Assessing the Damage …

Medicare's Impact on Claims Handling and Settlement

Mark Popolizio
VP of MSP Compliance & Policy
mpopolizio@iso.com
(786) 459-9117

ISO Claims Partners

SERVE | ADD VALUE | INNOVATE

Copyright 2015. ISO Claims Partners retains sole ownership and copyright rights to this presentation. Any use or reproduction of this presentation without prior written consent and approval of ISO Claims Partners is prohibited.

Antitrust Notice

- The Casualty Actuarial Society is committed to adhering strictly to the letter and spirit of the antitrust laws. Seminars conducted under the auspices of the CAS are designed solely to provide a forum for the expression of various points of view on topics described in the programs or agendas for such meetings.
- Under no circumstances shall CAS seminars be used as a means for competing companies or firms to reach any understanding – expressed or implied – that restricts competition or in any way impairs the ability of members to exercise independent business judgment regarding matters affecting competition.
- It is the responsibility of all seminar participants to be aware of antitrust regulations, to prevent any written or verbal discussions that appear to violate these laws, and to adhere in every respect to the CAS antitrust compliance policy.

Objectives

1. Identifying the key components of MSP compliance

2. Recognizing MSP claims issues in real time

3. Assessing how MSP issues impact claims

4. Developing claims strategies to minimize risk and reduce costs

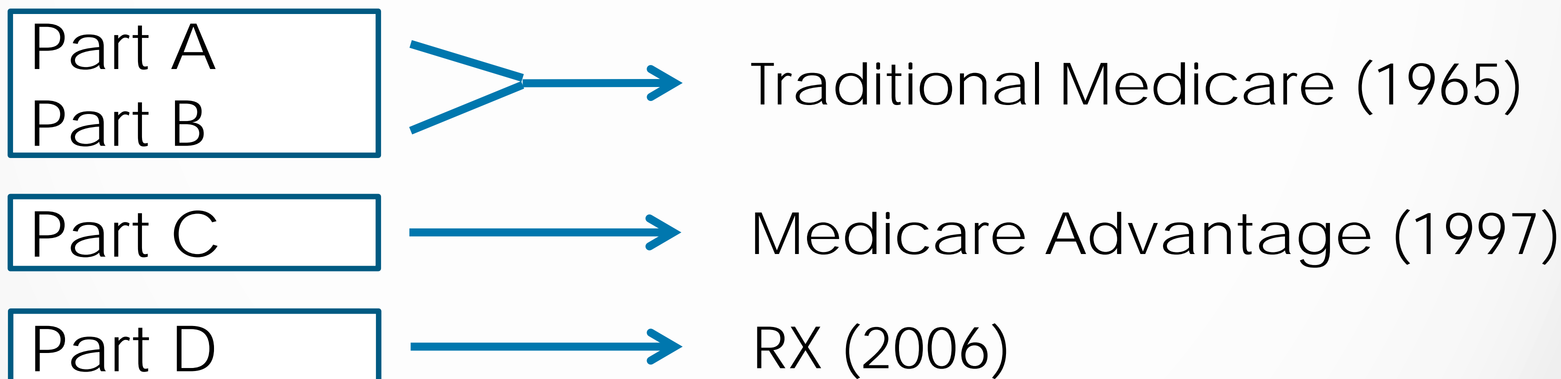
5. Understanding how new laws and policies will change MSP compliance

