Introduction:

The following is a Practical Guide to Medicare Secondary Payer (MSP) Compliance for primary payers and is intended to provide a brief explanation of the key elements of compliance and how to use the services of Care Bridge International. It contains suggested practices developed by Medicare and claims experts having extensive knowledge and experience.

MSP compliance involves four specific obligations imposed on carriers, TPAs, self-insured entities, beneficiaries, and their representatives drawing on statutory analysis, federal regulation and written guidance and policy published by the Centers for Medicare and Medicaid Services (CMS).

Care Bridge International has sought to discuss each of these components in a practical way with suggested tips to consider regarding the common scenarios encountered by the parties in the settlement process.

MMSEA Section 111 Reporting

1. Medicare Medicaid SCHIP Extension Act (MMSEA) signed into law 12/29/07.
2. Electronic reporting of ALL Medicare beneficiaries with S/J/A
    1. WC & Auto No Fault 10/1/10
    2. Liability 10/1/11
3. Ongoing Responsibility for Medical (ORM)

Conditional Payments

1. Medicare is secondary when a primary payer exists, so this is a coordination of benefit
2. Primary payer must refund Medicare for payments made r/t the injury claim
3. Report to the Coordination of Benefits
4. Conditional Payment Letter
5. Conditional Payment Final Demand

Medicare Set Aside

1. Closing or limiting future medicals?
2. Claimant age 62 ½ or older?
    - Total settlement > 25K
3. Is the claimant on SSDI, or has applied, denied, with intent to reapply?
    - Total settlement > $250K

Voluntary process to submit MSA to CMS for review and approval

Post Settlement MSA Administration

1. Medicare Set Aside Account
2. Funds placed in an interest bearing account
    1. Self Administration
    2. Professional Administration
3. Funding method – Lump Sum vs. Annuity
4. Only way to ensure that Medicare's interests are adequately protected and funds properly exhausted, fulfilling the intent of the law

Background:

On July 1, 1966 19 million Americans, age 65 or older enrolled in Medicare. Since then, the CMS has administrated Medicare and paid the medical expenses of those enrolled, certain disabled individuals, and those with permanent kidney failure. In 2015, 55.5 million were covered by Medicare; that is 13% more than in 2011. Also, in 2011, the national labor force participation rate for those age 65 years and older was 16.2 percent, meaning they are working as well. As the population ages, both of those numbers will grow. Medicare has always been secondary to Workers' Compensation (WC) claims. "Secondary" means that WC plans must pay before Medicare. Attempts have been made in Congress for several years to address the problems that exist when WC settlements overlap with Medicare. There will be another bill filed in the current Congress trying to codify CMS's current "guidance" published on their website into Federal law. This is an attempt by stakeholders to bring certainty to the system for future compliance.

Until 1980, Medicare was the primary payer of all medical expenses, except as noted above, for most Medicare beneficiaries' private insurers, both under Group Health Plans (GHP) and Property-Casualty (P/C), paid as secondary. Under the 1980 MSP Statute, both GHP and the P/C insurers, also called Non-Group Health Plans (NGHP), were defined as "primary payers". In the case of NGHPs, the law added liability, automobile and no-fault. The CMS, through rulemaking, added virtually all types of policies that potentially could pay for expenses and/or personal injuries, even those that typically do not do so, such as employment-related practices liability (ERPL) directors and officers (D&O), errors and omissions(E&O) and professional liability.

Almost all state regulatory systems require compensable WC claims to pay all related medical without duration limitations for the life of the employee. No such statutory law or regulation exists for any other insurance or obligation. This led the CMS to issue on July 23, 2001 the "Patel memo" directing the CMS's regional offices on how to address WC claims that involve future medical expenses. That was followed by 'Frequently Asked Questions' memos on July 21, 2003, October 15, 2004 and finally a policy memo on April 25, 2006 that outlined the CMS's view of set asides. Copies of these memos are available from Care Bridge International.

The CMS's goal is to ensure that an appropriate amount of the settlement covering future medical expenses is "set-aside" to protect Medicare's interests. Some have said that the best protection would be to hinder the settlement of as many cases as possible. By doing so the beneficiary would continue to have their bills always paid by the NGHP.

The Medicare Set Aside (MSA) review process by the CMS and it's contractor is inefficient, unpredictable, and very costly to the injured workers, employers, insurers and states administrators of the workers' compensation laws.

