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Navigating Medicare Secondary Payer compliance and False Claims Act liability

» The Supreme Court's recent decision in Escobar expands the potential for Medicare Secondary Payer Act (MSP) enforcement through the False Claims Act.

» The MSP impacts healthcare providers, insurers, employers, beneficiaries, and other parties.

» Medicare requires timely reimbursement of conditional payments.

» Non-compliance with MSP requirements can result in double damages.

» Providers need appropriate internal controls to monitor potential overpayments in a timely manner to avoid potential exposure under the MSP and FCA.

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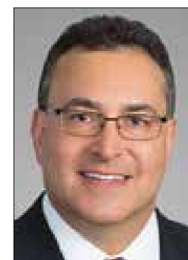
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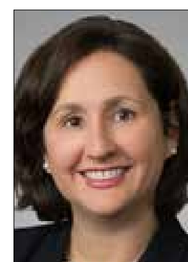
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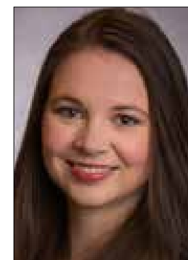
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The Medicare Secondary Payer Act (MSP) places certain responsibilities on insurers, employer health plans, and healthcare providers. Non-compliance with the MSP can result in monetary penalties and government enforcement action. Currently, the MSP is garnering attention as an enforcement tool under the False Claims Act (FCA).[1] This article gives a general overview of the MSP, discusses requirements for compliance, describes recent MSP enforcement actions under the False Claims Act (FCA), and gives some key takeaways to reduce potential liability.

The Medicare Secondary Payer Act basics

The MSP affects providers, employer-sponsored group health plans (GHPs), liability and no-fault insurers, workers' compensation funds and plans (collectively, non-group health plans, or NGHPs), and Medicare beneficiaries. Generally, the MSP:

- Requires that Medicare be a secondary payer if a beneficiary carries certain types of employer sponsored health plans;[2]
- Prohibits the Centers for Medicare and Medicaid Services (CMS) from making payments for Medicare-covered services if payment has been made, or can reasonably be expected to be made, by a another payer;[3] and
- Allows CMS to make "conditional payments" to the beneficiary if there is a delay in reimbursement from another entity for a covered service.[4]

Notably, Congress also enacted a parallel MSP provision that applies to state Medicaid plans.[5] Special rules

apply to Medicare beneficiaries covered under a GHP,[6] and Medicare is generally the secondary payer for these covered services when a beneficiary is entitled to Medicare.

In an effort to assist primary payers and providers in determining Medicare's payer status, CMS established a Coordination of Benefits (COB) system that collects beneficiary coverage data. The Benefits Coordination & Recovery Center (BCRC) administers the COB by ensuring the accuracy of the Common Working File (CWF), a CMS database that stores information regarding MSP data and investigations. CMS shares this data with other payers to ensure proper claim submission to Medicare.

Conditional payments

Medicare will make a conditional payment to a beneficiary if there is a delay in payment by the primary payer to keep the beneficiary from experiencing a gap in coverage.[7] Subsequently, Medicare may pursue reimbursement of conditional payments from:

- A beneficiary or other party, if both a primary and conditional payment were received;
- A primary payer, if a conditional payment was made pursuant to liability insurance settlements, disputed claims under group health plans, workers' compensation plans, or no-fault insurance; and
- The beneficiary or provider, if the filing of an improper claim resulted in a conditional payment, unless the claim was a result of false information provided by the beneficiary and the provider complied with certain regulatory procedures.

> If a primary payer or provider fails to pay back the conditional payments, CMS may assess double damages.

These conditional payments must be reimbursed to Medicare within 60 days of receipt of payment. If a primary payer or provider fails to pay back the conditional payments, CMS may assess double damages.

