Just Add CMS Guidance

Modernizing MSP Cost Containment Protocols

By John V. Cattie, Jr.

2013 appears to be the year when settling parties' roles and responsibilities will be "cemented" into place.

2013 appears to be a watershed year for the Medicare Secondary Payer (MSP) program, one that may have a drastic effect on your practice given some proposed changes to the MSP program.

You could think of the MSP like concrete. Among other things, concrete consists of cement, gravel, sand, and water. When combined, these separate and distinct components transform into a powerful bonding agent. But all components must be present to give the concrete its strength. This article explains the different components of the MSP in light of recent guidance, and how these components collectively strengthen Medicare's recovery rights.

Like concrete, the MSP (42 U.S.C. §1395y(b)(2), as amended by the Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2012, Pub. L. 112-242, 126 Stat. 2380), also consists of separate components that must all be addressed for maximum compliance. These components are Medicare Medicaid SCHIP Extension Act (MMSEA) Section 111 (Section 111) reporting, conditional payment reimbursement, and future medical expenses. Metaphorically, one could think of Section 111 as the gravel, conditional payment reimbursement as the cement and future medical expenses as the sand. The Centers for Medicare and Medicaid Services (CMS) will add the water this year by issuing regulations operationalizing the SMART Act and guidance for MSP compliance on future medical expenses. Once those regulations are issued, the MSP will morph from a bag of cement into industrial grade concrete, as it develops a strong foundation upon which MSP compliance programs can be built.

Medicare may collect double damages plus interest from parties responsible for reimbursing Medicare when the parties do not reimburse Medicare for conditional payments. 42 U.S.C. §1395y(b)(2)(B)(iii). But does this priority right of recovery apply evenly to future medical expenses as well as to past medical expenses? Does this priority right of recovery apply evenly to defendants as well as to plaintiffs? At the heart of the confusion surrounding MSP compliance is identifying who is responsible to Medicare for future medical expenses, referred to as "future medicals."

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This article has two purposes: (1) to explain the term "conditional payment" as Medicare applies it; and (2) to clarify how adding "water" in the form of regulations affects defendants and insurance carriers with respect to future medicals. Outside the scope of this article is a detailed discussion of potential regulations CMS may implement to operationalize the recently enacted SMART Act. *Id.*

The Composition of Concrete: MSP Recovery Obligations

At times, Medicare may make payments for medical services for which the program expects reimbursement. The payments cover medical services that beneficiaries have already received. These payments are known as "conditional payments," and under the MSP, Medicare must be reimbursed for the conditional payments that it makes. 42 U.S.C. §1395y(b)(2)(B)(ii). Conditional payments represent one key component of the MSP. When parties resolve their legal disputes in the form of a settlement, judgment or other payment, those events trigger Medicare's recovery right.

Future medicals represent another key recovery piece of the MSP. In lump sum compromise workers' compensation settlements where the settlement agreements allocate certain amounts for future injury-related medical expenses, Medicare will not pay for those expenses until the amount allocated is exhausted by paying for an equal amount of those medical expenses. *See* 42 C.F.R. §411.46(d)(2). CMS interprets the MSP to include a right to not pay certain future medicals when "payment has been made or can reasonably be expected to be made." 42 U.S.C. §1395y(b)(2)(A)(ii).

We cannot fully understand Medicare's right to remain a secondary payer post-settlement, by not paying for certain future medical expenses, without first understanding Medicare's right to be reimbursed for any conditional payments that it made prior to settlement.

The Cement of the MSP: Conditional Payment Reimbursement

Medicare does not automatically possess a recovery right under the MSP. Medicare's recovery rights ripen when a primary plan or payer, in resolving disputes involving medical expenses pled, claimed and/or released by a Medicare beneficiary, accepts responsibility (but not necessarily liability) for those expenses, which is demonstrated by a judgment or a payment conditioned upon a waiver, compromise, or release. 42 U.S.C. §1395y(b)(2)(B)(ii). If a payer demonstrates responsibility, then the payer and any entity that has received payment from the payer must reimburse Medicare for any conditional payments made. *Id.*

A "conditional payment" is an MSP term of art. Medicare defines a "conditional payment" as a Medicare payment for services for which another payer is responsible. 42 C.F.R. §411.21. Medicare makes a "conditional payment" when no one else has accepted responsibility for that medical expense or service. But the fact that Medicare makes a "conditional payment" does not automatically mean that payment must be reimbursed. Federal law provides Medicare a recovery right only under certain circumstances.

