



The Atlas Report

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Medicare's Move from SSN/HICN Numbers to Medicare Beneficiary Identifier (MBI)

The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) of 2015 requires CMS to remove Social Security Numbers (SSNs) from ALL Medicare cards by April 2019. In order to comply, CMS is currently in the process of implementing a new Medicare Beneficiary Identifier (MBI) system for all beneficiaries, which will replace the SSN-based Health Insurance Claim Number (HICN) present on all Medicare cards.

CMS anticipates that by January 2020 HICNs will no longer be exchanged and only the MBI will be in use.

As of April 2018, CMS has begun the process of sending out and issuing new Medicare cards with the new MBI to all beneficiaries, and anticipates continuing through December 2019. The MBI will consist of 11 digits (xxxx-xxx-xxxx), both letters and numbers, and will have no connection to the beneficiary's SSN/HICN. This should serve to assist in protecting seniors from fraud and Social Security theft.

Of interest for our purposes: CMS has specifically exempted all Medicare Secondary Payer

(MSP) processes from exclusive use of the MBI. Non-Group Health plan RREs (Responsible Reporting Entities) are permitted to continue to report for Section 111 mandatory insurer reporting using the full SSN, HICN, or MBI. When responding, however, CMS will utilize the MBI, where one has been assigned. In the electronic reporting system, all fields formerly labeled as "HICN" have been relabeled as "Medicare ID".

CMS anticipates that by January 2020 HICNs will no longer be exchanged and only the MBI will be in use. However, the exemption for MSP use and reporting will remain in effect. Just know that regardless of how the claim is reported, the CMS/Medicare entity responding will respond utilizing the MBI, once assigned.

For further information, click below to see the most recent NGHP User Guide, Chapter 1, p.4: Updates,

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ATLAS SETTLEMENT GROUP, INC.

Version 2.7 of the WCMSA Reference Guide Published March 19, 2018

The Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide is written and published by the Centers for Medicare & Medicaid Services (CMS) for the purpose of explaining the Workers' Compensation MSA development and approval process.

The guide, updated routinely, provides a good amount of information regarding the submission and approval process, and how CMS reviews files. It defines a Medicare Set-Aside (MSA), provides the thresholds for submission of workers' compensation MSAs (set forth *infra*), discusses lump-sum vs. structured plans, provides administration guidance, reviews the medical and pharmacy review guidelines, and supplies technical submission guidance. The guide also provides a sample submission and checklist. It is a solid resource for issues that arise in the WCMSA process.

Click the link below for the most current version:

[Click for More Info >>](#)

WCMSA Submission Guidelines: A Refresher

CMS will review a proposed WCMSA plan when the following workload review thresholds are met:

» The claimant is a **Medicare beneficiary** and the total settlement amount is **greater than \$25,000**; or

» The claimant has a reasonable expectation of Medicare enrollment **within 30 months of the settlement date** and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be **greater than \$250,000**.

A claimant has a **reasonable expectation** of Medicare enrollment within 30 months if any of the following apply:

» The claimant has applied for Social Security Disability Benefits;

» The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision;

» The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits;

The claimant is 62 years and 6 months old; or

» The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

> If a threshold is met, a WCMSA can be submitted to CMS for approval.

> These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all

WC cases and ensure that Medicare pays secondary to WC in such cases.

> The computation of the total settlement amount includes, but is not limited to, an allocation for future prescription medications of the type normally covered by Medicare, in addition to allocations for other Medicare covered and non-covered medical expenses, indemnity (lost wages), attorney fees, set-aside amount, non-Medicare medical costs, payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), amounts forgiven by the carrier, prior settlements of the same claim, and liability settlement amounts on the same WC injury (unless apportioned by a court on the merits).

There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures.

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Budget Act of 2018 Limits Medicaid Third-Party Recovery Rights (*Ahlborn* Once Again Law of the Land)

Just this past February, Congress enacted, and the President signed, the Bipartisan Budget Act of 2018, which, without much fanfare, fully repealed the expanded Medicaid recovery rights previously enacted.

