Medicare Secondary Payer (MSP), Conditional Payment and Set-Aside Update and Tips

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Statutory and Regulatory Background

- The Medicare Secondary Payer (MSP) Act, found at 42 U.S.C. 1395y(b)(2)(A)(ii), was created by the Omnibus Reconciliation Act of 1980 and was enacted by the United States Congress in 1981.
- It was amended throughout the 1980's and thereafter most recently in 2003.
- The purpose of the MSP is to prevent a primary payer of medical care from shifting its responsibility for payment of the cost of medical treatment to Medicare.
- The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for administering Medicare and enforcing the MSP.

Statutory and Regulatory Background

- The Medicare program in general was created in 1965 with the purpose of paying the medical expenses of certain qualified individuals. In order to qualify for Medicare benefits, an individual must be:
  - 65 years of age or older;
  - On Social Security Disability for 24 months or longer; or
  - Suffering from End Stage Renal Disease.

Statutory and Regulatory Background

- Under the MSP, Medicare will not pay for medical services if such costs have been paid or can reasonably be expected to be paid by a primary payer in one of the following categories:
  - Workers' Compensation
  - Liability
  - No-Fault
  - Automobile
  - Self-Insured

Statutory and Regulatory Background

- Prudent practitioner will consider:
  - Has Medicare already made payments for the condition or injury? If so, make sure all Medicare liens for "conditional payments" are satisfied at the time of the settlement; and
  - Does the settlement involve any future medical expenses? If so, then a Medicare Set-Aside (MSA) allocation will need to be considered. Depending upon whether the thresholds for review have been satisfied, CMS may or may not review the proposed settlement.

Medicare Set Asides

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MSAs in Workers' Compensation Settlements

- CMS has issued a significant amount of Memorandums over the years in an attempt to better explain the purpose of the MSP and how it will be enforced.
- Do not have the statutory enforceability of law
- The first Memorandum was issued by Parshar B. Patel on 7/23/01
  - The "Patel Memo"

MSAs in Workers' Compensation Settlements

- The Patel Memo consists of 12 "questions and answers"
- Established that an MSA allocation is only applicable if future medical benefits are being closed and if a "qualified individual" is involved
- Identified two classes of claims impacted by the MSP
- At that point, "Class I" involved a Medicare eligible claimant regardless of the settlement amount.
  - This threshold amount was subsequently changed to $10,000.00 by memorandum of July 11, 2005;
  - then to $25,000.00 by memorandum of April 25, 2006.
- "Class II" claim involved a claimant with a "reasonable expectation" of becoming a Medicare beneficiary within 30 months of the date of settlement and a settlement amount greater than $250,000.00
  - the definition of "reasonable expectation" was not explained until a subsequent memorandum dated April 22, 2003.

MSAs in Workers' Compensation Settlements

- The Patel Memo explained that no Medicare funds would be used for medical treatment until the entire lump-sum set-aside amount had been exhausted.
- However, if the MSA was funded by an annuity, then no Medicare funds would be used until the structured annuity payment during any particular year had been exhausted.

MSAs in Workers' Compensation Settlements

- The Patel Memo made it clear that, at a minimum, a submission packet must include a copy of the settlement agreement, a copy of the life care plan (if applicable), a rated age, and documentation for all projected medical expenses.
- As indicated above, several memorandums have been issued by CMS throughout the years following the Patel Memo, covering a range of topics, including the Section 111 reporting requirements.

CMS's Formal Rules Regarding MSAs

- Medicare's interests must be considered when negotiating a final settlement of a claim involving responsibility for medical treatment.
- Medicare's interests must always be considered with regard to conditional payments.
- However, Medicare's interests must also be considered with regard to future anticipated medical expenses.
- Medicare's interests are deemed protected upon approval by CMS.
- At this time, there are only formal review thresholds available in workers' compensation settlements.

