COPING WITH THE COMPLEXITY OF CMS:
A Guide to Settling Claims Involving Medicare Liens

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I. MEDICARE AND THE MEDICARE SECONDARY PAYER ACT

A. Medicare

1. *Purpose of Medicare*

Medicare was established in 1965 with the passage of the Social Security Act of 1965. Medicare provides federal health insurance benefits to senior citizens, the disabled, and people suffering from end-stage renal disease.

2. *Medicare Beneficiaries*

Medicare is available to persons who are:

a. Senior Citizens – Age 65+
b. Disabled – Recipients of Social Security Disability Income
c. End-Stage Renal Disease

3. *Types of Medicare Coverage*

Medicare Part A provides hospital insurance coverage for inpatient care in hospitals, skilled nursing facilities, hospice and home healthcare.

Medicare Part B provides medical insurance coverage for medically necessary and preventive services such as doctor's visits, outpatient care, medical equipment, and home health services.

Medicare Part C (also known as Medicare Advantage Plans) involves Medicare-approved private health insurance that provides the coverage under Medicare Part A and Medicare Part B. Medicare Advantage Plans usually offer additional coverage.

Medicare Part D provides prescription drug coverage.

4. *Medicare vs. Medicaid*

Medicare is not Medicaid. Medicaid is a state-run program that provides health coverage for low-income people, families and children, the elderly and people with disabilities.

B. Medicare Secondary Payer Act

1. *Purpose of Medicare Secondary Payer Act*

The original version of Medicare required the government to act as primary payer for all services covered under Medicare. In 1980, Congress enacted the Medicare Secondary Payer Act to shift the primary burden for healthcare services away from Medicare to private sources of payment.

2. *MSPA Legislation and Regulations*

The Medicare Secondary Payer Act is codified at 42 U.S.C. § 1395y. Regulations regarding administration and application of the Medicare Secondary Payer Act are codified at 42 C.F.R. Part 411.

3. *Primary Payer or Primary Plan*

As the secondary payer, Medicare provides coverage for any amount not covered by a primary payer or primary plan. The Medicare Secondary Payer Act identifies the following as primary plans:

a. Group Health Plans (GHP)
b. Workers' Compensation Plans
c. Automobile or Liability Insurance Policies, including Self-Insurance
d. No-Fault Insurance Plans

Under the Medicare Secondary Payer Act, a primary payer includes a tortfeasor and the tortfeasor's private insurer. *United States v. Baxter Int'l*, 345 F.3d 866 (11th Cir. 2003).

4. *Conditional Payments*

Many times, a primary plan or primary payer does not pay for a Medicare beneficiary's medical expenses. In such instances, Medicare must make a "conditional payment." Medicare must make a conditional payment if:

a. A primary plan has not made payment

b. A primary plan cannot reasonably be expected to make payment promptly

Under the Medicare Secondary Payer Act, if Medicare makes a conditional payment, Medicare obtains a right of reimbursement. A primary plan, or an entity that receives a conditional payment, must reimburse Medicare for any conditional payments made. A judgment or settlement triggers the obligation to reimburse Medicare.

If Medicare is not reimbursed in 60 days, interest begins to accrue.

5. *Medicare's Recovery Options*

The Medicare Secondary Payer Act allows the government to take legal action to recover conditional payments. Federal regulations set forth when and against whom the government may bring such actions. *See* 42 C.F.R. 411.24. The government may take legal action against:

a. Individual Medicare Beneficiaries
b. Medical Providers and Suppliers
c. Attorneys
d. Private Insurers
e. Defendants

If Medicare is not reimbursed, the government may seek recovery directly from these primary payers *even if they have already paid the Medicare beneficiary*.

II. MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007

A. Purpose of MMSEA

Since the enactment of the Medicare Secondary Payer Act in 1980, Medicare has had difficulty obtaining reimbursement of its conditional payments from primary payers. The Medicare, Medicare and SCHIP Extension Act (MMSEA) was designed to provide Medicare with a greater ability to enforce the reimbursement provisions of Medicare Secondary Payer Act. MMSEA Section 111 requires the reporting of claims involving Medicare beneficiaries

B. MMSEA Reporting Requirements

The MMSEA reporting requirements are found in Section 111, 42 U.S.C. § 1395y(b)(8).

1. *Required Reporting Entities*

Required Reporting Entities (RREs) must comply with the MMSEA reporting requirements. Providers of liability insurance (including self-insurance), no-fault insurance and workers' compensation are all Required Reporting Entities.

A provider's third-party administrator is not a Required Reporting Entity.

2. *Reporting Requirements*

Required Reporting Entities are required to report a vast amount of information, including:

a. Claimant Information (Name, Date of Birth, Social Security Number, Contact Information, etc.)
b. Injury Information (Date of Loss, Description of Injuries)
c. Insurance Information
d. Representative Information
e. Payment Information

3. *Penalties for Noncompliance*

The penalties for failing to comply with MMSEA Section 111 reporting requirements are steep. MMSEA authorizes penalties of $1,000 per day per claimant whose claim has not been timely and properly reported.

