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The 5 Pillars of a Successful Medicare Secondary Payer Compliance Program

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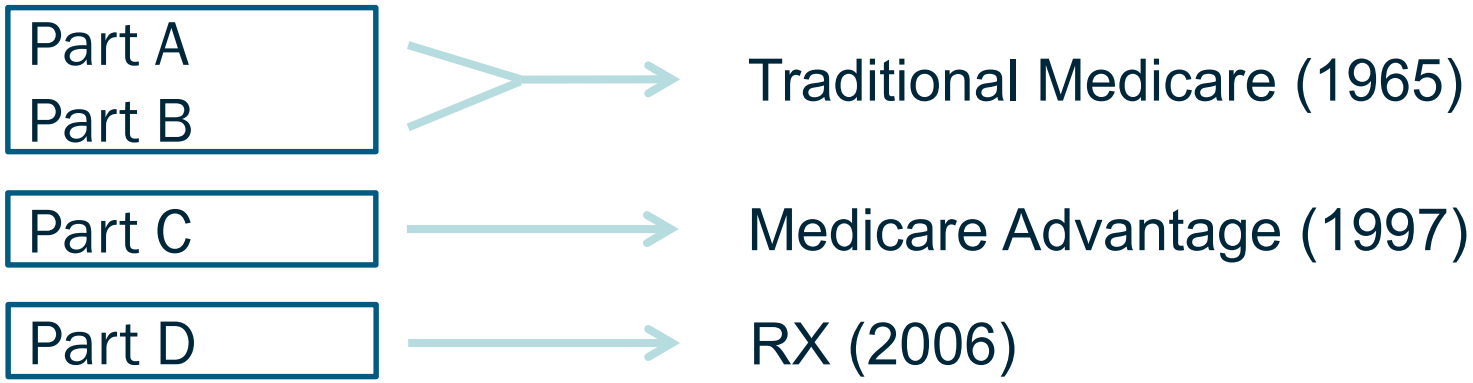
TODAY'S FOCUS…

- MSP compliance – in the bigger picture
- MSP and claims practice – issues and impact
- Building MSP protocols – considerations and approaches
- How can we improve our practices?

