THE BASICS: MEDICARE'S INTERESTS IN CLAIMS AND SETTLEMENTS

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If most non-attorney Americans were asked to list events which made 1965 an important year in American history, that list would probably include the ongoing Space Race, the Selma to Montgomery marches, passage of the Voting Rights Act, the arrival of the first U.S. combat troops in Vietnam, and maybe even the Beatles' performance at Shea Stadium. Their list would probably not include the exciting day, July 30, 1965, when President Johnson signed Medicare into law and ushered in healthcare for those 65 years and older.[1] So started the regulatory spaghetti which we have all grown to love—and hate—and attempt to understand.

Although not the most exciting of topics, most attorneys have questions related to Medicare's interests in claims and settlements, and how they should protect those interests. This article will only address three topics which are part of that regulatory framework:

- Section 111 Reporting;
- Medicare Conditional Payments and the Recovery Process; and
- Medicare Set-Asides.

Why do we event have to worry about Medicare's interest, you ask? When Medicare was enacted, it was designated as the primary payer in most instances. Effectively, this meant that Medicare paid for medical services even when another health plan or insurer was responsible. Medicare expanded in 1972 to include individuals below the age of 65 and who were receiving social security disability benefits. With increased coverage, Medicare was at risk of instability in the long-term.[2]

Enter the Medicare Secondary Payer Act (MSPA) which was enacted as part of the Omnibus Reconciliation Act of 1980.[3] The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees Medicare and acts to track and enforce MSPA compliance. The MSPA provided protection for Medicare by shifting costs to other sources of payment.[4] Essentially, the MSPA ensures that Medicare does not pay for medical treatment which should be paid by other payers, although it can make payments conditioned on reimbursement from the responsible primary payer.

Medicare utilizes three different mechanisms to regulate proper payment of claims. Working in conjunction of the MSPA, Section 111 of the Medicare, Medicaid and SCHIP Extension Act (Section 111) mandates reporting of Medicare beneficiaries who receive coverage under group health plans, as well as those who receive settlements, judgments, or awards from liability, workers' compensation, no-fault, or other non-group health plans.[5] Section 111 reporting puts Medicare on notice of potential secondary payer situations and helps to coordinate benefits and organize the secondary payer process from the beginning of a claim, including the tracking of Medicare conditional payments. Medicare set-asides, known as "MSAs" are a mechanism commonly used to protect Medicare's interests when a primary payer seeks to close its

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obligation to pay future medical benefits.

Section 111, Medicare Conditional Payments, and Medicare Set-Asides are all distinct, but intertwined topics that must be understood to properly protect Medicare's interests.

Section 111 Reporting

Section 111 is a simply a directive that responsible reporting entities (RREs) report the existence of claims that involve a Medicare beneficiary. The RRE, which is the primary payer of a claim, is generally the entity funding any settlement, judgment, or award to a Medicare beneficiary. This includes insurance carriers and self-insured entities. Section 111 requires that all group-health, workers' compensation, liability, no-fault, and other non-group health plans query their claimants to determine the Medicare eligibility of the claimant through the Section 111 process.

Section 111 reporting is only required when the claim involves a Medicare beneficiary. If the claimant is a Medicare beneficiary, data is reported on a quarterly basis and then at time of settlement. The information required by Section 111 reporting, including the diagnosis codes for the covered injury, assists Medicare in identifying conditional payments and estimating any future medical treatment needed for the injury. Having to complete the Section 111 process can also be a practical benefit to the defense attorney because the defense plan, including settlement strategies, change depending on a claimant's Medicare status.

Since the Medicare status of claimants can change throughout the life of a claim, the RRE should check into the claimant's Medicare status on a regular basis. Regularly assessing the claimant's Medicare status can also prevent the RRE from incurring stiff penalties. The MSPA provides for the assessment of civil monetary penalties for noncompliance with Section 111 reporting. Specifically, if a RRE fails to report, it "may be subject to a civil monetary penalty of $1,000 for each day of noncompliance with respect to each claimant."[6] This equals a potential penalty of $1,000 per day per claim. Although CMS has not levied a Section 111 penalty to date, proposed rulemaking was expected out in late 2019. Though not released yet, Section 111 rulemaking on civil monetary penalties is inevitable. Because Section 111 penalties can be severe if assessed, RREs should pay attention to the requirements and act accordingly.