Medicare Review Thresholds (Class I & II) for WC Claims

- No requirement for submission of **any** settlement to CMS for review
- WCMSA does not have to be submitted even if it falls within the review thresholds
- The submission process is completely voluntary, but it is also the only way CMS will tell the settling parties if the MSA proposal, in CMS's own opinion, has properly considered Medicare's interests.
- This is a workload threshold for review, so just because a settlement does not fall within the review thresholds does not mean a WCMSA is not "necessary"
- The workload review threshold has changed over time and could potentially change again.
- Currently, as most recently confirmed in the CMS Memorandum dated May 11, 2011, CMS will only review claims which fall within one of two specific review thresholds, as follows:

Medicare Review Thresholds (Class I & II) for WC Claims

- Claimant is already a Medicare recipient and total amount of settlement is greater than $25,000.00 (this is commonly referred to as “Class I”); or
- The settlement amount exceeds $250,000 and there is a “reasonable expectation” that the claimant will be enrolled in Medicare within 30 months of the settlement date (this is commonly referred to as “Class II”).

Reasonable Expectation of Medicare Enrollment

- Claimant has applied for Social Security Disability; or
- Claimant is appealing an adverse decision on an SSD application; or
- Claimant is 62 years and 6 months old; or
- Claimant has end-stage renal failure

Zero Allocation MSA

- Future medical liability disputed based upon legal defense (SOL, notice, subject matter jurisdiction, apportionment/offset, etc.)
- May be submitted to CMS for approval
- Current trend with CMS is that if ANYTHING paid on the claim (including initial medical care during investigation of compensability), then no $0.00 approval
- Caution: If submitted and denied, CMS may issue a counter-higher demand with full WCMSA funding amount.

Medicare Set-Aside Allocations

CMS allows MSA to be either self-administered by claimant or by third party professional administrator (PA)

- Must be “competent” administrator
- Medical bills processed and paid for life of claimant until all MSA funds depleted
- Maintain full accounting of expenditures and periodically report to CMS

Medicare Set-Aside Allocations

- If self administered, must submit “self-attestation” form when funds exhausted

- If PA, then annual accounting summary to CMS, along with verification of no payments from Medicare until MSA exhausted

Three Types of MSAs

1. Medicare Set-Aside Trust
   - Professionally administered. Typically very expensive and involve bank or formal trust.

2. Medicare Set-Aside Custodial Account
   - Professionally administered, but offers more diverse options. Most common type of MSA with PA.

3. Self-Administered MSA

Risks When Medicare's Interests Are Not Protected

- If Medicare reviews a case and determines that its interests were not adequately protected, the immediate risk lies with the Medicare beneficiary, not the Defendants.
- Medicare may suspend the beneficiary's coverage until such time as Medicare determines its interests have been properly considered (i.e., the entire settlement amount has been exhausted to pay for Medicare-covered expenses).
- Caution: If MSA is underfunded, CMS may consider any ongoing payments "conditional" in nature, in which case reimbursement may be sought against the carrier as a lien against the settlement.

Conditional Payments

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Tips for Working with Medicare's BCRC

- Effective February 1, 2014, the responsibilities of the Medicare Secondary Payer Recovery Contractor (MSPRC) and Coordination of Benefits Contractor (COBC) were transitioned to the new Benefits Coordination & Recovery Center (BCRC).

Tips for Working with Medicare's BCRC

- Conditional payment is a medical expense that has already been paid by Medicare.
- Medicare has made any payment, conditioned upon possible reimbursement, for medical services allegedly related to the underlying injury, for which the insurer may be deemed responsible by Medicare as a primary payer.
- This necessarily involves:
  - an individual who is already a Medicare recipient
  - medical services submitted for payment to Medicare instead of a primary payer.

Tips for Working with Medicare's BCRC

- CMS had no legal right to seek reimbursement or to pursue subrogation until one of two things happened:
  - the medical portion of the claim settled; or
  - a final adjudication was reached establishing the liability of a primary payer.

  - However, if primary payer status is established under Section 111 mandatory reporting, then the Commercial Repayment Center may pursue reimbursement immediately!!

