Medicare Watch List 2026:
Taking Control of MSP Compliance

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Focus Points

- CMS/Medicare – navigating a significantly changed MSP landscape!
- Being prepared and staying compliant
- Revisiting and re-tooling your MSP best practices
- Poll Questions
- How Verisk services can help you achieve “end-to-end” MSP compliance!

Watch List Item #1
Section 111 civil money penalties (CMPs)

Watch List Item #1 – Section 111 CMPs

Items to Watch in 2026…

Section 111 CMPs are live! Audits started in January!

- RREs may now actually be fined!
- Great time to reassess your CMPs readiness
- Let’s see where this heads this year – who will be fined?

Section 111 Civil Money Penalties (CMPs) – Snapshot

When can RREs be penalized?

When the RRE "[f]ails to report any beneficiary record within 1 year from the date of [TPOC], or the effective date where [ORM] has been assumed by the entity."

- **For TPOC** –
  - ✓ CMS uses the TPOC Date submitted, unless the "Funding Delayed Beyond TPOC Start Date" is submitted.
- **For ORM –**
  - ✓ CMS will compare the date of the RRE's file submission with the CMS Date of Incident reflected in the ORM coverage record.
- **Prospective Application:**
  - ✓ Only coverage record submissions **with coverage effective dates (ORM) or TPOC dates of October 11, 2024, or later** are in scope for CMPs.

How will CMS levy CMPs?

- **<u>Tier 1</u> – One year to two years late:**
  - ✓ $378 – each calendar day
- **<u>Tier 2</u> – Two years to three years late:**
  - ✓ $756 – each calendar day
- **<u>Tier 3</u> – Three years or more late:**
  - ✓ $1,512 - each calendar day
- **Max penalty for any single instance of non-compliance = $551,880**

<u>Note 1</u>: CMPs rates are adjusted yearly for inflation. Above CMPs rates per Federal Register update (January 2026)

<u>Note 2</u>: CMS's penalty "audits" started in January 2026 – RREs may now start to receive CMPs notices!

CMPs Key Dates & Scope

October 11, 2024
Rule became "applicable"

October 11, 2025
Coverages in scope for penalties may begin to be identified

January 1, 2026
Randomized quarterly audits began

Per CMS's Jan. 2024 Webinar and CMPs Webpage

- Only coverage record submissions **with coverage effective dates [ORM] or TPOC dates of October 11, 2024, or later** are in scope for penalties.
- ✓ CMS said it will **not** seek to assess penalties under its CMPs Final Rule for submissions where the coverage effective dates or TPOC dates occurred prior to October 11, 2024.
- ✓ Regarding pre-10/24 records, CMS has stated that accurate reporting is still statutorily required and that RREs may be subject to other actions including, but not limited to, False Claims Act suits or administrative recovery efforts if they fail to meet their full reporting obligations. See, CMPs webpage and CMPs webinars (1/18/24 and 10/17/24 webinars)

CMS – CMPs "Good Faith" Compliance Safe Harbor

Safe Harbor – Regulatory Provisions

RRE must request the Big 5 from the claimant and his/her attorney, or other rep, if applicable, or both, at least three (3) times as follows:

a. Once in writing (including electronic mail)

b. Then at least once more by mail

c. At least once more by phone or other means of contact in the absence of a response to the mailings.

RRE can stop the requests if they receive a **written response** from claimant or their lawyer (or rep) indicating that they clearly and unambiguously declines or refuses to provide any portion of the Big 5 data.

RRE must document its efforts to obtain the MBI or SSN (or last 5 digits of the SSN) – including any written rejection correspondence – for a minimum of 5 years.

CMS Webinar Statements

- 2 of the attempts must be in writing, mailed or e-mailed (at least one must be a physical mailing), to the individual and their attorney and/or rep. (three letters would satisfy the requirements)
- 1 attempt can be made via phone call, mail, or e-mail.
- Order of the attempts does not matter – only that 2 of the 3 attempts were made in writing
  - ✓ Safe harbor requires request to claimant *and* their attorney and/or rep.
  - ✓ If attorney refuses to provide info (in writing) – that is sufficient, no need to reach out to the claimant. However, if the attorney does not respond at all or does not respond in writing, then RRE must request the info from the claimant.

CMPs Application and Scope

Number of Records to be Reviewed

CMS will review 250 coverage records (combined NGHP and GHP) per calendar quarter

- Review will be proportionate to the records received between NGHP and GHP for that quarter.
- **CMS example:**
  - ✓ In one calendar quarter CMS receives 600k GHP records and 400k NGHP records for a total of 1M records
  - ✓ Then, 60% of the 250 records audited for that quarter will be GHP and 40% NGHP records

Random Audit Selection

"Random audit selection" of records from Section 111 submissions and sampled records from sources other than Section 111 reporting – randomized audits start Jan 2026.

- Possible that one RRE could have multiple records selected for review in any quarter.

Per CMS's 1/15/26 Webinar:

- **10/11/25** – CMPs "enforcement date" for No-Fault and Liability records.
- **February 2026** – Anticipated completion of CMS's first CMPs audit (liability and no-fault coverages).
- **March 2026** – Earliest mailing of an "informal notice" of a CMP if a record is deemed non-compliant.
- **July 2026** – CMS will begin its initial quarterly audit of worker's compensation coverages (delayed 2 quarters due to addition of new TPOC/WCMSA requirements in April of 2025).

Section 111 CMPs – Notice & Appeal

1. Advance (Informal) Notice and Mitigating Evidence

- CMS will first give **"informal"** notice

- RREs can then submit **"mitigating evidence"**
  - ✓ Must be submitted within 30 days of receipt of informal notice. CMS will **not** grant time extensions.
  - ✓ I**f CMS accepts** = No additional action necessary
  - ✓ **If not accepted** = Finding of non-compliance will stand and a proposed determination to impose a CMP will be issued

2. Formal Notice

- CMS will issue a **"notice of proposed determination"** if:
  - ✓ No response to informal notice
  - ✓ RRE has not provided adequate mitigating evidence

- This notice will note the CMPs amount and info on appeal

3. Appeal

- Must appeal within 60 calendar days of receipt of notice of proposed determination

- Appeals Process:
  - ✓ Administrative Law Judge (ALJ)
  - ✓ Department Appeals Board (DAB)
  - ✓ Judicial Review

CMPs Payment – CMS's "Final Determination"

"Notice of Final Determination"

CMS is looking for payment

Applies – When the RRE (a) did not file an appeal; or (b) exhausted its appeal rights. Final CMP – payment is due within 60 days.

- **CMPs Amount** – Based on the effective CMPs inflation adjusted amount at the time CMS's initial audit occurs.
- **CMPs "Clock"** – Stops ticking in terms of the daily penalty calculation as of the date the non-compliance was identified via the initial audit.

Payment – Only electronic payment accepted. RREs must use Pay.gov eBill (CMS will provide instructions).

Section 111 CMPs

Compliance Considerations – 2026

- Check your CMPs readiness – how does your reporting look?
- Make sure your RRE Profile Report is up to date!
- Remember –notice/appeal process has STRICT timelines!
- Verisk's Section 111 services can help!

