[C]onvoluted and complex and such a model of un-clarity.”

U.S. District Court Judge Mark Kravitz, describing the Medicare Secondary Payer Statute.1

The Medicare Secondary Payer (MSP) program is a longstanding—and until recently somewhat neglected—cog in the complex wheel of healthcare reimbursement. Long plagued by systematic shortcomings and infrastructure challenges, MSP has seen a resurgence in recent years due to enhancements in data collection and organizational capabilities, structural changes at the contractor level, agency focus, and significant statutory and regulatory developments including the passage of the SMART Act of 2013.2 These developments—fueled, in part, by the financial opportunities presented by MSP enforcement—have catapulted MSP considerations back onto center stage. Providers and other entities that depend on timely claims processing must be attentive to the nuances presented by these changes to MSP data collection. Similarly, the targets of potential MSP recovery actions must recognize the Centers for Medicare & Medicaid Services’s (CMS) evolving position with regard to MSP enforcement and the new tools coming to the enforcement regime within CMS. This article explores the consequences of the MSP program’s embrace of the information age, and looks at how the data collection, regulatory, and organizational changes will impact stakeholders and enhance the MSP program’s footprint in the claims processing environment, including recent MSP upgrades stemming from the Strengthening Medicare and Repaying Taxpayers Act (SMART Act).
The MSP program is a wide-ranging collection of statutes, regulations, administrative guidance, and contractor protocols, with significant consequences from both a regulatory and litigation perspective. In theory, MSP serves two important functions: the program ensures coordination of benefits by identifying payers that may be primary to Medicare; and, it facilitates Medicare’s recovery of paid funds when another payer is so identified. In practice, both functions have long been hampered by lack of consistent and reliable data upon which to act. This data gap is further complicated by the numerous stakeholders in the MSP process—beneficiaries, providers and suppliers, insurers, litigation defendants, plaintiffs, attorneys, CMS, and a myriad of contractors—all of whom participate in the flow of data within the MSP process.

An Old Friend
Medicare has long tried to identify other payers for MSP purposes, with varying degrees of success. Most of these efforts focus on identifying other traditional insurers that may be primary to Medicare, such as through the Initial Enrollment Questionnaire that specifically requests such information from the Medicare beneficiary. Data match and exchange processes between and among the Internal Revenue Service, Social Security Administration, CMS, and employers similarly seek to identify beneficiaries’ coverage. Providers must gather MSP data from patients, including the existence of insurance and whether another party may be liable for the patient’s injuries or illness, at each inpatient admission or outpatient encounter (with certain exceptions) and transmit such data inpatient admissions or outpatient encounters and whether another party may be liable for the patient’s injuries or illness, at each inpatient admission or outpatient encounter (with certain exceptions) and transmit such data appropriately code the MSP claim for subsequent follow up. As a general matter, this information flows into the Coordination of Benefits Contractor (COBC), which is tasked with evaluating the submitted MSP information and updating the Common Working File (CWF) for claims processing by the Medicare Administrative Contractor (MAC). These data collection processes, however, can miss subsequent events that impact the MSP analysis—most significantly, settlements with or payments to beneficiaries from alleged tortfeasors related to the medical expenses at issue. And, in many instances, collection of information at treatment may prove unreliable—particularly where information may be unknown at that time, including the existence of another payer or a tortfeasor that ultimately settles the matter. This area of MSP has seen the greatest change from a data collection perspective.

Coming of Age: MSP in the Information Age
Beginning in 2003, a rapid series of changes—both regulatory and structural—strengthened the MSP program within CMS by expanding the data gathering, collection, and organizational capacities. First, a series of high-profile federal court decisions in 2003 resulted in conflicting interpretations of the MSP Act regarding settling defendants’ exposure under the MSP program. As a result, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) clarified that an entity that finances all or part of a settlement/payment without recourse to insurance is an “insurer” for purposes of the MSP program. The MMA further clarified that such “self-insured plans” can demonstrate responsibility under the MSP regime by virtue of a settlement, payment, release, or “other means”—regardless of litigation claims or traditional notions of tort liability. These changes extended MSP’s reach to a wide range of parties, most significantly, defendants settling tort or product liability claims. Yet even with these changes, the process for notifying the COBC of the existence of a “self-insured plan” was nebulous at best, and many settling parties faced challenges with determining Medicare recovery exposure, which significantly impacted the structuring of settlements.

