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Medicare and Medicaid Liens in Personal Injury Cases

Resolving Healthcare Liens or Claims for Reimbursement, Maximizing Settlement Awards

THURSDAY, MARCH 12, 2020

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

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Today's Agenda – Secondary Payer and Reimbursement or "Lien" Laws

- Medicare Parts A and B
- Future Medicals and Medicare Set Asides
- Medicare Part C
- Medicare Part D
- Medicaid

Medicare Parts A and B – Program Overview

Medicare	WHO'S ELIGIBLE?	BENEFITS/CHARACTERISTICS
Part A (hospital insurance) **Administered by the Centers for Medicare and Medicaid Services (CMS).**	Age 65 or > & eligible for Social Security retirement or are qualified railroad retirement beneficiaries. Under age 65 and entitled to Social Security or railroad retirement disability for at least 25 months, or suffer from end-stage renal disease (ESRD) or ALS ("Lou Gehrig's") disease benefits. Age 65 or > who don't qualify under the means above may voluntarily enroll in Part A but are required to meet certain other requirements and pay a premium for coverage.	Typically covers: inpatient hospital visits, skilled nursing facility treatment, some home health services if ordered by a physician, and hospice care. Most qualifying individuals are automatically enrolled in Part A upon reaching age 65 and enrolling for Social Security benefits. Voluntary enrollment is only available to individuals meeting certain residency requirements and already enrolled in Part B.
Part B (medical insurance) **Administered by the Centers for Medicare and Medicaid services (CMS).**	All persons entitled to Part A. Persons not entitled to Part A who: are age 65 or older, U.S. resident, U.S. citizen, or alien lawfully admitted to the U.S. and living in the U.S. for 5 years preceding coverage request. "Environmental exposure affected individuals" as defined by § 10323(a) of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).	Typically covers: provider medical services, preventative services, medical supplies, and other outpatient healthcare services not covered by Part A. Requires most beneficiaries to pay a monthly premium to receive Part B benefits. Persons entitled to Part A are automatically enrolled in Part B unless they request to decline enrollment.

Medicare Secondary Payer – The Basics

- 42 U.S.C.§1395y(b)(2) (MSP provision of Medicare Act)
  - "[P]ayment may not be made . . . with respect to any [medical] item or service . . . to the extent that payment has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance plan (including self-insured) or no-fault insurance."
  - Extent payment **can reasonably be expected to be mad**e (liens)
  - To the extent payment **has been made** (future medicals)

- 42 U.S.C. § 1395y(b)(7)(A); 42 U.S.C. § 1395y(b)(8)(A).
  - MMSEA Section 111, all insurers—liability, no-fault, and workers' compensation—as well as self-insurers, collectively referred to as "responsible reporting entities," (RREs), **must report information regarding payments made to Medicare beneficiaries** and other data to ensure proper coordination of benefits with the Medicare program

Medicare Secondary Payer – Consequences for Failure to Address

All Parties

- Lawsuit plus double damages – the government may file a lawsuit to recover its conditional payment amount, plus double damages, plus interest. 42 C.F.R. § 411.24(c)(2). See also 42 C.F.R. § 411.24(m).
- Joining in action – Medicare has a separate subrogation right to join or intervene into any action related to events that required payment for medical care. 42 U.S.C. § 411.26(b).

Plaintiff – Beneficiary

- Benefit offsets – Medicare may recover against the beneficiary's Social Security benefits, Railroad Retirement benefits, or tax refunds.
- Loss of benefits – Medicare may refuse to pay for future medical care for the settlement related injury. 42 C.F.R. § 411.24(d).

Defendant "Primary Plan"

- May be assessed penalty up to $1,000 per day per claim not reported timely under MMSEA Section 111(2020 update infra.). 42 U.S.C. § 1395y(b)(8)(E)(i).

