

# Understanding the Difference

## *SCHIP Reporting and MSA Allocations*



# Medicare Secondary Payer (MSP)

- Passed in 1980: 42 USC 1395y and 42 CFR 411
- Primary Payers include: Workers' Compensation, Liability, Auto No Fault, USL&H, Jones Act, and Group Health
- Legislative Intent: Medicare will always be a "Secondary Payer" if a primary payer exists
- In July of 2001, CMS introduced the MSA Review and Approval process for certain WC settlements
- In December of 2007, SCHIP Extension Act was passed into law and affects all open claims and settlements, judgements, and awards involving Medicare beneficiaries
- On 8/1/2008, CMS released reporting requirements for primary payers to begin on 10/1/2009

# Basics of Medicare Recovery Rights

- The intent of the MSP is to reduce federal spending and protect the financial well being of Medicare
- There are 2 aspects to consider when protecting Medicare's interests:
  - Conditional Payments (payments made by Medicare on behalf of the primary payer, "liens")
  - Future Payments (protection for Medicare against future payments that are the responsibility of a primary payer, "the allocation")

# Conditional Payments

- Medicare may make conditional primary payer payments and seek reimbursement from the primary payer both pre and post Settlement, Judgement, or Award (S/J/A)
- Demand for conditional payments come from CMS' Lead Contractor (Chickasaw)
- Pre-S/J/A - Conditional payment amount must be resolved at the time of the S/J/A
- Post-S/J/A - CMS may refuse to recognize settlements that represent an attempt to shift costs to Medicare and pursue recovery from the primary payer

# Conditional Payments

- **Post-S/J/A - CMS may refuse to recognize settlements that represent an attempt to shift costs to Medicare and pursue recovery from the primary payer**
- **Post-S/J/A - CMS may also recover up to the entire settlement amount (minus certain costs) from the claimant a.k.a. the Medicare beneficiary**
- **Reimbursement must be made to Medicare when the conditional payments were made for injuries that are the responsibility of a “primary payer”**
- **42 USC 1395y(b)(2)(b) allows for recovery of double damages, plus interests, and costs of litigation**

# Future Payments

- In Workers' Compensation, settlements must "adequately consider" Medicare's interests
  - CMS may refuse to recognize the settlement if it is non-compliant
  - CMS may refuse benefits to the claimant for injury related medical services
  - Absent an allocation, CMS may recover the entire settlement amount
  - Medicare Set-Aside Allocations are the **ONLY** defined way to protect CMS

# Future Payments

- In Liability/No-Fault Auto, the entire payment (S/J/A) is subject to recovery by CMS before Medicare will begin making payments
  - Conditional payments made post-S/J/A are subject to recovery
  - Reporting to CMS stops payments for medical services related to the injury and places the burden on the claimant
  - Absent reporting to CMS, conditional payments not reimbursed by the claimant within 60 days from notice become the responsibility of the primary payer
  - Once reported, CMS may recover the entire S/J/A amount from the claimant, minus procurement costs

## SCHIP and MSAs

- **SCHIP makes NO CHANGES** in the WC MSA Review and Approval Program
- **SCHIP is a separate and distinct program that runs in parallel with the WC MSA Program**
- **SCHIP brings an additional step to the WC MSA settlement involving Class I beneficiaries**

# SCHIP Reporting

- Affects all Liability, No-Fault, Self, and WC claims
- As of 10/1/09, requires reporting of data to CMS quarterly on all open claims involving Medicare beneficiaries and a one-time reporting post-S/J/A on cases involving Medicare beneficiaries
- Mandates that primary payers check Medicare beneficiary status on ALL claims and report quarterly through a secure web-site which is under-development
- In S/J/A, applicable regardless of whether or not future medicals are closed
- CIVIL MONEY PENALTY FOR FAILURE TO REPORT:

*\$1,000.00 per day per claim*

# Why SCHIP Now?

- Plans to collect \$1.1 Billion in fines from “Primary Payers”
- They intend to use the data to collect past payments
- They intend to use the data to stop erroneous future payments
- With Medicare projected to be running a \$31 trillion debt over the next 40 years, what else can they do?

# SCHIP Compliance *Claims*



Step 1: On every claim, check the claimant's Medicare beneficiary status during each reporting period (SCHIP requires primary payers have knowledge of Medicare status)

Step 2: If the claimant is a Medicare beneficiary, report the claim to Medicare as part of the quarterly reporting requirement

Step 3: Medicare will use the reporting to identify any conditional payments, be prepared to research and resolve past conditional payments as Medicare beneficiaries are reported

*Note: If Claimant's not on Medicare after Step 1, eligibility status should be rechecked every quarter and just before entering into a S/J/A*

# SCHIP Compliance

## S/J/As



Step 1: When preparing an S/J/A, check the Claimant's Medicare beneficiary status (SCHIP requires primary payers have knowledge of Medicare status)

Step 2: If the Claimant is a Medicare beneficiary, begin conditional payment research and resolve past conditional payments prior to or as part of the S/J/A

Step 3: When appropriate, determine the amount you are going to allocate from the S/J/A proceeds to future medical care that is Medicare covered, and include language and the allocation amount in your agreement with the Claimant.

Step 4: Report the S/J/A to CMS with the data required at least quarterly

*Note: If Claimant's not on Medicare after Step 1, eligibility status should be rechecked just before entering into an S/J/A as beneficiary status may have changed during the months spent negotiating the S/J/A.*

# STEP 1

## Check the claimant's Medicare beneficiary status

- G&L must have the claimant name, SSN, or HICN to obtain and provide accurate data on beneficiary status
- G&L, through a VDOSA agreement with CMS, will determine Medicare beneficiary status on all claims

## STEP 2

The claimant is on Medicare, we need to be prepared to resolve conditional payments

- G&L will contact Medicare's Lead Contractor to determine the amount of the conditional payments made related to the injury
- Once the Conditional Payment Amount has been determined G&L will advise you of the amount Medicare determines is owed
- Simply advise us of your decision to accept or negotiate and our experts will work with Medicare to resolve the conditional payment amount

## STEP 3

### Determine allocation towards future medical care

- Depending on the type of insurance and settlement amount, an MSA Allocation may be needed (follow your MSA protocols)
- For cases not requiring an MSA, a Claim Settlement Allocation may be indicated based on S/J/A amount, Medicare status, age, insurance type, and/or client protocols
- All S/J/A should demonstrate consideration of Medicare's interest and disclose the responsibilities of the claimant post-S/J/A
- In either case, our dedicated Account Managers and Customer Service Representatives will be available for questions and to collect all the necessary documentation in order to properly resolve your S/J/A

## STEP 4

### Reporting claims and S/J/As to CMS

- Data requirements were provided by CMS on 8/1/08
  - There are up to 45 data fields that CMS will need on all cases
  - The insurer must report quarterly through a secure web-site
- G&L will report to CMS on all cases referred to us for SCHIP compliance that meet the requirements for MIR (Mandatory Insurer Reporting)
- Some S/J/As will need both CMS approval and SCHIP Reporting
- G&L will coordinate with all parties to ensure that the data received from the VDSA and SCHIP Reporting is accessible in your claims system

# Your Partner In Compliance



- Gould & Lamb has developed detailed compliance protocols for numerous insurers since 2002
- We have both an MSA and an SCHIP Compliance Program available for our customers with established services to address every aspect of compliance
- Insurers must establish compliant protocols or face serious financial penalties

# Contact Information



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