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Developing a Medicare Game Plan

Identifying Medicare Issues, Building Best Practices & Minimizing Risk

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Today's Focus…

1. MSP compliance – in the bigger picture
2. MSP and claims practice – issues and impact
3. Building MSP protocols – considerations and approaches
4. How can we improve our practices?

Starting point – the big picture

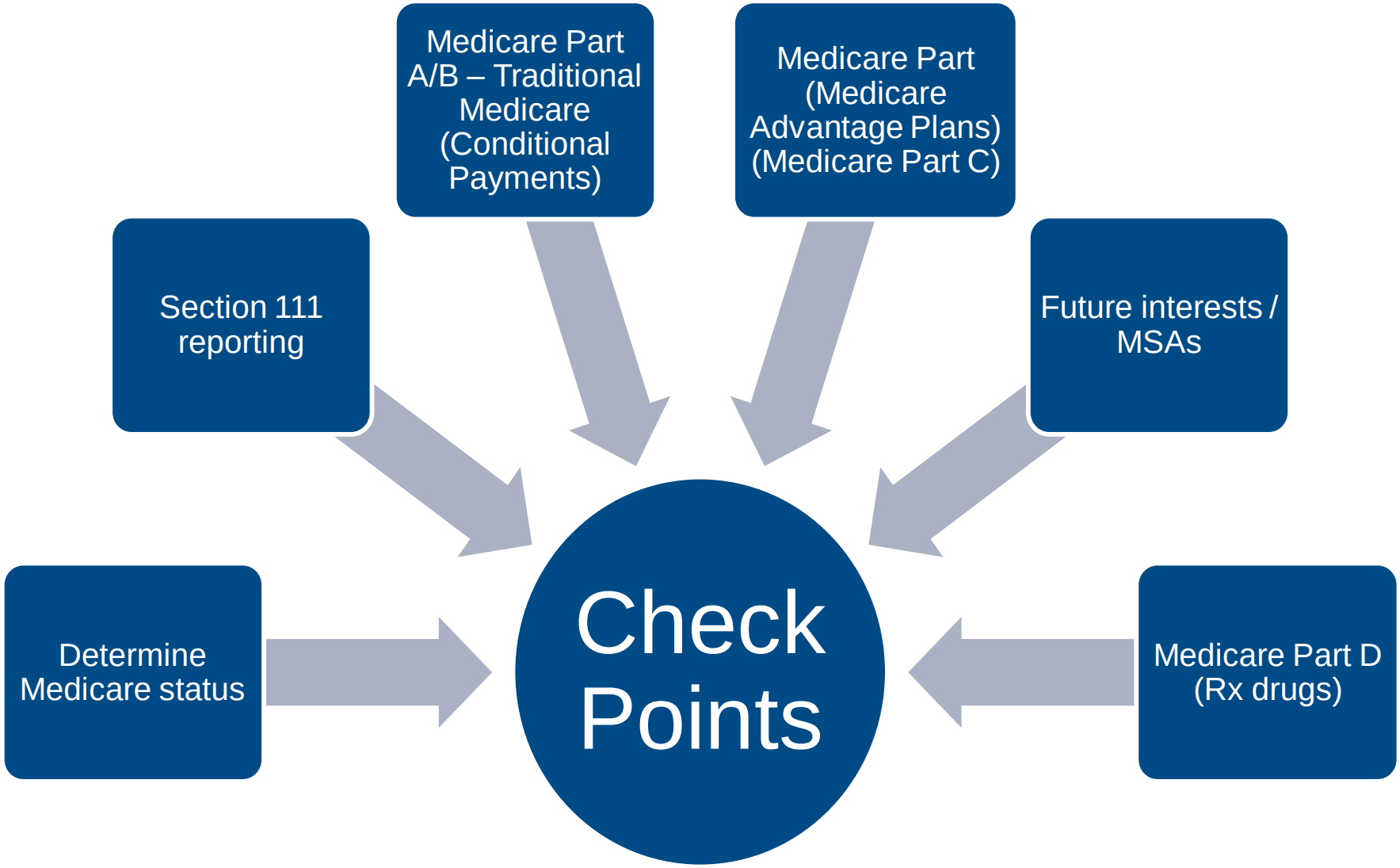
Medicare Level Set

- **Federal health insurance program**
- **Eligibility "red flags"**
  - 65 years old or older
  - People who are awarded social security disability (SSD)
  - People who have End Stage Renal Disease (ESRD) or ALS
- **Medicare has 4 main parts:**

Part A Part B	→ Traditional Medicare (1965)
Part C	→ Medicare Advantage (1997)
Part D	→ RX (2006)

- **Medicare vs. Medicaid (Medi-Cal in California)**

Compliance Basics



MSP Compliance Considerations

Status	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 (and never has been during the claim)	NO	NO	NO	POSSIBLE	NO

Medicare "Alphabet Soup"