Establishing the Claim

- Once Medicare is notified of a potential conditional payment issue, a “Rights and Responsibilities” letter will be issued to the Medicare beneficiary, as well as to any carrier identified as a primary payer.
  - Medicare has 30 days to send out this letter and establish a case identification number
- Then, within 65 days, an initial “Conditional Payment Letter” will be automatically generated and sent to anyone attached to the claim.
  - The 65-day period theoretically allows the Medicare contractor enough time to retrieve all available medical claims affiliated with the date of accident.
  - The payments are searched using CPT medical codes (currently ICD-9, but transitioning to ICD-10).

Establishing the Claim

- This function was previously handled by the Medicare Secondary Payer Recovery Contractor (MSPRC).
- Effective February 1, 2014, the responsibilities were transitioned to the new Benefits Coordination & Recovery Center (BCRC).

Establishing the Claim

- The Conditional Payment Letter is sent to all authorized parties, including:
  - Anyone identified by valid Consent to Release Form executed by the Medicare beneficiary or
  - a representative of the primary payer insurance carrier identified by a valid Proof of Representation.
- Contains the current conditional payment amount and a list of all expenses, including dates of services, provider, and CPT codes.

Establishing the Claim

- The Medicare beneficiary (or a beneficiary's attorney with a valid Consent to Release) can retrieve up–to-date conditional payment amounts from three sources:
  - MyMedicare.gov website
  - By telephone using the "MSPRC Self Service Information Feature" (1-866-677-7220).
  - Medicare Secondary Payer Recovery Portal
    - available for anyone to access, upon enrollment, by uploading a valid Consent to Release or Proof of Representation to the active claim file. The web portal allows access to the most recent conditional payment information and provides the ability to upload documents, request updates, dispute items based on relatedness, and submit settlement information.

Reporting the Settlement

- Before a final conditional payment demand will be issued, the settlement may be submitted to CMS.
  - However, in compliance with the SMART Act, CMS created provisions allowing authorized users to obtain a final conditional payment demand prior to settlement.
  - As of January 1, 2016, the final amount may be obtained via MSPRP (web portal)
  - The MSPRC web portal indicates that settlement information may also be uploaded.

Challenging Conditional Payment Claims

- Relatedness is the primary basis for challenging a conditional payment
  - Is the medical treatment causally related to the injury in the underlying claim?
  - The demand from CMS will indicate the relevant dates of service and ICD-9/10 codes.
  - The practitioner should make sure the dates of service are applicable, but also review the ICD-9/10 codes for relatedness to the claim, which is obviously a much more involved and difficult undertaking.

Challenging Conditional Payment Claims

- In addition to a challenge based on relatedness, 42 C.F.R. 411.28 provides the authority for CMS to waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.
  - Recovery = futile
  - Rare, but not impossible

Challenging Conditional Payment Claims

- There is also a process to request a compromise based upon hardship, including the beneficiary's present or future inability to pay
  - These requests appear difficult to have granted.

Challenging Conditional Payment Claims

- Appeal rights are specified in the final demand letter.
- With regard to the MSP, determinations made by CMS are not subject to federal question jurisdiction under 28 U.S.C. Section 1331
- Before a CMS decision may be appealed to the federal courts, all administrative remedies with CMS must be exhausted.

