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Medicare 360: A Comprehensive and Multi-Faceted Approach to Medicare Compliance in 2019

I. Workers' Compensation Medicare Set-Asides (WCMSAs) and Non-Submit Alternatives

What is the intended purpose behind a Workers' Compensation Medicare Set-Aside (WCMSA)? The WCMSA Reference Guide[1], Section 3.0 states: "A WCMSA allocates a portion of the WC settlement for all future work-injury-related medical expenses that are covered and otherwise reimbursable by Medicare. Essentially, the intent is to prevent future cost shifting to the Medicare Trust Fund.

CMS has set out two "review thresholds" in which it will review a WCMSA: Class 1- The claimant is currently Medicare eligible and the total settlement amount is $25,000 or greater; or Class 2- The claimant is reasonably expected to become Medicare eligible within 30 months and the total settlement amount is over $250,000.

While submission of an MSA to CMS where review thresholds are met is recommended by CMS, it is not required. CMS states that there "are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review" (see CMS memo dated May 11, 2011). However, according to 42 CFR 411.46(d)(2), if a specific amount of the settlement is designated for future medical services, CMS will only require that amount to be exhausted before providing coverage. In other words, CMS submission is not required, but designating a specific amount for future medical, which is reasonable and based upon the medical records, can also protect a beneficiary's Medicare benefits in that only the future medical amount will have to be exhausted before Medicare becomes a primary payer again. In other words, parties can also settle with a non-submitted WCMSA.

Why do parties submit MSAs to CMS for approval? Arguably, CMS' stamp of approval on a specific MSA amount should leave all questions answered, and the parties are able to settle with finality and no future recourse from Medicare regarding the set-aside. However, the unfortunate part of submitting an MSA to CMS is that there is no true due process in CMS' current re-review/reconsideration process. The parties are for the most part married to the amount CMS approves. The alternative is to have an MSA prepared and set-aside by the claimant which is based upon the medical records, medical and clinical principles, and adheres

[1] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2_8.pdf

to state workers' compensation laws and statutes. Arguably, such an MSA would be defendable and preserves the claimant's rights to administrative appeal should Medicare ever question the MSA amount.

II. Liability Medicare Set-Asides (LMSAs) and No-Fault Medicare Set-Asides (NFMSAs)

The Centers for Medicare and Medicaid Services (CMS) has been taking incremental steps recently to implement a review process for LMSAs and NFMSAs. Over the past year we saw a series of indications that CMS was looking to implement a review process. The Request for Proposal (RFP) for the Workers' Compensation Review Contractor (WCRC) stated that it would possibly require the new contractor to manage a voluntary review process for LMSAs and NFMSAs potentially as early as July 1, 2018. In addition, we saw CMS take steps with medical providers to coordinate benefits for LMSAs and NFMSAs through provider notices and adding fields to the Common Working File (CWF) as of October 1, 2017 which would notate an LMSA/NFMSA amounts.

Further, on September 19, 2017, CMS issued a MedLearn article to medical providers which stated that if a Medicare beneficiary alerts the provider that it has a WCMSA, LMSA or NFMSA, that the provider was to bill the MSA and not Medicare. However, the MedLearn Article was confusing at best in that it elaborated that no processes or requirements were currently in place for CMS to review an LMSA or NFMSA.

Unfortunately, the MedLearn article only seemed to cause confusion for primary payers and attorneys, and further there was serious concern that the guidance provided could cause benefits interruption for Medicare beneficiaries. However, on November 8th, CMS reissued this MedLearn article to clarify information. The revised MedLearn article now generally referenced Medicare Set-Asides (MSAs), however the article did not limit the discussion to WCMSAs, even though a formal review process only currently 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. Please continue to monitor this website for updates and announcements of town hall meetings in the near future."