- **MSP** – Medicare Secondary Payer Statute
- **CFR** – Code of Federal Regulations
- **CMS** – Centers for Medicare and Medicaid Services
- **WCMSA** – Workers' Compensation Medicare Set Aside
- **WCRC** – Workers' Compensation Review Contractor
- **BCRC** – Benefits Coordination and Recovery Contractor
- **CRC** – Commercial Repayment Center
- **MAP** – Medicare Advantage Plan (contrast: Traditional Medicare)

Determining Medicare Status

Medicare Status

- Key to determining what your MSP compliance obligations are (or may be)
- Protocol development tied heavily upon Medicare status

Determining Medicare Status

- CMS Query Process system:
  - Positives
  - Negatives
  - Issues
- Social Security Administration (SSA)
  - SSA request vs. Query Process request

Determining SSD Status

- Could also play a role in determining MSP obligations in some instances

Section 111 Reporting

Section 111 Reporting

- **What is Section 111 reporting?**
  - Mandatory electronic reporting requirement.
  - Requires all risk-bearing entities to report specific claims data to CMS for cases **(i)** which involve a Medicare beneficiary <u>and</u> (ii) which meet a CMS "reporting trigger."
  - Very simple in concept:
    - If the claim (or settlement) involves a Medicare beneficiary and a reporting trigger is hit, the reporting necessary.
- **Objectives**
  - Coordinate Benefits
  - Conditional Payment Recovery
  - Keep Medicare the "secondary payer"

Section 111 Reporting – Reduced to a math equation

.

If you are an RRE (Responsible Reporting Entity)

+

Claimant is/was a Medicare beneficiary

+

Claim meets a “reporting trigger”

Claim must be reported under Section 111

Query Process – Determining Medicare Status

- **Function/Role**

- **Data needed**
  - First name
  - Last name
  - Gender
  - Date of Birth
  - SSN/HICN (or, in some instances, last five digits of SSN)

- What information does the query provide and (and not provide)?

MMSEA/Section 111 Reporting Triggers

There are <u>two</u> Section 111 reporting triggers:

1. **TPOC**: Total Payment Obligation to the Claimant
2. **ORM**: On-Going Responsibility for Medicals

NOTE: Both triggers can be applicable depending on your case

<u>TPOC</u> involves the reporting of certain settlements, judgments, awards and other payments.	**<u>ORM</u>** involves the reporting of claims when the RRE "accepts ongoing responsibility for medicals."

• Medicals claimed, released, or settlement has the effect of releasing medicals
  • TPOC date
  • TPOCs greater than $750 get reported
	• Typically will involve WC, NF and Med Pay claims – Why?

Section 111 – WC Fact Pattern

- D/A 10/1/13 – WC claim. Compensable. Low back.
- CL not on Medicare on D/A – but in April 2015 he became a Medicare beneficiary based on age.
- Carrier provided treatment for the back from the outset. But, denied the alleged psychiatric condition.
- On 9/1/17 – global settlement for $60,000.
  - **Identify Section 111 reporting issues.**

Section 111 – WC Fact Pattern ANSWER KEY

- D/A 10/1/13 – WC claim. Compensable. Low back.

- CL not on Medicare on D/A – but in April 2015 he became a Medicare beneficiary based on age. ORM = April 2015 when CL became a Medicare beneficiary.

- Carrier provided treatment for the back from the outset. But, denied the alleged psychiatric condition. ORM for the low back, but not the psych.

- On 9/1/17 – global settlement for $60,000. ORM terminates and we have a TPOC (settlement).

  – **Discuss Section 111 reporting issues.**

Section 111 Check-List

- Understand role and limitations of Section 111 reporting
- Protocol to determine Medicare status
- Have plan when claimant refuses to cooperate
- Understand when Section 111 reporting is required
- Understand Section 111 outliers (i.e. reporting may be necessary for claims that typically do not involve medical treatment, such as loss of consortium, D/O, E/O. etc
- Game plan – who, what and when

Conditional Payments (Traditional Medicare)

