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Section 111 Bulletin: Upping Your Section 111 Game – Medicare Secondary Payer Developments Say It's Time

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It's time.

Nine years have passed since Congress enacted the Medicare and Medicaid SCHIP Extension Act of 2007 (MMSEA). Section 111 of MMSEA amended the Medicare Secondary Payer (MSP) statute to require casualty insurers to report to the Centers for Medicare & Medicaid Services (CMS) most payments they make to Medicare beneficiaries. 42 U.S.C. § 1395y(b)(8).

Six years have passed since Section 111 reporting began in earnest for most casualty insurers. From this reporting, CMS identifies primary payments it made to Medicare beneficiaries who also received payments from a casualty insurer. Medicare may then seek reimbursement of its payments from the insurer.

While CMS was slow to build its Section 111 program and may have lulled some into a minimum necessary compliance mode, recent developments in Section 111 law and agency enforcement make this an opportune time for casualty insurers to review and update their Section 111 practices. These developments include recognition by a growing number of federal courts that a Medicare Advantage (MA) Plan may enforce its secondary payer status and, if necessary, exercise a private cause of action in the MSP statute and sue casualty insurers for reimbursement of the Plan's primary payment of Medicare items and services.

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Section 111 Insurer Reporting and MSP Reimbursement

Here are seven of the more notable developments we are discussing with our clients – often when updating best claims practices specific to Section 111 issues or when negotiating settlement terms designed to mitigate the risk of insurer reimbursement of Medicare beneficiary services. How are you addressing these developments?

1. Medicare Advantage Plans are stepping up their reimbursement demands: Two federal circuits (the Third and the Eleventh) and four district courts in other circuits now recognize the right of MA Plans to obtain reimbursement from casualty insurers of the Plans' prior payment of Medicare beneficiary claims (Conditional Payments), and absent reimbursement, to sue the insurers. MA Plans are private, managed care companies that compete for Medicare beneficiaries with the Original, fee-for-service Medicare program administered by the federal government. Like Original Medicare, they are secondary payers under the MSP statute. While that is no longer disputed, how they can enforce that status has increasingly been the subject of litigation. Bottom line: MA Plans are stepping successfully into the shoes of CMS, and some are determined to make that the law in all the circuits. [Read recent Bulletins covering MA court decisions here and here.]

2. Medicare Drug Plans are making reimbursement demands too: With the rising cost of drugs, Medicare Part D Drug Plans may not be far behind MA Plans in renewed efforts to collect Conditional Payments. They are secondary payers just like MA Plans, but regulatory confusion has complicated and often thwarted their pathway to reimbursement from casualty insurers. Some believe that pathway could be cleared by SPARC Act legislation now pending in the House. [Read our recent SPARC Act analysis here].

3. Medicaid also is calling: A growing number of states have instituted, or are in the process of instituting, Medicaid reporting and/or reimbursement requirements for casualty insurers. Many anticipate the number will only increase with a decrease in federal Medicaid funding. We advise insurers to determine early in the claims process if the plaintiff/claimant is a Medicaid beneficiary and if the Medicaid program in that individual's state of residence has established reporting or reimbursement requirements for insurers. Because low-income elderly and disabled Medicare beneficiaries also qualify for Medicaid assistance (referred to as "dual eligible beneficiaries"), sorting out prior government program payments to plaintiffs/claimants can be challenging.

4. There is still no reporting exemption for Professional Liability payments: Despite informal CMS statements several years past that the agency might seek exemption of certain professional liability policies from Section 111 reporting, it has not sought an exemption. A claim under any casualty insurance policy that alleges and/or releases bodily injury and/or emotional distress will trigger reporting if paid or settled. There is no exemption for employment liability claims and often-overlooked legal malpractice claims that allege the claimant would have recovered damages (or additional damages) for bodily injury and/or emotional distress absent the malpractice. It may not be intuitive, but it is the law according to CMS.

5. Insurers are exercising new rights under the SMART Act: CMS was slow to implement the SMART Act amendments to Section 111, but the Act's new legal protections for casualty insurers are now in force. You should know when to claim them. *See* Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012, Pub. L. No. 112-242, 126 Stat. 2374 (2013). [Read our SMART Act Analysis here.]