Consequences for Failure to Address Medicare: U.S. v. Angino

- 2019 U.S. Dist. Lexis 30499; 2019 WL 931695
- Personal injury suit filed against pharmacy and medical care center for distribution of incorrect prescription medication that caused harm to plaintiff after ingestion.
- Plaintiff settled lawsuit assuming Medicare's lien totaled $1,212.00 based on a conditional payment amount. After reporting settlement, CMS issued a final demand in the amount of $84,353.00 but recognized a reduction for procurement costs for a total final demand amount of $53,295.14.
- Plaintiff did not pay the final demand amount, filed suit in U.S. district court challenging the amount but lost due to failing to exhaust admin remedies.
- Before the plaintiff lost his action, CMS filed a separate suit against the plaintiff's estate and the plaintiff's attorney in the personal injury action. CMS sought full reimbursement of the $84,353.00 plus interest, arguing that the law (42 CFR § 411.37(e)) allows CMS to not provide a procurement offset when it "must file" suit to recover its final demand amount.
- Current posture:
  - Summary judgement in favor of CMS was not appropriate given genuine issues of material fact as to when CMS "must file" suit to recover its lien
  - The US government's position is that the fact that the US brought suit is sufficient to establish that it "must file" to recover
  - Matter is still pending resolution (2020 update)
- Takeaways:
  - Don't rely on conditional payment amounts when settling
  - CMS is willing to pursue recovery through legal action and seek enhanced penalties
  - CMS is willing to pursue counsel directly for repayment
  - Consider paying final demands within 60 days and seeking reimbursement

Consequences for Failure to Address Medicare: Recent DOJ Settlements

- In the last 18 months, the Department of Justice (DOJ) obtained 4 settlements with law firms for alleged non-compliance with Medicare Secondary Payer obligations (2020 update)
- **June 2018**: Firm allegedly failed to repay conditional payments for 9 clients. Ultimately settled for $28,000, was required to designate and train an employee responsible for ensuring MSP debts were paid, and to review debts every 6 months with the employee to ensure compliance.
- **March 2019**: Firm allegedly failed to repay conditional payments for one client receiving a $1.15 million settlement. The case settled for $250,000 and the same conditions as the June 2018 settlement.
- **November 2019**: Firm allegedly failed to repay conditional payments for six clients, 4 of whom were either referred or part of a co-counsel arrangement. The firm was required to repay $91,406.98, with the U.S. DOJ noting that attorneys still had responsibilities, even if the cases has been referred out or part of co-counsel agreement.
- **January 2020**: Firm allegedly failed to repay conditional payments for 8 clients. Ultimately settled for $6,604.59, was required to designate and train an employee responsible for ensuring MSP debts were paid, to review debts every 6 months with the employee to ensure compliance, and to provide written certifications of compliance.

Best Practices – Medicare Parts A and B

Beneficiary & Counsel	"Primary Plan" – Insurer	All Stakeholders
• Screen clients for Medicare entitlement • Contact BCRC to confirm entitlement status and open a recovery claim • Provide proof to defendant that the recovery claim has been opened • Request updated conditional payment listings and audit claims for relatedness • Request final demand letter after settlement • Ensure payment of final demand amount is made to Medicare within 60 days of issuance of final demand	• Collect information to screen plaintiff for potential Medicare entitlement • Obtain proof that recovery claim has been opened • Ensure payment has been made to Medicare in satisfaction of its final demand • Report payments to Medicare beneficiaries in compliance with MMSEA Section 111 • Collect proof of payment of final demand	• Screen plaintiffs for Medicare eligibility • Coordinate initial reporting to BCRC to prevent creation of duplicate recovery claims • Coordinate MMSEA reporting information for consistency (ICD – 10 codes and related injury diagnoses) • Coordinate and document payment of final demand to Medicare

Best Practices – Release Language: Mayo v. NYU Langone Med. Ctr.

- 2018 NY Slip Op 30456(U)
- Medical malpractice settlement agreement reached for $725,000 with Medicare lien of $1,811.95, final lien believed to be $2,824.50, remainder payed to estate executor, care of attorneys
- Release signed and mailed to defendant – same date CMS sent its final lien letter seeking $145,764.08
- ALJ found plaintiff was responsible for conditional payments & interest
- Insurer and defendant did not sign agreement as required therein
- Plaintiff successfully moved to void agreement
  - Contract "effective upon execution by the parties"
  - Defendant drafted
  - Grounds of mutual mistake with error substantial to prevent a meeting of the minds

Medicare Secondary Payer – Minimizing the Financial Impact

Dispute Conditional Payments

- Medicare only entitled for payments from time of injury to settlement
- Only entitled to recoupment of medical expenses from litigation – related injury
- Use medical records and ICD – 10 tools
- Audit each conditional payment letter and "strike through" the unrelated charges