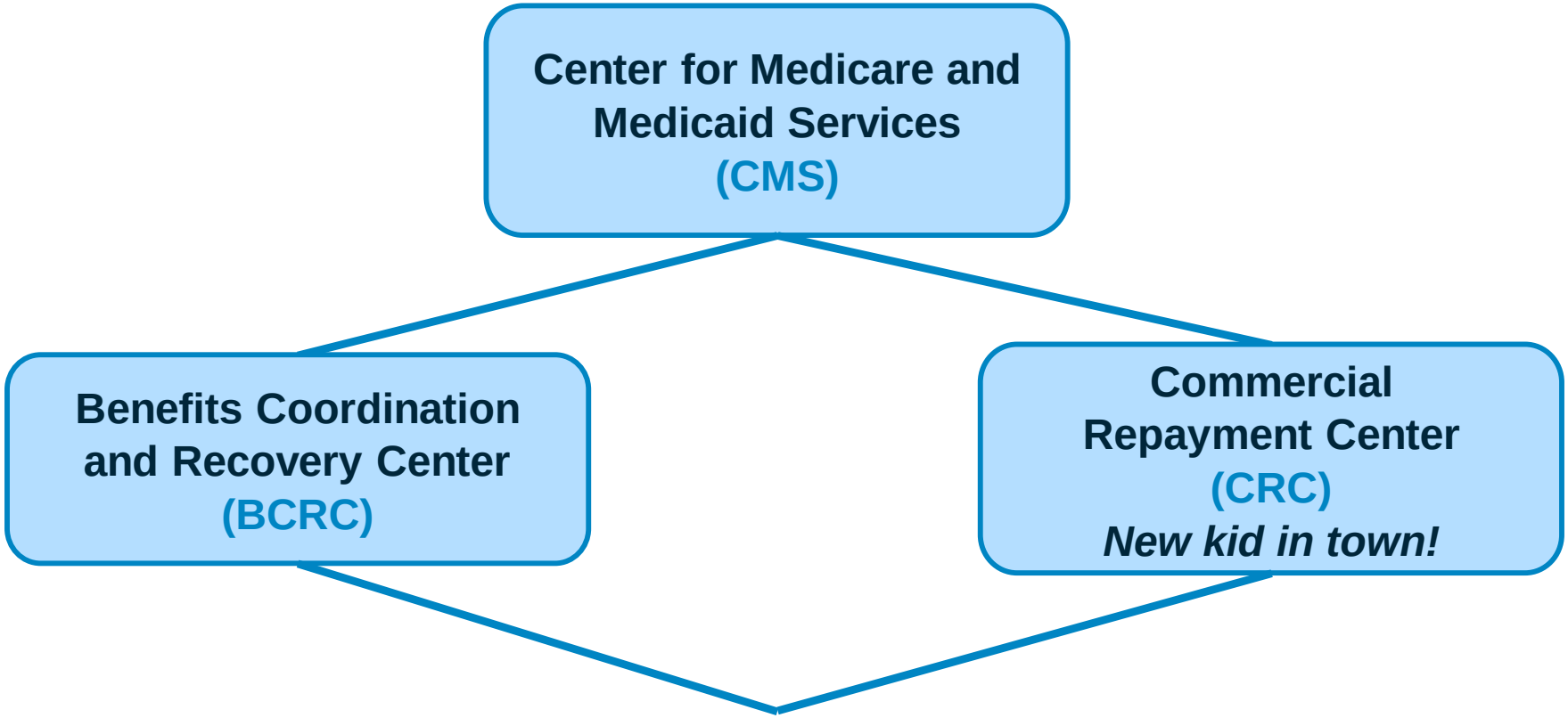
Medicare's Recovery Rights

- **Medicare has strong and broad recovery rights**
  - Can pursue party who "makes" **and/or** "receives" primary payment

- **Liability/Risk**
  - Interest accrual
  - U.S Department of Treasury Action
  - Department of Justice
    - Recent settlements with Philly and Baltimore law firms
  - Private Cause of Action (Double Damages)
    - Federal Government
    - Third Party

- **Medicare can seek reimbursement at different times**
  - Settlement **and/or** PRIOR to settlement when ORM
    - New CRC policy – CMS seeking recovery in ORM situations

CMS' Recovery Process – Who's Who?



These are the contractors that help CMS with its conditional payment recovery activities.

CMS Recovery Process – Current State

- The following chart depicts CMS' current process for conditional payment recovery:

What	When	Who/How
WC	ORM (rolling basis); and Settlement	CRC: pursues claims payer - ORM/pre-settlement BCRC: pursues claimant post settlement (growing trend)
No-Fault	ORM (rolling basis)	CRC: pursues claims payer - ORM
Liability	Settlement	BCRC: pursues claimant post settlement

CRC Practice Pointers

1. **Understand the new landscape:**
   - CMS (through CRC) may now seek recovery of conditional payments PRIOR to settlement where claims payer has ORM.
   - It does not matter if the case is not ready to settle, will never settle, or cannot settle – all that matters is ORM.
2. **Be Vigilant!**
   - All CPN and other notices from CMS, CRC, etc. must be reviewed immediately to determine if action is needed (i.e. the notice says you must respond/object within 30 days)
   - If you miss the stated deadline, the CPN will convert to a demand.
3. **Take Action!**
   - If you receive a CPN – address it immediately!! Time is of the essence!

