Medicare Set Aside Agreements

Helping Injured Workers Decide Between Self-Administration and Professional Administration

Presenters: Brian Bargender, Business Consultant Humana

Paul Sighinolfi, Senior Managing Director, Ametros

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Medicare Set-Aside Agreements: Helping Injured Workers Decide Between Self-Administration and Professional Administration

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Medicare Set-Asides

Duty to protect Medicare's interests, and……

Explore ways to protect your interests.

Role of Medicare Advantage and Prescription Drug Plans

- Brian Bargender, CSRP
  Subrogation & Other Payer Liability Business Consultant

Structure of the Medicare Statutes

- Part A:
- Part B:

} "Original Medicare"

- Part C: Medicare Advantage
- Part D: Prescription Drug
- Part E: Misc. provisions (including MSP)

Medicare Advantage Overview

- Alternative delivery mechanism for traditional Medicare benefits
  - Replaces coverage under Parts A and B
  - Same coverage determination rules as original Medicare
  - CMS sets additional rules (beneficiary protections, communication standards, benefit appeals process, etc.)
- Allows additional benefits not traditionally provided by Medicare
  - Built-in prescription Rx (aka “MAPD plans”)
  - Disease prevention & management
  - World wide emergency care coverage
  - Out of pocket maximums for financial protection
- Administered by private companies under contract with CMS

Medicare Advantage – Basic Structure

- Regional contracts with competing plans in each region
- Plans must meet state licensing & solvency requirements
- Per capita payments to plans based on enrollment, adjusted for:
  - MSP (primary group coverage identified by CMS)
  - Beneficiary health/risk status
  - Audit results
  - Star ratings (customer service metrics, beneficiary surveys/complaints, care delivery)

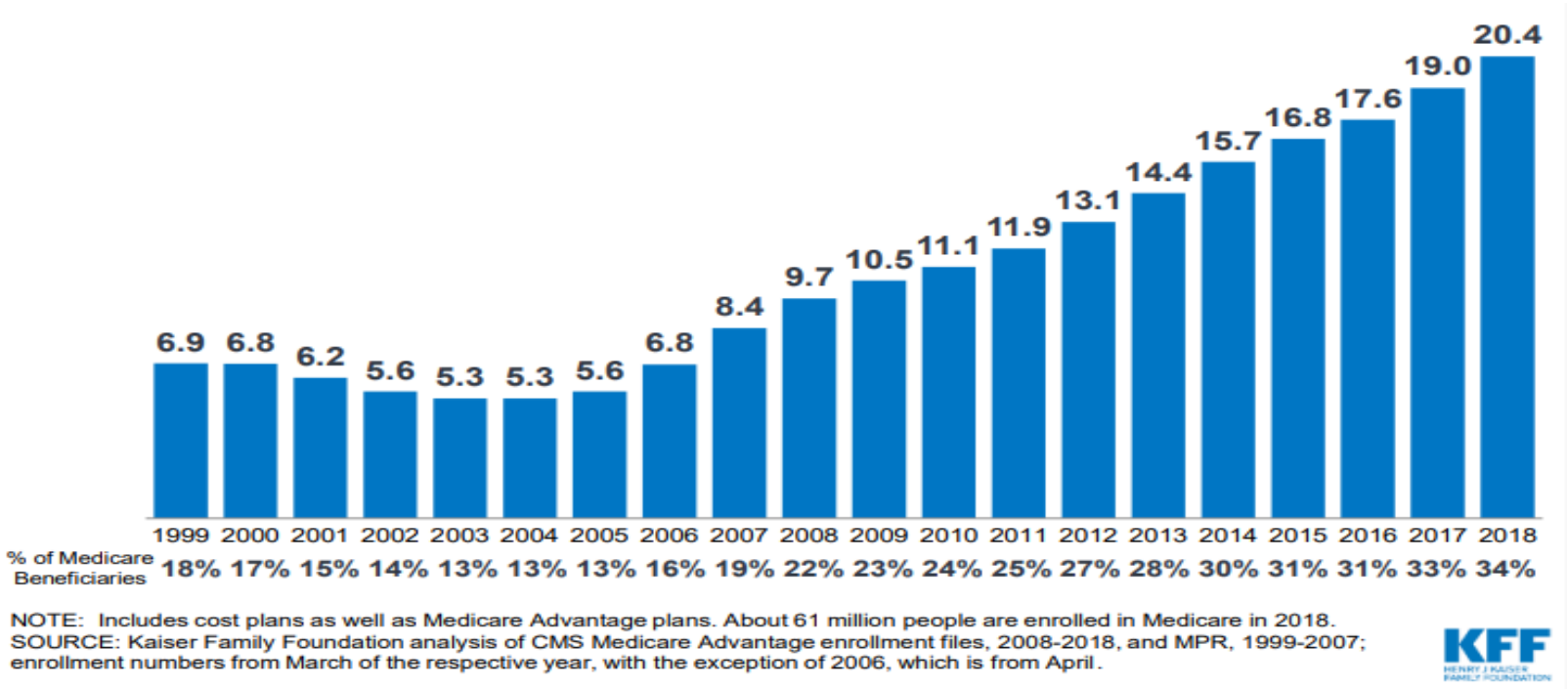
Medicare Part D (Prescription Rx) Overview

