



The Medicare Secondary Payer Commercial Repayment Center in Fiscal Year 2015

**Report to Congress as Required by Section 1893(h) of the
Social Security Act for FY 2015**

United States Department of Health and Human Services

Centers for Medicare & Medicaid

2016

Table of Contents

Executive Summary..... iii

Introduction 1

 Background 1

 Statutory Authority for the Medicare Secondary Payer Commercial Repayment Center 2

 How the MSP Commercial Repayment Center is Paid..... 2

MSP CRC Review Process 2

 Identification and Recovery of Mistaken Payments 2

MSP CRC FY 2015 Results..... 3

 Overview 3

 Mistaken Payments Identified 3

 Recoveries..... 4

 Future Enhancements..... 4

Appendices..... 4

 Appendix A. Amount Returned to the Medicare Trust Funds from the MSP Commercial Repayment Center in FY 2015 5

 Appendix B. MSP Commercial Repayment Center Informational Resources..... 6

 Appendix C. Flow Chart of the GHP Recovery Process 8

Executive Summary

This is the second annual report for the Medicare Secondary Payer (MSP) Commercial Repayment Center (CRC), the national contractor utilized by the Centers for Medicare & Medicaid Services (CMS) to identify and recover mistaken Medicare payments through post-payment review, for the fiscal year (FY) 2015 (October 1, 2014 through September 30, 2015).

The mission of the MSP CRC is to identify and recover primary payments mistakenly made by the Medicare program when another entity had primary payment responsibility. The MSP CRC is a single contractor with national jurisdiction that became fully operational in the second quarter of FY 2014.

The CMS, through its Coordination of Benefits & Recovery (COB&R) program, routinely collects data on other insurance coverage for Medicare beneficiaries. The Coordination of Benefits (COB) portion of the program is intended to prevent overpayments when another insurer is reasonably expected to act as primary payer for medical services. One example of such a situation is when beneficiaries have coverage under an employer-sponsored Group Health Plan (GHP) arrangement in addition to their coverage under the Medicare program. When Medicare's information about a beneficiary's additional insurance coverage is missing, incomplete, or inaccurate, the Medicare program may mistakenly make primary payment for services under Part A (Hospital Insurance) or Part B (Supplemental Medical Insurance) of title XVIII of the Social Security Act.

The CRC identifies potential GHP-based mistaken payments (that is, situations where Medicare made primary payment when it should have paid secondary to the GHP) and pursues recovery as appropriate. The CRC recovers these mistaken primary payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing third party administrator (TPA)). The debtors for these particular MSP debts do not have formal appeal rights, but do have the opportunity to dispute the debt through the established "defense" process. In FY 2015, the CRC identified \$292.2 million in mistaken payments and posted net collections of \$149.6 million on behalf of the Medicare program. Collections for the remaining identified debt will continue into FY 2016, as additional overpayments are simultaneously identified and collections initiated.

The CRC's work to date has only included the identification and recovery of mistaken primary payments when beneficiaries had coverage under a GHP arrangement. In FY 2016, CMS will expand the CRC's workload to include the recovery of certain conditional payments where a Non-Group Health Plan (NGHP) applicable plan (that is, a Liability insurer, No-Fault insurer, or Workers' Compensation entity) had or has primary payment responsibility.

Introduction

Background

Medicare beneficiaries frequently have other health coverage in addition to their Medicare benefits. In a situation where there are two or more payers that may be expected to make payment for a medical claim, the payer that is expected to pay first is referred to as the “primary payer.” In the event that the primary payment does not cover the entire amount owed, the provider or supplier will then bill the remaining amount to the “secondary payer,” and so forth.

The Medicare Secondary Payer (MSP) program involves two broad categories: Group Health Plan (GHP) and Non-Group Health Plan (NGHP). The term “GHP” refers to the arrangement between the employer or other plan sponsor (such as a union or employee health and welfare fund) and the insurer or claims-processing TPA. The term “NGHP” specifically refers to Liability insurance (including self-insurance), No-Fault insurance or Workers’ Compensation. Under the provisions of 42 U.S.C. §1395y(b), the Medicare program can generally only make secondary payments when a payment has been made (or can reasonably be expected to be made) by these GHPs or NGHP applicable plans.