Regulations previously promulgated by Medicare fill in the blanks created by the MSP statutory language. Medicare's recovery rights ripen under federal law only if: (1) a payer accepts responsibility for a claimant's medical expenses, and (2) that responsibility is demonstrated by a settlement, judgment, award, or other payment conditioned upon the recipient's compromise, waiver, or release (regardless of any determination or admission of liability) of payment for items or services included in a claim against the primary payer or its insured). 42 C.F.R. §411.22. Thus, under Medicare's own rules, a "conditional payment" is exactly what it sounds like: a payment that Medicare may make for items or services when repayment is conditioned on the subsequent act of a payer accepting responsibility for those items or services, and such responsibility is shown by an obligation to pay for those items or services whether by settlement, judgment, award, or otherwise.

Medicare's regulations also specify exactly who is on the hook for conditional payment reimbursement. Without question, Medicare may pursue any entity that makes or receives payments, if conditional payments are not reimbursed. 42 C.F.R. §§411.24(e), (g). While Medicare has the ability to cross-service a debt it is owed (*i.e.*, refer the eligible delinquent debt to the U.S. Department of Treasury for collection), and as a result, typically pursues a claimant and the claimant's attorney for conditional payment reimbursement before pursuing a primary payer, the CMS has demonstrated a willingness to pursue primary payers as well. *See United States v. Stricker,* 2010 WL 6599489 (N.D. Ala. Sep. 30, 2010); *see also Medicare Financial Management Manual*, CMS Pub. 100-06, Chap. 4, Section 70.3; *see also* Debt Collection Improvement Act of 1996, P.L. No. 104-134, 110 Stat. 1321, 1358 (April 26, 1996); *see also* 31 U.S.C. §3720C.

Like sand is more susceptible to nature's elements than cement, future medicals usually are more susceptible to interpretation.

Importantly, provided CMS does not pursue legal action, the maximum amount reimbursable to the CMS is capped by the gross damages award. 42 U.S.C. §1395y(b)(2)(B)(ii). Beyond that amount, the payer has not accepted responsibility for and cannot be held liable to Medicare for any additional funds. Medicare's recovery rights, outside that gross award for which a payer has accepted responsibility, have not ripened. If CMS does not have to pursue a legal action to recover, then it will recover the lesser amount of the conditional payment amount compared to the gross award. 42 C.F.R. §411.24(c)(1). If CMS is forced to take legal action against a payer to recover conditional payments, then it may seek to recover twice the amount of those conditional payments. 42 C.F.R. §411.24(c)(2).

Medicare also has promulgated certain regulations that primary payers should heed in particular. Medicare advises that if a beneficiary or other party that receives payment from a primary payer does not reimburse Medicare timely, the payer must reimburse Medicare even if it has already reimbursed the claimant or the other party.

42 C.F.R. §411.24(i)(1). Those same provisions also apply if a primary payer disburses proceeds to a claimant and knows or should have known that Medicare has made a conditional payment. 42 C.F.R. §411.24(i)(2).

Situations involving procurement costs follow a different set of rules. 42 C.F.R. §411.24(i)(3). These rules apply when counsel represents a claimant. Instead of 42 C.F.R. §411.24 dictating how much Medicare can recover for a conditional payment, 42 C.F.R. §411.37 becomes the operative regulation. Medicare advises that if it seeks recovery from a payer, in accordance with 42 C.F.R. §411.24(i), then it will recover nothing more than is permitted under 42 C.F.R. §411.37(c), §411.37(d), or §411.37(e). 42 C.F.R. §411.37(b).

According to the ANPRM, the individual or Medicare beneficiary would be *required* to satisfy Medicare's future interest by selecting one of seven proposed options.