- Primary Payers now also have the right to appeal

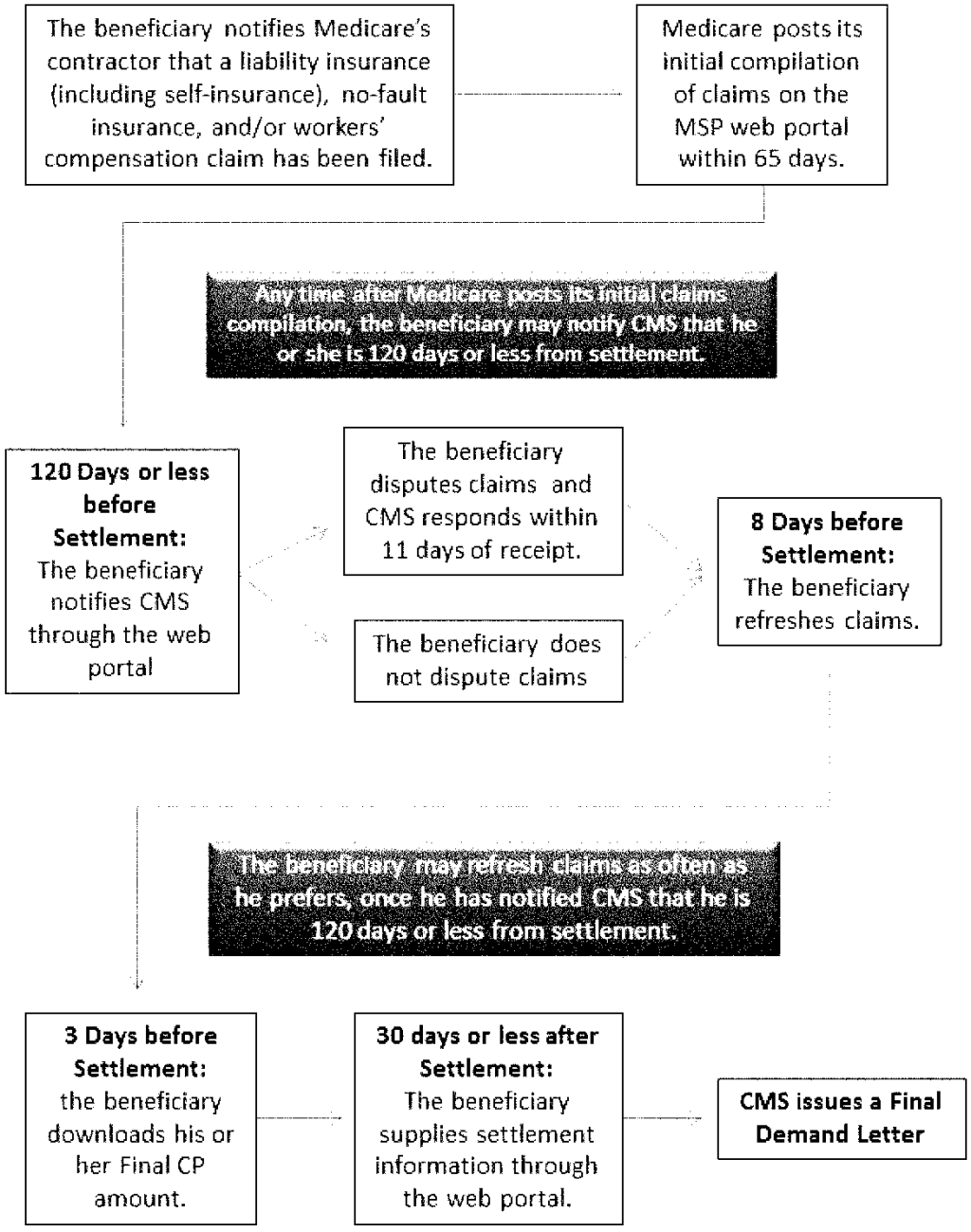
The SMART Act: Section-by-Section

- Section 201 – Final Conditional Payment Determination (effective January 1, 2016):
  - May initiate request for final lien within 120 days of reasonably expected settlement
  - Payments made by Medicare must be posted to CMS website within 15 days of payment
  - CMS can extend response time by 30 days for "exceptional circumstances" (anticipated to be less than 1% of cases)
  - If no response, second request may be made
  - CMS must respond within 65 days of request
  - If no response to second request within 30 days, no liability for conditional payment
  - But, If no settlement within 120 days, Secretary is exempt

