March, 2012

The Medicare, Medicaid and SCHIP Extension Act of 2007, Section 111 Reporting: One More Thing to Worry About in Your Settlements

Abstract:

The Medicare law, now in effect, could make it more difficult for plaintiffs and defendants to settle single event and mass tort personal injury claims. Now more than ever, all parties must embrace new procedures on the front end of cases in order to minimize disruption on the back end.

On December 29, 2007, President Bush signed into law the "Medicare, Medicaid and SCHIP Extension Act of 2007"[1] (MMSEA) adding more teeth to the Medicare Secondary Payer Statute.[2] Section 111 of the MMSEA requires the providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance (hereinafter "insurers") to determine the Medicare-entitlement of all claimants and report certain information about those claims to the Secretary of Health and Human Services.[3] With the objective of assisting the Secretary with coordinating benefits and uncovering potential reimbursement claims, this legislation reinforces that the federal government is intent on ensuring Medicare always is treated as the payer of last resort. The penalty for non-compliance is severe--$1,000 per day per claimant for each day the insurer is out of compliance. This penalty is in addition to the rarely-levied "Double Damages Plus Interest" that defendants can be fined if Medicare's reimbursement claim is ignored in any settlement.[4]

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[1] Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492.

[2] MMSEA amended §1862(b) of the Social Security Act (42 U.S.C. §1395y(b)) by adding at the end these new requirements as paragraph 8.

[3] Section 111 of the MMSEA also addresses new amendments to the Medicare Secondary Payer statute regarding reporting requirements for Group Health Plans. This article, however, only addresses the amendments related to providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance.

[4] Many things would need to go terribly wrong before a Medicare reimbursement claim gets to the point of a Defendant being liable for double damages plus interest. For instance, Medicare's final demand for reimbursement from the claimant after a settlement must be paid 60 days from the date the final demand was issued by the Medicare Secondary Payer ("MSP") department of the Centers for Medicaid and Medicare Services ("CMS"). The MSP department allows 180 days for payment. After these 180 days transpire, the department will send an "intent to refer" letter (i.e., refer to Treasury for collection) and provide an additional 60 days to respond. So, in effect, settling parties are allowed 240 days to address the final demand. (Certain exclusions apply to a referral involving a case pending on appeal). When a case ultimately is referred to Treasury, their first step is to send a letter to the beneficiary seeking collection of the debt. If unsuccessful, the second step is to seek the remedy available through the Tax Refund Offset Program ("TROP") whereby Treasury seeks satisfaction of the lien by being "constructively paid" through offsetting the claimant's government checks (benefits) and/or refunds (tax). The government will pursue this exhaustive solution to secure reimbursement from the beneficiary. Claimant's counsel and the defendant/carrier typically is not a target for reimbursement until the second step of Treasury recovery is fully explored. But see *United States v. Sosnowski*, 822 F.Supp. 570, 1993 U.S. Dist. LEXIS 7568, 41 Soc. Sec. Rep. Service 312 (W.D. Wis.1993). When payment was received, Sosnowski and his attorney neglected to reimburse Medicare from the settlement, as required under federal law (42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 411.24). The federal government therefore commenced an action against both Sosnowski *and* his attorney, jointly and severally, for recovery of the amount due. Consistent with the MSP provisions, the court ruled that the government did have a cause of action for recovery against not only the Medicare recipient, but also his attorney for the entire reimbursement. See also *United States v. Stricker*, No. CV-09-PT-2423-E, N.D. Ala. 2009, (U.S. brought an action against attorneys who represented Medicare beneficiaries, and against insurers who were a part of and paid into a mass tort settlement program involving PCB exposure to recover conditional payments plus double damages as part of a settlement program that appears to have not included a Medicare compliance program as part of its process. The attorney and corporate defendants challenged the Amended Complaint based on statute of limitations grounds. The 11th Circuit granted the Motion to Dismiss, and reserved its ruling on a tolling issue. The order further identified that for the corporate defendants a three