STARTING POINT - THE BIG PICTURE

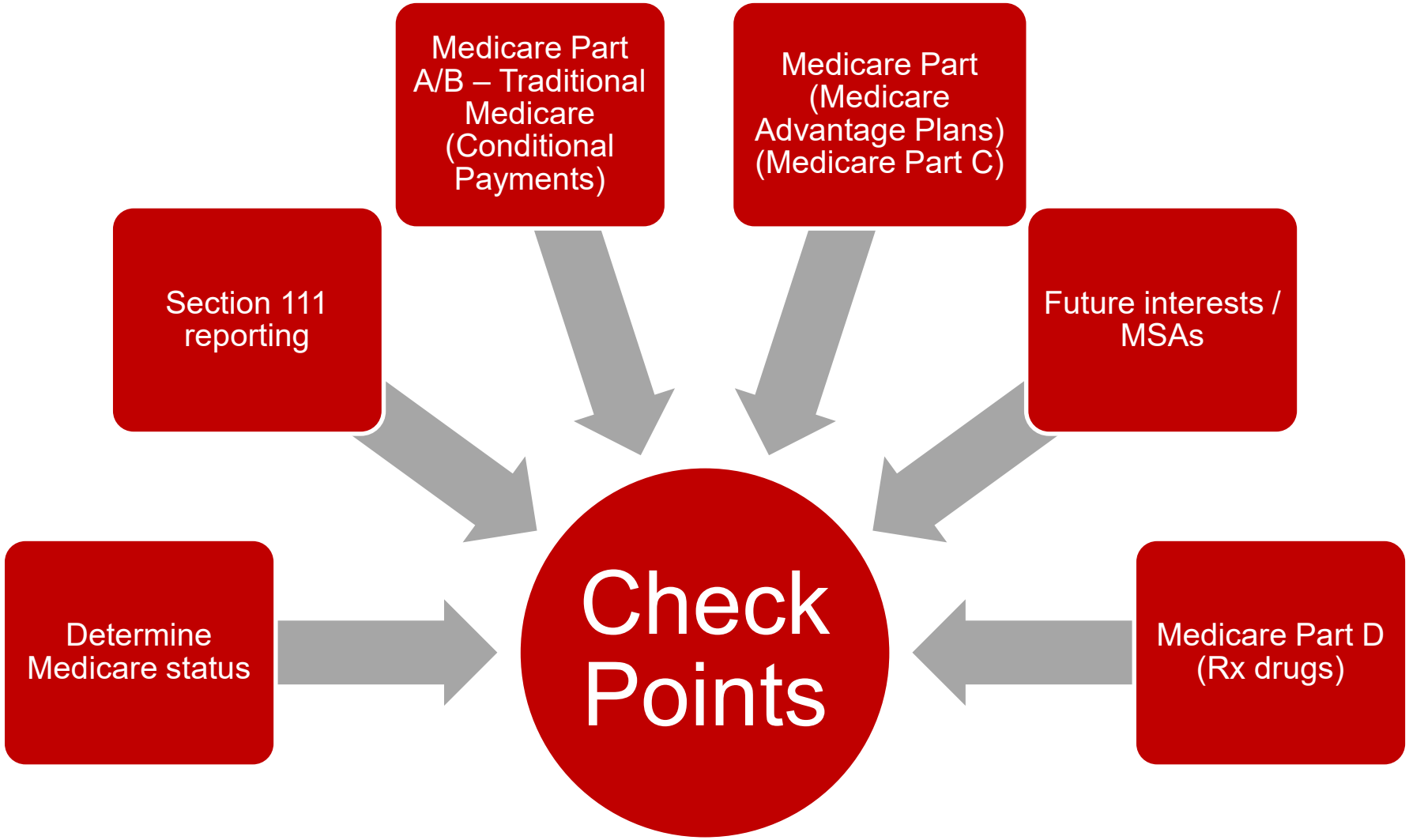
MEDICARE LEVEL SET

- **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:**



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

COMPLIANCE BASICS



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

PILLAR #1:
SECTION 111 REPORTING

SECTION 111 REPORTING

- **What is Section 111 reporting?**
  - Mandatory electronic reporting requirement for NGHP's.
  - Requires all risk-bearing entities to report specific claims data to CMS for cases **(i)** which involve a Medicare beneficiary and (ii) which meet a CMS "reporting trigger
  - If the claim (or settlement) involves a Medicare beneficiary and a reporting trigger is hit, the reporting necessary.
  - You are RRE + Claimant is/was Medicare Eligible + Trigger Met = REPORT

Effective 5/1/2009; Non-Group Health Plans (NGHP's) are obligated to notify Medicare about "settlements, judgments, awards, or other payment from liability insurers (including self-insurers), no-fault insurers, and workers' compensation" received by, or on behalf of, Medicare beneficiaries.

SECTION 111

- QUARTERLY REPORTING
  - Report Quarterly to Medicare (CMS) within 135 days of when a qualifying event occurs on a file involving a Medicare Beneficiary
  - Qualifying Events:
    - ✓ When assume Ongoing Responsibility for Medicals (ORM)
    - ✓ When Ongoing Responsibility for Medicals ends (ORM Termination*)
    - ✓ When a Total Payment Obligation to Claimant (TPOC) has been made

- Over 140 data fields must be submitted timely
- Records with errors are not accepted
- Discretionary penalties for non-compliance
- All S111 data is not completely transparent to other MSP interests

***CMS narrowly defines the period of Ongoing Responsibility for Medicals (ORM) as lasting till:** Benefits are exhausted, statutory timeframe ends, when the carrier maintains a statement signed by the beneficiary's treating physician that no additional medical items and/or services associated with the claimed injuries will be required

SECTION 111

- MONTHLY QUERY

Medicare Requires that NGHP's continue to investigate any injured claimant's Medicare status until their ongoing responsibility or total payment obligation ends

  - Once per month Medicare allows query of their data base
  - Determines who is, was, or will soon become Medicare Eligible
  - If Query is inaccurate or incomplete, required Quarterly Reporting could be missed, which creates risk of penalties or fines
  - Query Match is determined from full SSN and DOB, Gender, First Name, Last Name
    - Last 5 of SSN may be used but tougher to match
  - Information provided in Query Match is limited

Accuracy of data is key

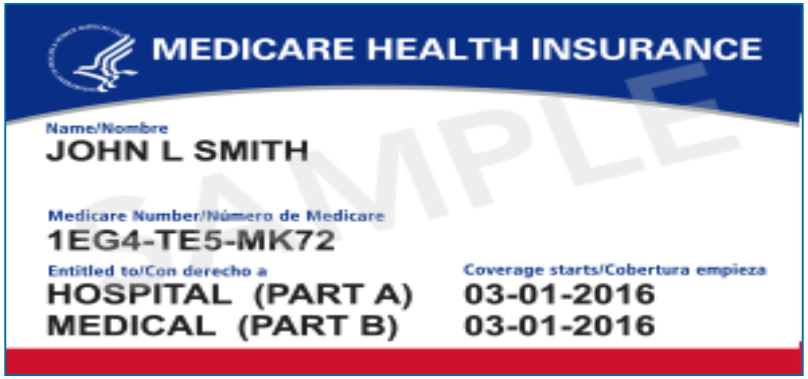
SECTION 111 CHECK-LIST

- **Understand the intent** of Mandatory Insurer Reporting
- **Follow the User Guide**
- **Understand when S111 reporting is required** – qualifying events
- **Utilize Medicare's Model Language** and protocols if claimant does not cooperate in providing data
- **Maintain strong data integrity**
- **Institute controls** to assure all injury claimants are properly identified, and those that are Medicare eligible are properly reported.
- **Apply Medicare's definitions** (i.e. period of time you have Ongoing Responsibility for Medicals)

