PUBLICATION

Mandatory Settlement Reporting Registration Deadline September 30

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By now, most health care entities have received basic information concerning the September 30 registration deadline and reporting requirements imposed by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). The amendments, codified at 42 U.S.C. § 1395 y(b)(8), require liability insurers (which are defined to include self-insured entities) to report payments related to bodily injuries incurred by Medicare beneficiaries. The reporting obligations are technically and technologically complex, with very limited safe harbor provisions.

Initially intended to capture payments on or after July 1, 2009, the starting date for reports has been moved to January 1, 2010 for all payments except those for ongoing medical expenses (ORM). These payments are usually, but not always, encountered in workers' compensation cases. They may be applicable to a limited number of general liability claims.

The Center for Medicare and Medicaid Services (CMS) required all Responsible Reporting Entities (RREs) to register with the agency for reporting purposes by Wednesday, September 30. CMS intends to commence testing with registered organizations immediately. The first official reports to CMS are scheduled for the quarter beginning April 1, 2010, during a seven-day window provided after an RRE registers and confirms registration through the submission of test data.

CMS defines a self-insured entity differently than how that term is commonly defined in the industry. The CMS definition includes an entity "that engages in a business, trade or profession…[and] carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance…plan) for a business, trade or profession." CMS User Guide at p. 216 (July 31, 2009), available at http://www.cms.hhs.gov/.

Failure to comply with the reporting requirements can trigger fines of $1,000 for each day of non-compliance for each claimant for whom a report should have been filed. By missing just one quarterly reporting window, an RRE could quickly incur a $90,000 penalty. There is no statutory limit to the liability for non-compliance.

All of the preceding information has been covered in a variety of governmental, legal newsletters, and private industry (third-party administrators [TPA] and structured settlement consultant) publications. The purpose of this alert is to specifically focus upon several practical issues that hospitals and clinics – particularly entities carrying high deductible or self-insured retention (SIR) policies – should address as these reporting requirements pass from the "registration phase" (in which RREs are supposed to register with CMS by September 30, 2009) to the "reporting phase." Hospitals and medical clinics face several unique dilemmas under these new reporting laws.

The following questions and answers encapsulate some of the more pressing concerns that have been expressed to us by hospital and clinic clients:

1. What do we do if our institution has not yet registered with CMS?

There is no explicit statutory penalty for failing to register by the September 30 deadline. Clearly, however, you need to register as soon as possible. Failure to register by the deadline could mean a failure to report because the system has not been established in the requisite time and reporting deadlines could be missed as a result. The registration process is not complex, but decisions regarding the method in which the RRE will report (directly or through a TPA) and which entity shall be the RRE in a business that has one or more subsidiaries or related entities need to be resolved. Hospitals and physician groups should assess their corporate structure, insurance coverage structure, and current outstanding claims (regardless of whether a claim has resulted in litigation) to determine if the entity can or should register more than once. CMS has specific rules regarding which legal entity may register and report for a multi-corporate structure.

The RRE must also be prepared to answer specific questions regarding who will be responsible within the organization for the reporting as an Authorized Representative. The Authorized Representative is required to hold an executive level position within the business entity and must have the authority to bind the company in substantive matters. CMS also requires information on those individuals actually controlling the process (Account Manager) and performing the reporting (Account Designees). If the RRE uses a TPA for reporting, it should give strong consideration to whether an employee or someone within the TPA should serve as the Account Manager. As discussed below, while the RRE maintains the liability for non-compliance, depending upon how or why there was a failure to report, this role could become a crucial factor when it comes to whether CMS chooses to assess a penalty, and if so, how severe the penalty will be.

2. What do we do if we have attempted to register, but have not received confirmation from CMS of a PIN necessary to submit test data for reporting purposes?