- Prescription Rx coverage (aka PDP)
  - Optional for both traditional Medicare & MA beneficiaries
  - Automatic for beneficiaries who are also eligible for Medicaid
- Provided through:
  - Medicare Advantage plans (MAPD)
  - Stand-alone Part D PDPs
- Contracting similar to MA
- Other rules: Medicare Prescription Drug Benefit Manual

Medicare Advantage v. Medicare Supplement

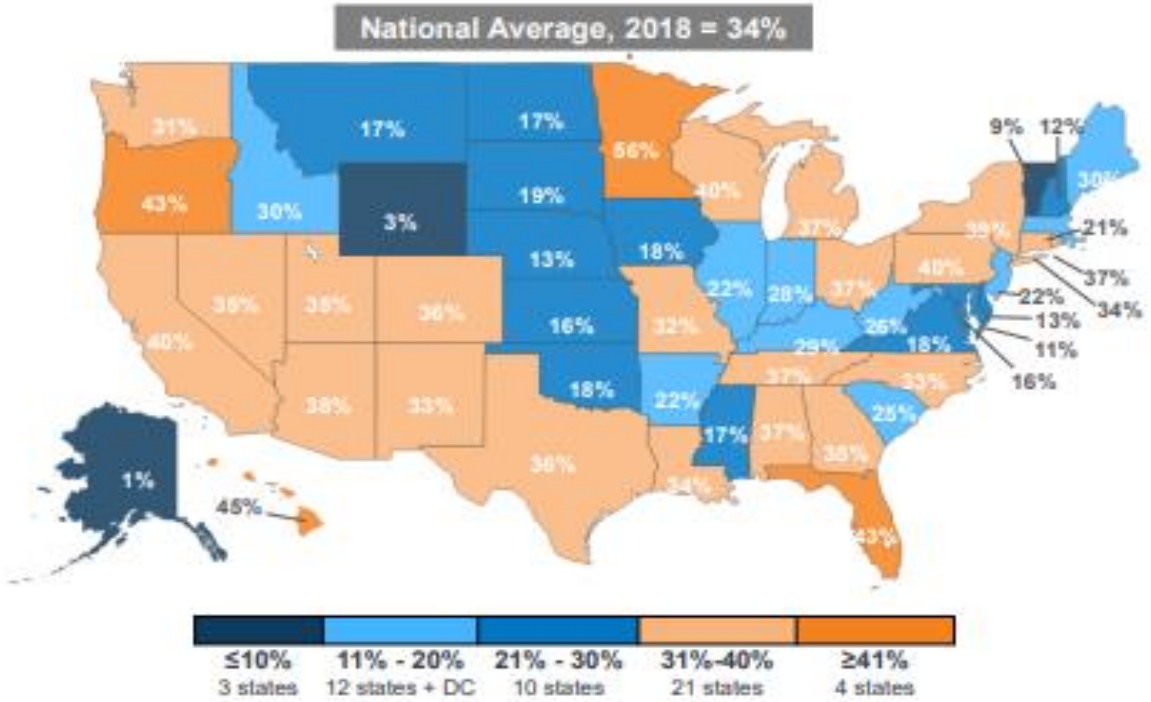
- Medicare Advantage (aka Part C or MAPD)
  - Medicare benefits provided **instead** of benefits under original Medicare under parts A & B
  - Recovery Rights: Same as original Medicare
- Medicare Supplement (aka “Medigap” see Part E § 1395ss)
  - Secondary benefits provided **after** Medicare parts A & B pay
  - Generally covers only Medicare copays, coinsurance, deductibles
  - Recovery rights: Same as private insurance

