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New Medicare Contractor Changes Compliance Landscape

I. History & Terminology

A. Medicare Compliance History and review of the Medicare Recovery Process

B. Terminology

C. Historical Review of contractors over the past 7 years, explore the need steps taken leading to the Commercial Repayment Center (CRC) Transition.

What is Medicare?

Medicare is an entitlement health insurance program for seniors. It also extends coverage for disabled workers that have received Social Security Disability Income (SSDI) for more than 24 months; or anyone afflicted with kidney disease (End Stage Renal Disease) or Lou Gehrig's disease (Central Nervous System Disorder).

Medicare became law in 1965 and provides benefits for hospital expense (Part A) and health care expense (Part B). In addition to these Government paid benefits, Medicare also allows private Group Health Plans to provide coverage when a Medicare beneficiary opts out of Medicare coverage by selecting a Medicare Advantage Plan (Part C). Such selection takes place once a year, during the enrollment period. At that time, a Medicare beneficiary can move from traditional Medicare (Part A and Part B) to Medicare Advantage or can return back to traditional Medicare coverage. Whether traditional Medicare is selected or Medicare Advantage, the coverage plan is in place for the upcoming year and can only be changed during the next period of enrollment.

Private Group Health Plans may also offer Medicare beneficiaries drug coverage. This coverage is commonly referred to as Part D. Traditional Medicare does not provide for drug coverage. Therefore, a Medicare beneficiary on traditional Medicare (Part A and/or Part B) or Medicare Advantage (Part C) could also, but not necessarily, have Part D drug coverage.

What is the Medicare Secondary Payer Act (MSP)?

When a Medicare beneficiary goes to the hospital or sees a doctor, their Medicare card is presented, or is on file to demonstrate their ability to pay for the items or services they will receive. Medicare is then billed by the Provider and pays for items and services. Under the MSP which was enacted on December 5, 1980, Medicare may refuse payment or pay conditionally, where treatment is related to a general liability claim or complaint. If Medicare in those situations should pay conditionally, it expects to be reimbursed. The MSP gives Medicare the authority to seek repayment, or file a lawsuit (for double damages) against the responsible party for the liability claim. To ensure Medicare is repaid, the MSP was modified in 2007 and requires the responsible party to electronically report information to Medicare about cases it settles or situations where it is responsible for ongoing payments for medical services. Failure to report a claim timely to Medicare can result in civil monetary penalties of up to $1000 per claim/per day.

Understanding the Rationale Behind the MSP

Congress is vested in protecting the financial viability of the Medicare Trust Fund. On December 5, 1980, the MSP was passed with the intention that Medicare be a secondary payer if other insurance/self-insurance was responsible to pay. The law covered for the first time Non-Group Health Plans (NGHP), such as workers' compensation, no-fault and liability. When NGHP responsibility is demonstrated the NGHP would have to pay for medical items and services first, and Medicare could legally withhold payments of Medicare benefits. However, Medicare could pay "conditionally" if the NGHP plan does not promptly pay, and be reimbursed when the NGHP resolves the workers' compensation, liability or no-fault claim.

Medicare payments represent about $1 Trillion or about 25% of the present U.S. Budget. Avoiding payments that are the responsibility of NGHPs saves Medicare costs by avoiding a "pay and chase" scenario. Medicare required NGHPs to notify it of their obligation to pay in 1989 under its regulation 42 CFR 411.25. However, the regulation was ignored because there were no obvious consequences for non-notification. That changed when Section 111 of the Medicare & Medicaid SCHIP Extension Act of 2007 (MMSEA).

As previously mentioned, the MMSEA provides that NGHPs can be assessed penalties for failure to notify – up to $1,000 per day for each claim. Furthermore, NGHPs were required to send in notifications electronically that is uploaded to Medicare's Common Working File database. Data has changed NGHP claims processing and have increased processing as well as the value of settlements, judgments and awards.

While the MMSEA data has been exchanged for several years, the Medicare Recovery contractor has changed and established significant new recovery actions. This panel will examine the impacts caused by the change and how the new process impacts the claim process.

History of the MSP Data Exchange

MMSEA became law in 2007 and overnight NGHPs began to identify third parties or build in-house IT programs to exchange data with Medicare. Initially, the law was to take effect on July 1, 2008, but because of its size and complexity, the Agency responsible for Medicare, the Centers for Medicare & Medicaid Services (CMS) delayed implementation on several occasions. The exchange was finally launched for NGHPS on January 1, 2011. At that time, NGHPS were required to report data going back to January 1, 2010.

CMS put in place two programs under the MMSEA. One program was a tool to assist NGHPs in determining Medicare status of their claimants. The MMSEA placed the burden of identifying Medicare status on the NGHP with no cooperation of the claimant or claimant's counsel. CMS created a query look-up tool to help NGHPs determine Medicare status.

The second program required NGHPs to timely report their Ongoing Responsibility for Medicals, the termination date of that responsibility and lump sum payments the Medicare beneficiary claimant would receive from a settlement, judgment, award or other payment.

CMS has been clear from the onset of the Medicare Secondary Payer law as amended by the MMSEA of two critical objectives. First, it will use the data to coordinate, or otherwise avoid payments that are the responsibility of the NGHP; and second, to research and recover any conditional payments it has made. These objectives has resulted in additional work for the front-lines claims handler that is unique to Medicare beneficiary claims.