- *Get a binding Conditional Payment amount before you settle*: CMS now offers parties settling a liability claim the option of requesting from CMS – immediately prior to settlement – a final, binding number that represents the Conditional Payment reimbursement that Medicare will accept to resolve both insurer and beneficiary liability. [Read about the final Conditional Payment Process here.] In the past, CMS only provided a tentative number that could increase after settlement if Medicare learned about other benefit payments between the date of providing the tentative number and the date of Section 111 notice.
- *Watch the Statute of Limitations*: The dispute is over; it is only three years. Under the SMART Act, CMS (and, we would assume, MA plans with a private right of action) may bring a recovery action for reimbursement of its Conditional Payments no later than "3 years after the date of the receipt of notice of a settlement, judgment, award or other payment made pursuant to [Section 111]."
- *$1,000-a-day penalty:* Accepting CMS practice, the SMART Act reclassified the mandatory insurer penalty for failing to report under Section 111 to a discretionary penalty.

6. Liability and No-Fault Medicare Set-Aside Agreements (MSAs) are back in the news: An MSA is a structured payment arrangement that allocates and sets aside funds from an insurer settlement, judgment, award, or other payment for a Medicare beneficiary's future medical care, paying primary to any Medicare reimbursement. Parties may welcome CMS approval if they are concerned that CMS might otherwise challenge the amount allocated to future medicals and reject Medicare's payment of the remainder. A year ago CMS announced that it was considering extending the formal, but voluntary, agency process that reviews Workers' Compensation MSAs to structured payment arrangements addressing liability and no-fault payments to Medicare beneficiaries. It bears repeating that no law or regulation requires, or has ever required, Medicare beneficiaries and casualty insurers to fund MSAs, nor has CMS issued Section 111 guidance addressing their use. [Read *Dispelling Medicare Myths in Tort Settlements*].

Recently, on June 8, 2017, in an *MLM Matters* article, CMS affirmed that it *will* establish two new set-aside review/approval processes – one for Liability Insurance Medicare Set-Aside Arrangements (LMSAs) and one for No-Fault Insurance Medicare Set-Aside Arrangements (NFMSAs). CMS anticipates these processes will open and accept review requests in mid-2018. In the same article, CMS notified the provider community that it will reject claims for services provided to Medicare beneficiaries during the period of time a casualty insurer accepts "ORM." (ORM is the Medicare acronym for "ongoing responsibility for medicals" and is used to identify an insurer's agreement to accept primary payment of future medical care.)

A growing number of plaintiff's attorneys are aware that Medicare can deny payment of their clients' future medical care if that care is for the same injury compensated by a casualty insurer. Although CMS cannot elect to pay for such care and later seek reimbursement of its payment from the insurer, the Medicare beneficiary's anticipation of non-payment by CMS has made MSAs a more frequent item of discussion during settlement negotiations. We typically do not recommend that a liability or no-fault insurer get involved in the set up or purchase of an MSA (e.g., determine the allocation between past and future medical needs), but we do understand an MSA's utility from the beneficiary's perspective and the desire for CMS sign-off. That said, that utility can increase the duration of negotiations while awaiting CMS approval, as well as the overall cost of

settlement.

7. CMS is issuing Demand Letters to casualty insurers in increasing numbers:

- As required by the SMART Act , CMS has implemented an administrative appeals process through which casualty insurers may appeal all or part of a CMS demand for reimbursement of Conditional Payments. Previously, only Medicare beneficiaries could appeal a Demand Letter. [Read our SMART Act analysis here.]
- Read the Demand Letter carefully. Insurers are encountering Demand Amounts that sweep in diagnosis codes not covered by insurer policies.
- Again, watch the Statute of Limitations. CMS has attempted to recover Conditional Payments long past the three-year mark.
- And remember that for most dates of incidence before December 5, 1980, the effective date of the Medicare Secondary Payer statute, Medicare remains the primary payer. CMS contractors have been known to forget that fact when insurers report ORM liability for a claim with a date of incidence before December 5, 1980.

We would welcome the opportunity to assist in auditing or updating your Section 111 practices. Please contact Kathryn Bucher at 202.719.7530 or kbucher@wiley.law.

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Our Section 111 Practice Group sends periodic Section 111 Bulletins to our clients addressing notable Section 111 and other Medicare Secondary Payer (MSP) developments, including coverage of CMS's Section 111 Town Hall Teleconferences. We maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please contact us if you wish further information on any MSP topic. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published here. You can sign up here to join the Section 111 Bulletin mailing list.