Developing a Medicare Game Plan: Meeting the MSP Challenge

By Mark Popolizio

Medicare Secondary Payer (MSP) compliance continues to present challenges to claims departments. To meet these concerns, primary payers need a Medicare strategy from the outset. Recognizing the major MSP issues and how best to navigate them should be an integral part of claims practice. This article intends to acquaint primary payers with the major factors for consideration in developing sound MSP compliance protocols and best practices for claims handling with respect to workers' compensation, liability and other non-group health claims.

Pregame planning

Embracing the new Medicare reality is an important first step. "Business as usual" no longer applies. The Centers for Medicare and Medicaid Services (CMS) now has access to more claims information than ever before as part of the Section 111 reporting law. And for primary payers, simply "pinning it on the claimant" is either not an option or will not provide ironclad protection.

Once in the proper mind-set, the primary payer can focus on building MSP compliance protocols. Decision makers at the highest levels should generate these parameters and disseminate them for companywide adherence. Ensuring that senior executives address MSP issues also promotes consistent claims practices, alleviates confusion, and minimizes risk by eliminating ad hoc approaches.

Identifying the MSP's five pillars of compliance

Any MSP compliance program should center around five main considerations:

1. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007

Section 111 involves the electronic reporting of certain claims and settlements to CMS by responsible reporting entities (RREs). RREs may be subject to penalties of up to $1,000 a day per claim for noncompliance. Qualifying as an RRE is based on certain factual and situational criteria. Typically, RREs are insurance carriers or self-insureds; claimants and their lawyers are never RREs. [1]

2. Conditional payment reimbursement

The issue of conditional payments involves claimants who are enrolled in what is referred to as "original" or "traditional" Medicare, which is administered directly by the federal government as part of Medicare Parts A and B. Conditional payments involve the statutory obligation of primary payers (and other parties) to reimburse Medicare for payments made for a claimant's accident-related medical care. Medicare enjoys strong and broad recovery rights against multiple parties for conditional payments, including assessing interest, referring delinquent debts to the U.S. Department of the Treasury for collection, and the right to seek "double damages" against primary payers in certain situations.

3. Medicare Advantage Plans

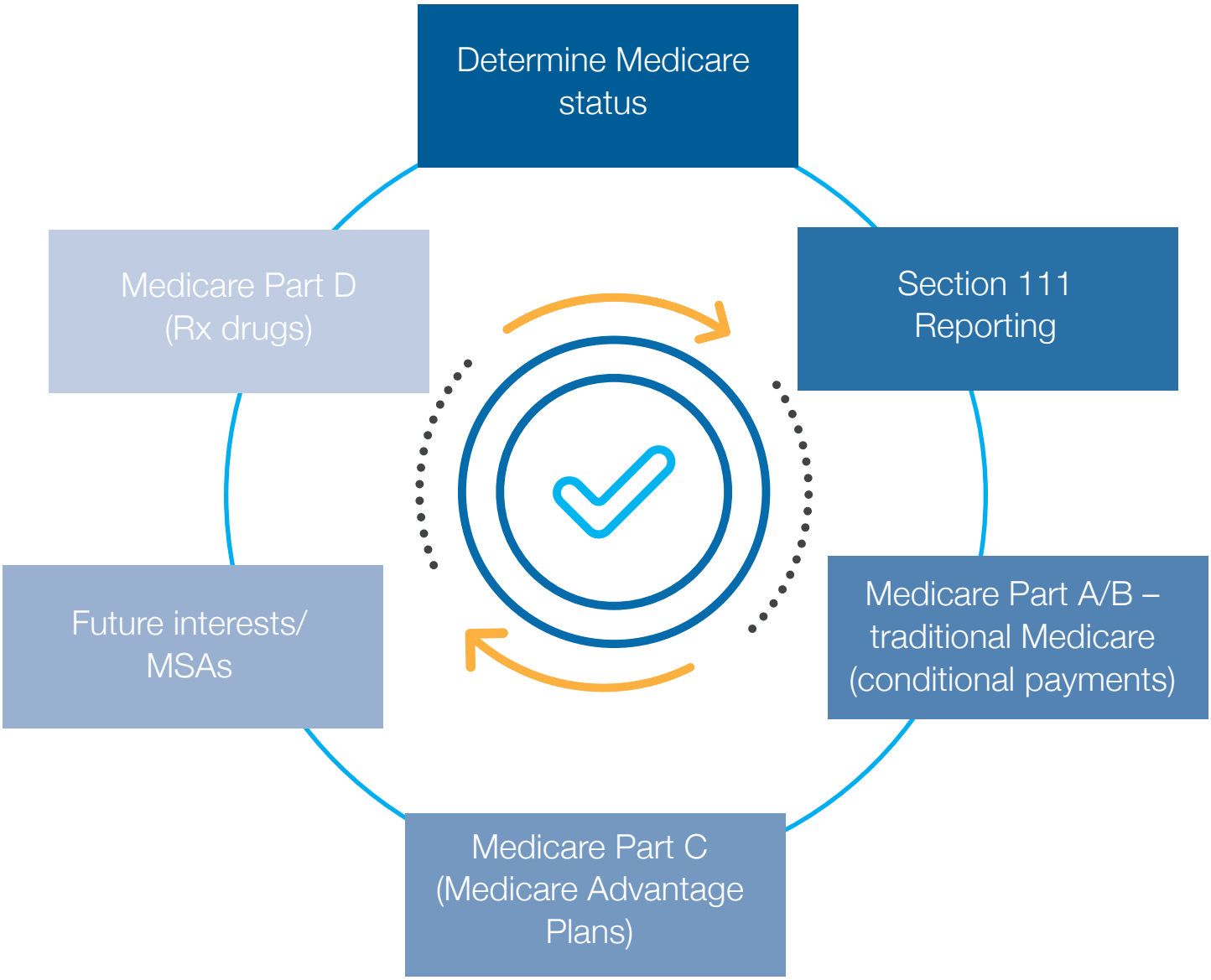
Medicare Advantage Plans (MAPs) are Medicare insurance programs provided by private insurance companies under Part C of the Medicare program. The federal government introduced MAPs in 1997 to help contain costs, provide alternative coverage options to government-run traditional Medicare, and spur private sector innovation. After a slow start, MAP enrollment has soared in recent years. Currently, 20.4 million individuals (or 34 percent of all Medicare beneficiaries nationally) are covered under a MAP. [2]

