CLM 2018 Annual Conference
March 14-16, 2018
Houston, TX

Historic Shift in Medicare Recovery Policy Looms Large in 2018

Liability Medicare Set-Asides (LMSAs) and No-Fault Medicare Set-Asides (NFMSAs) Are on CMS' Agenda for 2018

The Centers for Medicare and Medicaid Services (CMS) has been taking incremental steps recently to implement a review process for LMSAs and NFMSAs. Over the past year we saw a series of indications that CMS was looking to implement a review process. The Request for Proposal (RFP) for the Workers' Compensation Review Contractor (WCRC) stated that it would possibly require the new contractor to manage a voluntary review process for LMSAs and NFMSAs potentially as early as July 1, 2018. In addition, we saw CMS take steps with medical providers to coordinate benefits for LMSAs and NFMSAs through provider notices and adding fields to the Common Working File (CWF) as of October 1, 2017 which would notate an LMSA/NFMSA amounts.

Further, on September 19, 2017, CMS issued a MedLearn article to medical providers which stated that if a Medicare beneficiary alerts the provider that it has a WCMSA, LMSA or NFMSA, that the provider was to bill the MSA and not Medicare. However, the MedLearn Article was confusing at best in that it elaborated that no processes or requirements were currently in place for CMS to review an LMSA or NFMSA.

Unfortunately, the MedLearn article only seemed to cause confusion for primary payers and attorneys, and further there was serious concern that the guidance provided could cause benefits interruption for Medicare beneficiaries. However, on November 8th, CMS reissued this MedLearn article to clarify information. The revised MedLearn article now generally referenced Medicare Set-Asides (MSAs), however the article did not limit the discussion to WCMSAs, even though a formal review process only currently exists for WCMSAs. The MedLearn article goes on further to let providers know that Medicare is always secondary to liability, no-fault and workers' compensation insurance.

Further, on October 28, 2017 CMS issued another alert stating: "The Centers for Medicare and Medicaid Services (CMS) continues to consider expanding its voluntary Medicare Set-Aside Arrangements (MSA) review process to include liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS will work closely with the stakeholder community to identify how best to implement this potential expansion of voluntary MSA reviews. Please

continue to monitor this website for updates and announcements of town hall meetings in the near future."

Just recently, in a decision titled *Silva v. Burwell,* 2017 U.S. Dist. LEXIS 195032 (U.S. District Court of New Mexico, November 28, 2017) parties to a medical malpractice decision grappled with the lack of clarity regarding whether the Plaintiff Medicare beneficiary needed to set aside money in an LMSA. The Defendants in the malpractice action had serious concern that if the Plaintiff did not set up an LMSA, that CMS would come after them for recovery in the future. Although the parties settled in 2015, due to the need to petition federal court for a declaratory judgment on whether an LMSA was needed, the issue did not resolve until 2017 (2 years later) when the federal judge opined that there was no law or regulation requiring an LMSA. Interestingly, the court was quite vocal about CMS' repeated failure to clarify LMSA guidance was causing settlement delays.

It is anticipated that CMS will introduce a voluntary review process in 2018. However, there are serious concerns among the industry that LMSAs/NFMSAs will cause delay in settlement and increase costs. Further, many have questioned CMS' legal ability to require a LMSA/NFMSA. It is unclear how CMS would review an LMSA and take into account comparative negligence, policy limits, and other issues present in liability and no-fault claims that are not present in workers' compensation claims.

Clearly from a Third-Party Administrator (TPA) perspective, the impediments associated with submission of an LMSA, regardless of review criteria, will greatly affect the ability to resolve claims in a timely manner.

The resulting delays will bring on additional litigation and associated defense costs. Once there has been some definition relative to what CMS will be requiring, TPAs will need to develop strategies to deal with this new era of liability and No-Fault claim handling.

Liability carriers have much the same concerns. Carriers look for a level, consistent playing field and the ability to resolve claims fairly, with finality. Current LMSA ambiguity, not to mention the underlying conditional payment processes and the shadow world of MAPs, is not conducive to fair and efficient claim resolution.

