



**U.S. Department of
Health and Human Services
Centers for
Medicare & Medicaid Services**

**Annual Report on The Medicare Secondary
Payer (MSP) Commercial Repayment Center
(CRC)**

**Report to Congress
Fiscal Year 2023**

JULY 2024

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1.0 Executive Summary

As required by statute, this is the 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 fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023).

In FY 2023, the CRC identified \$432.69 million in mistaken and conditional payments and posted net collections of \$260.93 million on behalf of the Medicare program. Collections for the remaining identified debt will continue into FY 2024, as additional overpayments are identified, and collections are initiated.

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.

CMS, through its Coordination of Benefits & Recovery program, routinely collects data on other insurance coverage for Medicare beneficiaries. The Coordination of Benefits 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 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 have the opportunity to dispute the debt through the established "defense" process.

In FY 2016, CMS expanded the CRC's workload to include the recovery of certain conditional payments where an applicable Non-Group Health Plan (NGHP) entity, such as a Liability insurer, No-Fault insurer, or Workers' Compensation entity has or had primary payment responsibility. Upon learning that the applicable plan has or had primary payment responsibility, the CRC identifies and initiates recovery of conditional payments that it believes the applicable plan should have paid. These applicable plans were granted formal administrative appeal rights for debts established on or after April 28, 2015.

2.0 Introduction

2.1 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.”

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” refers to liability insurance (including self-insurance), no-fault insurance, or workers’ compensation. Pursuant to section 1862(b) of the Social Security Act (the Act), if another entity has primary payment responsibility, the Medicare program can generally only make conditional payments with respect to an item or service if a primary plan has not made or cannot reasonably be expected to make payment with respect to such item or service promptly.

CMS routinely collects information about any additional coverage a beneficiary may have or had for a specified period of time. Pursuant to section 1862(b)(7) and (b)(8) of the Act, data collection activities include mandatory insurer reporting, as required by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. This data is compiled and updated as necessary when coverage information changes. When a medical claim is submitted for payment under Part A or Part B, 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 in addition to 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 attempts to recover the payment from 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

the open GHP cases (and debts) that were transitioned from the MSPRC, as well as those initiated by the CRC.

In FY 2016, the CRC's mission was expanded to include the identification and recovery of payments Medicare made conditionally when an NGHP applicable plan has or had Ongoing Responsibility for Medicals (ORM). The CRC coordinates with the Benefits Coordination and Recovery Center to review new and updated NGHP records to identify conditional payments made by Medicare. When the CRC identifies conditional payments where the applicable plan has or had ORM, the CRC initiates recovery.

2.2 Statutory Authority for the Medicare Secondary Payer Commercial Repayment Center

Section 1893(h) of the Act requires the Secretary of the Department of Health and Human Services (HHS) 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 Act. It also requires the HHS Secretary to annually submit a report to Congress.

2.3 How the MSP Commercial Repayment Center is Paid

As with other recovery audit contractors engaged by CMS in accordance with section 1893(h) of the 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.

3.0 MSP CRC Review Process

3.1 Identification and Recovery of Mistaken Payments (“GHP Recovery”)

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 primary payment responsibility, Medicare will only make a secondary payment. Pursuant to section 1862(b)(2) of the Act, the Medicare program will 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 by Medicare for a given beneficiary. When the CRC identifies a potential mistaken payment, it issues a letter that demands repayment (called a “Demand letter”) from the entity that should have paid as primary. This Demand letter notifies the identified debtor(s) of the existence of the debt and includes claim specific information. The Demand letter 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 letter, identified debtors may make payment to Medicare. Interest is assessed on any unresolved balance after 60 days (interest accrues from the date the Demand letter is issued but is not assessed unless there is an outstanding balance 60 days after issuance of the Demand letter). 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 GHP 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 lack of 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.

3.2 Identification and Recovery of Conditional Payments (“NGHP ORM Recovery”)

The underlying process used by the CRC to identify and recover conditional payments from NGHP applicable plans is similar to that used to recover mistaken payments from GHPs. CMS collects data related to beneficiary coverage under liability insurance, no-fault insurance, or workers’ compensation plans, which is also known as an “MSP occurrence.” Information may be provided by the beneficiary, the beneficiary’s authorized representative, or from the insurer or workers’ compensation entity or the authorized representative of the insurer or workers’ compensation entity. This MSP occurrence is updated as additional information is received. As with GHP situations, Medicare will review these MSP occurrences to determine whether another entity has primary payment responsibility (although in contrast to GHP arrangements, NGHP coverage is usually limited to care that is related to the underlying illness or injury). Pursuant to section 1862(b)(2) of the Act, Medicare may not make payment if payment has been made (or can reasonably be expected to be made) by a liability insurer, no-fault insurer, or workers’ compensation entity. However, Medicare may make payment when there is evidence that the primary plan has not made payment to a provider or other supplier promptly,

or while a claim (and assumption of payment responsibility) is pending. The applicable plan must reimburse Medicare if it is later identified as responsible for the payment.