MMSEA represents the next adjustment in the long continuum of change since President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act in December 2003 (**"**MMA**"**).[5] The MMA further defined Medicare**'**s recovery rights, clarified its enforcement powers[6], and erased all doubt regarding a plaintiffs lawyer**'**s affirmative duty to verify and resolve conditional Medicare payments made from the date of injury through the date of settlement.[7] Whereas the penalties added to the Medicare Secondary Payer framework by MMA in 2003 were targeted at the plaintiff community, those just added by MMSEA are directed at insurers.[8] The ongoing transformation of Medicare reimbursement policy and practice creates continual challenges for lawyers and their clients and insurers in personal injury and workers**'** compensation cases. Simply put, the days of either ignoring Medicare or waiting until the end of the case are long gone.

Who Will Have to Report?

The "applicable plan" is responsible for complying with the reporting requirements of Section 111 of the MMSEA as referred to by CMS as "Responsible Reporting Entities ("RREs"). An "applicable plan" is defined as the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

- Liability insurance (including self-insurance)
- No fault insurance
- Workers' compensation laws or plans.[9]

For purposes of MMSEA compliance, this group of reporting entities is considered non-Group Health Plans, or "non-GHPs".

To better understand these reporting concepts, it helps to be able to distinguish who reports for non-GHP purposes and who does not. Under the MSP, the term "Group Health Plans" means a plan (including a self-insurance plan of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former

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year statute of limitations applies, measured from (at the latest) the date payment was made by those corporate defendants, and a six-year statute of limitations applies for the attorneys who represented the Medicare beneficiaries).

[5] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified within 42 U.S.C. **§**1395). Sec. 301 further clarifies the government's right to reimbursement that it had been seeking in *Thompson v. Goetzmann*, 337 F.3d 489, 2003 U.S. App. LEXIS 13594 (5th Circ. Tex. 2003) and *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 2003 U.S. App. Lexis 19067 (11th Cir. Ala. 2003). See also *Brown v. Thompson*, 374 F.3d 253, 2004 U.S. App. LEXIS 13967 (4th Cir. Va. 2004) (further clarifying congressional intent to modify the MSP statutes using **§**301).

[6] The Centers for Medicare and Medicaid Services (**"**CMS**"**) has a right to seek recovery "against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly" if those third-party funds--rather than Medicare--should have covered injury-related medical expenses. The right of reimbursement exists regardless of whether the settlement acknowledges liability and how the settlement agreement stipulates disbursement should be made. This includes situations in which the settlement does not expressly include damages for medical expenses. The plaintiff attorney and defendant can be held responsible for twice the amount owed to the agency. See 42 U.S.C. **§**1395y(b)(2)(B)(iii) (2000 & Supp. 2004). Until the 2003 amendments, there was little statutory support for this position, but 42 U.S.C. **§**1395y(b)(2)(B)(ii) now provides recovery from an entity that receives payment from a primary insurer.

[7] As a result, no matter how a particular settlement agreement is worded and no matter whether the tortfeasor is covered by a commercial insurance insurer or a self-insured insurer, or is just paying the claim out of its general assets, any payments Medicare makes are considered conditional.

[8] One could argue, however, that the indirect target of MMSEA is the plaintiff community since MMSEA would be superfluous if the federal government felt its interests were being protected by plaintiffs**'** bar after MMA..

[9] 42 U.S.C.§1395y(b)(8).

employees, the employer, others associate or formerly associated with the employer in a business relationship, or their families.[10] For example, any employer-sponsored plan which provides health insurance coverage, such as Blue Cross/Blue Shield, or a self-insurance plan such as Wal-Mart Associate's Health & Welfare Plan, would have a reporting obligation that started January 1, 2009. Non-GHPs, then, include everyone else who has an obligation or assumes the responsibility for medical payments for Medicare entitled beneficiaries.