Part I

Medicare Warm Up

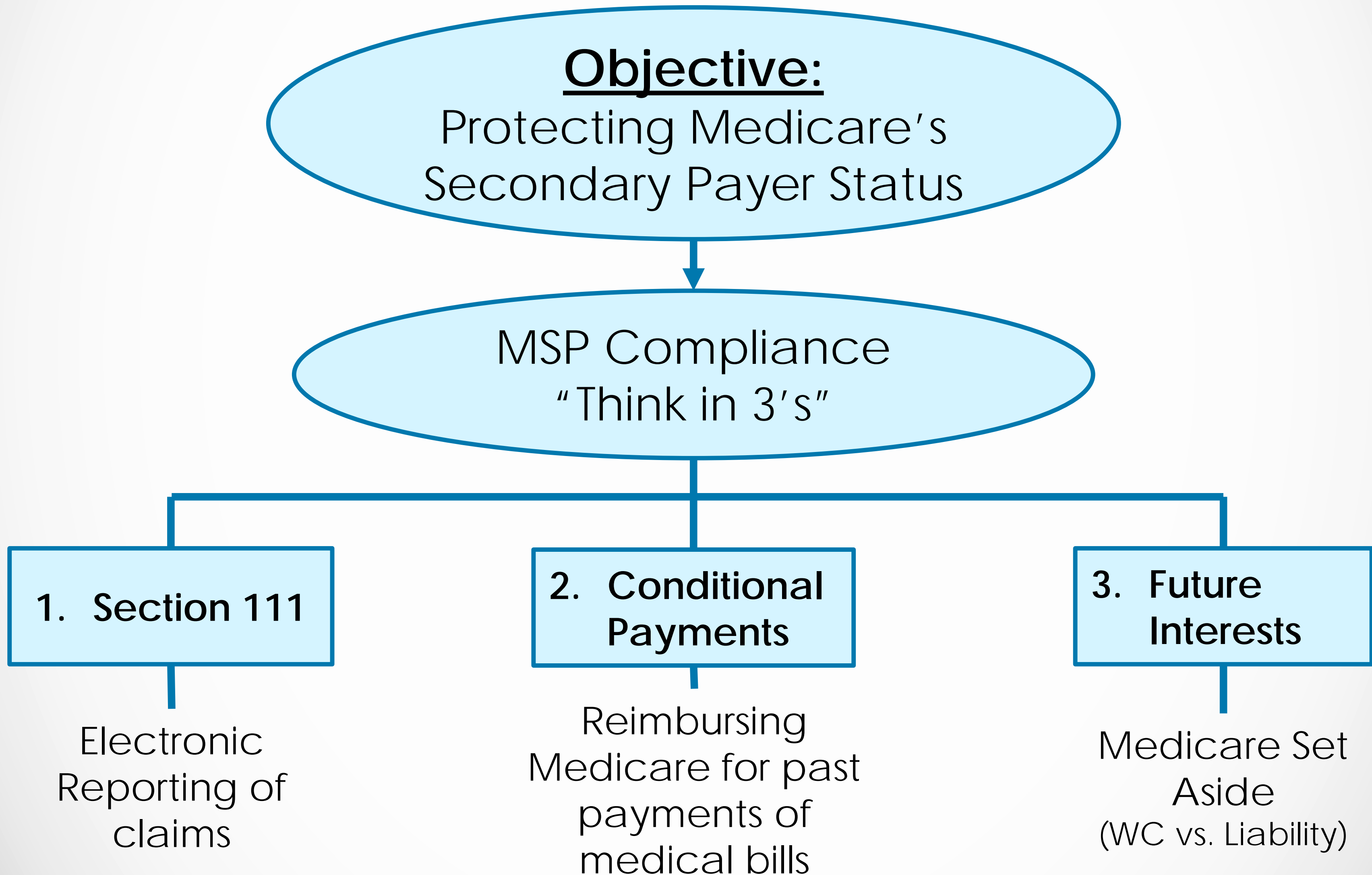
Medicare Level Set

- Federal health insurance program
- Provides medical benefits for certain people:
  - 65 years old or older
  - People who are awarded SSD
  - People who have ESRD or ALS
- Medicare has 4 parts:



- Medicare vs. Medicaid (Medi-Cal in California)

MSP Compliance – Thinking in 3's ...



Medicare "Alphabet Soup"

- **CMS** – Centers for Medicare and Medicaid Services
- **MSP** – Medicare Secondary Payer Statute
- **CFR** – Code of Federal Regulations
- **MAP** – Medicare Advantage Plan (contrast: Traditional Medicare)
- **MSA** – Medicare Set Aside
- **WCRC** – Workers' Compensation Review Contractor
- **MSPRC** – Medicare Secondary Payer Recovery Contractor
- **COBC** – Coordination of Benefits Contractor
- **BCRC** – Benefits Coordination and Recovery Contractor
- **CRC** – Commercial Repayment Center

Medicare Secondary Payer

Concept

- Medicare should be the payer of last resort whenever other insurance is available.

Origins

- MSP as a concept dates to 1965 and applies to WC, liability insurance, no-fault, and group health

Primary Payers - Requirements

- Report data (Section 111 Reporting)
- Repay Medicare (conditional payments)
- Reserve (Medicare Set-Asides)

Part II

Increased MSP Enforcement & ROI (GAO Study)

MSP Impact – By the Numbers

- Findings show increased compliance:

Factor	Findings (2008 to 2011)
Voluntarily reported NGHP MSP situations to CMS	Up from 141,890 to 392,254 (176% increase)
NGHP cases established by the MSP recovery contractor	Up from 238,293 to 480,188 (102% increase)
WCMSA proposals submitted to CMS for review	Up from 20,255 to 28,847 (42% increase) Note: the number of "ineligible" submissions increased by 148% during this period. Why?