Recognizing the data gap, in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Congress amended the MSP Statute to impose reporting requirements on insurers (including “self-insured plans”) for certain settlements with or payments to Medicare beneficiaries, beginning in a staged rollout in 2011. Section 111 reporting is an electronic data exchange process to confirm whether an individual is a Medicare beneficiary, and, if so confirmed, requires electronic submission of over 100 data points regarding the individual, the settlement/payment, and the insurer/self-insured. CMS explicitly notes that Section 111 data will be used in claims processing.

The Section 111 reporting requirements are broad. Reportable incidents to CMS extend beyond traditional litigation settlements, and include certain actions/payments even
Beginning in 2003, a rapid series of changes—both regulatory and structural—strengthened the MSP program within CMS by expanding the data gathering, collection, and organizational capacities.

outside of litigation; for instance, where a reporting entity has the responsibility to pay a Medicare beneficiary’s ongoing medical expenses associated with a specific injury or illness (i.e., ongoing responsibility for medicals or ORM). This category generally applies when an entity or insurer is legally or contractually obligated to cover such expenses, but can include a “self-insured plan” or provider/supplier’s voluntary decision to cover the costs or provide such services at no charge. CMS has informally advised that ORM applies if it is “clear” that the entity “is assuming on an ongoing basis the obligation to directly take care of future medicals” relating to a specific injury; however, the guidance is of limited utility for many complicated risk management programs. ORM can also include a clinical trial sponsor’s payment for compilations or injuries arising out of the trial. ORM reporting has a significant impact on claims processing, as it specifically implies that an entity other than Medicare has assumed responsibility for such expenses; and in fact many stakeholders have raised concerns of inappropriate Medicare claims denials due to the first stages of ORM reporting.

A separate Section 111 category addresses payments/actions intended to minimize liability by fostering goodwill with claimants or prospective claimants. Such payments (including gifts) can be reportable if they seek to lessen the probability of a liability claim or to facilitate customer goodwill, when there is a reasonable expectation that the individual has or will seek medical treatment as a consequence of the underlying incident giving rise to the risk.

Section 111 also instructs provider billing requirements. To the extent a provider or supplier reduces or writes off a charge to a Medicare beneficiary as a risk management tool, it is expected to reflect that reduction as “self-insurance” in the claims submission process. CMS instructs that Medicare’s interest with respect to the write-off is addressed through the claim submission, rather than a separate Section 111 report.

The interplay between these reporting sub-categories is an evolving and sensitive area fraught with significant consequences and implementation challenges, especially when the purpose of a specific payment or action could meet more than one category. Reporting entities must be cognizant of the MSP consequences from a billing and recovery standpoint, as well as the $1,000.00 per day penalty for non-compliance with Section 111 reporting.

Finally, the SMART Act, signed by President Obama on January 10, 2013, amends the MSP statute to clarify reporting and recovery processes. The changes contemplated by the SMART Act generally are effective upon issuance of regulations by CMS, thus putting a premium on the rulemaking process and input by relevant stakeholders. Among other issues, the Smart Act:

- Provides a process for litigants to obtain a final recovery demand before settlement;
- Establishes minimum thresholds for both recovery and Section 111 reporting;
- Establishes penalty assessment guidelines for non-compliance with Section 111 reporting requirements;
- Calls for alternatives to the current mandatory use of certain personal information in Section 111 report submissions; and
- Clarifies the statute of limitations for recovery actions.

In sum, given the broad scope of reportable events, the large number of reporting entities, and the extensive information included in each report, Section 111 submissions will flood the COBC with additional MSP data for processing.

