

The Medicare Secondary Payer Program, Medicaid Third Party Liability, and Coordination of Benefits Update

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Goals for this Session

- **Overview of MSP, TPL, and COB**
- **Review Legal Authorities Relating to Obligation to Repay Overpayments**
- **Discuss Two Recent Government Enforcement Actions and the 2008 OIG Work Plan**

Overview of the MSP Program

Goal – Shift Primary Payment Responsibility from Medicare to Other Third Party Payers (“TPPs”):

- **Employer Group Health Plans**
- **Workers’ Compensation**
- **Automobile, Liability, and No-Fault Insurance**

Congress sought to use the MSP provisions to reduce the growth of Medicare by shifting primary payment responsibility to EGHPs “to place the burden where it could best be absorbed.” See Provident Life & Accident Ins. Co. v. United States, 740 F. Supp. 492, 498 (E.D. Tenn. 1990).

Overview of the MSP Program

Three Interlocking Concepts:

- **Make Medicare Secondary**
- **Prohibit Health Benefits “Discrimination” Against Medicare Beneficiaries**
- **Prohibit Incentives for Medicare Beneficiary to Reject Coverage that would be Primary to Medicare**

“Congress intended that the MSP provisions be construed to make Medicare a secondary payer to the maximum extent possible.” 71 Fed. Reg at 9,466, 9,467 (2/24/2006)



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Overview of the MSP Program

- **Substance – Laws, Regulations, Sub-regulatory Documents, etc.**
- **Process – IEQ, Data Match, VDSA, COB Claims Processing, etc.**
- **Enforcement – CMPs, Tax Penalties, Collection Actions, etc.**

Overview of the MSP Program

The MSP statute affects:

- Rules for coordination of benefits (“COB”) where Medicare is involved
- Rules for calculating Medicare’s secondary payment
- Claims filing
- Plan design
- Government enforcement authorities
- Government collection rights
- TPP repayment obligations/limitation on TPP defenses

Overview of the MSP Program

Claims Filing

- **Affects liability and no-fault insurance and Workers' Compensation**
- **Dictates When Medicare:**
 - **Can't be billed**
 - **May be billed**
 - **Must be billed**

Overview of the MSP Program

Plan Design/COB

- Employer not required to offer health insurance
- Coverage and benefit requirements if health insurance is offered
- Discrimination/nondifferentiation/taking into account issues
- Bar on incentives to reject plan coverage
- National Association of Insurance Commissioners (“NAIC”) updated its COB Model Regulation effective February 2006 to address the situation where a Medicare beneficiary is also entitled to health benefits under two employer health plans, one of which is primary to Medicare and one of which is secondary to Medicare.
- COB with “Phantom” Medicare Part B/Part D

Overview of the MSP Program

Government Enforcement Authorities

- **Excise Tax on Finding EGHP Non-conforming**
- **Civil Monetary Penalties**
- **Imposition of Interest**
- **False Claims Act (“FCA”)**
- **Criminal Prosecution**

Government Collection Authorities

- **Administrative Offset/Reopening**
- **Treasury Offset Program**
- **Direct and Subrogated Causes of Action**
- **Federal Claims Collection Act**
- **Debt Collection Improvement Act of 1996**
- **Common Law Self-help**
- **Equitable Theories – unjust enrichment, payment by mistake of fact, common law fraud, or misrepresentation**
- **State Law – unfair business practices**

Government Collection Authorities

Other Repayment Issues/Authorities

- **Defend Private Recovery Cause of Action**
- **Private FCA Action**
- **Cannot Use Prior Primary Payment as a Defense under Certain Circumstances – A primary payer may not raise as a defense to a recovery action that it already made a primary payment to the provider “where it should have reimbursed Medicare.”**
71 Fed. Reg. 9,466, 9,468 (2/24/2006).

Medicare Overpayment Reporting and Refunding Statutory Authorities

42 U.S.C. §1395g(a) – “The Secretary shall periodically determine the amount which should be paid under this part to each provider of services . . . with necessary adjustments on account of previously made overpayments or underpayments. . . .”

Medicare Overpayment Reporting and Refunding Statutory Authorities

42 U.S.C. §1395cc(a)(1)(C) – Requirement for participating providers to have an agreement with CMS “to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.”

Medicare Overpayment Reporting and Refunding Statutory Authorities

42 U.S.C. §1395gg – Where an overpayment has been made and cannot be recovered from a provider, this statute states that “proper adjustments shall be made . . . by decreasing subsequent payments” on behalf of the beneficiary.