4. Future interests/MSAs

The issue of Medicare's future interests relates to ensuring that parties are not improperly shifting the burden of the claimant's future medical care to the Medicare program as part of claim settlement. The Medicare Set-Aside (MSA) is CMS's voluntary and recommended compliance vehicle in this area.

5. Medicare Part D (Rx drugs)

Another compliance area starting to emerge relates to prescription drugs under Part D of the Medicare program. Similar to Medicare Advantage Plans, Part D prescription plans are provided by private insurers referred to as "sponsors." Issues concerning the nature and extent of Part D recovery rights need to be considered.



Each of the above MSP components constitutes a separate and independent compliance consideration. As such, it is imperative to address each component on every claim to determine if specific compliance action is necessary.

MSP Compliance Considerations					
	Section 111	**Conditional Payments**	**Medicare Advantage Plans**	**Medicare Set-Aside**	**Medicare Part D**
Claimant **IS** a Medicare beneficiary	YES	YES	YES	YES	YES
Claimant is **NOT** a Medicare beneficiary	NO	NO	NO	POSSIBLE	NO

Communication is key

MSP compliance protocols are useless if not communicated effectively. The form of communication varies depending on the audience. To start, the primary payer must communicate and explain MSP protocols to all applicable claims personnel. An interactive training component should be part of this rollout. Likewise, defense counsel must know the protocols, along with the exact role counsel is expected to play. Too often, counsel interprets MSP compliance obligations differently or does not have a full understanding of client objectives.

Claimant's counsel should also be advised as to how MSP compliance issues will be addressed. In general, this involves clearly communicating what information is needed from counsel, how any conditional payment reimbursement issues or other potential recovery claims will be handled, and whether an MSA will be necessary.

Timing is also important. In advance of settlement negotiations, counsel needs to know how the primary payer proposes to address MSP compliance matters. Failure to communicate all relevant MSP matters in a timely fashion can ultimately derail a settlement and invite litigation. MSP compliance is simply too complex for "after the fact" considerations or eleventh-hour scrambling.

Communicate protocols to all frontline claims personnel

Advise defense counsel of special MSP claims-handling requirements

Clearly delineate roles and expectations of claim adjuster and defense counsel

Notify claimant counsel early about how MSP compliance obligations will be handled as part of claim settlement

Building MSP compliance protocols

After preparing a solid foundation, the primary payer must generate actual MSP compliance protocols. While an exhaustive review into each possible component is beyond the scope of this article, the following provides a general overview of key consideration points:

Determining Medicare status

The claimant's Medicare beneficiary status lies at the center of determining MSP compliance obligations. As such, primary payers need to establish processes to obtain this critical information. There are a few options to consider:

- Make a direct request to the claimant or his or her counsel as part of the discovery process. However, the obvious concern with this approach is it relies entirely on third-party representation without independent confirmation.
- Submit a request to the Social Security Administration. While this approach obtains information from an official source, the process can take time because the claimant's authorization is needed and there is a wide discrepancy in administrative response times.
- Use the CMS Query Process under Section 111, which is perhaps the most feasible option. Through this system, an RRE (or its duly registered reporting agent) can submit monthly electronic requests for a claimant's Medicare status, to which CMS generally provides a response within 14 days.