As background, parties resolving claims involving Medicaid had long looked toward two key decisions, the Supreme Court's rulings in *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) and *Wos v. E.M.A.*, 568 U.S., 133 S.Ct. 1391 (2013), which affirmed the basic principle of *Ahlborn*. These decisions limited Medicaid's recovery in third-party liability settlements to the proportion of the underlying settlement attributable to medical damages. For instance, if a claim settled for \$1,000,000, and \$600,000 was noted as attributable to pain and suffering, lost wages, non-medical, etc., and the remaining \$400,000 allocated to medical damages, Medicaid would only have been entitled to recovery up to the \$400,000 in medical damages.

Then, in 2013, the Bipartisan Budget Act, Section 202(b), was passed, which essentially overturned these two Supreme Court cases, providing Medicaid with significantly expanded rights of recovery. States were provided with the ability to recover against the full settlement, rather than the limited medical recovery. (While enacted in 2013, the implementation of these rights was delayed until October 2017.)

Between October 2017 and February 2018, just a few months of active recovery time, very few states actually utilized these expanded rights. Perhaps with more time we would have seen more aggressive recovery against the greater settlement. However, the Bipartisan Budget Act of 2018 returned us to the days of *Ahlborn*. Section 53102 fully repealed the 2013 Act in regards to Medicaid's

expanded rights and essentially affirmed the *Ahlborn* holding. In the Medicaid arena, recovery will again be limited to the medical portion of the claim. Medicaid still has recovery rights, but those rights are limited.

It is critical to note that these changes impact Medicaid, not Medicare. Medicare is not directly impacted. Although many make the argument that *Ahlborn* should apply to Medicare, CMS has never agreed with this argument, nor implemented regulations in accordance with the same. Medicare may still potentially seek reimbursement up to the entire amount of the settlement for treatment covered, and is not limited by the terms of settlement.



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New Commercial Repayment Center (CRC) Contractor Takes the Reins

CMS is responsible for ensuring that Medicare only pays for those services for which it is responsible. It relies upon its umbrella "organization" the Coordination of Benefits & Recovery (COB&R) to ensure that this goal is met. There are then several agencies within this umbrella that assist in carrying out the recovery efforts of CMS and the COB&R to ensure that any payments that should be reimbursed are in fact properly recovered.

BCRC: The Benefits Coordination & Recovery Center (BCRC) is responsible for ensuring that Medicare is repaid for any conditional payments (liens) that are related to a liability, no-fault, or workers' compensation case. However, for practical purposes, the BCRC largely has become the recovery agent in liability claims.

CRC: This is because the Commercial Repayment Center (CRC), as of 2015, took control of recovery of conditional payments (liens) where the debtor is identified as an insured/workers' compensation entity. Therefore, for all practical recovery purposes, where recovery is found in the insured/self-insured/carrier, as it is in a workers' compensation claim, the CRC handles recovery. (The BCRC still holds pre-2015 WC files and certain select cases.)

What is interesting to note is that Medicare utilizes outside vendors for this work. Thus, every few years we see a transition in the management of the team behind the BCRC/CRC or WCRC (Workers' Compensation Review Contractor) name.

As of February 12, 2018 we have a new Commercial Repayment Center (CRC) Contractor handling Medicare "lien" work, Performant Recovery, Inc.

Specifically, the new CRC vendor will be responsible for handling Non-Group Health Plan ORM (Ongoing Responsibility for Medicals) lien work. Typically we see ORM responsibility only with workers' compensation matters as this relates to files where the payer has an ongoing responsibility to pay for medicals associated with the claim.

The current address and fax for NGHP ORM under Performant Recovery is:

Medicare Commercial Repayment Center – NGHP
P.O. Box 269003
Oklahoma City, OK 73126
Fax: (844) 315-7627

Only time will tell if there are any significant changes under the new CRC vendor's leadership. However, here is the good news: we seem to be seeing an increase in activity that we have not seen in several years. Under the previous vendor we simply did not see "file closure" or "lien satisfaction" letters in workers' compensation cases where a prior \$0 Conditional Payment Letter (CPL) had been issued. Clients would wait quite some time, and while our partners were able to provide a \$0 screen shot from the on-line web portal, it became quite a challenge, if not impossible, to get the CRC to issue a formal closure letter.