There have been anecdotal reports regarding the CMS registration system being overloaded in recent weeks with a rush of entities trying to submit their registration. If your institution is experiencing this kind of issue, we would recommend first trying to register in off hours – times after work hours in which the traffic should be lighter. If this doesn't work, we suggest providing details of failed attempts in an email. There is an email link on the bottom of the Overview page of the CMS website which is intended for questions regarding the law and process.

3. Who is supposed to report a payment falling within a liability policy's deductible or SIR?

CMS has issued draft guidance indicating an intention (after public comment) to require a self-insured or high deductible company to submit a report of payment if the RRE makes the payment to the injured party. If the amount of the payment exceeds the deductible under the policy and the liability carrier makes the full payment, the insurer – not the RRE – would be responsible for the report. *See* CMS Alert for NGHPs, Draft Language for Public Comment (July 31, 2009 at Para. 6.b.). If the self-insured entity pays the injured individual directly, regardless of whether it is reimbursed by an insurer, the company is the RRE and must file a report. *Id*. at 75.

CMS is aware of the possibility that it will receive separate reports covering the same payment from self-insured entities and liability insurers, particularly excess insurers. The agency is expected to streamline the reporting process at some point. For now, hospitals and clinics carrying high deductibles or SIRs should assume as a practical matter that the entity making the payment will need to file the report of payment.

4. How do we handle "write-offs" or non-monetary benefits (such as meal tickets, parking expense, lodging expenses)?

Many hospitals or large clinics will attempt to resolve patient grievances by writing off all or a portion of the bill, or by providing small non-monetary "gratuities" arising from a patient's medical treatment. The payment might not even have been made directly to the patient; these indirect benefits are often given to family members in

an attempt to generate goodwill or as a mechanism of apologizing for an unanticipated event. Many times, perhaps on most occasions, these benefits are not given in return for the patient executing a Release. In many instances there is no formal claim, at least not a written claim, pending at the time of the payment.

Unfortunately, CMS has interpreted the MMSEA requirements as potentially encompassing such benefits. This means that anytime such benefits are paid, there is a potential reporting obligation that must be assessed in order to avoid the draconian fines associated with the failure to report such a payment. The statutory authority of this position comes from 42 U.S.C. 1395 y(2)(B)(ii) and implementing regulations 42 C.F.R. § 411.22, which state that reimbursements to Medicare may be established by a "judgment…waiver or release…or [b]y other means." The CMS User Manual states that reports are required for "…claims that are addressed/resolved (or partially addressed/resolved) through a settlement, judgment, reward or other payment…." User Guide Section 11.1.

Although the statements made by CMS and the implementing regulations lack clarity, CMS appears to be focusing upon whether there is a payment (which they have strongly implied will include indirect benefits such as write-offs) to an injured party who is a Medicare beneficiary resulting from a claim. The key is not whether there is a cash payment, nor even whether the patient receiving medical treatment is the person receiving the benefit. The provision of a Release in return for the payment certainly triggers a potential reporting obligation, but payment made in return for a Release does not absolve a hospital or clinic from reporting. The key appears to be whether or not the payment is made in connection with an "item or service" resulting in a Medicare payment, and further, whether a claim arises from the circumstances surrounding the payment.

Even if there is no claim at the time of an event such as a write off, if the patient later files a claim CMS will almost certainly take the position that the previous payment triggers a reporting obligation, regardless of whether the RRE contests the claim.

CMS will not initially require reports for total payment obligations of claimants (TPOC) of less than $5,000. Beginning January 1, 2011 through December 31, 2011, the payment trigger for a report is $2,000, and beginning January 1, 2012 it will drop to $600. These reporting thresholds may and probably will be modified in the coming months. However, there is no such threshold for ongoing responsibilities for medicals (ORM). Therefore, in the case in which a write-off is used and may be used again, the possibility exists that the payment would be considered an ORM. The possibility that a write-off or other indirect payment – whether or not a Release is obtained in return for it – may trigger reporting requirements should be enough to cause hospitals and clinics to establish internal procedures designed to systemize and track all such events. This is especially the case for indirect payments that are charged to the entity's SIR.