Compromises

- 42 C.F.R. § 401.613 allows CMS to accept less than full payment
- Criteria at 42 C.F.R. § 401.613 (b) and (c)
- May be made in writing to BCRC any time
- Considered on case by case basis and may take between 3 – 6 months

Procurement Offset

- Medicare must offset its lien by a % equal to the % of the settlement value devoted to attorney's fees and case expenses

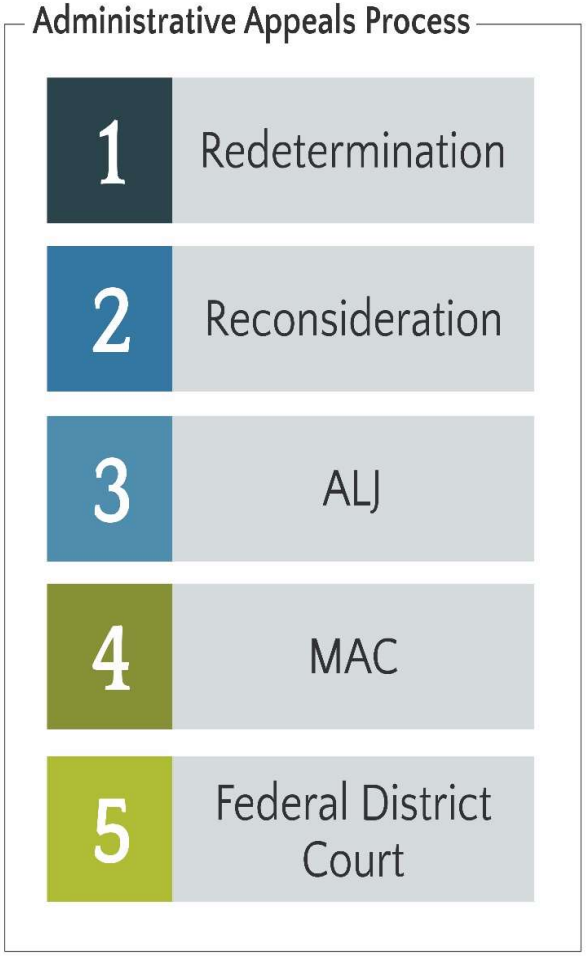
Waivers

- Allowed under Section 1870(c) of the Social Security Act
- Filed only after final demand
- Made in writing to BCRC with form SSA-632-BK, and supporting documentation
- Primarily based on financial hardship
- Decision generally takes 120 days from request

Medicare Secondary Payer – Minimizing the Financial Impact

Administrative Appeals

- Must be submitted post final demand
- Final demand amount should still be paid within 60 days of issuance
- Waivers and Compromises focus on principles of equity – appeals center on errors or legal arguments
- Contest unrelated charges/duplicate charges, incorrect settlement information considered, incorrect procurement offset applied
- Time for filing
  - 120 days from final demand
  - 180 days from redetermination
  - 60 days from reconsideration decision
  - 60 days from the ALJ decision
  - 60 days from the MAC decision



Medicare Secondary Payer – MMSEA Section 111 Reporting

- Insurers—liability, no-fault, and workers' compensation—as well as self-insurers, collectively referred to as "responsible reporting entities," (RREs), must report information regarding payments made to Medicare beneficiaries.
- Required if:
  1) the plaintiff – beneficiary is entitled to Medicare **and**
  2) a payment is made to or on behalf of the plaintiff – beneficiary
- Reporting obligation triggered when:
  1) RRE accepts ongoing responsibility for medicals (ORM) **or**
  2) makes a total payment obligation to claimant (TPOC).
- Reporting occurs electronically through the BCRC during a specific 7 day window each quarter (calendar).
- The RRE may perform reporting or engage a reporting agent, but the RRE maintains liability for compliant reporting.
- CMS has started implementation of a new Medicare ID format for beneficiaries. This impacts the information CMS returns to RREs in response to a Section 111 reporting query. Formerly, CMS query returns referenced the beneficiary's social security number-based Medicare ID number.

