



THE RISK REPORT

Volume XXXIV

No. 2

October 2011

MEDICARE SECONDARY PAYER ACT: DISPELLING THE “MONOLITH” MYTH

Rarely has there been so much misunderstanding by so many about one law. The Medicare Secondary Payer Act (MSP), most recently and significantly amended by the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA), is but one small section of the Medicare law; yet, it has engendered much travail, gnashing of teeth, and confusion in the general insurance and employer community. The MSP has become a frequent subject of discussion in insurance media, not to mention driving inflamed polemics on various blogs.

The MSP affects all bodily injury claims that involve Medicare-entitled persons, not only from a settlement standpoint, but also from a federal claim-reporting requirement. As such, it can hardly be avoided. Anyone involved in such claims should have at least a passing familiarity with this area of the law and what needs to be done to navigate the labyrinth of the affirmative obligations imposed by federal legislation.

This article endeavors to separate fact from fiction regarding the MSP and encourage those affected to carefully analyze the best way to deal with this complex topic.

A Brief History of the Medicare Secondary Payer Law

The MSP was included in the Omnibus Budget Reconciliation Act of 1980 (12/5/1980) and was intended to protect the solvency of the Medicare program by making Medicare a secondary payer if a primary payer existed (see 42 U.S.C. § 1395y(b) and 42 C.F.R. 411.20 through 411.54).

Medicare is due protection in two ways. The first is protection from past payments (these are known as “conditional payments”) made by Medicare for the injury or condition for which the primary payer is responsible. The second protection owed Medicare is the avoidance of any future payments for a condition, disease, or injury for which a primary payer is responsible. According to Title 42, CFR § 411.20, primary payers include:

- Workers compensation
- Liability insurance
- No-fault Insurance

Those areas cover virtually all sources of bodily injury claims.

For any conditional payments it may have made, Medicare has an absolute statutory, priority “right of recovery.” In order to protect Medicare from future payments, the Centers for Medicare and

Medicaid Services (CMS) have issued guidelines (via administrative fiat) **recommending** the use of Medicare Set-Aside Allocations (MSAs) at the time of settlement for a Medicare-entitled person or for a person who will potentially be Medicare-entitled within 30 months of the date of settlement, if that settlement includes irrevocable closure of future medical benefits as part of the resolution.

It is important to note that no statute or regulation contains any reference to Medicare Set-Aside Allocations. MSAs are merely the methodology **suggested** by CMS to ensure that funds will be available for related future treatment to avoid the possibility of Medicare being placed in a position to make payment. To add to the confusion surrounding the MSP, the current CMS memoranda provide guidance only for workers compensation claims. Liability and no-fault claims are not mentioned.

Currently, all MSA guidance is supplied to the industry by CMS through the public release of internal memoranda (with the first one being distributed in July 2001). The result is law intersecting with agency policy, overlapped by developing jurisprudence. Confusing? Of course it is.

A Brief History of the Medicare, Medicaid, and SCHIP Extension Act of 2007

On December 29, 2007, the MSP was amended to add two new sections: one for group health plan reporting, the other establishing a claim-reporting requirement for all non-group health plan (NGHP) primary property casualty (P/C) payers (WC, liability, no-fault) when a claim involves a Medicare-entitled person. This claim-reporting requirement is the third “leg” of the affirmative legal obligations (along with “conditional payment” reimbursement and protecting Medicare from future payment postsettlement of the underlying claim) extant regarding the MSP law.

The intent behind the MMSEA Section 111 reporting mandate was to provide Medicare with the necessary information for the identification of primary payers to protect Medicare from making unnecessary payments. Furthermore, this reporting provides CMS with the opportunity to recover conditional payments from a primary payer should a match between a reported claim and a Medicare file occur. This claim reporting presents a new obligation under the MSP, separate and apart, from the protection of Medicare postsettlement (MSAs) and conditional (past) payments. Confusion in the industry was to be expected given the eventual intersection of the activities triggered by this reporting.

