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What to Look Forward to:

New Jersey Collateral Source Rule Not a Bar to MSP Recovery

By Jessica C. Smythe, Esquire

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GAO Study Examines Health of MSP Program

By Martin Cassavoy, Esquire

The Government Accountability Office (GAO) recently released the most comprehensive examination of the Medicare Secondary Payer (MSP) program in recent memory. This long-anticipated report includes important historical data, CMS' present-day perspective on the MSP program, and key policy initiatives that CMS will be moving forward with.

This article highlights several important findings contained in the GAO report, and outlines the GAO's recommendations for improving the MSP program as follows:

Dollars & Cents

Perhaps most noteworthy, the GAO calculated annual MSP program savings over the last four years. (See the table on page 2). The GAO calculated savings as the accumulation of all dollars either recovered directly under the MSP program or prevented from being spent by Medicare. Payment prevention and recovery is obtained through coverage denials, data-match activities and actual dollars recovered. Interestingly, the GAO credited CMS with "savings" associated with the total amount of money approved by CMS in Medicare Set Asides annually.

The numbers demonstrate that the MSP program has grown from Fiscal Year (FY) 2008 to 2011, but that in 2011 the raw "savings" dropped by roughly $400 million. That drop was largely attributable to a reduction in the total amount approved for MSAs in FY 2011, when the raw dollars approved for MSAs dropped by approximately $340 million.

Despite that drop in set aside dollars, it is interesting to note that the volume of MSA submissions has increased every year since 2008. In FY 2011, the GAO reported a total of nearly 29,000 CMS submissions. However, the GAO reported that approximately 11,200 of those requests were ineligible for review due primarily to the fact these submissions did not meet CMS' MSA review thresholds.

Chart: GAO Calculated Annual MSP Savings (FY 2008-2011)

Year	Total Savings	MSA Savings
FY 2008	$1,662,540,728	$905,202,448
FY 2009	$1,804,412,759	$1,125,261,415
FY 2010	$2,364,551,277	$1,443,739,397
FY 2011	$1,964,397,373	$1,102,662,414

Current Issues GAO Found

The GAO examined all aspects of the MSP program, including the performance of the three primary contractors handling MSP activities (the Coordination of Benefits Contractor, Workers' Compensation Review Contractor and the MSPRC). In addition, the GAO spoke with CMS representatives about ways in which CMS was improving the MSP program.

The key items discussed were as follows:

1. **CMS is moving to a "self-service" model –** CMS officials explained to the GAO that they planned to move more and more MSP activities to a "self-service" model. In this model, beneficiaries, attorneys, claims payers and third parties could obtain or submit required information through web-sites or automated phone lines, as opposed to the fax/mail model. This has been demonstrated through the CMS' recent introduction of the WCMSA Portal allowing for electronic submission of MSAs, and the announcement earlier this month that the MSPRC was developing a Web portal for the conditional payment process.

2. **CMS and the GAO have a lack of insight into the way MSA dollars are spent –** The study explained that CMS only tracks cost-avoidance for WCMSAs (not LMSAs) and accounts for this by reporting the total of all approved WCMSA amounts in a given year. The GAO seemed to acknowledge that this is a gap in the process in that it does not accurately depict the actual annual savings to the Medicare program. The GAO also provided no discussion regarding monitoring the way MSAs are spent or administered, and seemed to credit CMS' conclusion that Medicare would not pay as long as the MSA contained funds.

3. **The MSPRC is unprepared to handle the current volume –** As the number of annually reported MSP situations pushed over 400,000, the GAO found that the average wait time to speak to an MSPRC representative increased to approximately 38 minutes. In FY 2011, about 220,000 telephone calls were abandoned, a 700% increase over 2008. In FY 2011, the average turnaround time to issue a conditional payment letter was 76 days. The average turnaround time to issue a demand letter was 48 days. These timelines are outside of CMS' targets.

