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CMS Re-Review of Medicare Set-Asides

The Centers for Medicare & Medicaid Services (CMS) has followed through on their previously announced intent to expand their Medicare Set-Aside (MSA) Re-Review process.

For those that need a refresher on CMS' MSA Re-Review process, where an MSA is submitted to CMS and the submitter disagrees with CMS' determination or believes an error has been made, generally there is no formal appeal process to have CMS re-consider the MSA. However, an administrative Re-Review process is available which involves review by the CMS Regional Office. If still unsatisfied with CMS' determination after a Re-Review, the submitter is without further due process or review at a higher level and CMS' determination is final.

Since CMS' MSA review process has been in place, the Re-Review process has been somewhat limited. For example, historically, where an MSA determination is issued, and the parties do not settle, and medical circumstances for the claimant have drastically changed, CMS would not re-review the MSA, even if doing so would result in an increased MSA, which would further protect Medicare's interests. Additionally, CMS would not review any documentation which post-dated the MSA determination. CMS clearly receives an abundance of MSAs for review each year and has workload limitations and therefore could not re-review all previously issued determinations. The changes that have now been implemented with an expanded Re-Review process have fixed this issue and are a welcome change to the workers' compensation industry!

What Changes Have Been Made to the Re-Review Process (Now Referred to as "Amended Review")?

CMS has provided their changes to the Re-Review process in their updated Workers' Compensation Medicare Set-Aside Portal User Guide, version 5.1. Section 12.4.3 provides the changes that have been made to the expanded Re-Review process. In summary, the changes to the Re-Review process are the following:

- The MSA must have been originally submitted between one and four years from the date the re-review is submitted;
- The re-review request cannot have had a previous request for an Amended Review; and
- Must result in a 10% or $10,000 change (whichever is greater) in CMS' previously approved amount.

A submitter may only submit an Amended Review once per case. The submitter must attach medical documentation which supports the MSA proposal resulting in a 10% or $10,000 change. Obviously, this is the one circumstance under which CMS will now review medical and/or legal documentation which post-dates CMS' original determination. The WCMSAP User Guide provides the following example:
An approved Medicare Set-Aside (MSA) is $80,000. Since $10,000 is greater than $8,000 (which is 10% of the approved MSA), then $10,000 will be used in calculation.
The New Proposed MSA Amount is $88,000. Since $8,000 ($88,000- $80,000) is at least a 10% change, this amount is eligible for an amended review.

What Has Stayed the Same with the Re-Review Process?

For recently submitted MSAs, the following options for Re-Review are still available and have not changed:

- You believe CMS' determination contains obvious mistakes (e.g., a mathematical error or failure to recognize Medical records already submitted showing a surgery, priced by CMS, that has already occurred).
- You believe you have additional evidence, not previously considered by CMS, which was dated prior to the submission date of the original proposal which warrants a change in CMS' determination.

This update to the Re-Review process by CMS is welcomed and we are happy to see that CMS will now consider medical and/or legal documentation which post-dates the CMS determination and medical circumstances have changed such that it will affect the MSA amount by at least 10% or $10,000. The only limiting factor is that the determination must have originally been submitted between 1 and 4 years prior. While it is understandable that at least a year should have passed for CMS to consider change in medical circumstances, not re-reviewing MSAs more than 4 years old will be limiting to some "old dog" cases which have not settled.

Liability Medicare Set Asides

On November 8th, CMS reissued a MedLearn article to clarify information. The revised MedLearn article now generally references Medicare Set-Asides (MSAs), however the article does not limit the discussion to WCMSAs, even though a formal review process only exists for WCMSAs. The MedLearn article goes on further to let providers know that Medicare is always secondary to liability, no-fault and workers' compensation insurance.

Further, on October 28, 2017 CMS issued another alert stating: *The Centers for Medicare and Medicaid Services (CMS) continues to consider expanding its voluntary Medicare Set-Aside Arrangements (MSA) review process to include liability insurance (including*

self-insurance) and no-fault insurance MSA amounts. CMS will work closely with the stakeholder community to identify how best to implement this potential expansion of voluntary MSA reviews.

The Centers for Medicare and Medicaid Services (CMS) is clearly continuing to take incremental steps toward a formal voluntary LMSA/NFMSA review process. The Workers' Compensation Review Contractor (WCRC) Request for Proposal (RFP) indicated that the WCRC may begin to review LMSAs and NFMSAs as early as July 1, 2018.

