Complying with the Medicare Secondary Payer Act: Everything You Need to Know in 2019

April 15, 2019

12:00 p.m. – 2:00 p.m.

CBA Law Center

New Britain, CT

CT Bar Institute Inc.

CT: 2.0 CLE Credits (General)
NY: 2.0 CLE Credits (AOP)

Lawyers' Principles of Professionalism

As a lawyer I must strive to make our system of justice work fairly and efficiently. In order to carry out that responsibility, not only will I comply with the letter and spirit of the disciplinary standards applicable to all lawyers, but I will also conduct myself in accordance with the following Principles of Professionalism when dealing with my client, opposing parties, their counsel, the courts and the general public.

Civility and courtesy are the hallmarks of professionalism and should not be equated with weakness;

I will endeavor to be courteous and civil, both in oral and in written communications;

I will not knowingly make statements of fact or of law that are untrue;

I will agree to reasonable requests for extensions of time or for waiver of procedural formalities when the legitimate interests of my client will not be adversely affected;

I will refrain from causing unreasonable delays;

I will endeavor to consult with opposing counsel before scheduling depositions and meetings and before rescheduling hearings, and I will cooperate with opposing counsel when scheduling changes are requested;

When scheduled hearings or depositions have to be canceled, I will notify opposing counsel, and if appropriate, the court (or other tribunal) as early as possible;

Before dates for hearings or trials are set, or if that is not feasible, immediately after such dates have been set, I will attempt to verify the availability of key participants and witnesses so that I can promptly notify the court (or other tribunal) and opposing counsel of any likely problem in that regard;

I will refrain from utilizing litigation or any other course of conduct to harass the opposing party;

I will refrain from engaging in excessive and abusive discovery, and I will comply with all reasonable discovery requests;

In depositions and other proceedings, and in negotiations, I will conduct myself with dignity, avoid making groundless objections and refrain from engaging I acts of rudeness or disrespect;

I will not serve motions and pleadings on the other party or counsel at such time or in such manner as will unfairly limit the other party's opportunity to respond;

In business transactions I will not quarrel over matters of form or style, but will concentrate on matters of substance and content;

I will be a vigorous and zealous advocate on behalf of my client, while recognizing, as an officer of the court, that excessive zeal may be detrimental to my client's interests as well as to the proper functioning of our system of justice;

While I must consider my client's decision concerning the objectives of the representation, I nevertheless will counsel my client that a willingness to initiate or engage in settlement discussions is consistent with zealous and effective representation;

Where consistent with my client's interests, I will communicate with opposing counsel in an effort to avoid litigation and to resolve litigation that has actually commenced;

I will withdraw voluntarily claims or defense when it becomes apparent that they do not have merit or are superfluous;

I will not file frivolous motions;

I will make every effort to agree with other counsel, as early as possible, on a voluntary exchange of information and on a plan for discovery;

I will attempt to resolve, by agreement, my objections to matters contained in my opponent's pleadings and discovery requests;

In civil matters, I will stipulate to facts as to which there is no genuine dispute;

I will endeavor to be punctual in attending court hearings, conferences, meetings and depositions;

I will at all times be candid with the court and its personnel;

I will remember that, in addition to commitment to my client's cause, my responsibilities as a lawyer include a devotion to the public good;

I will endeavor to keep myself current in the areas in which I practice and when necessary, will associate with, or refer my client to, counsel knowledgeable in another field of practice;

I will be mindful of the fact that, as a member of a self-regulating profession, it is incumbent on me to report violations by fellow lawyers as required by the Rules of Professional Conduct;

I will be mindful of the need to protect the image of the legal profession in the eyes of the public and will be so guided when considering methods and content of advertising;

I will be mindful that the law is a learned profession and that among its desirable goals are devotion to public service, improvement of administration of justice, and the contribution of uncompensated time and civic influence on behalf of those persons who cannot afford adequate legal assistance;

I will endeavor to ensure that all persons, regardless of race, age, gender, disability, national origin, religion, sexual orientation, color, or creed receive fair and equal treatment under the law, and will always conduct myself in such a way as to promote equality and justice for all.

It is understood that nothing in these Principles shall be deemed to supersede, supplement or in any way amend the Rules of Professional Conduct, alter existing standards of conduct against which lawyer conduct might be judged or become a basis for the imposition of civil liability of any kind.

--Adopted by the Connecticut Bar Association House of Delegates on June 6, 1994

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Agenda

12:00 p.m. – 12:20 p.m.	Introduction and brief overview of the Medicare Secondary Payer Act
12:20 p.m. – 12:40 p.m.	The Section 111 Reporting Requirement
12:40 p.m. – 1:15 p.m.	Obtaining, disputing, and compromising the Medicare Conditional Payment Amount (Medicare A, B, C, and D). Will include case law update.
1:15 p.m. – 1:50 p.m.	Medicare Set Asides: What is it? When do you need one? Can you avoid it? Will include a discussion of the Notice of Proposed Rule Making expected by September 2019.
1:50 p.m. – 2:00 p.m.	Questions

Faculty Biography

Christine Hummel is the President and founder of Hummel Consultation Services, a legal consultation practice specializing in the application of the Medicare Secondary Payer Act. An active attorney with licensure in the state of Colorado, she earned her Juris Doctor from the University of Denver in May 2000. In 2002 Christine opened her own firm, which recently celebrated its sixteenth continuous year of operation. With twenty years of experience, Christine is a published author and popular speaker on a wide array of topics related to Medicare compliance. Christine has significant experience working with the Centers for Medicare and Medicaid Services in regarding applicability of the Medicare Secondary Payer Act to liability settlements. She is a member of the American Bar Association, the Colorado Bar Association, and includes with her legal experience work in Medicaid, probate, and elder law. Christine volunteers her free time by giving presentations on the roles of women throughout multiple time periods in history.

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Connecticut Bar Association

April 15, 2019

Please feel free to email or call with questions at any time.

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Medicare Eligibility

- Over age 65
- Persons from Age 22 to 64: Social Security Disability.
- Minors and young adults: May be able to utilize a parent's work history to qualify for SSD and Medicare.

Medicare Eligibility

- How to Confirm Medicare Status/SSD status
  - Defendant/insurance company can "query" the injured person on the SSA database via the Section 111 reporting system.
  - Plaintiff can provide a Benefits Verification statement from this website: https://www.ssa.gov/myaccount/
  - Remember to verify the plaintiff's SSD status periodically until the case is fully resolved.

The Medicare Secondary Payer Act

- 42 USC 1395y (December 1980)
- Three basic requirements:
  - The Section 111 Reporting Requirement
  - Maintain Medicare as Secondary Payer post-settlement
  - The Conditional Payment Reimbursement

Can I completely avoid the MSP statute?

$750.00

(Note: 2019 Threshold)

Section 111: No Fault (PIP and Medpay)

- Must report when notified of claim; On-going Responsibility for Medicals (ORMs) begins.
- Second report when ORMs are terminated by:
  - Exhaustion of policy limits – payments to medical providers
  - Payment of balance of policy limits to Medicare beneficiary
  - Responsibility for ORMs terminated by statute, settlement, judgement, or other payment.

Section 111: Liability (Bodily injury; UM; UIM)

- Report case at the time of settlement.
- No ORMs in a liability case; only one Section 111 Report.

Section 111: Penalty

- Failure to timely report under Section 111 could result in a penalty of up to $1,000.00 per day per claim.
- Sliding scale for penalty.
- Must make a good faith effort to determine need for reporting.
- December 2018 alert: Notice of Proposed Rule Making to address Civil Financial Penalties. Will be published by September 2019.

Future Medical Allocations (MSA)

- 42 USC 1395Y(b)(2)(A)(ii): Requires that Medicare cannot make a payment with respect to any item or service to the extent that "payment has been made, or can reasonably be expected to be made under a workmen's compensation law or plan…or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

MSA continued

What Is Missing?

The magical phrase “Medicare Set Aside”

But does this matter?

MSA continued

- Medicare Set Asides are TOOLS for compliance with the MSP statute's requirement that Medicare remain a secondary payer.

- The MSA is the preferred method for compliance with the MSP, but even CMS acknowledges there may be other ways to comply, but CMS has never approved any other financial method or tool for compliance with the MSP.

MSA Continued

- Your settlement is primary to Medicare if a claim for future medical (or permanent medical; lifetime medical) damages was claimed by the plaintiff and this claim is "released" as part of the settlement agreement.

- Tip: Injured party controls the scope of the alleged damages/injuries not the insurance company.

MSA Continued

- Is there any way to avoid an MSA (or future medical allocation) if a claim for future medical damages was made at some point in the history of the case?

- YES! CMS Memo issued September 29, 2011

MSA continued

- What if I cannot get the doctor's statement? What about case law?
- Aranki v. Burwell: October 16, 2015 out of Arizona.
- Duff vs Mass Gen (September 13, 2016)
  - No Judge has ever stated the MSP statute and its requirement to keep Medicare secondary does not apply to Liability cases.
  - Narrowly tailored questions to the court: does MSP mandate use of a Medicare set Aside. This is not the same as asking the court to rule on the applicability of the MSP statute.
  - Re-read the cases with "fresh eyes"!

MSA Continued

- What medical care does the MSA pay for?
  - Medicare covered treatment related to the injury or illness in question
    - Office visits, diagnostic imaging studies, physical therapy
    - Surgery
    - Medications
    - Durable Medical Equipment
    - Pain management injections
    - Implantable devices

MSA Continued

- Ways to reduce the MSA exposure
  - Rated ages
  - If possible, see if the Plaintiff can be switched to generic medications or weaned off medications
  - Surgery/implantable device statements: 1) Doctor and 2) Plaintiff. NOTE: CMS not legally bound by either statement.

MSA Continued

- Ways to reduce the MSA exposure cont.
  - Obtain a treatment statement from the treating physician
    - Treatment statement must come from the actual treating physician; not an IME or Second Opinion physician. *This approach may backfire; use caution.

**42 CFR 411.47 is NOT a basis for reducing a future medical allocation. See July 11, 2005 CMS memorandum question/answer 11.

MSA Continued

- Can I get CMS approval of the MSA?
  - For No Fault and Liability – probably not, but you can try. This is likely to change in 2019 or 2020.
  - For Workers Comp –yes so long as the review thresholds are met.

MSA Continued

- With no formal MSA review process, how does CMS know the settlement is primary? And how much is primary?
  - Section 111 Reporting
  - Changes to the Common Working File effective October 1, 2017

MSA Continued

- Common Working File Changes (Effective: October 2017)
  - Tells Medicare billing when to pay
  - The Bulletin notifying of the change specifically states CMS is creating two new MSA processes: Liability and No Fault
  - If no MSA is created, the case will be evaluated under current MSP policy.

*MSP states the entire "primary payment" (settlement) is primary to Medicare.

MSA Continued

- November 8, 2017 CMS issued a MLN educational bulletin aimed at the Medical community. The title of the bulletin: Accepting Payment from Patients with Medicare Set-Aside Arrangements. Bulletin specifically tells medical providers that the Medicare is “always a secondary payer to liability insurance (including self-insurance), no fault, and workers compensation.”

MSA Continued

- December 2018: CMS issued an alert notifying the stakeholder community of its intent to publish a Notice of Proposed Rule Making by September 2019.
- NPRM will address obligation of settlements to protect the Medicare trust fund.
- NPRM will provide “options” for compliance.

MSA Continued

- Companion Workers' Compensation Claim
  - What is the status of the WC claim now?
  - If the WC claim closed out medical, did they do an MSA?
  - If the WC claim is open, will WC continue to pay medical benefits after your liability settlement?
  - Never lose track of the WC claim.

MSA Continued

- MSA Funding
  - Lump Sum
  - Annuity
- MSA Administration
  - Self-Administration
  - Self-Administration with Assistance
  - Professional Custodian/Trustee

MSA Continued

- Medicaid Recipients (Dual Eligibles)
  - MSA funds are countable assets
  - Must use SNT or Pooled/community trust to preserve on-going Medicaid eligibility.
  - If Medicaid recipient receives MSA funds directly they will be disqualified from Medicaid.

MSA continued

- What "fee schedule" is used when calculating an MSA?
  - Actual charges
  - Possibly workers' compensation fee schedule
  - NEVER: Medicare Fee Schedule
  - Medical bills must be paid utilizing the fee schedule used to calculate the MSA.

MSA Continued

- How long does the money have to stay in the MSA account?
- What happens to the MSA funds at the death of the beneficiary?

Medicare Conditional Payments:

Parts A, B, C, and D

Conditional Payments

- Statutes and Regulations (A, B, C, D)
  - 42 USC 1395y(b)(2)(B)
  - 42 CFR 411.24
  - 42 CFR 411.26 (subrogation and right to intervene)
  - 42 CFR 411.39 (Final CP Process)
  - 42 CFR 411.50
  - 42 CFR 411.52
  - 42 CFR 411.108 (Part C)
  - 42 CFR 423.462 (Part D)
  - 42 CFR 401.613 (Compromise)

Conditional Payments Continued

- Conditional Payment: Payments made by Medicare for the accident related injury from the Date of Injury to the Date of Settlement.

- Two Contractors do Conditional Payment Searches for Medicare A/B: Benefits Coordination and Recovery Center (BCRC) and Commercial Repayment Center (CRC)

Conditional Payments: General

- Medicare can recover, as conditional payments, any payment(s) paid by the Medicare program for the injury/illness from the date of injury (or date of Medicare entitlement) to the date of settlement.
- Make sure all parties agree on the date of injury.
- Plan Ahead: It will take the Medicare Contractor a minimum of 21-45 days to provide a tentative conditional payment letter or notice.

Conditional Payments: General

- Medicare can seek recovery for any payment with a date of service prior to your date of settlement even if the bill is paid after your settlement.

- If an expensive item (surgery) is not included in the tentative conditional payment letter; do some research and find out how the bill was paid. If billed to Medicare, notify the contractor of the excluded costs and ask for a revised letter.

Conditional Payment: General

- Disputes and appeals will take a minimum of 30 to 60 days to process.

- Unless utilizing the Final CP process, the Final Demand amount cannot be obtained from Medicare until after you have finalized your settlement and signed a legally binding settlement agreement that creates a payment obligation.

*The date of your mediation or arbitration is not the “date of settlement” if your state requires execution of a settlement agreement.

Conditional Payment: General

- Both the BCRC and CRC can only provide conditional payment information for Medicare Part A and Part B payments. (Part C and D conditional payment searches will be discussed later in the presentation)

Conditional Payment: BCRC (Bodily Injury, UM, UIM)

- The BCRC is the recovery contractor for Liability cases and any other case where the Medicare Beneficiary is deemed the “primary debtor” or “debtor of record”
- You must be the Medicare Beneficiary or have permission from the Beneficiary to obtain conditional payment information from the BCRC.

Conditional Payment: CRC (PIP or Med Pay)

- The CRC will only work with the Responsible Reporting Entity (Defendant/Insurance Provider) or their designated recovery agent.

- The CRC is the recovery agent for all Workers Compensation cases and No Fault cases newly reported to CMS after October 5, 2015.

Conditional Payment: CRC

- For cases with continuing ORM obligation, the CRC will maintain an open file in “continuous recovery status”.

- The CRC will audit all “open” files a minimum of one time per year and a maximum of four times per year.

Conditional Payment: CRC

- Due to the “audit” process, the CRC may issue conditional payment notices or letters up to four times per year. If no action is taken, a demand will be issued and payment of the conditional payment is required.

- This periodic review of the file will continue until ORMs are terminated.

Conditional Payment: Disputes/Appeals

- Any tentative conditional payment amount can be disputed.
- A final demand amount can be appealed.
- Should you continue to pursue the appeals process, the next level of review is with an outside contractor. When submitting a file for reconsideration with the outside contractor, make sure to include all possible reasons…

Conditional Payment: Disputes/Appeals

- for your appeal. Failure to introduce evidence at this level may waive your ability to introduce it later in the appeals process, such as at the district court.

- Every review process (dispute, appeal etc..) takes several weeks or months to complete.

Conditional Payment: Disputes/Appeals

- If a final demand has been issued, the final demand amount must be paid within 60 days to avoid interest.

- Interest will accrue on the Final Demand amount while an appeal, compromise, or waiver is pending.

Conditional Payments: Disputes/Appeals

- Payment of the Final Demand amount while an appeal is pending does not lessen your likelihood of success.

- Payment does not equal admission that the conditional payment amount is appropriate.

Conditional Payment: Waiver

- Can only be filed after a Final Demand issued
- Reviewed by the contractor
- Can ask for a waiver of the entire conditional payment amount
- Initial decision can be appealed
- Interest will accrue if waiver request takes longer than 60 days for review.

Conditional Payment: Compromise

- Can be requested on a Tentative or Final
- Must be willing to pay something
- Review by the Regional Office.
- Cannot be appealed

Conditional Payment: Part C and Part D

- 42 CFR 422.108: The Medicare Advantage organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary Exercises under the MSP Regulations in subparts B through D of Part 411 of this chapter.

- 42 CFR 423.462 applies the provisions of 42 CFR 422.108 to Part D plans.

Conditional Payment: Part C and Part D

- Part C and Part D plans administered by private health insurance companies.
- You must contact the plan separately to obtain their conditional payment information.
- You must still do a “traditional” Medicare conditional payment search (A/B) as a beneficiary can opt into and out of plans annually.

Conditional Payment: Part C and Part D

- If the A/B search returns $0.00 conditional payments this may be a red-flag that the plaintiff is participating in a Medicare Part C plan.

- If the plaintiff required medications for your injury, make sure to verify how the medications were paid. Possible Part D or C plan.

Conditional Payment: Part C and Part D

- Most current case law finding in favor of plan recovery rights. See In re Avandia, 2016 Humana decision and Aetna/Guerrera (March 2018 CT case).

Conditional Payment: Final CP Process

- 42 CFR 411.39
- January 1, 2016
- Allows parties to settlement to request the final demand amount prior to finalizing settlement.
- Must complete the process within 120 days
- Can appeal each conditional payment one time
- Must sign settlement agreement within three days AFTER final demand requested.

Conditional Payment: Final CP Process

- 42 CFR 411.39(d): Obligations with Respect to Future Medical: Final conditional payments obtained via the web portal represent Medicare covered and otherwise reimbursable items and services related to the Beneficiary's settlement, judgement, award, or other payment.

Conditional Payment: Final CP Process

- The Final CP Process is only available for Workers' Compensation and Liability settlements. (in reality just Liability)
- It is not available for No Fault settlements.
- The exact language from CMS is the process "may" be available; which means it may not be available for all cases.

Conditional Payment: CIGA Case

- California Insurance Guarantee Association v CMS
- United States District Court Central District California
- Case is still pending
- January 5, 2017 Judge issued order on Motion to Dismiss and Motions for Summary Judgment

Conditional Payment: CIGA Case

- Workers Compensation Case
- California Workers Compensation law a factor
- CMS practice of seeking recovery for full conditional payment amount even if the date of service includes non-compensable ICD codes unlawful.

Conditional Payment: CIGA Case

- The presence of one covered code does not ipso facto make CIGA responsible for reimbursing the full amount of the charge.
- CMS must consider whether the charge can reasonably be apportioned between covered and non-covered codes or treatments.
- Upon such consideration, CMS might still conclude that apportioning the charge is unreasonable.

Conditional Payment: Misc.

- The CMS system can only handle one type of claim file per date of injury. Therefore, if a plaintiff brings a case against multiple liability defendants, the system can only handle the first reported liability case. All subsequent cases will be handled at the time of settlement.

Conditional Payment: Misc.

- Automobile cases that have both a liability and no fault (PIP/Med Pay) claim, will have two lien search processes:
  - one with the CRC
  - one with the BCRC

Conditional Payment: Misc.

- CMS can still seek recovery from the Primary Plan or Payer even if they are not the initial primary debtor of record on a file (42 CFR 411.24(i)).

- If it is necessary for CMS to take legal action to recover the conditional payment amount from the primary payer, CMS may recover twice the amount. (42 CFR 411.24 (c)(2)).

- CMS can either assert a recovery action against the primary payer (42 USC1395(b)(2)(B)(iii)) or against any entity that received payment from the primary payer or proceeds from a payment made by the primary payer including the attorney representing the Medicare beneficiary (42 CFR 411.24(g)). See: United States v. Paul J. Harris

Conditional Payment: Misc

- If Plaintiff will be handling the conditional payment search; ensure defendant/insurance receives a copy of all correspondence to and from CMS/BCRC.

- Plaintiff will always be copied on correspondence from CMS.

Conditional Payment: Misc.

- Remember: Each Settlement is required to do its own conditional payment search.

- A prior conditional payment search, even if for the same date of incident, does not satisfy your requirement to give notice of settlement and do a conditional payment search.

Conditional Payment: Misc

- If the Final Demand amount is not paid timely, an “Intent to Refer” notice will be sent.
- Intent to Refer = Department of Treasury.
- Do Not let it get to Treasury!

Conditional Payment: Misc

- If no conditional payment search is started, CMS will automatically check for conditional payments at the time of the defendant's Section 111 report of settlement.

- Conditional Payments must still be reimbursed even if the plaintiff has died.

Conditional Payment: Self-Calculation

- Available for Liability Cases (conflicting information for work comp and no-fault)
- Must settle for $25,000.00 or less
- Must be done with all treatment for 90 days
- Date of incident must have occurred at least six months ago
- Must be a physical trauma injury; cannot be caused by ingestion, exposure, or implanted device.

Conditional Payment: Fixed Percentage

- Available for Liability cases
- Must settle for $5,000.00 or less
- Physical trauma based injury
- Must request within specific timeframe
- No final demand letter issued
- No other settlement dollars anticipated or expected

Practice Tips

- Include MSP language in the earliest possible writing:
  - High-low agreements (even if on “the courthouse steps”)
  - Mediation agreements
  - Arbitration Agreements
  - Failure to include complete MSP language early may prohibit you from including it in a later writing.

Practice Tips

- Confidentiality Clauses
  - You will need to provide settlement information to CMS for conditional payment purposes. Make sure all parties are aware of this disclosure requirement. Discuss up-front if this disclosure will violate the confidentiality clause.

Statute of Limitations:

- In general there is a three year statute of limitations for most MSP recovery actions. Therefore, ensure you have all file related records for a minimum of three years. Our office recommends keeping a complete electronic copy for minimum of seven years.

Practice Tips

- To ensure you obtain all Medicare Conditional payment information (A, B, C, and D); obtain a copy of the front and back of all “insurance cards” issued to the Plaintiff.

- Remember to check with Plaintiff from time to time to see if they changed their Medicare plan *Open Enrollment!

Practice Tips

- CMS is not bound by any allocation of settlement dollars in the Release Agreement. Therefore, even if all settlement dollars are allocated for “non-medical” damages or “pain and suffering” CMS may still determine that future medical damages were in fact “released” as part of the settlement agreement. CMS will look at the case as a whole; specifically, looking at what claims or pleas for damages were made by plaintiff in any court filing or in any formal/informal demand letter or other writing. (See CMS Dallas Regional Memo)

Practice Tips

- If there is no need for a Future medical allocation (MSA) in your settlement, state that and state the reason why no allocation is necessary.

*if you have a “no treatment” statement make sure to include it as an exhibit to the settlement release agreement.

Practice Tips

- Consider placing a portion of the settlement dollars in an escrow/trust account until all MSP issues are resolved.

- This can be a good strategy to meet statutory requirements to disburse settlement funds in 30-60 days; but still ensure funds are available to fund an MSA or reimburse a conditional payment amount.

Conclusion

- If you believe you have MSP issues in your case, address them early.
- If you feel overwhelmed, consult an expert.
- Do not ignore the statute and “hope for the best”.

THANK YOU!

Section 111 Reporting Requirement Presentation Outline

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Introduction: The following is a brief outline of the pertinent facts regarding Section 111 of the Medicare/Medicaid SCHIP Extension Act of 2007. CMS is still modifying and refining many of the procedures regarding Section 111 reporting; therefore, it is important to check the CMS website (see section VI of this outline for website) regularly for the most current information.