Disputing Conditional Payment Claims

- Medicare's conditional payment claims often contain unrelated or inappropriate charges.
  - Can you dispute these? Yes!
- Process
  - Informal disputes
  - Formal appeal (five level administrative appeals process)
- Best practices
- Practical considerations

Steps to Conditional Payment Compliance

Report/Register
Ensure that an MSP case is properly set-up with the MSP contractor – the Benefits Coordination and Recovery Center (“BCRC”)

Identify
Obtain Conditional Payment Letter (“CPL”) or Conditional Payment Notice (“CPN”)

Dispute
Engage BCRC / CRC in a dispute, where applicable, to mitigate cost/exposure

Resolve
Notify BCRC / CRC of resolution of claim and obtain Demand and reimburse Medicare

Protocol Considerations

1. Be proactive – address conditional issues early!
2. Carefully analyze and dispute (if applicable) conditional payment claims
3. Determine if you need an update
4. Determine who will be responsible for obtaining, disputing and repaying Medicare's "final" CP claim upon settlement
5. Settlement language

Medicare Advantage Plans (MAPs)

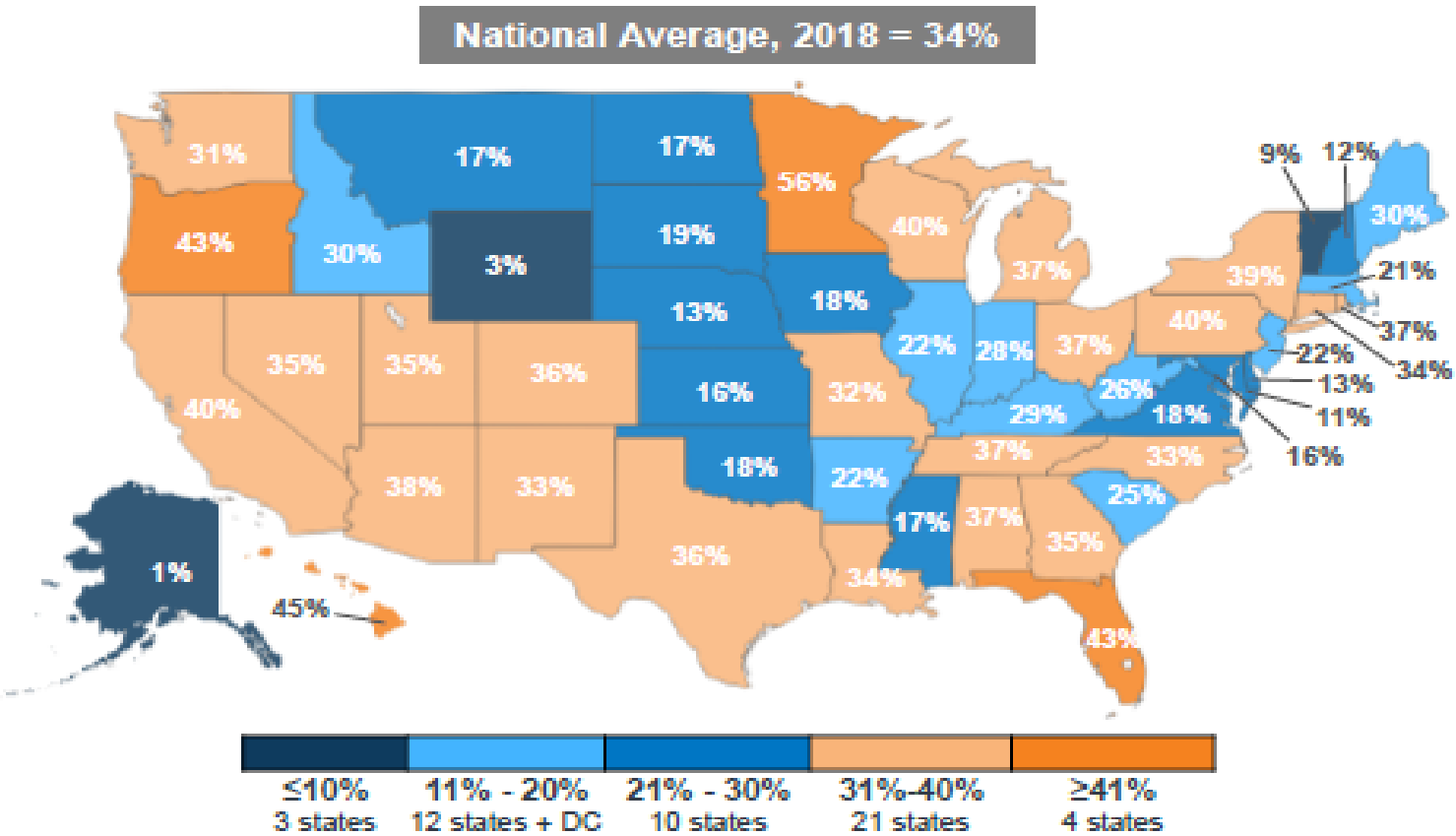
Medicare Advantage Plans – Recovery Claims

- **What are Medicare Advantage Plans (MAPs)?**
  - These are Medicare plans provided by *private insurers.*
  - 17 million people are enrolled in a MAP
  - Main MAP providers:
    - Humana;
    - United Health;
    - BC/BS; and
    - Kaiser

MAP Enrollment By State

Figure 3

Medicare Advantage Penetration, by State, 2018



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

KFF

MAP Liens/Recovery

Key Questions:

1. **Do MAPs have recovery rights under the MAP statutes and regulations?**

2. (And the big one) **Do MAPs have "private cause of action – double damages" right under the MSP?**

   - That is, can MAPs sue claims payers (and potentially other parties) for double damages if their recovery claims are not properly addressed?