Mandatory NGHP CMS Reporting Under MMSEA Section 111 of the Assumption of Ongoing Responsibility for Medicals (ORM) and Total Payment Obligation to Claimant (TPOC):

In December 2007, Section 111 of MMSEA mandated that NGHP including self-insurers, report information to the CMS as determined by the Secretary of Health & Human Services (HHS). Initial Reporting was to begin July 1, 2008. The CMS delayed reporting from 2009, to April 2010 and to finally January 1, 2011 for WC claims ORM. No-Fault ORM began as of October 1,2010, and on January 1, 2012 Liability TPOC(s) greater than $100,000 began after October 1, 2011.

Thus, began mandatory reporting to ensure that the CMS would in fact be secondary to those P/C lines of business subject to the MSP. Section 111 reporting gave the CMS a database of claims that they could use to flag those where the CMS should be the secondary payer and recover conditional payments, if applicable from the primary payer.

The statute created no framework for reporting and delegated the details to the CMS, to implement Section 111 by program instruction or otherwise. 42 U.S.C. § 1395y(b)(8)(H)

Prior to the mandatory reporting of claims involving a Medicare beneficiary, the CMS had no way to track MSP compliance in P/C lines claims. NGHP had little incentive to identify themselves as primary payers or were not aware of claimant's Medicare beneficiary status. They often believed that it was the beneficiary's responsibility or their representative to reimburse the CMS for the conditional payment(s). With the reporting requirements, vast amounts of data are provided to Medicare on a regular basis. This allows for the identification and recovery of past conditional payments, as well as access to settlement documents, to ensure Medicare's interests have been considered when future exposure exists.

Under MMSEA Section 111 mandatory reporting, NGHP report certain information to the CMS on all claims, settlements, judgments, awards or payments involving Medicare beneficiaries. The law applies to all NGHP and self-insureds. The MSP Act remained unchanged and the law is applicable to situations where a beneficiary files a claim and/or a civil action against a third-party seeking damages for injuries received and medical expenses incurred because of that illness/injury.

A CMS contractor identifies health benefits available to a Medicare beneficiary and coordinates the payment process to prevent mistaken payments. Reporting allows the CMS to move from a "pay and chase the recovery" model, to one that prevents the making of certain conditional payments. This Coordination of Benefit Contractor (COBC) enters, collects, manages, and reports other insurance coverage. The COBC must be notified of situations where medical services rendered to a beneficiary are related to a workers' compensation injury, automobile accident, or other liability because in these instances, a NGHP payer may have the primary responsibility for payment of medical claims related to the injury. The claimant and their counsel have significant responsibilities and obligations under the MSP law to notify the COBC of these situations.

TIP: If the claimant is Medicare eligible, remind the claimant that an obligation exists to report to Medicare within 60 days that they have made a claim for benefits.

Guidance is only posted on the CMS website and can be found here:
https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

The CMS requires that Responsible Reporting Entities (RRE), typically the insurer or self-Insured entity, must determine whether claimant is entitled to Medicare benefits. The CMS specifically does not recognize a third-party adjuster (TPA) as an RRE for a NGHP or self-insured plan. Policyholders' deductibles are considered a form of self-insurance under the CMS regulations, but to differentiate deductibles from self-insured retentions they required those with retentions and insurers with a deductible to report, regardless of size.

A RRE must report a claimant's identification (full name, gender, DOB, Social Security number or Health Insurance Claim number), including the names of beneficiaries to an estate in the case of a fatality, incident data (date of accident; dates of first and last exposure, ingestion or implantation), ICD-9 and/or ICD -10 Injury Codes and the claimant's attorney and/or representative information. The insureds' identification is never reported.

Once the RRE has accepted ORM, they do not report again. In situations where the applicable WC law or plan requires the RRE to make regularly scheduled periodic payments, pursuant to statute, for an obligation(s) other than medical expenses, to or on behalf of the claimant, the RRE does not report these periodic payments, if the RRE separately continues to assume ORM and reported this ORM appropriately.

Therefore, the RRE must report the ORM. The periodic payments to compensate for lost wages are not reported as TPOCs. In summary, under the circumstances, one claim report record is submitted reflecting ORM. If the NGHP closes their electronic or physical file but would still be responsible for any related future medicals, this is considered an administrative closing and no report to the CMS is required.