Dovetailing on these regulatory changes are administrative developments at CMS and on the contractor level to organize, analyze, and process the data collected as a result of expanded MSP information gathering. Within CMS, the newly reconstituted Division of MSP Program Operation, within the Office of Financial Management-Financial Services Group, acts as the conduit between the agency and the multiple contractors responsible for MSP operations. This newly enhanced division also serves as the introductory gatekeeper regarding MSP issues within complex products liability and mass tort circumstances.

At the contractor level, the COBC currently acts as the data intake and analysis filter, while the separate Medicare Secondary Payer Recovery Contractor (MSPRC) administers the MSP recovery process. In September 2012, CMS awarded a $300,000,000 contract for reorganization and consolidation of these and other functions into a single Coordination of Benefits and Recovery Business Program Operations Center. As described by CMS, this new entity will centralize and consolidate activities related to the “collection, management, and reporting of other insurance coverage” of Medicare beneficiaries, and the recovery of conditional payments or mistaken primary payments under the MSP program. The MSPRC also launched an electronic access portal to directly obtain and submit MSP information in July 2012.
The combination of enhanced data gathering tools and internal infrastructure modifications puts CMS in a stronger position to review and analyze the MSP landscape; however, as the data flow to the agency and its contractors increase on a real-time basis, so does the likelihood that claims will be denied, delayed, or otherwise scrutinized from a MSP perspective. The full implementation of Section 111 reporting is a primary tool in CMS’s strategic plan to transition from a “pay and chase” process to a “prevention and detection” cost-avoidance approach. The full scope of Section 111 data, along with other MSP information, will flow into the MSP contractor network for analysis. MACs will utilize that information for claims processing, with the possibility of claims denial or delay depending on interpretation of the MSP data. Additionally, the same MSP Contractor will administer recovery activities based on the data.

Challenges and Consequences of Data Collection
MSP data processes raise numerous challenges, aside from mere compliance with existing MSP billing requirements and Section 111 reporting obligations. For instance, the vast data exchange requirements raise ancillary concerns common to healthcare information management in the digital age. Health Insurance Portability and Accountability Act (HIPAA) considerations (where applicable), including business associate obligations and agreements with third-party MSP vendors or reporting agents, are further complicated by new regulations issued in January 2013 modifying the HIPAA Privacy and Security Rules. The sensitivity of the information reported via Section 111 was underscored by the SMART Act, which calls for revised guidelines regarding the (currently) mandatory use of Social Security Numbers and/or Medicare identification numbers in Section 111 reports.

More specific to MSP reporting, all Section 111 reporting entities must sign a Data Use Agreement with CMS that requires safeguards to protect data confidentiality and limits on the use, access, and disclosure of the subject information, and requires reporting entities to ensure that third-party vendors (such as consultants used to assist in reporting) establish appropriate safeguards to protect the exchanged information.

The increased focus on data gathering also has significant consequences for MSP recovery actions. The MSP statute provides broad authority for the federal government to pursue recovery of certain expenses paid on behalf of a beneficiary when the individual subsequently receives payment from a primary payer, such as a litigation settlement. In certain circumstances, recovery can be sought from the beneficiary, his/her attorney, or the insurer/settling defendant (even after settlement funds have been disbursed to the plaintiff). Enhanced MSP data empowers CMS to put its recovery mechanisms to full use. Changes from the SMART Act of 2013 further clarify these powers by streamlining the process for litigants to obtain amounts subject to recovery (the so-called “Medicare lien” amount).

Aside from traditional recovery matters, the increased MSP data flow through the contractor network raises a series of implementation questions and issues:

In June 2012, CMS requested formal comment on proposed guidelines regarding Medicare’s interest in and recovery of medical expenses incurred after a settlement/payment, commonly known as the “Medicare Set-Aside” or “Future Medicals” conundrum. These guidelines proposed several options under which parties can demonstrate that such post-settlement, future expenses are appropriately funded by the settlement or otherwise addressed by the parties. MSP data will help the contractor identify such issues.