The SMART Act: Section-by-Section

- Section 201 – Final Conditional Payment Determination (effective January 1, 2016):
  - Any disputes must be resolved via web portal within 11 business days of receipt
  - Once all disputes resolved, request final lien within 3 days of settlement
  - Case must be settled within 3 days of requesting final CP amount
  - Must submit settlement information within 30 calendar days of requesting final lien amount

DIAGRAM 1


The beneficiary notifies Medicare's contractor that a liability insurance (including self-insurance), no-fault insurance, and/or workers' compensation claim has been filed.
Medicare posts its initial compilation of claims on the MSP web portal within 65 days.
Any time after Medicare posts its initial claims compilation, the beneficiary may notify CMS that he or she is 120 days or less from settlement.
120 Days or less before Settlement: The beneficiary notifies CMS through the web portal
The beneficiary disputes claims and CMS responds within 11 days of receipt.
The beneficiary does not dispute claims
8 Days before Settlement: The beneficiary refreshes claims.
The beneficiary may refresh claims as often as he prefers, once he has notified CMS that he is 120 days or less from settlement.
3 Days before Settlement: the beneficiary downloads his or her Final CP amount.
30 days or less after Settlement: The beneficiary supplies settlement information through the web portal.
CMS issues a Final Demand Letter

The SMART Act: Section-by-Section

- Section 201 – Right of Appeal (effective April 28, 2015):
  - Beneficiary has always had right to appeal conditional payment determination
  - This gives the primary payer a right to appeal
  - Does not apply to WCMSA determinations
  - Carrier ("Applicable Plan") is included on initial CP letter
  - If Medicare pursues recovery directly against carrier, beneficiary is removed from appeal
  - May not appeal Medicare's decision to pursue any particular party

The SMART Act: Section-by-Section

- Section 202 – Safe Harbors (in effect—currently $1,000.00)
  - Stop wasting resources pursuing small recoveries
  - Secretary will establish minimum threshold dollar amount
  - Below this amount, no conditional payment reimbursement or mandatory reporting
  - Liability only (does not apply to workers' compensation)

The SMART Act: Section-by-Section

- Section 203 – Section 111 Reporting Fines (in effect)
  - The old reporting fine was $1,000 per day mandatory penalty
  - The new section changes the violation from “shall be subject” to “may be subject”
  - So the fine will be “up to” $1,000.00 per day, but not necessarily $1,000.00

The SMART Act: Section-by-Section

- Section 204 – Use of SSN and other identifying information (in effect)
  - Social Security Numbers will no longer be required
  - Secretary to modify reporting requirements within one year
  - Use of SSN's strongly encouraged to avoid mistakes

The SMART Act: Section-by-Section

- Section 205 – Statute of Limitations (in effect)
  - Three-year statute of limitations
  - Effective 6 months after effective date of Act (January 10, 2013), so July 10, 2013
  - Runs 3 years from Section 111 notice
  - Applies to conditional payment reimbursement only

How Much Can Medicare Recover?

- A carrier's liability may not necessarily be limited to the amount of the settlement.
- The MSP gives Medicare (or a private party) the legal right to seek double damages in a cause of action against a primary payer, recipient of payment, or attorney.
- Medicare has the unique ability to seek reimbursement for conditional payments pursuant to what has been described as a "super lien," which takes priority over any other primary payers.
- Medicare has the legal right to seek double damages for reimbursement of conditional payments.
- Because Medicare is not a party to the settlement, it does not consider itself bound by the terms of settlement.
- Medicare may pursue recovery, regardless of the settlement, if it does not believe the parties adequately considered Medicare's interests.

How Much Can Medicare Recover?

- Medicare will typically demand reimbursement of any conditional medical payments made related to the alleged injury, regardless of liability.
- A best practice is to determine in the settlement agreement which party will be responsible for the payments.
- If time permits, obtain a "final demand" prior to settlement.
- **Note:** If CMS is not required to bring suit to enforce reimbursement, then the Medicare conditional payment amount cannot exceed the amount of settlement, less Medicare's share of procurement costs. 42 C.F.R. 411.37(a)(d).

How Much Can Medicare Recover?