   - What are the courts saying?

MAP Liens/Recovery

Key Questions:

1. **Do MAPs have recovery rights under the Medicare Advantage statutes and regulations?**

2. (And the big one) **Do MAPs have "private cause of action – double damages" right under the Medicare Secondary Payer statute?**

   - That is, can MAPs sue claims payers (and potentially other parties) for double damages if their recovery claims are not properly addressed?

   - What are the courts saying?

Crux of the Debate – 42 USC 1395y(b)(3)(A)

- There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

- **Question:**
  - Does the statute apply to MAPs?

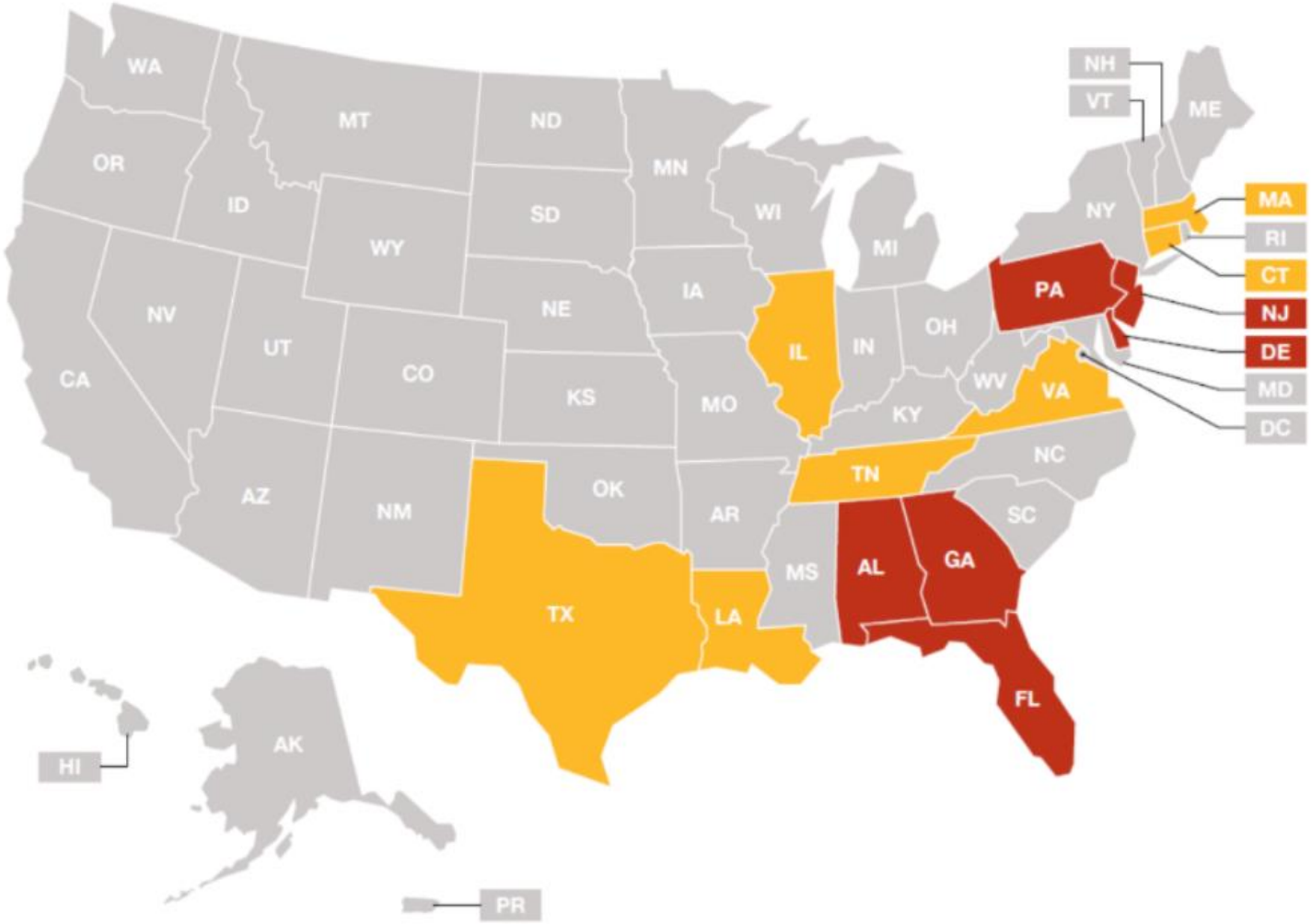
MAP Game Changer – Avandia

- ***In re Avandia***, 685 F.3d 353 (3rd Cir. 2012)
  - Humana argues the MSP's PCA statute is applicable to MAPs.
  - Third Circuit agrees – rules MAPs have PCA right under the MSP!