These three subparts prohibit Medicare from recovering more than the gross award from where Medicare is not required to take legal action to recover. When a conditional payment amount is less than the gross award, Medicare recovers a percentage of the amount of the conditional payments that it made, determined after applying a ratio of procurement costs to the gross award. 42 C.F.R. §411.37(c). When a conditional payment amount exceeds the gross award, Medicare recovers the total amount of the gross award less total procurement costs. 42 C.F.R. §411.37(d). If the CMS incurs procurement costs when it attempts to recover for a conditional payment due to opposition from the claimant, Medicare recovers the lesser of the total conditional payment or the gross award, minus the claimant's total procurement cost. 42 C.F.R. §411.37(e). Where (1) the CMS makes conditional payments for injury-related care after a Medicare beneficiary receives the care; and (2) a primary payer accepts responsibility for the beneficiary's medical costs as evidenced in a settlement, judgment, or award by a primary payer, thereby triggering Medicare's recovery right, parties need to ensure a reimbursement process exists to repay CMS for its conditional payments. The procurement cost offset rules lead one to the conclusion that claimant's counsel is better situated to address conditional payments, but also that defense counsel should ensure a formal process is established (by utilizing release language containing representations and warranties from plaintiff and evidence of lien satisfaction as a condition subsequent to the agreement). By following these rules, a payer's liability to Medicare for conditional payments will not exceed the amount of the gross settlement, judgment, or other payment amount.

Can CMS Make a Future "Conditional Payment"?

With this foundation, we can consider what kind of recovery right Medicare has regarding future medicals. More importantly, we can identify which parties have exposure to Medicare if that recovery right is not addressed compliantly. Specifically, would payments made by Medicare for a claimant's future injury-related care qualify as "conditional payments" as defined by Medicare under the regulations?

Though widely perceived that Medicare regularly makes "conditional payments" for future medicals, potentially exposing the insurance industry to penalties for failing to repay such payments, the truth is that this happens rarely. It would only happen if the settling parties collectively neglected to address conditional payment reimbursement and Medicare's right to remain a secondary payer post-settlement at the time of the settlement.

It is best to collaborate with plaintiff's counsel to address Medicare's recovery rights as part of a judgment. Specifically, a defendant should insist on verification of Medicare entitlement and evidence that a recovery record has been established with CMS, as well as satisfaction of any conditional payment reimbursement obligation as a condition subsequent to the settlement. This process enables defendants or insurance carriers to save time, resources, and money on these activities, which yields cost savings on an individual claim-by-claim basis, and significant savings over time without sacrificing risk management principles.

Remember that a "conditional payment" under the MSP is a payment that Medicare makes for services for which another payer is responsible but for which that payer has not yet accepted responsibility. 42 C.F.R. §411.21. So, would a payment made by Medicare after another payer has accepted responsibility as part of settlement and when no additional claims are pending with the payer be deemed a "conditional payment"? Probably not, and the payer has complete control to ensure that the answer is a resounding "no," when implementing the principles set forth above.

Post-settlement Medicare payments cannot be defined as true "conditional payments." When Medicare makes a post-settlement payment, no other payer has yet to accept responsibility. That is, as long as the payer has accounted for all the claims that would fall within the settlement to ensure that no additional claims are pending.

Conditional payments are about timing. Medicare made a payment that some other entity should have made. As the statute does not expressly state as much, regulations are needed. So, how could there be a future conditional payment? In reality, there should not be one, provided the parties follow a uniform process for addressing this obligation.

The Sand of the MSP: Future Medicals

We now turn to anticipated future medical expenses and current MSP obligations. If conditional payments are the cement (regulations are in place, though they will be strengthened later this year per the SMART Act), future medicals represent the sand. Like sand is more susceptible to nature's elements than cement, future medicals usually are more susceptible to interpretation.

Historically, parties have disagreed about MSP obligations. On one side of the spectrum, the argument goes that the MSP does not address Medicare set-aside arrangements (MSAs) specifically or broadly address future medicals. Therefore, the MSP does not impose obligations on other payers regarding future medicals. On

the other side of the spectrum is the argument that since CMS states its right not to pay future medicals in liability settlements stems from the same part of the statute as its right not to pay future medicals in the workers' compensation context, parties must fund an MSA in nearly all liability settlements meeting certain conditions.