MSP Impact – By the Numbers

- The study reported the following “savings:"

Factor	Savings 2008 to 2011
CMS payments to MSP contractors	Up from $86M to $106M (24% increase)
Conditional payment recoveries	Up by $124 million
MSAs approved (all lines)	Up from $737,338,280 to $1,102,662,414 (WCMSAs up from$136M to $142M during this period)

Impact on Claims Payers

- Programmatic
  - Increased claim values (especially WCMSAs)
  - Increased resources needed to address compliance obligations
  - Claim settlement challenges
  - MSP Best Practices/Protocols
    - Statutory/regulatory
    - CMS policy
    - Dealing with the grey
    - Risk Tolerance
    - MSP/CMS Reforms
- Trench Level
  - Adjuster training
  - Proactive cost reduction and settlement strategies
  - Minimizing risk/liability

Part III

Section 111 Reporting

CMS' Roadmap to Recovery

What is Section 111 About … and Not About?

- **Notice and reporting statute:**
  - Electronic reporting of claims involving Medicare beneficiaries to Medicare.
  - RREs report
    - Who is an RRE?
    - Claimants and their lawyers are **NEVER** RREs
  - Strict penalty - $1,000 per day, per claim
- **Query Process** – Determining Medicare status
  - Electronic inquiry
  - Function/Role
  - What data must be submitted?
  - Issues/Considerations

Boiling it All Down …

If you are an RRE

+ Claimant is/was a Medicare beneficiary

+ Claim meets a "Reporting Trigger"

Section 111 reporting required

Reporting Trigger #1 – TPOC

TPOC – Total Payment Obligation to the Claimant

- Settlement, Judgment, Awards or other payments
  - Claim resolution/partial resolution
  - Medicals claimed, released or settlement has the effect of releasing medicals
  - Reported only once
  - Case/Settlement status does not matter
  - Settlement allocation does not matter
- Monetary Thresholds (WC and liability)

Reporting Trigger #2 – ORM

ORM – Ongoing Responsibility for Medicals

- When RRE accepts "on-going responsibility" for medicals
  - ORM assumption/termination
  - On-going duty to monitor CL's MC status during ORM period
  - ORM could still exist on inactive or administratively closed files
    - ORM may still exist if claim is "subject to reopening or otherwise subject to a further request for payment"
- ORM – Exceptions
  - WC
  - Special exception (Doctor's note)
  - Qualified exception (look back period)

Section 111 – Claims Impact

- Home Grown System vs. Outsourcing
- Challenges
  - Determining Medicare status (in some quarters)
  - Reportability questions
    - Loss of consortium and other claims
    - Goodwill gestures, write offs, gift cards
  - Penalties
  - Error rates
- Understanding Section 111's limited function and role.

Part IV

Conditional Payments

New Policies & Opportunities

Conditional Payments

- **Claims Payers Challenges**
  - Obtaining CPs
  - Disputing CPs
  - Minimizing risk
  - Finality
  - Appeals Process
- **Recent Changes**
  - Recovery Agent
  - CRC Process
  - Appeals Process

Recovery Agent Process

- Effective as of 7/13/15
- RREs may submit recovery agent information as part of the Section 111 process.
- Both the RRE and recovery agent will be copied on recovery (Medicare conditional payments) correspondence.
- Optional and voluntary process.
- Objective/Goal
- Opportunities?

New CRC Process

Commercial Repayment Center (CRC)

- CMS will now use two different contractors pursue CP reimbursement: BCRC and CRC
- Which contractor CMS will use depends on who they choose to pursue.
- **As of 10/5/15**:
  - CRC will be used to pursue claims payers in ORM situations (unless BCRC had already created and developed the claim)
  - BCRC will be used to pursue recovery against the claimant.
- **BIG CHANGE**: CMS indicates that it may now seek reimbursement in ORM situations PRIOR to claim settlement

Commercial Repayment Center (CRC)

- **Consideration Points**
  - Understand the new CRC process.
  - CMS may now seek actual recovery of conditional payments PRIOR to claim settlement
  - Impact
    - Why is this significant?
    - Which claims will this impact?
    - What does it mean?
  - Claims considerations

Part V

Medicare Set Asides

WCMSA

CMS' MSA Process

- **Background**
  - 42 CFR 411.46
  - Commutation vs. Compromise
  - CMS Policy Memos
  - WCMSA Reference Guide
  - Review/Approval Process
  - WCRC
  - Submit or Non-Submit?