- ***Provider “shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent.”***

Medicare Overpayment Reporting and Refunding Statutory Authorities

42 U.S.C. §1395y(b)(2)(B)(ii) – “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.”

Medicare Overpayment Reporting and Refunding Statutory Authorities

42 U.S.C. §1395nn(g)(2) – “If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.”

Other Overpayment Reporting and Refunding Statutory Authorities

42 U.S.C. §1320a-7b(a)(3) – Criminal liability against whoever “having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized. . . .”

Medicare Overpayment Reporting and Refunding Regulatory Authorities

42 C.F.R. §489.20(h) – Duty “if the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.”

Medicare Overpayment Reporting and Refunding Regulatory Authorities

42 C.F.R. §411.22 – “ (a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment. . . . ”

Medicare Overpayment Reporting and Refunding Regulatory Authorities

42 C.F.R. §411.24(h) – “If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.”

Medicare Overpayment Reporting and Refunding Regulatory Authorities

Proposed Rule:

Reporting and Repayment of Overpayments, 67 Fed. Reg. 3662 (January 25, 2002) – states that “obligation to report and return overpayments is derived from” 42 U.S.C. §1395gg. Includes an interesting discussion concerning mandatory self-reporting of overpayments. 67 Fed. Reg. at 3662 – 3663. It also references 42 U.S.C. §1320a-7b(a)(3).

Other Overpayment Reporting and Refunding Authorities

- **Corporate Integrity Agreement**
- **Compliance Plans**
- **Sarbanes-Oxley (publicly traded companies)**

Other Overpayment Reporting and Refunding Authorities

Statutes of Limitations

- **6 years under 28 §2415**
- **When does this start running?**
- **What if no timely notice of overpayment?**
- **Elements of Cause of Action vs. Right to Sue**

Intersection of Two Medicare Risk Areas

- **OIG Report – *Review of Hospital Medicare Secondary Payer Issues* (OAS A-04-01-07002) (September 16, 2002).**
- **Audited MSP compliance through review of credit balance reports.**
- **Hospital targeted because ranked highest for its FI “in both number of claims and amounts of the credit balances reported.”**

Medicaid vs. Medicare

- **Mandatory Assignment and Cooperation**
- **“Payer of Last Resort”**
- **“Cost Avoidance”**
- **“Pay and Recover Later”**

Overview of TPL – How Medicaid Overpayments Arise

A Medicaid overpayment occurs where the Medicaid payment exceeds what should have been paid.

‘Overpayment’ means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under [42 U.S.C. §1396a] and which is required to be refunded under [42 U.S.C. §1396b]. See 42 C.F.R. §433.304

Medicaid vs. Medicare Recovery Actions

Medicare – Federal program – focus on recovery of Medicare overpayments from providers or TPPs.

Medicaid – Federal/State program – Federal focus on recovering from the State which, in turn, is expected to recover from the TPP or provider. See “Review of Medicaid Credit Balances at Baystate Franklin Med. Ctr. for the Period Ending June 30, 2006” (Report Number A-01-07-00002) (July 11, 2007) (reviewing federal and state roles in recovering Medicaid provider overpayments).

Medicaid Integrity Program

- **Enacted in DRA 2005**
- **Includes “identification of overpayments”**
- **\$5M for FY 2006, \$50M for FYs 2007 and 2008, \$75M for FY 2009 and thereafter**
- **Special overpayment contractor to assist “in developing approaches to data mining.”**

Selected Medicaid Statutory Recovery Authorities

42 U.S.C. §1396a(a)(25)(A) – that the State or local agency administering such plan [i.e., the Medicaid State Plan] will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan. . . .

Selected Medicaid Statutory Recovery Authorities

42 U.S.C. §1396a(a)(25)(B) – *that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability; . . .*

Selected Medicaid Statutory Recovery Authorities

42 U.S.C. §1396b(d)(2)(A) – The Secretary [of Health and Human Services] shall ... pay to the State, in such installments as he may determine, the amount so estimated [under the previous paragraph], reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

Selected Medicaid Statutory Recovery Authorities

42 U.S.C. §1396b(d)(2)(B) – *Expenditures for which payments were made to the State under subsection (a) of this section shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan **in compliance with section 1396a(a)(25) of this title.***

Selected Medicaid Statutory Recovery Authorities

42 U.S.C. §1396b(d)(2)(C) – *For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.*

Selected Medicaid Statutory Recovery Authorities

42 C.F.R. §433.312(a)(1) – Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to HCFA.

Selected Medicaid Statutory Recovery Authorities

42 C.F.R. §433.312(a)(2) – The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider, [unless the provider is bankrupt or defunct].