S.111 Reporting – MSP Navigator

Customizable solutions that ensure S.111 reporting accuracy

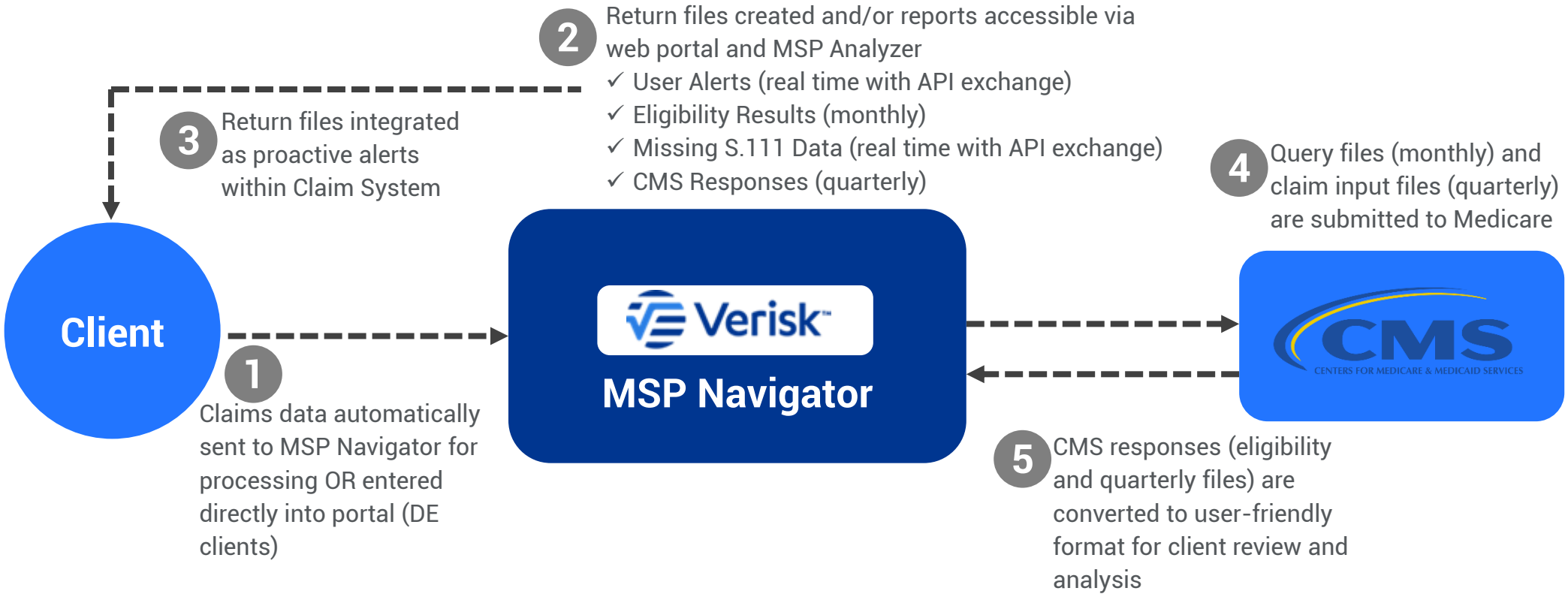
- **Error Free Reporting** with proactive data validation
- **Claim system integrations and multiple file exchange options** – Implementation accelerators available and all major file specifications accepted
- **New CMP Readiness dashboard**
- **PAID Act integration** – stay ahead of potential MAP liens
- **Robust reporting and analytic capabilities**
- **Self-service web-based portal** provides management reports to supplement compliance oversight
- **Compliance Audit & Protocol Review** services available

Experience Matters

- Facilitates error-free reporting for **~5,000** RREs
- ~400 **million claims queried** and **2 million claims reported** to CMS in 2024
- **22** dedicated Section 111 experts at your service

**Customizations available upon request*

Data Flow



Watch List Item #2
TPOC/WCMSA

Watch List Item #2 – TPOC/WCMSA Reporting

Items to Watch in 2026…

First full year of TPOC/WCMSA reporting

- Only applies to WC claims with Medicare beneficiaries
- Remaining issues/questions for CMS to address
- Presents challenges for insurer on several fronts
- Making it work better in 2026!

TPOC/WCMSA Compliance – Practical Perspective

Effective April 4, 2025*, WC insurers must report the new TPOC/WCMSA data fields for settlements with Medicare beneficiaries as follows:

WC settlement with a Medicare beneficiary:

- Greater than $25k
- $25k or less (low dollar settlement)
- No WCMSA or $0 WCMSA (CMS reserves right to audit)

In each of these scenarios, WC carrier must report the new TPOC data points

TPOC/WCMSA Data Points
1. MSA Amount
2. MSA Period
3. Lump Sum or Structured/Annuity Payout Indicator
4. Initial Deposit
5. Anniversary (Annual Deposit)
6. Case Control Number (optional)
7. Professional Administrator EIN (optional)

*Applies to Section 111 coverage reports with TPOC dates April 4, 2025, or later.

Compliance Impact – How CMS is using TPOC/WCMSA

MSAs are now tracked and validated against S.111 data

- Impacts Medicare payments
- May change status of MSA approvals
- Tracks MSA spend and administration

Provides CMS a pathway to audit MSA use in WC settlements involving Medicare beneficiaries

- CMS knows which cases include MSAs
- May bring all available means to enforce program including bringing a False Claims
  Act claim and auditing $0 WCMSA values.

What we are seeing, impact – and what CMS needs to address!

1. WCMSA beneficiary letters going to both the claimant *and* WC RRE.

2. BCRC EDI reps. may contact an RRE if a TPOC is reported while an MSA is currently pending CMS approval.

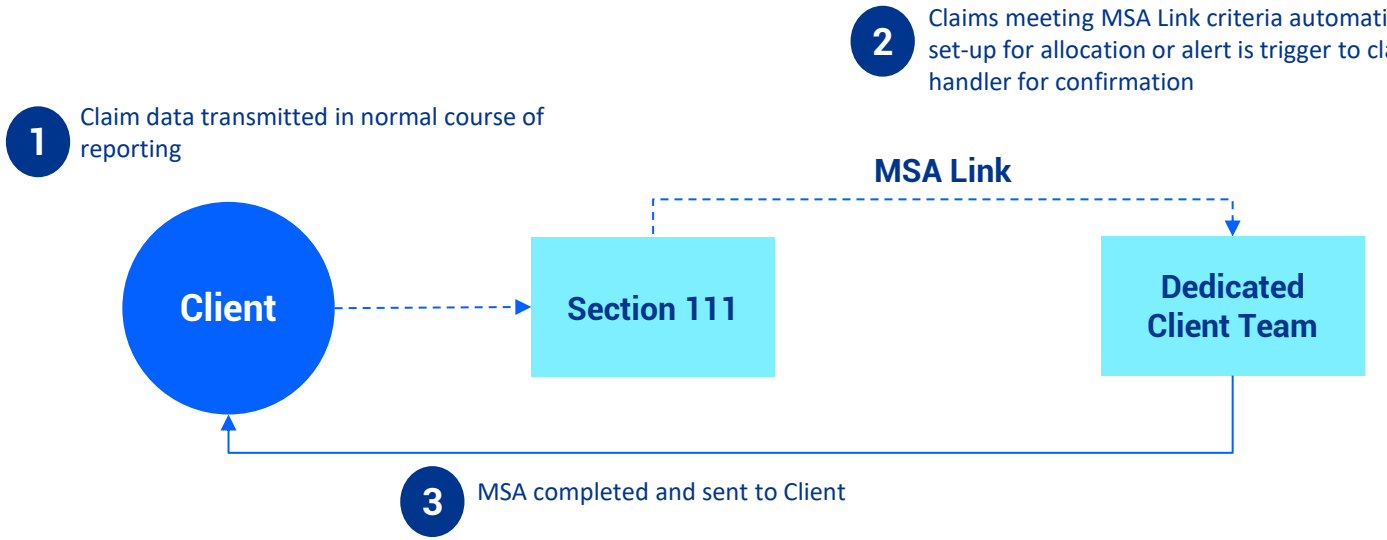
3. WCRC closed a pending MSA submission after TPOC was reported with a $0 MSA Amount.