- <u>Court's rationale:</u>
  - "Plain text" of the MSP's PCA provision affords these rights.
  - Chevron deference: 42 CFR 422.108 (f).
  - No Congressional intent to deny PCA rights to MAPs.
  - Lower court missed the issue.
  - Legislative History/ Policy considerations.

- What has happened since this case?

MAPs “double damages” rights – Current state



http://www.verisk.com/claimspartners-v/medicare-advantage/

MAPs – Protocol Considerations

- Keep an eye out for any new court decisions in 2019.

- Best practice considerations
  - Identifying potential MAP lien issues

  - Challenges in determining the “type” of Medicare the claimant has
    - No centralized data base to ping
    - Function of discovery

  - Beneficiaries can switch plans
    - This raises the possibility of different recovery claims (i.e. MAP and traditional Medicare conditional payments and/or multiple MAP claims)

  - Identifying, disputing and resolving MAP lien issues.

  - Settlement language

Part IV
WCMSAs & Related Issues

WCMSA Starter Points

- How will handle the “future medicals” issue?
  - WCMSA review thresholds?
  - Non-submission?

- Claim strategies
  - Cost reduction
  - Proactive approaches
  - Knowing the landscape

CMS' WCMSA "review thresholds"

WCMSA Review Thresholds	
WCMSA Threshold #1 **Medicare Beneficiaries**	**WCMSA Threshold #2** **Non-Medicare Beneficiaries**
Claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is > $25k	Claimant is NOT a Medicare beneficiary at the time of settlement, but: i. The total settlement is > $250k; AND ii. The claimant has a reasonable expectation of Medicare enrollment w/in 30 months of the settlement.