5. How will the individuals preparing quarterly reports of payments obtain the data from which the reports can be made?

Many hospitals and clinics are either subcontracting the reporting obligation to TPAs (although it must be repeated that the RRE is independently responsible for the accuracy of reports and is the entity that would be fined for inaccurate reports) or are assigning reporting responsibilities to internal billing or insurance coders. The reporting obligations presently require over 100 data point entries, and are expected to significantly increase in complexity and data entry over the next few years. CMS has issued a 225-page User Guide on reporting requirements which requires considerable training. CMS also provides some limited computer- based training which can be accessed through the CMS website link above.

It is imperative that hospitals and clinics devise systems by which the coders for CMS payment reports can easily retrieve the data that will be used to populate the 100+ fields in the reports. The easiest way to do this will be by redesigning internal claims management reports to match some of the most significant data fields for

the CMS reports. Claims managers and outside counsel handling claims need to document as soon as possible the injured party's name as it appears on a Medicare or Social Security card or disability application; the claimant's HICN or Social Security number, and date of birth, along with the date of the incident giving rise to the claim. (In some instances, such as ingestion of a foreign substance or implantation of medical devices, this date will not necessarily coincide with what a claims manager may assume to be the date of injury.)

Several critical fields require the use of ICD-9 codes. CMS has published a list of codes which are not permitted to be used in many circumstances. This issue has been the cause of some concern for RREs, and an extension as to their use has been granted by CMS. Until January 1, 2011 CMS will permit "free text" entry of the diagnosis and the cause of the injury/illness for which a payment is made. (These codes will become mandatory field entries after January 1, 2011, at which time ICD-10 coding should be in effect.)

The "Reason for Payment" information in a report may become subject to a public records request at some point; CMS has pointedly not assured RREs in response to questions at town hall teleconferences that all information reported will remain confidential. In addition, CMS is expected to use the information obtained from these reports in a variety of ways including possibly as a means to monitor so-called "never event" payment requests. It is important that the reason for payment come from a claims manager, or even an attorney, as the most knowledgeable person, rather than leaving this to the discretion of a coder who may have no information other than a billing summary.

We recommend that hospital or clinic claims management design internal claim summaries that contain a field for the entry of a free text description of injury that can be completed by the claims manager, perhaps in consultation with outside counsel in litigated matters, at a point when a payment is made arising from a claim. The facility needs an IT system that permits the internal reporting agent for the RRE to "lift" this entry and populate the reporting template with the information (although there are technical spacing requirements which may necessitate some degree of revision) in order to avoid errors in the coders' reporting of payment information. Unless an ICD-9 code is clearly applicable to the injury and payment, the free text field explanation for the payment, rather than the more arbitrary ICD-9 code, should be used in the report until such time as regulations require ICD-9 (or ICD-10) coding.

6. Outside of the reporting requirements, how should we handle payment of a settlement to a plaintiff or plaintiff's attorney in a situation where we have confirmed that the plaintiff is a Medicare beneficiary?

This is a dilemma, because there is nothing in the current statute or implementing regulations requiring that payment be directed to Medicare or CMS. At the same time, implementing regulations under the Medicare Secondary Payment Act require that the Medicare beneficiary or "other party," defined by the regulations as including the entity making the payment, must reimburse Medicare within 60 days of the payment. 42 C.F.R. §411.24(h). The regulations further provide that "[i]f Medicare is not reimbursed as required by Paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party." 42 C.F.R. §411.24(i)(1)-(2). In short, although federal law does not mandate that a hospital or clinic making a direct payment to settle a claim must make payment directly to Medicare, the hospital or clinic may nonetheless be liable to Medicare, potentially for double damages, if the beneficiary/payee does not reimburse Medicare within 60 days of the date of payment. See, e.g., Tomlinson v. Landers, 2009 WL 1117399 (M.D. Fla, April 24, 2009)

To further complicate matters, even if a plaintiff's attorney puts Medicare on notice at the inception of a claim and provides the information necessary for Medicare's contractors to evaluate the claim, the contractor will not issue a final demand letter setting forth Medicare's entitlement until notified of the settlement. Many times the demand letter includes medical bills having nothing to do with the injury giving rise to the claim, and the plaintiff

will contest the allocation through internal administrative procedures. Medicare's position is that it should receive its full demand entitlement pending resolution of such issues, and related requests for a waiver or compromise of the claim.