PILLAR #2:
CONDITIONAL PAYMENTS (TRADITIONAL MEDICARE)

MEDICARE PARTS A & B – CONDITIONAL PAYMENTS

For this Section…	Key questions to ask …
• Assume the claimant is on Medicare and enrolled in **"Traditional Medicare"** (a/k/a – "Government Medicare") • Medicare Parts A and B	– What type of rights does the Government (CMS) have? – What can happen if we do not take care of conditional payments?



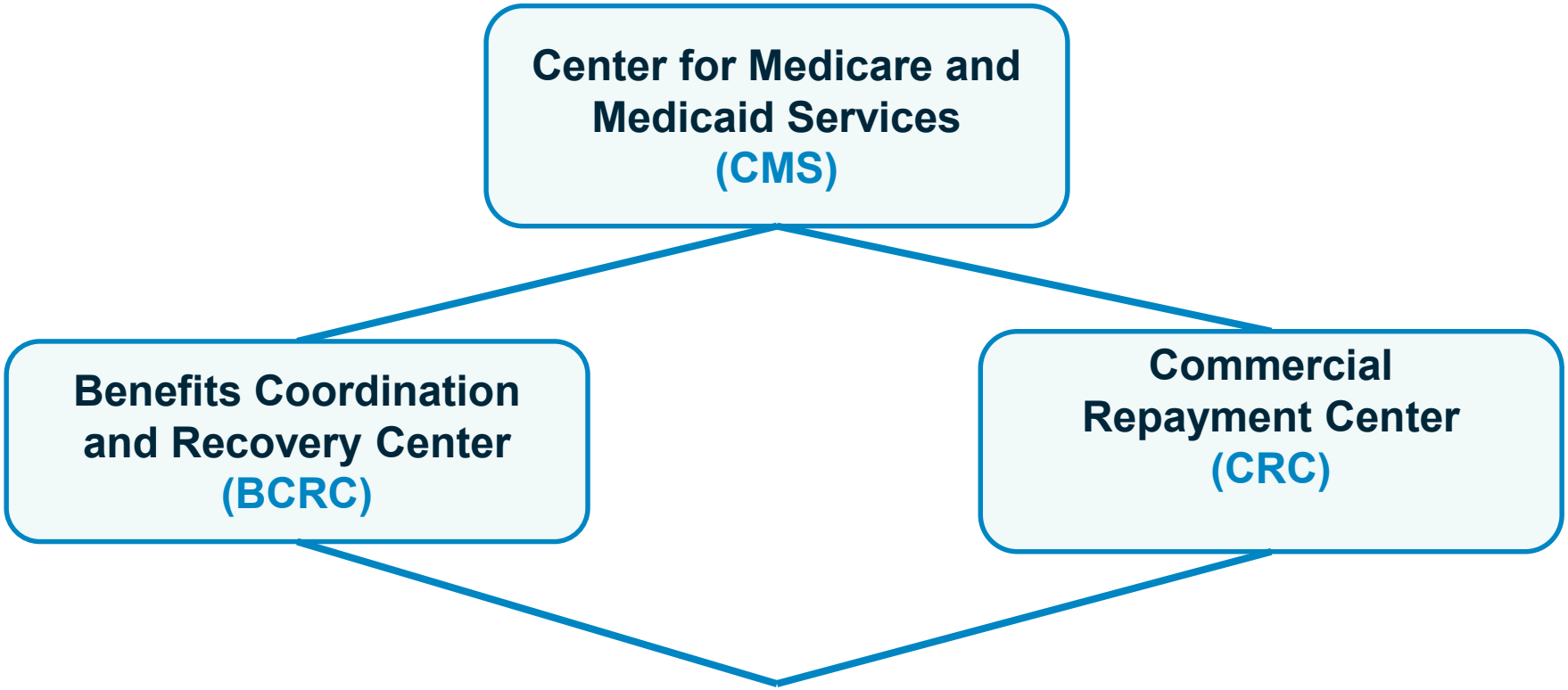
MEDICARE'S RECOVERY RIGHTS – PARTS A & B

Medicare has strong and broad recovery rights	Liability/Risk

• Can pursue party who "makes" **and/or** "receives" primary payment	• 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	

MEDICARE PARTS A & B: WHO'S WHO?