Medicare Advantage Enrollment, 1999-2017



"A Dozen Facts About Medicare Advantage", November 2018 Data Note, Henry J Kaiser Family Foundation, kff.org

Medicare Advantage by State



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

KFF
HENRY J KAISER FAMILY FOUNDATION

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Medicare Secondary Payer (MSP)

- Guidance from CMS

This much is clear…

- MA and Part D plans are part of Medicare
- CMS will penalize MA and Part D plans that fail to adequately enforce MSP
- MA and Part D plans must enforce MSP rules and **"will"** exercise same rights that original Medicare does under 42 CFR §411 subparts B through D (42 CFR §411.20 through 411.54)
  - "Medicare Secondary Payment Subrogation Rights", CMS Memo to MAOs and Part D Sponsors, Dec 5, 2011

Basic MSP Expectations for MA and PDP from CMS 42 C.F.R. § 422.101 and 42 C.F.R. § 422.108

- Observe rules established in manuals and in coverage determinations for original Medicare
  - Follow MSP rules in 42 CFR §411 subparts B through D (§422.108)
  - Program Manuals: Medicare Managed Care (MA) and Prescription Drug (PDP)
  - Original manuals: Medicare Secondary Payer and Claims Payment (§422.101)
- Identify payers that are primary to Medicare and pay secondary when possible, otherwise pay and pursue
- Plans that don't enforce MSP will see lower reimbursement from CMS

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Pre-payment Rights Extended under 42 CFR § 411 Subparts B through D

- Plans automatically authorized to obtain information needed to enforce MSP rules (§411.24(a))
- Preemption of state law COB rules and claim procedure rules imposed by primary payers (§411.32(a)(1))
- Payment denial for any injuries workers' comp should cover, even if claims are not filed (§411.43(b-d))
- Payment denial when automobile no-fault is available, even if claims are not properly filed (§411.50 and §411.50)

Post-payment Rights Extended under 42 CFR § 411 Subparts B through D

- All payments conditioned on reimbursement if/when another payer is identified (§411.52(b))
- Preemption of claim filing rules imposed by primary payers (§411.24(f) and §411.32(a)(1))
- Direct action against primary payers (§411.24(e) and §411.31)
- Recovery from beneficiaries, providers, attorneys and any others that received primary payment (§411.23 and 411.24(g))
- Offset of future payments to medical providers (§411.24(d))
- Subrogation and intervention rights (§411.26)
- Authority to collect interest on overdue reimbursements (§411.24(m))

MSP Enforcement Data Shared by CMS

- Data sources include:
  - MMSEA Section 111 mandatory insurer reporting
  - Beneficiary & plaintiff attorney self-reporting
  - Provider reporting
- Details include:
  - Primary payer and attorney information
  - Injury date diagnosis codes
  - Settlement indicators

Medicare Set-Aside (MSA) Guidance

- Approved MSAs become primary payers
- Minimal info provided to MA/PDP
  - Payer, administrator and diagnosis codes (but not medications)
  - MA/PDP must obtain the rest from the payer or the administrator
  - Only CMS contractors are allowed to fix errors
- Overpayments not recoverable from pharmacies
- Rely on CMS contractors to track MSA exhaustion of funds

MSP Obligations

- Beneficiaries and Third Parties

Beneficiary Obligations under 42 CFR § 411 Subparts B through D

- Cooperate with MSP efforts and submit proper claims against no-fault and work-comp payers (§411.23 and 411.24 (l))
- Pursue workers' comp claims and cooperate with recovery efforts(§411.43(a))
- Exhaust no-fault coverage (§411.51(a and b))
- Reimburse conditional payments within 60 days after payment obtained from a primary payer (§411.24 (h))

Primary Payer Obligations under 42 CFR § 411 Subparts B through D

- Release information needed for MSP enforcement ((§411.24(a) and 411.25)
- Provide reimbursement to the MAO/PDP whenever payment to beneficiary is conditioned on a release or when payment responsibility is demonstrated by settlement, award or a contractual obligation (§411.22)
- Reimburse MA/PDP even if payer has already made payment to the beneficiary (§411.24 (i))