Both beneficiaries and their fiduciary agents, such as attorneys, can be sued for recovery of improperly retained conditional payments. In one such case, a Medicare Advantage (MA) plan operated by Humana made a conditional payment to a beneficiary injured in a motor vehicle accident.[8] The beneficiary sued several insurance companies for payment, resulting in a settlement and the disbursement of settlement funds to the beneficiary's attorney. Humana issued a demand letter to the beneficiary, seeking reimbursement for its conditional payment, which it alleged was partly contained in the settlement amount. When the beneficiary failed to pay, Humana commenced a lawsuit against both the beneficiary and the beneficiary's counsel to recover the funds. On a motion to dismiss by the beneficiary's attorneys, the court ruled that the MSP allowed the MA plan to pursue recovery of conditional payments and double damages against beneficiary's counsel, as "plain language fails to limit the parties against whom suit may be maintained" and that there is a private right of action that a MA can use to recover conditional payments pursuant to 42 USC §1395y(b)(3)(A).[9]

MSP requirements and liability for providers and primary plans

The MSP also requires that GHPs, NGHPs, and providers report certain beneficiary

information to CMS. Non-compliance with these reporting requirements results in a minimum fine of $1,000 a day per unreported beneficiary and, potentially, double damages.

Group health plans (GHPs)

Generally, a GHP is sponsored by an employer to provide healthcare to employees and their families.[10] These include self-insured plans that may be administered through a third-party administrator (TPA) and plans arranged by employers through a health insurer. The MSP requires that GHPs with 20 or more employees report certain information to CMS to avoid payment conflicts (although smaller companies have certain limited reporting obligations). These plans are considered Responsible Reporting Entities (RREs) and must report all active covered individuals to Medicare. An active covered individual is defined as:

- Those between 45 and 64 years of age who are covered through the GHP, based on their own or a family member's current employment status;
- Those 65 and older who are covered, based on their own or their spouse's current employment status;
- All individuals covered under a GHP who have been receiving kidney dialysis or have received a kidney transplant due to end-stage renal disease (ESRD); and
- All individuals covered under a GHP who are under 45, are known to be entitled to Medicare, and have coverage in the plan, based on their own or a family member's current employment status.[11]

GHP RREs have multiple reporting options, but the basic option requires a GHP RRE to submit an MSP Input File containing information about each active covered individual, as outlined in the CMS manual. The GHP RRE reports through registering on the Coordination of Benefits Secure Website (COBSW).[12] The GHP may submit a Query Only Input File, which helps the GHP assess if potential employees are covered by Medicare. GHPs must be careful to obtain detailed information from their employees (including information about family members) to comply with this requirement.

Non-group health plans (NGHPs)

Although reporting requirements among GHPs are largely uniform, the same cannot be said for NGHPs. Thus, this article will not explore the nuances of each NGHP's reporting priority and specific guidance.

NGHPs are generally liability insurance plans (including self-insurance), no-fault insurance, and workers' compensation laws or plans.[13] The intent behind the NGHP reporting requirements is that if a Medicare beneficiary is injured and another payer (such as a workers' compensation plan) is responsible for paying for the medical treatment of the beneficiary, then the other party should be the primary payer. Unlike GHPs, there is no blanket requirement that all NGHPs register with Medicare, but those that have reportable information must register at least a quarter before submitting a report. NGHPs are required to submit a report when there is an ongoing responsibility for medical bills (ORM) or there is a total payment obligation to the claimant (TPOC).

An ORM must be reported when there is ongoing compensation to a party for medical care associated with a claim. ORM reports do not include dollar amounts, but just the fact that payments are being made for ongoing medical expenses, and the start and end dates. Additionally, an ORM report should include information about the cause of illness, injury, or incident associated with the

claim so that Medicare can determine if the NGHP, Medicare, or another payer is responsible for the claim.