To “encourage” adherence to the claim-reporting requirement outlined in the MMSEA, a “civil money penalty” of \$1,000 per day, per claim was established within the statute [42 U.S.C. § 1395y(b)(8)(E)(i)]. As anticipated, that area of the law garnered instant attention from the reporting population, later dubbed “responsible reporting entities” (RREs) by CMS. Naturally, the fear was that massive civil money penalties were going to be levied against reporting entities, and that the impetus behind the legislation was the collection of fines. CMS denied this allegation, indicating that the essence of the fining provision was to require reporting entities to send in claim information, the purpose of which is to match with conditional payments Medicare may have made on these claims.

The frequency, data elements, methodology, format, etc., for reporting was left up to the Secretary of Health and Human Services (HHS), who tasked CMS with developing a program. Policy was eventually published in the form of a “User Guide,” which has undergone several updates since it was first published on March 16, 2009, the latest iteration of which was issued by CMS dated August 17, 2011, and comprises

311 pages. While the statute called for the NGHP entities' (i.e., WC, liability, and no-fault) reporting to start July 1, 2009, implementation has been postponed twice to date. Workers compensation reporting was required as of January 1, 2011. With respect to liability, RREs' reporting has been delayed for a third time and is currently slated to go live on January 1, 2012.

CMS "Alerts" continue to be released on a regular basis, further amending the reporting program as the Centers for Medicare and Medicaid develop ongoing changes to the User Guide. Given this background, it is hard to imagine what it presently takes to become an MMSEA Section 111 reporting "expert."

The Myth of the Monolith

When CMS first started actively enforcing the MSP law via publication of the "Pashar Patel Memo" of July 2001, a cottage industry was born: the Medicare Set-Aside Allocation provider. The Patel Memo essentially launched a "voluntary" MSA review program extended to a particular subset of workers compensation claims. With the silence of the Patel memo on liability and no-fault claims, many in the P/C industry wrongly concluded that the MSP did not apply to non-WC claims in terms of secondary payer protection for Medicare, regardless of specificity of the statute in that regard.

A Medicare Set-Aside Allocation report is generated from the review of past medical treatment and recent physician opinions. The purpose of the report is to accurately predict the cost of future treatment over the remaining life expectancy of the injured person. The quality of Medicare Set-Aside Allocations varies wildly, depending on the experience of those who are providing the reports. Initially, insurers believed that first-time CMS approval indicated high quality, but they soon realized

that a high percentage of first-time CMS approvals actually meant the probability of the over-allocation of funds.

Medicare Set-Aside Allocations were surprisingly widely accepted, and quickly became a routine feature of WC settlements when the injured worker met CMS's criteria. In states that prohibited settlement of future medical benefits, MSAs were not needed because the injured worker was expected to return to the workers compensation insurer or self-insured employer if the occupational condition required additional treatment. Thus, Medicare was not imperiled.

Naturally, MSAs increased settlement costs. Aside from the average \$2,500 report cost, there were additional loss expenses that are more difficult to quantify. These include indemnity benefits that are being paid while waiting for CMS to approve the MSA amount (currently, CMS is taking approximately 6 months to review an MSA), as well as increased medical losses required to fund the allocation itself in the manner mandated by CMS.

So, what does an MSA have to do with the MMSEA Section 111 reporting requirement? As noted above, the MMSEA is strictly a reporting mandate. To date, CMS has indicated that the claims report information will allow Medicare to identify and pursue primary payers in cases where Medicare has exposure through "conditional payments" it has made. The question remains as to whether the reporting requirement will eventually develop into an MSA program guideline by CMS for the liability market.

In review, there are three separate areas of MSP compliance:

- Mandatory claim reporting
- Conditional payment pursuit and collection
- Medicare Set-Aside Allocations on certain settlements to preclude postsettle-

ment Medicare payments for treatment related to the injury, condition, or disease for which the underlying primary payer resolved the claim

Each of these areas may require a specific approach by the “primary payers.” “One size fits all” is a somewhat myopic philosophy to employ to meet compliance.