CMS has informally indicated that Section 111 data will be shared with Medicare Advantage (MA) plans, which retain independent reimbursement and recovery rights for their Medicare enrollees. A spate of litigation in this area in 2012, including briefs pending as of late February 2013 before the U.S. Supreme Court on petition for writ of certiorari, will likely result in significant developments regarding MA Plans’ ability to utilize MSP mechanisms for recovery purposes. Any increase in MSP data flow will necessarily impact such Plans’ interest in MSP matters.

As the availability and scope of reimbursement data increases, the use of modeling and analytics for MSP reimbursement and recovery purposes becomes more reliable. Accordingly, at a certain point both CMS and stakeholders will need to consider whether certain administrative processes can or should be amended to reflect the use of aggregate data modeling for MSP recovery and reimbursement.

Stay tuned as CMS issues new rules and administrative guidance in the following months, amidst consolidation at the contractor level and an expected increase in collection and recovery efforts.
MSP requirements are often confused with condition codes used in billing for “no cost” items, such as medical devices that are provided by a manufacturer at no cost or with full credit to the hospital due to warranty. While not a MSP issue, these condition codes serve a related purpose of directing the MAC to factors that may modify Medicare payment. These billing requirements often interact with MSP considerations due to the nature of the circumstances in which they are relevant—most significantly, product liability litigation.

Whether the high hopes accorded to the SMART Act come to fruition will depend largely on the details of forthcoming regulations by CMS and the scope of stakeholder input through the rulemaking and comment process.

The federal government recovered a record $4.2 billion in alleged healthcare fraud in fiscal year 2012. The well-publicized False Claims Act (FCA) enforcement environment, fueled by the Affordable Care Act’s (ACA) overpayment self-disclosure mandates, and combined with CMS’s newfound MSP data, strongly suggests that stakeholders should re-evaluate the delicate relationship between FCA and MSP obligations. For example, CMS’s 2012 proposed rule implementing the ACA’s overpayment reporting requirements specifically references MSP obligations. Little has changed in the last ten years to alter Judge Kravitz’s apt description of the MSP Statute as a “convoluted and complex” model of “un-clarity.” Multiple stakeholders and a complicated regulatory program unite many legal disciplines in frustration. These recent changes give CMS the knowledge and tools for increased activity in the MSP arena, with consequences for a wide range of healthcare providers, suppliers, litigants, attorneys, pharmaceutical and medical device manufacturers. Stay tuned as CMS issues new rules and administrative guidance in the following months, amidst consolidation at the contractor level and an expected increase in collection and recovery efforts. As it has been said, with great new data comes great new power.

About the Authors

Barry Alexander (barry.alexander@nelson-mullins.com) is a partner with the firm of Nelson Mullins Riley & Scarborough LLP and chairs the firm’s National Healthcare Practice Group. Mr. Alexander focuses his practice on Medicare and Medicaid reimbursement issues; healthcare fraud and abuse counseling and defense including matters arising under the federal health care program’s anti-kickback statute, the physician federal self-referral or Stark law, Medicare Secondary Payer compliance and recovery matters, and the federal civil False Claims Act; complex healthcare mergers and acquisitions and health care finance matters for private nonprofit and for-profit entities including publicly traded healthcare providers; administrative matters arising before the Centers for Medicare & Medicaid Services including Medicare policy, coverage, and reimbursement advocacy; and corporate compliance including representation before the Department of Health and Human Services’ Office of Inspector General. Mr. Alexander serves as Chair for AHLA’s Regulation, Accreditation, and Payment Practice Group, and is an active member of the North Carolina and District of Columbia Bar Associations.

Eli Poliakoff (eli.poliakoff@nelsonmullins.com) is a partner in the Charleston, SC, office of Nelson Mullins Riley & Scarborough LLP. His practice focuses on healthcare regulatory and operational matters; Medicare and Medicaid reimbursement issues; Medicare Secondary Payer requirements, including recovery/reimbursement obligations, MMSEA Section 111 Reporting, MSP billing, and MSP compliance for litigants, prospective litigants, healthcare providers and medical device manufacturers; and information privacy and security obligations under HIPAA and the HITECH Act for healthcare providers, technology vendors and services, and health information exchange (HIE) participants. Mr. Poliakoff is a member of AHLA’s Regulation, Accreditation, and Payment Practice Group.

