after the arm heals even in states with no statute of limitations.

OFM appropriately does not want the Trust Fund to have to pay for ORM claims that were the responsibility of third parties and from the inception of the Section 111 program included ORM reporting requirements in the User Guide. In an overreach, however, CMS never allowed reporting entities to "close" ORM in states with no limitation cutoff unless the reporting entity had a note from a "treating physician." The vast majority of such cases (like the ER example above) have no treating physician, and even if such a physician exists doctors will not sign such letters. As a result, there is no way for reporting entities to "close" the ORM record, even if the claim file was closed years earlier, and hundreds of thousands of such ORM records remain "open" in the CMS system.

This directly affects beneficiary care because when ORM remains "open," a flag is placed on the beneficiary common working file, and when providers see the flag they routinely refuse to treat, claiming that the care (which is unrelated to the accident or injury -- think cancer or hospice) should be paid by the "primary" payer. MARC members report receiving hundreds, and in some cases thousands, of beneficiary complaints every year about this issue; we estimate at least 200,000 beneficiaries each year are being improperly denied care because of "open ORM" that could be avoided but for the restrictive OFM policy.

MARC repeatedly has raised this issue with OFM, and in 2021 a modest, but insufficient, change was made to the policy. OFM has also worked with the Center for Medicare to issue MedLearn notices to providers instructing them not to deny care, but the notices have appeared to have no impact and the problem is getting worse. On December 9, MARC again met with OFM to address the issue, and OFM appropriately noted its role to protect the fiscal interests of the program. It is for that

reason we are asking that you personally engage in this issue to add the beneficiary care perspective to the policy discussion. CMS management needs to balance the ORM policy against the significant beneficiary harm it is causing.

Dr. Oz in an interview last August noted: "People go into health care, whether they're pharmaceutical companies or insurance companies or the PBMs or anybody in the space. Even at the CMS, the most impressive thing to me in my new task, and the President has appointed me to, is the remarkable quality of people within the organization, just unbelievably talented. They went into this job because they care about health care and about people. Somewhere along the lines, people forget. They put numbers ahead of patients. And when that happens, then you start running into problems."[1] OFM understandably is focused on the fiscal needs of the Trust Fund, but those numbers cannot come ahead of the impact the OFM policy is having on beneficiary access to care. That is why we are asking you to help restore that balance.

Recent OFM Changes to Reporting Claims: In November 2025, CMS updated the Section 111 User Guide to Version 8.2, fundamentally changing the manner in which cases with multiple events or multiple responsible parties are to be reported and asking for information to be reported in a manner that would be impossible to use for proper benefits coordination with the beneficiary following settlement. The reporting change cannot be implemented by many reporting entities and would require reporting inaccurate information – all of which OFM could have learned had it shared the proposed change in draft with the industry. We urge you to ask OFM to withdraw the change until a realistic solution that can be implemented by industry can be found.

In brief, current Section 111 reporting framework requires reporting entities to report a separate Total Payment Obligation to the Claimant (TPOC) record for each distinct claim or Date of Incident (DOI). Each report reflects the individual claim's facts — including the injury or body part, ICD codes, settlement amount, and date of injury— ensuring that CMS's data accurately aligns with the claim record, jurisdictional filings, and payment details. In the recent update, however, OFM added new guidance directing that, when a single settlement, judgment, award, or other payment resolves multiple incidents (different injury dates), the reporting entity should report a record for the earliest date of incident which includes all ICD codes for injuries being settled for all dates of incident back to the first date of injury. For example, if in 2020 the beneficiary sprained their wrist, in 2022 they broke their back, and in 2024 the claims were resolved in a settlement, the back injury would be reported as happening in 2020 when it only occurred in 2022.

The proposed change does not align with how industry retains claims files, is not implementable by industry due to the structure and design of reporting systems, and

[1] https://www.cbsnews.com/news/dr-mehmet-oz-cms-administrator-face-the-nation-08-03-2025/

would result in the reporting of inaccurate information to CMS. While the Agency claims "it will figure it out on the back end," that is not a solution to what already is an overly complex and broad system. We request your assistance in withdrawing the change.

MARC has previously asked CMS to propose these kinds of changes in a draft so that we and others could assist in identifying issues in the proposed changes, but OFM has refused to do so. We understand that OFM is claiming that "industry" asked for this "clarification," but no-one within MARC (or within any other MSP group we know) ever requested this change. Unfortunately, OFM has missed the mark; the systems that reporting entities rely upon cannot be changed to implement the new policy and reporting entities will not report false information.

User Guide Policy Change Procedures: As noted above, for years the MARC Coalition has urged OFM to engage with stakeholders before unilaterally modifying its User Guide. MARC's request was not extraordinary – as you know even when not required by the Administrative Procedures Act, CMS routinely issues Medicare policy and guidance changes in draft for comment. (Recent examples include the IRA drug price negotiation guidance and MFN guidance, and a recurring example is the Part C/D Call Letter – all issued in draft and modified in response to stakeholder comments).

By issuing proposed Section 111 User Guide changes in draft, CMS can learn whether the proposals can be implemented, whether the policies need clarification, or how they can be improved. While issuing drafts for comment may be new to OFM, it is not new to CMS. And given that the most recent policy change is the second that has created stakeholder confusion and has faced serious implementation problems (MSA reporting changes have caused similar challenges), we call on CMS to issue policy changes in draft and to engage with all stakeholders before finalizing reporting policy changes.

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We welcome further discussion about these issues 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