Setting aside, for the sake of discussion, the questionable legal right of Medicare and/or MAPs to make claim for future medicals, the general impact of LMSAs on the liability claim industry stands to cause significant harm. Injured parties will suffer the most harm. Delay in claim resolution is a certainty. LMSAs may well preclude settlement of claims when inflated by Medicare requirements (as with existing Work Comp MSA Rx), and where liability and/or causation are debated issues. This will force more claims into litigation, increasing the injured party's risk (and, ironically, that of Medicare), add to already overloaded court dockets and increase costs for all involved. Claim handling costs will be significantly impacted by increased training needs, extended claim life and LMSA vendor costs.

Carriers should consider participation in industry coalitions that can work with Medicare and, hopefully, develop a LMSA process that is beneficial to both the Medicare fund and beneficiaries. Carriers should anticipate the near-future implementation of LMSAs and the resulting impact that will require a shift in their claim handling process, claim handler training and oversight practices.

Medicare Advantage Plans (MAPs) Continue to Pursue Aggressive Recovery Efforts of Conditional Payments Nationwide

The current background of Medicare Advantage and Part D Litigation

Medicare Advantage Plans (MAPs), also known as Medicare Part "C" are private insurance plans that provide for a Medicare beneficiary's Part "A" and "B" benefits. A Medicare beneficiary can choose to enroll in a MAP rather than traditional Medicare. Part D plans provide for a Medicare beneficiary's prescription drugs. It is important to note that traditional Medicare generally does not provide prescription coverage directly; a beneficiary must enroll in a Part D plan to receive Part D benefits.

MAPs have recovery rights for conditional payments under the Medicare Secondary Payer Act (MSP). While case law across the country is scattered on what degree of recovery rights MAPs have for conditional payments, it is clear that at the very least, they have rights to recover the conditional payments they have made at least like any other medical lien, and in some jurisdictions, have the right to recover double damages for conditional payments that are not reimbursed. This article will explore the current state of confusion and ambiguity as to the recovery rights for conditional payments that MAPs plans have.

An exploration into the history of MAP recovery rights and case law is fundamental to understanding what brought us to this confusion today. On February 4, 2011, a wrongful death action involving a Medicare Advantage plan enrollee out of the U.S. District Court for the District of Arizona titled *Parra v. Pacificare of Arizona*[1] found that the MSP did not provide for a private cause of action for MAPs/Part D plans similar to that provided for Part A and B plans under 42 USC 1395y(b)(3)(A). Additionally, the *Parra* decision found no congressional intent to infer such a right. Due to express statutory and regulatory provisions regarding billing rights, the court found that the proper place for a MAP reimbursement claim lay in state court under traditional contract theories.

Subsequently, the U.S. District Court for the Eastern District of Pennsylvania ruled against Humana in its efforts to recover from GlaxoSmithKline in a case titled *In Re Avandia v. GSK*.[2] While Humana argued that the MSP, 42 USC § 1395y(b)(3)(A), unambiguously granted a private cause of action to MAPs, the court found that it did not. Rather, the court held that Humana only had a lien right under state law to recover such payments.

[1] *Parra v. PacifiCare of Ariz., Inc., 715 F.3d 1146 (9th Cir. Ariz. 2013).*

[2] *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig., 685 F.3d 353(3d Cir. Pa. 2012),* cert. denied, *133 S. Ct. 1800 (2013).*

On December 5, 2011, in response to the *Parra* and *In Re Avandia* decisions, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum in support of MAPs/Part D plans having the right to collect for payment of services where Medicare is not the primary payer. Within the memorandum, CMS went so far as to state that MAPs/Part D plans can exercise the same rights of recovery that the Secretary exercises under the existing MSP regulations. While the CMS memo was very clear on CMS' position on MAP/Part D recovery rights, a memorandum issued by an administrative agency is not binding, and therefore the case law continued. However, arguably the CMS memo would carry weight through *Chevron deference.* Chevron Deference is a well-known two-part test established by the Supreme Court for determining when a federal court ought to defer to the interpretation of a statute by the federal agency charged with implementing that statute.