I. **Alphabet Soup**: The following is a list of some of the key acronyms that are often utilized when discussing the Section 111 reporting requirement.

a. CMS: Centers for Medicare and Medicaid Services
b. COB: Coordination of Benefits Program
c. COBC: Coordination of Benefits Contractor
d. COBSW: COB Secure Web Site
e. HIPAA: Health Insurance Portability and Accountability Act of 1996
f. HICN: Health Insurance Claim Number
g. MBI: Medicare Beneficiary Identifier (replacing HICN)
h. MBD: Medicare Beneficiary Database
i. MMSEA: Medicare, Medicaid and SCHIP Extension Act of 2007
j. MSP: Medicare Secondary Payer
k. MSPRC: Medicare Secondary Payer Recovery Contractor
l. NGHP: Non Group Health Plan or Liability Insurance (including Self Insurance), No-Fault Insurance and Workers' Compensation
m. ORM: Ongoing Responsibility for Medicals
n. RRE: Responsible Reporting Entity
o. RRE ID: Responsible Reporting Entity Identification Number or Section 111 Reporter ID
p. TPOC: Total Payment Obligation to Claimant

Notes:_____
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II. History of the MMSEA

a. On December 29, 2007 President Bush signed into law the MMSEA. Section 111 of this Act modified the reporting and notification requirements of the Medicare Secondary Payer Act.

b. Section 111 of the MMSEA required that Group Health Insurance providers as well as Non Group Health Plans (including Self Insurance, No-Fault Insurance, and Workers Compensation) notify the federal Medicare program when the plan accepts a claim filed by a Medicare beneficiary as compensable or settles the medical portion of a claim filed by a Medicare beneficiary.

c. Section 111 became law on July 1, 2009, but implementation of the reporting requirement was delayed for several years.

d. Workers Compensation Claims involving Medicare Beneficiaries first started filing official quarterly reports with the COB on January 1, 2011.

e. Non-Workers' Compensation claims (Third Party Liability) began reporting claims and settlements to the COB on January 1, 2012.

f. Section 111 Reporting applies only to cases involving Medicare beneficiaries. If the claimant/injured party is not eligible for Medicare there is no obligation to report the claim/settlement to CMS.

Notes:_____
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III. Practical application of Section 111 Reporting

a. Who or What entity must report a claim/settlement to Medicare: All responsible reporting entities must ensure compliance with Section 111 reporting. CMS has indicated the following as RREs: Carriers, Self Insured Employers, Joint Pools, and State Assigned Funds. Third Party Administrators are generally not RREs except for their own insured workers' compensation or liability claims. An RRE can designate an Agent to report on its behalf. However, use of an Agent does not exempt the RRE from paying any fines or penalties asserted by CMS for failure to report a claim or settlement timely. Note: Plaintiffs/Medicare beneficiaries are never Responsible Reporting Entities.

b. When must a claim be reported to Medicare: The RRE is obligated under Section 111 to determine if a claimant is entitled to Medicare on any basis and report any such claims. To assist the RRE or its designated agent in confirming Medicare eligibility, CMS has allowed RREs access to the Social Security Database by performance of a "Query Search". The Query Search can be performed one time

per month by the RRE or its Agent. The Query Search will notify the RRE if their was a "match" in the Federal Database for a specific claimant as a "Medicare beneficiary". Once it has been determined that a claimant is a Medicare beneficiary, the RRE must report the claim when the following conditions are met:

i. The TPOC Trigger: Reporting is required upon claim resolution via a settlement, judgment, award or other payment to the Medicare Beneficiary. For 2017 the TPOC threshold for reporting is $750.00. A new MSP compliance threshold will be issued for 2019.

ii. The ORM Trigger: Reporting is required when the RRE has assumed an "ongoing responsibility for medical payments". ORM requires two reports: the first when the RRE assumes the responsibility for payment of medical expenses and the second when the ORM obligation has been terminated. The trigger for ORM is when the RRE assumes responsibility for medical payments; not when the first medical payment is actually paid. Medical payments do not actually have to paid on the claim for ORM reporting to be required.

c. What data must be reported to Medicare: The standard Section 111 Claim Input File contains approximately 132 individual data fields. If the claim involves multiple claimants or TPOC amounts, it may be necessary to file an Auxiliary Record. The Auxiliary file contains an additional 105 data fields. Data to be reported includes but is not limited to:

i. Name of Medicare Beneficiary
ii. Name and contact information for the Beneficiary's attorney
iii. Name and contact information for the RRE
iv. Date of injury
v. Description of injury/body party involved in the claim
vi. ICD-9 or ICD 10 codes for all diseases and body parts involved in the claim
vii. TPOC (settlement) amount
viii. Indication if ORM has been assumed and date ORM terminated

Notes:_____
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IV. What are the Penalties for failing to comply with Section111: Failure to report a claim timely will result in a penalty up to $1,000.00 per day per claim. NOTE: The Smart Act passed in January 2013 made this daily penalty discretionary. Also the Smart Act directed the Department of Health and Human Services to determine "safe

harbor" situations where this penalty may not be imposed if good faith efforts were made to identify a Medicare beneficiary.

December 2018: CMS issued an alert notifying the Stakeholder Community of the Agency's intent to publish a Notice of Proposed Rule Making by September 2019 addressing the civil money penalty attributable to Section 111 Reporting.

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V. Overall impact of the reporting requirement on Litigants and their Case:

a. Due to the possible significant penalty for failure to comply with the Section 111 reporting requirement, many defendants are delaying settlement negotiations until after the Query Search including the plaintiff's identifying information has been completed thus confirming the plaintiff's Medicare status. CMS is encouraging all plaintiffs and their attorneys to cooperate with defendants and provide the necessary information to complete the query search.

b. If a case takes several months or years to reach a conclusion, it is likely the Defendant(s) will confirm the plaintiff's Medicare status several times throughout the life of the case.

c. If a claim involves multiple RREs, each RRE must comply with the Section 111 reporting requirements. There cannot be one report filed for all RREs in the same case.

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VI. Resources:

a. For additional information go to: http://www.cms.hhs.gov/mandatoryinsrep

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Medicare Conditional Payment Outline

Prepared by:

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The purpose of this handout is to provide a practical guide to the Medicare lien search process (also known as the Medicare Conditional Payment). It is not intended to provide a historical or theoretical overview of the lien search process, but rather to provide helpful tips and guidance to assist the practitioner in obtaining both the tentative and final Medicare lien amount.

I. Step by Step Guide to obtaining the Lien amount (Conditional Payment)

a. As of February 2014 all conditional payment recovery efforts for Medicare Part A and Medicare Part B are handled by the Benefits Coordination & Recovery Center (BCRC). The MSPRC is no longer a relevant contractor and all work previously performed by the MSPRC is now handled by the BCRC.

b. As of October 5, 2015 the BCRC only handles Medicare Part A/B conditional payment recovery efforts for Liability Cases and cases where CMS is seeking direct recovery of conditional payments from the Medicare beneficiary.

c. Once initial case data is provided to the BCRC a file will be established in the BCRC system within 5-7 business days

d. Once the file has been created in the system, draft a letter to the BCRC specifically notifying them of the case and requesting the lien amount

e. Thirty to forty-five days after you send your letter, you will receive the Tentative Medicare lien notice from the BCRC. NOTE: Do not pay the tentative lien amount.

f. Review the tentative lien letter; if you believe an error has occurred and the BCRC has included inappropriate payments for reimbursement, you can draft a dispute letter to the BCRC requesting the lien amount be corrected/modified. The dispute process generally takes 1.5-3 months.

g. If you are satisfied with the tentative lien amount, send a letter to the BCRC with a copy of the fully executed settlement agreement and proof of attorney's fees and costs for the Medicare beneficiary and request the final Medicare lien amount.

h. Once you receive the final Medicare lien amount you will have 60 days to pay the lien. Failure to pay the lien amount within 60 days will result in the BCRC accruing interest on the lien amount.

i. In 2009 The Arizona District Court imposed an injunction on CMS from placing conditional payment funds in collections proceedings while an appeal or waiver request was pending. On September 4, 2013 the Ninth Circuit Court of Appeals issued an opinion overturning the 2009 injunction. See Haro v. Sebelius September 4, 2013 included with these materials.

j. On October 5, 2015 the Commercial Repayment Center (CRC) started lien collection practices for any new case filed after October 5, 2015 where CMS is seeking direct recovery of the debt from the Workers' Compensation carrier or No Fault carrier. The BCRC will continue to handle all debt collection proceedings against the Medicare beneficiary and in Liability cases.

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k. The CRC will issue a Conditional Payment Notice (not letter; CPN) to the responsible entity when notice is given of an on-going responsibility for medical (ORM) through Section 111 reporting by a responsible reporting entity (RRE). Once the CPN is issued the RRE must respond within 30 days if it wishes to dispute any charges outlined in the Conditional Payment Notice. If no response is made within the 30 day time period the CRC will automatically issue a Final Demand notice which must be paid within the time frame indicated on the final demand notice. The RRE does have formal appeal rights if it wishes to appeal the final demand amount. This process is only for ORM notification. The CRC may issue multiple Conditional Payment Notices on a file until the file is closed and ORM terminated.

l. The CRC will review the file a minimum of once per year and a maximum of four times per year. During any such review, if conditional payments are identified the RRE will receive a CPN. Therefore, it is possible the CPN and lien recovery process may happen as frequently as four times per year until the case is closed and ORM is terminated. If no conditional payments are identified at the time of a CRC file review, no letter will be generated.

m. For conditional payment recovery files at the BCRC, the Medicare beneficiary is the primary debtor of record. For conditional payment recovery files at the CRC the Primary Payer or Plan is the primary debtor of record. The primary debtor of record is the entity from which CMS will first seek recovery of the conditional payment amount. The primary debtor of record is the only entity that can dispute or appeal a conditional payment amount. NOTE: CMS can still seek recovery from the Primary Plan or Payer even if they are not the initial primary debtor of record on a file (42 CFR 411.24(i)).

n. Beginning January 1, 2016 there is the option to begin the process of determining the final Medicare A/B conditional payment amount from the BCRC prior to settlement. The process is called The Final CP Process. To utilize this new process the parties must be within 120 days of settling the claim. A number of other procedures apply to this process, including the requirement that the claim must be settled within three (3) days after the final conditional payment amount is requested. Failure to meet any of the time periods required by the Final CP Process voids the entire process. NOTE: The Final CP process can only be done one time per claim. If you begin the process and it is voided for any reason you cannot re-start the process.

o. Beginning April 1, 2019 an Electronic Payment option for the Medicare A/B conditional payment amounts will be available.

II. Helpful Hints

a. Provide a detailed description of the body part or illness that is the subject matter of the pending settlement. Also include a list of non-accident related medical conditions and specifically notify the BCRC or CRC that payments for the non-accident related medical conditions should not be included in the lien amount.

b. If you believe conditions such as financial hardship may exist that limit the party's ability to fully satisfy the lien amount, include these details in your initial contact letter with the BCRC. Do not wait to plead these factors in an appeal or waiver request.

c. Waivers of the conditional payment amount can only be requested after the Final Conditional Payment Letter has been issued by the BCRC. Therefore, you must be mindful of interest accruing while your waiver request is pending.

d. A compromise of the conditional payment amount issued by the BCRC can be proposed at any time; however, these decisions are reviewed directly by the CMS Regional Offices and the decisions cannot be appealed.

e. The Medicare lien search process can take several months to complete; therefore, it may be prudent to begin the process well before settlement negotiations begin.

f. If it is necessary for CMS to take legal action to recover the conditional payment amount from the primary payer, CMS may recover twice the amount. (42 CFR 411.24 (c)(2)).

g. As of January 1, 2019 CMS will not exercise its MSP right of recovery for cases that settle for $750.00 or less.

h. If your Liability case settles for $25,000.00 or less you may have the option of self-calculating your final Conditional Payment Amount prior to settlement. However, a number of conditions apply for this option to be valid. See model language from BCRC (formally the MSPRC) included with materials. NOTE: This calculation method is not available for workers compensation or no fault cases.

i. If your Liability case settles for $5,000.00 or less you can elect to pay a fixed percentage of the total settlement amount (25%) as the conditional payment amount. See model language from BCRC included with materials. NOTE: This calculation method is not available for workers compensation or no fault cases.

j. At present there is a split in the circuits regarding whether or not Medicare must apportion its conditional payment amount. See Bradley v. Sebelius and Hadden v. USA both included with these materials.

k. CMS can either assert a recovery action against the primary payer (42 USC1395(b)(2)(B)(iii)) or against any entity that received payment from the primary payer or proceeds from a payment made by the primary payer including the attorney representing the Medicare beneficiary (42 CFR 411.24(g)). See: United States v. Paul J. Harris included with these materials.

l. Effective July 10, 2013 a three year statute of limitations will apply to certain MSP recovery actions. The three year statute of limitations will begin to run upon receipt of the Section 111 report. (See the Smart Act for more information)

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m. Please be aware that the conditional payment search through the BCRC and CRC is for payments made by Medicare Parts A/B only. If the injured person is participating in a Medicare Part C (HMO/Medicare Advantage plan) or a Medicare Part D (drug) plan additional conditional payment searches will be required with the Part C/D plan administrator(s). Please see In Re Avandia and Humana v. Western Heritage Insurance Company (2016 decision) for a discussion of Part C Plan recovery rights.

n. Regarding Part C plan recoveries: in March 2018 United States District Court for Connecticut held that a Part C plan could bring a private cause of action for recovery of unpaid conditional payments but could only bring the recovery action against the Defendant (the primary plan or payer). The Part C plan could not bring the recovery action against the Medicare beneficiary or the Beneficiary's attorney. Given the holding in this case, Defendants who allow Plaintiff's to do the Part C conditional payment search must obtain copies of all letters and documents from the Part C provider. Further, it is recommended that the Defendant pay the Part C provider directly rather than distributing all settlement funds to plaintiff. See: Aetna Life v Guerrera.

o. NOTE: If you have reason to believe Medicare has made payments for the injury in question, but the Medicare A/B lien search (from the BCRC or CRC) comes back showing a zero-dollar conditional payment amount; this is likely a red-flag that the person is participating in a Medicare Part C plan. You must inquire with the Medicare Beneficiary or their attorney and determine if the beneficiary has opted into a Part C plan.

p. NOTE: If the injured party ever required prescription medications for the injury in question, it is recommended that the attorney ascertain how these medications were paid. If paid by a Medicare Part C or D plan, an additional Medicare conditional payment search is required.

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q. California Insurance Guarantee Associates (CIGA) v. Burwell et. al. On January 5, 2017 Judge Wright ruled on a Motion to Dismiss and Motions for Summary Judgment. CIGA argued that CMS had no right to seek recovery for conditional payments with ICD codes unrelated to the compensable workers' compensation injury. The Judge agreed with CIGA and determined that CMS could not seek full recovery for a conditional payment amount simply because the date of service in question include one code related to the compensable work injury. The Judge determined that even the MSP code and internal rules indicated that CMS was to be reimbursed for a "service" or an "item". The Judge did not find CMS' argument persuasive when the government indicated that it was the Agency's practice to "seek full reimbursement for a conditional payment as long as one diagnosis code was related." However, before the practitioner gets too excited regarding the CIGA case, the final determination from the Judge indicates as follows: "The presence of one covered code does not ipso facto make CIGA responsible for reimbursing the full

amount of the charge. Instead, CMS must consider whether the charge can reasonably be apportioned between covered and uncovered codes or treatments. Upon such consideration, CMS might still conclude that apportioning the charge is unreasonable. In addition, even if the charge should be apportioned, the Court takes no position on how CMS should do so (e.g., pro-rata by covered codes versus uncovered codes, or some other method)." A copy of the CIGA case is included with these materials.

r. Future Medical Obligation: 42 CFR 411.39(d) is titled "Obligations with respect to future medical items and services" and states: Final conditional payment amounts obtained via the web portal represent Medicare covered and otherwise reimbursable items and services that are related to the beneficiary's settlement, judgement, award or other payment. This means if the web portal is utilized for the final conditional payment process, Parties to settlement must ensure that they are only paying for transactions with ICD-9 and ICD-10 codes related to your specific injury. If you pay for a code unrelated to the actual injury, Medicare may refuse to pay for it in the future. It is important to review the codes in both the tentative and final conditional payment letter very carefully prior to issuing any payment. The CFR section is vague and it is unclear if it applies to all requests for the final conditional payment amount through the web portal or only those claims utilizing the "120 day" process that went into effect January 1, 2016.

s. June 18, 2018: Press Release from the United States Attorney's Office Eastern District of Pennsylvania. Settlement reached with plaintiff's law firm that required the firm to pay a financial settlement to the government, make internal policy and staffing changes, and required the firm to acknowledge a possible False Claims Act violation due to the wrongful retention of government funds.

III. Where to find additional information

a. For additional information regarding the lien search process, including copies of letter templates from the BCRC, go to: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html

b. For verification of a person's Social Security or Medicare status, a benefits verification letter can be requested here: https://www.ssa.gov/myaccount/

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Medicare Set Aside Presentation Outline

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Introduction: The following is a brief outline of the topics surrounding Medicare's interests in liability/no-fault settlements. The outline is not all-inclusive, but is intended to provide a general overview of Medicare issues. Each settlement scenario is unique and requires individual review and analysis to determine the appropriate course of action. A skilled Medicare compliance attorney should always be contacted before proceeding to settlement if you believe Medicare issues exist within the claim you are attempting to settle.

NOTE: The term Medicare set aside (MSA) is utilized in this outline as indicative of one tool utilized to ensure compliance with the Medicare Secondary Payer Act (MSP); specifically, compliance with the statutory requirement to maintain Medicare's secondary payer status any time settlement funds include consideration for a claim of future or permanent medical damages made by an injured party.

I. When Do I need a Medicare Set Aside (MSA) (Liability/No-Fault)?

a. If you are settling a liability/no-fault claim simultaneously with a workers' compensation claim or with a longshore claim, a MSA is required. This is also known as a global settlement (see Question 19 of the April 22, 2003 CMS Memorandum.)

b. A MSA is required in a global settlement even if the workers' compensation carrier does not put in any "new money" to the settlement offer and simply waives any lien it may be entitled to assert against the liability/no-fault settlement proceeds.

c. If the settlement is solely a liability settlement compliance with the MSP statute's requirement to maintain Medicare's secondary payer status is still required. During an October 29, 2008 CMS conference call regarding the Mandatory Insurer Reporting requirement, Ms. Barbara Wright of CMS stated: "….I don't believe there is a General Counsel Memo that says that there are no liability set asides. We, in brief, we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for workers' comp." CMS further reiterated its position during the March 24, 2009 conference call regarding the Mandatory Insurer

Reporting Requirement. During the March 2009 conference call, CMS officials restated CMS' position that the same statutory framework necessitating MSAs in workers' compensation settlements also mandate the creation of MSAs in liability situations. Especially liability settlements intended to compensate the injured party for at least some of their future medical expenses.

d. The statute CMS is relying on to mandate MSA allocations in non-workers' compensation settlements is: 42 USC 1395(y). A copy is included with these materials.

e. In May 2011 the CMS Dallas Regional Office issued a detailed policy memo for its Region making it clear that the MSP statute applies to liability settlements where a claim for future or permanent medical damages was made by the injured party and this claim is being released by the settlement agreement.

f. In June 2012 CMS published in the Federal Register seven "options" some of which will become formal agency rules for determining Medicare's future medical interests in liability and workers compensation settlements. NOTE: the options are intended as a guide for compliance with the MSP statute. But failure of CMS to finalize the options into formal agency rules does not nullify the MSP. Parties are still required to comply with the MSP and ensure Medicare remains the secondary payer when settlement funds are intended to compensate a person for medical damages

g. The June 2012 "options" were withdrawn by CMS in October 2014. It is believed that further information/guidance from CMS will be forthcoming to replace the 2012 "options" however; no time period from CMS has been announced as to when further data will be published.

h. Aranki vs. Burwell: Case out of Arizona October 16, 2015. This case has been held up by some attorneys as standing for the principle that liability settlements need not comply with the requirement of the MSP statute to maintain Medicare's secondary payer status as required by the MSP statute. Unfortunately the case is a declaratory judgement case and the only question required for answer by the judge was "can CMS mandate use of an MSA in a medical malpractice case?" Unfortunately the question is moot as even CMS has stated the "MSA" is not required by the MSP statute. CMS has stated there may be other "methods" by which a settlement or payment complies with the MSP statutory requirements. However, to date, the MSA is the only such tool or vehicle approved by CMS as compliant with the MSP statutory requirement to maintain Medicare's secondary payer status. **No one is disputing the applicability of the MSP statute, the only question is how to comply with the statute**. Unfortunately the Aranki case does not answer this question.

i. On June 9, 2016 CMS issued a technical alert indicating that the MSA review process may be expanded to include formal review of Liability MSAs and No Fault MSAs. At this time, the formal MSA review process will likely be expanded to

include Liability and No Fault MSAs in 2019. However, this does not mean no MSA is required until 2019 in these cases. The MSP statute is still applicable to liability and no fault cases. CMS review of any MSA, even in workers' compensation, is voluntary. The fact that the formal MSA review process has not yet been expanded to include no fault and liability cases does not lessen the impact or authority of the MSP statute. NOTE: This technical alert was reissued in October 2017.

j. On May 10, 2017 CMS issued a Medicare Learning Network Bulletin which indicates CMS is implementing two new MSA processes: one for liability settlements and one for no fault settlements. Further, if a settlement does not include an MSA, the Medicare billing claim will be handled under existing MSP procedures. The MSP statute allows CMS to deem the entire "primary payment" (or in this case, settlement amount) as primary to Medicare. Therefore, it is possible the CMS will not pay for future medical care post-settlement until the entire settlement amount is exhausted rather than a lesser amount of the settlement utilized to fund an MSA allocation. Changes to the common working file became effective October 1, 2017.

k. On November 8, 2017 CMS issued an MLN educational bulletin to the medical community. The educational bulletin specifically advised all medical providers that Medicare is always a secondary payer to liability, no fault, and workers compensation settlements. Further, the medical community was alerted that when notified by a patient of settlement of their liability, no fault, or workers compensation claim, the medical provider should be paid from settlement proceeds. Further, the medical providers are informed that Medicare should not be billed for future medical services until settlement funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

l. December 2018: CMS issued an alert notifying the stakeholder community of the Agency's intent to publish a Notice of Proposed Rule Making by September 2019. The title of the notice is "Miscellaneous Medicare Secondary Payer Clarifications and Updates." The intent of the proposed rule is to allow Medicare beneficiaries the opportunity to select "an option for meeting future medical obligations that fits their individual circumstances, while also protecting the Medicare Trust Fund."

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II. When Can I Get CMS Approval of the Proposed MSA Figure and How Long Does it Take?

a. CMS approval of a proposed MSA figure is always optional for every settlement; no CMS regulation requires approval.

b. CMS Workers' Compensation review thresholds: CMS will only review proposed MSA figures for the following situations:

    i. For Medicare eligible persons: CMS approval can only be obtained if the total settlement value exceeds $25,000.00.

    ii. For non-Medicare eligible persons: CMS approval can only be obtained if both of the following criteria are met: 1) there is a reasonable expectation that the injured person will be Medicare eligible within 30 months of the date of settlement, and 2) the total settlement value exceeds $250,000.00.

c. CMS approval generally takes 2 to 4 months. CMS decisions may be appealed, but will require additional approval time.

d. It is believed CMS will use the same review thresholds for liability/no-fault MSA submissions, but this has not been confirmed in writing by CMS.

e. <u>An MSA should still be done even if the CMS review thresholds are not met</u>.

f. NOTE: Liability/no-fault MSA proposals are being reviewed by the CMS Regional Offices on a case-by-case basis. Each Regional Office is establishing its own set of review criteria for Liability MSA submissions. It is believed CMS will expand the formal MSA review process to include liability and no-fault MSAs in 2020.

g. NOTE: Effective July 31, 2017 parties to a workers' compensation settlement can seek re-review of a previously approved workers' compensation MSA where no settlement occurred, if all of the following criteria are met: 1) CMS issued an approval letter at least 12 but not more than 48 months prior to the re-review request, 2) the case has not yet settled as of the date of the request for re-review, 3) projected care has changed so much that the submitter's new proposed MSA amount would result in a 10% or $10,000.00 change (whichever is greater) in CMS' previously approved amount, 4) Where a re-review request is reviewed and approved by CMS, the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased.

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III. What Types of Medical Care Must be Included in the MSA?

a. All regular and ongoing medical care to the injured party, including, but not limited to: physician office visits, prescribed medications, diagnostic testing, physical therapy, and durable medical equipment.

b. All medical care anticipated to take place in the future and as necessitated by the work injury, including, but not limited to: all recommended surgeries, pain management injections, and the purchase or replacement of durable medical equipment.

