MEDVAL UPDATE

A Practical Guide to Understanding the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act

On January 10, 2013, President Barak Obama signed into law provisions to strengthen Medicare Secondary Payer rules. Originally proposed in March 2010 as the Medicare Secondary Payer Enhancement Act of 2010 (H.R. 4796), the bill was revised and reintroduced to the 112th Congress in March 2011 as the Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2011 (H.R. 1069). The bill obtained bipartisan support in both the House and Senate (companion bill S. 1718). While the bill did obtain nearly 140 co-sponsors in the House and another 23 in the Senate, the bill was unable to move forward on its own merits. In December 2012, the bill was combined with the Medicare IVIG Access Act (H.R. 1845) and passed with nearly unanimous support. H.R. 1845 provided for a demonstration project to provide in-home coverage of intravenous immune globulin (IVIG) services and supplies to Medicare beneficiaries suffering from primary immune deficiency disease (PIDD). The disease is most commonly associated with its most public victim, David Vetter (the "bubble boy").

Title II of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act is substantially different than the SMART Act as originally introduced. During the September 2011 markups, Congressman Murphy amended the bill twice to implement use of the web portal and make other changes that obviously made the bill more palatable to the federal government. Most burdens fall upon the Secretary (through the Centers for Medicare and Medicaid Services (CMS)) to perform or propose within set timeframes. The following is an outline of the new provisions and when they will be initiated.

CONDITIONAL PAYMENT REIMBURSEMENT DETERMINATIONS

EFFECTIVE OCTOBER 2013

1. Notification

Beginning 120 days prior to the reasonably expected date of settlement, judgment, award or other payment, a claimant or applicable plan (as defined in paragraph 8(F)) MAY notify the Secretary that a payment is reasonably expected and of the expected date of that payment. Note that the wording of the statute makes the task optional, particularly given that there is no incentive or penalty attached to performance. The provision is also slightly redundant given that there already exists a regulation that requires notice about primary payment responsibility (42 C.F.R. 411.25) and the mandatory insurer reporting requirement once the settlement, judgment, award or other payment actually takes place. No action is required on anyone's part; however, if any party wants to participate in the electronic conditional payment reimbursement determinations made available through this new legislation, this notification will be necessary. Notification is required to trigger the "protected period" (defined under subsection (V)) needed to establish the window during which a web portal download will qualify as the basis for a final conditional payment amount.

IMPLEMENTATION TIMELINE

60 days:
CMS shall solicit public comments in Federal Register regarding creation of regulations for reporting penalties

July 2013:
Reporting penalty discretionary & US limited to 3 year SOL if pursuing private cause of action under 1395y(b)(2)(B)(iii) in recovery of reported NGHP TPOCs.

October 2013:
Conditional payment final determinations may be made through web portal & appeal available to NGHPs

November 15, 2013:
CMS must determine recovery exemption, obtain review of Comptroller General & report to Congress by this date

2014:
MSP recovery exemption available

July 2014:
CMS deadline to find SS# alternative (possibility of 1 year extensions)

MSP REIMBURSEMENT EXEMPTIONS

EFFECTIVE 2014

In the interest of "fiscal efficiency and revenue neutrality," claims constituting a total payment obligation to a claimant (TPOC) of less than the determined annual threshold shall be exempted from reimbursement obligations stemming from settlement, judgment, awards or other payments for obligations arising out of liability insurance (including self-insurance) and for alleged physical based trauma, excluding ingestion, implantation and exposure. The annual threshold shall equal the estimated cost of collection incurred by the federal government and be calculated annually no later than November 15th. The amount shall be reviewed by the Comptroller General of the United States and reported to Congress no later than November 15th each year. For purposes of this calculation, only costs associated with medical payments already made are considered and not costs associated with ongoing responsibility for medical expenses (ORM).

MANDATORY INSURER REPORTING (MIR) FINES

IMPLMENATION SUBJECT TO RULE PROMULGATION

The new law changes the mandatory $1,000 per day per claim penalty for reporting noncompliance to a discretionary fine of $1,000 per day per claimant. The legislation then requires that CMS begin the regulatory process to establish official rules by soliciting proposals through the Federal Register within 60 days of enactment. Proposals shall be accepted for 60 days, considered by CMS, then published in the Federal Register for a 60-day comment period. Upon final consideration of the public comments, the Secretary shall issue final rules for penalties associated with MIR violations. All provisions codified in clause (vii) of the MSP must be carried out no later than October 2013.