On July 12, 2012, in a surprising decision, the District Court decision from *In Re Avandia* was overturned by the Third Circuit Court of Appeals. The Third Circuit found that MAPs/Part D plans do in fact have the same rights to recovery as Medicare, and additionally that MAPs/Part D plans have a right to pursue a private cause of action for double damages under the MSP for conditional payments that are not reimbursed.

On April 15, 2013, The Supreme Court denied certiorari/review of the *In Re Avandia case;* therefore, the decision of the Third Circuit stood. Just four days later on April 19, 2013, the Ninth Circuit affirmed the initial decision in the *Parra* case which found that MAPs do not have the same rights to recovery as Medicare does and can recover conditional payments by way of their contract with the beneficiary.

The most recent and monumental decision on this issue was issued in September 2016 out of the Eleventh Circuit, titled *Humana Medical Plan, Inc. v. Western Heritage Insurance Company*[3] which found in favor of Humana being able to recover double damages for failure for Western Heritage to timely reimburse Humana within 60 days of the issuance of the settlement check.

Recently, Humana has also filed litigation against the Hartford, seeking to establish its rights to double damages recovery in the Ninth Circuit, which may overturn *Parra.* Further, Humana and other MAPs have been quite vocal that the plans intend to file litigation strategically nationwide so as to establish their rights. Further, there are several District court decisions in place that have found in favor of MAPs having this right.

The resulting question is, where do we stand today? Currently, we have two circuits, the Eleventh and Third Circuit, which have found in favor of MAPs having the right to recover double damages against a primary payer that fails to reimburse conditional payments. The six states encompassed in these two Circuits are: New Jersey, Delaware, Pennsylvania, Alabama, Georgia and Florida.

[3] 11th Circuit Court of Appeals, Case No. 15-11436.

Best Practices for Payers with Regard to Medicare Advantage and Part D Payments

Until Congress clarifies the Medicare Secondary Payer law, or the U.S. Supreme Court rules on this issue, more litigation is expected. Therefore, a best practice recommendation would be for insurance carriers to include consideration of Medicare Advantage when resolving a worker's compensation or liability claim with a Medicare beneficiary claimant, particularly in the six states where MAPs have established rights to double damages for unreimbursed MAP conditional payments: Alabama, Georgia, Florida, Delaware, Pennsylvania, and New Jersey.

MAPs are a particularly significant challenge to carriers. While Medicare shares Section 111 reporting data with MAPs, there is no reciprocation to the carrier by Medicare. Likewise, it is rather uncommon to receive early notification from a MAP of their existence. Thus, carriers are significantly prejudiced in their ability to identify a MAP.

Some best practice advice to carriers is to train file handlers to specifically ask insureds and claimants who they have their Medicare benefits through. Often, beneficiaries may not actually realize their benefits are via a MAP, so requesting a copy of the beneficiaries Medicare ID card is helpful. Claim handlers should also keep an eye out for $0.00-dollar conditional payment letters from Medicare. If the claim handler is aware treatment has occurred, a $0.00 Medicare conditional payment letter is a great clue those bills may have been paid by a MAP. In any event, a carrier best practice would be to consider including in their claim process specific steps to investigate the existence of a MAP.

Part D Prescription Drug Plans Beginning to Seek Recovery of Conditional Payments; Secondary Payer Advancement, Rationalization, and Clarification Act (SPARC) Legislation to Clarify These Rights

Medicare Part D Background and Recovery Rights

Part D plans provide for a Medicare beneficiary's prescription drugs. It is often misunderstood that traditional Medicare does not provide prescription coverage directly; a beneficiary must enroll in a Part D plan to receive Part D benefits. Roughly 3 out of 4 Medicare beneficiaries are currently enrolled in a Part D plan according to the Kaiser Family Foundation.