Medicare Advantage Plan ("MAP") Liens

The current background of Medicare Advantage and Part D Litigation

Medicare Advantage Plans (MAPs), also known as Medicare Part "C" are private insurance plans that provide for a Medicare beneficiary's Part "A" and "B" benefits. A Medicare beneficiary can choose to enroll in a MAP rather than traditional Medicare. Part D plans provide for a Medicare beneficiary's prescription drugs. It is important to note that traditional Medicare generally does not provide prescription coverage directly; a beneficiary must enroll in a Part D plan to receive Part D benefits.

MAPs have recovery rights for conditional payments under the Medicare Secondary Payer Act (MSP). While case law across the country is scattered on what degree of recovery rights MAPs have for conditional payments, at the very least, they have rights to recover the conditional payments they have made at least like any other medical lien, and in some jurisdictions, have the right to recover double damages for conditional payments that are not reimbursed. This article will explore the current state of confusion and ambiguity as to the recovery rights for conditional payments that MAPs plans have.

An exploration into the history of MAP recovery rights and case law is fundamental to understanding what brought us to this confusion today. On February 4, 2011, a wrongful death action involving a Medicare Advantage plan enrollee out of the U.S. District Court for the District of Arizona titled *Parra v. Pacificare of Arizona*[1] found that the MSP did not provide for a private cause of action for MAPs/Part D plans similar to that provided for Part A and B plans under 42 USC 1395y(b)(3)(A). Additionally, the *Parra* decision found no congressional intent to infer such a right. Due to express statutory and regulatory provisions regarding billing rights, the court found that the proper place for a MAP reimbursement claim lay in state court under traditional contract theories.

Subsequently, the U.S. District Court for the Eastern District of Pennsylvania ruled against Humana in its efforts to recover from GlaxoSmithKline in a case titled *In Re Avandia v. GSK*.[2] While Humana argued that the MSP, 42 USC § 1395y(b)(3)(A),

[1] *Parra v. PacifiCare of Ariz., Inc., 715 F.3d 1146 (9th Cir. Ariz. 2013).*
[2] *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig., 685 F.3d 353(3d Cir. Pa. 2012),* cert. denied, *133 S. Ct. 1800 (2013).*

unambiguously granted a private cause of action to MAPs, the court found that it did not. Rather, the court held that Humana only had a lien right under state law to recover such payments.

On December 5, 2011, in response to the *Parra* and *In Re Avandia* decisions, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum in support of MAPs/Part D plans having the right to collect for payment of services where Medicare is not the primary payer. Within the memorandum, CMS went so far as to state that MAPs/Part D plans can exercise the same rights of recovery that the Secretary exercises under the existing MSP regulations. While the CMS memo was very clear on CMS' position on MAP/Part D recovery rights, a memorandum issued by an administrative agency is not binding, and therefore the case law continued. However, arguably the CMS memo would carry weight through *Chevron deference.* Chevron Deference is a well-known two-part test established by the Supreme Court for determining when a federal court ought to defer to the interpretation of a statute by the federal agency charged with implementing that statute.

On July 12, 2012, in a surprising decision, the District Court decision from *In Re Avandia* was overturned by the Third Circuit Court of Appeals. The Third Circuit found that MAPs/Part D plans do in fact have the same rights to recovery as Medicare, and additionally that MAPs/Part D plans have a right to pursue a private cause of action for double damages under the MSP for conditional payments that are not reimbursed.

On April 15, 2013, The Supreme Court denied certiorari/review of the *In Re Avandia case;* therefore, the decision of the Third Circuit stood. Just four days later on April 19, 2013, the Ninth Circuit affirmed the initial decision in the *Parra* case which found that MAPs do not have the same rights to recovery as Medicare does and can recover conditional payments by way of their contract with the beneficiary.

The most recent and monumental decision on this issue was issued in September 2016 out of the Eleventh Circuit, titled *Humana Medical Plan, Inc. v. Western Heritage Insurance Company*[3] which found in favor of Humana being able to recover double damages for failure for Western Heritage to timely reimburse Humana within 60 days of the issuance of the settlement check.

Recently, Humana has also filed litigation against the Hartford, seeking to establish its rights to double damages recovery in the Ninth Circuit, which may overturn *Parra.* Further, Humana and other MAPs have been quite vocal that the plans intend to file litigation strategically nationwide so as to establish their rights. Further, there are several District court decisions in place that have found in favor of MAPs having this right.