“One Source Approach” versus “Best in Breed”

It is helpful to have an analytic to determine the most effective method(s) of dealing with legal obligations imposed by the MSP. Since there are three “legs” to MSP compliance, you should have certain logical considerations/questions when deciding a “best” course of action. In other words, is there a benefit to selecting one company as a partner in MSP compliance for all areas or not?

With the MMSEA Section 111 reporting requirements still in a state of flux, is it logical to assume that any company is currently an “expert” in this arena? There are numerous companies offering their services as MSP/MMSEA “compliance partners,” claiming that they are experts in both areas. Tread carefully here.

Given that MMSEA for workers compensation has only recently begun, and liability and no-fault claim reporting will not start until January 1, 2012, what type of experience can any company logically have in this area?

It is axiomatic that massive electronic transfer of case-specific claim data information has no relevancy to formulating Medicare Set-Aside Allocations. Virtually no company in the MSA industry has any experience in the type of information technology that would be required to handle this data-intensive application. What are the possible options?

- “Partner” with one company to handle MSP/MMSEA compliance.

- Choose a company with IT and data-handling expertise to perform only MMSEA reporting.
- Work with your internal IT department to develop your own MMSEA reporting solution.
- Select one or more “partners” for MSP (MSA) compliance.
- Develop an MSA department within your organization.

A review of the time line of the Section 111 reporting law and subsequent promulgation of the CMS User Guide suggests that no entity (especially in early 2008 when the law first became known) could legitimately hold itself out as an expert in a reporting process that was still developing and not yet implemented.

Given the above, an “external” reporting solution, especially by MSA providers, seems to be a risky proposition. After all, the data elements required by the MMSEA needed to be captured at the case level on the claims handler’s computer system. A third party could do nothing other than request those data elements to make the MMSEA reports. If the claims system lacked a needed data element, it would have to be added to the claims system. If all of the data elements were in the claims system, then an external MMSEA reporting “solution” would seem superfluous, as any entity that captures all the data should be able to dispense with the middleman and direct report.

If you believe that your optimum choice is an external MMSEA Section 111 reporting resource, it would be wise and prudent to take the time to visit them and find out what you are actually buying. An interview with the IT personnel who will be handling your data should also be in order to secure an understanding of their experience. An SAS 70 compliance report request, to make sure that your claims data is safe, is another relevant consideration.

For most responsible reporting entities (RREs), the claims system used to adjust their losses (either by an insurer, third-party claims administrator, or internal claims department) should already capture the vast majority of the required data elements. Although the potential number of Section 111 reporting elements is up to 132 per claim, most of these are not necessary on every case. However, an automated diary system to alert the adjusters when the "Section 111 Report Screen" must be completed is a feature that is important. A robust claims computer system, properly augmented with the Section 111 data elements, should be cable of doing most of the work without adding any extra burden to the adjuster or expense to the claim.

After dealing with the Section 111 reporting requirements, it is time to turn to the MSP (MSA) compliance arena. Here, you must also be logical in your analysis.

The knowledge and experience required to develop an expertise in MSA allocations is extensive. Additionally, most RREs do not possess the "critical mass" in terms of MSA volume to keep dedicated resources fully engaged. Also, it is difficult to gauge the volume of MSAs that may be needed during any quarter. All this, and dealing with CMS for case submission and MSA approval, often will lead to a decision to use an external solution.

For MSA work, consider issuing a request for information (RFI) to several companies. All invited providers should answer the same questions in the same format. A key concern should be not only the expertise that these companies provided for their MSA formulations, but also their level of customer service. Prices seemed to be somewhat standard across the board. But the selection of an MSA company that provides lackluster service means the claims adjusters handling the account will bear the brunt of a poor decision.

An often overlooked resource is to solicit opinions from frontline claims adjusters, claims supervisors, and claims managers. They are usually a blunt lot regarding vendor performance. It is also valuable to speak to the MSA vendors' current and past clients. Listen to that feedback, and take it seriously. It should heavily impact a decision on the MSA provider(s) selected.