Not long ago, in a decision titled *Silva v. Burwell,* 2017 U.S. Dist. LEXIS 195032 (U.S. District Court of New Mexico, November 28, 2017) parties to a medical malpractice decision grappled with the lack of clarity regarding whether the Plaintiff Medicare beneficiary needed to set aside money in an LMSA. The Defendants in the malpractice action had serious concern that if the Plaintiff did not set up an LMSA, that CMS would come after them for recovery in the future. Although the parties settled in 2015, due to the need to petition federal court for a declaratory judgment on whether an LMSA was needed, the issue did not resolve until 2017 (2 years later) when the

federal judge opined that there was no law or regulation requiring an LMSA. Interestingly, the court was quite vocal about CMS' repeated failure to clarify LMSA guidance was causing settlement delays.

It is anticipated that CMS will introduce a voluntary review process in 2018. However, there are serious concerns among the industry that LMSAs/NFMSAs will cause delay in settlement and increase costs. Further, many have questioned CMS' legal ability to require a LMSA/NFMSA. It is unclear how CMS would review an LMSA and take into account comparative negligence, policy limits, and other issues present in liability and no-fault claims that are not present in workers' compensation claims.

Clearly from a Third-Party Administrator (TPA) perspective, the impediments associated with submission of an LMSA, regardless of review criteria, will greatly affect the ability to resolve claims in a timely manner.

The resulting delays will bring on additional litigation and associated defense costs. Once there has been some definition relative to what CMS will be requiring, TPAs will need to develop strategies to deal with this new era of liability and No-Fault claim handling.

Liability carriers have much the same concerns. Carriers look for a level, consistent playing field and the ability to resolve claims fairly, with finality. Current LMSA ambiguity, not to mention the underlying conditional payment processes and the shadow world of MAPs, is not conducive to fair and efficient claim resolution.

Setting aside, for the sake of discussion, the questionable legal right of Medicare and/or MAPs to make claim for future medicals, the general impact of LMSAs on the liability claim industry stands to cause significant harm. Injured parties will suffer the most harm. Delay in claim resolution is a certainty. LMSAs may well preclude settlement of claims when inflated by Medicare requirements (as with existing Work Comp MSA Rx), and where liability and/or causation are debated issues. This will force more claims into litigation, increasing the injured party's risk (and, ironically, that of Medicare), add to already overloaded court dockets and increase costs for all involved. Claim handling costs will be significantly impacted by increased training needs, extended claim life and LMSA vendor costs.

Carriers should consider participation in industry coalitions that can work with Medicare and, hopefully, develop a LMSA process that is beneficial to both the Medicare fund and beneficiaries. Carriers should anticipate the near-future implementation of LMSAs and the resulting impact that will require a shift in their claim handling process, claim handler training and oversight practices.

III. Traditional Medicare Conditional Payment Recovery, Medicare Advantage Plan (MAP) and Part D Conditional Payments

Traditional Medicare offers the Part "A" and "B" Medicare programs. Under Part "A," a beneficiary, medical expenses for inpatient (hospital) care are provided, whereas Part "B" typically covers most outpatient expenses.

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, it is clear that 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*[2] 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*.[3] While Humana argued that the MSP, 42 USC § 1395y(b)(3)(A), 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

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

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*[4] 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.

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.

IV. Best Practices for Payers Regarding Medicare Advantage and Part D Payments

Until Congress clarifies the Medicare Secondary Payer law, or the U.S. Supreme Court rules on this issue, more litigation is expected. Therefore, a best practice recommendation would be for insurance carriers to include consideration of Medicare Advantage when resolving a worker's compensation or liability claim with a Medicare beneficiary claimant, particularly in the six states where MAPs have established rights to double damages for unreimbursed MAP conditional payments: Alabama, Georgia, Florida, Delaware, Pennsylvania, and New Jersey.

[4] 11th Circuit Court of Appeals, Case No. 15-11436.