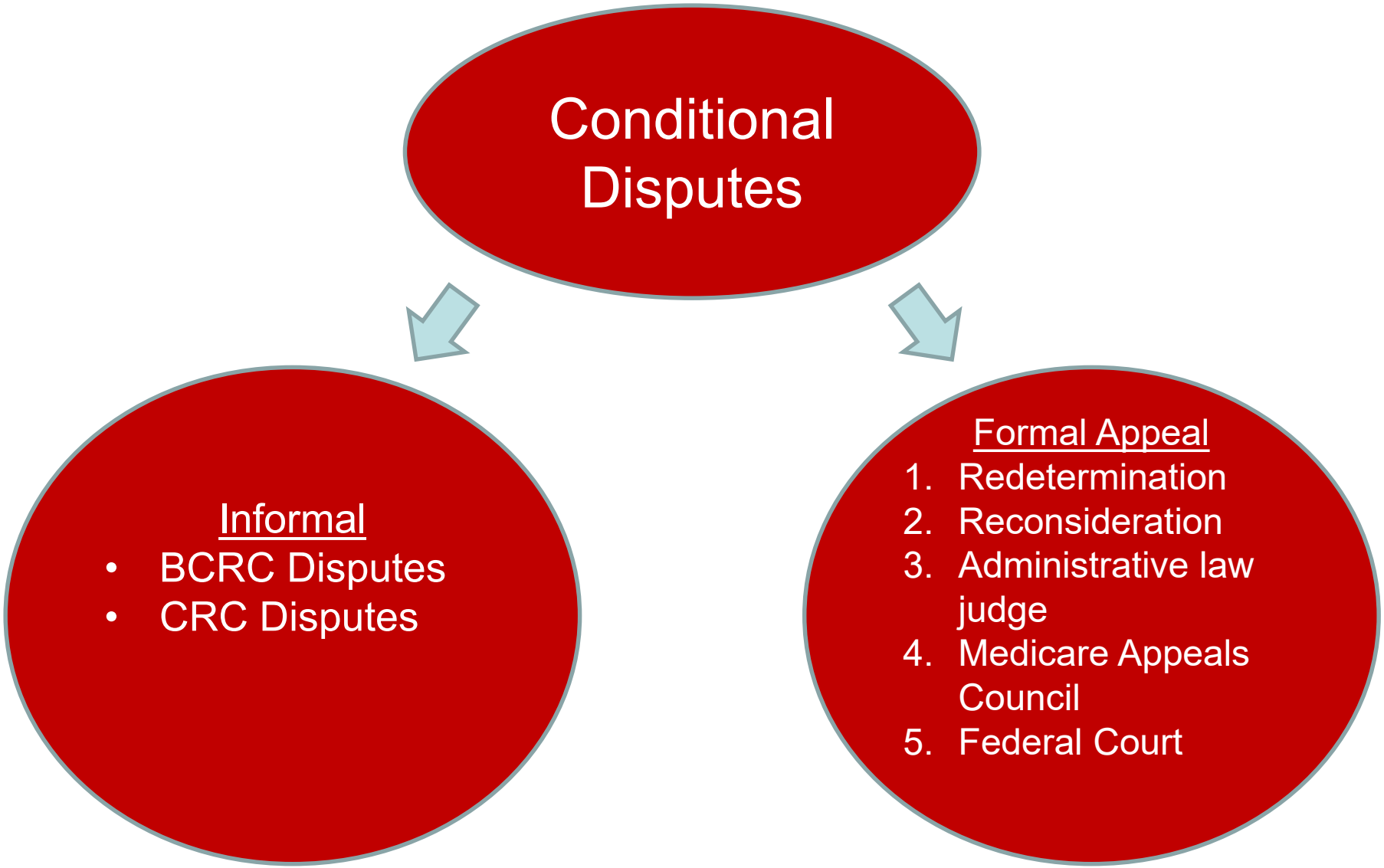
These are the contractors that help CMS with its conditional payment recovery activities.