Conditional Payments and the Recovery Process

If a claimant is a Medicare beneficiary (by age or disability), close attention should be paid to determining whether Medicare has made any conditional payments. Of course, if any conditional payments exist, priority should be assigned to resolving those payments in a timely manner. A conditional payment is any payment made by Medicare for medical services for which another payer (insurance carrier or self-insured entity) is responsible.[7] Medicare is granted the authority to make conditional payments, and to seek reimbursement for those payment via 42 U.S.C. § 1395y(b)(2). An entire administrative recovery process is in place to enforce Medicare's right to reimbursement, including dispute and appeals processes. The most important documents involved in the recovery process include:

- **Rights and Responsibility Letter (RAR):** Once a claim is identified through Section 111 reporting, Medicare will send an RAR that will set forth the recovery process and the applicable deadlines.
- **Conditional Payment Letter (CPL):** When requested, Medicare will issue a CPL which provides an interim list of all conditional payments made to date. Each conditional payment listed on the CPL should be evaluated to ensure they are accurate, medically necessary, and related to the injury claim. Examining the CPL also provides an opportunity, if applicable, to dispute liability for the conditional payments as a whole—that is, if the primary payer disputes liability for the injury for which the service was rendered.

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- **Conditional Payment Notice (CPN):** When Medicare is notified of an impending settlement, judgment, or award, it will issue a CPN. The CPN should also be examined, and a timely dispute should be completed, if necessary.
- **Recovery Demand Letter (RDL):** After a settlement, judgment, or award is completed, Medicare will issue an RDL. At this point, the recovery demand amount should be paid promptly to avoid interest accrual, which will accrue from the date of the demand letter and is assessed for each 30-day period thereafter. At this stage in the recovery process, the RDL amount can be appealed. If payment is not made within 180 days, the recovery will be referred to the Department of Treasury, unless an appeal is pending.

Although Medicare has an administrative recovery process, Medicare also has a private right of action against primary payers to recover its conditional payments. Medicare's private right of action means it can file suit against a primary payer and seek double damages for failure to reimburse its conditional payments. This private right of action has been extended in recent years to apply not only to Medicare Parts A and B, but also to Medicare Part C (Medicare Advantage Organizations) and Part D providers. However, Medicare's private right of action is subject to a three-year statute of limitation (with the three years beginning on the date the settlement, judgment, or award is made or when notice of a primary payment has been made to CMS).

Importantly, during a Town Hall teleconference in early January 2020, CMS made clear that it does not interpret the statute of limitations as applicable to its administrative recovery process. Based on this interpretation, CMS could potentially seek administrative recovery of conditional payments indefinitely.

The bottom line is that conditional payments should be requested regularly throughout a claim, should be thoroughly evaluated once received, and should be resolved promptly either through the dispute process or by payment.

Medicare Set-Asides

Medicare is prohibited by 42 USC § 1395y(b) from making payment where a primary payment (settlement, judgment, award, or other payment) has been made. In other words, when a claimant receives a primary payment, Medicare must remain the secondary payer until the proceeds from the primary payment are properly exhausted. Because of this directive, many parties choose to use a Medicare set-aside with the goal of estimating the cost of future medical expenses and setting aside an amount sufficient to meet those future expenses from the proceeds of a primary payment.

CMS has not issued detailed guidance about liability MSAs although CMS has signaled that it will move toward issuing guidance in that area sometime in 2020.