Unless through a TPOC or limitation, they no longer have an ORM. If the reporting is for the resolution of ORM or a TPOC, the RRE must report all settlements, judgments, awards and other payments made to Medicare beneficiary as compensation for/in exchange for release of medical expenses in the past or future.

TIP: Are you closing ORM when you should not? Are you closing ORM when there is a limitation or exhaustion of benefits?

Conditional Payments:

In many instances, Medicare will have paid for medical services received by a beneficiary following an injury. Medicare is said to have paid "conditionally", subject to their right to reimbursement from the primary payer at the time of settlement, judgment or award. Pursuant to the MSP Act, Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made under a workers' compensation plan, an automobile or liability policy or plan (including a self-insurance plan), or under no-fault insurance".

In addition, 42 U.S. Code §1395y(b)(2)(b) allows the United States on the CMS's behalf, to bring an action against ***any,*** or all, entities that are, or were, required, or responsible, (directly, as an insurer or self-insurer, as a third-party administrator), to make payment with respect to the same item or service (or any portion thereof) under a primary plan (conditional payments). The United States may, …collect ***double*** damages against any such entity. Accordingly, it is critical to identify the proper amount of the conditional payment(s) made by Medicare in any claim and to be certain that Medicare's subrogation rights have been satisfied. Failure to resolve conditional payments could result in the CMS recovering up to the entire settlement amount (minus certain procurement costs) from the Medicare beneficiary and seeking double damages from the primary payer as noted above. There have been instances where the primary payer paid the beneficiary and the CMS collected double from that same payer.

Between 1980 and 2007, the CMS wasn't successful at coordinating benefits and ensuring it paid secondary to private insurance. The CMS estimated it paid primary, but should have paid secondary, over 3 million NGHP claims a year because it did not know an NGHP claim existed or that the claim had been paid.

Under the existing statute, providers of services to beneficiaries may bill the CMS requesting reimbursement if they will not "promptly paid" within 120 days of the date of services for various reasons, including an NGHP claim that cannot be resolved or is disputed in whole or in part. The CMS's payment in either case is a "conditional payment".

TIP: Set your claims handling rules to identify those with potential Medicare beneficiaries that are over 120 from the date of loss. Conditional payments may have been made.

What are Medicare Advantage Part C Liens?

Medicare originally had just 2 parts, A and B, and there was a fee for service single payer insurer. Part A is offered free to any citizen at age 65. It provides mainly payments for in-patient hospital costs. Part B requires that the individual pay a monthly premium and covers mainly payments to doctors, medically necessary outpatient hospital services and some other services, as well as designated Medicare approved equipment and supplies. A beneficiary under these original parts has ***no cap*** on his or her annual out of pocket exposure. It is unlimited.

The Balanced Budget Act of 1997 created Part C of Medicare. Under Part C health plans, Part C covers the same medical services as Parts A and B, and typically include an annual physical exam and vision and/or dental coverage not covered under Medicare. Part C was followed by Part D, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as was the name Medicare Advantage. Estimated 97% of the beneficiaries in Part Care in one of Medicare Advantage plans (currently there are 3 major plans, but up to 12 or more), primarily in a classic HMO. The most important difference between a Part C health plan and Original Medicare is that all Part C plans include a ***limit*** on how much a beneficiary must spend annually out of pocket.

As of 2015, 15.1 million beneficiaries have elected to receive Medicare coverage by contracting to have their benefits delivered by these private health care plans rather than through traditional Medicare. Medicare Advantage Plans (MAP) provide the same benefits as Medicare, but premium payment and delivery of services are somewhat different. MAP are for profit entities, subsidized by the Federal government. Upon settlement, judgement or award, MAP can / will, like Medicare itself, assert their right to recover from the settlement pursuant to 42 U.S. CFR §422.108 "conditional payments" under MSP. Their argument is that since they are in place of the Federal government, they should have the same rights. When challenged, the CMS provided only a single memo in support of this argument, a copy of this memo is available from Care Bridge International. Others argue that it is not supported in the statute and that they should not have greater rights of reimbursement than any other GHP.

On July 12, 2012, the 3rd Federal Circuit which covers Pennsylvania, New Jersey and Delaware found that MAPs do have same recovery rights as Medicare: In Re Avandia Marketing, 685 F.3d 353(3d Cir. Pa. 2012), cert. denied, 133 S. Ct. 1800 (2013). Thus, it is recommended that Care Bridge International be involved in the Part C lien recovery process.