Medicare Secondary Payer – MMSEA Section 111 Reporting

Reporting Threshold	Derivative Plaintiffs	Exposure Cases
• Per Section 202 of the SMART Act, each year CMS must establish a minimum threshold or "safe harbor" for physical – trauma based liability cases, below which no reimbursement or MMSEA reporting requirements apply. • Currently, the minimum threshold is $750. • There are no MMSEA reporting or Medicare reimbursement obligations for physical trauma – based settlements with gross settlement values of $750 or less. • Threshold for reporting Worker's Compensation claims is $300. • Exposure case considerations.	• If medicals were pled, claimed or released for a Medicare enrolled derivative plaintiff, then the RRE has a reporting obligation on the derivative plaintiff and should report the full settlement value. • If medicals were pled, claimed or released for the primary plaintiff, who is not Medicare enrolled, and the derivative plaintiff is Medicare enrolled, the RRE has a reporting obligation on the derivative plaintiff and should report the full settlement value. • The RRE may use a no injury code (NOINJ) to report derivative plaintiffs no medical expenses were incurred.	• There is no reporting requirement when the injury was caused by exposure, ingestion or implantation before 12/5/1980 and all of the following are true: • All exposure or ingestion ended, or the implant was removed before 12/5/1980; • Exposure, ingestion, or an implant on or after 12/5/1980 has not been claimed in the most recently amended operative complaint (or comparable supplemental pleading) and/or specifically released; and • There is no release for the exposure, ingestion, or an implant on or after 12/5/1980; or where there is a release, it is a broad general release, which effectively releases exposure or ingestion on or after 12/5/1980. The rule also applies if the broad general release involves an implant.

SMART Act Section 203 – That $1,000/day fine: Civil Money Penalties

- 2020 Update: on 2/28/2020, CMS issued MMSEA Section 111 Civil Monetary Penalties (CMPs) Proposed Rule (85 FR 8793)
  - CMS can issue CMPs against Non-Group Health Plans (worker's comp, liability insurer, etc.) when:
  - Entity fails to register as a Responsible Reporting Entity
  - Entity fails to report a Total Payment Obligation to Claimant (settlement, judgment, award) within 1 year of the settlement, etc.
  - Entity response to CMS recovery efforts contradicts entity's Section 111 reporting
  - Entity exceeds error tolerance threshold in any of 4 out of 8 reports
- Monetary penalties will not be issued if the Non-Group Health Plan is unable to obtain information necessary for reporting from the individual and entity has made records of good faith attempt to obtain that information
- Monetary Penalties of NGHPs:
  - Up to $1,000 per day per individual that should have been reported (max $365,000 per individual per year)
  - Up to $1,000 per day per individual for response contradicting reporting (max $365,000 per individual per year)
  - Tiered approach for exceeding error threshold: 25% of max penalty for one period. 50% if exceeds for 2 consecutive periods, 75% for 3 consecutive, 100% for 4

SMART Act Section 203 – That $1,000/day fine: Civil Money Penalties

Avoiding CMPs

- Ensure primary payers are registered as Responsible Reporting Entities
- Report settlements in excess of the reporting threshold (current / past)
- Check reported settlements and correct any reporting errors
  - A report with an error is not a report
- If the claimant will not provide necessary reporting information, documents the refusal and efforts to obtain the information

Future Medicals and Medicare Set Asides

Summary Review of CMS Activity

- **2011**: Stalcup Handout
- **2011**: LMSA Policy Alert re: Treating Physician Letters
- **2012**: CMS submits Advanced Notice of Proposed Rule Making (ANPRM)
- **2013**: CMS submits Notice of Proposed Rule Making (NPRM)
- **2014**: CMS voluntarily withdraws NPRM
- **2015**: Department of Health and Human Services Future Meds Letter
- **2017**: CMS hires new contractor to perform voluntary reviews of MSAs (includes LMSAs)
- **2017**: CMS issues a MLN article advising providers to bill & accept payment from an MSA
- **2017**: CMS email stating it continues to consider expanding voluntary reviews to LMSAs
- **2018**: CMS discusses potential LMSA ideas with stakeholders; suggestions involve voluntary submission of information and focus obligation on beneficiary; CMS continues to reference the 7 – option framework presented in the June 2012 ANPRM (Fed. Reg. Vol. 77, No. 116 –link to ANPRM)
- **2019**: NPRM slated to be released in September 2019, delayed to October. As of March 2020, NPRM not issued (2020 update).