Though an MSA is applicable in liability and no-fault claims, it is most commonly used in workers' compensation claims (WCMSAs). If an MSA is used, the parties have the ***option*** to seek CMS approval of the MSA amount. There is ***no*** statutory or regulatory requirement that an MSA be used. Likewise, there is no statutory or regulatory requirement that an MSA be CMS approved. However, a CMS-approved MSA is one of the tools used the most to protect Medicare's interests and is currently the only method that CMS has approved for compliance with the MSPA. It follows that CMS-approved MSAs, particularly WCMSAs, provide the most certainty as CMS has stated:

CMS' voluntary, yet recommended, WCMSA amount review process is the only process that offers both Medicare beneficiaries and Workers' Compensation entities finality, with respect to obligations for medical care required after a settlement, judgment, award, or other payment occurs. When CMS reviews and approves a proposed WCMSA amount, CMS stands behind that amount. Without CMS' approval, Medicare may deny related medical claims, or pursue recovery for related medical claims that Medicare paid up to the full amount of the settlement, judgment, award, or other payment.[8]

Although CMS has approved liability MSAs in the past, those reviews and approvals have been sporadic and no formalized process for review of liability MSAs has been issued. Further, CMS has not issued detailed guidance about liability MSAs although CMS has signaled that it will move toward issuing guidance in that area sometime in 2020. CMS has, however, provided rather extensive guidance for WCMSAs.

For WCMSAs, CMS has established the following thresholds for ***review*** of WCMSAs. Therefore, a prudent approach would be to loosely apply the WCMSA guidance to liability cases when:

- The claimant is a Medicare beneficiary and the total settlement is greater than $25,000 or
- The claimant has a reasonable expectation[9] of Medicare enrollment within 30 months of the settlement date, and the total settlement is greater than $250,000.

If the review threshold is met, CMS will review the parties' proposed MSA. The review thresholds are ***not*** safe harbors for non-compliance with the MSPA. CMS's guidance indicates "[t]hese thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases."[10] Again, funding an MSA is voluntary, as is its submission to CMS for approval.

The most important aspect of every claim involving a Medicare beneficiary is to ensure compliance with the MPSA by being diligent about protecting Medicare's interests. Doing so requires an amalgamation of all of the above topics and continued efforts to understand (and come to love) the regulatory spaghetti more thoroughly.[11]

Ms. Coolidge *focuses on civil litigation, including defending employers in workers' compensation and retaliatory discharge claims; experience in personal injury, defense of long-term care and assisted-living facilities, and other healthcare-related, professional-liability cases, as well as general tort litigation; local government and municipality law, labor and employment issues, regulatory compliance, Medicare Set-Asides (MSAs), and insurance coverage disputes.*

As a registered nurse who has performed intensive patient care as well as utilization reviews, Ms. Coolidge has a unique background that assists her in defending against workers' compensation and personal injury claims, as well as healthcare-related professional-liability cases.

Endnotes

[1] Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., commonly known as the Medicare Act, established the Medicare program.

[2] In other words, Congress was afraid that if something did not change soon, Medicare would be pinching pennies, running on empty, be taken to the cleaners, chasing chips, trawling for treasure, or any other idiom which denotes the possibility of going broke.

[3] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599.

[4] *See Zinman v. Shalala*, 67 F.3d 841, 845 (9th Cir. 1995) ("The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs."); Christopher C. Yearout, *Big Brother Is Not Just Watching, He's Suing: Medicare's Secondary Payer Statute Evolves in Aggressive Pursuit of Fiscal Integrity*, 41 Cumb. L. Rev. 117 (2011).

[5] See 42 USC 1395y(b)(7)-(b)(8).

[6] The Medicare IMG Access and Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2012, signed into law by President Obama in 2013, softened the penalty language and provided Medicare with discretion in whether to assess the civil monetary penalty. After the SMART Act was signed into law, the Centers for Medicare and Medicaid Services (CMS) solicited proposed rulemaking related to the imposition of penalties. However, to date, no structured rulemaking has been completed.

[7] 42 CFR 411.21.

[8] *Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide,* Version 3.0 (October 10, 2019), Section 4.2.

[9] A claimant has a reasonable expectation of Medicare enrollment if he meets any of the below conditions:
- Applied for Social Security Disability (SSD) benefits.
- Anticipates appealing a SSD benefits denial.
- Currently appealing or re-filing for SSD benefits.
- Is 62 years and 6 months old.
- Has End Stage Renal Disease (ESRD).

[10] *WCMSA Reference Guide*, Version 30.2 (Oct. 10, 2019), Section 8.1.

[11] More information is available at https://www.cms.gov/Medicare.