TPOC reports are made when the sum of a total settlement, judgment, award, or other payment obligation is established. There are various mandatory reporting thresholds depending on the type of insurance and the date of payment.[14] NGHPs should be well versed in the intricacies of these requirements and the six detailed CMS reporting manuals issued on December 15, 2017.[15]

Healthcare providers

Healthcare providers have defined responsibilities under the MSP, although these responsibilities are less onerous than those placed upon GHPs and NGHPs. Generally, providers must implement certain procedures to determine each patient's Medicare eligibility status and submit claims to the proper insurer for reimbursement. These procedures include asking patients their Medicare eligibility status, checking the Common Working File, and creating and maintaining an internal database that stores information on each patient's insurance coverage. When inquiring about a patient's insurance coverage, providers are encouraged to use a CMS questionnaire found on the CMS website.[16] Providers must also submit an Explanation of Benefits (EOB) form with each claim to Medicare to ensure proper billing.[17] Providers should inquire as to whether the reason the patient is being seen for treatment is prompted by an injury that would be covered by an NGHP provider, such as an automobile accident, fall, or injury in the workplace.

When inquiring about a patient's insurance coverage, providers are encouraged to use a CMS questionnaire found on the CMS website.

If a provider submits an improper claim to Medicare but receives a conditional payment, the provider must reimburse Medicare within 60 days of receiving the payment. The provider will not be penalized if the provider maintains an internal database that stores information on each patient's insurance coverage and the provider can show that the claim was submitted as a result of false information provided by the beneficiary or someone acting on the beneficiary's behalf.[18] However, if a provider does not reimburse such a conditional payment within the timeframe mandated in a Medicare demand letter, the provider can face civil monetary penalties, such as paying interest on any outstanding payment and being subject to double damages.[19]

Recent FCA enforcement actions involving MSP

The Supreme Court's 2016 decision in *Universal Health Services, Inc. v. United States ex rel. Escobar* expands the potential for MSP enforcement.[20] In *Escobar*, the Supreme Court ruled that an implied false certification action can survive if the defendant made a misrepresentation "about compliance with a statutory, regulatory, or contractual requirement [that is] material to the Government's payment decision." Through the implied false certification theory of liability, both relators and the government have a potentially powerful tool to regulate non-compliance

with several regulations and statutes, including the MSP. Three recent decisions illustrate a potential rise in MSP-related FCA cases, especially in the wake of *Escobar*.

Incorrect billing

In *United States ex rel. Jersey Strong Pediatrics, LLC v. Wanaque Convalescent Center et al.*,[21] which is still pending in the District of New Jersey, a *qui tam* relator alleges that Wanaque Convalescent Center billed only Medicare/Medicaid for services rendered to patients admitted to its skilled nursing facility and failed to bill any third party, resulting in overpayments triggering MSP and FCA liability. In its amended complaint, the relator detailed eight instances of allegedly incorrect billing where the patient's medical record only listed Medicare or Medicaid as payer, even though the patient had multiple forms of insurance.[22]

The defendants filed a motion to dismiss the amended complaint, arguing that false claims were not submitted, because private insurance plans did not cover the services rendered, resulting in Medicare or Medicaid becoming the primary payer for the specific services. The defendants further contended that the relator's allegations lacked the heightened materiality standard set forth in *Escobar*, claiming that the relator merely cited to federal regulations that the relator deemed "material" to the government's decision to reimburse, rather than providing specific facts that any claim for payment has been rejected as being non-compliant with the MSP or any other regulation.[23] The relator responded that non-compliance with the MSP satisfies the "materiality" standard set by *Escobar*.

The court denied the motion to dismiss, noting that the government has a great interest in ensuring strict compliance with the MSP, such that compliance with the MSP is "material" to the government's decision to render payment. The court found that the amended complaint alleged sufficient detail to put the defendants on notice, sufficiently pleaded knowledge, and that the relator sufficiently pleaded that "MSP laws are material to the government's decision to pay Medicare/Medicaid claims in this context."[24]

Thus, still at issue while the case moves forward is whether the defendant may be liable under the FCA for violations of the MSP due to submitting allegedly improper claims to Medicare or Medicaid as the primary payer and impliedly certifying those claims as compliant with all federal laws and regulations.[25]

...the government has a great interest in ensuring strict compliance with the MSP...