Future Medicals and Medicare Set Asides

Guidance tells us

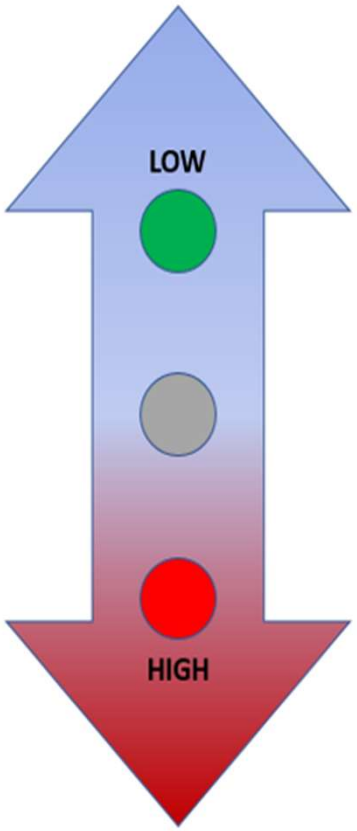
- Must protect trust fund
- Set Aside not required
- Allocating away future meds won't work
- Key consideration is what was pled, claimed, and/or released
- Primarily a plaintiff's issue
- A plaintiff-beneficiary must determine how much a settlement is "Prepaying" for future medical expenses & not bill Medicare for future injury related care until the prepaid amount is exhausted
- Must account for the "prepaid" amount

Future Medicals and Medicare Set Asides

Risk Tolerance Threshold

- With a statutory obligation but only informal regulatory and practical guidance, each case presents a clear obligation to consider Medicare's interest in future medicals but defining a clear "how to" process it open for interpretation.

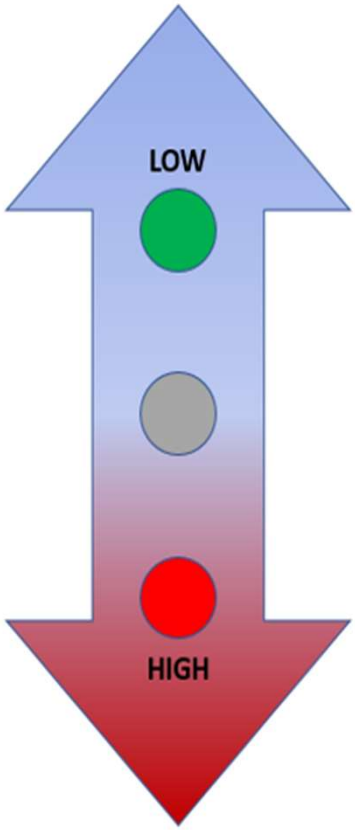
- The lack of regulatory clarity can be navigated based on an analysis of case-by-case details and establishing your acceptable "risk tolerance" threshold based on an understanding of best practices.



Case Screening and Initial Analysis – Risk Tolerance Threshold

Risk Tolerance Threshold

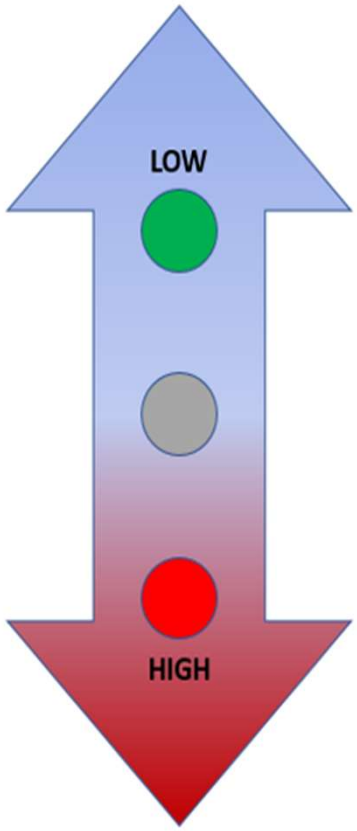
- Low Risk
  - Initial analysis on every case
  - Medicare entitlement within 24 months
  - Treating physician letter
- Medium Risk
  - Initial analysis on some cases
  - Current Medicare entitlement only
- High Risk
  - Initial analysis only if defense requires
  - "Allocate Away" future medicals