The truth is somewhere in the middle. Remembering that we have a statute but no regulations to date, this author and his colleagues have always said that as long as settling parties have: 1) a reasonable interpretation of the MSP on future medicals, 2) documented this reasonable interpretation, and 3) can produce it to CMS official upon request, then CMS most likely could not otherwise sanction the parties. *General Electric Company v. United States Environmental Protection Agency*, 53 F.3d 1324, 311 U.S. App. D.C. 360 (D.C. Cir. 1995). This approach is similar to wearing both a belt and suspenders. A rule or requirement establishing a substantive legal standard cannot take effect until the CMS issues a regulation on point, and as mentioned, CMS has not yet issued one. 42 U.S.C. §1395hh(a)(2).

The Water of the MSP: ANPRM

CMS has been working to establish a substantive legal standard since last year. On June 15, 2012, CMS issued an advance notice of proposed rulemaking (ANPRM) regarding future medicals and liability settlements under the MSP. http://www.regulations.gov/#!documentDetail;D=CMS-2012-0073-0001 (last visited Mar. 7, 2013). The ANPRM contains a "proposed general rule" and seven "proposed options." The proposed general rule states:

> If an individual or Medicare beneficiary obtains a "settlement" and has received, reasonably anticipates receiving, or should have reasonably anticipated receiving Medicare covered and otherwise reimbursable items and services after the date of "settlement," he or she is required to satisfy Medicare's interest with respect to "future medicals" related to his or her "settlement" using any one of the following options.

It is difficult to overstate the significance for insurers if CMS issues a final rule adopting this proposed general rule verbatim.

The proposed general rule contains two criteria. First, a claimant must obtain a "settlement." What CMS means to say here, and does in fact say within the ANPRM is that a claimant must obtain a "settlement, judgment, award or other payment." Remember, claim resolution is one of the two criteria that will trigger Medicare's priority right of recovery. 42 U.S.C. §1395y(b)(2)(B)(ii).

Second, future medicals must be in play. While the specific language might seem vague, particularly the "should have reasonably anticipated receiving" language, a conservative reading leads to the reasonable conclusion that the future medicals criteria may be triggered simply if plaintiffs plead or release future medicals. Therefore, the proposed general rule would apply if (1) a claimant obtains a "settlement," and (2) the pleadings or release language identify (either expressly or implicitly) future medical expenses as a component of the items or services over which the primary payer or its insured accepted responsibility. *See* GRG's Comments to CMS on ANPRM, http://garretsongroup.staging.wpengine.com/assets/GRGClientAlert-CMS-6047-ANPRM-final_v2_-8.15.12.pdf.

Once the proposed general rule applies, the ANPRM identifies the next steps to take (presuming CMS adopts the ANPRM in its entirety). According to the ANPRM, the individual or Medicare beneficiary would be *required* to satisfy Medicare's future interest by selecting one of seven proposed options. The very notion that the proposed general rule, once finalized, would contain a requirement is likely to quiet any debate about whether the MSP provides Medicare a right to remain a secondary payer post-settlement. Even CMS' workers' compensation regulations do not impose such a "requirement." *See* 42 C.F.R. §§411.46, 411.47. A requirement to satisfy Medicare's future medicals interest would exceed the obligations currently contained in the workers' compensation regulations.

The most interesting facet of the ANPRM addresses who would be responsible for failing to consider Medicare's future interests. Prior regulatory ambiguity about future medicals has forced insurers to adopt certain protocols to insulate themselves from exposure (whether actual or perceived) to the CMS regarding MSP-related future medicals.

A plain reading of the ANPRM, however, reveals that the CMS looks solely to the individual or the beneficiary for satisfaction of Medicare's future interests. If this is true, the CMS will remove a major hurdle for all constituents. By placing the onus on the plaintiffs' bar to address, manage, and calculate the future medicals obligation, insurers can focus on their own MSP obligations, namely (1) validating that conditional payment reimbursement has occurred (as we discussed above), and (2) reporting certain information to the CMS to comply with Section 111. *See* 42 U.S.C. §§1395y(b)(2)(B)(ii), 1395y(b)(8).