Potential Non-compliance Penalties

- Payers
  - Reimbursement with interest (42 CFR §411.24(m))
  - Potential MMSEA Section 111 reporting penalties (42 CFR §423.462)
  - Double damages
- Beneficiaries
  - Claim denial
  - Termination of PDP Coverage (WC MSA Manual §4.1.3 and Prescription Drug Manual Chap 14 §40.1)
  - Reimbursement with interest (Double damages?)
- Entities paid by primary payers (attorneys, providers & others)
  - Payment with interest (42 CFR §411.24(m), 411.23 and 411.24(g))
  - Reimbursement with interest (Double damages?)

The Private Cause of Action & Double Damages (42 U.S.C. § 1395y(b)(3)(A))

- MA plans can obtain double damages from primary payers that fail to reimburse conditional payments
- Primary payers remain liable for repayment until the MA plan is repaid even if they've paid the claimant.
- Case Examples
  - ***In re: Avandia, 685 F.3d 353*** (3d Cir. 2012)
  - ***Humana Med. Plan, Inc. v. W. Heritage Ins. Co.***, 832 F.3d 1229 (11th Cir. 2016)
    - ***Cariten Health Plan, Inc. (Humana) v. Mid-Century Ins. Co.***, No. 3:14-CV-476-TAV-CCS, 2015 WL 5449221 (E.D. Tenn. Sept. 1, 2015)
    - ***Humana Inc. v. Medtronic Sofamor Danek USA, Inc.***, 133 F. Supp. 3d 1068 (W.D. Tenn. 2015)

Tips

- Working with MSP with MA and Part D Plans

Red Flags

- Medicare eligible
- No identified payer for medical charges
  - **CMS NGHP portal & letters: “no payment” under parts *A or B***
  - No provider liens
- Beneficiary won’t provide info needed for MSP verification
- Claim history treatment gaps (especially for work-comp)
  - Ambulance claim w/o hospital
  - Chronic injury condition w/ sporadic treatment
  - Claimants non-compliant with work-comp treatment plan

Basic Precautions for Primary Payers

- Train front-line staff on MSP basics including MA & Part D
  - Assume older & disabled claimants have some form of Medicare
  - Medicare/Medicaid dual beneficiaries? …assume Part D paid Rx
- Proactively identify health plan or medical payers
  - Seek copies of benefit ID cards
  - Watch for other payer info in medical records
  - Watch for notices from other payers
  - Seek MA/PDP “no payment” letters

Payers: No-Fault and Accepted Work-Comp

- Reimburse MA/PDP directly (don't pay providers they've already paid)
- Promptly pay other providers
- Check for Medicare/MA/PDP before issuing payment directly to the beneficiary

Basic Precautions for Plaintiff Attorneys

- Identify MA and PDP early
  - Obtain health benefit ID cards from beneficiary
  - Watch for additional payer info in medical records
- Do not wait to be contacted -- initiate contact as early as practical

Settlement Considerations

- Address MSP repayment before agreeing to settlement
  - Finalize conditional payment reimbursement before settlement is finalized
  - Payers: Don't assume plaintiff will reimburse MA plan or unpaid providers
- Payers: Take as much control over conditional payment resolution as possible
  - Work directly with MA plan (especially if beneficiary is unrepresented)
  - Issue separate checks/joint checks when feasible
- **Reminder:** All injuries and conditions alleged in demands are subject to recovery under MSP rules
  - See *Taransky v. HHS*, 760 F.3d 307 (3d Cir. 2014)

The Biggest "Don'ts"

- **#1** Ignore letters, calls & emails
- **#2** Payers: Assume claimants/attorneys will resolve MSP liens
- **#3** Withhold any info that CMS can demand
- **#4** Treat requests from MA & PDP like regular health insurance subro claims
  - "Policyholder must authorize payment and/or release of information"
  - "We will only pay providers that submit fully complete CMS 1500 claim forms"
  - "We're not responsible for addressing liens"
  - "Settlement funds are already disbursed"