The authors work with a variety of healthcare providers, medical device manufacturers and product liability defendants on Medicare Secondary Payer and third party payer matters.
Endnotes

4 MSP Manual, Ch. 3, § 20.
5 42 C.F.R. § 489.20(g); MSP Manual, Ch. 3, § 20.1; Ch. 1, § 10.7.
6 MSP Manual, Ch. 3, §§ 30-50.
7 The CWF is the master beneficiary file updated daily and available through a shared contractor system, against which Part A and B claims are processed prior to claims payment. The CWF includes a wide array of data on the beneficiary and his/her claims, such as entitlement, utilization, history, and MSP information. See Medicare Claims Processing Manual, Ch. 27, § 10.
8 MSP Manual Ch. 6 § 10.
9 See United States v. Baxter Int’l, 345 F.3d 866 (11th Cir. 2003); Thompson v. Goetzmann, 337 F. 3d 489 (5th Cir. 2003).
12 42 U.S.C. §1395y(b)(8). This article is not a summary of MMSEA Section 111 reporting, which is an evolving and detail-intensive process governed by overlapping statutory, regulatory and informal administrative guidance by CMS. The CMS Section 111 website (www.cms.hhs.gov/mandatorysrep) includes a 2012 User Guide and other materials. Section 111 also includes reporting requirements by group health plan insurers or third-party administrators that provide coverage to Medicare beneficiaries (GHP Reporting), which serves a similar MSP identification purpose. Reporting obligations for GHPs are in the form of an ongoing data exchange with the government to identify which individuals with GHP coverage are Medicare beneficiaries. In contrast, reporting of settlements and other payments/actions are classified as Non-Group Health Plan (NGHP) reporting.
13 MMSEA Section 111 NGHP User Guide v.3.4, Ch. 1, § 4, at p.7.
14 Section 111 Teleconference, Apr. 24, 2012, transcript at 45.
15 MMSEA Section 111 NGHP User Guide v.3.4, Ch. III, § 6.5.1, at 40.
17 MMSEA Section 111 NGHP User Guide v.3.4, Ch. III, § 6.5.1, at 41; Section 111 Teleconference, May 27, 2010, transcript at 39.
18 MMSEA Section 111 NGHP User Guide v.3.4, Ch. III, § 6.5.1, at 41
20 Award Notice, Solicitation Number RFP CMS-2011-0048 (Sept. 27, 2012).
21 See https://www.cob.cms.hhs.gov/MSPRP/.
22 CMS Annual Report, FY 2012, at 23.
24 SMART Act, Pub. L. No. 112-242 (Section 204).
25 MMSEA Section 111 NGHP User Guide v.3.4, Ch. III, § 6.5.1, at 43.
29 Section 111 Teleconference, Mar. 22, 2012, transcript at 17. The traditional MSP recovery process applies to items and services directly paid under Parts A and B of the Medicare Program. With roughly a quarter of the Medicare beneficiary population now enrolled in a private Medicare Advantage (MA) plan, this creates a potential gap in MSP recovery. While MA plans are private commercial plans with their own right of recovery, MA plans would directly benefit from some sort of participation in data sharing of Section 111-reportable information.
32 The traditional MSP process works best, if at all, on an individual beneficiary basis. A number of high-profile products liability cases have pointed out challenges with the traditional reporting and recovery process, particularly where medical treatment may be ongoing (as opposed to a single/isolated group of expenses around a specific date—e.g., a car accident). As CMS moves to bundled and global episode of payment models in the traditional payment process, it seems reasonable that the agency will likewise consider application of these principles to MSP cases.
33 Medicare Claims Processing Manual, Ch.32, § 67.
35 See 77 Fed. Reg. 9179, 9181 (Feb. 16, 2012) (“Examples of overpayments could include . . . Receipt of Medicare payment when another payer had the primary responsibility for payment.”).

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