CMS RECOVERY PROCESS – CURRENT STATE (PARTS A & B)

- 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

DISPUTING CONDITIONAL PAYMENT CLAIMS



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

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

PROTOCOL CONSIDERATIONS

1. Be proactive – address conditional issues early!
2. If you have ORM, pay primary and promptly. Pay directly to the medical providers whenever possible.
3. Recognize when constructive lien notice exists
4. Be alert for Medicare Advantage plan involvement
5. Carefully analyze and dispute (if applicable) conditional payment claims
6. Work together and utilize Medicare's tools (portal, CTR)
7. Settlement language
8. File Documentation

PILLAR #3:
MEDICARE ADVANTAGE PLANS (MAPS)

MEDICARE ADVANTAGE PLANS: RECOVERY CLAIMS

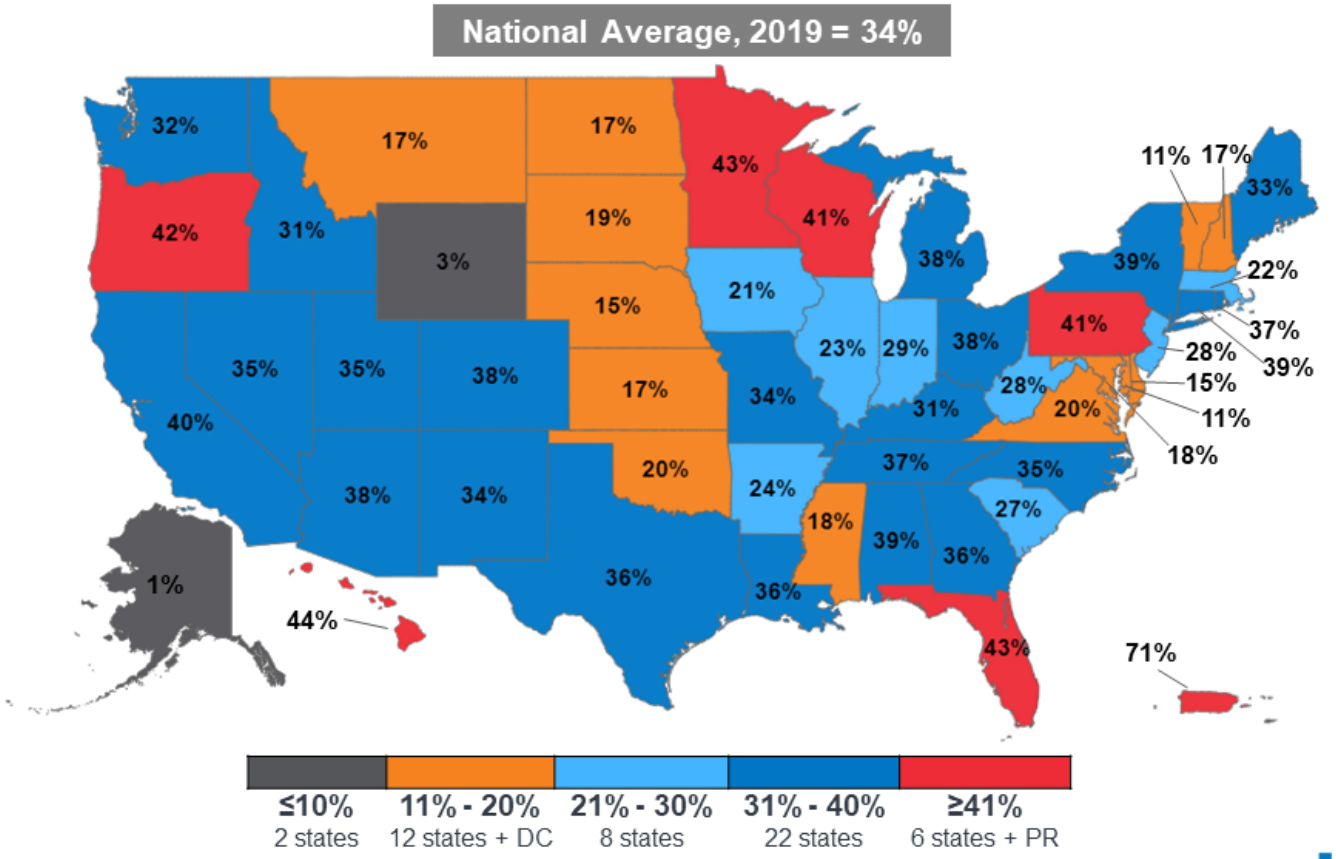
What are Medicare Advantage Plans (MAPs)?

- These are Medicare plans provided by *private insurers.*
  - ➢ Over 1,200 different MAP plans nationally
- 22 million people are enrolled in a MAP
- Who are the main MAP providers?
- Which states have the highest (and lowest MAP) enrollment rates?
  - ➢ Let's take a look ….

MAP ENROLLMENT BY STATE

Figure 2

Medicare Advantage Penetration, by State, 2019



NOTE: Includes cost plans, 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, 2019.