The CMS routinely collects information about any additional coverage a beneficiary may have or had for a specified period of time. Data collection activities include mandatory insurer reporting, as required by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 111), codified at 42 U.S.C. § 1395y(b)(7) and (b)(8). This data is compiled and updated as necessary. When a medical claim is submitted for payment under Part A or Part B of the Medicare program, Medicare reviews the beneficiary’s records to determine if the Medicare program has primary payment responsibility, or if another entity has that responsibility.

In certain situations after a Medicare claim is paid, CMS may receive new or updated information about health coverage other than Medicare benefits. The CRC reviews new and updated GHP records to determine whether Medicare may have mistakenly paid any claims as the primary payer. Once the CRC identifies mistaken payments, it recovers the payment from the GHP. In addition to recoveries it has initiated, the CRC maintains all open GHP recovery cases (and debts) that were established under previous MSP recovery contractors.

Prior to implementation of the CRC, recovery of these mistaken payments was performed by the Medicare Secondary Payer Recovery Contractor (MSPRC). In May 2013, the MSPRC transitioned all existing GHP recovery cases (including all open debts) to the CRC. The CRC began identification of new mistaken payments and other recovery activities in FY 2014, with operations at full volume in the second quarter of FY 2014. The CRC continues to maintain all of the open GHP cases (and debts) that were transitioned from the MSPRC as well as those initiated by the CRC.

Statutory Authority for the Medicare Secondary Payer Commercial Repayment Center

Section 1893(h) of the Social Security Act requires the Secretary of the Department of Health and Human Services (the Secretary) to utilize contractors as a part of the Medicare Integrity Program to identify and recover overpayments under the Medicare program associated with services for which payment is made under Part A or Part B of title XVIII of the Social Security Act.

How the MSP Commercial Repayment Center is Paid

As with other recovery contractors engaged by CMS and in accordance with the Tax Relief and Health Care Act, the CRC is paid on a contingency fee basis. The amount of the contingency fee is a percentage of the mistaken payment that the identified debtor has returned to the Medicare program. The CRC negotiated its specific contingency fee at the time of the contract award, and may only collect its fee once payment has been applied to a specific debt. In the event that excess collections have been made and a refund must be made to the identified debtor, the CRC must refund the contingency fee related to those collections.

MSP CRC Review Process

Identification and Recovery of Mistaken Payments

The other insurance data collected by CMS for an individual beneficiary is referred to as an “MSP occurrence.” The MSP occurrence is updated as additional information is received. When a medical claim is submitted to Medicare for payment, Medicare reviews the beneficiary’s records for an MSP occurrence to determine if the Medicare program has primary payment responsibility. If the MSP occurrence indicates that another entity has that responsibility, Medicare will only make a secondary payment. Under the provisions of 42 U.S.C. §1395y(b), the Medicare program will generally make only secondary payments when a beneficiary is known to have primary coverage through an employer-sponsored GHP.

The CRC reviews all GHP MSP occurrences as they are received and updated to determine whether any primary payments were mistakenly made for a given beneficiary. When the CRC identifies a potential mistaken payment, it issues a Primary Payment Notice (PPN) to the entities that CMS believes had primary payment responsibility (typically the employer or other plan sponsor and the insurer or claims processing TPA). This PPN requests that the recipients validate the information CMS has about the beneficiary; if the information provided to CMS was incorrect, the PPN affords the recipients an opportunity to correct the information. CMS is currently evaluating the effectiveness of the PPN process and piloting options to streamline this step.

The CRC then issues a letter that demands repayment (called a “Demand” letter) from the entities that should have paid as primary. This Demand notifies the identified debtors of the existence of the debt and includes claim specific information. The Demand also includes instructions for how to repay or rebut the debt, and consequences of failure to resolve the debt within the identified timeframe.

In response to the Demand, identified debtors may make payment to Medicare. Interest is assessed on any unresolved balance after 60 days (interest accrues from the date the Demand is issued, but is not assessed unless there is an outstanding balance 60 days after issuance of the Demand). If any portion of the debt remains unresolved, the CRC will notify the identified debtor of Medicare's intent to refer the debt to the Department of the Treasury for collection. Failure to resolve the debt after that notice is issued results in referral of the debt to the Department of the Treasury for collection.