4. **WCRC performance deficiencies persist –** The GAO reported that the timeline to review MSAs had increased 400% from April 2010 through September 2011. The review contractor explained that it would like to cut the average turnaround time in half. The increase is attributable to an increase in the volume of total submitted cases, as WCRC officials explained that they operated at a personnel deficit that prevented the completion of roughly 300 cases per month beginning in the spring and summer of 2010. In February 2012, the WCRC contract was awarded to a new contractor, Provider Resources, Inc.

GAO Recommendations

As a result of its investigation, the GAO made three major recommendations to improve the MSP program:

1. **Periodic review of Non-Group Health Plan Recovery Thresholds –** In order to promote efficiencies with MSP recoveries, the GAO recommended that the Acting Administrator of CMS periodically review recovery thresholds to ensure that non-Group Health Plans will not needlessly report on "cases for which the agency will not seek any recovery."

2. **Make ICD-9 codes optional in Section 111 reporting for liability NGHPs –** Because liability insurers have not historically tracked ICD-9 codes, the GAO found that CMS' required use of ICD-9 codes in Section 111 reporting unnecessarily increased the administrative burden in NGHPs. The GAO recommended that ICD-9 codes be made an optional component in liability reporting. CMS agreed to consider this recommendation, but responded that 95% of NGHPs reporting data to CMS have provided ICD-9 codes.

3. **GAO recommended that CMS re-haul its communication strategy for the MSP –** Specifically, the GAO recommended the development of a comprehensive MSP program website centralizing all information on the MSP program, develop guidance regarding liability and no-fault set asides, and review and revise MSP correspondence that is sent to Medicare beneficiaries. CMS agreed with all of these recommendations and, interestingly, noted that it would

utilize notice and comment rulemaking to "clarify some longstanding liability and no-fault policy."

Conclusion

The GAO provides a comprehensive analysis of the successes and failures of the MSP program. Based on the data compiled by the GAO, the MSP represents nearly $2 billion program. The scrutiny of the GAO study, as well as last June's Congressional hearing and the SMART Act, has pushed CMS to make adjustments in the MSP program. The next step for CMS will be to execute on much needed improvements.

About the Author

Martin Cassavoy, Esquire is the Vice President of Strategic Services at Crowe Paradis Services Corporation. Martin has been with CPSC since its inception, and prior to his current role overseeing the strategic services team, he managed the Medicare Set Aside department and the conditional payment negotiation unit. He was also the policy advisor to the creation of CPSC's Section 111 reporting product MSP Navigator. Martin and his team develop MSP compliance products, services and strategy for insurers, TPAs and self-insureds in all lines of insurance. Martin received his B.S. in Journalism from Boston University and he is a graduate of Suffolk University Law School. He is a member of the Massachusetts bar.

New Jersey Collateral Source Rule Not a Bar to MSP Recovery

By Jessica C. Smythe, Esquire

A New Jersey District Court, in a decision filed on March 23, 2012, held that the New Jersey collateral source rule ("NJCSS") did NOT exclude recovery of medical expenses paid by Medicare from a tort settlement since these expenses were subject to reimbursement. The collateral source rule, therefore, did not preclude Medicare's demand for reimbursement of medical expenses paid resulting from plaintiff's injuries.

In the case of *Mason v. Sebelius*, *et. al.*, Civil No. 11-2370 (JBS/KMW), 2012 WL 1019131 (D. New Jersey March 23, 2012) plaintiff was injured when he slipped and fell at the Showboat Hotel and Casino in Atlantic City, N.J. Medicare paid for plaintiff's medical expenses incurred as a result of his injuries in the amount of approximately $2,503. 71. Plaintiff and his wife later filed suit against the casino seeking damages for plaintiff's pain and suffering, **medical costs**, and his wife's loss of consortium.

Plaintiff and his wife then settled all claims against the casino in the amount of $40,000. The release did not specifically allocate the settlement funds between plaintiff's medical costs, his pain and suffering, or his wife's loss of consortium claim, but plaintiff did agree to indemnify the casino against any liability for Medicare liens. Plaintiff later sought an order from the Superior Court designating the settlement proceeds as all non-medical. The Superior Court denied plaintiff's motion, concluding such a determination must be made first through the Medicare administrative review process.