The applicable statutory language,[11] the definitions provided by the MMSEA's Paperwork Reduction Act Supporting Statement, and the Alert for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation: Who Must Report, clarifies which business entities need to report.[12]

Understanding the reason for Section 111 reporting is clarified when taken in context of the MSP. The sole purpose of Section 111 of the MMSEA is to ensure that settling parties fully comply with the MSP requirement – that is, **conditional payments** must be verified and resolved in all liability, workers compensation and no-fault settlements. In this regard, if the Medicare beneficiary's attorneys are already verifying and resolving Medicare's reimbursement claim in all their settlements, these new reporting rules should result in business as usual for those attorneys and their clients. And, according to the Supporting Statement of the MMSEA,[13] for most non-GHP RREs, gathering the data required may not create a huge burden for those entities that have traditionally coordinated proper claim payments with Medicare to ensure proper order of payment. Non-GHP RREs will, however, need to adopt the CMS reporting methodology set forth in the most recent version of the User Guide.

The history of the MSP statute provides further insight into the true meaning of Section 111 of the MMSEA. On December 5, 1980, the MSP statute as we know it today was modified to include liability settlements, judgments or other payments as being subject to Medicare's conditional payment recovery rights. It was not until twenty-three years later, under Section 301 of the MMA, when additional enforcement provisions were added to the MSP statute, focusing compliance on reimbursement obligations for settling parties, including attorneys and their Medicare-enrolled clients. Now, Congress has closed the loop with Section 111 of the MMSEA by placing a reporting obligation on self-insured defendants and/or insurance carriers. The User Guide emphasizes the fact that Section 111 of the MMSEA did not change or remove any existing MSP rules regarding recovery, but adds a reporting obligation to existing MSP requirements. As a result, for claimants and their attorneys, the obligation is still to "verify and resolve" Medicare's conditional payments, but for defendants, the sole obligation (through the MMSEA) is to verify Medicare entitlement and report to CMS when appropriate (presuming Medicare reimbursement will occur as part of the process such that double damages are not in issue). If the injured party is not represented, the RRE may want to enhance their claims processes and obtain approval from the claimant to direct the lien resolution process to ensure that any Medicare liens are being resolved.

What are the Reporting Rules?

[10] 42 U.S.C.§1395y(b)(1)(A)(iv), *citing* the income tax definition of group health plans under 26 U.S.C. §5000(b)(1).

[11] 42 U.S.C.§1395y(b)(8)(F).

[12] 42 U.S.C.§1395y(b)(8)(CMS-10265)(Aug. 1, 2008); *see also* Section 7.1 of Version 3.3 of the User Guide at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

[13] 42 U.S.C.§1395y(b)(1)(A)(iv), *citing* the income tax definition of group health plans under 26 U.S.C. §5000(b)(1).

For all triggering events, RREs must engage in a two-step process: Step 1: Determine whether an injured party (including an individual whose claim is unresolved) is a Medicare beneficiary. Step 2: If there is a settlement and if the injured party is a Medicare beneficiary, electronically submit data about the injured party, the claimant if different from the injured party, information about the injury, attorney/representative information, settlement data and plan and policyholder information to the Secretary of Health and Human Services through the Coordination of Benefits Secure Website ("COBSW").

While seemingly straightforward, when the MMSEA first became law, parties to the settlement needed clarification regarding the intended scope and definition of the provisions. Since then, guidance has been provided in the form of multiple "town hall" teleconferences with CMS representatives to ensure this process is understood and compliance is effective as of the appropriate trigger dates. On February 22, 2010, CMS published Version 3.0 of the User Guide, followed by updated versions, the most recent being Version 3.3 dated December 16, 2011, with copious information to assist RREs to comply with the federal law.

The Need for SSNs and HICNs in the Section 111 Reporting Process.

CMS understands the concern over keeping personal information confidential; however, CMS also recognizes the critical importance of RREs being able to obtain Social Security Numbers ("SSN") and/or Health Insurance Claim Numbers ("HICN"). The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet its administrative responsibilities to pay for health care and to operate the Medicare program. CMS also uses the HICN to ensure the Medicare program makes payment in the proper order and/or takes the proper recovery actions. Without this cornerstone, CMS could not systematically link the reported data to a particular beneficiary.

