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Medicare Secondary Payer Practices that Harm Medicare Beneficiaries

A group of organizations has identified collection practices in the Medicare Secondary Payer (MSP) program that are unnecessarily harmful to beneficiaries. On April 28, 2011, the Center for Medicare Advocacy, together with the American Bar Association Commission on Law and Aging, the Medicare Rights Center, and the Center for Health Care Rights, wrote to the Centers for Medicare & Medicaid Services (CMS) outlining their concerns.

The Medicare Secondary Payer (MSP) program assures that Medicare does not pay for health care required as a result of an injury when that care should be covered by another "primary plan" insurer. Insurers designated as "primary plans" include "a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan,) or no fault insurance."^[1] When a primary insurer does not pay "promptly" for health services needed by an injured beneficiary, CMS will make a "conditional" payment to the health care provider.^[2] Later, when the responsibility for payment by a primary plan has been demonstrated by judgment, compromise, waiver, or release, Medicare seeks to recover their payment.^[3]

CMS has contracted with a private organization, the Medicare Secondary Payer Recovery Contractor (MSPRC)^[4] to determine the amounts of the conditional payments and to collect the MSP claim from the beneficiary, often through his or her attorney. Collection amounts can be appealed, and can even be waived upon a showing of hardship to the beneficiary,^[5] or in the interests of the Medicare program,^[6] but problems remain.

Problems in MSP Collection Practices

1. The MSP Demand Letter. A form letter is sent to Medicare beneficiaries and their attorneys to assert the MSP claim and describe the rules for payment. This three page letter is not written in language or a format that is comprehensible to an average Medicare beneficiary, and perhaps not even many attorneys.^[7]

Of particular concern about the demand letter is the lack of clear explanations of the procedures for beneficiary appeals of the amount of the MSP claim, and for requests for hardship waivers. The predictable effect of these defects in the demand letter is that beneficiaries often simply pay the amount demanded by the MSPRC, even if it is incorrect or imposes a financial hardship on them. Statistics show that only a small percentage of beneficiaries appeal or request a hardship waiver.

2. The MSPRC Is Not User-friendly For Beneficiaries. The Medicare Secondary Payer Recovery Contractor (MSPRC) is responsible for gathering information about the amounts of conditional payments for various services, collecting MSP claims from beneficiaries, and making initial determinations on appeals and waiver requests. To obtain additional information about a specific MSP case, an individual must contact MSPRC by telephone. Unfortunately, beneficiaries, attorneys, and advocates all report serious problems communicating with MSPRC by telephone. These problems include a complicated phone tree that is difficult or impossible to navigate; extremely long call wait times that discourage beneficiaries from contacting MSPRC; and a revolving door of different MSPRC customer service representatives that provide conflicting advice each time a beneficiary calls.

3. MSPRC Recovery Claims Often Include Charges For Unrelated Services. MSP claim amounts often mistakenly include costs for medical services unrelated to the particular accident that gave rise to liability or worker's compensation insurance coverage. See *Wall v. Leavit*, 2008 WL 4737164 at *13 (E.D. Cal. Oct. 29, 2008), *adopted by Wall v. Leavitt*, 2009 WL 77090 (E.D. Cal. Jan. 9, 2009) In many cases over-collection of non-MSP monies is likely to occur. Such erroneous MSP claims occur because the MSPRC does not effectively distinguish expenditures for a beneficiary's care that is accident-related from expenditures for routine medical care received during the same time period. CMS needs to work with the MSPRC and beneficiaries to eliminate unrelated services from MSP claims, and to provide quick ways of correcting those remaining claims that include unrelated services.

4. The MSPRC Makes MSP Claims Against Beneficiaries In Old, Stale Cases. Advocates report that their clients are receiving belated MSP recovery claims with respect to liability and workers' compensation cases that were settled years earlier. MSPRC recovery demands have been documented in cases ranging from 2 to 15 years after settlement. In these old cases the Medicare beneficiary may have never heard about an MSP claim, and is at a severe disadvantage in showing that the claim is excessive or should be waived. There may also be nothing left from the settlement funds with which the beneficiary can pay the MSP claim.

5. The MSP Standards For Hardship Waiver Are Too Strict. Although the Medicare statute authorizes waiver of MSP recovery based on hardship to the beneficiary, few beneficiaries request waiver, and even fewer are granted

waiver. In FY 2009, the MSPRC granted full waiver of MSP recovery in only 9 of the 1,561 cases in which it was requested, and it completely *denied* waiver in 1,024 (more than 2/3) of the cases in which it was requested by beneficiaries.

One of the reasons so few beneficiaries submit waiver requests is that extensive documentation is required, and this comes well after settlement when most beneficiaries expected their injury liability claim to have been completed. Another reason is that the standards adopted by CMS are very restrictive.^[8] For example, waiver will be denied even to a beneficiary who is so poor as to be receiving SSI, if she was also poor before the injury resulting in liability.

6. Beneficiaries In Medicare Advantage Lack The MSP Protections In Traditional Medicare. Medicare Advantage (MA) plans also engage in MSP recovery.^[9] MA plans or their providers are allowed to charge any primary insurer - including liability insurers, workers' compensation insurers, and employer group health plans - for Medicare-covered services.