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IV. Will CMS Approve a $0.00 MSA Allocation?

a. CMS will approve a $0.00 MSA allocation only if the injured person has been fully discharged from all treatment for the work injury by the treating physician, and no settlement funds are allocated for future medical needs (see question 20 of the April 22, 2003 CMS Memorandum.) (Also see Liability MSA policy CMS policy memo September 29, 2011.)

b. CMS may approve a $0.00 MSA allocation in a workers' compensation settlement if the claim has been fully denied or disputed. Obtaining CMS approval in disputed cases is always recommended as CMS may demand an increase to the proposed MSA allocation. NOTEL $0.00 CMS submissions require a great deal of data and letters. Data will be required from both the injured worker and the workers compensation carrier. CMS changes the requirements for a $0.00 MSA periodically and, sometimes with very little notice of the change.

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V. What May Help to Decrease an MSA?

a. Rated ages.

b. Statements from the treating physician that the injured party is no longer a candidate for certain medical procedures, such as surgeries, intrathecal pain pumps, and spinal cord stimulators.

c. Statements from the injured party that they do not wish to proceed with a recommended surgery or treatment now or in the future. (Note: CMS is not necessarily bound by these statements and may still request an increase to the proposed MSA even if they are obtained.)

d. A statement from the treating physician that the party can be switched from brand name to generic prescription medications.

e. NOTE: 42 CFR 411.47 cannot be utilized to reduce future medical funding. CMS specifically stated this in its July 11, 2005 memorandum.

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VI. How is the MSA Account Funded?

a. One time lump sum payment.

b. Structured annuity approach. CMS requires that structured MSA accounts be initially funded with a seed payment in year one, with the annuity payments beginning one year post-settlement.

c. Fiscal Impossibility MSA for Liability Settlements. CMS has verbally indicated that it will consider lesser funding amounts in those liability cases where the gross settlement amount is significantly less than what would be required to fully fund an MSA account for the life expectancy of the injured person. CMS has not written any guidelines regarding "fiscal impossibility" MSA submissions, so each such submission is being reviewed on its individual merits. Use of a fiscal impossibility MSA is considered highly aggressive and the parties to settlement utilizing such an MSA should submit the file to CMS for review. (NOTE: This approached was developed by HCS and is not necessarily utilized by other Medicare Compliance firms)

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VII. How is the MSA Account Administered?

a. Self-administered by the injured person.

b. Self-administered by the injured person with the assistance of a competent adult (commonly used in head injury cases or cases with elderly persons suffering from dementia.)

c. Professionally administered by a third party custodial company. (NOTE: All professional administrators charge a fee for their services. CMS requires that these fees must be funded separately from the MSA funds.)

d. Note: Medicaid: MSA funds are countable assets for determining Medicaid eligibility. Therefore, Medicaid recipients should utilize a Disability Trust (Special needs) or a Community/pooled trust for MSA funds to ensure on-going eligibility for Medicaid and other needs-based programs.

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VIII. Section 111: The Mandatory Insurer Reporting Requirement

a. On December 29, 2007 President Bush signed into law the Medicare, Medicaid and SCHIP Extension Act (MMSEA). Section 111 of the MMSEA required that all workers' compensation and liability/no-fault insurers and benefit providers (i.e. self-insured entities) report to CMS any time they accept responsibility for payment of a Medicare beneficiary's medical treatment and when that responsibility for payment terminates (i.e. there is a settlement, judgment, or other award that terminates or closes the claim for benefits).

b. Workers' compensation claims settled on or after October 1, 2010 must be reported to the federal government through a secure website.

c. Liability claims/settlements began reporting settlements on January 1, 2012.

d. Additional information regarding the new reporting requirements can be found at the official CMS website: http://www.cms.hhs.gov/mandatoryinsrep

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§401.613 Compromise of claims.

(a) *Amount of compromise.* HFCA requires that the amount to be recovered through a compromise of a claim must—

(1) Bear a reasonable relation to the amount of the claim; and

(2) Be recoverable through enforced collection procedures.

(b) *General factors.* After considering the bases for a decision to compromise a claim under paragraph (c) of this section, CMS may further consider factors such as—

(1) The age and health of the debtor if the debtor is an individual;

(2) Present and potential income of the debtor; and

(3) Whether assets have been concealed or improperly transferred by the debtor.

(c) *Basis for compromise.* Bases on which CMS may compromise a claim include the following—

(1) *Inability to pay.* CMS may compromise a claim if it determines that the debtor, or the estate of a deceased debtor, does not have the present or prospective ability to pay the full amount of the claim within a reasonable time.

(2) *Litigative probabilities.* CMS may compromise a claim if it determines that it would be difficult to prevail in a case before a court of law as a result of the legal issues involved or inability of the parties to agree to the facts of the case. The amount that CMS accepts in compromise under this provision will reflect—

(i) The likelihood that CMS would have prevailed on the legal question(s) involved;

(ii) Whether and to what extent CMS would have obtained a full or partial recovery of a judgment, depending on the availability of witnesses, or other evidentiary support for CMS's claim; and

(iii) The amount of court costs that would be assessed to CMS.

(3) *Cost of collecting the claim.* CMS may compromise a claim if it determines that the cost of collecting the claim does not justify the enforced collection of the full amount. In this case, CMS may adjust the amount it accepts as a compromise to allow an appropriate discount for the costs of collection it would have incurred but for the compromise.

(d) *Enforcement policy.* CMS may compromise statutory penalties, forfeitures, or debts established as an aid to enforcement or to compel compliance, if it determines that its enforcement policy, in terms of deterrence and securing compliance both present and future, is adequately served by acceptance of the compromise amount.

§401.615 Payment of compromise amount.

(a) *Time and manner of compromise.* Payment by the debtor of the amount that CMS has agreed to accept as a compromise in full settlement of a claim must be made within the time and in the manner prescribed by CMS. Accordingly, CMS will not settle a claim until the full payment of the compromise amount has been made.

(b) *Effect of failure to pay compromise amount.* Failure of the debtor to make payment, as provided by the compromise agreement, reinstates the full amount of the claim, less any amounts paid prior to the default.

(c) *Prohibition against grace periods.* CMS will not agree to inclusion of a provision in an installment agreement that would permit grace periods for payments that are late under the terms of the agreement.

§401.617 Suspension of collection action.

(a) *General conditions.* CMS may temporarily suspend collection action on a claim if the following general conditions are met—

(1) *Amount of future recovery.* CMS determines that future collection action may result in a recovery of an amount sufficient to justify periodic review and action on the claim by CMS during the period of suspension.

(2) *Statute of limitations.* CMS determines that—

(i) The applicable statute of limitations has been tolled, waived or has started running anew; or

(ii) Future collections may be made by CMS through offset despite an applicable statute of limitations.

by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) *Scope.* This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

[60 FR 45361, Aug. 31, 1995, as amended at 71 FR 9470, Feb. 24, 2006]

§411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

Coverage or *covered services*, when used in connection with primary payments, means services for which a primary payer would pay if a proper claim were filed.

Monthly capitation payment means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

Plan means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

Primary payer means, when used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary payment means, when used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

Primary plan means, when used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

Prompt or *promptly*, when used in connection with primary payments, except as provided in §411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 45361, Aug. 31, 1995; 71 FR 9470, Feb. 24, 2006]

§411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.

(a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

(b) A primary payer's responsibility for payment may be demonstrated by—

(1) A judgment;

(2) A payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included

in a claim against the primary payer or the primary payer's insured; or

(3) By other means, including but not limited to a settlement, award, or contractual obligation.

(c) The primary payer must make payment to either of the following:

(1) To the entity designated to receive repayments if the demonstration of primary payer responsibilities is other than receipt of a recovery demand letter from CMS or designated contractor.

(2) As directed in a recovery demand letter.

[71 FR 9470, Feb. 24, 2006, as amended at 73 FR 9684, Feb. 22, 2008]

§411.23 Beneficiary's cooperation.

(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.

§411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) *Release of information.* The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) *Right to initiate recovery.* CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) *Amount of recovery.* (1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment recipient, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) *Methods of recovery.* CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) *Recovery from primary payers.* CMS has a direct right of action to recover from any primary payer.

(f) *Claims filing requirements.* (1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is a primary plan to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) *Recovery from parties that receive primary payments.* CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

(h) *Reimbursement to Medicare.* If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) *Special rules.* (1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the

[Code of Federal Regulations]
[Title 42, Volume 2]
[Revised as of October 1, 2010]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR411.24]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 411_EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT--Table of Contents

Subpart B_Insurance Coverage That Limits Medicare Payment: General Provisions

If a Medicare conditional payment is made, the following rules apply:

(a) Release of information. The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) Right to initiate recovery. CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) Amount of recovery. (1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment recipient, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) Methods of recovery. CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) Recovery from primary payers. CMS has a direct right of action to recover from any primary payer.

(f) Claims filing requirements. (1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is a primary plan to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) Recovery from parties that receive primary payments. CMS has a

right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

(h) Reimbursement to Medicare. If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) Special rules. (1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of Sec. 411.37(b) applies.

(j) Recovery against Medicaid agency. If a primary payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the primary payment, whichever is less.

(k) Recovery against Medicare contractor. If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, CMS may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) Recovery when there is failure to file a proper claim--(1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions: (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim

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is due to mental or physical incapacity of the beneficiary.

(ii) CMS will not recover from providers or suppliers that are in compliance with the requirements of Sec. 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) Interest charges. (1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision--

(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by CMS, is charged until reimbursement is made, and is applied for full 30-day periods; and

(iii) The rate of interest is that provided at Sec. 405.378(d) of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45361, 45362, Aug. 31, 1995; 69 FR 45607, July 30, 2004; 71 FR 9470, Feb. 24, 2006]

Title 42: Public Health
PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT
Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

§411.39 Automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation: Final conditional payment amounts via Web portal.

(a) *Definitions.* For the purpose of this section the following definitions are applicable:

Applicable plan means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement:

(1) Liability insurance (including self-insurance).

(2) No fault insurance.

(3) Workers' compensation laws or plans.

(b) *Accessing conditional payment information through the Medicare Secondary Payer Web portal*—(1) *Beneficiary access.* A beneficiary may access his or her Medicare Secondary Payer conditional payment information via the Medicare Secondary Payer Recovery Portal (Web portal), provided the following conditions are met:

(i) The beneficiary creates an account to access his or her Medicare information through the CMS Web site.

(ii) The appropriate Medicare contractor has received initial notice of a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment and has posted the recovery case on the Web portal.

(2) *Beneficiary's attorney or other representative or applicable plan's access using the multifactor authentication process.* A beneficiary's attorney or other representative or an applicable plan may do the following:

(i) Access conditional payment information via the MSP Recovery Portal (Web portal).

(ii) Dispute claims.

(iii) Upload settlement information via the Web portal using multifactor authentication.

(c) *Obtaining a final conditional payment amount.* (1) A beneficiary, or his or her attorney or other representative, or an authorized applicable plan, may obtain a final conditional payment amount related to a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment using the following process:

(i) The beneficiary, his or her attorney or other representative, or an applicable plan, provides initial notice of a pending liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlement, judgment, award, or other payment to the appropriate Medicare contractor before accessing information via the Web portal.

(ii) The Medicare contractor compiles claims for which Medicare has paid conditionally that are related to the pending settlement, judgment, award, or other payment within 65 days or less of receiving the initial notice of the pending settlement, judgment, award, or other payment and posts a recovery case on the Web portal.

(iii) If the underlying liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim derives from one of the following, the beneficiary, or his or her attorney or other representative, must provide notice to CMS' contractor via the Web portal in order to obtain a final conditional payment summary statement and amount through the Web portal:

(A) Alleged exposure to a toxic substance.

(B) Environmental hazard.

(C) Ingestion of pharmaceutical drug or other product or substance.

(D) Implantation of a medical device, joint replacement, or something similar.

(iv) Up to 120 days before the anticipated date of a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney, other representative, or authorized applicable plan may notify CMS, once and only once, via the Web portal, that a settlement, judgment, award or other payment is expected to occur within 120 days or less from the date of notification.

(A) CMS may extend its response timeframe by an additional 30 days when it determines that additional time is required to

address claims that Medicare has paid conditionally that are related to the settlement, judgment, award, or other payment in situations including, but not limited to, the following:

(*1*) A recovery case that requires manual filtering to ensure that associated claims are related to the pending settlement, judgment, award, or other payment.

(*2*) Internal CMS systems failures not otherwise considered caused by exceptional circumstances.

(B) In exceptional circumstances, CMS may further extend its response timeframe by the number of days required to address the issue that resulted from such exceptional circumstances. Exceptional circumstances include, but are not limited to the following:

(*1*) Systems failure(s) due to consequences of extreme adverse weather (loss of power, flooding, etc.).

(*2*) Security breaches of facilities or network(s).

(*3*) Terror threats; strikes and similar labor actions.

(*4*) Civil unrest, uprising, or riot.

(*5*) Destruction of business property (as by fire, etc.).

(*6*) Sabotage.

(*7*) Workplace attack on personnel.

(*8*) Similar circumstances beyond the ordinary control of government, private sector officers or management.

(v) The beneficiary, or his or her attorney, or other representative may then address discrepancies by disputing individual conditional payments, once and only once, if he or she believes that the conditional payment included in the most up-to-date conditional payment summary statement is unrelated to the pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment.

(A) The dispute process is not an appeals process, nor does it establish a right of appeal regarding that dispute. There will be no administrative or judicial review related to this dispute process.

(B) The beneficiary, or his or her attorney or other representative may be required to submit supporting documentation in the form and manner specified by the Secretary to support his or her dispute.

(vi) Disputes submitted through the Web portal and after the beneficiary, or his or her attorney, other representative, or authorized applicable plan has notified CMS that he or she is 120 days or less from the anticipated date of a settlement, judgment, award, or other payment, are resolved within 11 business days of receipt of the dispute and any required supporting documentation.

(vii) When any disputes have been fully resolved, the beneficiary, or his or her attorney or other representative, may download or otherwise request a time and date stamped conditional payment summary statement through the Web portal.

(A) If the download or request is within 3 days of the date of settlement, judgment, award, or other payment, that conditional payment summary statement will constitute Medicare's final conditional payment amount.

(B) If the beneficiary, or his or her attorney or other representative, is within 3 days of the date of settlement, judgment, award, or other payment and any claim disputes have not been fully resolved, he or she may not download or otherwise request a final conditional payment summary statement.

(viii) Within 30 days or less of securing a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney or other representative, must submit through the Web portal documentation specified by the Secretary, including, but not limited to the following:

(A) The date of settlement, judgment, award, or other payment, including the total settlement amount, the attorney fee amount or percentage.

(B) Additional costs borne by the beneficiary to obtain his or her settlement, judgment, award, or other payment.

(*1*) If settlement information is not provided within 30 days or less of securing the settlement, the final conditional payment amount obtained through the Web portal is void.

(*2*) [Reserved]

(ix) Once settlement, judgment, award, or other payment information is received, CMS applies a pro rata reduction to the final conditional payment amount in accordance with §411.37 and issues a final MSP recovery demand letter.

(2) An applicable plan may only obtain a final conditional payment amount related to a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment in the form and manner described in §411.38(b) if the applicable plan has properly registered to use the Web portal and has obtained from the beneficiary, and submitted to the appropriate CMS contractor, proper proof of representation. The applicable plan may obtain read only access if the applicable plan obtains from the beneficiary, and submits to the appropriate CMS contractor, proper consent to release.

(d) *Obligations with respect to future medical items and services.* Final conditional payment amounts obtained via the Web portal represent Medicare covered and otherwise reimbursable items and services that are related to the beneficiary's settlement, judgment, award, or other payment furnished before the time and date stamped on the final conditional payment summary form.

[78 FR 57804, Sept. 20, 2013, as amended at 81 FR 30492, May 17, 2016]

charges for services not covered under Medicare, $7,500 in charges for services covered under Medicare Part B, and $9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers' compensation payment rate, that is, in amounts the provider or supplier must accept as payment in full.

The Medicare reasonable charge for physicians' services was $7,000 and Medicare paid $5,600 (80 percent of the reasonable charge). The Part B deductible had been met. The Medicare payment rate for the hospital services was $8,000. Medicare paid the hospital $7,480 ($8,000—the Part A deductible of $520).

In this situation, the beneficiary's payments totalled $3,920:

Services not covered under Medicare	$1,500
Excess of physicians' charges over reasonable charges	500
Medicare Part B coinsurance	1,400
Part A deductible	520
Total	3,920

The Medicare overpayment, for which the beneficiary is liable, would be $2,080 ($6,000–$3,920).

Subpart D—Limitations on Medicare Payment for Services Covered Under Liability or No-Fault Insurance

§411.50 General provisions.

(a) *Limits on applicability.* The provisions of this subpart C do not apply to any services required because of accidents that occurred before December 5, 1980.

(b) *Definitions.*

Automobile means any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

Liability insurance means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

No-fault insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage", "personal injury protection", or "medical expense coverage".

Prompt or *promptly*, when used in connection with payment by a liability insurer means payment within 120 days after the earlier of the following:

(1) The date a claim is filed with an insurer or a lien is filed against a potential liability settlement.

(2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

Self-insured plan means a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay liability claims under the Federal Tort Claims Act.

Underinsured motorist insurance means insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

Uninsured motorist insurance means insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law, or is underinsured.

(c) *Limitation on payment for services covered under no-fault insurance.* Except as provided under §§411.52 and 411.53 with respect to conditional payments, Medicare does not pay for the following:

(1) Services for which payment has been made or can reasonably be expected to be made promptly under automobile no-fault insurance.

(2) Services furnished on or after November 13, 1989 for which payment has been made or can reasonably be expected to be made promptly under any no-fault insurance other than automobile no-fault.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990]

§411.51 Beneficiary's responsibility with respect to no-fault insurance.

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no-fault insurance.

(b) Except as specified in §411.53, Medicare does not pay until the beneficiary has exhausted his or her remedies under no-fault insurance.

(c) Except as specified in §411.53, Medicare does not pay for services that would have been covered by the no-fault insurance if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper claim, Medicare pays for the services if they are covered under Medicare.

§411.52 Basis for conditional Medicare payment in liability cases.

If HCFA has information that services for which Medicare benefits have been claimed are for treatment of an injury or illness that was allegedly caused by another party, a conditional Medicare payment may be made.

§411.53 Basis for conditional Medicare payment in no-fault cases.

A conditional Medicare payment may be made in no-fault cases under either of the following circumstances:

(a) The beneficiary, or the provider or supplier, has filed a proper claim for no-fault insurance benefits but the intermediary or carrier determines that the no-fault insurer will not pay promptly for any reason other than the circumstances described in §411.32(a)(1). This includes cases in which the no-fault insurance carrier has denied the claim.

(b) The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement stipulated in the policy.

§411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.

(a) *Definition.* As used in this section, *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions. Medicare benefits are payable notwithstanding potential liability insurance payments, but are recoverable in accordance with §411.24.

(b) *Applicability.* This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.

(c) *Basic rules*—(1) *Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(2) *Specific limitations.* Except as provided in paragraph (d) of this section, the provider or supplier—

(i) May not bill the liability insurer nor place a lien against the beneficiary's liability insurance settlement for Medicare covered services.

(ii) May only bill Medicare for Medicare-covered services; and

(iii) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under §413.35 of this chapter (when cost limits are applied to the services) or under §489.32 of this chapter (when services are partially covered).

(d) *Exceptions*—(1) *Nonparticipating suppliers.* The limitations of paragraph (c)(2) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or has not claimed payment for them under §424.64 of this chapter.

(2) *Prepaid health plans.* If the services were furnished through an organization that has a contract under section 1876 of the Act (that is, through an

(2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

Self-insured plan means a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. This term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay liability claims under the Federal Tort Claims Act. An entity that engages in a business, trade, or profession is deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

Underinsured motorist insurance means insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

Uninsured motorist insurance means insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law, or is underinsured.

(c) *Limitation on payment for services covered under no-fault insurance.* Except as provided under §§411.52 and 411.53 with respect to conditional payments. Medicare does not pay for the following:

(1) Services for which payment has been made or can reasonably be expected to be made under automobile no-fault insurance.

(2) Services furnished on or after November 13, 1989 for which payment has been made or can reasonably be expected to be made under any no-fault insurance other than automobile no-fault.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 71 FR 9470, Feb. 24, 2006]

§411.51 Beneficiary's responsibility with respect to no-fault insurance.

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no-fault insurance.

(b) Except as specified in §411.53, Medicare does not pay until the beneficiary has exhausted his or her remedies under no-fault insurance.

(c) Except as specified in §411.53, Medicare does not pay for services that would have been covered by the no-fault insurance if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper claim, Medicare pays for the services if they are covered under Medicare.

§411.52 Basis for conditional Medicare payment in liability cases.

(a) A conditional Medicare payment may be made in liability cases under either of the following circumstances:

(1) The beneficiary has filed a proper claim for liability insurance benefits but the intermediary or carrier determines that the liability insurer will not pay promptly for any reason other than the circumstances described in §411.32(a)(1). This includes cases in which the liability insurance carrier has denied the claim.

(2) The beneficiary has not filed a claim for liability insurance benefits.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

[71 FR 9470, Feb. 24, 2006]

§411.53 Basis for conditional Medicare payment in no-fault cases.

(a) A conditional Medicare payment may be made in no-fault cases under either of the following circumstances:

(1) The beneficiary has filed a proper claim for no-fault insurance benefits but the intermediary or carrier determines that the no-fault insurer will not pay promptly for any reason other than the circumstances described in §411.32(a)(1). This includes cases in which the no-fault insurance carrier has denied the claim.

(2) The beneficiary, because of physical or mental incapacity, failed to

(2) Approved waivers or modifications under this paragraph granted to any MA organization may be used by any other similarly situated MA organization in developing its bid.

(d) *Employer sponsored MA plans for plan years beginning on or after January 1, 2006.* (1) CMS may waive or modify any requirement in this part or Part D that hinders the design of, the offering of, or the enrollment in, an MA plan (including an MA-PD plan) offered by one or more employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof), or that is offered, sponsored or administered by an entity on behalf of one or more employers or labor organizations, to furnish benefits to the employers' employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations. Any entity seeking to offer, sponsor, or administer such an MA plan described in this paragraph may request, in writing, from CMS, a waiver or modification of requirements in this part that hinder the design of, the offering of, or the enrollment in, such MA plan.

(2) An MA plan described in this paragraph may restrict the enrollment of individuals in that plan to individuals who are beneficiaries and participants in that plan.

(3) Approved waivers or modifications under this paragraph granted to any MA plan may be used by any other similarly situated MA plan in developing its bid.

[65 FR 40320, June 29, 2000, as amended at 68 FR 50856, Aug. 22, 2003; 70 FR 4721, Jan. 28, 2005]

§ 422.107 Special needs plans and dual-eligibles: Contract with State Medicaid Agency.

(a) *Definition.* For the purpose of this section, a contract with a State Medicaid agency means a formal written agreement between an MA organization and the State Medicaid agency documenting each entity's roles and responsibilities with regard to dual-eligible individuals.

(b) *General rule.* MA organizations seeking to offer a special needs plan serving beneficiaries eligible for both Medicare and Medicaid (dual-eligible) must have a contract with the State Medicaid agency. The MA organization retains responsibility under the contract for providing benefits, or arranging for benefits to be provided, for individuals entitled to receive medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.

(c) *Minimum contract requirements.* At a minimum, the contract must document—

(1) The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits.

(2) The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under the Statute at sections 1902(a), 1902(f), 1902(p), and 1905.

(3) The Medicaid benefits covered under the SNP.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee's eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(d) *Date of Compliance.* (1) Effective January 1, 2010—

(i) MA organizations offering a new dual-eligible SNP must have a State Medicaid agency contract.

(ii) MA organizations with an existing dual-eligible SNP without a State Medicaid agency contract may continue to operate through 2010 provided they meet all other statutory requirements, that is, care management and quality improvement program requirements. However, they cannot expand their service areas during 2010.

(2) [Reserved]

[73 FR 54248, Sept. 18, 2008]

§ 422.108 Medicare secondary payer (MSP) procedures.

(a) *Basic rule.* CMS does not pay for services to the extent that Medicare is not the primary payer under section

1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the MA organization.* The MA organization must, for each MA plan

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions.