Any discussion of providing SSNs cannot be reviewed without referring to the federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its HITECH Amendments of 2009. HIPAA created regulations which strictly regulate data transfer issues such as when an SSN is to be used for personal health information, how that information is to be managed and used, who can collect it, and how it can be shared. Understandably, in light of today's "information age" and legitimate concerns surrounding identify theft, claimants may be hesitant about providing their SSNs to insurers and other RREs. However, the collection of SSNs and similar protected health identification information for the purposes of coordinating benefits with CMS is a required, legitimate and necessary use of the SSN under federal law.[14]

Despite the legitimate function of an RRE collecting this protected health information, Section 111 does not provide "implied consent" allowing RREs to request Medicare entitlement information. Section 111 of the MMSEA also does not require an injured party to authorize an RRE to obtain entitlement information from the Social Security Administration. CMS has also clarified in its many "town hall" teleconferences and in its guidance on MMSEA reporting that RREs remain responsible for creating procedures to determine an injured party's Medicare status. Finally, settling parties are also obtaining some measure of guidance through court action with respect to the propriety of requesting and using SSNs for purposes of coordinating benefits with Medicare.[15]

[14] *See footnotes* 12, 13 and the Supporting Statement for the MSP Mandatory Insurer Reporting Requirements of Section 111 of the MMSEA, which notes that while collecting SSNs is a legitimate federal function, MSP and HIPAA laws also preempt any state statutes which might otherwise attempt to limit this information.

[15] *See Seger v. Tank Connection, LLC*, 2010 U.S. Dist. LEXIS 61796 (D. Neb. June 1, 2010) (Plaintiff refused to provide information requested by Defendant; Court averred no harm in providing information for Medicare compliance purposes); *Hackley v. Garofano*, 2010 Conn. Super.

Verification of Entitlement- The Query Process – Step One:
To attempt to address this seeming dichotomy, CMS has developed, and added to its Section 111 MMSEA website for RREs, a QUERY ACCESS System. RREs can use this system to determine an injured party's Medicare entitlement status, provided the RREs submit the appropriate identifying health information.

Query files can be submitted once a month to determine if injured parties who have filed a personal injury or workers compensation claim are Medicare enrolled. The query can be submitted every month throughout the claims process to ensure that the Medicare enrollment status has not changed. If you receive a "no match" from a query, you will need to query it again at the time of settlement since the critical date of enrollment is at the date of settlement. Five data points are needed for the query:

- First letter of the first name;
- First six letters of the last name;
- SSN or HICN;
- Date of birth; and
- Gender.

When determining enrollment, the COBC must first find an exact match in its database on the HICN or SSN. Then, at least three out of the four final remaining criteria must be matched exactly. If a match is found, based on the SSN, the COBC will provide the correct HICN to the RRE in the response file.

In addition to the once per month upload of all cases for which the RRE is requesting Medicare enrollment status, as described above, the RRE may also go directly to the COBSW and enter the five data points to obtain an immediate response of the enrollment status. This query option can only be used 100 times per month per RRE ID.

What Triggers a Reporting Obligation for Non-GHPs?
Reporting for non-GHPs is event-specific. The triggering events are the dates when a RRE accepts responsibility for medical payments or when a RRE settles or concludes a dispute such that there is an award, judgment, settlement or other payment involving an injured person currently entitled to Medicare. Pending settlements should not be reported and attempting to report such pending settlements does not constitute compliance with respect to Section 111 reporting obligations. RREs must report settlements, judgments, awards or other payments **regardless of an admission or denial of, or determination of liability.**

On-going responsibility ("ORM") for Medicals:
When the RRE assumes responsibility to pay, on an on-going basis, for the injured party's medicals then the requirement to report is triggered. This typically occurs on workers' compensation and no-fault claims. When ORM is assumed, the RRE should query CMS for Medicare enrollment status. If the injured party is enrolled, then the RRE must report the assumption of ORM in the next quarterly submission. Reporting is required whether any actual medical payments have been made; rather the assumption of ORM triggers reporting.