4. WCRC converted an “approved” MSA to a “non-approved” MSA status after TPOC reported with an MSA amount less than the CMS approved value.

5. WCRC converted a prof. administration designation to self-admin. based on the TPOC MSA data.

Data Driven Protocol Adherence for Allocations: MSA Link

MSA Link leverages existing S.111 data to ensures adherence to company specific protocols mitigating risk, while streamlining compliance tasks for greater claims handler efficiency. To customize to a client's specific protocols, we offer fully automated and trigger options.



Benefits

- **Drives programmatic compliance in line with your established protocols.**
- **Mitigates risk and assists with WCMSA TPOC reporting.**
- **Streamlines claims handler workflow driving efficiency.**

MSA Link Options*

1. Fully Automated
2. Email Trigger with Claims Handler Intervention

Decision Points*

1. Low dollar settlement protocols
2. Opt-out Authority
3. Nonresponse process

S.111 Data Logic*

- ✓ Medicare Beneficiary = YES
- ✓ Claim Status = OPEN
- ✓ One(1) ICD Code listed
- ✓ No TPOC (not settled)
- ✓ Jurisdiction = Closes Medical
- ✓ ORM = Y
- ✓ Age of Claim = 18 months

**Customizations available upon request*

Data-Driven Medicare Set-Aside

Data-Driven MSA leverages Verisk's unparalleled medical, legal, and data science expertise with our expansive claims data sources for low dollar settlements ($25k or less). This automated MSA enables claims staff to quickly access a future medical allocation, while avoiding the time, expense, and subjective nature of the traditional MSA Review Process.

Submit referral for a Data-Driven MSA

Verisk runs claims data from S.111 through custom-built models

Verisk automatically returns 1 page data-driven MSA report

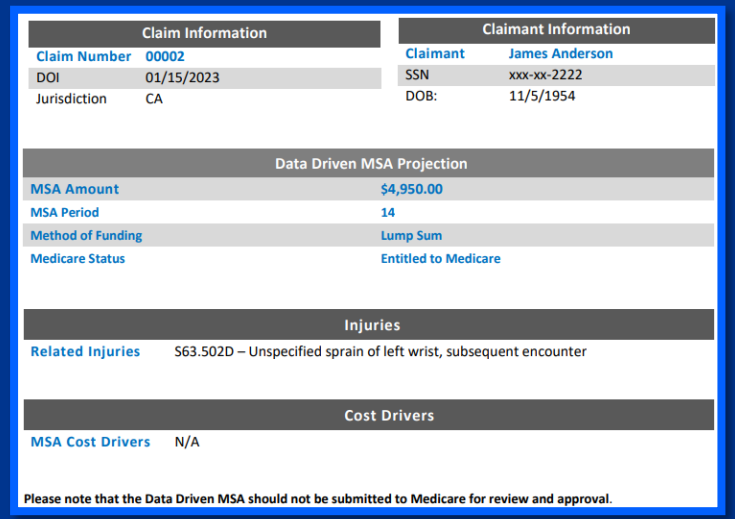
Report is QA'd and delivered within hours of referral

Benefits

- Addresses low dollar settlements
- Ensures consistency in evaluation and mitigate compliance risk

Data-Driven MSA:

- Ensures consistent process and protocol adherence
- Fast turnaround time
- Cost effective
- Fuels new MSA TPOC reporting requirements
- Allocation accounts for injured party's life expectancy and treating location
- Supported by Verisk's team of experts



Claim Information		Claimant Information	
Claim Number	00002	Claimant	James Anderson
DOI	01/15/2023	SSN	xxx-xx-2222
Jurisdiction	CA	DOB:	11/5/1954

Data Driven MSA Projection	
MSA Amount	$4,950.00
MSA Period	14
Method of Funding	Lump Sum
Medicare Status	Entitled to Medicare

Injuries	
Related Injuries	S63.502D – Unspecified sprain of left wrist, subsequent encounter

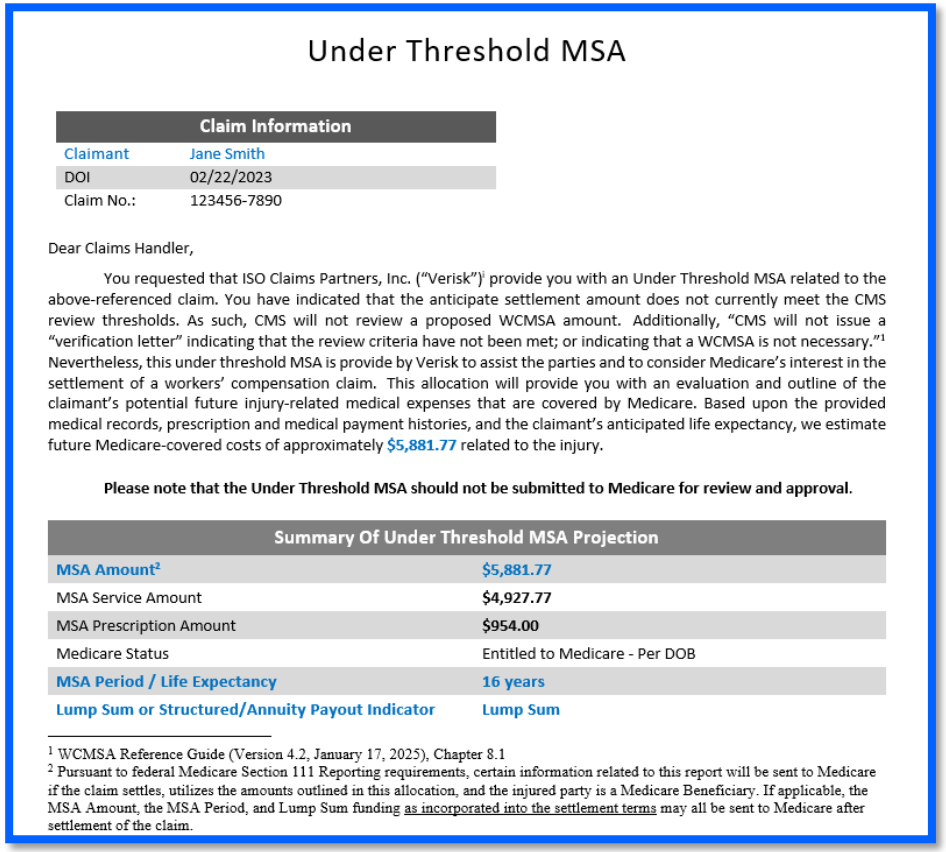
Cost Drivers	
MSA Cost Drivers	N/A

Please note that the Data Driven MSA should not be submitted to Medicare for review and approval.

Verisk's Under Threshold MSA

Cost effective solution to address MSAs regarding low dollar settlements – Utilizes nurse and attorney to review medical records.

- **Allocation created by nurse and attorney**
  - ✓ Like a traditional MSA or Pre-MSA nurses and attorneys are involved.
- **Considers last 6 months of medical records and Rx pay histories**
  - ✓ There is a summary of future treatment but not a narrative.
  - ✓ A treatment itemization is also provided.