The Query Process requires the claimant's Social Security number (SSN) (or in some instances, the last five digits of the SSN can be used) or health insurance claim number (HICN) to use this system. Accordingly, the compliance protocols should contain an identified process to obtain this information. This is one area where defense counsel may be particularly helpful. There should also be a contingency plan for instances where a claimant refuses to provide his or her SSN. Be sure to document the efforts made to obtain this information (and the claimant's refusal to provide it). In addition, RREs and their counsel must be aware of recent judicial decisions in which some courts have permitted discovery aimed at obtaining a claimant's SSN for Query Process purposes. Such decisions may provide the basis for an appropriate court motion to compel the release of this information or prove helpful in working out the issue with claimant's counsel short of bringing the matter before the court.

Claimant is a Medicare beneficiary

Positive confirmation of Medicare status triggers consideration of all five MSP compliance considerations as follows:

Section 111: If the RRE has accepted "ongoing responsibility for medicals" (ORM), the claim is reportable. The ORM reporting trigger typically involves workers' compensation, no-fault, or med-pay claims. In addition, under the CMS "total payment obligation to the claimant" (TPOC) reporting trigger, all settlements, judgments, awards, or other payments involving a Medicare beneficiary that exceed the agency's monetary reporting threshold are reportable.

Conditional payments: If the claimant is enrolled in traditional Medicare (Medicare Part A and/or B), it is critical that Conditional payments: If the claimant is enrolled in traditional Medicare (Medicare Part A and/or B), it is critical that Medicare conditional payments are addressed because the government has strong and broad rights. For example, the government can pursue the primary payer, claimant, and/or claimant's

counsel for recovery. The government has several recourses if conditional payments are not properly reimbursed, including suing the primary payer for "double damages" or referring the matter to the U.S. Treasury Department. Developing protocols aimed at understanding the CMS recovery process, including when and how CMS uses its recovery contractors, is critical to ensure that conditional payments are properly identified, disputed (if applicable), and reimbursed.

Building MSP Compliance Protocols: Spotting the Issues

Section 111

- Determining Medicare status
- CMS reporting triggers
- Building efficient reporting systems

Conditional payments

- Obtaining conditional payment information
- Challenging/reducing conditional payment claims
- Ensuring Medicare is reimbursed

Medicare Advantage Plans

- Determining MAP enrollment status
- Identifying potential MAP lien/recovery claims
- Developing practices to address recovery and avoid "double damages" claims

Future interests/MSAs

- Determining compliance obligations
- CMS WCMSA thresholds and process
- Addressing issues of MSA funding and administration

Medicare Part D (Rx drugs)

- Determining Part D beneficiary status
- Identifying potential Part D recovery claims
- Determining Part D recovery obligations

Medicare Advantage Plans (MAPs): It is important to keep in mind that a claimant may elect Medicare coverage through a private MAP plan versus traditional Medicare. In this instance, it is possible that there could be a MAP recovery claim (or claims) that needs to be addressed. Over the past several years, MAPs have become quite aggressive in pursuing their recovery rights and have secured several favorable court rulings finding that they can sue claim payers for "double damages."[3] Thus, primary payers need to develop practices aimed at identifying possible MAP enrollment, along with determining if there is a MAP recovery claim(s) and resolving any such recovery claim(s).

Medicare Set-Asides: A positive confirmation of Medicare status also raises the issue of whether inclusion of an MSA or some other action is appropriate to address Medicare's future interests.

Regarding workers' compensation, the primary payer should consider CMS MSA policies. Since 2001, CMS has had in place a voluntary MSA review process for certain settlements which meet the agency's review thresholds.[4] As part of this process, settlements greater than $25,000 (as defined by CMS) involving Medicare beneficiaries meet a CMS review threshold and can be submitted to the agency for review and approval.[5] Depending on various factors and risk tolerance, primary payers may also wish to consider alternative allocation approaches outside the CMS WCMSA review process.

The issue of future interests concerning liability remains the source of great debate and uncertainty for a variety of reasons, including the lack of guidance from CMS. A complete examination into this complex issue is outside the scope of this article, although it is noted that CMS is expected to release "future medicals" compliance proposals by September 2019 that are expected to include liability claims. In the interim, primary payers should determine their compliance obligations based on their interpretation of the MSP statute and related regulations, review of various CMS statements, and other considerations, such as the developing case law in this area.