LEXIS 1669 (in a personal injury settlement, Court held that insurance carrier could condition its disbursement of settlement funds upon receipt of SSN, and that the insurer had a right to verify all Plaintiffs information to determine which ones were Medicare enrolled, but since the parties did not reach a meeting of the minds on the settlement terms, specifically disclosure of confidential information, consequently, the Court refused to require the settlement to proceed);*Smith v. Sound Breeze of Groton Condo. Ass'n*, 2011 Conn. Super. LEXIS 194 (Court agreed that the SSN could be obtained by the RRE but issued protective order, limiting the use of the acquired SSN to compliance under MMSEA Section 111).

If the injured party is not enrolled with Medicare at the time ORM is assumed, the RRE has the obligation to continue to query CMS to determine if the injured party's Medicare enrollment status changes. If the injured party becomes Medicare enrolled prior to ORM being terminated, then the RRE must report the assumption of ORM in the quarterly submission following the date of enrollment.

Once the ORM has been reported, no additional reporting is required until the assumption of ORM is terminated. The termination of ORM is reported in the next quarterly submission by the RRE.

If a file is closed due to a "return to work," but a payment responsibility is subject to reopening or otherwise subject to an additional payment request, the RRE cannot terminate the claim until ORM has ended. To address this situation, RREs may submit a termination date for ORM if they have a signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or otherwise subject to a claim for further payment.[16]

Liability:
RREs are to report to CMS only with respect to injured parties who were Medicare beneficiaries at the time of settlement, award, judgment or other payment (including a deceased individual who was Medicare enrolled at the time of his/her death). If a reported individual is not a Medicare beneficiary or CMS is unable to validate a particular SSN or HICN based on the submitted information, CMS will reject the record for that individual.

The question of whether a particular settlement is reportable or, in other words, whether it must be reported depends upon the "TPOC" and the "TPOC Date" of the settlement. The term "TPOC", which is an acronym for "Total Payment Obligation to Claimant", "refers to the dollar amount of a settlement, judgment, award, or other payment."[17]

It "generally reflects a 'one-time' or 'lump-sum' payment of a settlement, judgment, award, or other payment intended to resolve/partially resolve a claim."[18] In a mass tort aggregate settlement, the TPOC for a given injured party is the amount of the injured party's settlement award, not the total amount of money for the entire settlement group.

What are the minimum reporting requirements?
Liability:
Taking into account both the TPOC and the TPOC Date, CMS have provided the following guidelines for determining whether MMSEA reporting is necessary for a given settlement.

- TPOCs over $100,000 must be reported if the TPOC Date is on or after October 1, 2011, with mandatory reporting in the first quarter of 2012;
- TPOCs over $50,000 must be reported if the TPOC Date is on or after April 1, 2012, with mandatory reporting in the third quarter of 2012;
- TPOCs over $25,000 must be reported if the TPOC Date is on or after July 1, 2012, with mandatory reporting in the fourth quarter of 2012; and

[16] Section 11.8 of Version 3.3 of the MMSEA Section 111 Liability Insurance (Including self-insurance), No-Fault Insurance, and Workers' Compensation User Guide at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

[17] Version 3.3 of the MMSEA Section 111 Liability Insurance (Including self-insurance), No-Fault Insurance, and Workers' Compensation User Guide at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

[18] *Id.*

- TPOCs over the "minimum reporting threshold" must be reported if the TPOC Date is on or after October 1, 2012, with mandatory reporting in the first quarter of 2013.

In addition to the interim reporting thresholds set forth above, the User Guide also provides for minimum reporting thresholds. Applying the minimum reporting thresholds to the interim reporting thresholds, one can identify the following reporting guidelines as a continuation of the outlined provisions above:

- TPOCs over $5,000 must be reported if the TPOC Date is on or after October 1, 2012, with mandatory reporting in the first quarter of 2013;
    - TPOCs over $5,000 may be voluntarily reported even if the TPOC date is prior to October 1, 2012;
- TPOCs over $2,000 must be reported if the TPOC Date is on or after January 1, 2013, with mandatory reporting in the quarterly submission following the TPOC Date;
- TPOCs over $600 must be reported if the TPOC Date is on or after January 1, 2014, with mandatory reporting in the quarterly submission following the TPOC Date; and
- All TPOCs must be reported if the TPOC Date is on or after January 1, 2015, with mandatory reporting in the quarterly submission following the TPOC Date.