Responding to Government Overpayment Recovery Demands

- 1. Are the claims administratively “final” and, therefore, no longer subject to governmental recovery actions?**
- 2. Did the government follow the applicable recovery requirements? Is there a cause of action?**
- 3. Is a waiver available?**
- 4. Is there, in fact, an overpayment?**
- 5. Has the amount of the overpayment been calculated properly?**
- 6. Is the recovery action time-barred?**

The Changing Environment

Use of FCA Authority in Recovery Actions

- ***U.S. ex rel. McCaslin v. Harris County Hosp. Dist.*, S.D. Tex., No. H-03-4438, settlement signed 6/4/07 – recovery of MSP and TPL overpayments.**
- ***United States ex rel. Drescher v. Highmark Inc.*, Nos. 00-cv-3513 and 03-cv-4883 (E.D. Pa.) – Settled June 19, 2006 – Exhibit A to the Settlement Agreement is a “model MSP process” that was “created to address how data regarding employee counts can be captured and how information regarding the small employer exception will be disseminated and utilized.”**

The Changing Environment

Use of Criminal Authority in Recovery Actions

18 U.S.C. §1347 (health care fraud) – East Tennessee Heart Consultants (E.D. Tenn.) (Pretrial Diversion Agreement, Federal and State Settlements – January 4, 2007) – Federal, State, Private Health Plan, and Patient Credit Balances

Use of Contractors to Identify Medicare and Medicaid Overpayments

FY 2008 OIG Work Plan - MSP

We will assess the effectiveness of current procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage. For example, we will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amount. (OAS; W-00-08-35317; various reviews; expected issue date: FY 2008; new start)

FY 2008 OIG Work Plan - Medicare Part D COB With Other Prescription Drug Coverage

We will review the coordination of benefits structure under the Medicare Part D program. Pursuant to 42 CFR § 423.464, Medicare Part D plans must coordinate benefits with other providers of prescription drug coverage. We will assess the systems used by Medicare Part D prescription drug plans to ensure that they coordinate benefits with other prescription drug insurers serving Part D beneficiaries. (OEI; 00-00-00000; expected issue date: FY 2008; new start)

FY 2008 OIG Work Plan - The Medicare and Medicaid Data Matching Project

We will review CMS's oversight and monitoring of Medicare and Medicaid Data Matching Project (Medi-Medi) contractors to determine whether they are meeting contractual requirements outlined in the Medi-Medi Task Orders. The Medi-Medi Project was initiated in 2001 by CMS in partnership with the State of California and continues, pursuant to section 1893 of the Social Security Act, to improve coordination of Medicare and Medicaid program integrity efforts. The objective of the project is to match Medicare and Medicaid data to proactively identify program vulnerabilities and potential fraud and abuse that may have gone undetected by reviewing Medicare and Medicaid program data individually. As of 2007, there were 10 active Medi-Medi Task Orders in the States of California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio, and Illinois. *(OEI; 00-00-00000; expected issue date: FY 2008; new start)*

FY 2008 OIG Work Plan - Recovery Audit Contractors: Reducing Medicare Improper Payments

We will review CMS's oversight and monitoring of recovery audit contractors (RAC) to determine whether they meet contractual requirements outlined in the RAC Task Orders. The RAC program, authorized in section 306 of the MMA, is designed to reduce Medicare improper payments through detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments. (OEI; 00-00-00000; expected issue date: FY 2008; new start)

FY 2008 OIG Work Plan - Medicare/Medicaid Credit Balances

We will review providers, including independent laboratories and hospitals, to determine whether there are Medicare/Medicaid overpayments in patient accounts with credit balances. For Medicare, section 1862(b) of the Social Security Act and 42 CFR Part 411 require participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. For Medicaid, section 1902(a)(25) of the Social Security Act, 42 CFR 433 Subpart D, and various States' laws require that Medicaid be the payer of last resort and that providers identify and refund overpayments received. Prior OIG work has identified Medicare/Medicaid overpayments in patients' accounts with credit balances. *(OAS; W-00-08-31311; various reviews; expected issue date: FY 2009; new start)*

FY 2008 OIG Work Plan - State Medicaid TPL

We will review States' reporting of third party liability data and CMS's monitoring and evaluation of these data. A 2006 GAO review found that States had encountered problems verifying third party liability coverage for Medicaid beneficiaries. Under section 1902(a)(25) of the Social Security Act and 42 CFR 433, Subpart D, States are required to take reasonable measures to identify other sources of health coverage that Medicaid beneficiaries may have and to recover reimbursements from liable third parties. We will determine the extent to which States report cost avoidances data and the way in which CMS uses these data to monitor and evaluate the effectiveness of States' cost avoidance programs. *(OEI; 00-00-00000; OAS; W-00-07-31213; expected issue date: FY 2009; work in progress)*

Medicare Part D & OPL

Questions & Answers