The Medicare Secondary Payer Act (MSP) is a federal law that amended the Social Security Act in the 1980s to make Medicare a secondary payer where a primary plan is available: primary plans include workers' compensation, no-fault, and liability insurance. The MSP applies to self-insured entities and insurance carriers alike. While the MSP has made recovery for traditional Medicare conditional payments (Medicare liens) rather straightforward, recovery rights for Part D plans and Medicare Advantage Plans (MAPs) have not been clear. MAPs are provided through private insurance plans similar to Part D plans; however, MAPs provide for Medicare Parts A and B benefits as would otherwise be covered under traditional Medicare.

When Congress created the Medicare Part D program in 2003, it failed to address secondary payer issues beyond simply stating that Part D Prescription Drug Plans' secondary payer rights were "in the same manner" as Medicare Advantage (Part C) Plans' secondary payer rights. 42 USC 1860D-2(a)(4). CMS' Prescription Drug Benefit Manual adds little more direction or guidance to Part D plans' obligations under the MSP. In fact, it only goes so far as stating: "The MMA extended MSP laws applicable to MA organizations to Part D sponsors. Accordingly, Part D sponsors will have the same responsibilities under MSP laws as do MA plans...." See CMS' Medicare Prescription Drug Benefit Manual, Chapter 14, Coordination of Benefits, Section 50.13.

The limited guidance available creates what appears to be a process whereby Part D plans pay for a beneficiary's prescription drugs, but then later are forced to seek reimbursement for those payments. This kind of process is inefficient and costly to enforce. Further, pursuit of secondary payer recovery for Part D often costs more than can be recovered and thus is a waste of government and Part D plan resources. Finally, even though Section 111 of the Medicare Medicaid SCHIP Extension Act requires payers who settle claims with Medicare beneficiaries to report those settlements to Medicare, this process is not linked to Part D plans so the data about a settlement is not shared with Part D plans leaving such plans with no opportunity to identify a recovery or coordination of benefits opportunity at the time but instead only long after the case is resolved.

The Solution to Proactively Address the Ambiguity behind Part D Recovery Rights: The SPARC Act

In attempt to solve these issues, MARC[4] is working on proposed legislation similar to the SMART Act which was signed into law in January 2013 as part of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 and helped improve the processes for Medicare secondary payer recovery and reporting under Parts A and B for all stakeholders.

The Secondary Payer Advancement, Rationalization and Clarification Act (SPARC) Act, which will be re-introduced in 2018, would make clear who is responsible for prescription drug costs and when they must be reimbursed. It would also clarify when that responsibility begins, how a Prescription Drug Plan (PDP) can recover for past payments, and when and how CMS must share data to help facilitate the secondary payer recovery process. The SPARC Act, built to augment the SMART Act, would clarify, streamline, and bring cost-saving efficiency to the relationships between Medicare beneficiaries, entities settling claims with beneficiaries, and the Part D plans providing medications to beneficiaries.

[4]The Medicare Advocacy Recovery Coalition is a national Coalition advocating for the improvement of the MSP programs. The Coalition collaborates and develops strategic alliances with beneficiaries, affected companies, and a wide range of other stakeholders to work with the Congress and government agencies to implement MSP reforms that will improve the process for all.

The SPARC Act: Four (4) Main Principles Which Will Clarify Part D Recovery Rights

SPARC promotes responsible recovery efforts. The bill would limit Medicare Plans' claims to only those where the potential recovery might exceed the cost of collection. The SPARC Act would permit the PDPs to waive recovery altogether in the best interests of the program. This provision is virtually identical to the waiver rights allowed the federal government under 42 U.S.C. §1395(y)(b)(2)(B)(v), or the Part A/B statute. PDP recovery costs would no longer be considered "administrative costs," meaning that the PDP could not include those costs in its annual bid amount, and would not be subsidized by the federal government for those costs. This would not only save beneficiaries and the federal government money on PDP costs, but would also give the PDPs flexibility to only pursue those claims where the recovery would exceed the cost of collection.