MSA Review Thresholds

WCMSA Review Thresholds	
WCMSA Threshold #1 Medicare Beneficiaries	**WCMSA Threshold #2** Non-Medicare Beneficiaries
Claimant is a Medicare beneficiary at the time of settlement and the **total settlement amount** is > $25k	Claimant is *NOT* a Medicare beneficiary at the time of settlement, but: i. The total settlement is > $250k; AND ii. The claimant has a **reasonable expectation of Medicare enrollment w/in 30 months of the settlement**.

CMS' Position

If a proposed WCMSA amount meets the workload review thresholds outlined below, the proposal can be submitted to CMS for approval.

If the parties to a WC settlement stipulate a WCMSA amount but do not receive CMS approval, then CMS is not bound by the amount stipulated by the parties, and it may refuse to pay for future claim-related medical expenses, even if they would ordinarily have been covered by Medicare.

However, if CMS approves the WCMSA amount and that amount is later properly spent, Medicare will pay Medicare-covered, claim-related medical bills regardless of the amount of care the claimant continues to require.

There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval.

WCMSA Reference Guide Version 2.3 (January 5, 2015, Section 8.0)

Non-Threshold Cases

- Deciphering CMS' position
- Issues/Considerations
- Drawing Lines

Non Submission Issue

- **CMS' Review Process**
  - Voluntary/Optional
  - Possible CMS recourses
  - Advantages/Disadvantages
  - Over the past few years, there has been increased consideration for "non-submission" approaches – Why?
    - CMS TATs (though less of an issue currently)
    - CMS' process and approaches:
      - Unpredictable
      - Unreasonable (i.e . RX)
      - Lack of independent process to challenge

CMS' Position

If a proposed WCMSA amount meets the workload review thresholds outlined below, the proposal can be submitted to CMS for approval.

If the parties to a WC settlement stipulate a WCMSA amount but do not receive CMS approval, then CMS is not bound by the amount stipulated by the parties, and it may refuse to pay for future claim-related medical expenses, even if they would ordinarily have been covered by Medicare.

However, if CMS approves the WCMSA amount and that amount is later properly spent, Medicare will pay Medicare-covered, claim-related medical bills regardless of the amount of care the claimant continues to require.

There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval.

WCMSA Reference Guide Version 2.3 (January 5, 2015, Section 8.0)

Non-Submission - Considerations

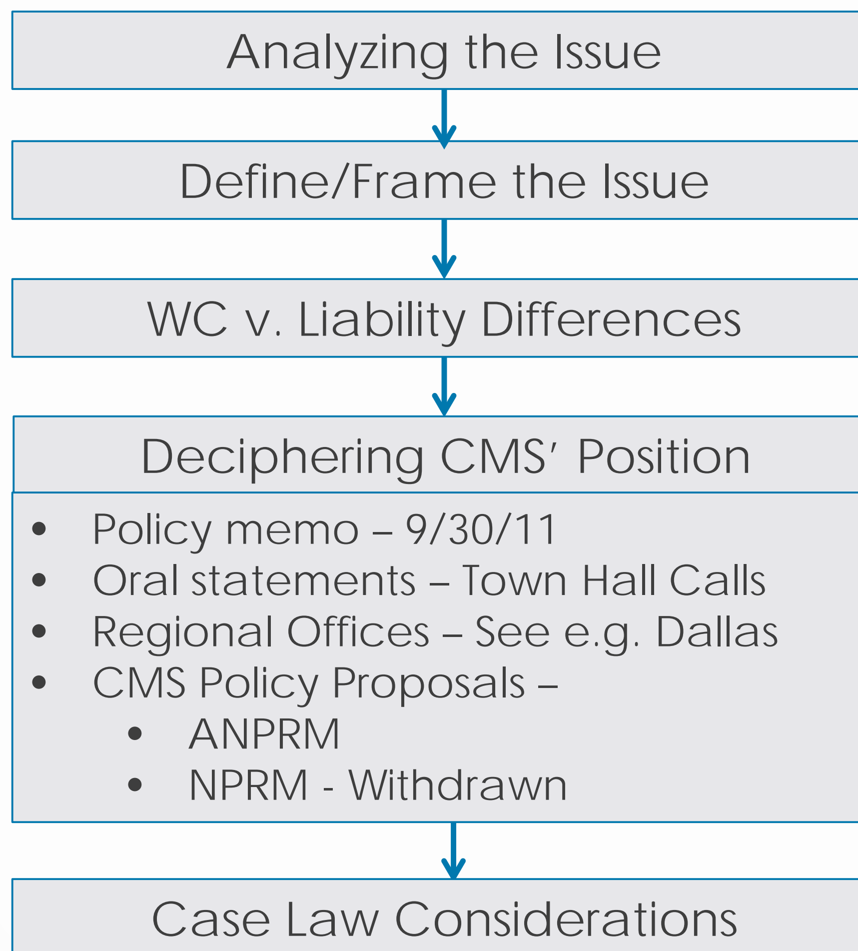
- Risk tolerance
- CMS recourse
- Whether and When?
- Issues
  - Calculating future medicals (options/approaches)
  - Practical considerations
  - Settlement language