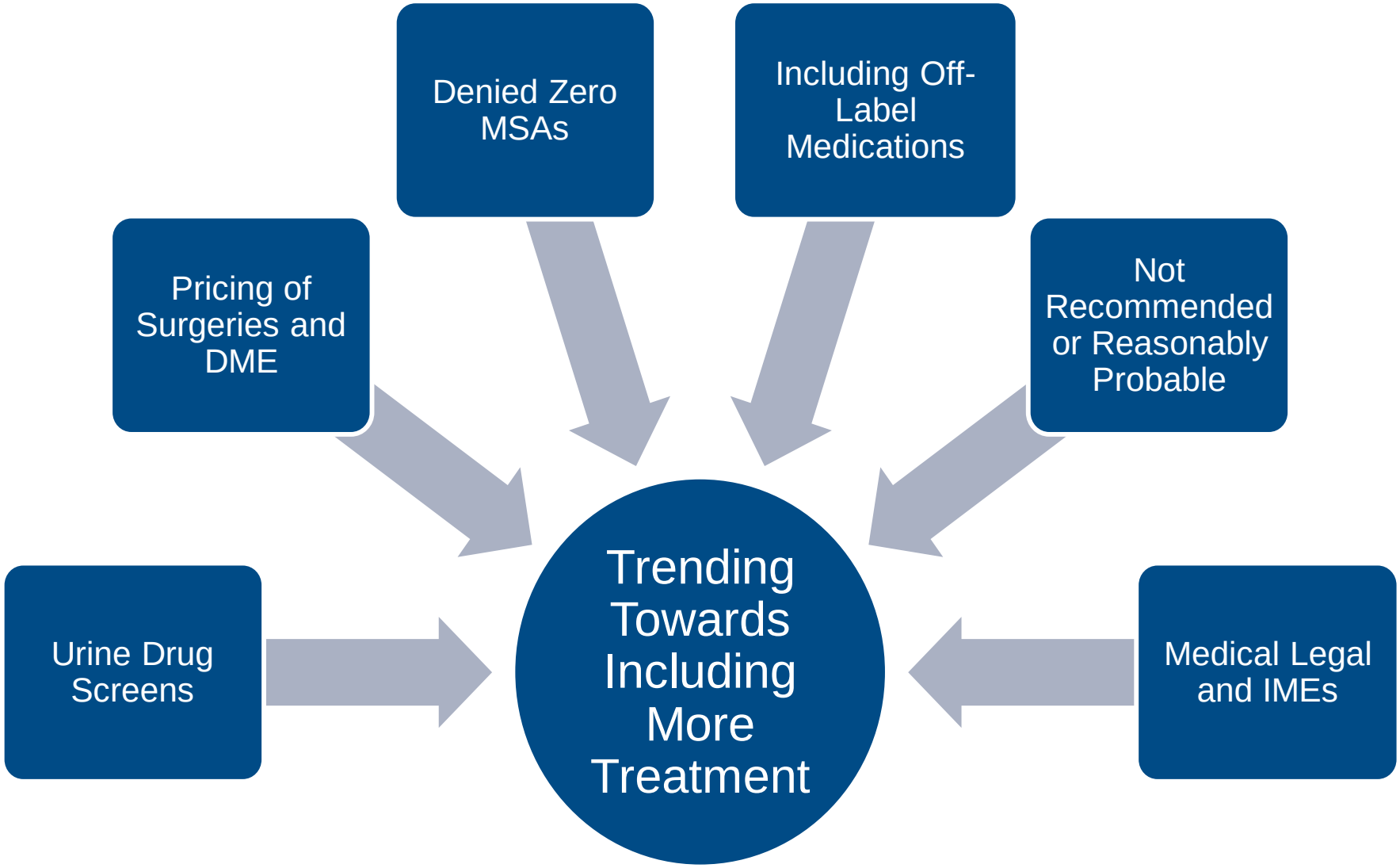
CMS' definition …

Total Settlement Amount	
Includes, but is not limited, to:	
• An allocation for future prescription medications of the type normally covered by Medicare • Allocations for other Medicare covered and non-covered medical expenses • Indemnity, lost wages • Attorney fees • Set-aside amount • Non-Medicare medical costs	• Payout totals for all annuities rather than cost or present values • Settlement advances • Lien payments, including repayment of Medicare conditional payments • Amounts forgiven by the carrier • Prior settlements of the same claim • Liability settlement amounts on the same workers' compensation claim

CMS' definition …

Reasonable Expectation
Includes, but is not limited to, situations where the claimant: • Has End Stage Renal Disease but does not yet qualify for Medicare • Is 62 ½ years old or older • Has applied for social security disability (SSD); • Has applied for SSD; was denied, but anticipates appealing or re-filing for SSD; **or** • Is in the process of appealing or re-filing for SSD.

WCMSA Trends - What is CMS up to?



Challenging CMS' WCMSA Determination

- **Situation**:
  - WCMSA proposal submitted to CMS
  - But, CMS comes back with a "counter-higher"

- **Question:**
  - Can you challenge CMS' determination?
  - Yes – CMS has an informal (and limited) "re-review" process

- **"Re-Review" Options:**

1. CMS makes an "obvious mistake"
2. Records pre-dating the WCMSA submission
3. NEW! Amended Review process

Amended Review Option

Qualifications

- WCMSA originally decided by CMS 1-4 years from current date
- Only one Amended Review option allowed
- Current treatment will be reduced or increased by at least 10% or $10,000, whichever is greater from the initially approved amount*
- Settlement must not have occurred

Likely Triggers

- Surgeries or implants have occurred
- Change in medication regimen
- Claims in which cost to adjust the file significantly decreased
- Change in personal health/ rated age

MSA general consideration points

- Best time for MSA referral?
- Best time to submit the MSA to CMS?
- Cost mitigation (reducing MSA amounts)
  - Identify cost drivers
  - Understand CMS policy, trends, what they are looking for, etc.
  - Develop the plan to obtain the evidence/opinions you need
  - Execute the plan
  - Challenging CMS

What if my case does NOT meet CMS' WCMSA "review thresholds?"…

…Non-Threshold Cases

Non-Threshold Cases

Settlements which do NOT meet CMS' WCMSA "review thresholds."

CMS Position

- CMS has consistently indicated that parties still need consider its future interests even if the settlement does not meet its WCMSA review thresholds.
- Thus, claims payers need to determine how best to consider Medicare's interests in non-threshold cases.