[3] 11th Circuit Court of Appeals, Case No. 15-11436.

The resulting question is, where do we stand today? Currently, we have two circuits, the Eleventh and Third Circuit, which have found in favor of MAPs having the right to recover double damages against a primary payer that fails to reimburse conditional payments. The six states encompassed in these two Circuits are: New Jersey, Delaware, Pennsylvania, Alabama, Georgia and Florida.

1. How have these recent CMS developments affected claim handling? **(5 minutes)**
<u>What type of information are we seeing on these recovery letters?</u>

As of the end of 2017, CMS seeks recovery utilizing two contractors who operate independently. The types of letter these contractors issue varies dramatically. The Benefits Coordination Recovery Center (BCRC) issues letters seeking recovery for past conditional payments in the form of a demand letter. This letter provides the dates of services, diagnosis codes, as well as provider and associated costs. On the other hand, the Commercial Repayment Center (CRC) will issue Conditional Payment Notices (CPN). A CPN can be issued throughout the life of a claim when the Responsible Reporting Entity (RRE) has reported an Ongoing Responsibility for Medical (ORM) coverage. A CPN, while similar to a demand, will issue a time sensitive Notice allowing parties to respond within 30 days before the demand issues.

2. A) Considerations when settling a Workers' Comp claim? **(5 minutes)**
<u>CRC Recovery actions vs. BCRC Recovery actions</u>

An interesting process has evolved between the two contractors, at times the workers' compensation claim can be caught in the middle. The CRC will provide conditional payment information while ORM has been reported. Once a settlement takes place, the Total Payment Obligation (TPOC) is reported electronically along with the associated diagnosis codes. The recovery efforts then change from the CRC to the BCRC for recovery against the settlement. The interesting disconnect results when the CRC has proceeded with recovery actions on has resolved these exposures, then the BCRC opens a new file and can unwind what the CRC has done and seek additional recovery. Data integrity is crucial to ensure the same diagnosis codes were used by both contractors. Both recovery files will need to be resolved in this situation.

3. c) Language in the release and settlement documents?

Medicare does not require release language to be utilized. The goal of the settlement language would be to facilitate a meeting of the minds as to how the Medicare issues will be resolved. The responsibility to consider Medicare's interests falls on both parties. Utilizing settlement language provides a clear picture of what the parties intend to do following the settlement.

3. D) Submit vs. Non Submit of MSAs for review

For years, the industry has struggled with submitting WCMSAs as the review process within CMS is not consistent with evidence based medicine or the reserve practice utilized by the industry. The resulting headache has been seen in the development

letters issued by CMS, as well as the counter higher responses. The agency seems to disregard the various national guidelines when calculating a WCMSA. The question was made clear during the town hall calls as the Mandatory Insurer Reporting was rolled out, wherein CMS clearly stated on multiple occasions that the review process is an optional process. Why submit then? The reality is the goal of submission is to preserve the amount of non-Medicare future medical care as compared to the total settlement. What then are the alternatives? The conversation of professional administration then becomes a viable solution to the bridge the gap between submission vs. non-submission.

How have these recent CMS developments affected claim handling? The Carrier's perspective.

How are carriers handling the conditional liens? Negotiate vs. Paying

Any conditional lien letter should be handled immediately upon receipt by the adjuster. One of the first actions a carrier should take is to carefully review the lien letter for accuracy including claimant information, date of birth and date of loss. A carrier needs to ensure that they are responsible for the claim and identify any collateral issues such as apportionment or Second Injury Fund issues. A carrier should also review the amount of the conditional lien and review what is the accepted Industrial Injury. A carrier will also want to review the diagnosis codes listed in the page entitled "Statement of Reimbursement" of the conditional lien letter. The carrier should compare what treatment to which body part is being billed by Medicare versus what is the accepted injury. If the two do not match up, it is recommended that the carrier forward the conditional lien letter to their Medicare vendor for review. It should be noted that the carrier has 60 days to pay the lien or 120 days to dispute the lien letter.

Data capture of the ICD and CPT codes is important – inside view as to the claimant's complete medical history.