4. *New Timeframe for Reporting Requirements*

Since MMSEA was signed into law in 2007, the government has delayed implementation of the reporting requirements several times. Currently, the timeframe for reporting claims will be implemented on a rolling basis.

No matter when reporting actually begins, each Required Reporting Entity will have to report claims on a quarterly basis. Each Required Reporting Entity is assigned a seven-day period each quarter during which it must report claims. All claims with a TPOC date occurring in the previous quarter must be reported in this seven-day period.

The implementation of reporting claims depends on the Total Payment Obligation to the Claimant ("TPOC"). Both the date and amount of the TPOC drives the implementation of the reporting requirements. The TPOC amount is the amount of a settlement, judgment or other award. The TPOC date is the date the settlement, judgment or other award was

entered. The current timeframe for implementation of the reporting requirements is as follows:

TPOC Amount:	**TPOC Date:**	**Reporting Required:**
$100,000 +	October 1, 2011	January 1, 2012
$50,000 - $100,000	April 1, 2012	July 1, 2012
$25,000 - $50,000	July 1, 2012	October 1, 2012
Minimum Threshold	October 1, 2012	January 1, 2013

Medicare has established a minimum threshold for reportable claims. The current minimum threshold is $5,000. Claims with a TPOC date occurring in 2013 will be subject to a $2,000 minimum threshold. Claims with a TPOC date occurring in 2014 will be subject to a $600 minimum threshold. Beginning in 2015, all claims will be subject to the reporting requirements.

Note that this timeframe applies only to liability insurance carriers. Reporting of claims for other types of primary payers will use a different schedule.

Examples:

a. On September 15, 2011, a jury returned a $175,000 verdict in favor of a plaintiff, a Medicare beneficiary.

   Reporting Not Required: Because the TPOC date for this claim (September 15, 2011) occurred before the October 1, 2011 implementation deadline, reporting is not required.

b. On October 15, 2011, a jury returned a $175,000 verdict in favor of a plaintiff, a Medicare beneficiary.

   Reporting Required: Because the TPOC date for this claim (October 15, 2011) occurred after the October 1, 2011 implementation deadline, reporting is required. This claim should already have been reported during the 2012 First Quarter reporting window (quarter beginning January 1, 2012).

c. On January 7, 2012, a liability insurance carrier reached a pre-suit settlement with a claimant. The claimant is a Medicare beneficiary. The settlement amount is $75,000. The claimant signed the settlement agreement on January 20, 2012.

Reporting Not Required: Because the TPOC date of this claim (January 20, 2012) occurred before the April 1, 2012 implementation deadline, reporting is not required.

d. On March 30, 2012, a liability insurance carrier reached a pre-suit settlement with a claimant. The claimant is a Medicare beneficiary. The settlement amount is $75,000. The claimant signed the settlement agreement on April 5, 2012.

Reporting Required: This claim must be reported during the 2012 Third Quarter reporting window (quarter beginning July 1, 2012). The TPOC date is calculated using the date on which the claimant signed the settlement agreement. Because this date falls after the April 1, 2012 implementation deadline, reporting is required.

e. On November 15, 2012, an arbitration panel awards a Medicare beneficiary $3,500 in compensatory damages.

Reporting Not Required: Because this claim falls beneath the minimum threshold for reporting claims, reporting is not required. The minimum threshold for claims with a TPOC date after October 1, 2012 is $5,000. Any claim for less than this amount does not have to be reported.

f. On February 15, 2013, an arbitration panel awards a Medicare beneficiary $3,500 in compensatory damages.

Reporting Required: Because this claim exceeds the minimum threshold for reporting claims, reporting is required. The minimum threshold for claims with a TPOC date anytime in 2013 is $2,000. Because this claim exceeds that amount, the claim must be reported during the 2013 Second Quarter (quarter beginning April 1, 2012).

III. SETTLEMENT OF MEDICARE CLAIMS

A. Information Gathering

1. *Necessary Information*

Information is key to making the settlement process as smooth as possible. Anyone involved in the settlement of a claim with a Medicare beneficiary should gather the following information:

a. Beneficiary's Name
b. Beneficiary's Social Security Number and Medicare Number
c. Beneficiary's Date of Birth
d. Amount of Conditional Payments Made
e. Potential for Future Medical Expenses

2. *Avenues for Information Gathering*

There are many avenues for gathering the information necessary to effectuate a Medicare settlement:

a. Insurance Carrier's Formal Process
b. Informal Exchange with Opposing Counsel
c. Medical Authorizations / Healthcare Provider Records
d. Written Discovery Requests
e. MSPRC Conditional Payment Search
f. New MSPRC Online Portal