Medicare Part D (Rx drugs): CMS recently amended its Medicare Prescription Drug Benefit Manual (Part D Manual) to add, in part, stronger language regarding Medicare Part D sponsors' secondary payer rights and recovery. As part of these changes, CMS is directing Part D sponsors to ensure processes are in place to effectuate proper secondary payer recovery efforts. Further, the new updates preclude Part D sponsors from paying for a prescription that should be paid under the MSP provisions or submitting these claims to CMS for payment. If acted upon, these updates could lead Part D plans to more aggressively assert their secondary payer status, either through coverage denial in the first instance and/or increased Part D recovery claims regarding workers' compensation, liability, and other non-group health claims. Primary payers should have processes in place to address Part D recovery notices to assess what responsibility, if any, may be owed and whether grounds exist to challenge said claims.

Claimant is not a Medicare beneficiary

If the claimant is not a Medicare beneficiary at the time of settlement and has not been a beneficiary at any point during the claim, Section 111 reporting, conditional payments, MAP liens, and potential Part D recovery claims are nonissues. However, Medicare's future interests must still be considered.

For example, under the CMS workers' compensation MSA review thresholds, a settlement involving a claimant who is not a Medicare beneficiary at the time of settlement meets CMS' review thresholds if the settlement amount (as defined by CMS) is greater than $250,000 and the claimant has "a reasonable expectation of Medicare enrollment within 30 months of the settlement date." Primary payers need to consider CMS statements on these points and determine how best to address the situation. It should be noted that the Query Process does not return the information needed to determine whether a claimant has a "reasonable expectation of Medicare enrollment" per CMS's definition of the term. As such, separate processes to obtain the information must be established.

Conclusion

CMS continues to intensify and expand its enforcement activities aimed at protecting Medicare's secondary rights. With implementation of Section 111's electronic reporting mandates, CMS now has the tools to take those efforts to much higher levels. To meet the challenge, now is the time for primary payers to establish the necessary compliance protocols to avoid possible—and significant—liability and penalties under the MSP.

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[1] See e.g., CMS' MMSEA (Section 111) NGHP User Guide, Version 5.5 (January 4, 2019), Chapter III – Policy Guidance, Chapter 6.1.

[2] *A Dozen Facts About Medicare Advantage*, The Henry J. Kaiser Family Foundation, November 2018.

[3] See e.g., *In re Avandia*, 685 F.3d 353 (3rd Cir. 2012); *Humana v. Western Heritage*, 832 F.3d 1229 (11th Cir. 2016); *Collins v. Wellcare Healthcare Plans, Inc.,* 73 F.Supp.3d 653 (E.D. La. 2014); *Humana Ins. Co. v. Farmers Tex. Cnty. Mut. Ins. Co*., 95 F.Supp.3d 983 (W.D. Tex. 2014); *Cariten Health Plan, Inc. v. Mid-Century Ins. Co.*, No.: 2015 WL 5449221(E.D. Tenn. 2015); *Humana Ins. Co. v. Paris Blank LLP*, 187 F.Supp.3d 676 (E.D. Va. 2016); *Aetna v. Guerrera*, 300 F.Supp.3d 367 (D. Conn. March 13, 2018); *Humana v. Shrader*, 2018 WL 1384529 (S.D. Tex. March 16, 2018); and *MAO-MSO Recovery II, LLC v. State Farm*, 2018 WL 340021 (C.D. Ill. January 9, 2018).

[4] See, CMS' Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide (Version 2.9, January 4, 2019), Sections 4.0 and 8.1. Regarding CMS' review thresholds, it is noted that CMS views its thresholds as administrative "workload" thresholds and indicates that are not *"intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases."* As such, parties should also consider how best to address settlements which do not meet CMS' review thresholds. See, Section 8.1.

[5] See, CMS' Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide (Version 2.9, January 4, 2019), Section 8.1.

[6] See, CMS' Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide (Version 2.9, January 4, 2019), Section 8.1.

About the Author

Mark Popolizio is vice president of MSP compliance and policy for ISO Claims Partners and a nationally recognized authority on MSP compliance. Mark practiced insurance defense litigation for ten years concentrating in workers' compensation and general liability. Since 2016, he has dedicated his practice exclusively to MSP compliance, working with insurers, self-insureds, third-party administrators, and other claims professionals in addressing MSP compliance issues.

Mark is a featured presenter on MSP issues at national seminars and other industry events and has authored national articles on MSP matters. He is active with MARC, DRI, and NAMSAP.

Mark graduated summa cum laude from Quinnipiac University with BS degrees in legal studies and sociology. He graduated from Nova Southeastern University School of Law in 1995 and is licensed to practice law in Florida and Connecticut.