Under Threshold MSA

Claim Information	
Claimant	Jane Smith
DOI	02/22/2023
Claim No.:	123456-7890

Dear Claims Handler,

You requested that ISO Claims Partners, Inc. ("Verisk")[1] provide you with an Under Threshold MSA related to the above-referenced claim. You have indicated that the anticipate settlement amount does not currently meet the CMS review thresholds. As such, CMS will not review a proposed WCMSA amount. Additionally, "CMS will not issue a "verification letter" indicating that the review criteria have not been met; or indicating that a WCMSA is not necessary."[1] Nevertheless, this under threshold MSA is provide by Verisk to assist the parties and to consider Medicare's interest in the settlement of a workers' compensation claim. This allocation will provide you with an evaluation and outline of the claimant's potential future injury-related medical expenses that are covered by Medicare. Based upon the provided medical records, prescription and medical payment histories, and the claimant's anticipated life expectancy, we estimate future Medicare-covered costs of approximately $5,881.77 related to the injury.

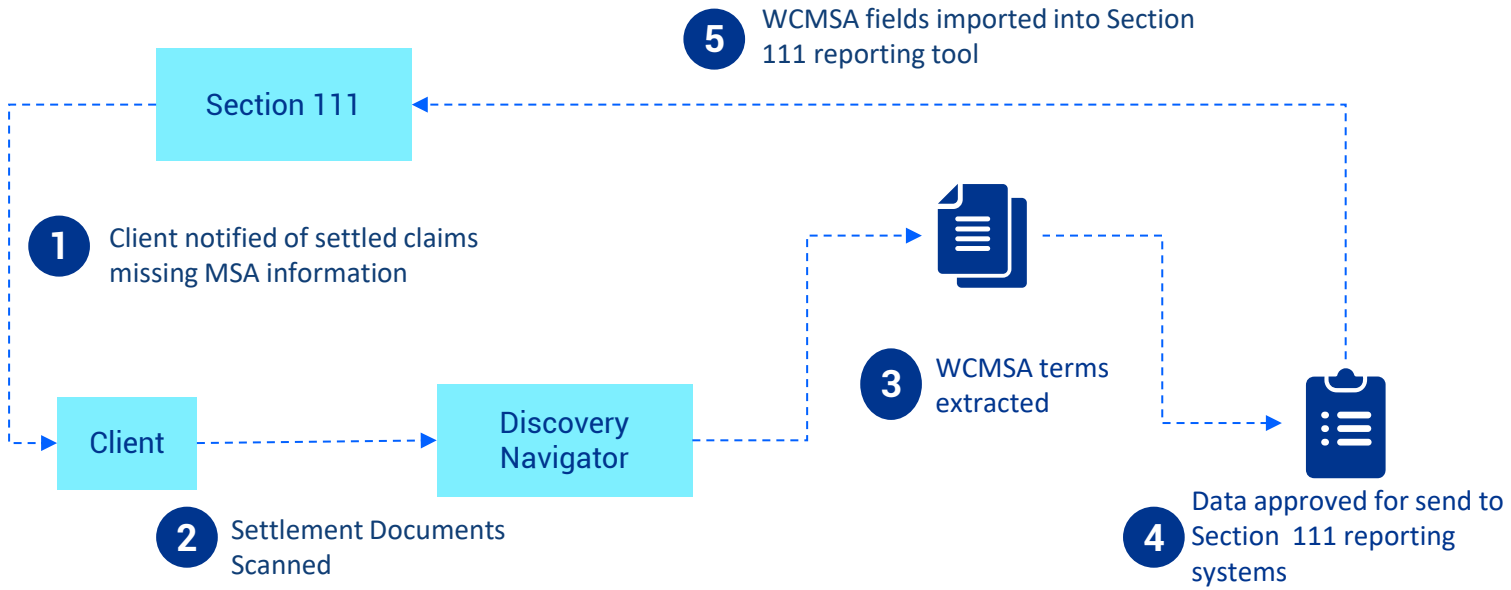
Please note that the Under Threshold MSA should not be submitted to Medicare for review and approval.

Summary Of Under Threshold MSA Projection	
MSA Amount[2]	$5,881.77
MSA Service Amount	$4,927.77
MSA Prescription Amount	$954.00
Medicare Status	Entitled to Medicare - Per DOB
MSA Period / Life Expectancy	16 years
Lump Sum or Structured/Annuity Payout Indicator	Lump Sum

[1] WCMSA Reference Guide (Version 4.2, January 17, 2025), Chapter 8.1
[2] Pursuant to federal Medicare Section 111 Reporting requirements, certain information related to this report will be sent to Medicare if the claim settles, utilizes the amounts outlined in this allocation, and the injured party is a Medicare Beneficiary. If applicable, the MSA Amount, the MSA Period, and Lump Sum funding as incorporated into the settlement terms may all be sent to Medicare after settlement of the claim.

Section 111 Data Sync

Section 111 Data Sync automate identification and extraction of WCMSA reporting fields from settlement document with seamless integration into the Section 111 workflow.



Benefits

- Automate retrieval of newly required WCMSA TPOC data
- Mitigate risk, automate workflow, minimize adjuster burden

Section 111 Data Sync

Automate the retrieval and entry of new WCMSA TPOC data requirements.

Example:

- Workers' compensation claim
- Medicare beneficiary
- File settles/ TPOC

= Applicable data elements automatically extracted from settlement agreement to satisfy new WCMSA TPOC reporting obligations

Watch List Item #3
CMS/Treasury Recovery Claims

Watch List Item #3 – CMS/Treasury Recovery Claims

Items to Watch in 2026…

CMS conditional payment claims (recovery claims) and Treasury actions will continue unabated.

- Understanding the connection between Section 111 and CMS recovery is important.
- Avoiding Treasury claims (and offsets) will be critical.

CMS Recovery Claims (Parts A/B) – Nutshell

CMS Conditional Payments

CMS recovery claims relate to claimants who are (or were) enrolled in Medicare Parts A and/or B of the Medicare program ("Traditional Medicare")

CMS has strong and broad recovery rights including, but not limited to:

- ✓ Interest accrual
- ✓ "Double Damages"
- ✓ Can pursue claimant, claimant lawyer, insurers, and other parties
- ✓ Treasury (including offset)
- ✓ Department of Justice

CMS uses Section 111 reporting (ORM and TPOC reports) to "trigger" its recovery activities and its recovery process differs based on ORM/TPOC status

- CMS uses two contractors to help pursue recovery:
  - ✓ BCRC – Benefits Coordination and Recovery Center
  - ✓ CRC – Commercial Repayment Center
- Remember, the Section 111 Query can help you determine Part A/B enrollment.
- Challenging/Disputing Conditional Payment claims (5 levels appeal process)

Parts A & B: Which Contractor Does CMS Use and When?