These plans present challenges to NGHP claims handlers. Should they treat them as if they have the same reimbursement rights as Medicare? How do you determine if a claimant has a Medicare Advantage Plan? Unlike Medicare, a beneficiary can move from one plan to another each year, many do not know that they have the coverage. NGHP must decide how they will handle the requests for reimbursement and incorporate the practices into their claims handling.

TIP: Are You following the decisions in the various Federal District and know which have upheld Medicare Advantage plans rights to recover conditional payments?

TIP: Have claims handlers ask if the beneficiary is paying a monthly fee to any other health insurance above the deduction from social security.

Medicare Part D: Prescription Drugs

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act authorizing Medicare coverage of outpatient prescription drugs. Medicare began covering outpatient prescription drugs on January 1, 2006. In April 2009, the CMS announced the requirement to include Medicare Part D prescription drug allocations in a Workers' Compensation Medicare Set-Aside (WCMSA).

The CMS then began to review Medicare Part D prescription drugs for adequacy and sufficiency on June 1, 2009. At that time, they published guidance for allocating Part D Prescription drugs in WCMSA to include the pricing of drugs per the Redbook average wholesale price (AWP). Tapering of prescriptions are allowed per the treating physician's recommendation, acknowledgement of patent expiration and availability of generic equivalents when patents expire. The memo further expanded upon utilization review, brand versus generic drugs, and off-label drug use for Food and Drug Administration (FDA) approved drugs.

Upon implementation of prescription drugs to satisfy Medicare's future interests in a WCMSA, there was a spike in WCMSA totals, as much as 66% increase or more. The allocation of prescription drugs has been a source of contention in claim settlements, often to the detriment of settlement.

TIP: There are ways to mitigate prescription drug exposure in WCMSAs as follows:

1. **Identify all related and non-related prescription drugs, secure a written statement from the treating physician stating which prescription drugs are related and, have been paid for by the carrier, and which are unrelated to the claim.**
2. **Identify all brand drugs and work with a pharmacy benefit manager or treating physician to convert them to generic**
3. **If a drug is inappropriate, and/or over-prescribed, engage a physician peer to peer service and a drug utilization review company to work with the treating provider to secure a weaning plan and schedule for appropriate, prescriptions. Consider usage of Maximus Federal decisions as these are upheld within the MSA review process by the CMS.**

Medicaid Liens

Medicaid is a U.S. health program administered by the individual states. Initially, it provided medical insurance to people receiving Social Security benefits. Today, a much larger group is covered who meet income requirements; low-income families, pregnant women, people with disabilities, and those who need long-term care. States can tailor their Medicaid programs to best serve the people in their state,

so there's a wide variation in the services offered. These health care benefits are available to U.S. citizens and eligible immigrants who qualify. The Affordable Care Act (ACA) expanded coverage by creating an opportunity for states to provide Medicaid eligibility, effective January 1, 2014, for individuals under 65 years of age with incomes up to 133 % of the federal poverty level (FPL). Two of the most populous states, California and New York, now provide Medicaid coverage for low-income adults without children. It is important to note that U.S. citizens and eligible immigrants may be dual Medicare and Medicaid beneficiaries.

Upon receipt of a settlement, judgment, award, or benefits, the state may have a lien for any payments it made for medical services resulting from the loss that created the claim. If so, the state must be reimbursed per its' law. Failure to repay a Medicaid lien may result in interruption of benefits, and/or litigation.

Medicaid liens can be extremely problematic in that unlike Medicare, there is not an age indicating that the individual is on Medicaid. Parties can come on and off a state's Medicaid roll. There is also no single method to report to a state that a payment has been made. The individual states have created their own reporting schemes that sometimes apply to insurers, self-insureds, and third-party administrators.

TIP: Have you done a survey of the state Medicaid reimbursement laws for the states that you are doing business in or handling claims from?

CMS Submission of Workers Compensation Medicare Set Aside (WCMSA):

The establishment of a WCMSA is designed to relieve Medicare of the obligation to provide future medical care for a beneficiary who requires continued care related to an accident. A portion of settlement funds are held in a separate, interest-bearing account and are to be used for Medicare covered accident related future medical services.