The CRC reviews a specific type of NGHP MSP occurrence, i.e., those where a liability insurer, no-fault insurer, or workers' compensation entity has or can be reasonably expected to have primary payment responsibility for treatment for a given illness or injury prior to or in addition to a settlement, judgment, award, or other payment to the beneficiary. This is referred to as the applicable plan having ORM. When the CRC identifies conditional payments made under these circumstances, it issues a Conditional Payment Notice (CPN) to the applicable plan. This CPN lists the conditional payments identified by the CRC and affords the recipients an opportunity to rebut or correct the information. The CPN allows 30 days to dispute responsibility for repayment (in part or in full) before the recovery case proceeds to the demand stage. The CRC then issues the Demand letter. This Demand letter formally notifies the identified debtors of the existence of the debt and includes claim specific information. The Demand letter also includes instructions regarding how to repay or appeal the debt, and the consequences of failing to resolve the debt within the identified timeframe.

In response to the Demand letter, identified debtors may make payment to Medicare. Interest is assessed on any unresolved balance after 60 days (interest accrues from the date the Demand letter is issued but is not assessed unless there is an outstanding balance 60 days after issuance of the Demand letter). 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, unless an appeal has been filed.

An identified NGHP debtor has 120 days from receipt of the Demand letter to file an appeal. Pursuant to section 1862(b)(2)(B)(viii) of the Act, NGHP entities from which the CRC recovers conditional payments were granted formal administrative appeal rights as of April 2015. The basis of the appeal may be the lack of existence (that is, the debtor did not actually have primary payment responsibility) or the amount (the specific responsibility for some or all of the conditional payments) of the debt. The CRC processes the first level appeal, called a request for redetermination. The identified debtor must provide documentation to support its request which, if successful, results in an adjustment of the debt. If the appeal is unsuccessful, the identified debtor may request a higher-level appeal. The higher levels of appeal are reconsideration by the CMS Qualified Independent Contractor, a hearing by an Administrative Law Judge within the Office of Medicare Hearings and Appeals, and review by the Departmental Appeals Board's Medicare Appeals Council. If an NGHP requests an appeal, the debt will not be referred to the Department of Treasury while the appeal is being processed, but interest will continue to accrue.

4.0 MSP CRC FY 2023 Results

4.1 Overview

The CRC nominal net collections decreased by 13% in FY 2023 compared to FY 2022. The demand volume decreased by 8%, and the demand amount decreased by 5% in FY 2023. Reduction in collections is anticipated due to the ongoing improvements to the collection of coordination of benefits information. This improved coordination of benefits information allows for appropriate payment of claims, reducing mistaken and conditional payments.

In FY 2023, the CRC identified a total of \$432.69 million in mistaken and conditional payments for both the GHP and NGHP ORM workload. The CRC processed collections of \$301.22 million on behalf of the Medicare program. Taking into account refunded excess collections of \$40.28 million, the CRC posted \$260.93 million in net collections.

Taking into account agency administrative costs of \$41.46 million (including contingency fees paid to the CRC), CMS returned \$219.48 million to the Medicare Trust Funds as a direct result of this program, compared to the return of \$253.17 million for FY 2022.

4.2 Mistaken and Conditional Payments Identified

The CRC issued 83,523 Demand letters relating to 94,587 individual beneficiaries, representing \$754.21 million in potential mistaken and conditional payments made by the Medicare program during FY 2023. In response to these Demand letters, the CRC received information that validated \$432.69 million as correctly identified mistaken and conditional payments to be recovered.

4.3 Recoveries

The CRC's net collections totaled \$260.93 million in FY 2023. This amount includes mistaken and conditional payments identified through the end of FY 2023 (collection efforts will continue into FY 2024 for mistaken payments identified in FY 2023). A total of \$253.67 million of these payments were direct payments (that is, payment received directly from debtors). A total of \$47.55 million of these payments were collections made by the Department of Treasury on delinquent debts and processed by the CRC during FY 2023. In addition, \$40.28 million in excess collections were identified and refunded to the identified debtors (excess collections can occur when the debtor fails to respond in a timely manner).

4.4 Amount Returned to the Medicare Trust Funds from the MSP Commercial Repayment Center in FY 2023

Figure 1: Amount Returned to the Medicare Trust Funds

Direct Collections	Treasury Collections	Excess Collections Refunded	CMS Administrative Costs*	Amount Returned to Medicare Trust Funds
\$253,671,174.86	+ \$47,545,291.19	- \$40,282,946.54	- \$41,458,106.16	= \$219,475,413.35

*“CMS Administrative Costs” include contingency fees paid to the CRC as well as certain CMS administrative costs and funds paid to support contractors to facilitate CRC work.