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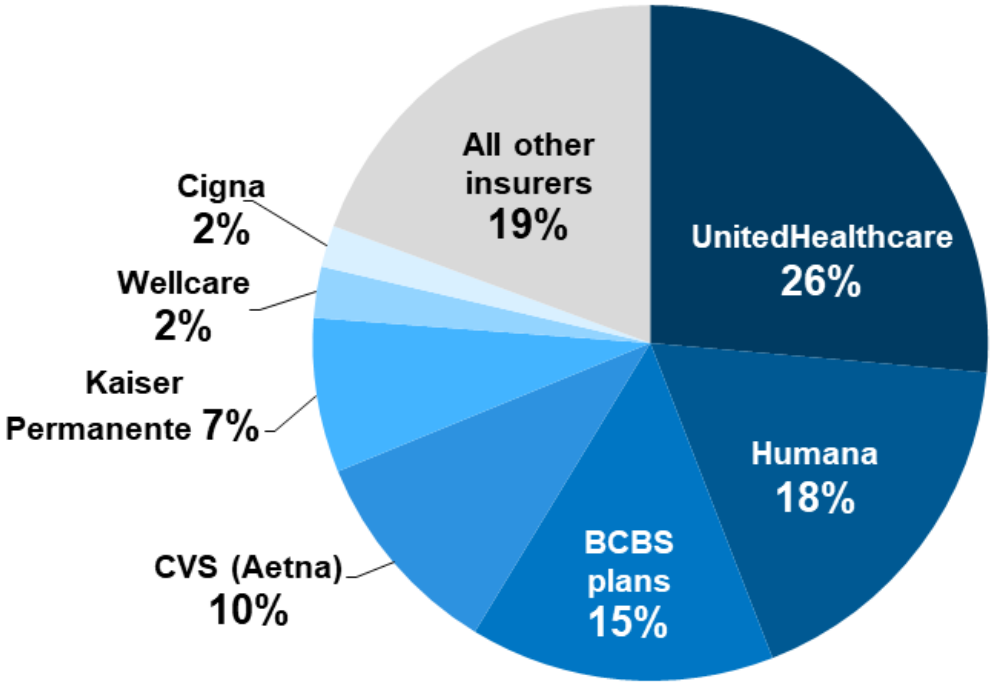
WHO ARE THE MAIN MAP PROVIDERS?

Figure 4

Medicare Advantage Enrollment by Firm or Affiliate, 2019



Total Medicare Advantage Enrollment, 2019 = 22 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans is less than 2% of total enrollment.
Percentages may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2019.

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MSP VS MAP RECOVERY PROCESS – COMPARE & CONTRAST

Traditional MSP	Medicare Advantage
• Consolidated CMS contractors (CRC & BCRC) • Process & Notice ▪ Correspondence: CPL, CPN, Demand, ITR, Treasury • Sec. 111 query process and reporting • Enforcement: Direct right of recovery, Treasury, action	• Individual plans and through third-parties • No specified process • No consolidated contractor or entity • Enforcement through direct recovery attempts and/or lawsuits

MAP RECOVERY

1

- Do MAPs have recovery rights under the MAP statutes and regulations?
- Answer: Yes (Nature and extent?)