(c) *Collecting from other entities.* The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an MA organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the MA organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

(e) *Collecting from group health plans (GHPs) and large group health plans (LGHPs).* An MA organization may bill a GHP or LGHP for services it furnishes to a Medicare enrollee who is also covered under the GHP or LGHP and may bill the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

(f) *MSP rules and State laws.* Consistent with §422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000; 70 FR 4721, Jan. 28, 2005; 75 FR 19805, Apr. 15, 2010]

§422.109 Effect of national coverage determinations (NCDs) and legislative changes in benefits.

(a) *Definitions.* The term *significant cost*, as it relates to a particular NCD or legislative change in benefits, means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is $100,000; and

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in §422.308(a).

(2) The estimated cost of Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national average per capita costs.

(b) *General rule.* If CMS determines and announces that an individual NCD or legislative change in benefits meets the criteria for significant cost described in paragraph (a) of this section, a MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits. If CMS determines that an NCD or legislative change in benefits does not meet the "significant cost" threshold described in §422.109(a), the MA organization is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.

they love, and unable to act as a legal surrogate if their partner is incapacitated.

For all of these Americans, the failure to have their wishes respected concerning who may visit them or make medical decisions on their behalf has real consequences. It means that doctors and nurses do not always have the best information about patients' medications and medical histories and that friends and certain family members are unable to serve as intermediaries to help communicate patients' needs. It means that a stressful and at times terrifying experience for patients is senselessly compounded by indignity and unfairness. And it means that all too often, people are made to suffer or even to pass away alone, denied the comfort of companionship in their final moments while a loved one is left worrying and pacing down the hall.

Many States have taken steps to try to put an end to these problems. North Carolina recently amended its Patients' Bill of Rights to give each patient "the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient"—a right that applies in every hospital in the State. Delaware, Nebraska, and Minnesota have adopted similar laws.

My Administration can expand on these important steps to ensure that patients can receive compassionate care and equal treatment during their hospital stays. By this memorandum, I request that you take the following steps:

1. Initiate appropriate rulemaking, pursuant to your authority under 42 U.S.C. 1395x and other relevant provisions of law, to ensure that hospitals that participate in Medicare or Medicaid respect the rights of patients to designate visitors. It should be made clear that designated visitors, including individuals designated by legally valid advance directives (such as durable powers of attorney and health care proxies), should enjoy visitation privileges that are no more restrictive than those that immediate family members enjoy. You should also provide that participating hospitals may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. The rulemaking should take into account the need for hospitals to restrict visitation in medically appropriate circumstances as well as the clinical decisions that medical professionals make about a patient's care or treatment.

2. Ensure that all hospitals participating in Medicare or Medicaid are in full compliance with regulations, codified at 42 CFR 482.13 and 42 CFR 489.102(a), promulgated to guarantee that all patients' advance directives, such as durable powers of attorney and health care proxies, are respected, and that patients' representatives otherwise have the right to make informed decisions regarding patients' care. Additionally, I request that you issue new guidelines, pursuant to your authority under 42 U.S.C. 1395cc and other relevant provisions of law, and provide technical assistance on how hospitals participating in Medicare or Medicaid can best comply with the regulations and take any additional appropriate measures to fully enforce the regulations.

3. Provide additional recommendations to me, within 180 days of the date of this memorandum, on actions the Department of Health and Human Services can take to address hospital visitation, medical decision-making, or other health care issues that affect LGBT patients and their families.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA.

§ 1395y. Exclusions from coverage and medicare as secondary payer

(a) Items or services specifically excluded

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title,[1]

(E) in the case of research conducted pursuant to section 1320b–12 of this title, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1395m(c)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(nn) of this title, and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,

(G) in the case of prostate cancer screening tests (as defined in section 1395x(*oo*) of this title), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title,

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1395w–3a(c)(6)(C) of this title for which payment is made under part B of this subchapter that is furnished in a competitive area under section 1395w–3b of this title, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under part B of this subchapter,

[1] See References in Text note below.

(L) in the case of cardiovascular screening blood tests (as defined in section 1395x(xx)(1) of this title), which are performed more frequently than is covered under section 1395x(xx)(2) of this title,

(M) in the case of a diabetes screening test (as defined in section 1395x(yy)(1) of this title), which is performed more frequently than is covered under section 1395x(yy)(3) of this title,

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1395x(s)(2)(AA) of this title,

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1395x(ggg) of this title), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, and

(P) in the case of personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), which are performed more frequently than is covered under such section;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, in the case of services for which payment may be made under section 1395qq(e) of this title, and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), (H), (K), or (P) of paragraph (1));

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A of this subchapter in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate quality improvement organization (under part B of subchapter XI of this chapter) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1395w-4(i)(2)(B) of this title applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.];

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w–3(a) of this title) by an entity other than an entity with which the Secretary has entered into a contract under section 1395w–3(b) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(i) of this title and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the operation of subsection (g) or (*l*)(2) of section 1395x of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h) of this section, for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1395m(e)(1)(B) of this title for which payment is made under the fee schedule established under section 1395w–4(b) of this title and that are furnished by a supplier (as defined in section 1395x(d) of this title), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1395m(e)(2)(B) of this title;

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title. In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure consistent with subsection (*l*) of this section that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals

under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exeception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A of this subchapter under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[2] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997,[2] (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) "Current employment status" defined

An individual has "current employment status" with an employer if the individual

[2] So in original. The comma probably should not appear.

is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made[3] or can reasonably be expected to be made[3] under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii)[4] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required

Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this

[3] So in original. Probably should be "made,".
[4] So in original. Probably should be "subparagraph (A)".

subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) Use of website to determine final conditional reimbursement amount

(I) Notice to Secretary of expected date of a settlement, judgment, etc.

In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) Secretarial providing access to claims information through a website

The Secretary shall maintain and make available to individuals to whom items and services are furnished under this subchapter (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this subchapter relating to a potential settlement, judgment, award, or other payment.

(III) Use of timely web download as basis for final conditional amount

If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) Resolution of discrepancies

If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on

the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) Protected period

In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) Effective date

The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after January 10, 2013.

(VII) Website including successor technology

In this clause, the term "website" includes any successor technology.

(viii) Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this subchapter for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii),[5] under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination[6]

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a 7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

[5] So in original. Probably should be "subparagraph (A)."
[6] So in original. Probably should be followed by a period.

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(*l*)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(*l*)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(*l*)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A of this subchapter or enrolls under part B of this subchapter, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(E) End date

The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B of this subchapter unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a

civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this subchapter; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

(i) shall share information on entitlement under part A and enrollment under part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

Sect. 111

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term "claimant" includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) Exception

(A) In general

Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) Annual computation of threshold

(i) In general

Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) Publication

The Secretary shall include, as part of such publication for a year—

(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) Exclusion of ongoing expenses

For purposes of this paragraph and with respect to a settlement, judgment, award, or

other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this subchapter.

(D) Report to Congress

Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this subchapter achieved by the Secretary implementing each such threshold.

(c) Drug products

No payment may be made under part B of this subchapter for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) Items or services provided for emergency medical conditions

For purposes of subsection (a)(1)(A) of this section, in the case of any item or service that is required to be provided pursuant to section 1395dd of this title to an individual who is entitled to benefits under this subchapter, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e) Item or service by excluded individual or entity or at direction of excluded physician; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a–7, 1320a–7a, 1320c–5, 1320c–9 (as in effect on September 2, 1982), 1395u(j)(2), 1395y(d) (as in effect on August 18, 1987), or 1395cc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

[Code of Federal Regulations]
[Title 42, Volume 2]
[Revised as of October 1, 2010]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR411.26]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 411_EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT--Table of Contents

Subpart B_Insurance Coverage That Limits Medicare Payment: General Provisions

Sec. 411.26 Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a primary payer.

(b) Right to intervene. CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

(2) *Request for waivers.* Cost plans or PACE organizations seeking to offer qualified prescription drug coverage may request from CMS in writing-

(i) A waiver of those requirements under this part otherwise applicable to cost plans or PACE organizations that are duplicative of, or that are in conflict with, provisions otherwise applicable to cost plans or PACE organizations.

(ii) A waiver of a requirement under this part otherwise applicable to cost plans or PACE organizations, if such waiver improves coordination of benefits provided by the cost plan under section 1876 of the Act, or by the PACE organization under sections 1894 and 1934 of the Act, with the benefits under Part D.

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 20506, Apr. 15, 2008]

§ 423.462 Medicare secondary payer procedures.

(a) *General rule.* The provisions of § 422.108 of this chapter regarding Medicare secondary payer procedures apply to Part D sponsors and Part D plans (with respect to the offering of qualified prescription drug coverage) in the same way as they apply to MA organizations and MA plans under Part C of title XVIII of the Act, except all references to MA organizations and MA plans are considered references to Part D sponsors and Part D plans.

(b) *Reporting requirements.* A Part D sponsor must report credible new or changed primary payer information to the CMS Coordination of Benefits Contractor in accordance with the processes and timeframes specified by CMS.

[70 FR 4525, Jan. 28, 2005, as amended at 75 FR 19819, Apr. 15, 2010]

§ 423.464 Coordination of benefits with other providers of prescription drug coverage.

(a) *General rule.* A Part D plan must permit SPAPs (described in paragraph (e)(1) of this section) and entities providing other prescription drug coverage (described in paragraph (f)(1) of this section) to coordinate benefits with such plan. A Part D plan must comply with all administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between such plan and SPAPs and entities providing other prescription drug coverage for—

(1) Payment of premiums and coverage; and

(2) Payment for supplemental prescription drug benefits as described in § 423.104(f)(1)(ii)(including payment to a Part D plan on a lump sum per capita basis) for Part D eligible individuals enrolled in the Part D plan and the SPAP or entity providing other prescription drug coverage.

(3) Retroactive claims adjustments, underpayment reimbursements, and overpayment recoveries as described in paragraph (g) of this section and § 423.466(a) of this subpart.

(b) *Medicare as primary payer.* The requirements of this subpart do not change or affect the primary or secondary payer status of a Part D plan and a SPAP or other prescription drug coverage. A Part D plan is always the primary payer relative to a State Pharmaceutical Assistance Program.

(c) *User fees.* CMS may impose user fees on Part D plans for the transmittal of information necessary for benefit coordination in accordance with administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between a Part D plan and SPAPs and entities providing other prescription drug coverage in a manner similar to the manner in which user fees are imposed under section 1842(h)(3)(B) of the Act, except that CMS may retain a portion of user fees to defray its costs in carrying out such procedures. CMS will not impose user fees under this subpart on a SPAP or entities providing other prescription drug coverage.

(d) *Cost management tools.* The requirements of this subpart do not prevent a Part D sponsor from using cost management tools (including differential payments) under all methods of operation.

(e) *Coordination with State Pharmaceutical Assistance Programs*—(1) *Requirements to be a State Pharmaceutical Assistance Program (SPAP).* A State program is considered to be a State Pharmaceutical Assistance Program for purposes of this part if it-

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-14-00
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: September 29, 2011

FROM: Acting Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer—Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals -- INFORMATION

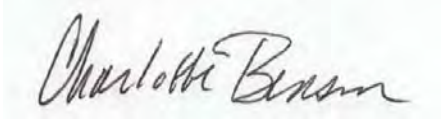
TO: Consortium Administrator for Financial Management and Fee-for-Service Operations

The purpose of this memorandum is to provide information regarding proposed Liability Medicare Set-Aside Arrangement (LMSA) amounts related to liability insurance (including self-insurance) settlements, judgments, awards, or other payments ("settlements").

Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) "settlement" has been completed as of the date of the "settlement", and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement", satisfied. If the beneficiary receives additional "settlements" related to the underlying injury or illness, he/she must obtain a separate physician certification for those additional "settlements."

When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that Medicare's interest with respect to future medicals for that "settlement" has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician's certification.

The above referenced guidance and procedure is effective upon publication of this memorandum.



Charlotte Benson

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

AETNA LIFE INSURANCE COMPANY,	:	
Plaintiff,	:	CIVIL ACTION NO.
	:	3:17–cv–621 (JCH)
v.	:	
	:	
NELLINA GUERRERA, et al.,	:	MARCH 13, 2018
Defendants.	:	

RULING RE: MOTION TO DISMISS (DOC. NO. 36) AND CROSS-MOTION TO AMEND COMPLAINT (DOC. NO. 38)

This case comes before the court pursuant to a Complaint (Doc. No. 1) filed by the plaintiff, Aetna Life Insurance Company ("Aetna"), against the defendants, Nellina Guerrera ("Guerrera"); Carter Mario Injury Lawyers ("Carter Mario"); Attorney Sean Hammil ("Hammil"); Attorney Danielle Wisniowski ("Wisniowski"); and Big Y Foods, Inc. ("Big Y"). The case arises out of a dispute regarding payment for medical services received by Guerrera following an injury that Guerrera sustained at a Big Y retail location.

On July 5, 2017, the defendants filed a Motion to Dismiss (Doc. No. 26) pursuant to Federal Rule of Civil Procedure 12(b)(1) and (6), arguing that the case does not belong in federal court, either because this court lacks subject matter jurisdiction or because Aetna has not stated a plausible claim with respect to their federal cause of action. On July 26, 2017, Aetna filed a Cross-Motion to Amend its Complaint (Doc. No. 38). In a Memorandum filed in support of the Cross-Motion and in opposition to the Motion to Dismiss, Aetna clarified that it is opposing the Motion to Dismiss, but is cross moving to amend its Complaint "should this Court determine that Aetna's Complaint, as it is currently drafted, fails to create subject matter jurisdiction over Aetna's claims, or

fails to state viable claims against Defendants." Plaintiff's Memorandum of Law in Opposition to Defendant's Motion to Dismiss and In Support of Cross-Motion for Leave to Amend its Complaint ("Pl.'s Response") (Doc. No. 39) at 17.

For the reasons that follow, the defendants' Motion to Dismiss (Doc. No. 36) is granted in part and denied in part, and Aetna's Motion to Amend (Doc. No. 38) is denied.

I. STANDARD OF REVIEW

When deciding a motion to dismiss pursuant to Rule 12(b)(1), the plaintiff bears the burden of proving subject matter jurisdiction by a preponderance of the evidence. See Aurecchione v. Schoolman Transp. Sys., Inc., 426 F.3d 635, 638 (2d Cir. 2005). However, the allegations of the complaint should be construed in the plaintiff's favor. A plaintiff need not show a likelihood of success on the federal claim, but need only adequately raise a federal question for the court to adjudicate. See id. (district court erred in dismissing civil rights claim where the plaintiff had "sufficiently raised the question of whether Title VII of the Civil Rights Act of 1964 is applicable in this instance" which was "a federal question over which the district court has subject matter jurisdiction"). Federal question jurisdiction exists if the complaint sets forth a cause of action under federal law that is neither clearly "immaterial and made solely for the purpose of obtaining jurisdiction," nor "wholly insubstantial and frivolous." Lyndonville Sav. Bank & Tr. Co. v. Lussier, 211 F.3d 697, 701 (2d Cir. 2000) (quoting Bell v. Hood, 327 U.S. 678, 682–83 (1946)).

With respect to a motion to dismiss pursuant to Rule 12(b)(6), the court must determine whether the plaintiff has stated a legally cognizable claim by making allegations that, if true, would show that the plaintiff is entitled to relief. See Bell Atl.

Corp. v. Twombly, 550 U.S. 544, 557 (2007) (interpreting Rule 12(b)(6), in accordance with Rule 8(a)(2), to require allegations with "enough heft to 'sho[w] that the pleader is entitled to relief" (alteration in original)). The court takes all factual allegations in the complaint as true and draws all reasonable inferences in the plaintiff's favor. Crawford v. Cuomo, 796 F.3d 252, 256 (2d Cir. 2015). However, the tenet that a court must accept a complaint's allegations as true is inapplicable to "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements." Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (citing Twombly, 550 U.S. at 555).

To survive a motion pursuant to Rule 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" Id. (quoting Twombly, 550 U.S. at 570). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged. The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." Id. (quoting Twombly, 550 U.S. at 556).

II. ALLEGED FACTS[1]

Defendant Guerrera is a resident of Monroe, Connecticut. Complaint ("Compl.") at ¶ 5. Defendant Big Y is a Massachusetts corporation with a location in Monroe, Connecticut. Id. at ¶ 9. On or about February 20, 2015, Guerrera allegedly sustained personal injuries at the Big Y location in Monroe, for which she subsequently sought and received medical care. Id. at ¶ 12. Aetna is a Medicare Advantage Organization

[1] In deciding a Rule 12(b)(1) or (6) motion to dismiss, the court accepts all factual allegations in the complaint as true and draws all reasonable inferences in the plaintiff's favor. Crawford v. Cuomo, 796 F.3d 252, 256 (2d Cir. 2015).

("MAO") and operates a Medicare Advantage health insurance plan ("MAO Plan"). Id. at ¶¶ 4, 10. At all relevant times, Guerrera was Medicare-eligible and was enrolled in and maintained health insurance coverage through Aetna's MAO Plan. Id. at ¶ 10. Following the February 20, 2015 accident, Aetna paid approximately $9,854.16 in medical expenses on behalf of Guerrera. Id. at ¶¶ 15–16. Guerrera retained the services of the law firm Carter Mario and Attorneys Hammil and/or Wisniowski to represent her in a claim against Big Y for the injuries she sustained on February 20, 2015. Id. at ¶ 22. Guerrera settled her claim against Big Y for $30,000.

Aetna made multiple attempts to place the defendants on notice that it had a lien on the medical expenses resulting from Guerrera's injuries at Big Y, and to recover those expenses from one or more of the defendants, beginning on September 22, 2015, a year before the settlement agreement was made. Id. at ¶¶ 26–35. On March 10, 2016, Big Y agreed that it would not send the full amount of any settlement to Guerrera, Carter Mario, Hammil, and/or Wisniowski without first dealing with Aetna's lien. Id. at ¶ 31. Nevertheless, Big Y subsequently sent the full $30,000 settlement payment to Guerrera, Carter Mario, Hammil, and/or Wisniowski on or about September 15, 2016. Id. at ¶ 32.

III. RELEVANT HISTORY OF THE MEDICARE SECONDARY PAYER ACT

In light of the complex nature of the statutory framework at issue in this case, it is worthwhile to sketch a brief history of the Medicare Secondary Payer Act ("MSP"), title 42, section 1395y(b) of the United States Code.

Congress enacted the Medicare Act in 1965 as a "federally funded health insurance program for the elderly and disabled." Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 506 (1994). The Medicare Act consists of five parts, the first two of which

"create, describe, and regulate traditional fee-for-service, government-administered Medicare." In re Avandia Mktg., 685 F.3d 353, 357 (3d Cir. 2012). The third part, Part C, outlines the Medicare Advantage Program, described further below. The fourth and fifth parts are not at issue here.

In 1980, Congress amended the Medicare Act to add the Medicare Secondary Payer Act ("MSP"), in an effort to reduce the escalating costs of Medicare to the federal government. Omnibus Reconciliation Act of 1980, Pub. L. No. 90-499, 94 Stat. 2599. "As its title suggests, the statute designates Medicare as a 'secondary payer' of medical benefits, and thus precludes the program from providing such benefits when a 'primary plan' could be expected to pay.'" Taransky v. Sec'y of HHS, 760 F.3d 307, 310 (3d Cir. 2014). The MSP is codified at section 1395y of title 42 of the United States Code. The MSP provides that Medicare cannot pay medical expenses when "payment has been made or can reasonably be expected to be made under a workman's compensation law or plan of the United States or State or under an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii).

In subsection 1395y(b)(2)(B) of the MSP, Congress gave "[t]he Secretary" authority to make conditional payments "if a primary plan . . . has not made or cannot reasonably be expected to make payment with respect to such item or service promptly," but such payment "shall be conditioned on reimbursement." Id. at (b)(1)(B)(i). Congress further provided an enforcement mechanism for the "United States" in cases where conditional payment has been made. Subsection 1395y(b)(2)(B)(ii) provides that "a primary plan, and an entity that receives payment

from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." 42 U.S.C. § 1395y(b)(2)(B)(ii). Subsection (2)(B)(ii) also contains a responsibility-triggering provision, which explains that responsibility for repayment "may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." Id. Finally, subsection (2)(B)(iii) creates a cause of action for "the United States," which provides, in relevant part:

> In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

42 U.S.C. § 1395y(b)(2)(B)(iii).

Congress also created a private right of action, codified at section 1395y(b)(3)(A) of title 42 of the United States Code, and described herein as the "Private Cause of Action" provision. In comparison to the cause of action created for the United States, the Private Cause of Action provision is relatively sparse. It provides as follows:

> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs [(b)](1) and [(b)](2)(A).

42 U.S.C. § 1395y(b)(3)(A). That is the entirety of the Private Cause of Action provision; it does not make explicit who may bring suit or against whom, or even under what conditions precisely suit may be brought. Paragraph (b)(1) governs situations in which group health plans must provide payment, while paragraph (b)(2)(A) governs situations including liability insurance settlements. 42 U.S.C. §§ 1395y(b)(1), (b)(2)(A).

In 1997, Congress once again amended the Medicare Act to add Part C, which "afford[s] beneficiaries the option to receive their Medicare benefits through private organizations" known as Medicare Advantage Organizations ("MAOs"). Collins v. Wellcare Healthcare Plans, Inc., 73 F. Supp. 3d 653, 659 (E.D. La. 2014). "Pursuant to these amendment, most Medicare beneficiaries can now elect to receive their benefits through Original Medicare or through an MAO." Id. at 659–60. Part C provides that the Center for Medicare and Medicaid Services ("CMS") pays MAOs a fixed amount per enrollee, and the MAOs assume the risk of insuring each enrollee. See 42 U.S.C. §§ 1395w-21, 1395w-23.

Part C does not contain an enforcement provision equivalent to either the government enforcement provision, subsection (b)(2)(B)(iii), or the Private Cause of Action provision, paragraph (b)(3)(A). Absent an enforcement mechanism in Part C, disputes have arisen as to whether Part C created an implied right of action, see, e.g. Parra v. PacifiCare of Arizona, Inc., 715 F.3d 1146, 1154 (9th Cir. 2013); Konig v. Yeshiva Imrei Chaim Viznitz of Boro Park, Inc., No. 12-CV-467, 2012 WL 1078633 (E.D.N.Y. Mar. 30, 2012), or—at issue in this case—whether the Private Cause of

Action is available to MAOs, see, e.g., Avandia, 685 F.3d at 359–65; Collins, 73 F. Supp. 3d at 666.

IV. SUBJECT MATTER JURISDICTION

In its Complaint, Aetna alleges claims pursuant to the Medicare Act, title 42, section 1395y of the United States Code, as well as common law claims arising out of Aetna's insurance contract with Guerrera. See generally Compl. The defendants move to dismiss the Medicare Act claims for lack of subject matter jurisdiction pursuant to Rule 12(b)(1), or, in the alternative, for failure to state a claim pursuant to Rule 12(b)(6). See generally Defendants' Memorandum of Law in Support of their Motion to Dismiss ("Def.'s Mem.") (Doc. No. 36-1). The defendants also urge the court to decline to exercise supplemental jurisdiction over Aetna's state law claims. See id. at 11.

The defendants vigorously assert that this court lacks subject matter jurisdiction over Aetna's claims because Aetna's Medicare Act claims are improper for a variety of reasons, and because this case arises, "if at all, under state contract law." Def.'s Mem. at 10. Aetna asserts that its Medicare Act claims raise federal questions, which are properly decided by this court, and accuses the defendants of "conceptually and organizationally conflat[ing] the jurisdictional issue (i.e., whether the Court can hear Aetna's claims) with the pleading issue (i.e., whether Aetna's Complaint asserts a viable claim)." Pl.'s Response at 8–11.

The court agrees with Aetna that it has adequately alleged federal claims to give this court federal question jurisdiction pursuant to section 1331 of title 28 of the United States Code. Indeed, in the case relied on most heavily by the defendants, Parra, the Ninth Circuit rejected a virtually identical subject matter jurisdiction challenge. Parra, 715 F.3d at 1151–52. The Parra court concluded that, "'[b]ecause interpretation of the

federal Medicare Act presents a federal question,' the district court had subject matter jurisdiction to determine whether that act created a cause of action in favor of Pacificare against the [defendants]." Id. (quoting Avandia, 685 F.3d at 357) (internal citation omitted); see also Plante v. Dake, 621 Fed. App'x 67, 68 (2d Cir. 2015) (summary order) (rejecting subject matter jurisdiction challenge because "Plante asserts claims under the [Medicare Act], which is a federal statute"); id. at 68 n.4 ("Federal question jurisdiction exists . . . over a claim stating a cause of action under federal law unless the allegation was clearly immaterial, or the claim was made solely for the purpose of obtaining jurisdiction." (quoting Parra, 715 F.3d at 1152)).