All is not lost when a conditional lien letter is received. The diagnosis codes listed on the conditional lien letter provide valuable information as to other medical conditions and comorbidities the claimant may have in addition to the industrial injury. Consider this a 3000 foot view into the claimant's Medicare file. This information could be used for Independent Medical Examinations, to gauge the relatedness of treatment, settlement negotiations and at times, for reserve purposes. The diagnosis codes should be tracked and memorialized in the file.

4. Cost Mitigation Strategies

A. The Tools

A. State Medical Treatment Guidelines

There are several states which have their own individual medical treatment guidelines and prescription formularies applicable to workers compensation. For example, the NY Non Acute Pain Guidelines and the Texas ODG closed formulary. It is important to ensure that the claimant's medical treatment is compliant with these rules and regulations.

i. Auditing the MSA

It is important to review each line item of the Medicare Set Aside to ensure the appropriate allocations are included. The adjuster should review each line item as ask themselves: does this medical treatment make sense? Is accurate? Does it reflect the current treatment as we sit here today? If any of the line item allocation are not accurate or reflective of the current treatment, the adjuster should contact the MSA vendor to discuss.

Examples of treatment frequently included in MSA allocations that should be discussed between the adjuster and MSA vendor are:

- Spinal Cord Stimulator included because it was mentioned at least once in the medical record
- Surgery is included in the MSA but the claimant has repeatedly elected against going under the knife
- The prescription regimines which are not compliant with state guidelines medical treatment guidelines
- Brand name medication being allocated for in the MSA when there is a generic equivalent available or even an over the counter equivalent available

- Is the medication appropriately being prescribed on an as needed basis (PRN), or is it being prescribed on a daily basis. Examples of medication frequently written on a PRN basis are Viagra and Ambien

- Pharmacological alternative combinations available?
  Example: Percocet is a combination of Oxycodone and Acetaminophen (Tylenol). You could see if the doctor is willing to prescribe those two medications separately to reduce the costs of the MSA. On its own, Acetaminophen is a Non-Qualifier. Oxycodone is covered by Medicare, but at a substantially lower rate than Percocet. Percocet costs $3.37 per tablet whereas

Oxycodone 10mg costs $.62 per tablet. Making that switch in this case would drop the cost of MSA allocation by thousands.

5. Settlement Tools and Techniques

A. Annuitize the MSA

A prudent approach to settlements of significant size is to begin with the premise that the offer will be structured. Because a structure can be funded with less money now than the overall future lifetime payments, they can be useful in reaching the dollar value demanded while staying within authority level.

The rationale for the claimant is the security and reliability of the routine payments. From the defense side, structures can allow the payer to potentially save funds and they provide some protection against claimants irresponsibly exhausting their settlement funds. With MSA's, structures allow the claimant to potentially save more of their MSA funds over time, especially in the event they have a catastrophic year in which they otherwise would have spent their entire lump sum.

Other advantages of a using a structure to fund the MSA include the following:

- Provides the injured individual with an opportunity to turn proceeds into lifetime security According to studies and surveys, most claimants exhaust benefits meant to last a lifetime and often cannot pay for necessary future costs like medical expenses. Structures offer flexible guaranteed future payouts uniquely tailored to the injured individual's needs.
- Structures afford protection from premature dissipation, loss of needs based entitlements, misuse, bad investments, market volatility, recessions, and product risk.
- Structures provide a continual stream of income, regardless of stock market conditions, interest rates and bond performance.
- can bridge the negotiation gap and push past issues that stall settlements
- Structures protect funds from needs-based entitlement programs. Since the payments are not assets, Medicaid, AFDC, and SSI will likely be unaffected. They also provide freedom from probate as well as creditors, including those arising from divorce or bankruptcy.

B. Submission v. Non-submission of the MSA

At the outset, it should be noted that the CMS review process is voluntary. There is no statute which requires the MSA to be submitted to CMS for review.

If it is decided that there will be no submission, then one should consider taking an Evidence Based Medicine approach towards crafting the MSA in conjunction with having the MSA professionally administered.

It should also be remembered that Non-qualified amounts can always be negotiated since these specific items are not included in the MSA. For example, medications such as Lyrica and Lidoderm are typically not included in the MSA and are considered non-qualified expenditures. Therefore they will not be subject to CMS review. These non-qualified expenses can and should be negotiated depending on the label use of the drug, the applicable evidenced based or state guidelines, the claimant's age, comorbidities and impaired life expectancy.