ORM
On-going responsibility for medicals

CMS uses CRC →

CRC Recovery
✓ CRC pursues WC/NF/Med-Pay/ PIP when ORM = YES
✓ Debtor = Carrier/Self-Insured
• Authorization Required = Letter of Authority (LOA)
• CRC Correspondence is time sensitive
• Deadlines must be adhered to
• Demands are made prior to settlement
• Rolling recovery = Multiple recovery cases and multiple lien demands

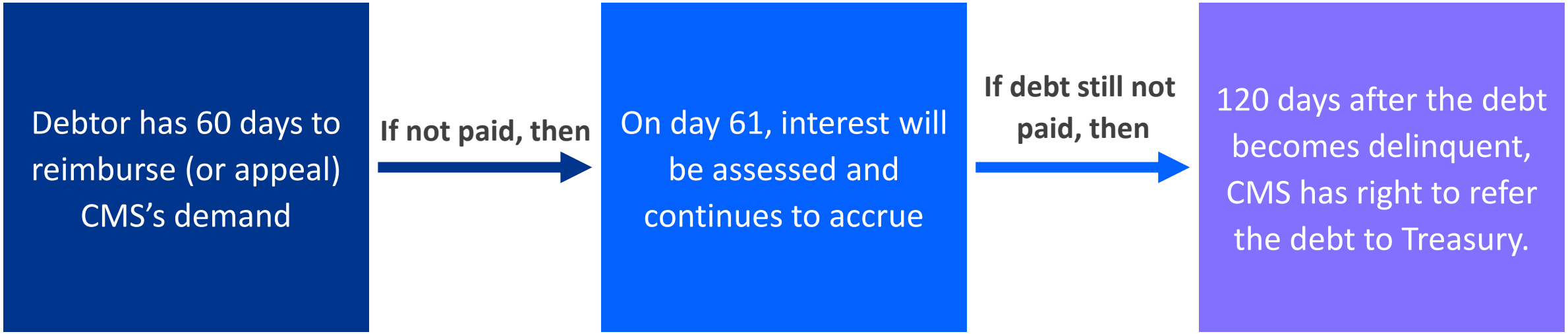
TPOC
Settlement judgment award or other payment

CMS uses BCRC →

BCRC Recovery
✓ BCRC pursues **Liability Settlements** and Post-TPOC WC claims
✓ Debtor = Plaintiff/ Medicare Beneficiary/Claimant – but remember, insurer remains ultimately liable per 42 CFR 411.24
• Authorization Required = Proof of Representation (POR)
• Post TPOC WC Claims - debtor switches to claimant/POR is required
• Demand is made post settlement

Avoiding Treasury Claims!

- If CMSs demand is not reimbursed timely, then they will refer the debt to the Treasury Department.
- Here is how a claim gets to the Treasury:



Treasury uses the Treasury Offset Program and a panel of Private Collection Agencies to collect debts

Challenging Conditional Payment Claims

Challenging/Appealing CMS Claims
1. Redetermination
2. Reconsideration (Qualified Independent Contractor (QIC)
3. Administrative Law Judge (ALJ)
4. Medicare Appeals Council (MAC)
5. Federal Court

NOTE: Courts are strict about adhering to the filing timelines and exhausting administrative remedies before the court has jurisdiction

CMS/Treasury Recovery Claims

Compliance Considerations – 2026

- Evaluate your best practices – where/how can they be improved?
- Are Treasury claims an issue? If so, what is going wrong?
- Staying compliant – adjuster updating/training.
- Consider CMS open-debt report.
- Consider Verisk's CMP Link program!

Watch List Item #4
Medicare Advantage Plans (MAPs) Recovery Claims

Watch List Item #4 – Medicare Advantage Plans (MAPs) Recovery

Items to Watch in 2026…

MAP recovery claims should be on the radar – "double damages" lawsuits continue!

- MAP enrollment at historic highs (over 50% of all Medicare beneficiaries are in a MAP!).
- MAP recovery is different from CMS recovery! Two different processes!
- What are key cases and issues to watch in 2026?

Medicare Advantage Plans (MAPs) (Parts C) – Nutshell

MAP (Part C) Recovery

Medicare Advantage Plans (MAPs) recovery relates to claimants who are (or were) enrolled in a private MAP plan.

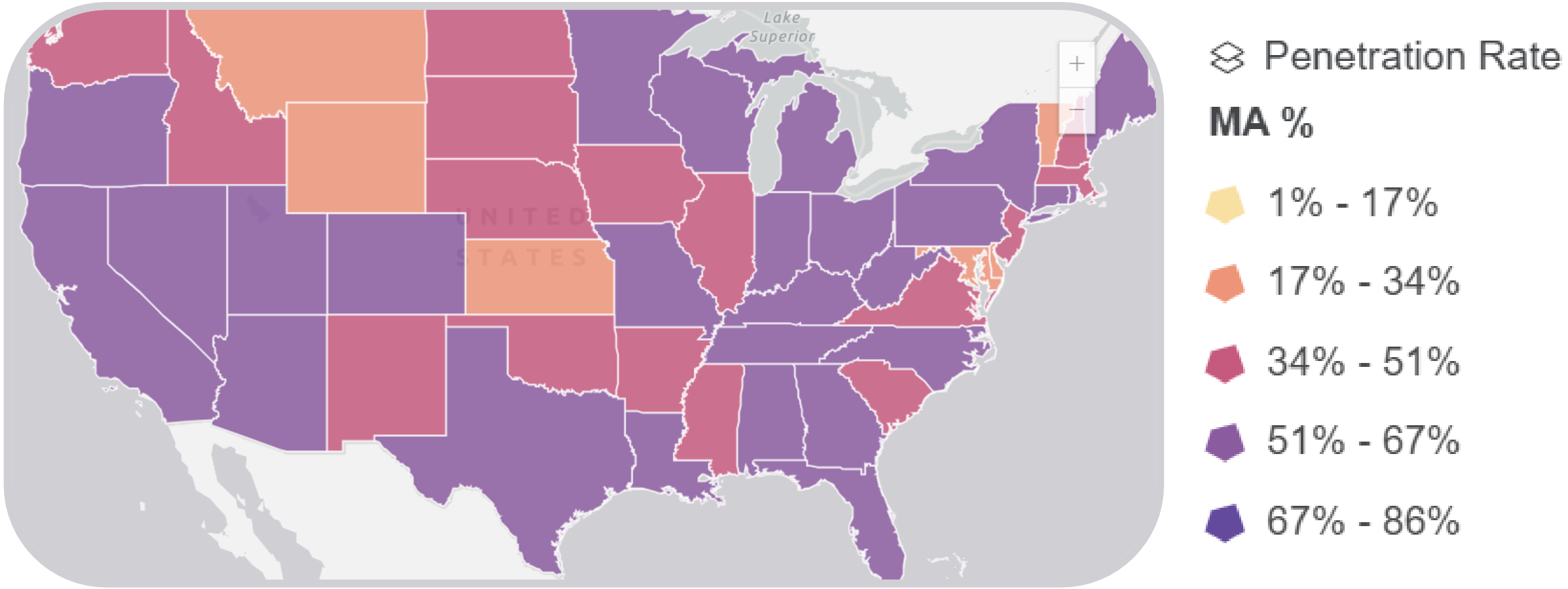
- MAP program highlights:
  - ✓ Private Medicare plans
  - ✓ Almost 4k plans
  - ✓ 51% of all Medicare benes nationally are in a MAP
  - ✓ Top MAPs: United Healthcare (27%), Humana (18%), and BC/BS (14%)

Medicare Advantage Plans (MAPs) have recovery rights. MAP recovery is different from CMS recovery claims.

- ✓ MAPs have recovery rights under MAP statutes/regs.
- ✓ MAPs also have "double damages" rights in some jurisdictions.