In short, Aetna has adequate pled a federal question such that this court may exercise subject matter jurisdiction over Aetna's Complaint. The defendants' arguments to the contrary are more appropriately addressed as challenges to the pleadings than jurisdictional challenges.[2]

V. PRIVATE CAUSE OF ACTION PROVISION

As stated above, Aetna brings claims pursuant to the Medicare Act and state law. See generally Compl. The defendants have not raised substantive challenges to Aetna's state law claims, but rather urge the court to dismiss Aetna's federal claims and decline to exercise supplemental jurisdiction over Aetna's state law claims. The questions before the court, therefore, revolve around the Medicare Act, specifically the Private Cause of Action provision.

[2] Indeed, in their Reply to Aetna's Opposition to the Motion to Dismiss, the defendants do not substantively dispute Aetna's argument that the defendants' claims are more properly raised pursuant to Rule 12(b)(6) than Rule 12(b)(1). Instead, the defendants acknowledge that their Motion to Dismiss "involves a merits-based inquiry" and that "regardless of whether dismissal is accomplished under Rule 12(b)(1) or 12(b)(6)," the court should decline to exercise supplemental jurisdiction. Def.'s Reply at 9.

The parties dispute who may bring an action pursuant to this provision, against whom they may bring it, and under what circumstances it may be brought. The court will address each of these arguments in turn.

A. Who May Sue

The first question the court must answer is whether Aetna, an MAO, may bring suit pursuant to the Private Cause of Action provision. Aetna asserts that the Private Cause of Action provision "provide[s] a private cause of action to private entities, specifically MAOs." Pl.'s Response at 12; see also Pl.'s Reply (Doc. No. 44) at 5–6 ("MAOs do have a private right of action under the MSP Private Cause of Action Provision to seek reimbursement, as a secondary payer, for conditional payments made on behalf of its members.").

The defendants, on the other hand, have not meaningfully challenged Aetna's right to bring suit as a MAO. In their Memorandum, defendants merely observe that "[t]he MSP Act does not specify whom or what is granted this private right of action against primary plans" and then "assum[es], for the sake of argument, that the MSP Act permits an MAO to bring a private right of action."[3] Def.'s Mem. at 4. In their Reply to the plaintiff's Response, the defendants assert that, as an MAO, Aetna "has no authority to bring [the] claims," but the substance of their argument appears to construe Aetna's claim as alleged under the government's cause of action, subsection (2)(B)(iii). See Defendants' Reply to Plaintiff's Response ("Def.'s Reply") (Doc. No. 43) at 2 ("Section (b)(2)(B) of the MSP Act grants a right to make conditional payments only to 'the

[3] Similarly, in the defendants' Reply to Aetna's Response, the defendant's "put[ ] aside that Section 1395y(b)(3)(A) makes no specific reference to MAOs." Def.'s Reply at 3.

Secretary,' id. § 1395y(b)(2)(B)(i), and grants only to 'the United States' a right to bring an action to recover from an entity that fails to reimburse the Secretary for conditional payments, id. § 1395y(b)(2)(B)(iii)."). As Aetna accurately observes, this argument—and the cases that the defendants cite in support of their position—go to the government's cause of action, set forth in subsection (2)(B)(iii). Pl.'s Reply at 7; see Primax Recoveries Inc. v. Yarmosh, No. 3:03-CV-1931 (AWT), 2006 WL 8424020 (D. Conn. Sept. 7, 2006) (holding that MAOs may not bring suit pursuant to subsection (2)(B)(ii)). That argument is inapposite in this case, as Aetna's MSP claim was brought pursuant to the Private Cause of Action provision.[4] See Compl. at ¶ 1 (citing 42 U.S.C. § 1395y(b)(3)(A)).

In sum, although the defendants have repeatedly expressed doubt that an MAO may bring suit pursuant to the Private Cause of Action, they have cited no authority on this question aside from pointing out that the Private Cause of Action provision does not mention MAOs. See Def.'s Mem. at 4; Def.'s Reply at 3. However, the Private Cause of Action provision does not list any entity who may sue. See 42 U.S.C. § 1395y(b)(3)(A). Clearly, Congress did not create a cause of action for no one. The court concludes that the absence of a specific reference to MAOs is not probative of Congress's intent. See 42 U.S.C. § 1395y(b)(3)(A).

[4] The court acknowledges that Aetna's Complaint and subsequent argument muddies the "waters" with respect to which provision it is suing under by citing both the Private Cause of Action provision, paragraph (3)(A), and the conditional payment provision, paragraph (2)(B). See, e.g., Compl. at ¶ 45 (stating that Aetna made payments "conditionally pursuant to 42 U.S.C. § 1395[y](b)(2)(B)(i)"); Exh. F, Compl. (stating that defendants' refusal to reimburse Aetna "plainly contravenes 42 U.S.C. § 1395y(b)(2)(B)(ii)")). However, the court interprets Aetna's Medicare Act claims as alleged pursuant to the Private Cause of Action provision, paragraph (3)(A). To the extent that Aetna is attempting to sue the defendants pursuant to the government's cause of action, subsection (2)(B)(iii), those claims are dismissed.

The Second Circuit has never directly addressed whether MAOs may bring suit pursuant to the Private Cause of Action provision. The only two circuits who have addressed this question, the Third and Eleventh Circuits, have both reached the conclusion that MAOs may sue under the Private Cause of Action provision.[5] See Humana Med. Plan, Inc. v. W. Heritage Ins. Co., 832 F.3d 1229, 1238 (11th Cir. 2016) ("We see no basis to exclude MAOs from a broadly worded provision that enables a plaintiff to vindicate harm caused by a primary plan's failure to meet its MSP primary payment or reimbursement obligations."); Avandia, 685 F.3d at 359 ("[W]e find that the [Private Cause of Action provision] is broad and unambiguous, placing no limitations upon which private (i.e., non-governmental) actors can bring suit for double damages when a primary payer fails to appropriately reimburse a secondary payer."). Since Avandia was published, a significant number of district courts have followed the reasoning of the Third Circuit to find that MAOs may avail themselves of the Private Cause of Action provision. See, e.g., MAO-MSO Recovery II, LLC v. State Farm Mutual Automobile Ins. Co., No. 1:17-CV-1537-JBM-JEH, 2018 WL 340020, at *1 (C.D. Ill. Jan. 9, 2018) (collecting cases). This court, too, finds the reasoning of the Third and Eleventh Circuits persuasive, and concludes that Aetna, as a MAO, may sue under the Private Cause of Action provision.

Aetna also argues that, even if the Private Cause of Action provision were ambiguous, the court should defer to CMS regulations interpreting the statute, which

[5] The Ninth Circuit expressly reserved judgment on this issue in Parra. 715 F.3d at 1154 (declining to address whether the Private Cause of Action provision "provided a MAO a private right of action against third-party tortfeasors for medical expenses advanced on behalf of plan participants" because the plaintiff did not bring claims against the primary plan).

militate in favor of permitting MAOs to sue under the Private Cause of Action. See Pl.'s Response at 14–15. Aetna specifically cites the court to section 422.108(f) of title 42 of the Code of Federal Regulations ("section 422.108(f)"), which provides that a "[MAO] will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations . . . ." 42 C.F.R. § 422.108(f).[6] Aetna urges the court to accord the regulation deference in keeping with the Chevron doctrine, first articulated in Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984). The Chevron doctrine instructs that, "[w]hen Congress has 'explicitly left a gap for an agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation,' and any ensuing regulation is binding in the courts unless procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute." U.S. v. Mead Corp., 533 U.S. 218, 227 (2001) (quoting Chevron, 467 U.S. at 843–44).

The defendants argue that "[f]ederal regulations can inform the scope of a right already created by Congress, but cannot themselves create a right of action that does not exist by statute." Def.'s Mem. at 8; see also Def.'s Reply at 4–5. The court agrees with this statement. See Alexander v. Sandoval, 532 U.S. 275, 291 (2001) ("Language in a regulation may invoke a private right of action that Congress through statutory text

[6] In addition, Aetna notes that, in a 2011 memorandum, "CMS clarified that it understood MAOs, like Aetna, to have the same rights and responsibilities to collect from primary payers as traditional Medicare." Pl.'s Response at 14. However, memoranda are "not subject to sufficiently formal procedures to merit Chevron deference." Coeur Alaska, Inc. v. Southeast Alaska Conservation Council, 557 U.S. 261, 283–84 (2009) (citing U.S. v. Mead Corp., 533 U.S. 218, 234–38 (2001)). The court could still find the reasoning in the 2011 memorandum persuasive and accord it deference pursuant to Auer v. Robbins, 519 U.S. 452 (1997), but because the court concludes that Chevron deference is appropriate as to section 422.108(f), the court does not reach the question of what deference, if any, to give the 2011 memorandum.

created, but it may not create a right that Congress has not."). However, in this case, the CMS regulation does not create a new cause of action, but rather clarifies ambiguity in the Private Cause of Action provision. Cf. Digital Realty Trust, Inc. v. Somers, --- S. Ct. ----, 2018 WL 987345, at *13 (Feb. 21, 2018) (holding that agency regulation was not entitled to Chevron deference as to the meaning of a statutory provision that was "unambiguous"). Although the court has already concluded that the Private Cause of Action provision unambiguously permits suit by MAOs, the court further concludes that, even if it were ambiguous, the CMS regulation would be entitled to Chevron deference and would lead the court to the same conclusion. See Avandia, 685 F.3d at 366 (concluding that "the plain language" of section 422.108(f) "suggests that the Medicare Act treats MAOs the same way it treats the Medicare Trust Fund for purposes of recovery from any primary payer" and that the court is "bound to defer to the duly-promulgated regulation of CMS"); see also Humana Ins. Co. v. Paris Blank LLP, 187 F. Supp. 3d 676, 680 (E.D. Va. 2016) (concluding that section 422.108(f) is a "permissible interpretation of the MSP statute" that is entitled to Chevron deference and gives MAOs a right to recover under the Private Cause of Action provision).

The defendants cite the court to Konig, 2012 WL 1078633, an unpublished case from the Eastern District of New York, for the proposition that section 422.108(f), as a regulation, cannot create a right of action. Def.'s Reply at 5. In Konig, however, the debate surrounded the government's enforcement mechanism, subsection (2)(B)(iii). In that context, the Konig court rejected the argument that section 422.108(f) "places [MAOs] in the same shoes as the government, thereby granting them the power to bring a private right of action." Konig, 2012 WL 1078633, at *2 n.2. The court views this case

as distinguishable from Konig, however, as the Private Cause of Action provision, unlike the government's cause of action, is (at a minimum) ambiguous with respect to whether MAOs may bring suit.

However, the court also acknowledges that Konig, while clearly focused on the government's cause of action as opposed to the Private Cause of Action provision, contains broader language suggesting that the Private Cause of Action provision is not a cause of action for MAOs. See id. ("Nothing in the Medicare statute itself creates a cause of action, and the parties cannot fashion one by invoking the regulations." (emphasis added)). To the extent that this language makes Konig inconsistent with this Ruling, the court finds Konig unpersuasive and declines to follow it. For the reasons articulated above, the court concludes that the Private Cause of Action provision unambiguously permits suit by MAOs and, further, that even if it was ambiguous the CMS regulation that addresses MAO enforcement mechanisms, section 422.108(f), grants MAOs the right to sue under the Private Cause of Action provision.

In reaching this conclusion, the court is mindful of the precise language of section 422.108(f), which specifically equates the enforcement authority of MAOs with that of "the Secretary." See 42 C.F.R. § 422.108(f). At first blush, this language implies that section 422.108(f) interprets the government's cause of action, subsection (2)(B)(iii), not the Private Cause of Action provision, paragraph (3)(A). With respect to subsection (2)(B)(iii), section 422.108(f) is entitled to no Chevron deference on the issue of who may bring suit, as subsection (2)(B)(iii) unambiguously creates a right of action for the government alone. See 42 U.S.C. § 1395y(b)(2)(B)(iii) (creating a cause of action for "the United States"). However, because subsection (2)(B)(iii) itself provides that the

Secretary may collect double damages "in accordance with paragraph (3)(A)," the cause of action provided to the government is, itself, consistent with the Private Cause of Action. See id. Therefore, as the Avandia court concluded, "the regulation refers, ultimately, to the private cause of action in § 1395y(b)(3)(A) and deference to it supports [the MAO's] right to bring suit under that provision." Avandia, 685 F.3d at 367.

For the reasons articulated above, the court concludes that Aetna may bring suit under the Private Cause of Action provision in this Action. The next question is whom Aetna may sue.

B. Who May Be Sued

In its Complaint, Aetna brings claims pursuant to the MSP Private Cause of Action provision against three categories of defendant: (1) a Medicare beneficiary, Guerrera; (2) the law firm, Carter Mario, and the lawyers, Hammil and Wisniowski, who represented Guerrera in her personal injury settlement with Big Y; and (3) a tortfeasor, Big Y. See generally Compl. In their Motion to Dismiss, the defendants argue that the Private Cause of Action provision permits suits only against a "primary plan," and that Aetna has failed to allege that any of the defendants—Big Y, Guerrera, or her attorneys—constitute a "primary plan." Def.'s Mem. at 6–7. In response, Aetna argues that other federal courts have upheld the right of MAOs to sue all three types of defendants at issue here pursuant to the Private Cause of Action provision, and urges this court to follow suit. Pl.'s Response at 22. Aetna further argues that, although its Complaint does not use the term "primary plan," that deficiency "elevates form over substance" because "[t]he Complaint clearly identifies the MSP Act and its Private Cause of Action Provision as the federal statutes pursuant to which Aetna has filed suit, and Defendants are obviously on notice of same." Id. at 6.

1. Suit may only be brought against a primary plan[7]

In order to determine against whom suit may be brought, the court turns first to the language of the Private Cause of Action provision. Unfortunately, as with the question of who may sue, the express language of the Private Cause of Action provision does not specify who may be sued. Instead, the Private Cause of Action provision states that suit may be brought "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." 42 U.S.C. § 1395y(b)(3)(A). Thus, the language of the provision itself does not clarify against whom suit is proper.

When interpreting the MSP Private Cause of Action, the Second Circuit has clearly concluded that suit may be brought against the primary plan itself. See Manning v. Utils. Mut. Ins. Co., Inc., 254 F.3d 387, 391–92 (2d Cir. 2001) ("Congress has authorized a private cause of action and double damages against entities designated as primary payers that fail to pay for medical costs for which they were responsible, which are borne in fact by Medicare." (emphasis added)); Woods v. Empire Health Choice, Inc., 574 F.3d 92, 95–96 (2d Cir. 2009) (describing the Private Cause of Action provision as one which allows private parties to "recover amounts owed by a primary plan"); Mason v. Amer. Tobacco Co., 346 F.3d 36, 42–43 (2d Cir. 2003) ("[P]ursuant to [the Private Cause of Action provision] individuals may be awarded double damages against a primary plan that has wrongfully denied them payment . . . ."); see also Parra,

[7] The court notes that the MSP, the CMS regulations interpreting the MSP, relevant case law, and the parties themselves variously use the term "primary payer" and "primary plan." The court is aware of no substantive difference between these two terms, but uses the term "primary plan" throughout this Ruling because that is the term used in the Private Cause of Action provision at issue.

715 F.3d at 1154 (affirming dismissal of claim in part because it was not brought against the primary plan). In short, the Second Circuit has concluded that, at a minimum, primary payers may be sued pursuant to the Private Cause of Action provision.

Aetna urges the court to find that beneficiaries and their attorneys may also be sued pursuant to the Private Cause of Action. Pl.'s Response at 20–21. The court concludes, however, that the MSP and interpreting regulations do not give MAOs the right to sue beneficiaries or their attorneys. The court reaches this conclusion for several reasons.

First, the plain language of the Private Cause of Action provision, while admittedly vague, suggests that Congress intended suit against only primary plans. The provision is triggered when "a primary plan . . . fails to provide for primary payment (or appropriate reimbursement)." 42 U.S.C. § 1395y(b)(3)(A). Had Congress intended to create a cause of action for double damages against beneficiaries who received payment from a primary plan, Congress could simply have created a cause of action when "any entity or person" failed to reimburse an MAO.

In support of its interpretation, Aetna cites the court to a CMS regulation section 411.24(g) of title 42 of the Code of Federal Regulations ("section 411.24(g)"), which states that "CMS has a right of action to recover its payments from any entity, including a beneficiary, . . . that has received a primary payment." 42 C.F.R. § 411.24(g). Aetna further cites the court to the government's cause of action in the MSP, subsection (2)(B)(iii), which states that "the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." 42 U.S.C. § 1395y(b)(2)(B)(iii). Far from conflicting with

the court's interpretation, however, this authority supports a reading of the Private Cause of Action provision that permits suit only against primary plans. This is because the government's cause of action permits only recovery from beneficiaries, while providing that the government may "collect double damages against" entities including "any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan." 42 U.S.C. § 1395y(b)(2)(B)(iii). In other words, the government's cause of action provides only for recovery of payment against beneficiaries or their attorneys, while allowing the government to sue primary plans for double damages. See Mason, 346 F.3d at 38 ("The [MSP] provides for the government to receive double damages in successful actions against primary payers."). Notably, the government's cause of action, subsection (2)(B)(iii), references the Private Cause of Action provision, paragraph (3)(A), in the course of allowing for double damages "against any such entity," where "such entity" describes primary plans. 42 U.S.C. § 1395y(b)(2)(B)(iii). This cross-reference suggests that the Private Cause of Action, like the government's cause of action, allows for double damages only against primary plans.

Aetna also directs the court to a Ruling by a court in the Eastern District of Louisiana, which held that beneficiaries who had received a settlement from a tortfeasor were, in effect, converted into primary plans. Collins, 73 F. Supp. 3d at 667–68. The Collins court concluded that the settlement itself—as opposed to the entity that funded the settlement—was the "primary plan" because "there is no real distinction between a

claim against a tortfeasor or his insurer to obtain reimbursement and a claim against a beneficiary to obtain reimbursement from a settlement funded by a tortfeasor or his insurer." Id. at 667.

The court declines to follow the lead of the Collins court, however, as its interpretation of the Private Cause of Action provision cannot be reconciled with the text of the MSP. Unlike much of the language at issue in the MSP, "primary plan" has a clear definition that does not include beneficiaries who have received benefits or settlement funds. The MSP defines "primary plan" as "a group health plan or large group health plan . . . and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance . . . ." 42 U.S.C. § 1395y(b)(1)(A)(ii). In addition, elsewhere the MSP repeatedly distinguishes between primary plans and other entities. See, e.g., id. at (b)(2)(B)(vii)(I) (governing notice of settlement by "the claimant or applicable plan"); id. at (b)(8)(D) (defining "claimant" as "an individual filing a claim directly against the applicable plan" or "an individual filing a claim against an individual or entity insured or covered by the applicable plan"); id. at (b)(8)(F) (defining "applicable plan" as "[l]iability insurance (including self-insurance)," "[n]o fault insurance," or "[w]orkers' compensation laws or plans").

In the alternative, the Collins court concluded that, even if the Private Cause of Action provision did not unambiguously allow for suit against beneficiaries, proper deference to CMS regulations would direct the same result. Collins, 73 F. Supp. 3d at 667–68. However, what the CMS regulations provide is that MAOs will have the "same rights to recover" as the Secretary. 42 C.F.R. § 422.108(f). As analyzed above, the

government's cause of action allows for double damages only against primary plans, who do not include beneficiaries or their attorneys. In fact, this distinction is spelled out even more explicitly in another CMS regulation, section 411.24. See 42 C.F.R. § 411.24. Section 411.24(c) states, "If it is necessary for CMS to take legal action to recover from a primary payer, CMS may recover twice the amount [of the Medicare primary payment]." 42 U.S.C. § 411.24(c)(2) (emphasis added). In contrast, section 411.24(g), which governs recovery of payments "from parties that receive primary payments," including "a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment," includes no double-damages provision, permitting CMS only to "recover its payments." 42 U.S.C. § 411.24(g) (emphasis added). Thus, the CMS regulations do not suggest that the Private Cause of Action provision allows collection of double damages from beneficiaries or their attorneys, but only from primary plans.

In Collins, the Medicare beneficiary had already received medical expenses from a tortfeasor, and the Collins court observed that precluding suit against beneficiaries would "produce[ ] an odd result, as that interpretation would encourage beneficiaries to hide their settlements from the MAOs and provide no recourse to the MAOs against the beneficiaries for such action." Collins, 73 F. Supp. 3d at 667. However, both the Collins court and the parties in this case have overlooked another provision in section 411.24, which provides "[s]pecial rules" in circumstances including "liability insurance settlements." 42 C.F.R. § 411.24(i). Section 411.24(i) states, "If Medicare is not

reimbursed as required by paragraph (h)[8] of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party." 42 C.F.R. § 411.24(i)(1) (emphasis added). In short, section 411.24(i) explicitly addresses the situation with which the Collins court was concerned, and addresses the issue not by treating beneficiaries and primary plans alike, as Aetna urges the court to do here, but by clarifying that primary plans could not evade their obligations to Medicare simply through settlement with beneficiaries. See Glover v. Liggett Group, Inc., 459 F.3d 1304 (11th Cir. 2006) ("The MSP authorizes a private cause of action against a primary plan that pays a judgment or settlement to a Medicare beneficiary, but fails to pay Medicare its share." (citing section 411.24(i))).

Aetna also cites the court to a decision from the Eastern District of Virginia, Humana Insurance Company v. Paris Blank LLP, in which the court held that the plaintiff, a MAO, could pursue a claim under the Private Cause of Action provision against a beneficiary and her attorneys. 187 F. Supp. 3d 676, 681. As in Collins, the Paris Blank holding relied on section 422.108(f), which equates the rights of recovery for MAOs to the rights of recovery for the government, in combination with section 411.24, which permits recovery against beneficiaries and their attorneys, as the court has just described. Id. at 681–82. However, section 411.24 does not provide for double damages recovery against beneficiaries and their attorneys, consistent with the text of the government's cause of action, subsection (2)(B)(iii). Thus, to conclude that beneficiaries and their attorneys may be sued under the Private Cause of Action

[8] Paragraph (h) states: "If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days." 42 C.F.R. 411.24(h).

provision would mean that MAOs would not have rights equal to those of the government, but rather rights greater than those of the government, because the Private Cause of Action provision only provides for double damages.

Relevant to this issue, the court notes that the Collins court interpreted the Private Cause of Action provision to allow for either single or double recovery, depending on whether a primary plan (which, for the Collins court, includes beneficiaries who have received settlement payments) "intentionally withh[e]ld payment." Collins, 73 F. Supp. 3d at 669–70. The text of the Private Cause of Action provision does not, however, provide for single recovery. As described above, the Private Cause of Action provision creates "a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide payment (or appropriate reimbursement)." 42 U.S.C. § 1395y(b)(3)(A) (emphasis added). The Collins court reached its conclusion that the provision allowed for either single or double damages, depending on the circumstances, by effectively shifting the second parenthesis to include another clause, converting the clause "which shall be in an amount double the amount otherwise provided" to say, instead, "which shall be in an amount double the amount otherwise provided in the case of a primary plan which fails to provide payment."[9] Collins, 73 F. Supp. 3d at 670. In the view of this court, however, such a reading is explicitly precluded by the way Congress wrote this sentence, which unambiguously defines the damages available under the Private

[9] The Collins opinion illustrates its interpretation of the Private Cause of Action by emphasizing the two clauses that it read together: "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." Collins, 73 F. Supp. 3d at 670 (quoting 42 U.S.C. § 1395y(b)(3)(A)).

Cause of Action provision as double damages. See W. Heritage Inc. Co., 832 F.3d at 1240 (holding that the Private Cause of Action provision requires double damages because, "[u]nlike the Government's cause of action, the private cause of action uses the mandatory language 'shall' to describe the damages amount"); see also Mason, 346 F.3d at 38 (describing the Private Cause of Action provision as providing for "double damages against a primary plan").