B. Settlement Process

The process of settling a claim with a Medicare beneficiary can be rather lengthy, but each claim involves at least the following steps:

1. *Treatment*

a. Injury/Damage/Loss Occurs
b. Medicare Beneficiary Seeks Treatment
c. Healthcare Provider Provides Treatment
d. Healthcare Provider Submits Claim for Payment
e. Medicare Makes Conditional Payment

2. *Reporting*

f. Beneficiary and/or Required Reporting Entity Reports Claim to Medicare
g. Medicare Issues Rights and Responsibilities Letter to Beneficiary
h. Medicare Searches for Related Medicare Payments
i. Medicare Issues Conditional Payment Letter
j. Beneficiary Accepts or Disputes Conditional Payment Letter

3. *Medicare Lien*

k. Parties Reach Settlement, Judgment or Other Award
l. Beneficiary Submits Final Settlement Detail Document

m. Medicare Issues Demand Letter Outlining Lien
n. Beneficiary Accepts or Disputes Demand

Once Medicare identifies its interest, the beneficiary may accept Medicare's demand, may negotiate with Medicare to reduce or waive its interest, or may ignore payment altogether. Depending on the outcome, Medicare may pursue recovery through formal legal action.

4. *Documents Needed Throughout Settlement Process*

Medicare requires several documents to be submitted throughout the settlement process:

a. Consent to Release Protected Health Information
b. Proof of Representation
c. Rights and Responsibilities Letter
d. Conditional Payment Letter
e. Final Settlement Detail Documents

5. *New Developments Affecting Settlement: Fixed Percentage Option*

The Fixed Percentage Option allows certain beneficiaries to pay Medicare 25% of the total settlement in lieu of the current recovery process. In order to be eligible to participate in the Fixed Percentage Option, the beneficiary:

a. Must have suffered a physical, traumatic injury
b. Must have received a settlement of $5,000 or less

6. *New Developments Affecting Settlement: MSPRC Online Portal*

The government is launching an online portal that will allow Medicare beneficiaries, as well as insurers, to access case-specific information in an online portal. This online portal is expected to cut down on the time necessary to accomplish certain tasks throughout the settlement process.

7. *New Developments Affecting Settlement: SMART Act*

Bipartisan legislation introduced in the United States Senate would bring much-needed reform to the Medicare Secondary Payer Act. The SMART Act would accomplish the following:

a. Provide conditional payment information before settlement
b. Prohibit Medicare from pursuing recovery on claims where expenses are too great

c. Require alternative identification of Medicare beneficiaries
d. Establish a three-year statute of limitation for Medicare recovery

C. Special Considerations

1. *Waiver, Reduction and Minimum Liability Threshold*

Although the Medicare Secondary Payer Act grants the government the right to recover conditional payments made, the government may not always seek to enforce its interests. Federal regulations set forth the circumstances under which the government may waive or reduce its interest in recovery. For instance, federal regulations call for the government to reduce its interest in recovery by the amount of procurement costs (attorneys fees, litigation expenses, etc.).

Additionally, the government has recently announced that it will not seek recovery in any circumstance in which the total settlement is $300 or less. There are proposals to increase this minimum liability threshold to $5,000. *See* ERIC HELLAND & FRED KIPPERMANN, RECOVERY UNDER THE MEDICARE SECONDARY PAYER ACT: IMPACT OF REPORTING THRESHOLDS (Rand 2011).

2. *Medicare Set-Aside Allocations*

In many injury cases, present injuries may require future medical treatment. For Medicare beneficiaries, this may require Medicare to pay for future medical expenses. However, because Medicare is always the secondary payer, a settlement or judgment should take into account its obligation to act as primary payer, even for future medical expenses. A Medicare Set Aside is an allocation of funds that are "set aside" in order to protect the interests of Medicare in the payment of future medical expenses.

There is a heated debate over whether Medicare Set Asides are even required. Some argue that they are never required. Others argue that they are required, but only in workers' compensation claims. Still others argue that they are required for all claims, including third-party liability claims.

The government continues to announce developments regarding third-party liability Medicare Set Asides. If a beneficiary's treating physician certifies in writing that the treatment has been completed as of the date of the settlement or judgment, and that future treatment will not be required, Medicare will consider its future interest satisfied.

There are numerous considerations to take into account in deciding to create a Medicare Set Aside:

a. Claimant's Life Expectancy
b. Predicted Amount of Medical Expenses
c. Inflation and Present Value of Money
d. Administrative Costs

IV. CONCLUSION

A. **Practical Recommendations**

1. Identify Medicare issues as early as possible.

2. Once issues are identified, gather as much Medicare-related information as possible.

3. Keep up to date to ensure full compliance with constantly changing Medicare rules.

4. Always protect the interests of Medicare as closely as possible.