- Medicare does allow for a reduction in the amount of its conditional payment lien if the amount of settlement is less than the lien.
- Under 42 C.F.R. § 411.37(d), Medicare will generally reduce its recovery by procurement costs, with the total recovery not to exceed the amount of settlement.
- Medicare essentially takes the attorney's fees and costs off the top, and then demands the entire remaining amount of settlement, leaving no net recovery to the plaintiff.
- Under this reduction, only the plaintiff's attorney gets paid.

When Do Conditional Payments Stop?

- As illustrated in United States of America v. James J. Stricker, et. al., because CMS does not consider itself bound by the terms of settlement, it may attempt recovery of double damages for medical payments incurred after the date of settlement.
- The key appears to be documentation that Medicare's interests have been "considered" (as opposed to completely overlooked or ignored)

Who is at Risk?

- Clear that CMS does pursue recovery from anyone who receives payment, directly or indirectly, from a settlement resolving medical liability where the burden is improperly shifted to Medicare.
- In cases of conditional payments, this includes not only Medicare beneficiary and insurance carrier, but also self-insureds, attorneys who are paid fees from the settlement, medical providers, or anyone else who has received a portion of a third-party payment.
- Medicare may suspend a beneficiary's Medicare coverage until an entire settlement has been exhausted.

Private Cause of Action

42 U.S.C. § 1395y(b)(3)(A)

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42 U.S.C. § 1395y(b)(3)(A)

- The MSP Act contains a private cause of action provision
- Allows third-parties to sue on behalf of Medicare to enforce reimbursement
- Currently, we are seeing two categories of plaintiffs:
  - Medicare Part C Plans
  - Medicare beneficiaries

Medicare Part C Plans

- Humana v. GlaxoSmithKline
  - United Stated Court of Appeals, Third Circuit (04/15/13)
  - Medicare Advantage Plan had a private cause of action to sue tortfeasors for double damages based upon Medicare conditional payments.
  - GlaxoSmithKline manufactured Avandia, diabetes drug
  - Humana sought reimbursement for cost of treating beneficiaries who were injured by Avandia
  - Humana was allowed to sue GlaxoSmithKline for reimbursement and double damages

Medicare Part C Plans

- Bio-Medical Applications of Tennessee v. Central States
  - United Stated Court of Appeals, Sixth Circuit
  - Medical facility could sue insurer under private COA
  - Bio-Medical operated kidney dialysis centers
  - Insured diagnosed with ESRD and received dialysis treatments at Bio-Medical facility
  - 3 months after ESRD diagnosis, became Medicare eligible
  - Central States denied coverage under terms of policy due to Medicare eligibility

Medicare Part C Plans

- Bio-Medical Applications of Tennessee v. Central States
  - Central States violated MSP's Group Health Plan provisions because discriminated against policyholders due to consideration of Medicare status
  - Bio-Medical allowed to proceed under private COA provision
  - But how do you calculate double damages? Based on amount charged or amount recoverable by Medicare?
  - Remanded to District Court to determine if double damages based on amount billed or amount recoverable by Medicare (conditional payment lien)

Private COA by Beneficiary

- Estate of Clinton McDonald v. Indemnity Insurance
- Private Cause of Action by Claimant's Estate – Granted
- Western District of Kentucky, 6th Circuit (09/25/13)
- WC claim arising out of MVA with fatal injuries
- $180,185.75 in bills paid by Medicare prior to death
- Employer denied claim, but awarded by Kentucky Workers' Compensation Board
- For 2 years, nothing done to repay Medicare
- Estate sued WC carrier for failure to reimburse Medicare, seeking double damages
- The next week, a conditional payment letter was sent to the carrier
- WC subsequently paid Medicare, closure letter issued
- WC carrier filed motion to dismiss
- Court recognized a private right of action to enforce payment of Medicare
- Purpose is to encourage beneficiaries to bring suit, and double damages is incentive
- Estate was awarded the full amount of conditional payments, plus double damages