Subsequent to the settlement, Medicare demanded reimbursement of its conditional payments in the amount of $1,423.43, which represented a discount from the earlier $2,503.71 after deduction of certain allowable legal fees and costs. Plaintiff paid the demand under protest and proceeded to apply for a waiver and a refund of this amount through the Medicare administrative appeals process. **As part of this appeal, it is important to note plaintiff did not raise any constitutional due process challenges or claims.** Medicare ultimately denied plaintiff's request for a refund.

Plaintiff consequently filed an Amended Complaint against Medicare alleging the following three separate causes of action:

1. A declaratory judgment that Medicare is not entitled to seek reimbursement of medical expenses from lump sum tort settlements in New Jersey due to the NJCSS;

2. Damages for violations of plaintiff's due process rights; and

3. Recovery of the medical expenses reimbursed to Medicare based upon the fact that Medicare's demand for reimbursement was unauthorized.

In response, Medicare moved to dismiss all of plaintiff's claims for lack of subject matter jurisdiction and failure to state a claim.

A breakdown of plaintiff's arguments and the court's ruling on each of these points is as follows:

I. New Jersey Collateral Source Rule ("NJCSS")

The NJCSS provides that a tort plaintiff may not receive damages from a defendant when plaintiff has already received money from a different source for the same injury. For example, if a plaintiff's medical expenses are paid by private health insurance, the plaintiff cannot also recover the cost of this medical treatment from the alleged person or entity (tortfeasor) responsible for the injury. Otherwise, he/she would receive a double recovery.

In *Mason*, plaintiff argued that the NJCSS prohibited him from recovering the medical expenses paid by Medicare resulting from his injuries; therefore, since he was barred from recovering these expenses, Medicare could not demand reimbursement from him of these payments.

The court rejected plaintiff's argument, following the case of *Lusby v. Hitchner,* 273 N.J.Super. 642 A.2d 1055, a New Jersey appellate decision which determined *Medicaid* benefits did *not* constitute a collateral source. The *Mason* court, like the court in *Lusby*, reasoned that Medicare payments, similar to Medicaid benefits, *are* subject to reimbursement, and therefore could not be considered a collateral source. No double recovery results since the expenses must be reimbursed per statute.

Accordingly, the court ruled that the NJCSS did *not* prevent Medicare from seeking reimbursement of conditional payments.

II. Violation of Due Process

Plaintiff also argued that Medicare's demand for reimbursement violated his due process rights under the United States Constitution.

Since plaintiff's claims arose under the Medicare Act; plaintiff could only bring a claim in New Jersey district Court after complete exhaustion of his administrative appeals at Medicare. While plaintiff did pursue administrative remedies, he failed to present his constitutional claims for review.

Therefore, the New Jersey district court ruled that it lacked jurisdiction over plaintiff's due process claims and granted Medicare's motion to dismiss. The court also noted agency review of plaintiff's constitutional claim was available, so the district court was NOT his only avenue for appeal.

III. Recovery Not Proper Under the MSP

Plaintiff also contended that Medicare's reimbursement demand was unauthorized by statutory Medicare Secondary Payer provisions and Medicare's own MSP policy manual. Thus, he argued that Medicare should have waived its claim for reimbursement.

Plaintiff's claims were based on the following grounds: (1) MSP reimbursement was not authorized because the tort defendant (the casino Showboat) and its insurer were not primary plans under the MSP; (2) the MSP only permits reimbursement on a showing the primary plan had demonstrated responsibility to pay for the medical costs paid by Medicare, and (3) Medicare reimbursement is not authorized under the MSP because plaintiff's settlement was for an undifferentiated lump sum and not specifically allocated to medical expenses.