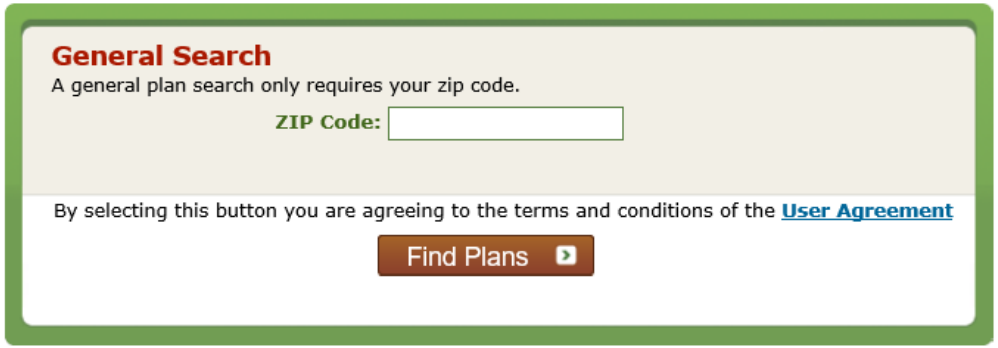
Disputing MSP Determinations by MA/PDP

- Formal process limited to beneficiaries, providers and representatives acting on behalf of the beneficiary
  - See 80 Fed. Reg. 10611 pg. 10616
  - Representatives need a CMS-compliant authorization from beneficiary
  - MA/PDP can require same info CMS requires for their review
- Same time limits as original Medicare (120 days after MSP determination)
- Levels 1 & 2 through plan; Level 3 and beyond through CMS

Identifying MA/PDP When All Else Fails

CMS Medicare Plan Finder

(verifies MA beneficiary plan selection)



https://www.medicare.gov/find-a-plan/questions/home.aspx

CAUTION: CMS records not always updated promptly

Contacting MA Plans

Humana bbargender@humana.com 920-343-1684	**Aetna** The Rawlings Group (502) 587-1279 http://www.rawlingsgroup.com/contact.asp
UnitedHealth Optum (866) 876-2791	**Anthem** Meridian Resource Group (800) 645-9785 mrcadmin@meridianresource.com
CVS Health (Silverscript Part D) claimsescalation@cvscaremark.com	**Others** Ask for Subrogation, COB or Legal Dept.

Life After Settlement: Advocacy After the Claim Closes

What is a Professional Administrator?

- A professional administrator is an independent party that helps both sides bridge the gap to settling a future medical claim
- A professional administrator:
  - Establishes a bank account for the injured party's future medical care
  - Receives bills and pays them on behalf of the injured party
  - In the case of an MSA, a professional

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Professional Administration and the Settlement Process

- Liability protection for all parties involved in the settlement process
- Management of future medical expenses
- Addresses and overcome injured

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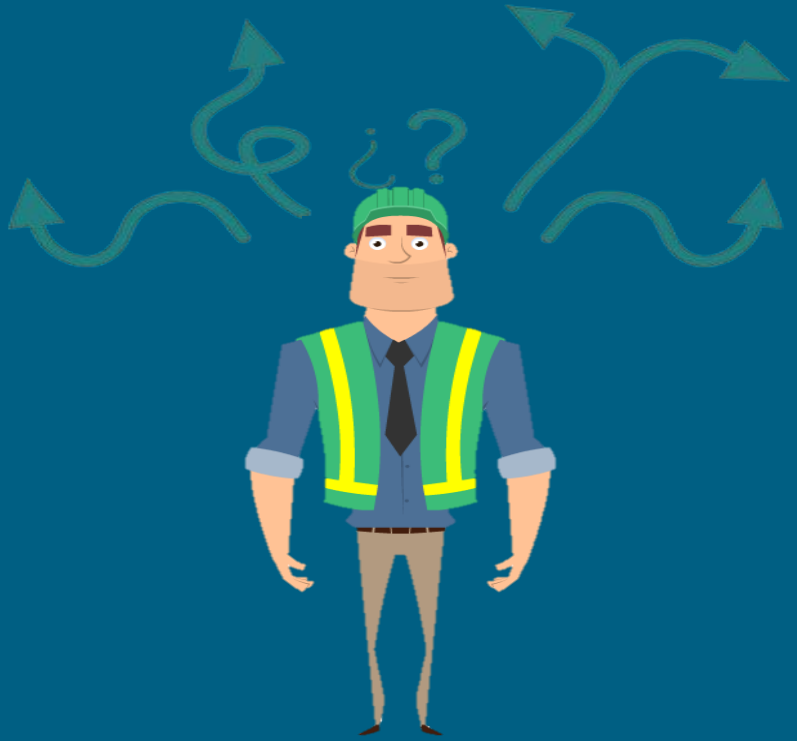
Settling Can be Daunting for an Injured Worker…