Admittedly, this interpretation of the Private Cause of Action provision—that it allows for double damages against primary plans, but does not allow for recovery of payment from beneficiaries or their attorneys—conflicts with the intention of CMS that MAOs be accorded the same rights to recover as the government, see section 411.108(f), because the government's cause of action grants the United States the authority to sue beneficiaries and their attorneys for recovery of payment. 42 U.S.C. § 1395y(b)(2)(B)(iii) ("[T]he United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity."). CMS regulations, however, are only entitled to deference where they interpret ambiguous statutory language. See Digital Realty Trust, Inc. v. Somers, --- S. Ct. ----, 2018 WL 987345, at *13 (Feb. 21, 2018) (declining to defer to an agency regulation where "Congress has directly spoken to the precise question at issue" (quoting Chevron, 467 U.S. at 842)). With respect to the damages available, the language of the Private Cause of Action provision is unambiguous.

For the foregoing reasons, the court concludes that the Private Cause of Action provision permits suits for double damages against primary plans, as defined in the MSP, see title 42, section 1395y(b)(1)(2)(A)(ii), which excludes beneficiaries and their

attorneys. The court therefore grants the defendants' Motion to Dismiss the Medicare Act claims with respect to Guerrera, Carter Mario, Himmel, and Wisniowski.

2. Aetna has adequately alleged that Big Y is a primary plan

Having concluded that Aetna, an MAO, may sue under the Private Cause of Action provision, and further having concluded that Aetna may sue a primary plan, the question remains whether Aetna has adequately pled that Big Y is a primary plan. As stated above, the MSP defines primary plan, in pertinent part, as "a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance." 42 U.S.C. § 1395y(b)(1)(2)(A)(ii). The MSP further provides that "[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." Id.

The defendants assert that Big Y, a tortfeasor, is not a "primary plan" within the meaning of the MSP. In support of this argument, the defendants cite the court to three cases: Parra, 715 F.3d 1146, Mason, 446 F.3d 36, and Woods, 574 F.3d 92. However, the court finds these cases either inapposite or, in the case of Mason, superceded by statutory amendment in December 2003. See Taransky, 760 F.3d at 313 n.5 (describing the impact of the 2003 amendment on Mason).

In Parra, the facts alleged were materially different than those before the court in this case. 715 F.3d 1146. Manuel Parra was struck by a car, hospitalized, and eventually passed away due to injuries suffered in the accident. Id. at 1150. PacifiCare, an MAO, paid his medical expenses. Id. His wife and children made a demand for wrongful death damages against the driver's GEICO automobile insurance

policy, and the MAO made a claim against the same policy for reimbursement of the medical expenses. Id. GEICO issued a settlement check jointly payable to the survivors and PacifiCare to be held in trust pending resolution of the parties' dispute. Id. The survivors then brought suit seeking injunctive and declaratory relief regarding entitlement to the settlement, and PacifiCare counterclaimed with a contract claim and a claim under the Medicare Act. Id. The Ninth Circuit concluded that the Private Cause of Action was not triggered because PacifiCare had not alleged that GEICO, the primary plan, had "fail[ed] to provide for primary payment." Id. at 1154 ("PacifiCare makes no claim against GEICO, the primary plan, nor has that plan failed to provide for payment."). While the court agrees that Parra's reasoning applies to the Private Cause of Action provision analysis as to Guerrera and her attorneys, Parra is not applicable to the analysis with respect to Big Y, because Aetna has alleged that Big Y is a primary plan who failed to appropriately reimburse Aetna, in contrast to the decision in Parra, where it was not alleged that GEICO had failed to reimburse the survivors. See Compl. at ¶ 32.

The decision in Mason is unpersuasive for two reasons. First, the section of the Mason opinion to which the defendants cite is specifically cabined to alleged tortfeasors, in a case where liability had not yet been determined. Mason, 346 F.3d at 42. Indeed, the Second Circuit distinguished an Eleventh Circuit case on the basis that, in that case, the "defendants had assumed obligations to pay for the medical costs of plaintiff class members." Id. (discussing U.S. v. Baxter Int'l, Inc., 345 F.3d 866, 873–74 (11th Cir. 2003)). The Mason holding is thus specific to situations in which tort liability was an open question. Here, Aetna alleges that Big Y has paid a settlement, which is one of

the ways that responsibility for primary payment may be established according to the MSP. See 42 U.S.C. § 1395y(b)(2)(B)(ii) ("A primary plan's responsibility for such payment may be demonstrated by . . . a payment conditioned upon the recipient's compromise, waiver, or release . . . ."). The facts in Mason are therefore materially different than Aetna's allegations.

In a portion of the Mason opinion to which the defendants do not cite, the Second Circuit went further to opine that the MSP statute likely does not apply to tort litigation writ large. Mason, 346 F.3d at 42–43 (noting that the MSP "has apparently never been successfully used to pursue a non-insurance entity" and that "courts have rejected all efforts to apply the statute's heavy remedy of double damages in the context of tort litigation" (quoting U.S. v. Philip Morris Inc., 156 F. Supp. 2d 1, 5 (D.D.C. 2001)). Two months after Mason was published, however, Congress amended the Medicare Act to include tortfeasors in the definition of "primary plan," to add the following: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." 42 U.S.C. § 1395y(b)(2)(A)(ii). Thus, as multiple courts have since noted, this holding from Mason is no longer good law. See, e.g., Taransky, 760 F.3d at 313–14.

Finally, the defendants cite the court to Woods, a case in which the Second Circuit held that the Private Cause of Action provision is not a qui tam statute. Woods, 574 F.3d at 101. In Woods, the Second Circuit held that the Private Cause of Action provision "does not create a qui tam action, but rather merely enables a private party to bring an action to recover from a private insurer only where that private party has itself

suffered an injury because a primary plan has failed to make a required payment to or on behalf of it." Id. From this statement, the defendants urge the court to conclude that it is fatal to Aetna's claim that Aetna failed to allege that any of the defendants, including Big Y, were primary plans. Def.'s Mem. at 5–6. The court agrees with Aetna, however, that this allegation elevates form over substance. Pl.'s Response at 6. Woods does not stand for the proposition that an entity seeking to exercise the Private Cause of Action provision must recite the phrase "primary plan" in order to survive a motion to dismiss. The operative question is not whether Aetna has recited the phrase "primary plan," but whether Aetna has pled "factual content that allows the court to draw the reasonable inference" that Big Y is a primary plan. Iqbal, 556 U.S. 662, 678; see also infra Section VII (discussing the conclusory nature of inserting the phrase "primary plan" in the Complaint). Furthermore, the court notes that, although the Woods opinion describes the Private Cause of Action provision as a cause of action for a "private party" to "recover from a private insurer," this language does not preclude Aetna's cause of action against Big Y, as Aetna is a "private party" and, according to the MSP definition, Big Y is a "private insurer."

In their Reply, the defendants assert that the "2003 amendment to the definition of 'primary plan' does not change the analysis when one looks to Second Circuit precedent." Def.'s Reply at 8. The defendants do not attempt to argue that Mason was unaffected by the 2003 amendment, but rather note that Woods was decided six years after the 2003 amendment was passed and "held that the private right of action created by § 1395y(b)(3) was not equal to (and was narrower than) 'the governmental action' permitted by § 1395y(b)(2)(B)." Id. The holding to which the defendants refer, however,

relates to the fact that the plaintiff in Woods brought suit without alleging that he had personally suffered an injury. Id.; see Woods, 574 F.3d at 100. The court finds this argument by the defendants puzzling, as this holding in Woods is completely irrelevant to the case at bar, where no one, including the defendants, has argued that Aetna has failed to allege injury. It is the court's view that this argument by the defendants has no relevance to either the 2003 amendment or to this case more generally.

In sum, Parra, Mason, and Woods are either readily distinguishable from this case or, in the case of Mason, reliant on a materially different version of the MSP.

The defendants also assert that Avandia, cited by Aetna in its Complaint, is inapplicable in this case because "the complaint lacks any allegation that a defendant is a 'primary plan.'" Def.'s Mem. at 6. However, Aetna's Complaint alleges that Big Y paid Guerrera a $30,000 settlement. Compl. at ¶ 25. Although Aetna does not expressly allege that Big Y is a "self-insured plan," the allegation that Big Y paid Guerrera a settlement is sufficient, on its own, to plausibly allege that Big Y is a "primary plan" within the meaning of the MSP. In the government's cause of action provision, the MSP provides as follows:

> A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

42 U.S.C. § 1395y(b)(2)(B)(ii). Although this language is not expressly stated or incorporated in the Private Cause of Action provision, the phrase "primary plan" implicitly incorporates this responsibility-triggering provision because a primary plan, by definition, is responsible for payment. See MSP Recovery, LLC v. Allstate Ins. Co., 835

F.3d 1351, 1358–59 (11th Cir. 2016) (concluding that the "demonstrated responsibility requirement" is incorporated by reference into the Private Cause of Action provision). In other words, the phrase "primary plan" in the Private Cause of Action provision "presupposes an existing obligation . . . to pay for covered items or services." W. Heritage, 832 F.3d at 1237; see also Paraskevas v. Price, No. 16-CV-9696, 2017 WL 5957101, at *10 (N.D. Ill. Nov. 27, 2017) ("[T]he Medicare Act allows for reimbursement recovery from a tortfeasor."). Here, Aetna's allegation that Big Y paid a settlement to Guerrera (or her attorneys) to resolve a personal injury claim is sufficient to bring Big Y within the definition of "primary plan." Aetna has therefore adequately pled facts that allow the plausible inference that Big Y is responsible for the misconduct alleged. The court therefore denies the defendants' Motion to Dismiss with respect to Big Y.

C. When Suit Is Proper

The final issue for the court with respect to interpretation of the Private Cause of Action provision is to determine whether Big Y, as a primary plan, has "fail[ed] to provide for primary payment (or appropriate reimbursement)" within the meaning of the MSP. 42 U.S.C. § 1395y(b)(3)(A).

In its Complaint, Aetna alleges that Big Y was notified of Aetna's lien on Guerrera's medical expenses, but nevertheless paid Guerrera and/or her attorneys "the full amount of the Settlement Proceeds." Compl. at ¶¶ 26–32. Arguably, the fact that Big Y paid a settlement means that it did not "fail[ ] to provide for primary payment." 42 U.S.C. § 1395y(b)(3)(A). However, the court concludes that Big Y did not satisfy the obligation outlined by the Private Cause of Action provision, because the Private Cause of Action provision also includes the clause "or appropriate reimbursement." Id. (emphasis added). The word "appropriate" signals that primary plans may not satisfy

their obligations under the MSP simply by paying a settlement to a beneficiary, where they are on notice that a secondary payer has already paid the beneficiary's medical expenses.

CMS regulations support this interpretation. As described above, see supra Section V(B)(1), section 411.24 states,

> In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

42 C.F.R. § 411.24(i)(1) (emphasis added); see Glover, 459 F.3d at 1310 ("The MSP authorizes a private cause of action against a primary plan that pays a judgment or settlement to a Medicare beneficiary, but fails to pay Medicare its share." (citing section 411.24(i))). The "paragraph (h)" to which section 411.24(i) refers provides that "[i]f the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days."[10] 42 C.F.R. § 411.24(i)(1). Taken together, these two provisions describe the facts alleged by Aetna, namely that a beneficiary and/or her attorneys received a primary payment from a "liability insurance

[10] Although section 411.24 specifically describes situations in which Medicare has made a conditional payment, as opposed to an MAO, elsewhere CMS has stated that an "MA[O] will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations." 42 C.F.R. § 422.108(f). For that reason, the court concludes that section 411.24 applies to situations in which conditional payment is made by MAOs.

settlement."[11] To the extent that the MSP is vague with respect to what "appropriate" reimbursement means in the context of a settlement agreement, section 411.24 clarifies the position of CMS that payment to the wrong entity, namely the beneficiary, is not "appropriate" reimbursement.

Faced with a set of facts similar to those before the court in this case, the Eleventh Circuit concluded that a primary plan was liable to an MAO for double damages after settling a case with a beneficiary and failing to reimburse Medicare. See W. Heritage Ins. Co., 832 F.3d at 1239–40. The Eleventh Circuit looked to CMS regulations to determine what "appropriate reimbursement" meant:

> If a beneficiary or other party fails to reimburse Medicare within 60 days of receiving a primary payment, the primary plan 'must reimburse Medicare even though it has already reimbursed the beneficiary or other party.' 42 C.F.R. § 411.24(i)(1). This regulation applies equally to an MAO. See id. § 422.108(f). Thus, Western's payment to Ms. Reale or any other party is insufficient to extinguish its prospective reimbursement obligation to Humana. Sixty days after Western tendered the settlement to the Reales and their attorney, because no party reimbursed Humana, Western became obligated to directly reimburse Humana. See id. § 411.24(i)(1). Even after receiving Humana's demand for reimbursement, Western has declined to do so. Therefore, Western failed to provide for 'appropriate reimbursement' as defined by the CMS regulations.

Id. The court finds the reasoning of the Eleventh Circuit to be relevant and persuasive, and similarly concludes that the facts alleged here, if true, constitute a failure to

[11] The court notes that, while there are no allegations in Aetna's Complaint that a liability insurance plan paid the settlement, a tortfeasor that pays a settlement is considered a "self-insured plan" for the purposes of the MSP. See 42 U.S.C. § 1395y(b)(2)(A)(ii) ("An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."). Therefore, the court concludes that the facts as alleged in the Complaint put this case in the category of a "liability insurance settlement." 42 C.F.R. § 411.24(i)(1).

appropriately reimburse Aetna in violation of the MSP.

In sum, the court concludes that, pursuant to both the text of the Private Cause of Action provision and the CMS regulations interpreting the MSP more broadly, Aetna has adequately alleged that Big Y's settlement payment to Guerrera and/or her attorneys was not "appropriate reimbursement." Aetna has therefore pled facts sufficient to state a claim pursuant to the Private Cause of Action provision section 1395y(b)(3)(A) of title 42 of the United States Code against Big Y. Therefore, the defendant's Motion to Dismiss Aetna's Medicare Act claims against Big Y is denied.

VI. SUPPLEMENTAL JURISDICTION

Aetna's Complaint consists of six counts, including claims for declaratory and injunctive relief, attorneys' fees, an equitable restitution claim, a breach of contract claim, and a breach of fiduciary duty claim, as noted above. See generally Compl.

In addition to their request that the court dismiss Aetna's Medicare Act claims, the defendants urge the court to decline to exercise supplemental jurisdiction over Aetna's state law claims. Def.'s Mem. at 11 ("Because the plaintiff's federal claims are deficient and subject to dismissal . . . the proper course is for this Court to decline to hear these state law claims.").

"In the absence of diversity jurisdiction, a federal court presented with both federal and state claims may hear the state claims only if they are so closely related to the federal questions as to form part of the same 'case or controversy' under Article III." Lussier, 211 F.3d at 704. Furthermore, even where a federal court may exercise supplemental jurisdiction, whether or not to do so remains a discretionary determination influenced by several factors, including "judicial economy, convenience, fairness, and comity." Valencia ex rel. Franco v. Lee, 316 F.3d 299, 305 (2d Cir. 2003) (quoting

Carnegie-Mellon Univ. v. Cohill, 484 U.S. 343, 350 n.7 (1988)) (noting the distinction between "the power of a federal court to hear state-law claims and the discretionary exercise of that power"). These factors are codified in section 1367(c) of title 28 of the United States Code, which states that district courts may decline to exercise supplemental jurisdiction if "the claim raises a novel or complex issue of State law," the state claims "substantially predominate[ ]" over the federal claims, the district court has dismissed all federal claims, or in other "exceptional circumstances." 28 U.S.C. § 1367(c).

In this case, Aetna asserts that the facts underlying the federal claims and the facts underlying the state claims are part of the "same nucleus of facts," specifically the failure of Guerrera, her attorneys, and Big Y to reimburse Aetna for conditional payment of Guerrera's medical expenses arising from her injury at Big Y. Pl.'s Response at 31. The court agrees. Whether Aetna paid Guerrera's medical expenses, whether Aetna was reimbursed for those expenses, and who, if anyone, should have reimbursed Aetna are factual questions that underlie all the claims raised in this case, federal and state alike.

The court further concludes that the balance of the discretionary factors militates in favor of exercising supplemental jurisdiction. "Once a common nucleus [of fact] is found, a federal court's exercise of supplemental jurisdiction, 'while not automatic, is a favored and normal course of action.'" Rivera v. Ndola Pharmacy Corp., 497 F. Supp. 2d 381, 387 (E.D.N.Y. 2007) (quoting Promisel v. First Am. Artificial Flowers, 943 F.2d 251, 254 (2d Cir. 1991)). The defendants' argument to the contrary is largely based on an assumption that the court will dismiss all the federal law claims which, as described

above, the court has declined to do with respect to Big Y. See Def.'s Mem. at 11. The defendants also assert that, "[g]iven the small sum of money at issue in this case, these claims have no place in federal court." Id. The relatively small amount of money at stake, however, does not constitute an "exceptional circumstance[ ]" that would justify the court's declining jurisdiction; the small amount of money is what is at issue in the federal claim. 28 U.S.C. § 1367(c). Nor do the state law claims "raise[ ] a novel or complex issue of State law" or "substantially predominate" over the Medicare Act claim. Id.

For these reasons, the court concludes that exercising supplemental jurisdiction over Aetna's state law claims against the defendants is appropriate and denies the defendants' Motion to Dismiss with respect to the state law claims.[12]

VII. AETNA'S MOTION TO AMEND THE COMPLAINT (DOC. NO. 28)

In addition to opposing the defendants' Motion to Dismiss, Aetna also filed a Cross-Motion to Amend its Complaint (Doc. No. 38). In its Response to the Motion to Dismiss, Aetna maintains that amendment is not necessary, but requests leave to amend its Complaint "should this Court determine that Aetna's Complaint, as it is currently drafted, fails to create subject matter jurisdiction over Aetna's claims, or fails to state viable claims against Defendants." Pl.'s Response at 33. Aetna attached a proposed amended complaint to its Response. See Exh. 2, Pl.'s Response (Doc. No. 39-4) (proposed amended complaint with edits highlighted). Aetna asserts that the proposed amendments "are neither conclusory nor baseless, simply amplify and expand

[12] The court notes that the defendants did not challenge Aetna's state law claims on the merits. See Def.'s Mem. at 11 ("Though the defendants maintain that the plaintiff's claims likewise will fail under state law, the fact remains that the proper forum for any such claims to be litigated, if they are to be litigated, is in state court.").

the allegations already contained in the Complaint, and do not add any new parties or claims." Pl.'s Response at 27–28. In pertinent part, Aetna has proposed an amendment that specifically alleges that Big Y is a "primary plan." See Exh. 2, Pl.'s Response at ¶ 39.

In their Reply, the defendants argue that this amendment is both conclusory and baseless because, according to the defendants, Aetna "acknowledges that it has no idea whether Big Y or some 'completely separate,' 'undisclosed entity' is in fact the 'primary plan' that it should attempt to sue."[13] Def.'s Reply at 10.

In light of the court's conclusion that Aetna adequately alleged that Big Y is a primary plan in its initial Complaint, the court finds that amendment is unnecessary. See supra Section V(B)(2). In addition, the court agrees with the defendants that the proposed amendments are conclusory, in that they largely insert legal terms as opposed to facts. See Def.'s Reply at 10 ("Simply inserting the term 'primary plan' . . . is a textbook example of 'conclusory.'"). However, the court disagrees with the defendants' argument that Aetna has failed to allege the necessary facts to show that Big Y fits within the statutory definition of a "primary plan." See id. The problem with the proposed amendments is not that they are unsupported by facts, but that they are unnecessary in light of the facts that were previously alleged in the Complaint.

Therefore, Aetna's Cross-Motion to Amend the Complaint (Doc. No. 38) is denied

[13] The court notes that the defendants' argument that Aetna does not know who the primary plan is—made with respect to the proposed amended complaint—could, arguably, apply to the initial Complaint. The defendants did not raise this argument with respect to the initial Complaint, however, presumably because that is a dispute of fact not properly considered at the pleading stage. See Iqbal, 556 U.S. at 678 ("To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.' (emphasis added) (quoting Twombly, 550 U.S. at 570).

with respect to the amendments as proposed in Exhibit 2 to Aetna's Response.

That being said, it is the court's view that Aetna's Complaint is unclear as to which claims are specifically brought pursuant to the Medicare Act, as opposed to state law, and against whom each state claim is brought. See Def.'s Mem. at 11. In light of the court's Ruling with respect to the Medicare Act claims, the court concludes that it would be expedient, and consistent with the standard established in Rule 15 of the Federal Rules of Civil Procedure, to permit Aetna to amend its Complaint—consistent with this Ruling—in order to clarify its claims and specify, with respect to the state claims in particular, against whom the claims are alleged. See F.R.C.P. 15(a)(2) ("The court should freely give leave [to replead] when justice so requires."). Aetna is therefore given leave to replead within twenty-one days of the date of this Ruling.

VIII. CONCLUSION

For the foregoing reasons, the defendants' Motion to Dismiss (Doc. No. 36) is **GRANTED IN PART** and **DENIED IN PART**. Aetna's claims pursuant to the Medicare Act are dismissed with respect to Guerrera, Carter Mario, Hammil, and Wisniowski. Aetna's Medicare Act claim will proceed against Big Y. Furthermore, the court will exercise supplemental jurisdiction over Aetna's state law claims.

In light of the court's Ruling with respect to the Motion to Dismiss, Aetna's Cross-Motion to Amend the Complaint (Doc. No. 38) is **DENIED** with respect to the proposed amended complaint. However, Aetna is given leave to replead, consistent with this Ruling, within twenty-one days of the issuance of this Ruling, to clarify which claims are federal law claims, and against whom each state claim is alleged.

SO ORDERED.

Dated this 13th day of March 2018 at New Haven, Connecticut.

/s/ Janet C. Hall
Janet C. Hall
United States District Judge

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HHS/CMS **RIN:** 0938-AT85 **Publication ID:** Fall 2018

Title: • Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047-P)

Abstract:

This proposed rule would ensure that beneficiaries are making the best health care choices possible by providing them and their representatives with the opportunity to select an option for meeting future medical obligations that fits their individual circumstances, while also protecting the Medicare Trust Fund. Currently, Medicare does not provide its beneficiaries with guidance to help them make choices regarding their future medical care expenses when they receive automobile and liability insurance (including self-insurance), no fault insurance, and workers' compensation settlements, judgments, awards, or payments, and need to satisfy their Medicare Secondary Payer (MSP) obligations.

Agency: Department of Health and Human Services(HHS)
Priority: Economically Significant
RIN Status: First time published in the Unified Agenda
Agenda Stage of Rulemaking: Proposed Rule Stage
Major: Yes
Unfunded Mandates: No
EO 13771 Designation: Regulatory
CFR Citation: Not Yet Determined (To search for a specific CFR, visit the Code of Federal Regulations.)
Legal Authority: 42 U.S.C. 1395y(b)
Legal Deadline: None
Timetable:

Action	Date	FR Cite
NPRM	09/00/2019	

Regulatory Flexibility Analysis Required: No
Government Levels Affected: None
Federalism: No
Included in the Regulatory Plan: No
RIN Data Printed in the FR: No
Related RINs: Related to 0938-AR43

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HHS/CMS **RIN:** 0938-AT86 **Publication ID:** Fall 2018

Title: •Civil Money Penalties and Medicare Secondary Payer Reporting Requirements (CMS-6061-P)

Abstract:

Section 516 of the Medicare Access and CHIP Reauthorization Act of 2015 amended the Social Security Act (the Act) by repealing certain duplicative Medicare Secondary Payer reporting requirements. This rule would propose to remove obsolete Civil Money Penalty (CMP) regulations associated with this repeal. The rule would also propose to replace those obsolete regulations by soliciting public comment on proposed criteria and practices for which CMPs would and would not be imposed under the Act, as amended by Section 203 of the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act)

Agency: Department of Health and Human Services(HHS)
Priority: Other Significant
RIN Status: First time published in the Unified Agenda
Agenda Stage of Rulemaking: Proposed Rule Stage
Major: Undetermined
Unfunded Mandates: No
EO 13771 Designation: Regulatory
CFR Citation: Not Yet Determined (To search for a specific CFR, visit the Code of Federal Regulations.)
Legal Authority: 42 U.S.C. 1395y(b)(8)
Legal Deadline: None
Timetable:

Action	Date	FR Cite
NPRM	09/00/2019	

Regulatory Flexibility Analysis Required: No
Government Levels Affected: None
Federalism: No
Included in the Regulatory Plan: No
RIN Data Printed in the FR: No
Related RINs: Related to 0938-AR88

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April 22, 2015

APPEAL RIGHTS FOR APPLICABLE PLANS

Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation

Summary & Background

On February 27, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a final rule implementing certain provisions of the Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART ACT). This final rule establishes a formal appeals process for applicable plans in situations where the Secretary seeks Medicare Secondary Payer (MSP) recovery directly from an applicable plan. The rule is effective on April 28, 2015 and applies to demand letters issued on or after April 28, 2015.