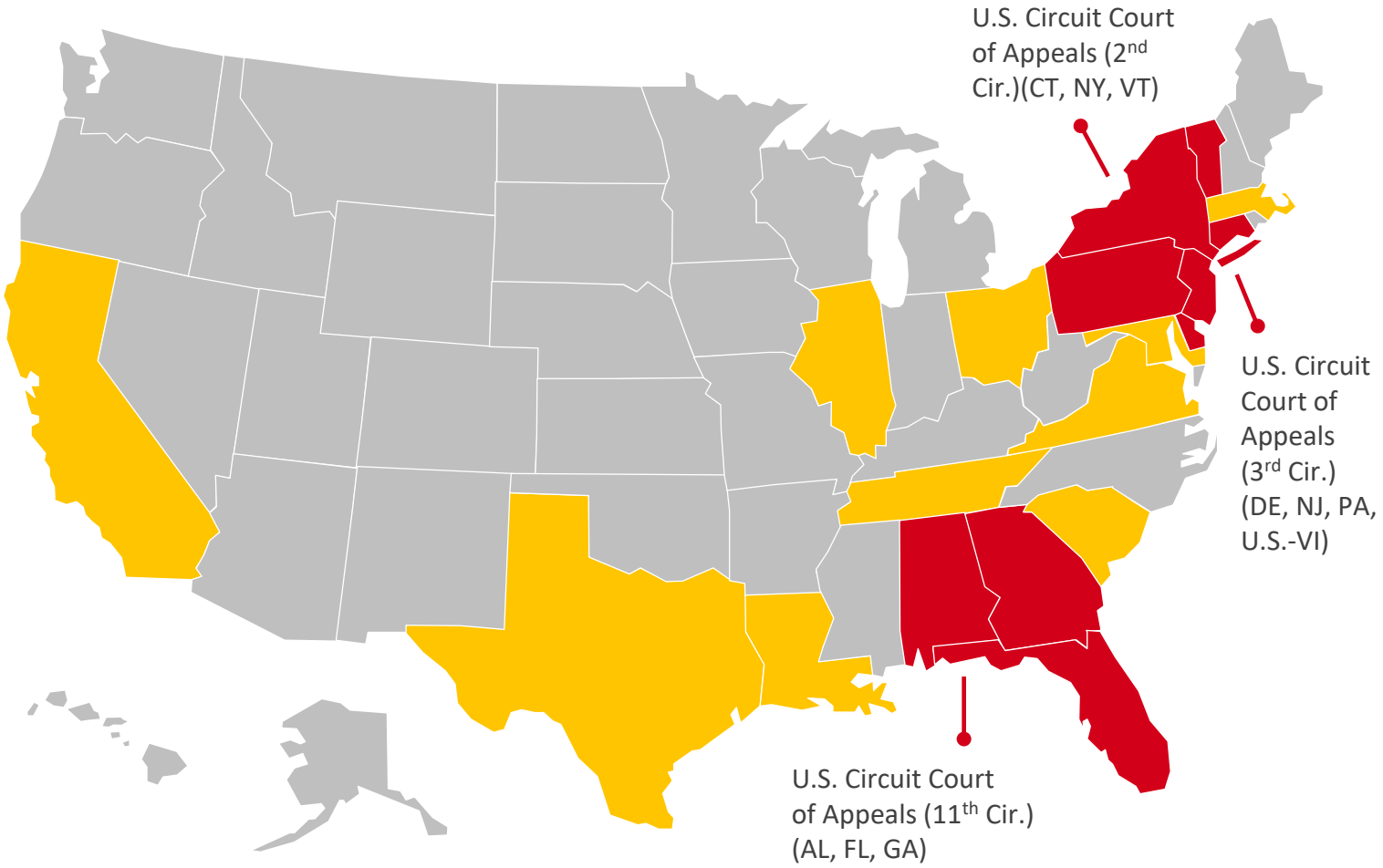
- CMS (its contractors and Treasury) are **NOT** involved in MAP recovery – rather, you must deal directly with the applicable MAP plan!
- Remember, the Section 111 Query can help you determine MAP enrollment.
- Remember, claimants can switch Medicare plans during annual enrollment (and at other points in some instances), so you can face multiple recovery claims.

Medicare Advantage: Enrollment Rates (CMS Data)



Source: CMS, Data.CMS.gov, Medicare Enrollment Dashboard | CMS Data (September 2025); retrieved 1/14/26

Medicare Advantage Plans: “Double Damages” Issue



Can Medicare Advantage Plans sue for double damages?

- U.S. Circuit Courts of Appeals = Yes
- U.S. District Court(s) = Yes
- Not yet addressed

Question: How about D Plans?

Cases, Issues, etc. to Watch in 2026

MAO-MSO Recovery v. GEICO, 2024 WL 2924063 (June 10, 2024, D. Maryland)

U.S. District Court for Maryland ruled:	New Update
MAPs, and certain "first tier" and "downstream entities," can sue insurers for "double damages" under the MSP's private cause of action (PCA) provision.	• Defendant recently filed a motion for an interlocutory appeal before the U.S. Circuit Court of Appeals, Fourth Circuit regarding the district court's 2024 decision.
• Plaintiffs could pursue its MSP subrogation claim against the defendant.	
• Certified questions to the Maryland Supreme Court re: plaintiffs' assignments of rights violate Maryland public policy. (Maryland Supreme Court said "no" in a decision rendered in June 2025).	• Will the Fourth Circuit address the issue of whether MAPs can sue insurers for "double damages?"

Medicare Advantage Plans (MAPs) Recovery Claims

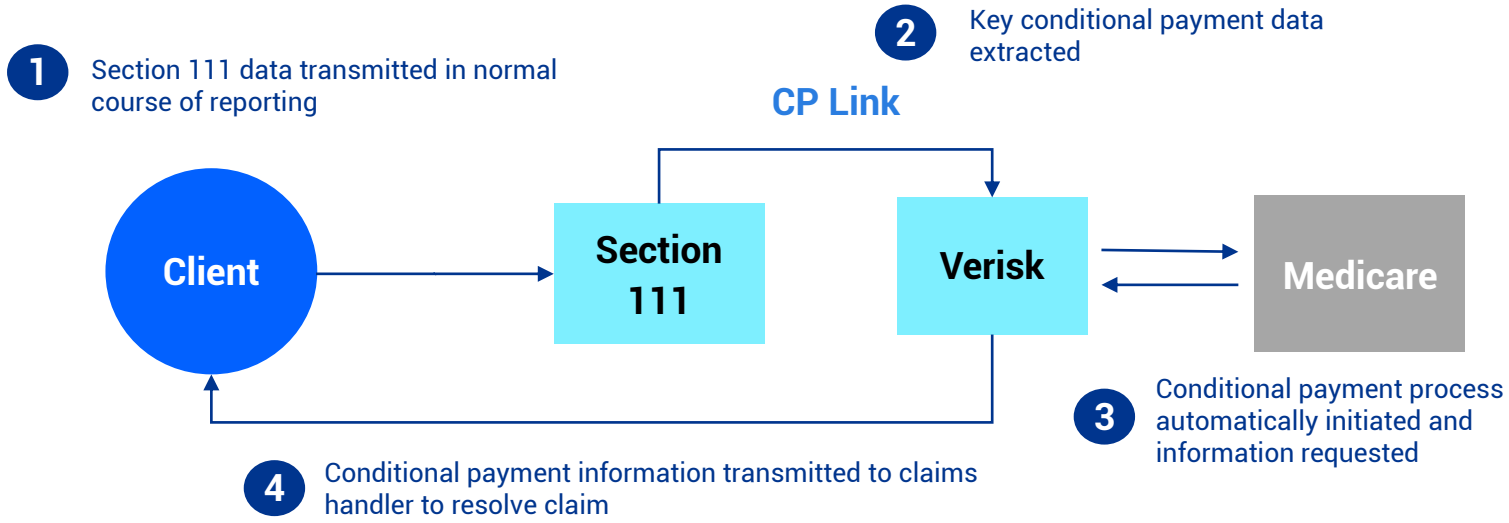
Compliance Considerations – 2026

- Understand MAP recovery process and how it differs from CMS recovery.
- Do you have MAP best practices?
- Staying compliant – adjuster updating/training.
- Consider Verisk's CP Link program!

Verisk's CP Link

Data Driven Protocol Adherence for Conditional Payments: CP Link

The best way to ensure conditional payment compliance is to leverage the same data to address liens as Medicare uses to identify them: Section 111. CP Link automates the handling of conditional payments saving adjusters time and ensuring no file is missed.