Now, just a month after the new vendor has taken the reins, we are seeing case closure letters on several of these older files. Hopefully this is not an anomaly, but a new process this vendor is putting back into place.

One thing that we would caution with the new vendor is that they are very precise in their process and the data that they will and will not accept. When attempting to secure information regarding conditional liens ALL information must be reported exactly as it is in their system.

For example: a prior or partial address cannot be utilized. The parties must report the current and exact address. Full names, dates of injury and dates of birth must be precise. The vendor does not allow for any inaccuracies. This can delay a claim if a claimant has moved during the course of their case or is using a hyphenated last name.

Additionally, when seeking a lien satisfaction/case closure letter, the new CRC vendor is requiring that the Responsible Reporting Entity (RRE) for Section 111 reporting purposes, ensure that the final ORM termination date is reported in the Section 111 electronic reporting system. This means that upon resolution of a claim, whichever entity is reporting Section 111 information (carrier, self-insured, TPA), that party must first ensure that ORM term dates are quickly and correctly reported so that a final lien satisfaction or closure letter can be obtained.

Thus, while we are generally finding the transition to be a smooth one, we also do caution that in an effort to save time in seeking lien information it is perhaps best to ensure all information is up-to-date prior to attempting to secure conditional payment information via this new CRC vendor.



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New Workers' Compensation Review Contractor in Place

Around the same time Medicare brought in a new CRC contractor, a new Workers' Compensation Review Contractor (WCRC) was also brought on board. Capitol Bridge won the contract to provide services to Medicare as WCRC, and took over on March 19, 2018. As with previous review contractors, their primary job will be to review and approve workers' compensation Medicare Set-Aside submissions through CMS.

Capitol Bridge has promised that the review, decision making processes, and all review timeframes will remain the same. They anticipate review of a properly submitted WCMSA should be complete within 20 days. (This timeframe is always

extended if they seek additional "development" material not initially submitted with the file, but promise that they will notify the parties of the need for this additional information within 10 days of submission.)

WCMSA proposals may continue to be submitted via the online portal or by mail to the Oklahoma City address.

For customer service inquiries they have provided a phone number (833)295-3773 and email WCRC@capitolbridgellc.com. Thus far we are not finding any hold-up in the review process.

LMSA Status – Is CMS Moving Toward Review?

As the new Workers' Compensation Review Contractor (WCRC) takes over this spring, one of the key questions is whether or not this will have any impact in the liability MSA arena. When CMS was soliciting bids from the various potential vendors, leading up to the September 2017 award to Capitol Bridge, LLC, they requested that the potential WCRC vendor be responsible for reviewing not only workers' compensation plans, but liability MSAs as well. The WCRC bidding proposal requested information regarding the contractors' ability to review LMSA plans.

This followed closely on the heels of the CMS 2016 announcement, noting that they were again *considering* expanding the Medicare Set-Aside (MSA) voluntary review process to include the review of proposed liability insurance and no-fault insurance plans. CMS noted that the agency would work with the community to identify how to best implement the potential expansion. CMS provided no further details, but indicated that future announcements and town hall meetings were anticipated to follow. Thus, the industry has again been waiting for further liability guidance to follow.

It was anticipated that we would be potentially be presented with information related to Liability and No-Fault MSA review at the time of announcement of the contract award winner, or perhaps as Capitol Bridge began work in the spring. However, so far we have not heard anything further.

Current Status of Liability Review:

At present there are still no specific thresholds for the voluntary review of liability MSAs. The Medicare/MSA industry asked for clarification of policies and in October 2017 CMS issued the following statement:

The Centers for Medicare and Medicaid Services (CMS) continues to consider expanding its voluntary Medicare Set-Aside Arrangements (MSA) review process to include liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS will work closely with the stakeholder community to identify how best to implement this potential expansion of voluntary MSA reviews. Please continue to monitor CMS.gov for updates and announcements of town hall meetings in the near future.

Clearly CMS is continuing the process of considering whether they want to establish a more formal system of voluntary liability plan review (or simply development), and how to do so. In the interim, CMS has continued to assert that their interests should be accounted for in any significant liability settlement involving a Medicare beneficiary. While they will "allow" each of the 10 Regional Offices to undertake review should they opt to do so, there is very limited actual review at this stage. The offices do not as a practice have resources devoted to the process and typically note that "resource constraints" limit their review.