Settlements with TPOCs below the minimum reporting threshold applicable on the TPOC Date should not be reported and will be rejected by CMS if reported.

Workers' Compensation, No-Fault and Liability ORM:

- For no-fault insurance, there is no de minimus dollar threshold for reporting the assumption/establishment of ORM or for reporting the total payment obligation to the claimant ("TPOC") (i.e., a lump-sum settlement amount);
- For liability insurance, there is no de minimus dollar threshold for reporting the assumption/establishment of ORM; and
- For workers' compensation ORM, claims meeting all of the following criteria are excluded from reporting for file submissions due through December 31, 2012:
    - "Medicals only"; and
    - "The associated "lost time" for the worker is no more than the number of days permitted by the applicable workers' compensation law for a "medicals only" claim (or 7 calendar days if the applicable law has no such limit); and;
    - All payment(s) has/have been made directly to the medical provider; and
      Total payment does not exceed $750.00.

The User Guide also informs us that these thresholds are solely for purposes of Section 111 reporting, and have no applicability to any other obligations or responsibility with respect to any other MSP provisions.

When must the Reportable Events be Reported?

Although the TPOC Date of a settlement determines whether the settlement is reportable, it does not necessarily determine when a settlement becomes reportable. Generally speaking, the term "TPOC," "refers to a 'one-time' or 'lump sum' payment of a settlement, judgment, award, or other payment

intended to resolve/partially resolve a claim."[19] The TPOC Date, in turn, "is the date the payment obligation was established."[20]

The User Guide[21] provides guidance on how to determine when the TPOC Date for a given judgment, settlement, award, or other payment becomes reportable. Specifically, it states:

"Timeliness" of reporting -- [Non-Group Health Plan] TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met:

- The alleged injured/harmed individual to or on whose behalf payment will be made has been identified.
- The TPOC amount for that individual has been identified.

In single plaintiff settlements, these criteria are fairly easy to apply, because the plaintiff's identity and settlement amount are both usually known at the time of settlement, i.e., on the TPOC Date.[22] In mass-tort aggregate settlements, however, the application is trickier, as the following CMS example illustrates:

- There is a settlement involving an allegedly defective drug.
- The settlement contains/provides a process for subsequently determining who will be paid and how much. Consequently, the fact that there will be payment to or on behalf of a particular individual and/or the amount of the settlement, judgment, award or other payment to or on behalf of the individual is not known as of the TPOC Date.
- Timeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the date there is a determination both that payment will be made to or on behalf of the beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of that beneficiary.
- Submit the date of the settlement in the TPOC Date field and the date when there is a determination both that payment will be made to or on behalf of that beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of the beneficiary in the corresponding Funding Delayed Beyond TPOC Start Date field.

As the example shows, a plaintiff's award may not be reportable on the TPOC Date, because the RRE might not know the plaintiff's identity or particular award amount to be allocated to that plaintiff on the TPOC date. An RRE needs both pieces of information to report properly.

In aggregate settlement programs, the TPOC Date for all of the plaintiffs' settlements will likely be the same (in that it will likely be the later of the date the master settlement agreement was executed or the date of court approval, if required). The reportable date, however, may vary for each plaintiff within the aggregate settlement. The reportable date for many aggregate settlements may be the date that a given plaintiff signs a release, because that is usually the point at which that particular plaintiff becomes entitled to payment (plaintiff identified and allocation to that plaintiff is known). If on the TPOC date the participants are known and the allocation to each has been determined, then the TPOC date will also

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[19] User Guide at 12.

[20] *Id.*

[21] Section 11.10.2 of Version 3.3 of the MMSEA Section 111 Liability Insurance (Including self-insurance), No-Fault Insurance, and Workers' Compensation User Guide at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

[22] User Guide at 111-12.

trigger the reportable event. Each aggregate settlement will need to be reviewed to ensure that the proper TPOC date and reportable date are properly identified.