Relying solely on what the MSA vendors articulated about themselves and price to determine who to appoint as an MSA service provider will ultimately yield a set of inferior choices for the claims adjusters handling files. You will undoubtedly discover that each potential MSA provider claims it is the best in the field. MSA providers routinely advertise that they will save you the most money and have the most outstanding customer service. But, it is the feedback of others external to the MSA provider who necessarily have a more objective viewpoint based on experience who should yield the most valuable perspective.

In the end, you may find a discerning analytic and investigation will lead to a "best-in-breed" solution. In terms of selecting an MSA provider(s), MMSEA Section 111 reporting should have nothing to do with an allocation vendor.

It is often wise to select a "panel" of MSA providers instead of only one vendor. One choice is no choice. A panel approach tends to keep everyone on the panel "honest" in terms of product quality and customer service. If one of the MSA providers allows customer service to slip, the adjusters have other companies they may use for MSAs that provide them with better client service and a superior allocation product.

You may take a different approach, but keep in mind that you should always consider exhibiting an inquisitive nature when choosing an MSP compliance company.

Beware of Marketing over Substance

"I'll do your SCHIP reporting for free; just give me all of your MSAs." Most everyone in the field has heard this latest MSA provider marketing scheme during the last 3 years. It is one in the long line of maneuvers to capture clients into an exclusive relationship.

An MSP/MSA marketing history lesson in brief: First there was the MSA/pharmacy benefit management tie-in when Medicare Part D (Medicare prescription coverage) was implemented in 2006 in an attempt to capture a postsettlement pharmacy market share. This resulted in poor allocations and weak client service. This was followed by the dubious "MSA guarantee" that permitted insurers to settle claims without waiting for the CMS opinion because the MSA vendor agreed to pay any difference.

The latest strategy is "gratis" MMSEA Section 111 reporting services for exclusive or preferred rights to all MSA business available from that RRE. While it sounds logical that an MSP compliance firm should be in the best position to ensure appropriate MMSEA reporting compliance, the facts, when examined objectively, could not be any further from the truth.

The MMSEA User Guide is a constantly changing document. CMS spent \$30 million building what it believed to be appropriate system to capture all the data it felt necessary to administer its programs. However, the insurance industry then proceeded to poke holes in it. The CMS took a quick course in insurance, made a few calls, learned about things like captives and self-insurance, and adjusted their approach. The property and casualty insurance industry will continue to "poke holes," and CMS will continue to adjust until the program is viable from both ends.

Those who still don't have a reporting solution for their organizations, or those regretting their decisions and already

encountering enough trouble to support breach of contract, may want to engage in a more detailed analysis prior to making any new decisions. Consider the following:

1. The CMS monthly telephone "town hall" meetings on the MMSEA reporting requirements routinely involved attendees asking about liability MSAs. Barbara Wright and her colleagues at CMS always answered the same—that the MMSEA has nothing to do with Medicare Set-Aside Allocations. Do not confuse the two.
2. All of the 132 MMSEA claim-reporting elements had to emanate from the claims handlers' computer system; no reporting vendor to date has created a reporting solution that is able to "fish" in existing systems to retrieve the required data, especially if no information is routinely captured by that insured and therefore is absent from the system. Adding a middleman to the process potentially adds nothing but time and error.
3. There are no MSA companies that have ever been experts on massive electronic data element transfer, and pronouncements by them to the contrary do not make them so. From the time the MMSEA was passed in December 2007 until the first User Guide was published by CMS in March 2009, no one was an expert in the way the reports were going to be processed because CMS had not yet disclosed its methodology for reporting. Although reporting recently began for workers compensation, it is clear that there will be further revisions to the CMS User Guide for Section 111 reporting. MSA companies can do nothing other than try to build a system that merely adheres to the data that everyone else in the industry was being provided by CMS. "Guaranteed error free" reporting