Submitting a WCMSA to the CMS for review and approval has always been, and continues to be, a voluntary, but recommended process. The CMS Workers' Compensation Medicare Set Aside (WCMSA) Arrangement Reference Guide, Version 2.4, April 2016 states in Section 4.1 Considerations and Guidelines, "A claimant may consider seeking CMS approval of a proposed WCMSA amount for a variety of reasons. The primary benefit is the certainty associated with CMS reviewing and approving the proposed amount with respect to the amount that must be property spent. It is important to note, however, that CMS approval of a proposed WCMSA amount is not required". The guide also states, "Any claimant who receives a WC settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's interest with respect to future medicals into account", meaning that whenever future medicals are closed in a WC claim, Medicare's future interests must be protected. This does not mean that CMS will review every WCMSA submitted for review and approval. CMS has established a work-load review threshold of the types of cases they have the capacity to review. This threshold is subject to change and it is the expectation that funds are being set aside even if the MSA is not submitted to CMS for review.

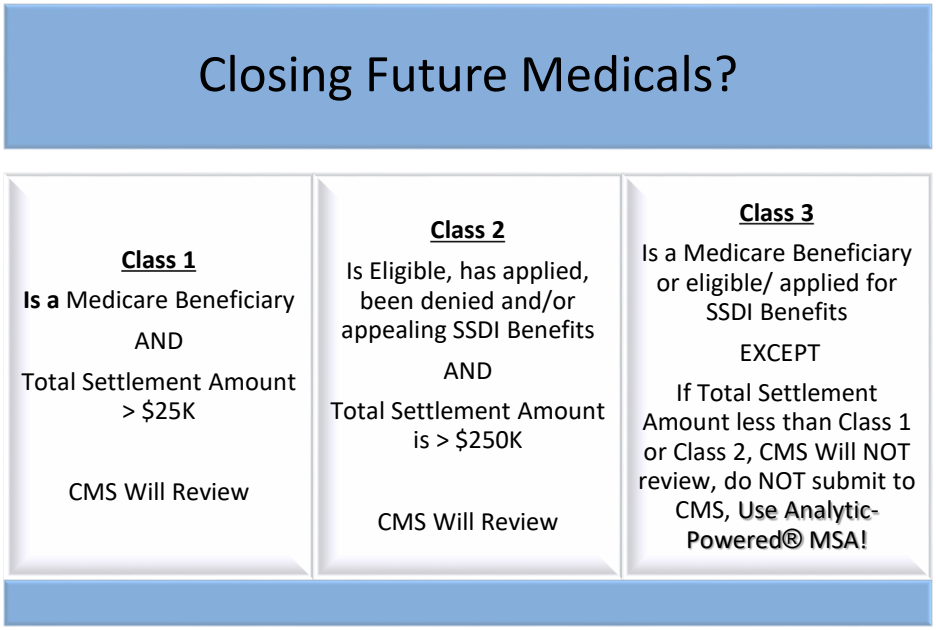
CMS Submission of WCMSAs Workload Review Threshold:

CMS will review the following WCMSA submissions: The claimant is a Medicare beneficiary and the total settlement amount (Indemnity, medical, legal fees, structured annuity, etc.) is greater than $25,000; OR

the claimant has a reasonable expectation of Medicare enrollment within 30 months if any of the following apply:

1. The claimant has applied for Social Security Disability Benefits;
2. The claimant has been denied Social Security Disability Benefits, but anticipates appealing;
3. Claimant is in the process of appealing a denial or re-filing for Social Security Disability benefits;
4. The claimant is 62 years and 6 months' old;
5. The claimant has a diagnosis of End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD.

If these thresholds are met, a WCMSA can be submitted to CMS for approval.



TIP: Always consider Medicare's future interests when closing future medicals via a settlement. If future medicals are not closed, and the case is, a WCMSA is not needed. If future medicals are closed via a compromise and release (C&R), consider a WCMSA CMS submission if the settlement meets the CMS review threshold. If the settlement falls outside of the CMS threshold for review, consider the use of a MSA Estimator or MSA to allocate funds in the settlement language.

The CMS's January, 2019 WCMSA Reference Guide can be found here:
https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2_9.pdf

Future Medical Payments: WCMSA

NGHP, beneficiaries and their representatives recognize that the CMS's review is not required to set up a WCMSA, it's completely voluntary. That gives rise to the consideration of certain claims such as; closed end injuries where it is unlikely that there will be any future medicals, injuries where there will be significantly less treatment since claimants tend reduce treatments after a settlement or an award, and those where the injury, co-morbidity or the current usage of certain prescription drugs estimated over lifetime would significantly reduce the beneficiary's life expectancy. These WCMSAs reviewed by CMS often result in future medical costs that exceed the reasonable expectations of the parties to the settlement.

