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Improving the MSP Recovery Process

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On June 22, 2011, the Subcommittee on Oversight and Investigations of the House Energy and Commerce Committee held a hearing that underscored the growing frustration of casualty insurers with the Medicare Secondary Payer (MSP) recovery process and the inability of the Centers for Medicare and Medicaid Services (CMS) to administer a system that permits insurers to timely meet their statutory obligations while not bottlenecking their own claims handling.

This public vetting stood in stark contrast to the Section 111 Town Hall teleconference held by CMS a week later on June 29, during which the agency focused on the minutia of technical reporting. There was no discernible progress on the open issues that have stalled countless numbers of claims settlements, including the application of the effective date of the MSP statute on mass action settlements, beneficiary refusals to supply Health Insurance Claim Numbers (HICNs) and Social Security numbers (SSNs) and CMS's failure to provide timely accountings of conditional payment demands (Final Demands).

The June 22 congressional hearing provided a rare forum for discussion of MSP issues outside CMS Town Hall teleconferences, and the industry did not waste the opportunity to voice serious concerns. The hearing was motivated partially by H.R. 1063, introduced by Rep. Tim Murphy, R-Pa., a member of the House Energy and Commerce Committee, as well as by a general concern about the practical problems with the MSP recovery process for NGHPs. The tone of the committee hearing indicated that congressional interest in MSP issues is rising.

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CMS Highlights the Positive

The hearing included the testimony of witnesses from CMS, the Government Accountability Office (GAO), a self-insured entity, an insurance company, the plaintiffs' bar and a Medicare beneficiary rights group. Deborah Taylor, from the Office of Financial Management at CMS, painted a fairly rosy picture of the MSP recovery process, pointing out that in fiscal year 2010, the Medicare Secondary Payer Recovery Contractor (MSPRC) returned $413 million to the Medicare Trust Fund, with an average rate of return on recoveries of $9.32 for each dollar spent since fiscal year 2008, one of the highest returns of any CMS program integrity initiative.

She attempted to demonstrate MMSEA's positive impact on recovery efforts by contrasting the approximately 222,000 NGHP cases and 43,000 recovery demands in fiscal year 2007 (prior to the passage of MMSEA) with approximately 413,000 new NGHP cases and over 74,000 NGHP recovery demands in fiscal year 2010. Taylor expressed resistance to any legislative changes to the Section 111 or MSP recovery processes and did little to acknowledge or address the concerns of the other participants with regard to MSPRC shortcomings.

The NGHP Town Hall teleconference mirrored Taylor's myopic view of Section 111 reporting and MSP programs. Agency representatives spent a great deal of time answering technical reporting questions concerning error codes, TIN Reference Files and password changes, but dismissed several questions related to the MSP recovery process (concerning, for example, the accounting and timing of conditional payment demands) as falling outside the scope of the Section 111 call. These dismissals demonstrate CMS's fragmented view of Section 111 and the MSP recovery process.

Other Witnesses Criticize Delay in Obtaining Final Demand Amount; One Representative Offers an Interesting Solution

In contrast to Taylor's testimony, the other witnesses called for changes to the MSP recovery process and expressed dissatisfaction with the status quo. They criticized the MSPRC's slow pace in providing conditional payment information (dollars, dates of service and service codes) to parties attempting to settle liability claims, and the MSPRC's inability under the MSP statute to provide a Final Demand amount until after settlement.

Witnesses testified that these delays held up settlement discussions and in some cases, caused them to come to a standstill. Witnesses stated that they understood and accepted the obligation to repay the Medicare Trust Fund, but deplored the unintended effects the inefficient MSP recovery process is having on their ability to efficiently resolve claims and settle court cases.

H.R. 1063

This bill offers a new process. It would require CMS to provide parties approaching settlement with the agency's Final Demand within a statutorily prescribed time period and would cause CMS to forfeit its rights of recovery if it did not meet this schedule. In addition to forfeiting all recovery rights in egregious situations, the legislation would reduce the amount of money reimbursable to the Medicare Trust Fund because CMS would lose the right to recover Medicare's payment for services received between the date of the Final Demand and

the date of settlement.

Under current law, CMS can recover 100 percent of conditional payments made during this time. Recognizing that the Medicare beneficiary may receive a double recovery of sorts if Medicare must continue to pay for medical services that ultimately are paid by a private insurer, Rep. Phil Gingrey, R-Ga., offered what may be a workable compromise.

He suggested that CMS be required to provide a preliminary conditional payment demand amount and then limit Medicare's recovery to no greater than a specified percentage over the initial demand. This process should give settling parties a reasonable expectation of their ultimate liability to CMS and enable them to move forward with settlements.