The court rejected all of these arguments. In an excellent dissertation on the history of the Medicare Secondary Payer statutory provisions, the court found plaintiff's argument that Showboat and its insurer were not primary plans under the MSP to be an incorrect interpretation of the law, based upon 2003 amendments to the MSP which specifically named tortfeasors and their insurers as primary plans responsible for reimbursement of Medicare's conditional payments.

In addition, refuting plaintiff's second argument that the primary plans (Showboat and its insurer) had not demonstrated responsibility for payment of medical expenses by virtue of settlement alone, the court correctly noted the MSP clearly provides that "responsibility" for repayment by a primary plan is demonstrated by a payment conditioned upon "the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured." 42 C.F.R. 411.22(b)(2)(ii).

In other words, when plaintiff released his claims against defendants, which included all claims for medical expenses, this release was sufficient to trigger the obligation to reimburse Medicare's conditional payments. (This is made even clearer in light of plaintiff's general release executed as part of the settlement, which included plaintiff's agreement to indemnify defendants against any claim of lien made by Medicare. This seems to indicate some negotiation between the parties as to the amount of Medicare's conditional payments and inclusion of this amount in the total settlement proceeds).

Finally, the court also concluded based upon the evidence in the record that plaintiff's lump sum settlement included payment for medical expenses previously paid by Medicare. Since these claims were released, plaintiff and the primary plans were responsible for reimbursement even if the medical expenses were not specifically allocated in the release. As part of its rationale, the court cited *Hadden v. U.S.*: "the scope of the plan's responsibility for the beneficiary's medical expense- and thus of his own obligation to reimburse Medicare-is ultimately defined by the scope of his own claim against the third party that is later released in settlement."

Conclusion

Challenges to MSP statutory provisions are presently being litigated across the country. In some cases, decisions seem contradictory, and circuits are split. The patchwork of this litigation, however, reveals a number of important recurring themes. These themes are reflected in *Mason.*

First, most courts, including the New Jersey Supreme court, will follow the *Mason* court's lead and will hold the collateral source rule does not preclude MSP reimbursement. Second, a settlement releasing plaintiffs' claims for medical expenses covered by Medicare is sufficient authorization for collection by Medicare of conditional payments. Following this logic, courts may very well look beyond the language of the release to the original pleadings filed in the case, which more likely than not will demand payment of medical expenses related to the plaintiff's injuries. Parties' facile attempts to circumvent the plain language of the pleadings and the true intent of the settlement most likely will fail.

About the Author

Jessica Smythe, Esquire is a national Medicare Secondary Payer compliance consultant with Crowe Paradis Services Corporation. Prior to joining Crowe Paradis, Jessica was a North Carolina defense attorney. Her clients included national and international corporations, self insured companies, insurance carriers and TPAs. Jessica, consequently, dealt with the issues of Medicare compliance while defending claims and now uses this practical knowledge in her current role as a compliance consultant and national speaker.

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Assessing the Impact of Recent Court Rulings & the GAO's Findings and Recommendations

Over the past few weeks, there have been several interesting court rulings on major Medicare Secondary Payer (MSP) compliance issues regarding Section 111, MSAs and Conditional Payments. In addition, the Government Accountability Office (GAO) recently released its long awaited critique of the MSP program, and issued several recommendations aimed at improving current CMS practices and processes.

What do these recent court rulings and the GAO report say? What do they mean in the bigger picture of MSP compliance? How do they (or can they) impact every day claims handling and settlement practices? What's next?

Join Mark and Marty as they break down these court decisions and analyze the GAO report in a logical, easy to understand and practical manner as follows:

- *Section 111*: Does a legal malpractice fund have to report under Section 111?
- *MSA*: Can an ex-wife take a percentage of a claimant's MSA?
- *Conditional Payments*: Does the collateral source rule preclude Medicare's reimbursement claim?
- *GAO Study Breakdown*
  - GAO findings – the good, the bad and the ugly
  - Dollars and cents -- making sense of the numbers
  - MSA figures and data – submissions vs. savings
  - GAO recommendations – improving the MSP process
  - Looking to the future – where is CMS headed?

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