Current Challenges

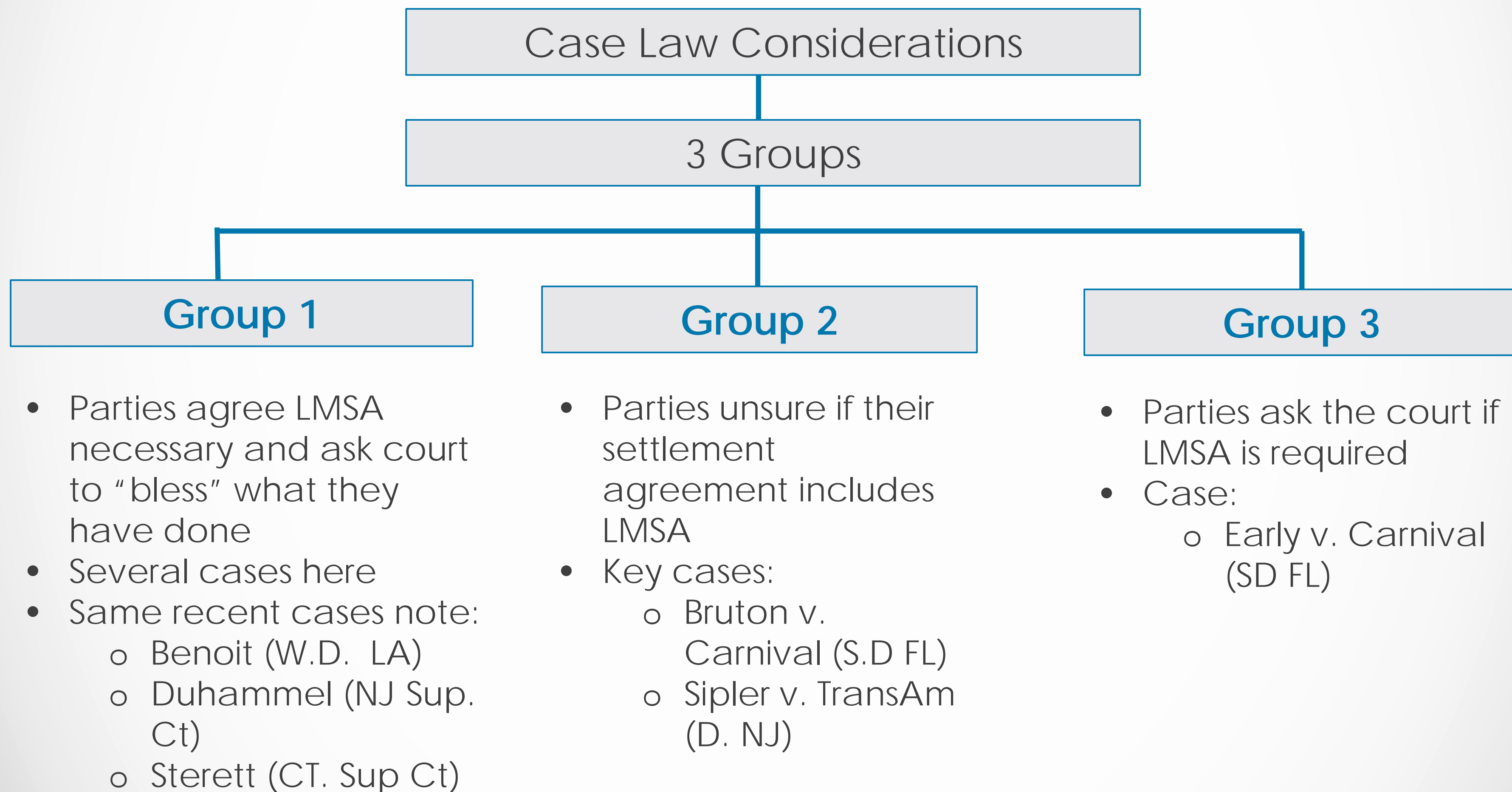
- High MSA amounts
- Missed mitigation opportunities at claims level
  - Timing
  - Lack of proactive strategies
- Limited recognition of state law
- No independent dispute/appeals process