FIGURE 1
MSP PROVIDER SELECTION GUIDELINES

- ✓ Finding a trusted MSP compliance provider (i.e., an MSA company) should be a separate analytic exercise from selecting an MMSEA reporting solution. Expertise in one doesn't confer expertise in the other.
- ✓ If you have a relationship with a single MSA provider, or a panel of MSA providers, their performance and customer service should be examined annually. If your provider(s) are not meeting your expectations, it might be time to look elsewhere. Be open to looking for new and better solutions than what you presently experience.
- ✓ Consider using a request for information or request for proposal when selecting an MSA provider. Contrast and compare the service claims made by these organizations. Check not only with present clients, but ask former customers of the vendor why they left. Perform the due diligence on these companies prior to selecting your partner(s), and monitor their performance quarterly so you can make sure they are living up to their customer service and product quality claims.
- ✓ Consider an MSA panel over a single provider. Exclusivity does nothing to foster competition through superior client service. Even if you have a panel, there may be a provider in that panel who has "slipped" and should be dropped or replaced.
- ✓ Regularly solicit feedback from your organization about how each vendor is performing. Replacing an underperforming vendor with a new partner may be a good solution.
- ✓ Consider the range of your vendor's experience. Has it handled liability cases as well as workers compensation cases? There are instances in liability settlements when Medicare must be protected, and workers compensation MSAs do not necessarily fit the needs of the settlement.
- ✓ If you are an RRE, perform an independent analysis on MMSEA reporting options. This includes the option of reporting directly, using your claims handler to report in your stead, or retaining a professional reporting entity. There are also vendors that provide assistance with developing internal capabilities.
- ✓ If you do choose to outsource your MMSEA Section 111 reporting requirements, perform due diligence before making a reporting company selection. An on-site visit may be necessary to prove that the reporting solution you are being tied to is nothing more than a server in a closet. Review the contracts carefully to determine who ultimately bears the cost for inaccurate or nonreporting.

(that some MSA companies claimed) is providing the industry some amusement during the first reporting period for workers compensation.

4. Insurance companies, third-party administrators, self-insured and self-administered employers, monopolistic state funds, competitive state funds, and the like all have larger and more experienced IT departments than do MSA providers. That should be obvious. Consider that even the oldest MSA firm has only been in business no more than 10 years. The amount of resources that the property and casualty insurance industry RREs brought to bear on this federal legislative claim-reporting requirement was much more massive than anything MSA vendors could muster. Nevertheless, some RREs have proven vulnerable to MSA company claims of MMSEA Section 111 reporting compliance expertise.
5. Consider why an MSA provider would be so anxious to come up with an MMSEA Section 111 reporting solution. As the middleman in the reporting process, they will know every claim an RRE had that involved a Medicare-entitled person. That provides a ready-made marketing list for securing additional MSAs.

Being an “expert” MSA provider is nothing more than that—an expert in MSA compliance, not an IT expert. Being “first to market” with a supposed MMSEA reporting solution was taken seriously by many RREs; however, they are likely to come to a different conclusion when they spend a bit more time investigating the MMSEA, the User Guide, the information being disseminated by CMS personnel during the phone-in “town halls,” and the reality that no one can be an expert on a new reporting law where the parameters are evolving every time CMS revises a document.

Selecting/Evaluating Providers

Much of the industry has already contractually intertwined the claims reporting requirement of the MMSEA with their affirmative obligations under the MSP to protect Medicare as a secondary payer. Again, understand that these are two separate and distinct obligations under the MSP, and that each imposes entirely different mandates, as shown in Figure 1.

The Centers for Medicare and Medicaid Services have continually counseled that MSAs and MMSEA reporting should be viewed as two separate obligations which impose distinctly different requirements. Keep this in mind when anyone tells you differently.

With the intersection of law, administrative fiat, and legal jurisprudence, the MSP obligations and programs are anything but clear. However, the law must be taken into consideration on certain settlements involving Medicare entitled individuals, and ignorance of practice and procedure is no defense for failure to do so. To ignore the MSP is to invite shipwreck.

Lastly, develop a habit of “scholarly investigation” when you are being told something by a company that will profit from you selecting it. It is in the interests of MSA providers to lump the MMSEA in with the MSP and market you as complete compliance partners. After all is said and done, a Latin phrase may still provide the best advice when attempting to navigate the labyrinth of the MSP: caveat emptor.

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