Benefits

- **Ensures complete compliance**
- **Provides insight/visibility (risk, efficacy, success, etc.)**
- **Saves claim time and conserves resources**
- **Life of the claim pricing saves money over the long term.**

Decision Point

❖ Automatic conditional payment process

S.111 Data Logic

- ✓ Medicare Beneficiary = YES
- ✓ Claim Status = OPEN
- ✓ One(1) ICD Code listed
- ✓ No TPOC (not settled)
- ✓ ORM = Y (WC and NF claims)

Additional Filtering Options Available

- ❑ P4S
- ❑ Rep Status
- ❑ Insured
- ❑ ORM Termination or TPOC Date
- ❑ Plan Enrollment Date
- ❑ Jurisdiction

Filtering Customizable by:

- RRE
- Line of Business
- Medicare A/B vs. MAPs/Part D

Watch List Item #5
Understanding CMS's New "$0 WCMSA" Policy

Watch List Item #5 – Navigating CMS's New "$0 WCMSA" Policy

Items to Watch in 2026 …

- **First full year of CMS's new $0 WCMSA policy.**
- You can still have $0 WCMSAs – although CMS will no longer review/approve them.
- Navigating CMS's criteria is key.
- Maintaining supporting documentation is critical.

CMS has waived goodbye to reviewing $0 WCMSAs!!

CMS no longer reviews $0 WCMSAs effective 7/17/25

Let's break down CMS's new $0 WCMSA policy effective 7/17/25

$0 WCMSA Requests – New Change Effective 7/17/2025

Effective 7/17/2025, CMS no longer accepts or reviews $0 WCMSA requests – You can still have $0 WCMSAs after 7/17/25, but you must maintain documentation in support of your $0 WCMSA!

Under WCMSA Reference Guide, Section 4.2 , CMS notes the following bases for a $0 WCMSA:

Medical Basis	Denied Claim and No Payments	Court Determination	Denied claim and payments made within pay without prejudice period
• Treating Physician Note • Physician indicates: To a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury.	• Denied claim under law • No payments medical or indemnity, unless investigating • Medical and indemnity not actively paid • Settlement does not allocate amounts for specific future or past medical or pharmacy services	• Ruling on the merits that no benefits are owed • Medical and indemnity not actively paid • Settlement does not allocate amounts for future medical services	• Denied claim under law • Payments made without prejudice within rules of WC law • Medical and indemnity not actively paid • Settlement does not allocate amounts for future medical services

CMS reserves the right to audit $0 WCMSAs as part of their new TPOC/WCMSA reporting requirements

Understanding CMS's New "$0 WCMSA" Policy

Compliance Considerations – 2026

- Understand CMS's new $0 WCMSA policy and criteria.
- Adjuster updating/training.
- Getting it right – remember, CMS can audit $0 WCMSA values.
- Identify cases ripe for "$ 0 WCMSA" – secure and maintain supporting documentation.
- Verisk can help!

Watch List Item #6
Medicare Part D – New Developments!

Watch List Item #6 – Medicare Part D – New Developments!

Items to Watch in 2026…

Will Part D sponsors become more aggressive in pursuing their recovery rights or elect to use CMS's new prior authorization/point of sale edit option to coordinate benefits regarding certain WCMSAs?

- Over 80% of all Medicare beneficiaries have a private Medicare RX drug plan
- Important for insurers to understand the issues to determine their compliance approaches – "touching all the MSP bases"

NEW! WCMSA RX Data Sharing Starts Feb.2026

CMS will provide WC case control number and up to 12 National Drug Codes (NDCs) to Part D sponsors.

- Part D sponsors can use new **“Prior Authorization/Point of Sale Edit”** re: claimant’s WCMSA related RXs – an alternative to traditional conditional payment recovery.
- Some limitations:
  - CMS cannot transmit NDCs on all existing WCMSAs.
  - Only 12 NDCs can be provided.
  - The NDC codes are NOT part of TPOC/MSA reporting – thus, the available data to be provided to Part D sponsors will apparently come from WCMSAs submitted to CMS or review/approval.

Compliance Impact

- Does NOT change and S. 111 reporting obligations or WCMSA submission process.
- Greatest likely impact on post-settlement WCMSA admin.
- Will Part D sponsors start apply the new Prior Authorization/Point of Sale Edit?
- From another angle, remember, Part D sponsors also have conditional payment rights (though, in general, they have not been that active)

Medicare Part D – New Developments!

Compliance Considerations – 2026

- Keep Part D in mind when re-evaluating MSP best practices.
- Remember that CMS provides information regarding a claimant's Part D enrollment status through the Section 111 Query process – good starting point to determine if there could be Part D issues in your case.
- Consider professional WCMSA administration – CMS's new Rx WCMSA data share.

Watch List Item #7
WCMSA Amended Review – Reducing WCMSAs!

Watch List Item #7 – WCMSA Amended Review – Reducing WCMSAs!

Items to Watch in 2026…

First full year of CMS's new updates to Amended Review (positive CMS update!)

- Amended Review can help you reduce prior approved WCMSAs on unsettled claims to help get the claim settled! "Breathing new life for potential settlement!"
- Understanding the criteria and updates are key to optimize this process!

Challenging CMS – Amended Review

Criteria	What to look for (common triggers)
1. Allowed one time;	• Surgeries or implants have occurred
2. Note: Effective 4/7/25, CMS eliminated its prior policy of having to wait one year to file an Amended Review!! Positive development! There is no more one-year waiting period to file!	• Change in medication regimen
3. Settlement has not occurred (case is still open); and	• Claims in which cost to adjust the file significantly decreased
4. Projected care has changed at least 10% or $10,000 (whichever is greater from the initially approved amount)	• Change in personal health/ rated age

WCMSA Amended Review – Reducing WCMSAs!

Compliance Considerations – 2026

- Take advantage of Amended Review to get claims settled!
- Check your inventory – do you have cases where Amended Review can be used?
- Include as part of settlement projects, initiatives, etc.
- Adjuster updating/training.
- Verisk's "Second Look" service.

Watch List Item #8
LMSAs – Is there anything new?

Watch List Item #8 – LMSAs – Is there anything new?

Items to Watch in 2026…

Will CMS revisit LMSAs in 2026?

- **Status**: All has been quiet on this front since October 2022. Presenters not aware of any CMS announcements or plans to revisit LMSAs in 2026.
- **History**: CMS has made two attempts to establish formal liability "future medicals" proposals – withdrew the proposals.
- To presenter's knowledge, nothing from CMS about "revisiting the issue."

Watch List Item #9
Keeping our eyes on D.C.

Watch List Item #9 – Keeping our eyes on D.C.