There are other approaches to set asides that the parties may consider. First, determine through a review of the available information what reasonable parties with available medical knowledge believe should be the set aside. Second, include that amount in the documentation of the settlement release. Third, determine what the cost of an annuity will be to provide the annual future medical costs and purchase it as part of the settlement. Fourth, arrange for that portion of the settlement that is for future care be professionally administered. Lastly, in some jurisdictions, request a zero-sum set aside from CMS for approval under the state's administrative law.

TIP: Are you establishing appropriate set asides for the appropriate claims?

NGHP have seen that the delays, errors and misapplication of information create suggested set asides that truly bear no resemblance to what reasonable professionals believe appropriate. This search for the perfect set aside has added both to the cost of the claims and the associated expenses. It has created a "cottage industry" the members of which all assure the potential customers that they have the solution and reach the appropriate results. Like the confusion in Babel, each speaks in their own tongue as to why the other is incorrect, leaving some customers unsure and confused with which path to pursue. The time has come for NGHP to take control of this within their own organizations. They should ask themselves, "*How can I do this differently*?". "*Can we find a way to reduce the administrative and loss costs both?"*

NGHP have learned that given certain size, the best way to control the outcomes and quality is to embed the operation within the enterprise. This has been the "Best in Class" practice addressing, outside property and liability adjusting, automobile appraisals and the defense of litigation against customers.

TIP: Are set asides vendors and third-party adjustors performance, and compliance under of MSP being included in audits and enterprise risk management reviews?

Liability Medicare Set-Asides (LMSA)

There has been much discussion on the notion that there is such a thing as a LMSA. This type of set-aside would be created to pay for future medical services in claims covered by a liability plan or self-insurance. Those with a financial interest in the current industry that services WCMSA(s)have long proposed that beneficiaries, their representatives and NGHP have a duty to take Medicare's interest into the settlement of these claims. They tend to ignore a fundamental point that has created WCMSA(s), as stated above, <u>most all state regulatory schemes require compensable WC claims to pay all related medical without duration limitations for the life of the employee</u>. No such mandate exists in liability claims.

Most liability claims in the United States occur as an automobile accident involving a strain or sprain. Parties at the scene most often do not exhibit any injury. A disproportionate number of individuals injured in these accidents are eligible for Medicare, since younger parties have a greater ability to withstand the impact of the vehicle. Most claims are settled with what the CMS would define as a "broad form release" which states that the payment of any monies is not an acknowledgement of fault nor can any future action be brought against the party allegedly at fault.

That is not to say that there are not claims that involve future medicals that are resolved by NGHP. These claims are few, but often have large settlements. They very often stem from construction site accidents, medical malpractice or large trucking accidents. After these claims, there is a "broad form release" as well. Some would have you believe that there is a need for LMSA in these claims. They have lobbied the CMS to create the guidance needed to subjugate NGHP to a system that would require them.

On June 15, 2012, the CMS issued an Anticipated Notice of Rulemaking (ANPRM) and asked parties to comment on various proposals to deal with future medicals in WC, liability and no-fault claims. Thousands of comments were received and by law, the CMS had to review them all. Many raised similar concerns: 1) CMS does not have the statutory right to future medicals, liability claims are settled without admitting liability; 2) liability claims are settled without a detailed breakout of what the payment is for; 3) Medicare by law cannot require a physician to attest to an illness or injury, but only offer the professional opinion; and 4) that Medicare has only the right to recoup in liability claims the payments it made "conditionally" up to the date of settlement. It was also noted that if a court of competent jurisdiction awards future medicals, the beneficiary must use those funds prior to requesting benefits for the injury.

The CMS then determined what they would suggest in a Notice of Proposed Rulemaking (NPRM) that was, as required by law, sent to the Office of Management and Budget (OMB) before it is approved for publication in the Federal Register. Interested parties asked for, and met with, representatives of OMB as well as the White House to discuss the proposed rule without being able to review it. After these meetings, the proposed rule was withdrawn on October 8, 2014. Most recently, the CMS announced in a single paragraph ALERT dated June 9, 2016 that they were again reviewing their options. This has led some to believe that there will, in the future, be a LMSA.