Determining the Prepaid Amount – Risk Tolerance Threshold

Risk Tolerance Threshold

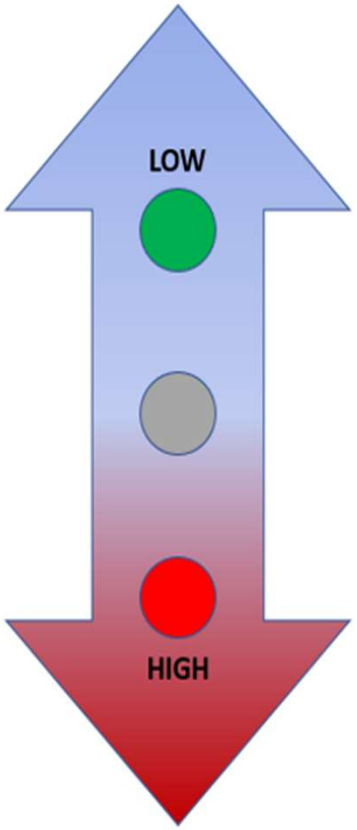
- Low Risk
  - Utilize defensible allocation methodology
  - Client education protocol
  - Third party opinion
- Medium Risk
  - Utilize life care plan only
  - Have client sign indemnification/ hold harmless
- High Risk
  - Arbitrary allocation
  - Require CMA or court approval of amount



Administering the Prepaid Amount – Risk Tolerance Threshold

Risk Tolerance Threshold

- Low Risk
  - Client provider education protocol and support
  - Professional administration
- Medium Risk
  - Law firm administration
  - And/or client education protocol and indemnity
- High Risk
  - Client administration
  - No client education protocol



Future Medicals and Medicare Set Asides – Best Practices

- Develop and implement a process for identifying cases where future medicals are pled and/or released & your client requires future injury related care likely to be covered by Medicare
- Utilize a reasonable, defensible future medicals allocation methodology to determine if the settlement "prepays" for future accident – related care covered by Medicare and if so, for how much
- Advise your client of compliant spend down options to ensure Medicare is not billed prematurely, whether through set aside administration or other methods
- What's at risk:
  - Benefit offsets – Medicare may recover against the beneficiary's Social Security benefits, Railroad Retirement benefits, or tax refunds
  - Loss of benefits – Medicare may refuse to pay for future medical care for the settlement related injury. 42 C.F.R. § 411.24(d)
  - Ethical considerations for law firm relative to client losing Medicare benefits

Medicare Part C – The Basics and Recent Developments

- In 2019, 22 million (34%) beneficiaries are enrolled in a Part C plan (+ 7.3% from 2018)
- Parra v. Pacificare of Arizona, 715 F.3d 1146 (9th Cir. Ariz. 2013) found that a Part C plan did not have access to the MSP private cause of action provision.
- In re Avandia, 685 F.3d 353 (3d Cir. 2012), cert. denied, 133 S. Ct. 1800 (2013). 3rd Circuit rules and SCOTUS denies certiorari:
- The MSP private cause of action provision (42 U.S.C.§1395y(b)(3)(A)) and CMS regulations (42 C.F.R.§422.108) grant Part C plans parity with traditional Medicare to recover past medical expenditures on accident related care.
- Subsequent Jurisprudence
  - Part C plan may recover double damages. Humana v. Western Heritage, 832 F.3d 1229 (11th Cir. 2016).
  - Part C plan may recover directly from plaintiff – beneficiary. Collins v. Wellcare, 73 F. Supp. 3d 653 (E.D. La. 2014).
  - Part C plan may use federal preemption to defeat state law recovery limitation. Estate of Ethridge v. Recovery Management Systems, 326 P.3d 297 (Ariz. Ct. App. Div. 1 2014).
  - Part C plan may pursue beneficiary's attorney for recovery. Humana v. Paris Blank, 2016WL2745297 (E.D. Va. May 10, 2016).
  - (2020 update) Part C plan, or assignee, is not required to file private cause of action suit for double damages within the 3 year time period found in 42 U.S.C.§1395y(b)(2)(B)(vi). MSPA Claims1, LLC v. Kingsway Amigo Insurance, 2020 WL 728625 (11th Cir. February 13, 2020). However, the 3 year statute of limitations implemented by Section 203 of the 2SMART Act was not before the Court.