60-day repayment window

In *Kane ex rel. United States v. Healthfirst, Inc. et al.*,[26] the United States and the State of New York filed complaints-in-intervention (the complaint), alleging that the defendant, Healthfirst, a private, non-profit insurance program with contracts with New York hospitals, issued electronic remittances to certain providers relating to Medicaid patients. Although the remittances should have stated that Medicaid could not be billed as a secondary payer for certain covered services, due to a computer "software" glitch, they failed to include that information, resulting in improper payment by Medicaid for claims which triggered MSP and FCA liability.[27]

The relator alleged that the defendant violated the 60-day window mandate by reimbursing Medicaid more than 60 days

from the time the relator compiled the list of possible overpayments. In its ruling denying defendant's motion to dismiss the complaint, the district court concluded that the 60-day window for reimbursement commenced when the provider has been put on notice of a potential overpayment, noting that allowing an individual or entity to commence repayment only after definitively identifying an overpayment would be incompatible with the legislative history and intent of the FCA. Subsequently, this case settled for $2.95 million.[28]

Automobile insurance

A third FCA case involving the MSP has a twist, as it involves the intersection of MSP law with New Jersey state automobile insurance law. In *Negron ex rel. United States v. Progressive Casualty Insurance Co. et al.*,[29] the relator purchased an auto insurance policy from Progressive, which gave her the choice of selecting a "health first" policy or a "personal injury protection (PIP)" policy as her primary insurer. Under a health first policy, the enrollee's private health insurer is the primary payer for medical bills resulting from an automobile accident. The relator's primary insurance was Medicare; however, Medicare and Medicaid recipients are not eligible for this type of insurance coverage, as Medicare and Medicaid are treated as secondary payers in such situations.[30]

A few months later, after the relator was involved in a car accident, Medicare conditionally paid for a claim that should have been reimbursed by the auto insurance policy. The relator brought a FCA action against Progressive and its New Jersey subsidiary, stating that the insurer had failed "to make reasonable and prudent inquiries to ensure compliance with the MSP Act" and that Medicare had improperly paid her bills as the primary payer.[31] Subsequently, the insurer moved to dismiss the complaint. In denying the motion to dismiss, the court found that the practice of allowing Medicare and Medicaid beneficiaries to select the "health first" policy was a violation of the MSP, because it allows Progressive to remain willfully ignorant of a beneficiary's primary plan coverage. The court chided the auto insurance company for its lack of controls. Specifically, the court looked at the underwriting process, which should have involved some investigation into the beneficiary's eligibility for Medicare and Medicaid. It also noted that the claims adjustment process should have involved an identical investigation to determine the appropriateness of a "health first" or PIP policy for each beneficiary.[32]

The court stated that Medicare should not pay conditionally for the services rendered to the relator just because the auto insurance company eventually paid Medicare back, and found that this manipulation of the "conditional payment" provision of the MSP ignores the requirement that a conditional payment is only to be made if prompt payment is not made by a primary payer. Ignoring this requirement allows the defendants to "receiv[e] an interest free loan from the government on claims they are obligated to pay and were always obligated to pay."[33] As such, the court found that there was a "sufficient allegation [in the complaint] demonstrating economic loss to plead that the claims were false or fraudulent." Subsequently, after the U.S. Department of Justice and the State of New Jersey intervened, the defendants settled the case for $2 million.[34]

Although *Negron* involves New Jersey state auto insurance laws, the court's findings are instructive for healthcare providers. The burden of investigating a patient's health insurance coverage is squarely on the shoulders of the provider, and merely

allowing a patient to elect certain coverage without more inquiry may not be a sufficient defense against FCA liability based upon MSP violations.