While perhaps inconsistent with settling parties' previous understanding, this conclusion is perfectly consistent with previous statements that the CMS has made about future medical services under the MSP. In the workers' compensation context, the CMS states the following about future medical services: "If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received a portion of a third party payment either directly or indirectly." Introduction to WC, Centers for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/workerscompensationoverview.html (last visited Mar. 7, 2013).

Rarely would a defendant or carrier be deemed an entity that received a portion of a third-party payment. Defendants or carriers make the payment as a primary payer or its insured. The ANPRM, if adopted in such a manner as to identify which party is responsible for ensuring Medicare's future interests are satisfied, would validate this currently existing guidance.

When the DRI Medicare Secondary Payer Task Force submitted comments to the CMS on behalf of DRI in response to the advance notice of proposed rulemaking, the members sought clarification on this point. Medicare Secondary Payer Task Force, DRI.org, http://www.dri.org/News/MSP (then follow "DRI Formal Comments to Centers for Medicare and Medicaid Services on Proposed Rulemaking" hyperlink) (last visited Mar. 7, 2013). Though the task force believes that the current language provides sufficient clarity, it may not soothe the most conservative carrier or self-insured entity. Clarification from the CMS in the final regulations would allow entities to keep files permanently closed without fearing that

CMS will seek post-settlement dollars, provided that conditional payments have been reimbursed.

Other groups such as the American Insurance Association (AIA) agree:

> We understand that the proposed options do not seek to place any obligations on an insurer or self-insured with respect to "future medicals," as *there is no statutory authority permitting CMS to impose any such obligation or granting it a right of recovery against an insurer or self-insured with regard to "future medicals"* (emphasis added). CMS' lack of authority with respect to insurers and self-insureds regarding "future medicals" underscores the importance of properly focusing the seven options solely on beneficiaries.

Am. Insurance Ass'n, AIM Medicare Medicaid Task Force Comments on CMS-0647-ANPRM, available at http://www.regulations.gov/#!documentDetail;D=CMS-2012-0073-0059 (last visited Mar. 7, 2013).

Defense attorneys may consider obligating claimants to provide evidence that future medicals have been addressed in some way, shape, or form as part of the settlement.

DRI and the AIA agree that future medicals are claimants' task to handle, and claimants alone have exposure to the CMS. This author and his colleagues agree. Much like addressing conditional payments, claimants are best situated to address the future medicals obligation. Plaintiffs have access to the key data needed to make an informed decision. Defense attorneys may consider obligating claimants to provide evidence that future medicals have been addressed in some way, shape, or form as part of the settlement.

Future Medicals Compliance While Awaiting Final Regulations

While the ANPRM represents the direction CMS is heading, we are not quite there. You may ask yourself this: "How do I comply on this issue in the interim? I must ensure 100 percent compliance, but can I do that in a more cost-effective manner?" By piecing together opinions from three recent cases involving future medicals under the MSP, we can answer that question in the affirmative.

The first case, *Guidry*, provides readers with a peek behind the curtain regarding how to consider and protect Medicare's future interest. *Guidry, et al. v. Chevron USA, Inc.*, Civ. No. 6:10-cv-00868, 2011 U.S. Dist. LEXIS 148942 (W.D. La. December 28, 2011). There, the parties had agreed to fund an MSA as part of settling a claim. However, they weren't sure how much should be allocated. The parties hired an MSA vendor who set the MSA allocation at $77,204.16. The parties submitted the settlement agreement to the Court along with the MSA allocation. The Court held that the parties had reasonably considered and protected Medicare's future interest. Specifically, the Court advised that as long as the parties relied upon "sound methodology" in analyzing the MSA issue, then the parties reasonably considered and protected Medicare's future interest.