How do I know this process is fair?
Is the insurance company ripping me off?
Did my attorney leave money on the table?
Is it enough money?
How does the structured annuity work?
How much future treatment will I have?
What if my condition gets worse?
What do my treatments actually cost?
Will prices increase?
How do I report this MSA?
Could I lose my Medicare or Medicaid benefits?
What if I live longer than expected?
What if I run out of money?
What if I miss a bill payment?
What's related to my injury?
When can I use my own insurance?
Can I still call my adjuster or attorney?
Can my beneficiary have any remaining funds?

Who will help me over the long-

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CMS is Running Out of Money

Medicare Part A (hospital care) is expected to run out of money by 2026, three years earlier than projected in 2017.

*https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

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Increasing CMS Oversight

In 2014, CMS issued a 31 page "Self-Administration" Toolkit for Workers' Compensation MSAs:

- The vast majority of claimants self-administer their MSA resulting in inaccurate administration
- Claimants are left with the responsibility of adhering to difficult treatment and reporting guidelines

High Level Medicare (CMS) Administration Expectations	
CMS Expectations	Common Issues
Place funds in separate interest-bearing bank account	Funds often co-mingled with other funds
Identify if treatment or Rx is related to injury and Medicare covered	Funds used for unrelated injury treatment and non-Medicare covered items
Pay bills according to the specific state workers' compensation fee schedule	Providers typically over bill and Claimant unaware of how to locate fee schedule rates
Track all expenses, treatment, dates of service, and related ICD-9/10 codes annually	No reporting is completed or submitted

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MSA Requirements

For those with MSAs it's even more complicated…

1. Money must be put into a separate interest bearing bank account
2. Funds can only be used on treatments related to the injury
3. Funds can only be used for Medicare-covered expenses
4. Bills must be paid according to the appropriate state fee schedule
5. Prepare & submit annual reporting to CMS
6. Maintain line item detail for duration of eligibility

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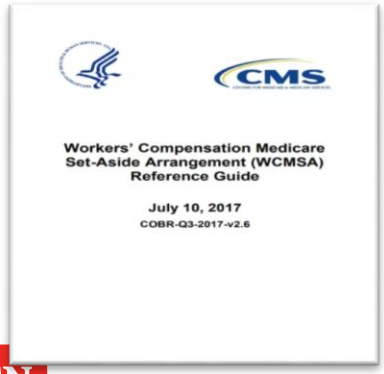
Professional Admin vs. Self Admin

Professional administration handles everything for the injured party ensuring they stay compliant with CMS guidelines so they don't jeopardize their benefits



Self-Administration allows the injured party to have the control over their funds and fulfil the requirements to CMS on their own while still receiving guidance

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Medicare compliance is only one component of professional administration and the support injured workers need post-settlement

Support/Advocacy

Medical Consultants / Care Coordinators

Savings

Technology

Resources

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Is the system fulfilling it's promise?

- Most injured workers who must treat consistently post-settlement are getting the short end of the stick

- If we don't start thinking about these people who are out there on their own navigating this complex process there will be long-term ramifications for:
  - Injured Workers
  - Attorneys
  - Payers
  - Medicare
  - System as a whole

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Top 5 reasons claimants settle

1) We ease their fears and frustrations, and demonstrate they are not alone after settlement
2) We save them money on future medical expenses, the savings can be left to their beneficiaries/estate
3) No more utilization review or independent medical evaluations
4) We handle all paperwork including Medicare Reporting of a MSA
5) They can treat as they want, no medical provider network, they can go to any doctor or pharmacy

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Win, Win, Win!

It's not just about the money at stake, or creating innovative settlement tools, it is about doing the right thing for our injured workers

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Questions?

- Is it possible to coordinate care between multiple providers and multiple insurers?
- How can an injured worker best avoid disruption in Medicare coverage?
- What is the impact of self-administration and Medicare on the WC stakeholders aside from the injured worker?