LMSA

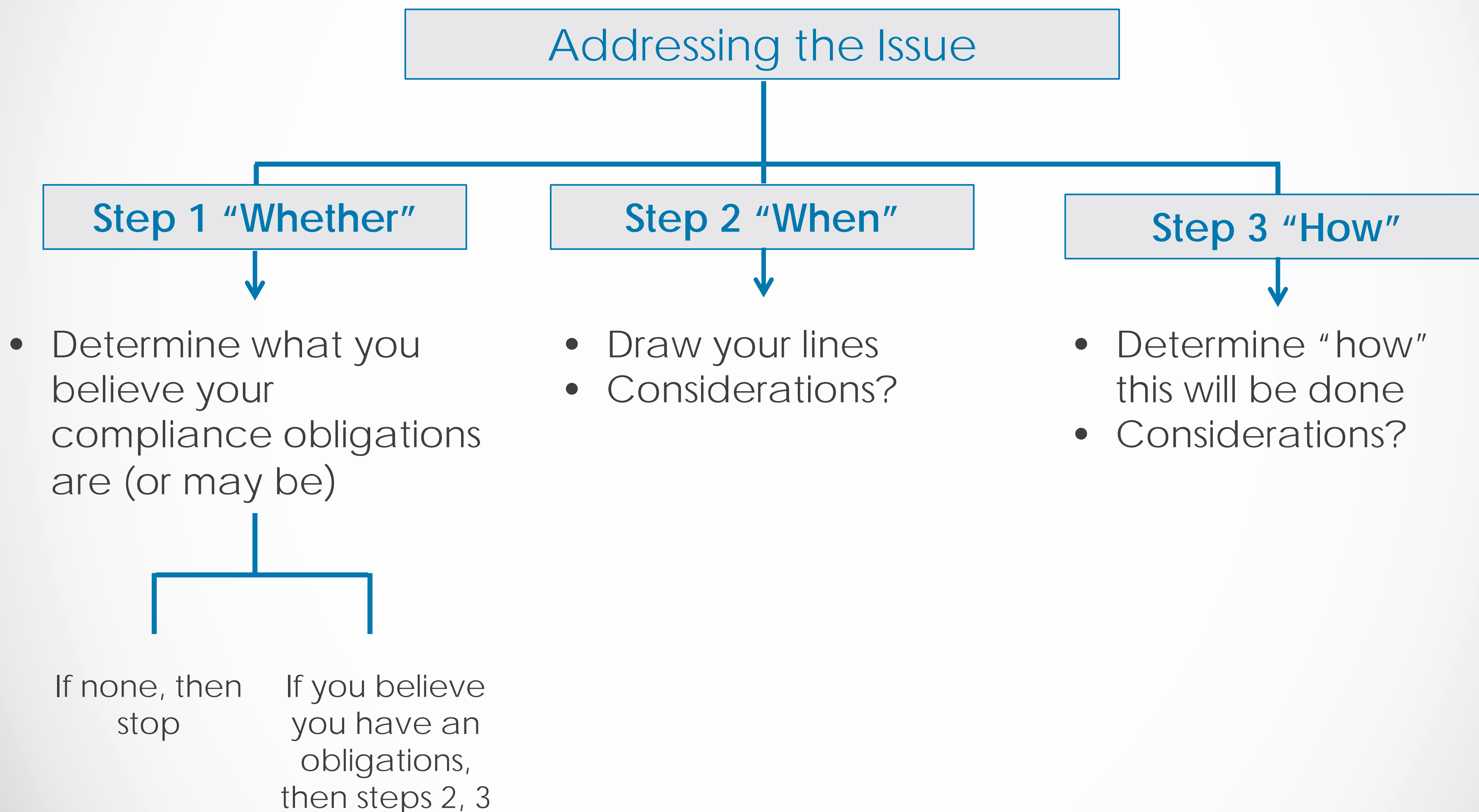
Addressing LMSA Issue



LMSA – Case Law



Practical Considerations



Part VI

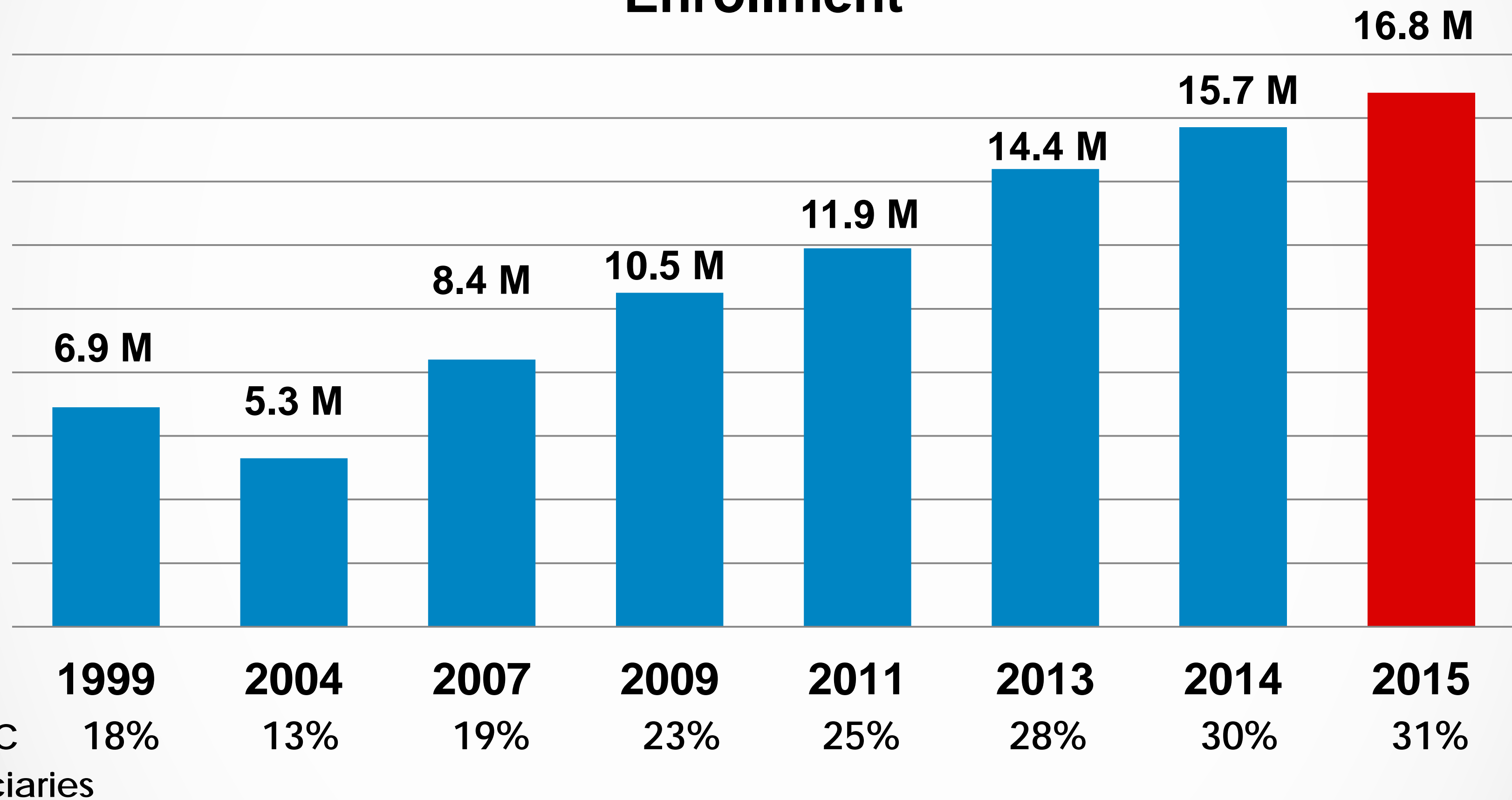
Medicare Advantage Plans

Next Compliance Frontier

Medicare vs. Medicare Advantage

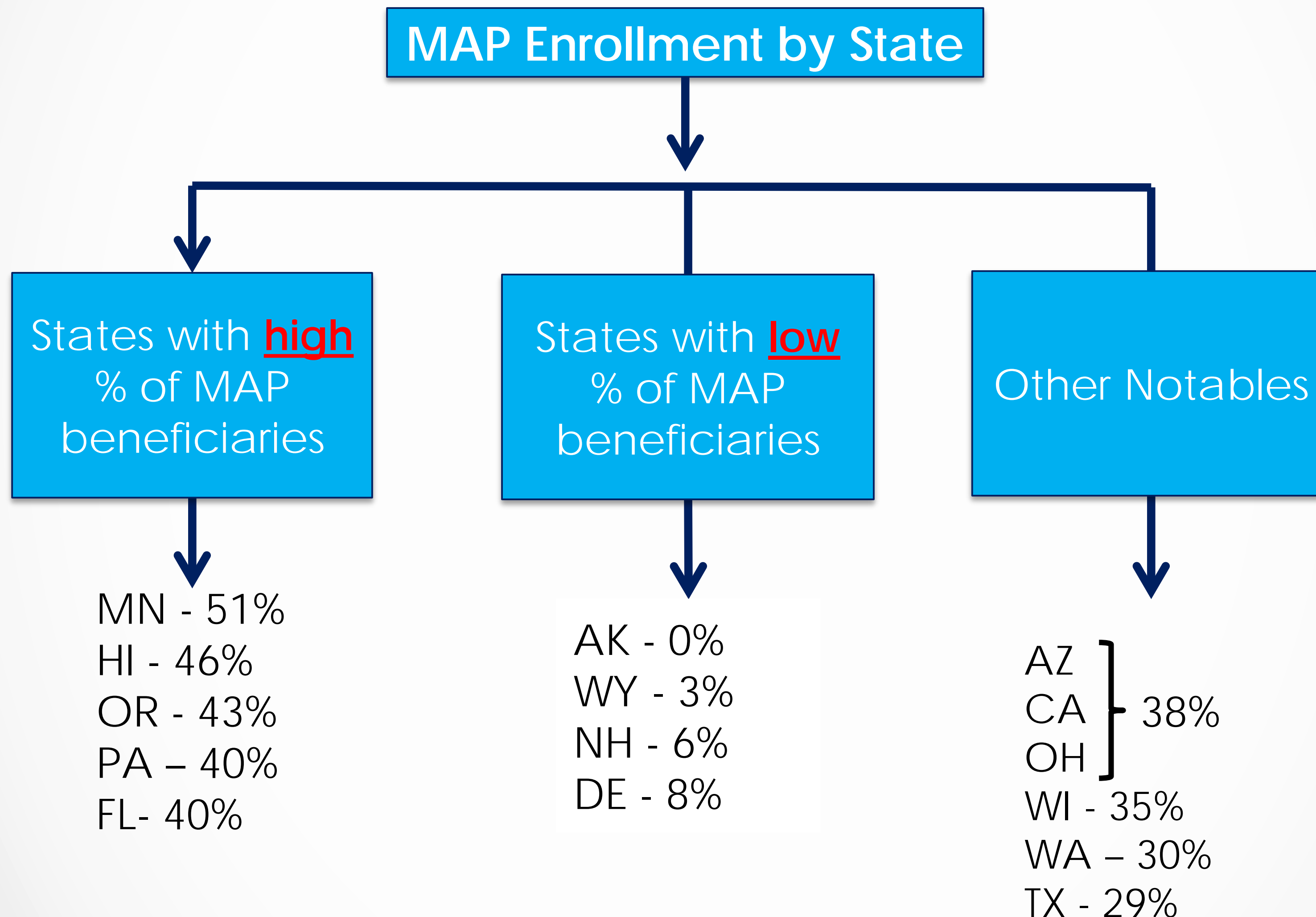
Traditional Medicare	Medicare Advantage Plans (MAPs)
• 1965 • Run by the federal government • Part A – inpatient hospitalization • Part B – outpatient services • 39M beneficiaries • Medicare Secondary Payer (MSP Act)	• 1997 • Run by private insurance carriers • Objectives: More options, cost containment, innovation • Must cover at least what Traditional Medicare covers • Most plans offer additional options • 15.7M beneficiaries (30% of MC beneficiaries) • 1,945 plans nationally (2015) • Medicare Advantage Act

MAPs – By the Numbers



Source: Medicare Advantage Fact Sheet, The Henry J. Kaiser Family Foundation, June 2015 (Figure 1).

MAPs by the Numbers



Source: Medicare Advantage Fact Sheet, The Henry J. Kaiser Family Foundation, June 2015 (Figure 2).

MAPs – Decision Points

- First, understand the issues and landscape
- Then ask: how should we approach this?
  - Jurisdictionally?
  - Monolithically?
  - Plaintiff/claimant?
- Consider current practical claims limitations and challenges (i.e. identification, discovery, etc?

Questions?

Mark Popolizio
VP, MSP Compliance
(786) 459-9117
mpopolizio@iso.com

Jeff Ballou
Account Manager
813-505-8432
jballou@iso.com