MAPs are a particularly significant challenge to carriers. While Medicare shares Section 111 reporting data with MAPs, there is no reciprocation to the carrier by Medicare. Likewise, it is rather uncommon to receive early notification from a MAP of their existence. Thus, carriers are significantly prejudiced in their ability to identify a MAP.

Some best practice advice to carriers is to train file handlers to specifically ask insureds and claimants who they have their Medicare benefits through. Often, beneficiaries may not actually realize their benefits are via a MAP, so requesting a copy of the beneficiaries Medicare ID card is helpful. Claim handlers should also keep an eye out for $0.00-dollar conditional payment letters from Medicare. If the claim handler is aware treatment has occurred, a $0.00 Medicare conditional payment letter is a great clue those bills may have been paid by a MAP. In any event, a carrier best practice would be to consider including in their claim process specific steps to investigate the existence of a MAP.

V. PAID Act

Congress should enact the Provide Accurate Information (PAID) Act – legislation recently introduced before Congress in 2018, with re-introduction planned in early 2019 to require CMS to respond to a "Section 111 Query" with enrollment and eligibility information about the beneficiary's Medicare Advantage, Part D and Medicaid status. Such information is already provided by CMS as part of the Query Response File for Group Health Plan reporting under MSP requirements. This law is asking CMS to do the same for Non-Group Health Plans.

Primary plans deserve to know who a Medicare Advantage, Part D or Medicaid beneficiary before any settlement, judgment or award is. This will make it easier for the settling parties to contact those entities, identify any liens, and pay them at the time of settlement. The Medicare Advocacy Recovery Coalition (MARC) is pleased to support this important legislation, and urges Congress to enact this important improvement to the Medicare Advantage and Part D conditional payment processes, and the Medicaid Third Party Liability (TPL) process.

VI. Medicaid Third Party Liability

Medicaid is similar to Medicare in that it is a government program that provides health care benefits to certain groups of people. However, Medicaid is different in that it is for the most part a need-based program, whereas Medicare is entitlement based (generally based upon being at least 65 years of age and/or disabled). Further, unlike Medicare, states and not the Federal government are responsible for program administration of Medicaid.

Medicaid is a creature of Federal law as of July 1, 1969. There are certain uniformity principles put in place by the Federal legislation that states must implement in exchange for Federal government reimbursement payments for a portion of the benefits that are paid under the Program. One of the major guiding principles is that Medicaid is the payer of last resort (a secondary payer).

Third Party Liability (TPL) identification and ensuring Medicaid's secondary payer status where a primary payer is available is therefore an important obligation of the states under Federal law. If

it is not done correctly, reimbursement payments by the Federal government include charges that should be the responsibility of a third party. If third party liability identification recovery and coordination is not properly pursued by the State, it therefore increases the burden on the U.S. Budget.

VII. **The Future of Medicaid Recoveries**

Medicaid is the next Medicare that we must be prepared for and manage the compliance issues that develop. We have recently seen California (Medi-Cal) as well as Pennsylvania Medicaid step up recovery and reporting requirements and even penalties for failure to report a claim/settlement with a Medicaid beneficiary.

Congress attempted recently to further strengthen rights of state Medicaid TPL Programs. Recently, the Murray/Ryan Budget Deal of 2013 went into effect October 1, 2017 but was repealed as of February 2018, would have allowed Medicaid to recover 100% of their lien. Essentially, Medicaid would not have been limited to recovery from the medical portion of the settlement and could recover the "full value" of the claim. However, once Murray/Ryan was repealed in 2018, state Medicaid agencies were back to only being able to recover only from the past medical portion allocation in settlements. This is something to keep an eye on as it is possible that Congress may try to bring similar legislation back in the future to strengthen Medicaid's recovery rights.

Further, the current political landscape, with CMS Administrator Seema Verma in power who is in favor of block grants, seems to indicate that Medicaid budgets may be squeezed. As a result, Medicaid agencies will be looking to third party liability recoveries to enhance budgets and recover additional dollars.