Important Terminology:

Conditional Payment Letter (CPL) - CPLs will be issued by the BCRC when a beneficiary self-reports that a liability, workers' compensation, or no-fault insurance has primary responsibility and Medicare has made a conditional payment. CPLs will be issued only when the MSP instance was not otherwise reported through MMSEA Section 111 Reporting.

Conditional Payment Notice (CPN) - CPNs will be issued by the CRC when an applicable plan has notified Medicare via MMSEA Section 111 Reporting that it has ongoing responsibility for medicals (ORM) and otherwise reports that it has primary payment responsibility.

Statement of Reimbursement (SOR) - This is similar to the BCRC's payment summary form and will be provided as an enclosure with CPLs, CPNs, demand letters, and redetermination decision.

Disputes - Upon receipt of a CPN, the applicable plan has 30 days to dispute the CPN and may do so only once. If not responded to within 30 days, the CRC will issue a demand letter. To dispute medical claims on a CPN, the applicable plan must submit required documentation within 30 days of the CPN date plus five days for mailing. CPLs have no time limit to respond.

Disputes submitted to the CRC through the Medicare Secondary Payer Recovery Portal (MSPRP) may only be done so on the basis of relatedness and in response to a CPN. All other dispute types must be submitted in writing outside of the MSPRP. If the debtor has more than one dispute for the same case (i.e., relatedness and claims paid to provider), the entire dispute package should be submitted through the mail and not the portal.

Demand Letter -When a demand letter has been issued, it will reflect a "response due date for payment" on the letter. Demand letters issued will have appeal instructions along with the deadline to appeal. Once the demand letter is issued, interest will begin to accrue.

CRC contact information is the following: PO Box: 93965, Cleveland, OH 44101; Fax: 216-583-0228

II. Significant Changes to Medicare

The Commercial Repayment Center will manage recovery cases where the Responsible Reporting Entity (RRE) has reported Ongoing Responsibility for Medical (ORM), ORM Termination or Total Payment Obligation to Claimant (TPOC) via Section 111 reporting and CMS has identified the primary debtor as the RRE. Conditional Payment Notices (CPNs) are issued by the CRC as of October 25, 2015 from Section 111 data that is processed on or after October 5, 2015.

If a case is reported manually to the BCRC prior to Section 111 data being sent, the BCRC will handle the recovery. However, the BCRC will always handle the recovery where the primary identified debtor is the Medicare beneficiary. This would be typical for liability claims.

The major change is for no-fault and workers' compensation claims, which will be handled by the CRC because the primary debtor is the RRE/Primary Plan.

The CRC will issue Conditional Payment Notices (CPNs) based on the Section 111 data. A settlement, judgment, or award is no longer the applicable trigger. ORM without a TPOC or ORM Termination Date will result in a CPN, and if such notice is not acted upon a Demand for Payment will issue 30 days from CPN Notice date. CMS has not commented on the volume of letters a RRE may expect, but CMS did indicate that the RRE should expect multiple CPN letters and multiple Demand letters over the life of a claim.

BCRC will continue to issue a Conditional Payment Letter (CPL), unless they are made aware of a settlement, award or judgment before a CPL has issued, in that case a Demand would issue. A CPL has no timeline for a response. The CPL and CPN will differ on one key point, only the CPN will indicate a time due for response. Parties should scrutinize all correspondence carefully.

Interest accrues from the first day of a Demand letter; but will not be assessed if the debt is paid within 60 days.

Inquiry was made on a CMS webinar of what legal authority CMS has to recover conditional payments on cases where there has not been a full and final settlement, judgment or award. CMS pointed to the text of the MSP statute, where it indicates that once responsibility is demonstrated, Medicare recovers for conditional payments. She indicated that responsibility is demonstrated where a Responsible Reporting Entity (RRE) reports ORM.

III. Impact on the Industry

Primary Plans, Applicable plans and Responsible Reporting Entities are all impacted by this transition. ORM only cases are now subject to CMS recovery claims for reimbursement. When a CPN is received, swift action is required to dispute it, otherwise a debt will be automatically established with the United States Government in the form of a Demand Letter. Particularly, workers' compensation and no-fault payers are impacted. Any workers' compensation or no-fault claim that does not have a valid ORM Termination Date, is subject to a potential CPN. Also, any administratively closed WC or no-fault claim after January 1, 2010 that has not been subject to ongoing query for Medicare is also potentially exposed to CPNs. Reporting agents must properly conduct Medicare queries to avoid significant contingent liabilities. Medicare query does not end when a file is administratively closed and the CRC will no doubt at some point compare data of RREs for anomalies. Insurers should be particularly concerned about the impact of conditional payment recoveries on files that have reported ORM and have not reported an ORM termination. An easy calculation of possible exposure is to look at the average conditional payment letter per claim, multiplied by the number of ORM claims that involve a Medicare beneficiary – regardless of claim status (include both open and procedurally closed ORM claims). A further evaluation is to look at the procedurally closed ORM claims since 1/12010 involving a Medicare beneficiary and again multiply this number by the average CPL. Since reserves fall off once the file is closed, it is easy to conclude the unreserved liability is of great concern to insurers, self-insured and entities as the financial impact of mass recovery could be significant.