When approaching settlement, especially on legacy claims, it is important that one think outside the box in an effort to resolve the claim.

B. Settlement Initiatives – schedule meeting with the injured and/or their attorney. Make sure you have your settlement partners with you including the MSA, structure and professional administration vendors. Schedule the meeting near a location convenient for injured worker such as local workers compensation board or the attorney office
C. Settlement Offer Letters - send the injured worker an outright offer including the amount of the MSA and the structure terms. This shouldn't be the best and final offer, but it should be enough to get the injured worker thinking about settlement.
D. Mass mediation when available – consider hiring a mediator to give their objective point of view of the case. Instead of doing a traditional mediation, schedule three or four meetings with claimant's counsel in one day. This maximizes the mediator's time and cut the waste out of the process. It also gives the injured worker an independent perspective as to the value of the case.

Professional Administration of MSA's or Self-Administration, Reversionary clause

Once a workers' compensation settlement involving a Medicare beneficiary takes place, the settlement funds are distributed. There are then two basic options to administer the Medicare Set Aside account. The most common, yet complicated option is for the beneficiary to administer their own account. The funds are to be placed in an account separate and apart from their personal banking, in an interest-bearing account. The beneficiary is then to make payment to the medical providers for care that is Medicare reimbursable. If the WCMSA is priced and approved at a state wc fee Schedule the beneficiary should pay for services and goods at the same price schedule as the allocation report. The beneficiary will also need to file an annual accounting with CMS explaining the payments made from the account and the respective balance. Professional administration takes this burden away from the beneficiary and sets forth a program wherein a claims professional administers the fund, similar to establishing a medical only claim. The employer can close their file as all funds have been disbursed

and the professional administration company takes over post settlement administration.

Another frequently overlooked aspect of the WCMSA and settlement is the determination of how the funds will be disbursed when the beneficiary passes away. CMS has stated that absent disbursement instructions within the settlement agreement, the cash balance left in the WCMSA account shall be disbursed to the estate. However, the intent of the entire process is to provide a mechanism to pay for related Medicare reimbursable care, thus preventing the shift of financial responsibility to Medicare. There is no windfall requirement in the statute or regulations to mandate a disbursement of the remaining cash to the estate.

Thus, consideration should be taken when discussing the cash disbursement. Utilizing a reversionary clause outlines all or a portion of the remaining cash in the WCMSA Account be returned to the settlement funding source. This settlement tool creates accountability for the beneficiary as well as capturing potential unused funds following the death of the beneficiary. This settlement tool sets the stage for negotiation wherein the employer could seek a full return of the cash at the time of death, moving to a percentage split during negotiations. This will increase the asset value to the beneficiary without increasing the cost of the settlement. Reversionary clauses are most commonly utilized in partnership with Professional Administration.

Professional Administration is becoming increasingly popular as it has become much more affordable and is also now "highly recommended" by Medicare per Section 17 of the latest WCMSA Reference Guide. Providing an administrator as part of the settlement offer can greatly increase the chances of settling the claim. Administrators can help the claimant

1. **Save money** on their ongoing medical expenses, thereby making every settlement dollar for medical expenses last longer
2. **Handle bills.** The administrator takes on the burden of collecting and verifying every bill
3. **Report their MSA to Medicare.** The administrator ensures that the claimant's Medicare benefits are protected. This also provides protection for the plaintiff attorney that their client will use the funds properly and it provides protection for the payer that they took Medicare's interests into consideration.

There are new services for self-administration that provide automated assistance to claimants while they keep the funds in their own bank as well. These services are typically even more affordable and still provide comfort to the claimants that settling their medical funds is an attractive option.

Some payers are using professional administration to request "reversionary" language on their medical settlements. This allows the administrator to pass back what is left in the medical

account at the time of death of the claimant to the payer. This may help some payers get comfortable settling cases where they are uncertain about the life expectancy of the claimant or their use of the medical funds. It can also sometimes make settlement more challenging.

Medicaid / Public Benefits Considerations

Addressing any concerns about the claimant's public benefits after settlement is be a critical component of settlement strategy. Often times, plaintiff attorneys and their clients are afraid that the settlement will trigger the loss of Medicaid, public housing, food stamps, etc. Working with a group that expertise in these fields and presenting a comprehensive approach to maintaining these benefits results in much higher success. Often times, a Special Needs Trust can ensure the claimant's benefits remain intact and that they can still settle the case.