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Medicare Secondary Payer Issues in Your Mediation:
Don't Let MSP Issues Prevent You from Settling

I. Every Case Must Address 3 Core Components of Medicare Law (Intro)

The Medicare Secondary Payer Act (MSP) became law in December 1980. Its purpose was made clear from the outset: Medicare is a secondary payer whenever there is a primary payer responsible for medical payments associated with an auto, liability, no-fault, or workers compensation claim. Since then the Act has been amended several times, adding better reporting, more consistent recovery, and future consideration, all with the purpose of keeping Medicare a secondary payer pre and post settlement. As a result, today all parties involved with a Medicare beneficiary must protect Medicare's interests in any auto, liability, no-fault, and work comp claim. This includes a formal Mandatory Insurer Reporting (MIR) program, an intricate Conditional Payment Resolution (CPR) system, and a complicated and expensive Medicare Set Aside Allocation (MSA) process. Our panel will discuss these three core components of Medicare law as litigants prepare to mediate and hopefully resolve their cases.

II. Is the Claimant a Medicare Beneficiary? (10 minutes)

Perhaps the most important component of Medicare Secondary Payer compliance is figuring out if the claimant is a Medicare beneficiary. In order to make certain of this, the Centers for Medicare and Medicaid Services (CMS) has put together a formal MIR program. The program provides payers, also known as Responsible Reporting Entities (RRE) to submit 5 key data points (Last Name, First Name, DOB, SSN/MIN, Gender) through a Query process. Upon receipt of these key data points, CMS will formally communicate to the RRE if the claimant has been identified as a current Medicare beneficiary.

If the claimant is identified as a current Medicare beneficiary, there are further reporting requirements which include over 100 data elements reported to CMS via the Mandatory Insurer Reporting quarterly cycle. If the claimant is not identified as a current Medicare beneficiary through the Query process, the RRE should continue to Query such files on a monthly basis so as to continuously and consistently know whether any of its claimants become Medicare beneficiaries, which would require further reporting.

If the claimant is identified as a Medicare beneficiary, one of the early reporting requirements is to determine whether the RRE has accepted Ongoing Responsibility for Medical (ORM). Mostly found in no-fault and work comp claims, the MIR program requires reporting the date of ORM acceptance, specific International Classification of Disease (ICD-9 or ICD-10) codes accepted as related to the claim, and if ORM has been terminated, the date of such ORM termination.

If the claimant has been identified as a Medicare beneficiary, one of the late reporting requirements is to determine whether Total Payment Obligation to Claimant (TPOC) taken place. In other words, the MIR program requires reporting of settlements, judgments, awards, or other payments. If so, the MIR program requires the date and amount of TPOC to be reported. If TPOC is reported, and ORM will also be terminated, MIR requires the date of ORM termination to also be reported. It is important to note that if a TPOC is reported, but ORM is not terminated, Medicare will continue to hold the RRE as the primary payer, which will have severe consequences in as far as responsibility for conditional payments is concerned.

III. Have Medicare Conditional Payments been resolved? (10 minutes)

Perhaps more than any other area of Medicare Secondary Payer compliance, dealing with conditional payments has become the most time consuming and challenging component of mediation preparation. First, the parties must know if the claimant is a Part A and B (traditional Medicare) beneficiary. If so, the parties must also find out if the Commercial Repayment Center (CRC) has provided the payer with a Conditional Payment Notice (CPN) seeking reimbursement of conditional payments prior to settlement. Or has the Benefits Coordination Recovery Center (BCRC) provided Claimant/Counsel/Payer with a Conditional Payment Letter (CPL) asking for reimbursement of conditional payments post settlement? If either of these have taken place, then it is important to know if

either of the parties have disputed any of the payments requested by Medicare (CRC/BCRC). There are multiple levels of appeals, so it is also important to know the status of any Dispute, Request for Redetermination, Request for Reconsideration, Request for ALJ Hearing, or Request for Review by Appeals Council. If these disputes and appeals have been exhausted, in preparation for mediation, it is important to know if either of the parties have received a final demand or final determination.

Ultimately, the goal with regards to all conditional payments is to make sure Medicare has been reimbursed all payments related to the auto, liability, no-fault, or work comp claim so that Medicare is able to close its conditional payments file. To this end therefore, if disputes and appeals have been exhausted, in preparation for mediation the parties must know if either of the parties have received a final demand or final determination from CRC or BCRC and who is responsible for reimbursing Medicare its conditional payments within 60 days of final demand or final determination. If the opposing side is responsible for reimbursing Medicare, has opposing party provided you with proof of payment and closure letter from CRC/BCRC?

