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CMS Requests Input on Proposed Rule for Resolving Medicare Secondary Payer (MSP) Obligations Relating to Future Medical Care

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CMS recently published an advance notice of proposed rulemaking (ANPRM) seeking comments on proposed rules governing how Medicare beneficiaries may resolve their Medicare Secondary Payer (MSP) obligations when they receive settlements from insurers for future medical care. CMS, Medicare Program; Medicare Secondary Payer and "Future Medicals," 77 Fed. Reg. 35917 (6/15/12) [PDF]. Comments are **due by August 14, 2012**.

The notice provides guidance on the MSP provisions, which bar Medicare from paying a beneficiary who is reasonably expected to receive payment from a workers compensation, liability insurance, or no-fault insurance plan. When a beneficiary is unable to receive prompt payment, Medicare is permitted to advance conditional payments, with the expectation that Medicare will be repaid if the beneficiary receives a "settlement" — i.e., settlement, judgment, award, or other payment — from a workers compensation, liability insurance, or no-fault insurance plan. Medicare is thereby deemed the secondary payer until the beneficiary exhausts settlement proceeds obtained from his or her primary payer.

In the ANPRM, CMS has proposed a general rule requiring any individual or beneficiary who obtains a "settlement" and has received or anticipates receiving "future medicals" (defined as Medicare-covered services received post-settlement) to satisfy Medicare's interest with respect to such services by following one of seven standardized options. Options one through four are designed for Medicare beneficiaries and individuals who are not yet Medicare eligible or enrolled. Options

five through seven would be available to Medicare beneficiaries alone. Concisely described, the options are:

1. The individual/beneficiary pays for all related future medical care until his/her settlement is exhausted and documents it accordingly.
2. Medicare will not pursue "future medicals" if the individual/beneficiary's settlement is below a defined amount and certain other criteria are met. CMS requests comments on the appropriate defined amounts.
3. The individual/beneficiary acquires or provides an attestation from his or her treating physician regarding the "Date of Care Completion," which facilitates CMS's ability to pursue appropriate recovery.
4. The individual/beneficiary submits a proposed Medicare Set-Aside Arrangement (MSA) for CMS's review and obtains approval.
5. The beneficiary participates in one of three available recovery options for low-dollar liability settlements involving $25,000 or less.
6. The beneficiary makes an upfront payment to compensate Medicare for future medical expenses.
7. The beneficiary obtains a compromise or waiver of recovery.

CMS explained that the proposed general rule and options are issued in response to industry requests for clarity regarding "future medicals" and MSP requirements. The guidance is designed to provide for a more flexible, efficient, and timely coordination of the benefits process and is aimed at protecting Medicare Trust Funds and the interests of beneficiaries. CMS is seeking feedback on the efficacy and practicality of its proposed schema and is soliciting suggestions for additional options that could facilitate the resolution of "future medicals" obligations under the MSP. Comments on the proposed guidelines are due August 14, 2012.