The second case, *Early*, involved injuries a cruise ship passenger allegedly suffered. *Early v. Carnival Corporation*, No. 12-20478-CIV-Goodman (S.D. Fla. February 7, 2013). At mediation, the parties agreed that defendant would pay an undisclosed sum to the plaintiff, and the mediator's fees, with the parties to each pay their own attorneys' fees and costs. Notably, the parties could not agree on whether a MSA was needed, and asked the Court to determine that issue. The Court ruled that, under the governing law, settlements must be "mutually agreeable on every essential term," and that the parties had failed to reach an agreement on the essential term of whether an MSA was needed. The Court declined to make that determination and ruled that because the MSA issue was undecided, the parties had failed to reach a settlement.

In its ruling the Court distinguished this case from others where the parties had asked the Court to enforce a settlement agreement. Here, the parties asked the Court to assist with a critical term of a *potential* settlement agreement. The Court noted that it could not draft an essential term of the agreement, nor issue an advisory opinion on the matter.

The third case, *Sterrett*, involves a Court's recognition that, although the parties had reasonably considered Medicare's future interest, an MSA was not required. *Sterrett v. Klebart*, 2013 Conn.Super. LEXIS 245 (filed February 5, 2013). The parties asked the Court to determine whether, in reaching the decision on the MSA issue, they had reasonably considered Medicare's interests. The Court determined that the parties had adequately considered Medicare's interests, even though an MSA was not needed, because the parties had properly evaluated the terms of the settlement, by recognizing that the settlement award did not address future medical expenses. Instead, the Court held that the settlement proceeds represented Plaintiff's noneconomic damages as well as some "modest allocation for future medical expenses arising out of the possible need for home health aides" though such costs are not typically covered by Medicare.

Read together, *Guidry*, *Early* and *Sterrett* demonstrate how parties can reasonably consider and protect Medicare's future interest in today's environment. Defendants and insurance carriers have an interest to ensure that files stay closed, because CMS will not pursue them for any additional funds post-settlement. Plaintiffs' counsel share this concern (with the additional concern of protecting the plaintiff's Medicare card going forward). *Early* advises that the burden is on the parties, not the Court, to address the future medicals issue. *Guidry* provides the reasoning that, so if you use sound methodology to reach your conclusion, then you have reasonably considered and protected Medicare's future interest. *Sterrett* stands for the conclusion that an MSA is not needed if there are no damages paid for future medical treatment. Instead of automatically funding an MSA, a defendant or insurance carrier can be MSP compliant for a much lower cost.

Understand this is a short term approach. Once CMS issues final rules and regula-

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tions, the process changes. Until then, this author and his colleagues believe the best approach is to address the issue proactively, documenting your file with the conclusion of whether a set aside is needed along with the records obtained and reviewed to reach that conclusion. The formal analysis should involve an upfront screening to verify a claimant's Medicare eligibility and/or enrollment status. As parties identify the potential damages award, they can then determine if proceeds for future medicals exist within the gross award, either in the form of a specific carve out or within the undifferentiated lump sum.

In order to assist with this future medicals analysis, you may choose to utilize technology based solutions, such as the MSA Decision Engine, which provide compliant solutions for minimum costs to the file. *See*, for example, http://www.garretsongroup.com/services/medicare-set-asides (last visited Mar. 19, 2013). Tools like this allow a user, after answering certain questions, to obtain immediate feedback on the need for an MSA in a particular case as well as what the maximum possible MSA amount could be based on a particular fact pattern.

Currently, the lowest cost of compliance on the future medicals issue means utilizing sound methodology with cost containment protocols. When CMS issues final regulations placing this obligation on the plaintiffs' bar, defense attorneys can focus their MSP attention on their clients' areas of exposure: conditional payment reimbursement and Section 111 reporting.

The MSP concrete is hardening in 2013. Until now, identifying settling parties' roles and responsibilities under the MSP have largely been a product of intense dialogue between the parties. 2013 appears to be the year when CMS adds water to cement these issues and roles into place. This concrete will add structure to the MSP process. GRG and the DRI Medicare Secondary Payer Task Force will continue to monitor these developments and provide updates. For more information, please see http://www.garretsongroup.com/ and http://www.dri.org/News/MSP. FD