Reporting – Step Two:
If a claimant is Medicare enrolled, then the RRE must include the TPOC, or assumption of ORM, in their once-per-quarter submission. The trigger for submission is when there has been a settlement, judgment, award or other payment; or when on-going responsibility for medicals ("ORM") has been accepted. Each RRE will need to provide data elements within the following general areas:

- Injured party/Medicare beneficiary information;
- Injury/incident/illness information;
- Self-insurance information;
- Plan information;
- Injured party's attorney or other representative information;
- Settlement, judgment, award or other payment information; and
- If the injured party is deceased, information about the party bringing the claim.

There is a reporting requirement for settlements, awards or judgments or other payments in which medicals are claimed and/or released, regardless of whether medicals have actually been incurred. CMS is considering whether an exception should be provided to exclude MMSEA reporting on cases where no medicals were paid and the only provision that mandates MMSEA reporting is the general/broad release. As of this writing, CMS has not determined whether they will provide this exception.

When a RRE registers with the COBC, each RRE will receive a RRE identification number. Each RRE can have multiple RRE IDs. For each RRE ID, a seven day submission window will be assigned and all files must be submitted on a quarterly basis during the RRE's assigned, 7-day file submission window. The RRE will submit any TPOCs that were agreed to after the last submission window and prior to this quarter's 7-day window. This also applies to any cases where the RRE has accepted responsibility for on-going medicals (ORM).

However, if the settlement, judgment, award or other payment is within 45 days prior to the first day of the 7-day file submission timeframe, then an RRE may submit that claim on the next quarterly file. This grace period allows the RRE time to process the newly addressed/resolved (partially addressed/resolved) claim information internally prior to submission for Section 111. For example, if there is a reportable TPOC with a TPOC Date of May 1, 2012, and the file submission period for the second calendar quarter of 2012 is June 1-7, 2012, then the RRE may delay reporting that claim until the third calendar quarter file submission during September 1-7, 2012. However, if the TPOC Date is April 1, 2012, then the RRE must include this claim on the second calendar quarter file submission during June 1-7, 2012.[23]

What are the Penalties?
Medicare can assess a $1,000 per day, per claimant civil penalty on the RRE for noncompliance with the provisions of Section 111.[24] Understanding that Section 111 only requires the RRE to report settlements reinforces the concept that CMS is serious about ensuring that conditional payments are resolved and that CMS remains the payer of last resort on future medical expenses related to the injury being settled.

[23] Section 11.10.1 of Version 3.3 of the MMSEA Section 111 Liability Insurance (Including self-insurance), No-Fault Insurance, and Workers' Compensation User Guide at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

[24] Appendix G of Version 3.3 of the MMSEA Section 111 Liability Insurance (Including self-insurance), No-Fault Insurance, and Workers' Compensation User Guide at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPGuideV3.3.pdf.

How will Medicare Use This Information?
We have discussed what needs to be reported and when, but how will Medicare utilize this claimant/settlement information. The Secretary shall specify the information that insurers must submit that will enable the Secretary to make **"**an appropriate determination concerning coordination of benefits, including any applicable recovery claim.**"**[25]

The phrases **"**coordination of benefits**"** and **"**applicable recovery claim**"** address two separate and distinct timeframes. The former speaks to who should be paying for medical care *presently* and/or in the *future*, and the later speaks to who should have been paying in the past.

More specifically, in the personal injury and workers**'** compensation context, *coordination of benefits* refers to the concept that if there is another source of coverage that is available for someone**'**s injury-related care, he or she should use it. If no other source of coverage is available (and the person is eligible for Medicare), Medicare will begin paying for injury-related care. Further, in the same context, *recovery claim* refers to situations where some other source of funding is later found that should have been paying all along. In that instance, Medicare gets reimbursed for past injury-related expenses.

A rational interpretation of Section 111 of MMSEA is that the new requirement for defendants to report information about TPOCs and ORM claims is a sign that CMS is not yet content with the entire regulatory framework utilized to enforce its secondary payer status. Medicare will match the settlements reported by the RRE for the specific claim being settled with records showing whether there were any liens related to that injury and determine whether the related lien has been resolved. If there was a lien and it was not resolved, then Medicare will be able to pursue reimbursement. The reason for reporting under Section 111 is to give Medicare knowledge of a settlement so that they can be ensured that they have been reimbursed for any conditional payments and it will also allow CMS to avoid making future payments related to that injury since they should be a secondary payer on future medical expenses.