Applicable plans include liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans. The SMART Act further requires that the Medicare beneficiary who received the items and/or services in question be notified of the applicable plan's intent to appeal. The final rule can be found at 80 FR 10611, February 27, 2015.

Overview

Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans. Medicare may make conditional payments, if payment for items or services has not been made promptly or cannot reasonably be expected to be made promptly by the applicable plan. The expectation is that these payments will be reimbursed to the appropriate Medicare Trust Fund if there is a settlement, judgment, award, or other payment (hereafter referred to as "settlement"). This includes situations where Ongoing Responsibility for Medicals (ORM) exists. Once there has been a settlement, Medicare pursues recovery of its conditional payments.

If an MSP recovery demand is issued to the beneficiary as the identified debtor, the beneficiary has formal administrative appeal and judicial review rights. Prior to this regulation, recovery demands issued to the applicable plan as the identified debtor had no formal administrative appeal rights or judicial review. CMS' recovery contractor addressed any dispute raised by the applicable plan, but prior to this final rule there was no multilevel formal appeal process for applicable plans.

The appeals process established in the final rule parallels the existing process for claims-based beneficiary and other appeals for both non-MSP and MSP, and is used for appeals involving both pre-payment denials as well as overpayments.

PROVISIONS OF THE FINAL RULE: Appeal Rights for Applicable Plans

Who does this regulation apply to? When is it effective?
"Applicable plan" means liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans. The final rule is effective April 28, 2015. The formal appeals process applies to MSP recovery demand letters issued directly to applicable plans as the identified debtor on or after April 28, 2015. Please note that receipt of a courtesy copy ("cc") of a MSP recovery demand letter by an applicable plan does not mean that the applicable plan has the ability to file an appeal..

What is the process?
The final rule establishes a formal multilevel appeal process for applicable plans where MSP recovery is pursued directly from the applicable plan. This process includes:

- An "initial determination" (the MSP recovery demand letter),
- A "redetermination" by the contractor issuing the recovery demand,
- A "reconsideration" by a Qualified Independent Contractor,
- A hearing by an administrative law judge (ALJ),
- A review by the Departmental Appeals Board's Medicare Appeals Council, and
- Judicial review.

The MSP recovery demand letter and any subsequent appeal determination will specify any timeframe or other requirement to proceed to the next level of appeal.

Who can appeal?
The applicable plan is the only entity with appeal rights/party status when Medicare pursues recovery directly from the applicable plan. The beneficiary is not a party to applicable plan appeals. However, CMS is required to provide notice to the beneficiary of the applicable plan's intent to appeal and will provide such notice if the applicable plan files a request for a redetermination.

What is required for proof of representation?
Proper proof of representation must be submitted in writing prior to or with a request for appeal in order for an attorney, agent or other entity to file an appeal on behalf of an applicable plan or act on behalf of an applicable plan with respect to an appeal that has been requested. Appeal requests without proper proof of representation will be dismissed. Proper proof of representation may be submitted with a request to vacate the dismissal, but the better course of action is to make sure that proper proof of representation has been submitted when requesting a redetermination. Separate proof of representation is required even where an applicable plan may have identified an agent for recovery correspondence as part of the Medicare, Medicaid & SCHIP Extension Act of 2007 Section 111 reporting process.

What can be appealed?
The applicable plan may appeal the amount of the debt and/or the existence of the debt. The regulation does not permit applicable plans to appeal the issue of who is the responsible party/correct debtor. Requests for appeal on the basis that the applicable plan is not the correct debtor will therefore be dismissed. Medicare's decision regarding who or what entity it is pursuing recovery from is not subject to appeal.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Rachel Aranki, Plaintiff, vs. Sylvia Matthews Burwell, Defendant.	No. CV-15-0668-PHX-SMM **ORDER**

Pending before the Court are Defendant Sylvia Matthews Burwell's Motion to Dismiss for Lack of Subject Matter Jurisdiction (Doc. 10), Plaintiff Rachel Aranki's Motion to Amend Complaint (Doc. 14), and Plaintiff's Request for Order to Amend Complaint (Doc. 17). The parties have responded and the motions are fully briefed. Having reviewed the parties' briefing, the Court will grant Defendant's motion to dismiss and deny both of Plaintiff's pending motions.

I. Background and Procedural History

A. Medicare and "Set-Aside Agreements"

Medicare, a program enacted by the U.S. federal government to provide health insurance benefits to eligible aged and disabled persons, is administered by the Centers for Medicare and Medicaid Services ("CMS"), a component of the U.S. Department of Health and Human Services ("HHS"). See Title XVIII of the Social Security Act; 42 U.S.C.A. § 1395-1395ccc (West 2015). Due to the strain on the federal budget from increased Medicare claims, Congress enacted the Medicare Second Payer ("MSP") statute, 42 U.S.C. § 1395y. The MSP statute ensures that Medicare payment obligations

are subrogated to other payment plans, such as automobile or liability insurance or workers' compensation. Id.; see Zinman v. Shalala, 67 F.3d 841, 843 (9th Cir. 1995). Simply put, "Medicare serves as a back-up insurance plan to cover that which is not paid for by a primary insurance plan." Thompson v. Goetzmann, 337 F.3d 489, 496 (5th Cir. 2003); see Estate of Ethridge v. Recovery Mgmt. Sys., Inc., 235 Ariz. 30, 33 (Ct. App. 2014), review denied (Nov. 6, 2014), cert. denied, 135 S. Ct. 1517 (2015).

To comply with the provisions outlined in the MSP statute, in workers' compensation cases CMS mandates the creation of a Medicare "set aside" ("MSA") account. 42 C.F.R. § 411. The purpose of a MSA is to allocate a portion of a workers' compensation award to pay potential future medical expenses resulting from the work-related injury so that Medicare does not have to pay. Workers' Compensation Medicare Set Aside Arrangements, Center for Medicare & Medicaid Services, http://www.cms.gov/Medicare/Coordination-of-Benefits/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSAP-Overview.html (last visited Sept. 30, 2015); see In re Arellano, 524 B.R. 615, 624 (Bankr. M.D. Pa. 2015); Sipler v. Trans Am Trucking, Inc., 881 F. Supp. 2d 635, 638 (D.N.J. 2012). However, no federal law or CMS regulation requires the creation of a MSA in personal injury settlements to cover potential future medical expenses.[1] Id.

B. Plaintiff's Arizona Superior Court Case

In 2009, Plaintiff Rachel Aranki, a Medicare beneficiary, was injured in a medical malpractice incident that left her partially paralyzed and in chronic pain. (Doc. 1) Plaintiff filed a medical malpractice action in Arizona state court against the doctors who treated her. (Id.) A settlement agreement was reached in that case. (Doc. 10) The final consummation of that settlement agreement was stalled, however, because the issue arose whether CMS would mandate the creation of a MSA. (Doc. 1.) Plaintiff petitioned CMS, who did not respond. (Id.) The Arizona Superior Court Judge presiding over that case,

[1] In 2012, CMS published an advance notice of proposed rulemaking to consider whether it should implement a similar MSA review process for personal injury settlements as it has for workers' compensation. 77 Fed. Reg. 35917-02 (June 15, 2012). However, this report was merely a solicitation of opinion, and as of today no such process exists.

nonetheless, enforced the settlement agreement and also ordered Plaintiff to file a declaratory judgment action in federal court on the MSA issue. (Id.) Plaintiff subsequently brought this action against Defendant Ms. Burwell, the current United States Secretary of HHS.

II. Standard of Review

A. Declaratory Judgment Act and Subject Matter Jurisdiction

The Declaratory Judgment Act provides that "[i]n a case of actual controversy within its jurisdiction . . . any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a). The phrase "actual controversy" refers to "cases and controversies" that are justiciable under Article III of the Constitution. Aetna Life Ins. Co. v. Haworth, 300 U.S. 227, 240 (1937). Plaintiffs carry the burden to prove the existence of an actual controversy such that subject matter jurisdiction exists. Cardinal Chem. Co. v. Morton Int'l Inc., 508 U.S. 83, 95 (1993).

Before it entertains a declaratory judgment, the district court must examine "whether there is an actual case or controversy within its jurisdiction." Principal Life Ins. Co. v. Robinson, 394 F.3d 665, 669 (9th Cir. 2005). If not, then the case is not ripe for review and the court lacks subject matter jurisdiction. Id. Second, if "an actual case or controversy exists, the court must decide whether to exercise its jurisdiction by analyzing the factors set out in [Brillhart], and its progeny." Id.; see Brillhart v. Excess Ins. Co. of Am., 316 U.S. 491 (1942). Those factors include, "[1)] the district court should avoid needless determination of state law issues; [2)] it should discourage litigants from filing declaratory actions as a means of forum shopping; and [3)] it should avoid duplicative litigation." Principal Life Ins. Co., 394 F.3d at 672.

While the Act authorizes the Court to provide declaratory relief, the Court is not required to do so. Brillhart, 316 U.S. at 494. There is no presumption in favor of abstaining from, nor is there a presumption in favor of exercising this remedial power. See Huth v. Hartford Ins. Co. of the Midwest, 298 F.3d 800, 803 (9th Cir. 2002); see also

Wilton v. Seven Falls Co., 515 U.S. 277, 289 (1995) (stating that appellate court reviews the district court's decision to grant or refrain from granting declaratory relief for abuse of discretion "because facts bearing on the usefulness of the declaratory judgment remedy, and the fitness of the case for resolution, are peculiarly within their grasp."). "In the declaratory judgment context, the normal principle that federal courts should adjudicate claims within their jurisdiction yields to considerations of practicality and wise judicial administration." Id. at 288.

B. Sovereign Immunity

As a sovereign, the United States and its constituent agencies, including HHS, is generally immune from suit except to the extent it consents to be sued. See United States v. Lee, 106 U.S. 196 (1882). "The party who sues the United States bears the burden of pointing to . . . an unequivocal waiver of immunity." Prescott v. United States, 973 F.2d 696, 701 (9th Cir. 1993) (quoting Holloman v. Watt, 708 F.2d 1399, 1401 (9th Cir. 1983)). "Only Congress enjoys the power to waive the United States' sovereign immunity." Dunn & Black, P.S. v. United States, 492 F.3d 1084, 1090 (9th Cir. 2007). "Sovereign immunity is not merely a defense to an action against the United States, but a jurisdictional bar." Powelson v. United States, 150 F.3d 1103, 1104 (9th Cir. 1998).

C. Leave to Amend Complaint

Federal Rule of Civil Procedure 15(a) requires that leave to amend "shall be freely given when justice so requires." However, a district court may deny leave to amend upon consideration of several factors, including prejudice to the opposing party, bad faith, undue delay, and futility. AmerisourceBergen Corp. v. Dialysist W., Inc., 465 F.3d 946, 953 (9th Cir. 2006). Each of these factors, however, is not given equal weight. Bonin v. Calderon, 59 F.3d 815, 845 (9th Cir. 1995). "Futility of amendment can, by itself, justify the denial of a motion for leave to amend." Id.

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III. Discussion

A. There is no Justiciable Case or Controversy Here.

Both parties spend ample time in their motions analyzing ancillary issues such as subject matter jurisdiction under 28 U.S.C. § 1331, "channeling" requirements, Mandamus Jurisdiction under 28 U.S.C. § 1361, and sovereign immunity. But this analysis is of little import, as the main threshold matter in this case lies in first determining whether an actual case or controversy exists pursuant to the Declaratory Judgment Act. The Court finds that there is no justiciable case or controversy ripe for review. As such, the Court does not have subject matter jurisdiction to hear this case.

This case is not ripe for review because no federal law mandates CMS to decide whether Plaintiff is required to create a MSA. That CMS has not responded to Plaintiff's petitions on the issue, is not reason enough for this Court to step in and determine the propriety of its actions. There may be a day when CMS requires the creation of MSA's in personal injury cases, but that day has not arrived. Because the first prong in the declaratory judgment analysis is not met here, the Court need not examine the second.

B. The United States has not Waived Sovereign Immunity.

Even if a justiciable case or controversy existed or the Court found other grounds to exercise jurisdiction, the United States in this case is immune from lawsuit as it has not waived its sovereign immunity. Plaintiff, who bears the burden of proving waiver has not unequivocally shown that the United States consents to be sued on this matter. This absence of waiver, therefore, acts as an additional bar to the Court exercising jurisdiction here.

C. Amending the Complaint Would be Futile.

In light of the previous discussion, the Court finds that it would be futile for Plaintiff to amend her complaint. Plaintiff asked for leave to amend her original complaint on the basis that she "inadvertently left out allegations of proper jurisdiction under 28 U.S.C. §§ 1331 and 1361." (Doc. 14 at 2.) Even if language establishing jurisdiction was placed in her complaint under these statutes, Plaintiff would still not be

able to clear the case and controversy and sovereign immunity hurdles. Therefore, the Court denies Plaintiff's motion.

IV. Conclusion

The Court is sympathetic to the uncertain predicament that CMS has placed upon Plaintiff. However, in light of the Court's findings, judgment in favor of Defendant is proper. Accordingly,

IT IS HEREBY ORDERED granting Defendant's Motion to Dismiss (Doc. 10.) The case will be dismissed because the court lacks subject matter jurisdiction over the matter; rendering Plaintiff's other pending motions moot. The Clerk of Court shall terminate this matter.

IT IS FURTHER ORDERED denying Plaintiff's Motion to Amend Complaint (Doc. 14.)

IT IS FURTHER ORDERED denying Plaintiff's Request for Order to Amend Complaint. (Doc. 17.) Defendant adequately responded to and addressed the futility of Plaintiff's Motion to Amend Complaint in its Reply in Support of its Motion to dismiss (Doc. 16.)

Dated this 16th day of October, 2015.

Honorable Stephen M. McNamee
Senior United States District Judge

O

United States District Court
Central District of California

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION,

Plaintiff,

v.

SYLVIA MATHEWS BURWELL, Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; and CENTER FOR MEDICARE & MEDICAID SERVICES,

Defendants.

Case № 2:15-cv-01113-ODW (FFMx)

ORDER ON MOTION TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT [63, 68, 87]

I. INTRODUCTION

This is an action for judicial review of Medicare reimbursement demands. At various times, the Center for Medicare and Medicaid Services ("CMS")—which administers the federal Medicare program and the Medicare Secondary Payer statute, 42 U.S.C. § 1395y ("MSP")—paid health benefits to three individuals. These individuals were also insured under several workers' compensation policies administered by the California Insurance Guarantee Association ("CIGA"). Because Medicare benefits are always secondary to any other applicable insurance, CMS sought reimbursement from CIGA for some of the benefits paid. CIGA alleges,

however, that CMS calculated its reimbursement liability in a manner that is contrary to the MSP and the implementing regulations, resulting in over-inclusive reimbursement demands. CIGA seeks a judicial declaration to that effect, as well as a permanent injunction barring CMS from reapplying the offending practice to future demands against CIGA. Defendants raise a litany of defenses to this action, including that: (1) CIGA's claims are moot because CMS recently ceased efforts to collect on the three reimbursement demands at issue; (2) CIGA did not make a *prima facie* case that CMS's demands were over-inclusive; (3) CMS's practice is in any event based on a reasonable interpretation of the MSP and the implementing regulations; (4) CIGA did not adequately plead its request for injunctive relief; (5) an injunction affecting future reimbursement demands effectively (and impermissibly) bypasses the mandatory administrative appeals process; and (6) directing CMS not to use a particular method to calculate reimbursement liability constitutes an impermissible "programmatic attack" on Medicare.

Defendants have moved for summary judgment, and CIGA has moved for partial summary judgment. Defendants have also moved to dismiss the action as moot. For the reasons discussed below, the Court rejects each and every argument Defendants advance, and concludes that Defendants' interpretation of the MSP and the relevant regulations are contrary to law and not entitled to deference. Accordingly, the Court **DENIES** Defendants' Motion to Dismiss (ECF No. 87),[1] **DENIES** Defendants' Motion for Summary Judgment (ECF No. 63), and **GRANTS** CIGA's Motion for Partial Summary Judgment (ECF No. 68).

II. BACKGROUND

A. Factual Background

CIGA is a statutorily-created association of insurers admitted to transact certain classes of insurance business in California. Cal. Ins. Code § 1063(a). CIGA provides

[1] After considering the papers filed in connection with this Motion, the Court deemed the matter appropriate for decision without oral argument. Fed. R. Civ. P. 78(b); C.D. Cal. L.R. 7-15.

a fund from which insureds can obtain financial and legal assistance in the event their insurers become insolvent. *Id.* To that end, CIGA is generally required to pay insurance claims that are covered under policies issued by insolvent insurers, subject to certain statutory limitations and exceptions. *See generally id.* § 1063.2.

Medicare is a health insurance program run by the federal government that provides benefits to elderly people and people with certain types of disabilities. *See generally* 42 U.S.C. §§ 1395 et seq. Where Medicare pays benefits for a loss that is covered under another insurance plan, however, the MSP requires those other plans (called "primary plans") to reimburse Medicare. 42 U.S.C. § 1395y(b)(2)(A)(ii), (B)(ii). To determine whether a potential primary plan covers a particular medical charge, CMS looks to the medical diagnosis code recorded by the provider for that charge. These codes are commonly used in the medical billing industry to indicate the condition treated and/or procedure used. (Defs.' SUF 7, 9, ECF No. 75-1; Pl.'s SUF 41, 42, ECF No. 76-1.) It is not uncommon, though, for multiple diagnosis codes to appear under a single charge—some of which relate to a medical condition covered by the primary plan, and some of which do not. In those instances, CMS determines if any one code relates to a covered condition. (Pl.'s SUF 43; Defs.' SUF 9.) If so, CMS seeks reimbursement for the full amount of the charge, even if some unsegregated portion of the charge is for medical services *not* covered by the plan. (Pl.'s SUF 44–46; Defs.' SUF 9.)

Here, CIGA informed CMS that it was paying certain medical costs for three people under three separate workers' compensation policies. (Defs.' SUF 5.) CMS determined that it had also paid benefits to those people, and thus sent conditional payment letters to CIGA seeking full reimbursement for each charge containing at least one covered diagnosis code—even though many charges also contained codes that were indisputably not covered. (Defs.' SUF 5; Pl.'s SUF 2–4, 6, 9, 15, 25, 26.) For example, under Claim No. 108-7200001951 ("Claim 1"), CIGA's policy covered medical costs incurred by a worker as a result of a slip and fall accident that caused

back and leg injuries. (Pl.'s SUF 5.) Although each charge for which CMS sought reimbursement contained at least one diagnosis code related to this injury, several charges also contained codes relating to diabetes, insulin use, and bereavement. (Pl.'s SUF 5–11.) Likewise, under Claim No. 113-OSB80012157 ("Claim 2"), CIGA was paying for medical costs incurred by a worker after he stepped into a hole and injured his left knee, left hip, and spine; yet CMS sought full reimbursement for charges that also contained codes relating to high blood pressure, bronchitis, tobacco use, and eczema. (Pl.'s SUF 14–21.) Finally, under Claim No. 113-9500002572 ("Claim 3"), CIGA was paying for medical costs incurred by a worker for asbestos exposure, but CMS sought reimbursement for charges that also contained codes relating to stomach ulcers, dizziness, and giddiness. (Pl.'s SUF 24–30.) CIGA responded to CMS's letters by raising a host of defenses, including that numerous charges contained diagnosis codes that its policies did not cover. (Pl.'s SUF 12–13, 22–23, 32–33; Defs.' SUF 8.) CMS nevertheless issued a formal demand letter for the full amount of each charge. (*See* Pl.'s SUF 66.) This lawsuit soon followed.[2]

B. The Pleadings

1. First Amended Complaint

In its First Amended Complaint ("FAC"), CIGA asserted several theories that broadly challenged CMS's ability to seek *any* reimbursement from CIGA.[3] (FAC ¶ 29.) First, CIGA alleged that workers' compensation plans are not "primary plans"

[2] At the time this dispute arose, there was no administrative appeals process in place to challenge final reimbursement determinations against primary payers. Thus, as Defendants concede, the issuance of a formal demand letter to the primary payer constitutes "final agency action" that is subject to judicial review. *See Haro v. Sebelius*, 747 F.3d 1099, 1114 (9th Cir. 2014). CMS has since passed regulations requiring that such reimbursement disputes go through the same appeals process as Medicare benefit determinations. *See generally* Medicare Program; Right of Appeal for Medicare Secondary Payer Determinations Relating to Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Laws and Plans, 80 Fed. Reg. 10,611-01 (Feb. 27, 2015) (codified in scattered sections of 42 C.F.R. § 405).

[3] CIGA brings these challenges using the following procedural vehicles: (1) the Administrative Procedure Act, 5 U.S.C. § 702; (2) the Medicare Act, 42 U.S.C. § 1395ii; and (3) the Declaratory Judgment Act, 28 U.S.C. § 2201. (ECF No. 40.)

under the MSP when administered by CIGA. (*Id.* ¶ 28.) Next, CIGA alleged that it can pay only statutorily-defined "covered claims," Cal. Ins. Code § 1063.2, and that the statutory definition excludes (1) obligations to the federal government, *id.* § 1063.1(c)(4), and (2) any claims that are not "within the coverage of an insurance policy of the insolvent insurer," *id.* § 1063.1(c)(1)(A). (FAC ¶¶ 27, 32.) Finally, CIGA asserted that it was obligated to pay claims only if they arose after the date of the issuing-insurer's insolvency, and that CMS made many of the benefit payments before that date. (*Id.* ¶ 35.) CIGA sought declaratory and injunctive relief, including "an order permanently enjoining Defendants . . . from enforcing the MSP provisions against CIGA with respect to government claims for reimbursement that are not 'covered claims.'" (FAC, Prayer for Relief ¶ 4.)

Defendants moved to dismiss the FAC. (ECF No. 24.) The Court held that CIGA-administered insurance plans constitute "primary plans" within the meaning of the MSP, and that the MSP preempted the California Guaranty Act's prohibition on paying obligations to the federal government. (Order at 17, ECF No. 38.) However, the Court determined that CIGA had stated a plausible claim to the extent CMS sought reimbursement for claims that were not "within the coverage of an insurance policy of the insolvent insurer." (*Id.* at 25.) Finally, the Court held that CIGA did not plead sufficient facts in support of its remaining claims and theories, which the Court dismissed with leave to amend. (*Id.*)

2. Second Amended Complaint

In its Second Amended Complaint ("SAC"), CIGA reasserted its theory that CMS was improperly seeking reimbursement for charges that did not fall "within the coverage of an insurance policy of the insolvent insurer." (SAC ¶¶ 43–47, 48–52, ECF No. 40.) But CIGA also alleged two new theories: that the payments at issue were not "covered claim[s]" because (1) CMS did not file timely proofs of claim in the defunct insurer's insolvency proceedings, and (2) CMS was impermissibly asserting claims as an assignee or subrogee of the insured. (*Id.* ¶¶ 26–42.) The prayer

for relief in the SAC was identical to the prayer in the FAC. (*Id.*, Prayer for Relief ¶¶ 1–5.) Upon motion by Defendants, the Court dismissed the new theories without leave to amend. (ECF No. 50.) This left only CIGA's original theory that the policies it administered did not cover all of the losses for which CMS sought reimbursement. Defendants answered CIGA's SAC thereafter. (ECF No. 51.)

3. Proposed Third Amended Complaint

In May 2016, CIGA moved for leave to file a Third Amended Complaint to add, among other things, a request to permanently enjoin Defendants from seeking reimbursement from CIGA for "charges . . . that are not covered by the workers compensation insurance policy of any insolvent insurer." (ECF No. 55.) The Court denied the motion, holding that such relief could and should have been pleaded in prior iterations of its complaint. (Order at 8, ECF No. 61.)