Medicare Part C – Best Practices

- Determine plaintiff enrollment status (Medicare A/B v. Part C)
  - Verify entitlement status through traditional means (web portal, screenings, etc.)
  - Take note when Medicare A/B payments made one year but not subsequently
- Comply with any notice requirements
  - 42 C.F.R. § 422.108(b) puts notice burden on the Part C plan
  - However, beneficiary may have contractual notice obligations
- Account for administrative differences
  - BCRC does not handle Part C recovery actions
  - Resolution occurs directly with plan and/or its private recovery contractor
- Utilize traditional Medicare resolution and reduction methods
  - Excepting the administrative remedies, utilize the offset provisions, dispute process and any other pre – administrative recourse tactics to reduce the lien in the same manner as traditional Medicare
- Know the jurisprudence in your jurisdiction

Medicare Part D – History and Recent Developments

- Jurisprudence with respect to Part C plans equating to Part D plan rights
  - Parra v. Pacificare; In re Avandia; Western Heritage; Collins; Paris Blank
  - Conflicting opinions from 9th and 3rd Circuits
- 2011 CMS memo that Part D plans have same MSP right as Parts A/B
- 2018 CMS updated Medicare Prescription Drug Benefit Manual to provide clarity and require Part D sponsors to adjudicate reimbursement rights in accordance with MSP Act
- SPARC Act (Secondary Payer Advancement, Rationalization, and Clarification Act) Re-Introduced as H.R. 1122 on 3/01/2017 by Congressman Murphy (R-PA)
  - Clarify and strengthen Part D secondary payer status
  - Allow plans to waive negative recovery claims based on cost of pursuit
  - CMS to share MMSEA Section 111 claims data to assist Part D recovery
  - Require benefit coordination with primary plan accepting ORM
- 2019 SPARC Act Update: stalled in committee

Medicare Part D – Best Practices

- Determine plaintiff enrollment status (Medicare Parts A, B, or C)
  - Verify entitlement status through traditional means (web portal, screenings, etc.)
  - If Medicare eligible or confirmed enrolled, Part D is almost certainly in play
- Identify Part D plan
  - Client screening questionnaire, copies of insurance cards, discovery, review of pharmacy records and/or medical records and bills
  - Companies administering Part D plans can be identified by region
  - Be aware of potential for Part C plan to provide Part D benefits
- Address identified Part D implications prior to settlement and payment of proceeds
  - Part D plans are relegated to a "pay and chase" recovery method due to unclear guidance, increasing potential for the issue to come up after funds are disbursed
- Know the jurisprudence in your jurisdiction

Provide Accurate Information Direct Act (PAID Act) (H.R. 1375)

- Query process will return information on beneficiary's enrollment in Medicare Part C and/or D
- Information returned will provide the name and address of Part C and/or D programs in which beneficiary enrolled over past three years
- Unlike the 2018 version, it will not include Medicaid enrollment information
- Settling party may then reach out directly to Medicare Part C and/or D plan to notify of primary payment and negotiate reimbursement
- Bipartisan bill sponsored by Ron Kind (D-WI) and Gus Bilirakis (R-FL)
- Congressional Budget Office Cost Estimate expected to indicate this bill saves the government money

Medicaid – Health Insurance Program Overview

- Means – based eligibility program administered by states with CMS oversight
- Approximately 73 million beneficiaries
- Eligibility requirements typically include low income (based on FPL) and:

Receive SSI Benefits	Disabled	Parent of minor
Minor	Pregnant	Receive Medicare
Section 115 Waiver	Childless Adult in ACA	Breast or Cervical Cancer

- Enrollment almost doubled from 37.3 million to 72.5 million after ACA expansion (enrollment is expected to reach 82 million people by 2026)
- Expenditures: $592 billion combined in FY 2017 – fed share was $370 billion (63%)
- Spending is expected to grow at an avg. annual rate of 5.7% and to reach $1 trillion by 2026
- Both fed and state have a stake in recovering third party liability payments
- Medicaid is usually the second largest line item in state budgets, 16% of state dollars and right behind education
- 70% of Medicaid beneficiaries receive benefits from a managed care organization (MCO)