There is case law stating that "[t]he provisions of the law require the conclusion that any insurer with an ounce of business sense would include the lien holder Medicare as a payee on the check when it has been notified of an MSP situation." *Wall v. Leavitt*, 2008 WL 4737164 (E.D. Cal., Oct. 29, 2008). But unless the mechanism of paying the settlement by issuing a check to Medicare as co-payee along with the plaintiff and the plaintiff's attorney is clearly covered in settlement negotiations and memorialized in a Release memorializing the key elements of the agreement at the time of settlement, it is possible that a court will not permit the hospital or clinic to satisfy its obligations in this manner. *See Thomason v. Landers*, supra. at p. 4: "The Court finds it readily apparent that the parties were engaged in ongoing negotiations regarding the inclusion, or lack thereof, of Medicare as a payee on the settlement check, and that no meeting of the minds ever occurred regarding this point of contention between the parties."

Many commentators have noted the likelihood that CMS will have a strong incentive to use RRE Reports as the first line of collection of Medicare's conditional payments rather than bothering to chase down claimants and claimants' attorneys who often fail to engage Medicare in the claims resolution process at all, or wait until just before settlement to take that action. The responsibility of the RRE as a primary payer is clearly established under the statute and implementing regulations. CMS has the additional bonus of possibly not having to deduct the plaintiff's attorney's procurement cost from its recovery if it proceeds directly against the payer rather than the Medicare beneficiary.

Starting January 1, 2010, which is the applicable reporting date for most liability payments, outside counsel and claims managers should be instructed to negotiate for the right to issue a settlement check to Medicare as a co-payee along with the plaintiff and the plaintiff's attorney as an essential element of any proposed settlement. The issue should explicitly be addressed at the time of settlement and not left to a post-settlement argument between counsel.

An alternative which may be acceptable to some plaintiffs' attorneys would be to enter into an enforceable Settlement Agreement, which would be reported to Medicare, but deferring the actual payment of the settlement funds until such time as the plaintiff and plaintiffs' attorney obtain a final demand letter from Medicare setting forth Medicare's entitlement. Separate checks can then be issued to Medicare on the one hand, and the plaintiff and plaintiff's attorney on the other. It is advisable to insist upon the plaintiff providing a Medicare Release before releasing payment to the plaintiff and plaintiff's attorney. In some instances, the plaintiff may wish to contest the contractor's allocation after the payment is made or may wish to seek a waiver or compromise of Medicare's entitlement, but that should be a matter between the claimant and CMS, not the RRE making the payment.

7. We have a TPA handling our group health and workers' compensation insurance programs. They have agreed to handle our liability reporting requirements as well. Why do we have to worry about reporting responsibilities once we subcontract the responsibility out?

As previously noted, the law requires the designation of a responsible individual within a hospital or clinic as the representative for the RRE. The substantial penalties and fines that can be associated with failing to report a payment to a Medicare beneficiary will be levied directly against the RRE, not the third-party entity handling the reports through a contractual arrangement. Most TPA contract indemnity provisions would not cover the fines and penalties associated with MMSEA obligations. At a minimum, the indemnity language in such contracts needs to be closely examined.

There are a number of practical difficulties associated with MMSEA in terms of unintended consequences of the law that will make it more difficult to settle claims that would otherwise be settled for nominal or substantially reduced payments. Those issues, and possible counter-measures that can be considered to overcome them, will be the subject of a separate alert.