ICD-9 Codes Continue To Cause Headaches

Scott Gilliam, a witness from Cincinnati Insurance Company, voiced concerns about the NGHP's required selection of ICD-9 diagnosis codes when reporting a claims payment under Section 111. He referenced situations where claimants incurred medical expenses but only had ICD-9 "v-codes" (such as for observation or a routine medical exam) recorded on the provider invoices.

Because CMS will not allow reporting of "v-codes" for purposes of Section 111 and will not permit the ICD-9 field to be left blank, an NGHP in this situation literally must make up a diagnosis for the CMS computer system to accept its report. During the Town Hall teleconference, CMS stated that it understood the coding concerns the industry was voicing and that it had tried to provide more information to assist insurers.

CMS, for example, suggested that RREs use the ICD-9 Computer Based Training (CBT) module on the Section 111 website and reminded RREs that they were not required to report the codes listed on medical claims forms. Frankly, this situation does not appear to be one to be remedied by more education.

Possible Solution for HICN and SSN Reporting Concerns

Some witnesses also discussed the Section 111 burden on insurers and self-insured entities to collect HICNs or SSNs from claimants who are reluctant to part with their personal information, particularly when handing it over to adverse parties. H.R. 1063 would preclude CMS from requiring this data for beneficiary identification but fails to address a very practical issue-how CMS's current Medicare database, which is built on HICNs (the beneficiary's SSN plus an alpha identifier), would match NGHP payments with Medicare paid claims without an investment of hundreds of millions of dollars to build a new computer data system.

Gilliam suggested that the MSPRC permit beneficiaries and insurers to provide only the last four digits of a HICN or SSN, a means of identification currently allowed when pharmacies submit E1 eligibility queries under the Medicare Part D drug program. While this suggestion appears to be a common sense compromise between CMS and the industry, it raises practical concerns. CMS guidance on submitting E1 queries indicates that pharmacies are more likely to receive a successful data match if the entire HICN or SSN is provided, rather than just the last four digits.

In the context of Section 111 reporting, failure to obtain a match during the querying phase is typically equated with Medicare ineligibility, unless the RRE has reasons to believe the query results were inaccurate. If queries using the last four digits of SSNs are less reliable than queries using all numbers, RREs could fail to report settlements and incur penalties or conceivably report settlements for the wrong beneficiary, possibly resulting in the denial of the wrong individual's Medicare claims.

We therefore propose that any statutory amendment require the claimant to attest to his or her Medicare status when providing only a four-digit number. If a four-digit query or report fails to identify a self-proclaimed Medicare beneficiary, then the parties and CMS will need to engage in discussion to resolve what was likely a database or query error. Another issue, however, is presented if the claimant hides his Medicare beneficiary status from the NGHP.

In that instance, it would appear that Congress needs to offer the NGHP a statutory safe harbor protecting the insurer against Section 111 penalties, conditional payment demands and double damages under the MSP statute, where the insurer received and relied upon the claimant's fraudulent attestation of Medicare ineligibility.

Medicare Denial of Provider Claims

Along the same lines, the MSPRC was accused at length during the hearing of making demands, or denying Medicare coverage, for medical services that were unrelated to the injuries at issue in liability cases. Witnesses cited anecdotal evidence of the MSPRC denying Medicare claims for breast cancer treatments due to an alleged relationship with an injury from a previous car accident that was settled with an NGHP, and denying Medicare claims for gynecological services based on the argument that they were related to a NGHP-compensated slip and fall accident.

Ilene Stein, a witness from the Medicare Rights Center, emphasized that the MSPRC's poor customer service and failure to appropriately close out cases make it difficult for beneficiaries and other parties to resolve denials for services unrelated to prior liability claims.

Proposed Change to Mandatory Section 111 Penalties

Finally, underscoring the rapidly approaching start date of full Section 111 reporting, Gilliam called for Congress to amend the $1,000-per-claim-per-day fine for noncompliance with Section 111 to become a discretionary fine of up to $1,000 per beneficiary per day.

Currently, some interpret the statutory language as requiring a mandatory flat fine per day per claim for all cases of noncompliance. *See* 42 U.S.C. § 1395y(b)(8)(E)(i) ("An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant.").

Although many would like to believe that CMS will adopt safe harbors when it begins to use the statutory fine as an enforcement tool, the mandatory language in the statute does create some concern that the agency or other government stakeholders will call for stricter imposition of penalties due to the current budget crisis.

The hearing notably did not address the still-unresolved issues backlogging the settlement of mass tort actions due to uncertain application of the Dec. 5, 1980, effective date of the MSP statute to, for example, long-tail or latent exposure claims.

CMS announced during the Town Hall teleconference that it had not yet set a date for the next "mass torts working group" call or revised the draft of written guidance it previously shared with interested parties. CMS also noted that it hopes to release version 3.2 of the NGHP User Guide by Aug. 1, 2011.