Options

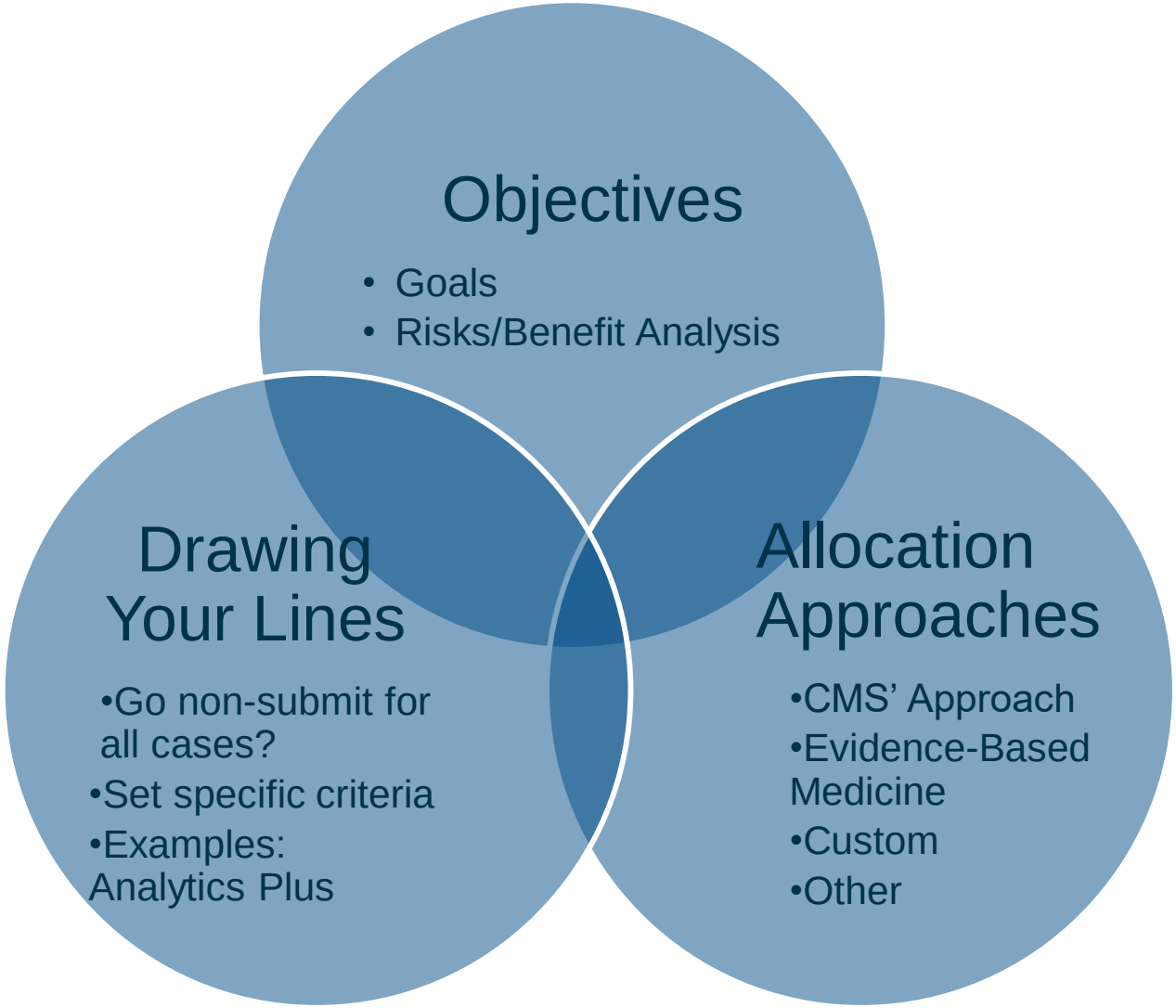
- Settlement language
- Future medical allocation (this would NOT get submitted to CMS)
- Other?

Examples

- Settlement is close, but does not quite meet CMS review thresholds.
- Others?

WCMSA Non-Submission

WCMSA Non-Submission



Medicare Part D
The next compliance frontier?

Part D: Background

The Basics

- Added in 2003, benefits began 2006
  - Voluntary outpatient prescription drug benefit plan available to all Medicare beneficiaries.
  - Traditional Medicare: “stand-alone” Part D plans
  - Medicare Advantage Plans: may purchase a plan as part of their coverage under their particular MAP program

By the Numbers

- In 2018, more than 43 million Medicare beneficiaries were enrolled in a Part D plan. Of this total, 58% of traditional Medicare beneficiaries were enrolled in a stand-alone prescription drug plan, while roughly 42% were enrolled in a Medicare Advantage Drug plan
- United Health, Humana, and CVS Health account for 55% of all Part D enrollees.

The Henry J. Kaiser Foundation, *Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing,* Data Brief, May 2018

Part D (RX Drugs)

- October 2018: CMS updates Section 50.12 of its **Medicare Prescription Drug (Part D) Benefit Manual**

- Main features:

  - CMS is directing Part D sponsors to ensure processes are in place to effectuate proper secondary payer recovery efforts.

  - New updates preclude Part D sponsors from paying for a prescription that should be paid under the Medicare Secondary Payer (MSP) provisions or submitting these claims to CMS for payment.

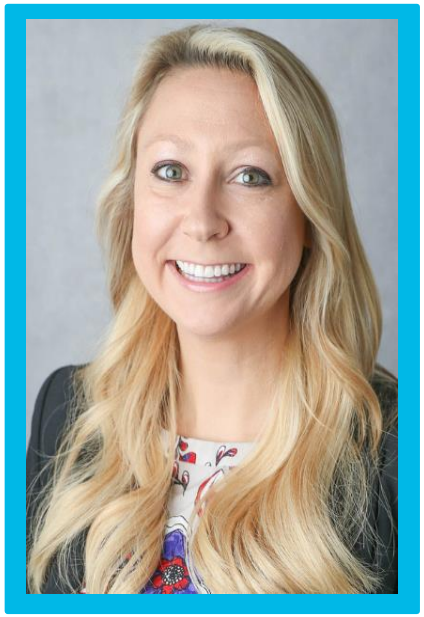
- Questions:
  - Part D recovery rights?
  - Will Part D plan get more aggressive?
  - Claims impact and process?

Finally… communication is key

Communication is Key

- Communicate protocols to all frontline claim 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 claims settlement

Thank you!



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