In 2019, 36% of all Medicare beneficiaries will receive their Medicare benefits from a Medicare Advantage Plan (MAP). As a result, it is no longer best practice to only inquire about conditional payments with traditional Medicare Parts A and B. Instead, in order to appropriately prepare for mediation, parties must also investigate whether Medicare Advantage conditional payments have been resolved. In order to do that, the parties must figure out if the claimant is a Part C (Medicare Advantage Plan) beneficiary. If so, has the MAP been contacted, have the parties received its request for reimbursement, have either of the parties disputed the MAP's request for reimbursement and received a final demand for reimbursement? If so, it is important to reach an agreement on who will be responsible for paying such conditional payments. If the opposing side is responsible for reimbursing the MAP, has opposing party provided you with proof of payment and closure letter from the MAP?

Of the 64% of Medicare beneficiaries who will receive their Medicare benefits from the federal government, over 90% obtain their medication through a private Prescription Drug Plan (PDP). Therefore, it is also important to know if such plans have made conditional payments related to the auto, liability, no-fault, or work comp claim, and whether such payments have been resolved. The first step in this sequential process is to determine if the claimant is a Part D (Prescription Drug Plan) beneficiary. If so, have either of the parties contacted the PDP, received its

request for reimbursement, disputed its request for reimbursement, received its final demand? If so, it is important to reach an agreement on who will be responsible for paying such conditional payments. If the opposing side is responsible for reimbursing the PDP, has opposing party provided you with proof of payment and closure letter from the PDP?

In some cases, in addition to Medicare, the claimant may also be eligible and receiving Medicaid. Therefore, the parties should investigate and figure out if the claimant is a Medicaid beneficiary. If so, it is important for the parties to know whether the State Medicaid Agency (SMA) has provided either of the parties with a Third Party Lien Notice asking for reimbursement of payments, whether either of the parties have disputed any of the payments requested by Medicaid, the status of such disputes and appeals, and if such disputes and appeals have been exhausted, whether either of the parties have received a final demand? If so, it is important to reach an agreement on who will be responsible for paying such conditional payments. If the opposing side is responsible for reimbursing the SMA, has opposing party provided you with proof of payment and closure letter from the SMA?

IV. Do I Need to Take Medicare's Future Interests into Account? (10 minutes)

Perhaps the most controversial aspect of the MSP Act is the determination on how to take Medicare's future interests into account when settling an auto, liability, no-fault, or work comp claim. Although the MSP Act itself is silent on how to do this, the CFR provides some leadership specifically pertaining to workers compensation claims, but very little guidance on auto, liability, and no-fault claims. CMS has published extensive guides and reference manuals on the workers compensation process, but nothing on auto, liability, and no-fault matters. Consequently, today there is an elaborate voluntary review process for workers compensation entities to appropriately take Medicare's interests into consideration when settling future medical care, but no process in place for auto, liability, and no-fault claims.

Based on the current work comp process, the parties must know if the claimant is a current Medicare beneficiary, or whether the claimant is not a current Medicare beneficiary, but anticipates becoming one with 30 months of settlement due to age, receipt of disability insurance benefits (DIB), or certain Medicare eligible diagnosis. If neither of these apply, it is important for the parties to have documentation that there is no expectation of Medicare eligibility within 30 months of settlement.

V. Do I Need a Medicare Set Aside? (10 minutes)

The MSP Act requires Medicare to remain a secondary payer pre and post settlement. To this end, Medicare expects parties to take its future interests into account when settling future medical care related to any auto, liability, no-fault, or work comp claim. Although no current guidelines exist for auto, liability, and no-fault situations, in workers compensation matters, CMS has established some procedures for parties to consider when taking Medicare's future interests into consideration. In such situations, CMS has indicated that if the claimant is a current Medicare beneficiary, the recognized and preferred methodology is to produce a Medicare Set Aside Allocation (MSA). Since the program remains voluntary, the first question for those attending the mediation is whether the parties have agreed to produce an MSA. If so, several factors play a role in the creation of that allocation amount, including life expectancy, treating physician(s) recommendations for future medical care and treatment, and the medical fee schedule used to project future costs, just to name a few. Ultimately, the MSA allocation provides a breakdown of future medical/prescription needs related to the auto, liability, no-fault, or work comp claim, that Medicare would cover or allow. There is a breakdown for medical care and another one for prescriptions, with then a total MSA allocation that should provide claimant with sufficient funds to pay for such related care throughout the remainder of his/her life expectancy.