REIMBURSEMENT DETERMINATIONS (CONTINUED)

2. Web Portal

As opposed to the original provisions in the SMART Act involving the traditional correspondences with CMS/MSPRC, the new bill utilizes internet technology to make certain determinations. Medicare beneficiaries have had access to their claim data for some time through the www.mymedicare.gov website. In July 2012, CMS made available the Medicare Secondary Payer Recovery Portal (MSPRP) that allows other users to register and gain access to those same records. The web portal provides the ability to electronically submit releases, obtain conditional payment information, dispute included claims and submit settlement information. In order to use the web portal, one must register in a manner very similar to MMSEA Section 111 reporting. For more information about how to use the web portal, please see: https://www.cob.cms.hhs.gov/MSPRP/login. Access to the Medicare beneficiary's claim information through www.mymedicare.gov or the web portal will be essential to being able to benefit from the new provisions of this law.

Provisions provided under Section 201(II) task the Secretary with management and improvements to enhance the usefulness of the web portal. First and foremost, the Secretary shall maintain and make available to the public the website (or any successor technology). All information about claims and payments must be input no later than 15 days after payment is made. The information must be as complete as possible and accurately identify that payments are related. The system must provide for secure electronic communications, include an official time and date stamp and permit a statement download of reimbursement amounts.

3. Determining Final Conditional Payment Amount

Rather than reach out to the MSPRC months prior to settlement, the new law permits conditional payment information obtained through the website at the time of settlement to serve as a final conditional amount. So long as a settlement, judgment, award or other payment takes place during the "protected period" (triggered by the notification above), the last statement of reimbursement amount downloaded within 3 days before that event shall serve as the final conditional payment recovery amount.

4. Disputing Information Obtained from the Website

If there are items identified in the conditional payment recovery amount that do not appear to be related to the proposed insurance settlement, the new law creates a new process through which to dispute discrepancies. The beneficiary or representative must provide documentation to CMS explaining

REIMBURSEMENT DETERMINATIONS (CONCLUDED)

the discrepancy and propose how to resolve the same. Within 11 business days of receipt of this documentation, CMS shall determine if there is a reasonable basis to include or remove the items. If no such determination is made in 11 days, it shall be accepted as proposed. If the proposal is rejected, CMS must respond in a timely manner with documentation as to why it does not agree and establishing an alternative discrepancy resolution. This is not to be treated as an appeal nor does establish a right to appeal the Secretary's determinations made under this process.

5. Creation of an Appeal for NGHPs

Subsection 8 calls for the Secretary to promulgate regulations establishing a right of appeal and an appeal process for NGHPs. This is probably the most important outcome of the entire Act given that these plans have reimbursement obligations but prior to this, only the beneficiary could pursue the Medicare appeal process necessary to challenge a demand. There is no timeline for the Federal Register process as is provided for the reporting fines in Section 203, however the regulations to carry out the entire clause must be promulgated by no later than October 10, 2013.

SO WHAT DOES THIS ALL MEAN?

Other than the new appeal right, not much has changed. We have been using the web portal since July 2012 and the only true change is the ability to use the information obtained there to make a final determination. Reporting penalties have never been assessed, therefore there is nothing to change per se. Statute of limitations has not been resolved because the Act only limited a very narrow group of claims. Overall, the SMART Act is no great victory over CMS, but it is a start. While this will expedite some of our settlements, our problems were never with the undisputed claims. Issues with the subjective, inconsistent nature of decisions made by CMS and its contractors and the unwaivering refusal to back down from their decisions, even when proven in error, will continue to pose challenges. Also remember that there is absolutely nothing in the Act that addresses future medical obligations and Medicare Set-asides. So enjoy the provisions contained herein but don't lose momentum. Continue pressing members of Congress for continued reform and please participate in the federal rule making process.

SOCIAL SECURITY NUMBERS
IMPLEMENTATION TBD

The Secretary has 18 months to propose an alternative method to the use of social security numbers for purposes of mandatory insurer reporting. This period may be extended by one or more periods of up to a year if the Secretary notifies Congress that absent such an extension that patient privacy or integrity of the MSP program is threatened. Until such a time as a viable alternative is established, RREs shall continue to use social security or health insurance claim numbers (HICNs) in their quarterly reporting.

STATUTE OF LIMITATIONS
EFFECTIVE JULY 2013

For private causes of action made by the United States for recovery of non-group health plan (NGHP) debt filed pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii) only, a complaint MUST be filed no later than 3 years after reported to the Secretary by the RRE pursuant to MIR obligations. This will not apply to group health plan (GHP) recoveries, claims made pursuant to 1395y(b)(3) or any overpayments recovered pursuant to the Federal Claims Collection Act, the False Claims Act or any other federal debt collection provisions.

ABOUT MEDVAL, LLC

MEDVAL was the first firm in the nation to deliver a fully-integrated Medicare Secondary Payer (MSP) solution. From initial Medicare Set-Aside evaluation to administration of MSA funds, MEDVAL serves attorneys, carriers, and TPAs seeking a better MSP compliance process for complex personal injury and workers' compensation claims. More information is available at www.medval.com.

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