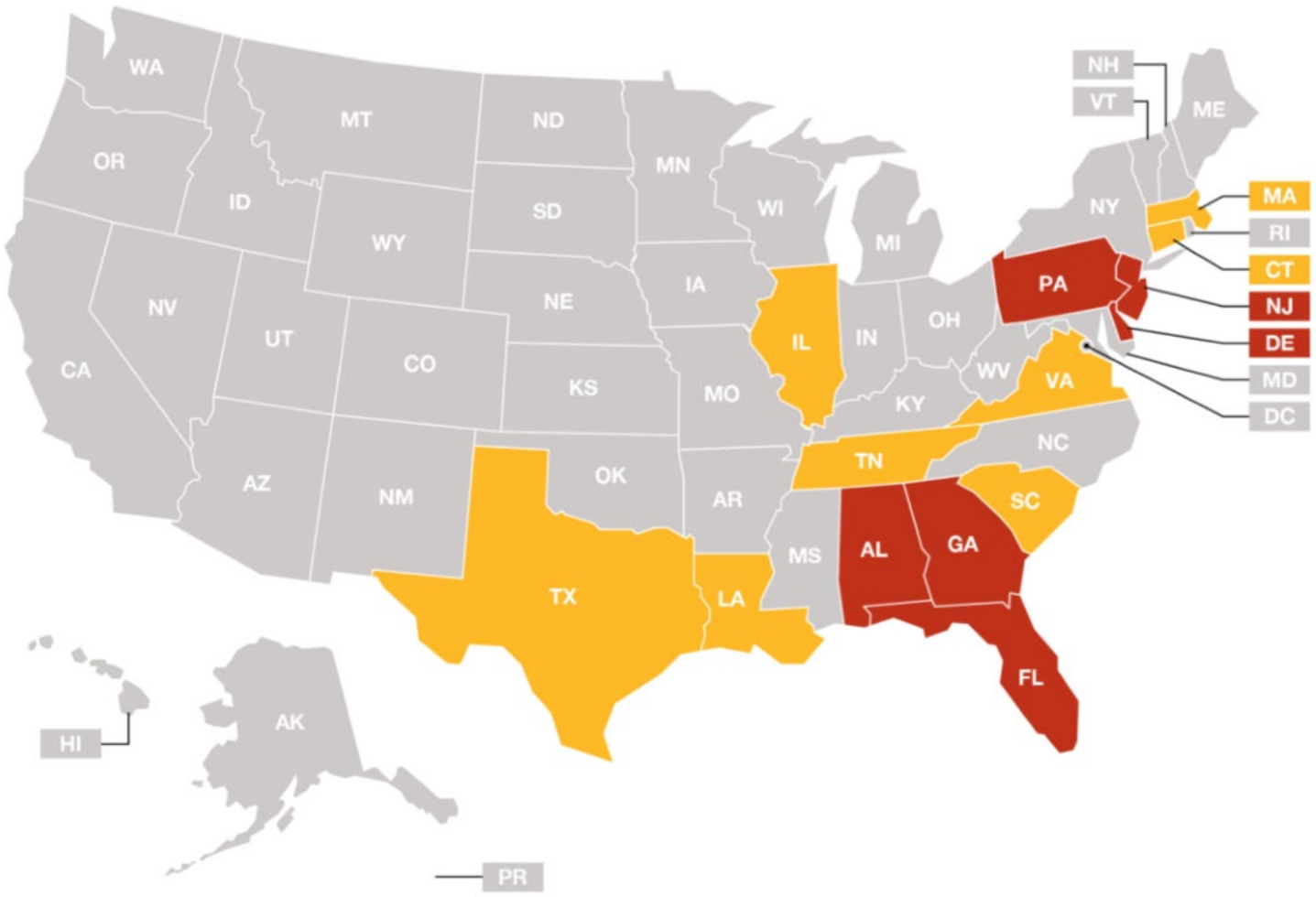
2

- Do MAPs have "private cause of action – double damages" rights under the MAP statutes and regulations?
- Answer: Courts have said "no" … But …

3

- (And the big one) Do MAPs have "private cause of action – double damages" rights under the MSP?
- Answer: Depends on the jurisdiction - - growing number of jurisdictions are saying "Yes"

MAPS “DOUBLE DAMAGES” CURRENT STATUS



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

MAPS – PROTOCOL CONSIDERATIONS

1. Keep an eye out for any new court decisions.

2. Best practice considerations
    - Identifying potential MAP lien issues

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

4. 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)

5. Identifying, disputing and resolving MAP lien issues.

6. Settlement language

PILLAR #4:
MSAS & RELATED ISSUES

MEDICARE SET-ASIDES

WCMSA	LMSA

• Key Decisions points
  • CMS submission?
  • Non-submission alternatives
  • Cost mitigations
	• Current status?
	• Expecting CMS proposal
	• Here and now