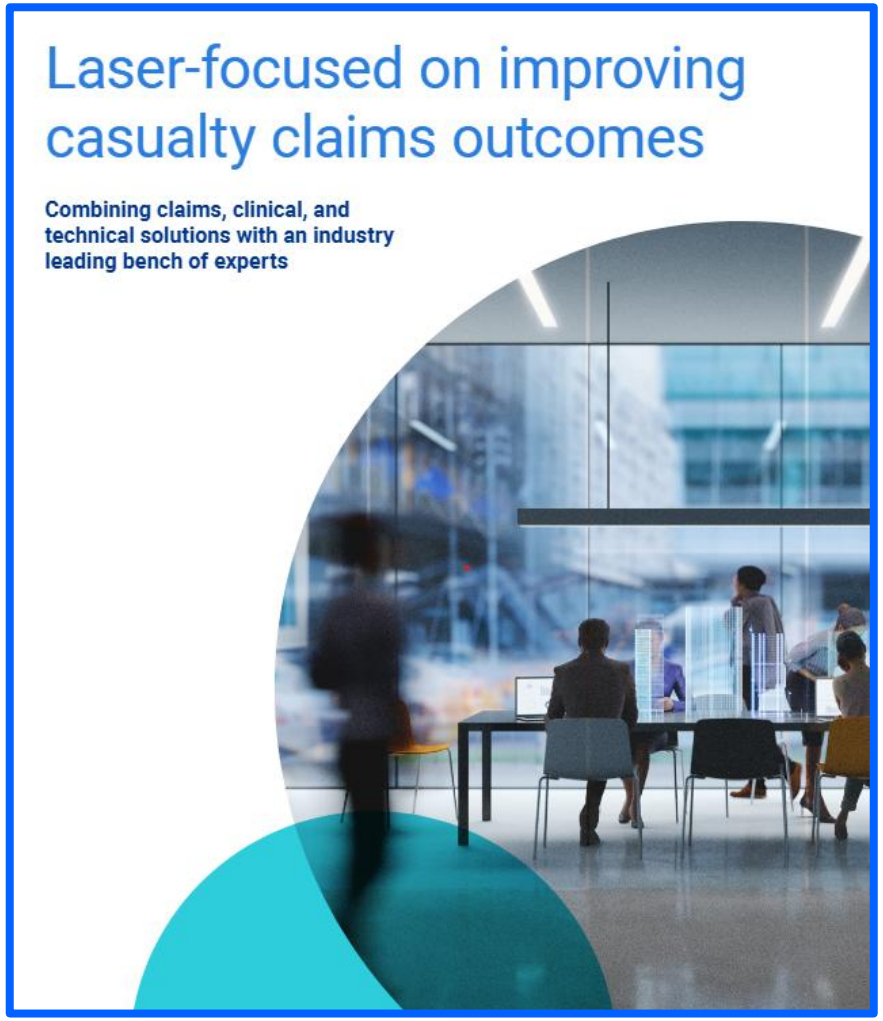
Items to Watch in 2026…

Will the Repair Abuses of MSP Payments (RAMP) Act be passed into law?

- **Status**: Introduced in the House in June 2025 – (H.R. 4056). Bill now needs to be introduced into the Senate.
- **Proposal**: If passed into law, the RAMP Act would eliminate non-group health plans from the MSP's private cause of action provision, which is the provision of the statute that allows for "double damages" recovery against insurers (and potentially other parties) in certain circumstances.
- **Potential Claims Impact:**
  - Medicare Advantage "double damages" actions.
  - Other MSP related issues.

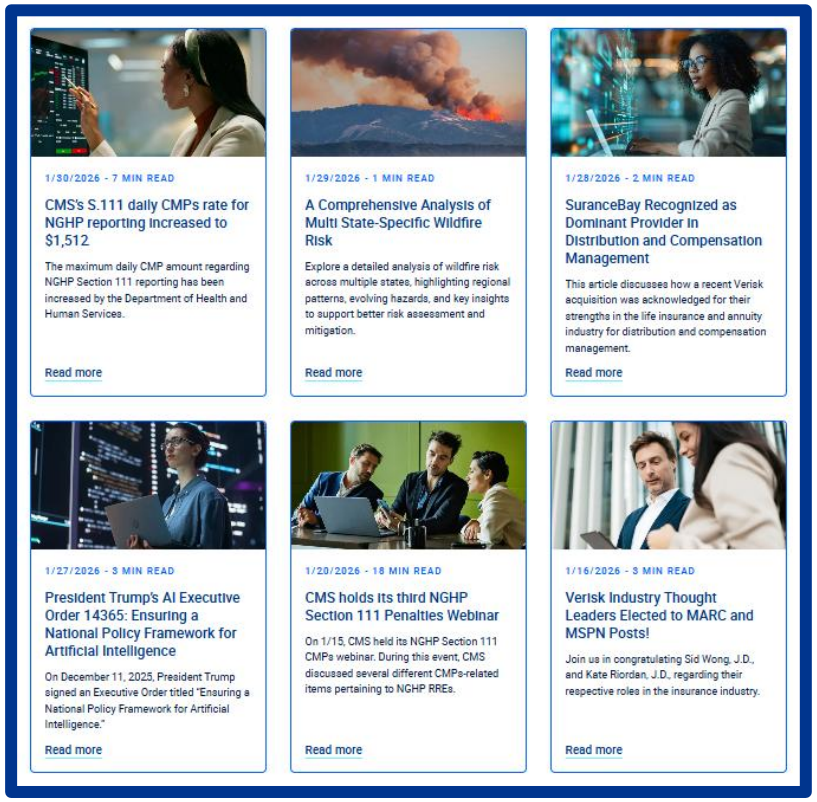
Resources

Verisk's Product Navigator Brochure



Click here to access our Product Navigator Brochure!

Verisk's Visualize Blog – Article Resources



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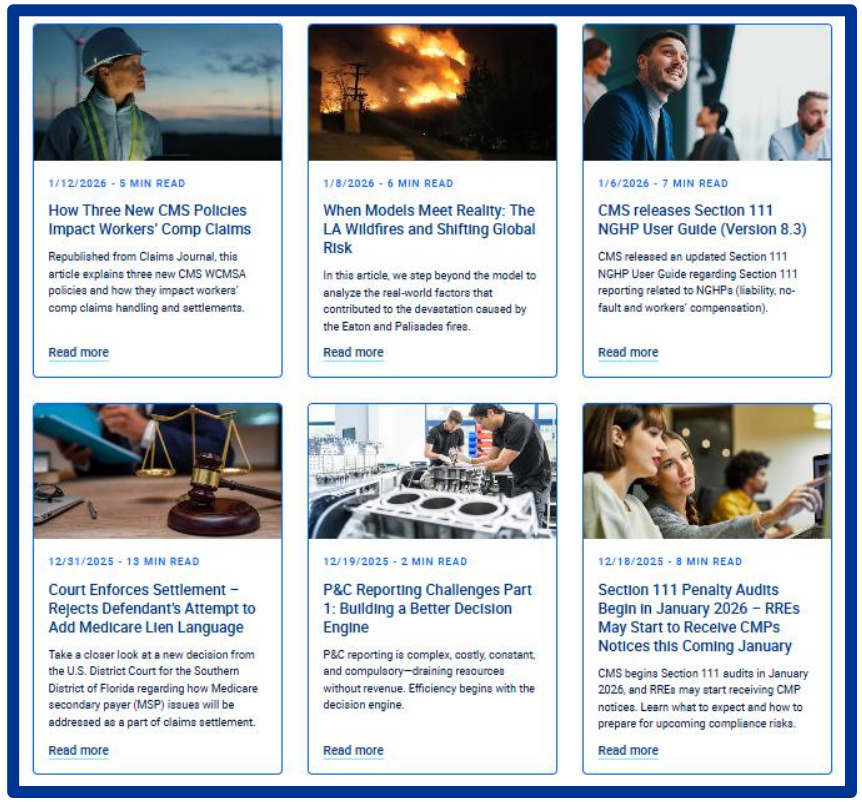

Click **here** to access
Verisk's Visualize Blog Article Resources

Medicare 2026 Watch List Report – Download coming soon!

- Our annual (and popular) comprehensive MSP report!
- “Prospective look” at MSP compliance topics for 2026
- Practical claims strategies to stay compliant
- Roadmap to re-tool your Medicare best practices
- How Verisk’s services can help – automating compliance to improve claims outcomes and reduce costs!

Questions?

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