Private COA by Beneficiary

- Caldera v. Insurance Co. of State of Pennsylvania
- Private Cause of Action by Claimant – Dismissed (no established responsibility)
- U.S. Court of Appeals, 5th Circuit (05/14/13)
- 1995 WC back claim filed in Texas
- Claimant subsequently eligible for Medicare
- Had 2 surgeries (2005 & 2006) without WC pre-authorization; paid by Medicare ($42,637.41)
- Carrier later denied responsibility based on relatedness
- Claimant lost at several levels trying to establish relatedness, but parties ultimately reached "Agreed Judgment" on extent of injury; no damages awarded
- Claimant then sued WC carrier under MSP private COA
- Court analyzed 42 C.F.R. 411.40 through 411.47
- 5th Circuit determined that WC carrier can be a primary plan and subject to double damages under private COA
- But must determine under state law if WC reasonably expected to cover expenses
- In Texas, WC doesn't pay if treatment not pre-authorized
- Medicare's recovery will be limited by state law
- Claimant did not file a proper WC claim (i.e., did not seek pre-authorization)
- Medicare could have denied payment
- Claimant's private COA fails

Private COA by Beneficiary

- Glover v. Liggett Group
  - 11th Cir. 2006
  - Plaintiffs filed suit against Phillip Morris USA and Liggett Group, individually and as private attorneys general, seeking to recover costs paid by Medicare for medical treatment related to health issues allegedly caused by cigarette smoking
  - Until Defendants' responsibility to pay for a Medicare beneficiary's expenses has been demonstrated (for example, by a judgment), Defendants' obligation to reimburse Medicare does not exist under the relevant provisions. Therefore, it cannot be said that Defendants have "failed" to provide appropriate reimbursement. Based on this language, we conclude that an alleged tortfeasor's responsibility for payment of a Medicare beneficiary's medical costs must be demonstrated before an MSP private cause of action for failure to reimburse Medicare can correctly be brought under section 1395y(b)(3)(A).

Best Practices

- Do not rely on mandatory reporting under Section 111 to "trigger" a conditional payment letter.
  - Be prepared to investigate potential conditional payments independently of Section 111 mandatory reporting requirements.
- Do not rely upon the employee to share conditional payment information with the carrier.
  - When in doubt, notify BCRC of your claim to begin the conditional payment investigation.
- Specify in the settlement agreement exactly how conditional payments have been addressed, including how they will be reimbursed.
- Verify whether a Medicare Advantage Plan has made any payments related to your claim. Negotiate resolution of any Medicare Part C lien directly with the insurance plan.
- Upon receipt of any final award establishing responsibility for medical payments, notify BCRC of the claim and request a conditional payment letter.

Section 111 Mandatory Reporting

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MMSEA Section 111

- The monetary fines associated with Section 111 mandatory reporting are focused on the insurance carriers who are responsible for actually reporting the claims to Medicare.
- Statutory Authority applies to liability insurance, no fault insurance and workers' compensation insurance

MMSEA (cont.)

- If claimant is a Medicare beneficiary must report the claim if beneficiary receives settlement, judgment, award or other payment

- Applicable Fines – Section 203 of the SMART Act changed the Section 111 Mandatory Reporting Fines. The old reporting fine was a $1,000 per day mandatory penalty. The new section changes the violation from “shall be subject” to “may be subject.” So the fine will be “up to” $1,000.00 per day, but not necessarily $1,000.00.

MMSEA (cont.)

- CMS allows the reporting entities to subcontract out these reporting requirements to other agents/vendors, but it is important to know that if these third-party vendors make mistakes, CMS takes the position that the Responsible Reporting Entity (RRE) is the liable party with regard to fines, *not* the agent (although the agent may have other contractual liability to the RRE).

Who Must Report

- Liability Insurer
- Workers' Compensation Insurer
- Liability or Workers' Compensation Self-Insurance
- No Fault Insurance

There are a lot of rules surrounding Section 111. Please reach out to us if you have questions.

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