Medicaid and Medicaid Secondary Payer – The Basics

- Federal statutes require that states implement "lien" laws
  - See 42 U.S.C.§1396a et seq.
- Anti – lien statute prohibits Medicaid liens on personal property prior to death
  - See 42 U.S.C.§1396p(a)(1)(A)
- 53 implementing agencies with individual statutory schemes

Evolution of Medicaid Secondary Payer

Ahlborn	Wos	BBA 2013	BBA 2018
The anti-lien statute prohibits state Medicaid plans from recovering lien amounts from the personal property of beneficiaries. Personal property = settlement proceeds not attributable to payment for past medical expenses.	States and Medicaid agencies must establish and utilize a non-arbitrary process for determining which part of a beneficiary's settlement is payment for past medical expenses.	Section 202(b) of the Bipartisan Budget Act of 2013 negates Ahlborn & Wos, and allows states to recover entire lien amounts from the entire amount of a beneficiary's settlement proceeds.	The provisions of the BBA of 2013 did not become effective until October 2017. Three months later, Section 53102 of the Bipartisan Budget Act of 2018 permanently repealed the 2013 changes. Ahlborn and Wos are again valid SCOTUS rulings.

Medicaid Secondary Payer – Key Considerations for Resolution

- Medicaid Managed Care (MMC)
  - All but 3 states utilize MMC to some extent and approximately 70% of all beneficiaries are enrolled in a form of MMC
  - 50% of states contract with 6 or more MCOs annually (complicating factor)
- Notice Requirements
  - Notice requirements affirmatively on plaintiff (mandated by federal law), but procedure may vary
  - Some states implement reporting requirements on defendant/primary plans
- Medical Assistance Intercept System (MAIS)
  - Adopted by 2nd state, Texas, in April 2019 (2020 update)
  - System electronically matches Medicaid recipients with liability and worker's compensation insurance claims
  - Designed to intercept settlement payments of $500 or more
- Audit, Dispute, and Offsets
  - Audits and disputes apply, but automatic offset of procurement cost may not be recognized by state law depending on the state
- Administrative Remedies
  - State by state determination
- Benefit Protection
  - Receiving settlement proceeds in cash may cause beneficiaries to lose eligibility

Medicaid Secondary Payer – Best Practices

- Know the details of your state program
  - MMC status and identity of MCO plans, contacts at the state department, eligibility criteria, administrative remedy framework, procurement offset rules, etc.
- Identify beneficiaries and comply with notice requirements
  - Requires examination of laws from state to state and mandatory eligibility criteria set by federal law
- Utilize Ahlborn and Wos
  - Law of the land limiting the Medicaid recovery right to the portion of settlement proceeds identifiable as payment for past medical expenses
  - Arkansas Dep't of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006)
  - Wos v. E.M.A., 133 S.Ct. 1391 (2013)
- Benefit protection
  - Take steps to prevent the beneficiary's unnecessary loss of benefits by examining the utility of a special needs trust or other protection vehicle

List of Acronyms

Acronym	Full Terminology
CMS	Centers for Medicare and Medicaid Services
MSP	Medicare Secondary Payer
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
BCRC	Benefits Coordination and Recovery Center
ICD	International Classification of Diseases (ICD – 10 is "Tenth Revision")
ALJ	Administrative Law Judge
MAC	Medicare Appeals Council
RRE	Responsible Reporting Entities
ORM	Ongoing Responsibility for Medicals
TPOC	Total Payment Obligation to Claimant
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
MSPRP	Medicare Secondary Payer Recovery Portal
CP	Conditional Payment
CPL	Conditional Payment Letter
CPN	Conditional Payment Notice
LMSA	Liability Medicare Set Aside
ANPRM	Advanced Notice of Proposed Rulemaking
NPRM	Notice of Proposed Rulemaking
WCMSA	Workers Compensation Medicare Set Aside
HHS	U.S. Department of Health and Human Services
SPARC	Secondary Payer Advancement, Rationalization, and Clarification Act
FPL	Federal Poverty Level
ACA	Patient Protection and Affordable Care Act
BBA	Bipartisan Budget Act
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MMC	Medicaid Managed Care
MCO	Managed Care Organization
CMP	Civil Money Penalty

Thank You

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