SPARC is transparent. The SPARC Act would require CMS to provide plans with timely access to settlement data, so that they can speedily assert any claims for recovery at the time of settlement. SPARC would require CMS, within 15 days of receipt of notice from a beneficiary or other potentially responsible party of a claim, settlement, judgment or award to pass that information to the relevant PDP covering the affected beneficiary in a form useful to the PDP so the PDP can coordinate benefits. As a corollary, the bill would require a PDP to instruct the pharmacy or other entity providing prescription drugs to bill the entity who has reported to CMS that they have an ongoing responsibility to pay for medical benefits, thus avoiding the PDP paying those benefits and then chasing a recovery.

SPARC builds on expedited repayment procedures created by the SMART Act, now found in the Social Security Act Section 1862(b)(2)(vii). Provisions of the SPARC Act would require Medicare to, within 10 days, notify the relevant PDP of an existing request for expedited repayment through the CMS website, and would require the PDP to provide any prescription drug claims for which it seeks recovery to the Secretary for the Secretary to include in the final recovery statement to settling parties. This would allow for the settling parties to have pertinent conditional payment information at the ready before settlement. In the event the settling parties use the expedited repayment process, CMS can collect prescription drug costs included on the final statement and must remit those payments to the relevant PDP. Using the SMART Act "portal," would allow beneficiaries and settling parties to repay more dollars to PDPs sooner, and with finality.

But as much as the bill would improve commercial insurance processes, the SPARC Act would promote access to care and claim finality. The SPARC Act would promote beneficiary access to timely and appropriate care, particularly in the area of prescription drugs related to a non-group health insured event. Most often, it is at the intersection of insured claims and the ongoing

medical and pharmacy needs of a Medicare beneficiary that collisions can happen. PDP plans or pharmacies can be unaware of the existence of an insured claim. Treatment, services, or prescriptions can be upheld. And at the end of a claim process, resolutions can be suspended without finality. None of these results is favorable in our industry. The SPARC Act represents workable rules, developed by the multiple stakeholders affected by medical liability settlements – employers, insurers, healthcare providers, and above all, beneficiaries.

We believe that the SPARC Act will continue to garner bipartisan support in 2018 as the SMART Act did in 2012. SPARC, if enacted, would provide commonsense reform to improve healthcare outcomes for Medicare Part D for beneficiaries, insurance carriers, and PDPs alike for the reasons outlined above.

Medicaid Third Party Liability (Medicaid Secondary Payer) To Be More Strongly Enforced in 2018

Medicaid is similar to Medicare in that it is a government program that provides health care benefits to certain groups of people. However, Medicaid is different in that it is for the most part a need based program, whereas Medicare is entitlement based (generally based upon being at least 65 years of age and/or disabled). Further, unlike Medicare, states and not the Federal government are responsible for program administration of Medicaid.

Medicaid is a creature of Federal law as of July 1, 1969. There are certain uniformity principles put in place by the Federal legislation that states must implement in exchange for Federal government reimbursement payments for a portion of the benefits that are paid under the Program. One of the major guiding principles is that Medicaid is the payer of last resort (a secondary payer).

Third Party Liability (TPL) identification and ensuring Medicaid's secondary payer status where a primary payer is available is therefore an important obligation of the states under Federal law. If it is not done correctly, reimbursement payments by the Federal government include charges that should be the responsibility of a third party. If third party liability identification recovery and coordination is not properly pursued by the State, it therefore increases the burden on the U.S. Budget.

The Future of Medicaid Recoveries

Medicaid is the next Medicare that we must be prepared for and manage the compliance issues that develop. We have recently seen California (Medi-Cal) as well as Pennsylvania Medicaid step up recovery and reporting requirements.

Further, the Murray/Ryan Budget Deal of 2013 which went into effect October 1, 2017 now allows Medicaid to recover 100% of their lien. Essentially, Medicaid is not limited to recovery from the medical portion of the settlement and can recover the "full value" of the claim. Further, the current political landscape, with CMS Administrator Seema Verma in power who is in favor of block grants, seems to indicate that Medicaid budgets may be squeezed. As a result, Medicaid agencies will be looking to third party liability recoveries to enhance budgets and recover additional dollars.