The entities from which the CRC recovers mistaken payments do not have the same appeal rights as providers or beneficiaries. However, identified debtors do have the opportunity to rebut the debt, in part or in full, in response to the Demand letter. The basis of the rebuttal may be the existence (that is, the debtor did not have primary payment responsibility) or the amount (the specific amount owed to Medicare for the claim or claims in question) of the debt. The identified debtor must provide documentation to support the rebuttal. This documentation is reviewed by the CRC and, if validated, the rebuttal is referred to as a Valid Documented Defense and the balance of the debt is adjusted accordingly.

Please see Appendix C for a flow chart illustrating the recovery process.

MSP CRC FY 2015 Results

Overview

In FY 2015 the CRC identified \$292.2 million in mistaken payments, representing an increase of almost 25% over the \$234.2 million identified in FY2014. The CRC processed collections of \$154.29 million on behalf of the Medicare program, which represents an increase of almost 140% over the \$64.4 million in collections processed in FY 2014. Taking into account refunded excess collections of \$4.69 million; the CRC posted \$149.6 million in net collections. This is an increase of over 150% compared to the \$59.3 million in net collections in FY 2014.

Considering agency administrative costs of \$24.55 million (including contingency fees paid to the CRC), CMS realized a return of \$125.05 million dollars to the Medicare trust funds as a direct result of this program, an increase of 147% over the return of \$50.6 million for FY 2014.

The CRC also introduced a new, secure web-based tool designed to provide identified debtors with a way to electronically manage their GHP recovery activities. The Commercial Repayment Center Portal (CRCP) is designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program.

Mistaken Payments Identified

CRC issued 31,968 Demand letter packages relating to 41,847 individual beneficiaries, representing \$585.19 million in potential mistaken payments made by the Medicare program during FY 2015. In response to these Demand letters, the CRC received information that validated \$292.2 million as correctly identified mistaken payments to be recovered.

Recoveries

The CRC's net collections totaled \$149.6 million in FY 2015. This amount includes mistaken payments identified through the end of FY 2015 (collection efforts will continue into FY 2016 for mistaken payments identified in FY 2015). A total of \$144.21 million of these payments were direct payments (that is, checks received from debtors). During FY 2015 the CRC processed \$10.08 million in collections from the Department of the Treasury on delinquent debts. In addition, \$4.6 million in excess collections were identified and refunded to the identified debtors. Excess collections can occur when the Treasury offsets against a payment due to the debtor by another Federal program at the same time that a debtor makes direct payment to the CRC.

Future Enhancements

In FY 2016, the CRC workload will expand to include the recovery of certain NGHP conditional payments where an applicable plan (that is, a Liability insurer, No-Fault insurer, or Workers' Compensation entity) had or has primary payment responsibility. The CRC will recover directly from the applicable plan as the identified debtor when the applicable plan reports that it has Ongoing Responsibility for Medicals (ORM) or otherwise notifies CMS of its primary payment responsibility.

Appendices

- A. Amount Returned to the Medicare Trust Funds from the MSP Commercial Repayment Center
- B. MSP Commercial Repayment Center Informational Resources
- C. Flow Chart of the GHP Recovery Process

Appendix A. Amount Returned to the Medicare Trust Funds from the MSP Commercial Repayment Center in FY 2015

Direct Collections	Treasury Collections	Excess Collections Refunded	CMS Administrative Costs*	Amount Returned to Medicare Trust Funds
\$144,206,681.4	+ \$10,079,801.36	- \$4,691,087.63	- \$24,548,192.35	= \$125,047,202.78

*CMS Administrative Costs include contingency fees paid to the CRC as well as funds paid to support contractors to facilitate CRC work.

Appendix B. MSP Commercial Repayment Center Informational Resources

Website	Information Provided
http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html	Overview of the COB&R program
http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html	Overview of GHP recovery, as performed by the CRC
http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/GHP-Recovery-Process-Flowchart.pdf	High level flow chart of the GHP recovery process

Appendix C. Flow Chart of the GHP Recovery Process

To access the GHP Recovery Process Flow Chart please use the following link <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/GHP-Recovery-Process-Flowchart.pdf>