Surprisingly, the statute and regulation do not limit the MSP amounts that an MA plan and their providers can recover to Medicare program rates. This means that a beneficiary enrolled in an MA plan can be required to reimburse the plan at higher market rates, rather than the negotiated rate that the MA plan actually paid the provider, or the capitation payment that supposedly covered the full Medicare package of services. In addition, there appear to be no clear requirements for notices, appeal or waiver rights for beneficiaries who are enrolled in MA plans, unlike those in traditional Medicare A and B.

Recommended Corrective Actions

- The MSP demand letter to beneficiaries should be revised to incorporate readability principles appropriate for elderly and disabled Medicare beneficiaries.
- The MSPRC should be required to allow beneficiaries to communicate effectively about their cases. This would include simplifying the MSPRC telephone tree, shortening call wait times, and assigning a specific MSPRC staff member to each case.
- Better systems for excluding non-accident-related medical costs from initial MSP demands should be developed. The MSPRC should also be required to make decisions quickly when beneficiaries dispute the inclusion of medical costs in its initial demand.
- CMS should modify its collection practices to eliminate initiation of recovery efforts with respect to old claims. MSP claims should not be initiated when more than two years have elapsed since settlement of a

liability or worker's compensation claim.

- The standards for hardship waivers should be revised to allow waiver of MSP recovery up to a reasonable amount for low income individuals.
- MSP collection by MA plans should be subject to the same general rules as are applied in traditional Medicare A and B. Thus, amounts recovered should be limited to the lower of Medicare payment levels or to actual payments to MA providers. And MSP notices, appeals and waiver rights should extend to MA enrollees the same protections that are provided to traditional Medicare enrollees.

Readers who have had problems with MSP recovery collection are invited to submit information to the Center by contacting attorney Sally Hart at shart@medicareadvocacy.org.

[1] 42 U.S.C. § 1395y(b)(2)(A).

[2] 42 U.S.C. § 1395y(b)(2)(B)(i).

[3] 42 U.S.C. § 1395y(b)(2)(B)(ii).

[4] See <http://www.msprc.info>.

[5] 42 U.S.C. § 1395gg(c).

[6] 42 U.S.C. § 1395y(b)(2)(B)(v).

[7] MSP Manual (CMS Pub. 100-05), Chap. 7, Sec. 50.5.2.1, Exhibit 2.

[8] MSP Manual (CMS Pub. 100-04), Chap. 7, § 50.6.

[9] 42 U.S.C. §1395w-22(a)(4); 42 C.F.R. §422.108.

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Preserve Medicaid - Share Your Story!

The Center for Medicare Advocacy would like to bring to your attention this request from the National Academy of Elder Law Attorneys (NAELA) for stories about the importance of Medicaid.

Do you provide time and financial support to a family member who receives Medicaid for nursing home services? Are you married to someone who is receiving Medicaid services? Would you be impoverished by paying for the nursing home care your loved one needs, if not for Medicaid? Do you have a client or clients in these situations?

In Washington, right now, Congress is trying to eliminate these Medicaid services.

To put a face to those who receive these services, please help us share your story of Medicaid nursing facility and home and community based services.

With these stories, advocates can better demonstrate what Medicaid really means. These stories will show Congress what Medicaid is and what it means to their constituents. We are looking for stories demonstrating that Medicaid for nursing facility and home and community based services:

- Keeps a family member safe and cared for at home or in the community.
 - Ensures that nursing homes maintain quality standards.
- Assists families and communities already contributing time and finances to long term care.
- Protects someone married to a person receiving Medicaid services from impoverishment.
- Is the main program that Medicare beneficiaries rely on for nursing facility and home and community based services.
- Protects family members from exhausting resources to pay for care.

Please share your story of what Medicaid means for you, along with your contact information. **Send your story, or questions for more information, to Fay Gordon at fgordon@consumers.org.**

Please submit stories by May 20 so they can be shared with policy makers in June.

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Send Us Medicare Summary Notices (MSNs)

The Center is concerned about the use of MSNs that do not reveal to beneficiaries that their service was denied based on a National Coverage Determination. Such an MSN will instead provide a misleading explanation, such as "Medicare does not cover this service," or "information provided does not support the need for this service."

If you have such an MSN please contact shart@vanosteen.com.

Medicare Does Not Require "Improvement" for Coverage

The Center for Medicare Advocacy has launched a campaign to end this unfair standard. [We need your stories!](#)

If you or someone you know has been denied Medicare coverage because the person's condition is not showing improvement, Medicare coverage is being unfairly denied.

If Medicare coverage is denied because "your underlying condition will not improve," "you have plateaued," "you are not likely to improve," "you are chronic and stable" or "you need maintenance services only," [share your story now](#) or

contact us at (860) 456-7790 or [by email](#).

You may [remove your address from our mailing lists](#) at any time. If you would like an address corrected, or would like to add an address, please contact [Matthew Shepard](#). If you would like to receive a text-only version of this alert, please reply to this message with the subject "text only".

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