Post Settlement MSA Account Administration:

Beneficiaries who settle WC claims, are to use the monies paid for related medical care before the CMS is obligated to make any payments. In some cases, before a settlement is reached, parties ask the CMS's contractor to approve an amount to be set aside to pay for future medical care. To do so, the claimant must be a Medicare beneficiary and the total settlement amount must be greater than $25,000.00; or at the time of settlement, there is a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00. The contractor will look at the medical documentation submitted and suggest an amount of money from the settlement. This practice offers all parties to the settlement no haven from future claims from the CMS.

Failure to establish a Medicare Set Aside account may result in denial of benefits to the beneficiary, continued conditional payment lien accrual, and/ or litigation commended by the beneficiary against the primary payer.

Releases

When the claim has been settled and the monies are to be paid, it is important that the "broad form release" reflects accurately the settlement agreement. Most NGHP have already reviewed all the releases that they are using considering Medicare, Medicaid and the exposure they have as a primary plan. Some have tried to include that the parties, the beneficiary and their representative, must indemnify the NGHP should CMS look to be reimbursed by the primary plan. Those releases, at times, are rejected by the parties. Often, they are rejected since a plaintiff attorney cannot indemnify and hold harmless a defendant for any future liability since it might be a violation of the state's professional code of conduct. This makes for frustrating discussions by all involved without the resolution of the claim. It is more likely that the release putting the burden on the beneficiary alone might be acceptable.

The releases should always address key item. For example, it should address: which party will be responsible for the reimbursement of conditional payments; were monies paid specifically for future medicals and if so, how much; if no monies were paid for future medicals, it should say so; and if there is a WCMSA, the release should reflect who will be responsible for administering it.

Caution should be taken when resolving a claim with a beneficiary who Is not represented. The release needs to clearly spell out what is being agreed to and it might be helpful to have available a fact sheet to share with the claimant.

Penalties

The reporting requirements established in 2007 included a penalty provision which was $1,000 per day per claim improperly reported. This is an onerous amount on any NGHP who is a RRE. The CMS has established reporting requirements that allow for each RRE to report quarterly. It has been pointed out to the CMS that a large RRE, who unintentionally has an incorrect file submitted, could be penalized as much as $90,000 per claim for a single error even though they would not be able to make correction until their next quarterly report.

For the CMS to begin issuing penalties, it must go through the Federal Rulemaking process. It has not done so. The CMS did issue an Anticipated Notice of Proposed Rule Making (ANPRM) taking feedback from stakeholders on how they feel the rulemaking for penalties should be implemented. During this time, the CMS has consistently refused to address penalties prospectively since reporting has been known since 2007. Given their indication that they will penalize retrospectively, some have urged that they adopt a criminal standard before pursuing penalties. In other words, penalize only RREs that have knowingly and repeatedly disregarded the reporting regulation. Although the CMS understands the comments submitted, they must issue a Notice of Proposed Rulemaking (NGHP), take comments and finalize the rules before RRE will know what standard will be applied.

TIP: If settling a disputed claim, seek to include in the release that the claimant will reimburse the CMS for conditional payments within 60 days from the receipt of payment.

Federal False Claims Act

Insurers have in the past focused on state regulation and market conduct exams, but Medicare and MSP offer them an opportunity of what they need to be very aware. That is the False Claims Act. This federal law imposes liability on companies who defraud governmental programs. It is the Government's primary tool to combat fraud. The law includes a provision that allows people who are not affiliated with the government to file actions on behalf of the government. Persons filing under the Act stand to receive a portion of any recovered damages. Insurers failing to comply with all the requirements discussed above, are exposing themselves to such an action and the costs can be substantial not only in monetary terms, but to their market capitalization and reputation.

TIP: Are you affirmatively attempting to adhere to the MSP statute and are you sharing that with your employees?

Conclusion

Care Bridge International has spent considerable time and effort researching and discussing these issues over the course of several years. The company offers specialized technology, deep knowledge and resources designed to ensure an enterprise risk management approach to Medicare Secondary Payer compliance, that offers risk protection and costs savings for all parties to a settlement.

For More Information visit our Resources page at https://www.carebridgeinc.com/resources

Or Call Us Toll-Free at 888-434-9326 with your questions or to schedule a FREE Webinar Training