As such, if you have a liability case involving a Medicare beneficiary (or a significant case in which you know the Plaintiff will immediately become a beneficiary), the parties should consider whether or not Medicare's interests should be protected in the matter. The parties should contemplate whether a MSA should be included in the claim, whether or not formal review thresholds are available from Medicare at this time. Plaintiff, particularly, should be aware that s/he should likely anticipate future denials from Medicare and that Medicare will require proper exhaustion of the MSA before they are likely to agree to step in as primary payer. Medicare is paying attention to post settlement medicals and whether or not the parties have protected the government's interests under the Medicare Secondary Payer Act, and we expect to see more of this in the future.

At present, we suggest reviewing liability matters on a case by case basis and will be happy to discuss a file with you in an effort to determine if a liability MSA is suggested. In the interim, here are a few suggestions for initial review in the liability arena.

These are suggestions and not formal liability guidelines:

» If the Plaintiff is a **current Medicare beneficiary and the liability settlement is significant** (and there is no underlying WC action which will remain open - i.e. - a workers' compensation carrier continuing to pay open medicals post settlement), then we suggest the parties consider a MSA. Review by the Regional Offices is very limited at this time (pending formal liability guidelines), but regardless of submission, the value of a MSA can be included in settlement documents with all appropriate indemnity language.

LMSA Status (continued)

» If Plaintiff is not yet a Medicare beneficiary, but has a “reasonable expectation” of Medicare eligibility within 30 months, we suggest the parties exercise due diligence in considering a MSA, factoring in settlement value, future medical needs, and time prior to eligibility. A MSA may potentially be warranted in more substantial claims where medical need and clear access to impending eligibility are evident.

» Finally, where there is a liability claim with an underlying workers’ compensation claim, CMS issued limited guidance via a memorandum in 2003 (4/21/03 Memo Q19).

“To the extent that a liability settlement is made that relieves a workers’ compensation carrier from any future medical expenses, a CMS approved workers’ compensation Medicare Set-aside Arrangement is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a WCMSA would be if it can be documented that the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.”

These dual cases are particularly complicated and should be addressed on a case by case basis. We do see claims where workers’ compensation remains open thus the MSA is not neces-

sary. We also see cases where the workers’ compensation case resolves, and thus a WCMSA is prepared. However, we also see cases where the workers’ compensation case closes and no WCMSA is prepared/obtained. In these cases, we frequently see the parties obtain a liability MSA for incorporation in the global settlement release. As there are many incarnations, and a variety of ways that this may or may not be approved, it is key to look at these issues early on in the process.

These sample scenarios cover many, but not all settlement situations and are not formal legal guidelines. Please address with your counsel the legal and business ramifications concerning Medicare issues in your individual claims.



Atlas Settlement Group, Inc., offers a full range of Medicare services focused on ensuring compliance with the Medicare Secondary Payer Act. On a national scale Atlas Settlement Group and our partners can assist in providing services for determining Medicare or Social Security Disability eligibility, preparing Medicare Set-Aside (MSA) allocations and submitting the same for approval to CMS. We also collect and submit the necessary medical records for obtaining rated ages, help prepare settlement language in compliance with the MSP, and our team will provide assistance with securing administration of MSA accounts or annuity quotes to fund the MSAs.

From initial proposed allocation through structure of a settlement and CMS approval, we can assist in your MSA process from start to finish. We pride ourselves on doing so with utmost care and Professionalism, while also offering unparalleled efficiency. Our trained professionals have vast experience in workers’ compensation as well as liability claims, and are happy to discuss potential cases.

In addition to our full stable of Medicare services, Atlas Settlement Group, Inc. is committed to keeping our clients informed regarding the Medicare Secondary Payer news via “The Atlas Report” and interim bulletins. We are also available for one on one discussions regarding this pertinent field, free educational conferences and seminars for your team (with CLE and CE credit available in many states), and any other questions or concerns that you may have. Please contact us so that we may be of assistance in your settlement.

*All Materials Current through April 16, 2018

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