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

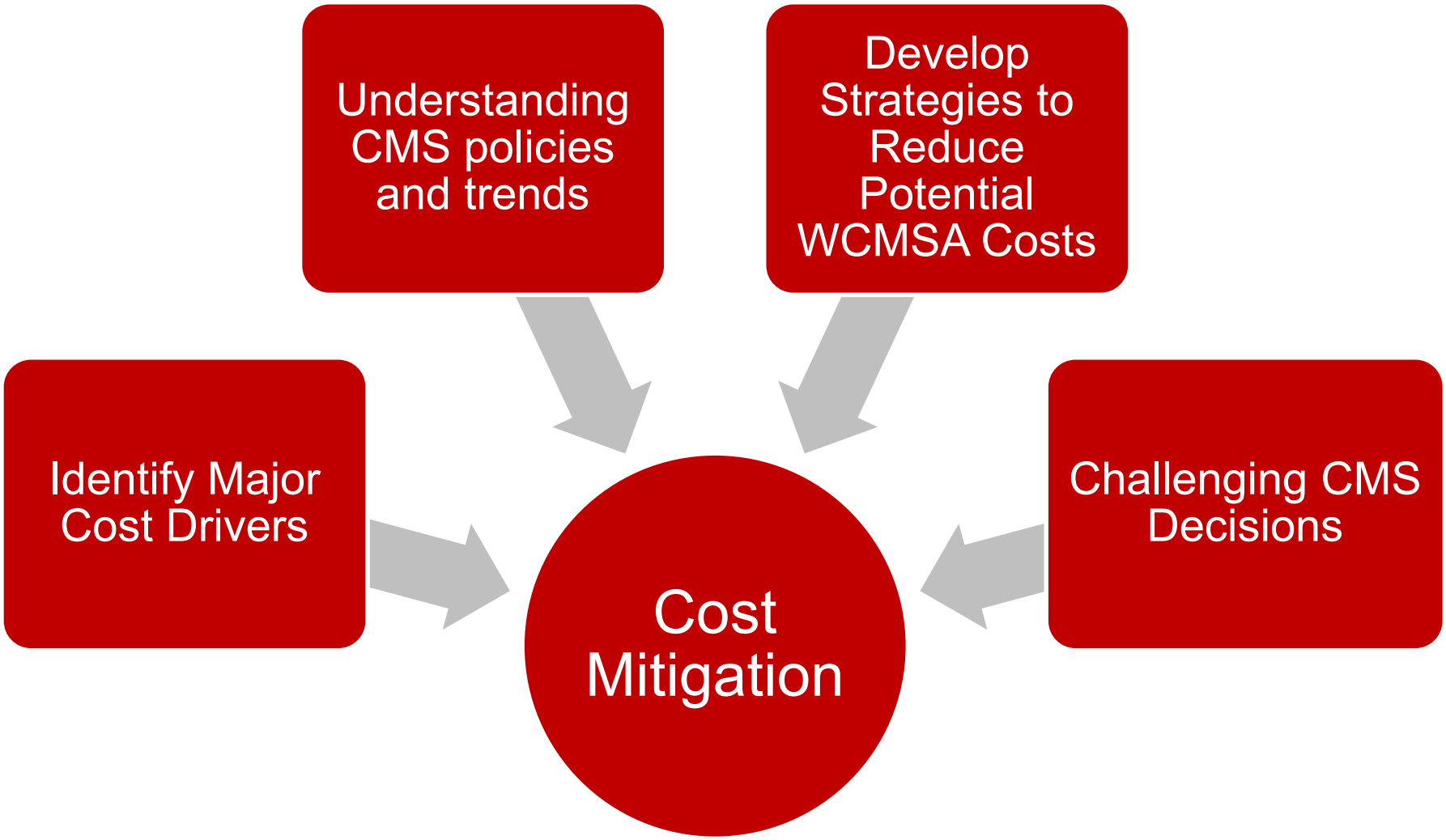
CMS' DEFINITION …

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 COST MITIGATION



WCMSA NON-SUBMISSION

Objectives

- Goals
- Risks/Benefit Analysis

Drawing Your Lines

- Go non-submit for all cases?
- Set specific criteria

Allocation Approaches

- CMS' Approach
- Evidence-Based Medicine
- Custom
- Other

LIABILITY MSAS?

LMSA CURRENT STATUS

What we know …	What we do not know …
• CMS apparently interested in "revisiting" MSAs for liability and other non-group health claims • OIRA notice Dec 2018 & Sept, 2019. CMS ready to issue proposals for liability claims. • Proposals expected October, 2019. • What will then happen?	• Exactly "what" CMS may be contemplating from a substantive, policy standpoint • Exactly "how" CMS plans to develop whatever planned expansion is contemplated • Exactly "when" any planned expansion will be implemented – "go live" date

PILLAR #5:
MEDICARE PART D

MEDICARE PART D

Part D

- Began 2006
- $43 million beneficiaries
- United Health and Humana account for 55% of Part D enrollees

Questions:

- Do Part D plans have recovery rights?
- Nature/extent of recovery rights

Recovery Considerations

- CMS policy Manual update (October 2018)
- Current Status

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

REMEMBER…
COMMUNICATION IS KEY

COMMUNICATION IS KEY

Front Line Claim Handlers

- Discuss Early & Often
- Pay Primary / Protect Liens
- Recognize actual or constructive lien notice
- Know who paid claimant's medical bills
- Use Medicare's Tools & build internal resources
- Strong data integrity

Defense Counsel

- Discuss Early & Often
- Pay Primary / Protect Liens
- Include Medicare considerations in discovery requests

Internal Cross Functional Partnerships

- Operations
- Process
- Legal
- Compliance
- Technology
- Quality
- Training

External Relationships

- Vendors
- CMS & Contractors
- Medicare Advantage Plans / Medicaid
- Trade Groups/ Peers

QUESTIONS

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