Can Agents Report of Behalf of RREs? Yes, RREs can appoint agents with the COBC during the registration process. CMS recognizes that business entities use third party administrators and other agents to handle the large volume of claims and administration processes. Agents are not, however, RREs for purposes of Section 111 of the MMSEA. RREs may contract with agents to handle reporting, however, the RREs remain solely responsible and accountable for complying with CMS instructions for implanting Section 111 and for the accuracy of data submitted.

Changing Habits:
Medicare**'**s role in settlements is undeniably evolving, causing all parties to the settlement to implement formal procedures to ensure that Medicare's interests are considered.[26]

For plaintiff attorneys the MMSEA provisions will place greater importance on making sure that an appropriate Medicare *verification* and *resolution* strategy is fully integrated into their practice. The tenets to such a successful strategy would include protocols for getting started early, enhanced client intake information, client education modules [27] and, for complex cases, perhaps changes in retainer

[25] 42 U.S.C.§1395y(b)(8)(B)(ii).

[26] Medicare**'**s right to reimbursement is superior to almost all other claims, including those of the injured individual. 42 C.F.R. **§**411.26, amended by 71 Fed. Reg. 9466-01 (Feb. 24, 2006). See also footnote 4 for discussion of *United States v. Sosnowski*.

[27] Visit www.garretsongroup.com for educational materials.

agreements that allow the attorney to seek outside assistance to handle lien verification and resolution.

For the defense, indemnification language, alone, may no longer be sufficient. Now that the RRE is notifying Medicare of the settlement, the RRE should receive verification that a tort recovery record has been opened and that the lien has been resolved. Accordingly, RREs will need to institute internal procedures for compliance with the provisions under MMSEA. Such procedures will need to be updated as CMS updates the provisions required by the Secretary.

Conclusion

As discussed above, the MMSEA directly impacts insurers, but indirectly impacts the plaintiff. The new reporting requirements are designed to close the MSP reporting loop, ensuring that claimant and their counsel alike have satisfied their obligations to verify and resolve Medicare's (conditional payment reimbursement claim) interests. At the same time, the new reporting requirements have significant penalties, with a $1,000 per day per beneficiary penalty for non-compliance.

Section 111 reporting will continue to evolve over time. Areas where CMS has provided less clarity about how to properly comply include exposure, ingestion and implantation cases, pre and post December 5, 1980 issues, loss of consortium claims, multiple defendants, foreign insurers and the clinical trials. If you have questions about how to handle any of these issues, Garretson Resolution Group can review your specific scenarios and provide advice for your situation.

In light of the MMSEA, claimants, defendants and insurers must communicate and cooperate to make sure the MMSEA does not add yet another disruptive layer to the already complex and time-consuming settlement process. With all settlement-related Medicare issues, a proactive rather than reactive approach yields a better result. Integrating claims procedures to verify entitlement with claimants' attorneys (if any) with existing procedures to verify and resolve those subrogation issues will insulate the settling parties from the potentially harsh realities of today's MSP program.

It is equally important to not fall into the trap of believing that the MMSEA does more than add a reporting requirement to insurers and other RREs. The statutory history and recent CMS guidance does not bear out the premature and incorrect missives that the new reporting obligations means Medicare Set Asides are required under the law. Instead, if the parties focus on compliance through collaboration on the reporting end, and analyzing every case to identify and quantify Medicare's interests under the law through formalized processes, including implementing standard operating procedures based on CMS guidance, you can settle your cases with confidence that Medicare's interests are being properly addressed so that double damages will not be attached and penalties will not accrue.

Given the lead time needed to gather the required information, however, the parties need to start earlier in the settlement process. That is the true meaning of the MMSEA. Simply put, if you know you are going to have to deal with it in the end, why not start addressing it in the beginning?

To learn how the Garretson Resolution Group is taking proactive measures to implement MMSEA requirements, please contact us at (866) 694-4446.