Practical recommendations for providers

Given the recent trend in MSP and FCA enforcement, providers should consider the following practical recommendations so as to avoid liability:

- Implement adequate controls when submitting reimbursement claims to Medicare and Medicaid to ensure correct payer status.
- Actively investigate each patient's health-care coverage to determine if the patient carries a primary policy or if another party is responsible, prior to submitting a claim for reimbursement.
- Reassess the patient's primary payer coverage at each encounter.
- Conduct random internal billing audits to ensure MSP compliance.
- Educate any case management/billing staff on the MSP and potential liability issues.

Once an overpayment is identified, providers are on notice that next steps involve confirming an overpayment and beginning the refund process as necessary. As a result, providers need appropriate internal controls to monitor potential overpayments in a timely manner to avoid potential exposure under the MSP and FCA laws.

1. For more updates on MSP enforcement, see http://bit.ly/2DrGhF6.
2. 42 USC § 1395y(b)(2)(A)(i); 42 CFR § 411.20 .
3. 42 USC § 1395y(b)(2)(A)(ii); 42 CFR § 411.20 .
4. 42 USC § 1395y(b)(2)(B); 42 CFR §§ 411.21 & 411.24
5. 42 USC § 1396a(a)(25); 42 CFR §§ 433.135-140
6. 42 USC § 1395y(b)(1); 26 USC § 5000(b)(1)
7. 42 USC § 1395y(b)(2)(B); 42 CFR §§ 411.21 & 411.24
8. *Humana Ins. Co. v. Paris Blank LLP*, 187 F. Supp. 3d 676 (E.D. Va. 2016)
9. Id. at 681
10. 26 USC § 5000(b)(1)
11. CMS: Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) Section 111: MSP Mandatory Reporting: GHP User Guide 7-2—7-3 (v5.0 2017). Available at http://go.cms.gov/2DrY5h1
12. CMS: COB Secure Web site (COBSW). Available at http://bit.ly/2DhlT6c
13. 42 USC § 1395y(b)(8).
14. CMS: MMSEA Section 111 MSP Mandatory Reporting: NGHP User Guide Ch. III (v5.3 2017). Available at http://go.cms.gov/2zIX58k
15. Id.
16. CMS.gov: Your Billing Responsibilities. Available at http://go.cms.gov/2AUYPZj
17. Medicare Secondary Payer Manual, Ch. 3 § 30.5.B.
18. 42 CFR § 489.20.
19. 42 CFR § 489.24.
20. *Universal Health Services, Inc. v. U.S.*, Supreme Court decision: 136 S. Ct. 1989, 1996 (2016).
21. *United States ex rel. Jersey Strong Pediatrics v. Wanaque Convalescent Ctr.*, No. 14-6651-SDW-SCM, 2017 U.S. Dist. LEXIS 150566 (D.N.J. Sept. 18, 2017).
22. Id. at *2.
23. See id. at *9-10.
24. Id. at *7-9.
25. Id. at *7-8.
26. *Kane ex rel. United States v. Healthfirst, Inc. et al.*, 120 F. Supp. 3d 370 (S.D.N.Y. 2015).
27. Id. at 375-77.
28. Department of Justice, Justice News press release: "Manhattan U.S. Attorney Announces $2.95 Million Settlement With Hospital Group For Improperly Delaying Repayment Of Medicaid Funds" August 24, 2016. Available at http://bit.ly/2bBBH59.
29. *Negron ex rel. United States v. Progressive Cas. Ins. Co. et al*, No. 14-577(NLH/KMW), 2016 U.S. Dist. LEXIS 24994 (D.N.J. Mar. 1, 2016).
30. Id. at *5-*9.
31. Id. at *27.
32. Id. at *7.
33. Id. at *8.
34. DOJ, Justice News press release: "Two Insurance Companies Agree To Pay More Than $2 Million To Resolve False Claims Act Allegations" November 14, 2017. Available at http://bit.ly/2CVW8bA