If the claimant is not a current beneficiary but anticipates Medicare eligibility within 30 months of settlement, Medicare expects the parties to also protect Medicare's future interests when settling future medical care related to any auto, liability, no-fault, or work comp claim. Again, since the program remains voluntary, the first question for those attending the mediation is whether the parties have agreed to produce an MSA. If so, several factors play a role in the creation of that allocation amount, including life expectancy, treating physician(s) recommendations for future medical care and treatment, and the medical fee schedule used to project future costs, just to name a few. Ultimately, the MSA allocation provides a breakdown of future medical/prescription needs related to the auto, liability, no-fault, or work comp claim, that Medicare would cover or allow. There is a breakdown for medical care and another one for prescriptions, with then a total MSA allocation that should provide claimant with sufficient funds to pay for such related care throughout the remainder of his/her life expectancy.

If claimant is neither a current Medicare beneficiary or anticipated to become eligible within 30 months of settlement, then the parties need to make sure they have documented there is no expectation of Medicare entitlement within 30 months of settlement by confirming or verifying claimant has not applied for DIB, if applied and denied, has no pending appeal, has not been previously awarded DIB, and does not suffer from a diagnosis or impairment that would automatically qualify him/her for Medicare coverage.

VI. Will you be Submitting the MSA to CMS for Approval? (10 minutes)

Just like the creation of an MSA in any auto, liability, no-fault, or work comp settlement, submission of any such MSA to CMS for their review and approval is voluntary for both the claimant and the payer. Although by submitting their MSA to CMS, the parties may end up with a higher MSA amount than they submitted to CMS, the benefit of submission is that once approved and appropriately spent, Medicare will then become the primary payer of any medical care and treatment related to the auto, liability, no-fault, or work comp claim. In other words, if CMS has the opportunity to review, analyze, and ultimately approve the parties MSA allocation, CMS assures future coverage for the claimant and provides the payer the assurance of compliance, so that there is no future liability for the payer.

If the parties have agreed to submit the MSA to CMS for review and approval, who will be submitting MSA to CMS? Who will be responsible for communicating with CMS, including providing any further documentation that may be necessary? Once CMS has reviewed and approved the set aside allocation, if the amount approved is different than the proposed amount, is there an agreement on what happens next? Is the settlement agreement no longer valid, do the parties agree to re-mediate, or will one side or the other agree to fund the extra amount?

If the parties will not be submitting the MSA to CMS for approval, who will be responsible for any potential future inquiries, requests for information, requests for reimbursement, or denial of coverage by CMS? How will the parties document that they have appropriately considered Medicare's future interests? In other words, it is eminently important to make sure that there is detailed information and analysis, as well as written documentation that the parties did not shift future responsibility of claim related medical care to Medicare. Last, before leaving the mediation conference, the parties should reach an agreement as to who will inform Medicare about the date of settlement, amount of settlement, as well as MSA date and amount.

VII. Before you Sign the Mediation Settlement Agreement, Must Know Details (10 minutes)

By now the parties are tired. The mediation may have run several hours, sometimes multiple days. Everyone just wants to be done, go home, and take a break from the file. But before doing so, there are several matters that are extremely important, and that without attention, will create havoc some time down the line. Therefore, it is best to spend a few extra minutes thinking through the details- like how will such an allocation be funded, lump sum or annuitized? If annuitized, it is imperative that the settlement agreement provide specifics about the life insurance company which will be making periodic payments, the monthly or annual annuity payments, the overall worth of such payments over the agreed time period as well as costs to buy such payments, and of course the timing of such payments. Should claimant pass away before the term of the annuity are completed, what happens to such periodic payments, will they cease altogether, or will they continue to a beneficiary for a certain time period or for life? If so, the details of same should be included in the settlement agreement.

Another very important issue that should be decided at mediation is how the MSA will be administered. Will the claimant self-administer his own MSA account, or will there be a professional administrator attending the account? Either one is permitted by CMS, therefore, providing clarity is best so that there is no confusion as to who will become responsible for the day to day administration of such MSA funds.

If self-administered, there should be some details about the expectation of same from CMS' perspective. In other words, CMS expects claimant will be able to appropriately decide what medical care is related to the auto, liability, no-fault, or work comp claim, whether such care and treatment is covered by Medicare, and what the correct fee pursuant to the appropriate fee schedule should be for that service.

If the MSA is to be professionally administered, the settlement agreement should provide specifics about the administrator, his/her fees and who will pays such fees, and as previously mentioned, what would happen to any MSA funds left in the MSA account in case of claimant's unexpected or premature death.

Last, but certainly not least, the settlement agreement should also include details about who will provide accurate and detailed accounting to CMS on an annual basis. In other words, who will collect, process, and ultimately provide annual

accounting of all monies in/out of the MSA account to CMS on a timely basis? If the MSA was annuitized, and such periodic payments are appropriately depleted prior to the next payment having been received, who will provide early depletion accounting to CMS? If the MSA was paid in a lump sum, who will provide an annual accounting of same, and total exhaustion accounting of same to CMS?