C. Pending Motions

In June 2016, CIGA moved for partial summary judgment on its APA claim, and Defendants moved for summary judgment on the entire action. (ECF Nos. 63, 68.) At the hearing on the motions, the Court expressed deep skepticism with Defendants' interpretation of the MSP. (ECF No. 79, 81.) The Court ultimately took both motions under submission and ordered the parties to mediate further. (*Id.*) Four weeks later, the parties submitted a joint report stating that they were unable to reach a settlement. (ECF No. 87.) Defendants also indicated, however, that they had since recalculated CIGA's liability for the disputed charges based on their "discussions with CIGA," and that the "total recalculated amount was substantially lower than that of the original demands." (*Id.* at 5.) Defendants thus decided to withdraw those demands. (*Id.*) Defendants argued that this rendered the action moot, and that "[a]ny new demands [for payment] would be based on the recalculated amounts, [which] would be subject to a full administrative appeals process as provided by Medicare regulation." (*Id.* at 5–6.) Defendants requested leave to move to dismiss the action as moot, which the Court granted. (ECF No. 84.)

The parties' summary judgment motions, as well as Defendants' motion to dismiss, are now before the Court for decision.

III. MOTION TO DISMISS

Defendants argue that because CMS will no longer seek reimbursement for the payments allegedly owed under the three claims, this action is moot and must be dismissed. (Defs.' Mot. to Dismiss at 6–7, ECF No. 87; Defs.' Reply at 2–5, ECF No. 89.) CIGA responds that Defendants' conduct does not make it "absolutely clear" that CMS will never again reopen these claims or reapply the offending practice, which means the case is not moot. (Pl.'s Opp'n at 3–6, ECF No. 88.) The Court agrees with CIGA that no part of the case is moot.[4]

"[A] case becomes moot when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." *Murphy v. Hunt*, 455 U.S. 478, 481 (1982) (internal quotation marks omitted). The Supreme Court "ha[s] recognized, however, that a defendant cannot automatically moot a case simply by ending its unlawful conduct once sued. Otherwise, a defendant could engage in unlawful conduct, stop when sued to have the case declared moot, then pick up where he left off, repeating this cycle until he achieves all his unlawful ends." *Already, LLC v. Nike, Inc.*, 133 S. Ct. 721, 727 (2013) (citations omitted). Accordingly, voluntary cessation moots a claim only where "subsequent events made it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur." *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 189 (2000) (internal quotation marks omitted); *see also Nw. Envtl. Def. Ctr. v. Gordon*, 849 F.2d 1241, 1245 (9th Cir. 1988) (a case is not moot if the court can grant "*any* effective relief"). The party asserting mootness bears the "heavy burden" of meeting this standard. *Rosebrock v. Mathis*, 745 F.3d 963, 971 (9th Cir. 2014).

[4] The Court addresses Defendants' arguments regarding the propriety of injunctive relief in Section IV.C.

Here, the government clearly has not met that burden. Defendants have not changed their practice with respect to reimbursement calculations; rather, they have simply withdrawn their reimbursement demands for the three particular claims at issue in this lawsuit. "'[T]he government cannot escape the pitfalls of litigation by simply giving in to a plaintiff's individual claim without renouncing the challenged policy, at least where there is a reasonable chance of the dispute arising again between the government and the same plaintiff.'" *Rosemere Neighborhood Ass'n v. U.S. Envtl. Prot. Agency*, 581 F.3d 1169, 1175 (9th Cir. 2009) (quoting *Legal Assistance for Vietnamese Asylum Seekers v. Dep't of State*, 74 F.3d 1308, 1311 (D.C. Cir. 1996)). Indeed, given the timing of the withdrawals (i.e., immediately after a hearing in which the Court made clear that CMS's practice would not withstand scrutiny), it seems obvious that this is simply a strategic maneuver designed to head off an adverse decision so that CMS can continue its practice in the future.[5] *See Knox v. Serv. Emps. Int'l Union, Local 1000*, 132 S. Ct. 2277, 2287 (2012) ("The SEIU argues that we should dismiss this case as moot. In opposing the petition for certiorari, the SEIU defended the decision below on the merits. After certiorari was granted, however, the union sent out a notice offering a full refund to all class members, and the union then promptly moved for dismissal of the case on the ground of mootness. Such postcertiorari maneuvers designed to insulate a decision from review by this Court must be viewed with a critical eye. . . . [Moreover], since the union continues to defend the legality of the Political Fight–Back fee, it is not clear why the union would necessarily refrain from collecting similar fees in the future. . . . For this reason, we conclude that a live controversy remains . . . ."). Thus, neither the claim for declaratory relief as to the three reimbursements demands, nor the request for injunctive relief as to future reimbursement calculations, are moot. *See also*

[5] This also rebuts any presumption that the government was acting in good faith in withdrawing the payment demands. *Rosebrock*, 745 F.3d at 972; *Am. Cargo Transp., Inc. v. United States*, 625 F.3d 1176, 1180 (9th Cir. 2010).

Rosemere, 581 F.3d at 1173 (in an action to compel EPA to adjudicate plaintiff's outstanding administrative claim and for an injunction requiring EPA to timely adjudicate plaintiff's future claims, EPA's adjudication of the outstanding claim did not moot the request for injunctive relief because the government did not show it was "absolutely clear" that future administrative claims by plaintiff would be timely adjudicated).

IV. MOTIONS FOR SUMMARY JUDGMENT

A. Legal Standard

1. Summary Judgment

A court "shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). Courts must view the facts and draw reasonable inferences in the light most favorable to the nonmoving party. *Scott v. Harris*, 550 U.S. 372, 378 (2007). A disputed fact is "material" where the resolution of that fact might affect the outcome of the suit under the governing law, and the dispute is "genuine" where "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1968).

The district court "is not required to resolve any facts in a review of an administrative proceeding"; rather, "the function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." *Occidental Eng'g Co. v. I.N.S.*, 753 F.2d 766, 769 (9th Cir. 1985). As a result, summary judgment is an appropriate vehicle for deciding such cases. *Id.*

2. Standard of Review

When a party seeks judicial review of agency action under the APA, "[t]he reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; . . . (C) in excess of statutory jurisdiction, authority, or

limitations, or short of statutory right; [or] (D) without observance of procedure required by law." 5 U.S.C. § 706(2)(A), (C), (D).[6] Under the APA, questions of statutory interpretation are addressed under the *Chevron* and *Skidmore* framework, and questions of regulatory interpretation under *Auer*.

i. *Chevron* Deference

Courts review an agency's construction of a statute that it administers using a two-step test. "First, applying the ordinary tools of statutory construction, the court must determine 'whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *City of Arlington, Tex. v. F.C.C.*, 133 S. Ct. 1863, 1868 (2013) (citations omitted). "But 'if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.'" *Id.*

While administrative regulations are the classic vehicle for an agency's interpretation of a statute, deference is not foreclosed to interpretations contained in other mediums. Rather, the Court must analyze "the form and context" in which the interpretation arose. *Price v. Stevedoring Servs. of Am., Inc.*, 697 F.3d 820, 826 (9th Cir. 2012) (en banc); *United States v. Mead Corp.*, 53 U.S. 218, 226–27 (2001). The Ninth Circuit has taken a very skeptical approach to statutory interpretations advanced only during litigation or in the government's briefs. *Price*, 697 F.3d at 825–32; *Andersen v. DHL Ret. Pension Plan*, 766 F.3d 1205, 1212 (9th Cir. 2014) ("[T]he government's brief here is not entitled to deference pursuant to *Chevron* insofar as it interprets the statutory text directly.").

[6] CIGA does not move for summary judgment on its claims under the Medicare Act or the Declaratory Judgment Act. Defendants also do not address those claims, even though they move for summary judgment on CIGA's entire lawsuit. Because of this, Defendants have not met their burden of showing that they are entitled to judgment as a matter of law on those claims.

ii. *Skidmore* Deference

"Where *Chevron* is inapplicable, reasonable agency interpretations may still carry 'at least some added persuasive force.'" *Price*, 697 F.3d at 832 (quoting *Metro. Stevedore Co. v. Rambo*, 521 U.S. 121, 136 (1997)). Under *Skidmore*, "an agency's interpretation may merit some deference whatever its form, given the 'specialized experience and broader investigations and information' available to the agency, and given the value of uniformity in its administrative and judicial understandings of what a national law requires." *Mead Corp.*, 533 U.S. at 234 (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944)). "Under this level of review, [the court] look[s] to the process the agency used to arrive at its decision. Among the factors [the court] consider[s] are the interpretation's thoroughness, rational validity, consistency with prior and subsequent pronouncements, the logic and expertness of an agency decision, the care used in reaching the decision, as well as the formality of the process used." *Tablada v. Thomas*, 533 F.3d 800, 806 (9th Cir. 2008) (citations, internal quotation marks, and brackets omitted). Whether deference is due an agency's litigating position is "likely to turn on factors such as the consistency of its position and its application of that position through administrative practice than on the quality of its court advocacy." *Price*, 697 F.3d at 832 n.8.

iii. *Auer* Deference

Finally, when an agency interprets its own regulations, that interpretation "is entitled to substantial deference." *Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 149 (1991) (internal quotation marks omitted). "In situations in which the meaning of regulatory language is not free from doubt, the reviewing court should give effect to the agency's interpretation so long as it is reasonable [and] the interpretation sensibly conforms to the purpose and wording of the regulations." *Id.* (citations, brackets, and internal quotation marks omitted). Such deference is usually warranted "even when that interpretation is advanced in a legal brief." *Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2166 (2012). However,

"*Auer* deference is not warranted in *all* circumstances." *Vietnam Veterans of Am. v. Cent. Intelligence Agency*, 811 F.3d 1068, 1078 (9th Cir. 2016) (emphasis added).

> Deference is undoubtedly inappropriate, for example, when the agency's interpretation is plainly erroneous or inconsistent with the regulation. And deference is likewise unwarranted when there is reason to suspect that the agency's interpretation does not reflect the agency's fair and considered judgment on the matter in question. This might occur when the agency's interpretation conflicts with a prior interpretation, or when it appears that the interpretation is nothing more than a convenient litigating position, or a *post hoc* rationalization advanced by an agency seeking to defend past agency action against attack.

Christopher, 132 S. Ct. at 2166 (citations, brackets, and internal quotation marks omitted).

B. Analysis

CIGA does not dispute that each charge for which CMS sought reimbursement contained at least one diagnosis code that is covered by CIGA's policies, and Defendants do not dispute that each charge also contained codes that were *not* covered by those policies. (Defs.' SUF 9, 10; Pl.'s SUF 6–7, 15–16, 25–26.) Thus, the parties' arguments center on two main issues: (1) whether CIGA made a *prima facie* case to CMS that the reimbursement requests were erroneous; and (2) whether the MSP and the implementing regulations support Defendants' position that CIGA must always fully reimburse CMS for a charge containing one covered code regardless of whatever uncovered codes are also present.

1. Burden

The parties agree that Medicare reimbursement disputes are subject to a burden-shifting analysis. That is, CIGA "ha[s] the initial burden of making a *prima facie* case that Medicare's reimbursement request were overinclusive." *Estate of Urso v. Thompson*, 309 F. Supp. 2d 253, 260 (D. Conn. 2004). If CIGA meets this burden, the burden shifts to CMS to justify its reimbursement requests. *Id.*; *see also Wall v. Leavitt*, No. CIV S05-2553FCDGGH, 2008 WL 4737164, at *15 (E.D. Cal. Oct. 29,

2008) (following *Urso*); *Weinstein v. Sebelius*, No. CIV.A. 12-154, 2013 WL 1187052, at *6 (E.D. Pa. Feb. 13, 2013) (same); *Young v. Sec'y of Health & Human Servs.*, No. 4:11CV002-B-A, 2012 WL 379510, at *4 (N.D. Miss. Feb. 3, 2012) (same).

Defendants argue that CIGA failed to make a *prima facie* case to CMS that it was not responsible for the disputed payments. (Defs.' Mot. at 9–10, ECF No. 63.) The Court disagrees. CMS sent conditional payment letters to CIGA identifying the charges for which it believed CIGA was responsible. For two of the three demands at issue, CIGA disputed its liability for the charges on several grounds—including that they contained diagnosis codes that were not covered by the underlying workers' compensation policies. (Azaran Decl., Exs. C, E, G, ECF No. 68-4.) CIGA included a list of such codes for one of the claims, and has since identified additional uncovered codes for each of the three claims. (Azaran Decl., Ex. G; Young Decl. ¶ 3, Ex. A, ECF No. 68-3; SAC ¶¶ 46, 50, 52.)[7] Defendants contend that simply providing a list of purportedly uncovered diagnosis codes is insufficient because this does not prove that the codes were in fact uncovered, and that it in any event does not show how the inclusion of uncovered codes renders CMS's reimbursement demands over-inclusive (or by how much). (*See* Defs.' Mot. at 9–10, ECF No. 63; Defs.' Reply at 2–5, ECF No. 78; Defs.' Opp'n at 4–6, ECF No. 76.) Given the scope of CIGA's argument, however, identifying the unrelated codes is sufficient. Whether or not the listed codes were covered by CIGA's policies has never been in dispute—with only a few exceptions, all parties have always agreed that they are not. (*See* Pl.'s SUF 6–30, 58–60, 62–65.) Rather, as Defendants concede, CMS sought full reimbursement for the disputed charges because it is CMS's practice to "seek full reimbursement for a conditional payment as long as one diagnosis code was related." (Defs.' Reply at 4.) To the extent CIGA is only challenging this blanket practice, it is sufficient that CIGA

[7] While Defendants argue that CIGA's interrogatory responses and employee declarations do not show that it has met its burden, Defendants do not appear to argue that such evidence cannot be considered for this purpose. Thus, the Court only assumes, without deciding, that this is the case.

identified diagnosis codes that everyone agrees is plainly unrelated to any medical conditions that the workers' compensation policies cover.

2. Validity of CMS's Practice

Under the MSP, "a primary plan . . . shall reimburse [Medicare] for any payment made . . . with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." 42 U.S.C. § 1395y(b)(2)(B)(ii). The critical phrase—"item or service"—is defined by regulation, which reads in relevant part: "Any item, device, medical supply or service provided to a patient (i) which is listed in an itemized claim for program payment or a request for payment . . . ." 42 C.F.R. § 1003.101. Defendants appear to argue that the term "an item or service" refers to whatever (and however many) medical treatment(s) a provider lumps into a single charge, and that CIGA has a "responsibility to make payment with respect to such item or service" if the provider lists one or more diagnosis code(s) that are covered by the CIGA-administered policy. Defendants are wrong on both counts.

i. Definition of "Item or Service"

The statutory phrase "an item or service" clearly does not refer to multiple medical treatments just because they appear under one charge. The singular form of the words "item" and "service" itself suggests that those words are not referring to multiple medical treatments. Moreover, the use of the phrase "item or service" elsewhere in the MSP does not support Defendants' interpretation. *Util. Air Regulatory Grp. v. E.P.A.*, 134 S. Ct. 2427, 2441 (2014) ("One ordinarily assumes 'that identical words used in different parts of the same act are intended to have the same meaning.'" (citation omitted)). For example, the MSP describes an individual "submit[ting] *a* claim for payment for item*s* and services," 42 U.S.C. § 1395y(e)(2) (emphases added), thus suggesting that a single claim for payment can contain multiple "items" or "services." Similarly, the MSP also describes the situation in which "*a* payment" is made by CMS "for item*s* and services provided to the

claimant," *id.* § 1395y(b)(2)(B)(vii)(1), which makes clear that a single payment (which Defendants appear to assume always corresponds to a single charge) can be made for multiple items or services. Defendants do not point to anything suggesting that Congress intended the definition of "item or service" to depend in any way on the manner in which a provider bills for them. It thus seems clear that one "item or service" refers to only *one* medical treatment, regardless of how it is billed.

To the extent any ambiguity remains in the statute, the regulation defining "item or service" actually detracts from Defendants' interpretation. That regulation defines a singular "item or service" as "[a]ny item, device, medical supply or service provided to a patient . . . which is listed in an itemized claim for program payment or a request for payment." 42 C.F.R. § 1003.101. Notably, the terms "item, device, medical supply or service" are also in the singular form. If the agency contemplated multiple medical treatments to potentially qualify as one "item or service," it should have (at the very least) used the plural form of these words. And despite Defendants' suggestion otherwise, the fact that an "item or service" must be "listed in an itemized claim for program payment" does not compel a different result. Just because an item or service must be listed in a claim for payment does not mean that their character as either a single or multiple "item or service" depends on *how* they are listed.

ii. CIGA's "Responsibility to Make Payment" for the Item or Service

The Court is also unconvinced that CIGA has a "responsibility to make payment" for a treatment not covered by its policy just because that treatment is lumped together with other covered treatments on a line-item charge. Whether a compensation carrier has a "responsibility to make payment" with respect to an item or service is generally a matter of state law. *See* 42 U.S.C. § 1395y(b)(2)(A)(ii); *Caldera v. Ins. Co. of the State of Pa.*, 716 F.3d 861, 863–65 (5th Cir. 2013). California law is clear that where a patient receives multiple treatments for multiple conditions, the compensation carrier is not responsible for the treatments that are not

attributable to an industrial accident—at least to the extent they are separable from the treatments that are so attributable. *See S. Coast Framing, Inc. v. W.C.A.B.*, 61 Cal. 4th 291, 297 (2015) ("It has long been settled" that a compensation carrier must pay benefits only for "an injury [that] 'arise[s] out of the employment,'" which means that the injury "must 'occur by reason of a condition or incident of [the] employment'"); *Granado v. Workmen's Comp. App. Bd.*, 69 Cal. 2d 399, 405 (1968) ("Medical treatment unrelated to the industrial injury need not be furnished by the employer."); *Indus. Indem. Co. v. Indus. Acc. Comm'n*, 103 Cal. App. 2d 249, 250 (1951) ("It is clear from these provisions that the award of compensation for medical treatment can only be made where the necessity for such treatment results from an injury incurred in the employment.").

Defendants point to several cases holding that a workers' compensation carrier cannot seek to apportion the cost of a single medical treatment just because that treatment is also used to cure an uncovered condition. *See Granado*, 69 Cal. 2d at 405–06 ("So long as the treatment is reasonably required to cure or relieve from the effects of the industrial injury, the employer is required to provide the treatment, and treatment for nonindustrial conditions may be required of the employer where it becomes essential in curing or relieving from the effects of the industrial injury itself."); *Rouseyrol v. Workers' Comp. App. Bd.*, 234 Cal. App. 3d 1476, 1485 (1991) (an employer cannot "apportion[] the entire need for [medical] care to nonindustrial causes on the theory that, despite industrial contribution to the need for attendant care, natural progression of a preexisting disease would have resulted in a need for the same level of care at the present time even if there had been no industrial injury"). However, this says nothing about apportioning a charge that represents the cost of *multiple* medical treatments.[8]

[8] There may be a factual dispute as to whether each contested charge represents one medical treatment or if there are some that represent two or more treatments. Nevertheless, this does not preclude summary judgment. Defendants have made clear that CMS's practice is to seek full reimbursement for a charge that contains one or more covered diagnosis codes, regardless of

Defendants also argue that even if state law allows for apportionment, it is preempted by the MSP. However, Defendants do not show that the MSP even requires anything different. Assuming that "an item or service" could be construed as potentially referring to multiple medical treatments, the MSP does not make CIGA's obligation to pay for that "item or service" an all-or-nothing proposition. For example, the MSP describes CMS's ability to bring a direct action for reimbursement against entities "that are or were required or responsible . . . to make payment with respect to the same item or service (*or any portion thereof*) under a primary plan." 42 U.S.C. § 1395y(b)(2)(B)(iii) (emphasis added); *see also id.* § 1395y(b)(2)(B)(vi) (describing "entit[ies] required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan . . ."). The MSP therefore contemplates that a primary plan could be "responsible" for paying only a "portion" of an "item or service." *Id.* Defendants do not point to anything in the MSP showing that CIGA must reimburse CMS for more than what CIGA is otherwise "responsible" for paying.

iii. Deference

Defendants argue at length that the Court must defer to their interpretation of the MSP and the relevant regulations. The Court again disagrees. First, Defendants' brief is not entitled to *Chevron* deference to the extent it attempts to interpret the MSP directly. *Andersen*, 766 F.3d at 1212. Second, the relevant regulation (42 C.F.R. § 1003.101) actually supports CIGA's interpretation of the MSP, and thus any deference to it would not help Defendants. Third, Defendants' interpretation of § 1003.101 is not entitled to *Auer* deference both because it "conflicts with" CMS's MSP Manual, and because it appears to be just "a *post hoc* rationalization seeking to defend past agency action against attack." *Christopher*, 132 S. Ct. at 2166. The MSP

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anything else, and that they applied this practice to calculating the reimbursement demands here. Thus, Defendants acted contrary to law.

Manual provides:

> If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work related, Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare.

(Pl.'s SUF 55.)

Defendants argue that this provision relates only to conditional payments for which CMS can always seek reimbursement rather than payments for which reimbursement is not expected (or required) from the compensation carrier. However, the Court is not convinced that this provision is wholly unrelated to reimbursement. Where a doctor furnishes services to a patient "for a condition which was not work related," a workers' compensation carrier has no obligation to pay for that service or to reimburse CMS for that service. (*See supra*.) Thus, by stating that "Medicare benefits may be paid" in the event that the charges are not covered by either workers' compensation or "any other source which is primary to Medicare," the manual is not simply stating that a reimbursable conditional payment may made, because the built-in assumption here is that there is no primary payer that can reimburse CMS for that payment. Accordingly, this provision contemplates the payment of benefits *without reimbursement* "for a condition which was not work related" when furnished "concurrently with services which were work related."

The relevance of this provision to reimbursement is buttressed by the testimony of Ian Fraser, who is a health insurance specialist employed by CMS. When asked in deposition about the effect of this provision on CMS's reimbursement procedures, Fraser remarked that he found this provision "difficult" because it was either impractical or impossible to split a single charge containing "both work related services and nonwork related services." (Fraser Depo. at 36–38, ECF No. 68-1.) However, he testified that he did not disagree "with the actual substance of that [provision]." (*Id.*) Fraser thus tacitly acknowledged that this provision not only

relates to reimbursement but that it requires something other than what CMS actually does with respect to calculating reimbursements for single charges. Defendants cannot wiggle out of this testimony by submitting a subsequent declaration from Fraser stating that this provision simply relates to conditional payments and not reimbursement, which contradicts his deposition testimony.[9] At bottom, it is quite clear that the real reason CMS calculates reimbursement demands in the manner that it does is simply because it is too difficult to do otherwise, not because that is what is required (or even permitted) by any statute, regulation, or policy manual. For these reasons, the Court declines to give *Auer* deference to Defendants' interpretation of the implementing regulations.[10]

On a final note, the Court wishes to emphasize the limits of its decision. The Court simply holds that if a single charge contains multiple diagnosis codes—some of which relate to a medical condition covered by CIGA's policy and some of which do not—the presence of one covered code does not *ipso facto* make CIGA responsible for reimbursing the full amount of the charge. Instead, CMS must consider whether the charge can reasonably be apportioned between covered and uncovered codes or treatments. Upon such consideration, CMS might still conclude that apportioning the charge is unreasonable. In addition, even if the charge should be apportioned, the Court takes no position on *how* CMS should do so (e.g., pro-rata by covered codes versus uncovered codes, or some other method).

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[9] Defendants also suggest that Fraser was essentially tricked in his deposition into believing that this provision concerned reimbursement. After reviewing the context of the questioning, the Court sees no trickery here. Defendants do not explain how a health insurance specialist who has worked in CMS's MSP unit for 13 years would not have had a thorough understanding of what portions of the MSP Manual applied to reimbursements versus benefit coordination, and thus be able to point out during his deposition that the provision put in front of him had nothing to do with reimbursements.

[10] For the same reason, the Court declines to give *Skidmore* deference to Defendants' interpretation of the MSP. *Price*, 697 F.3d at 832 n.8 (*Skidmore* deference usually turns in part on "the consistency of [the agency's] position").

C. Injunctive Relief

Defendants contend that even if CMS's practice is arbitrary and capricious, CIGA is not entitled to injunctive relief barring CMS from applying the practice for future claims because: (1) CIGA did not adequately plead the specific type of injunctive relief it now seeks; (2) such relief would constitute an end-run around the mandatory administrative appeals process for future reimbursement disputes; and (3) it would constitutes an impermissible "programmatic attack" against a federal agency. None of these reasons show that CIGA is not entitled to injunctive relief.[11]

1. Sufficiency of the Pleadings

In both its FAC and SAC, CIGA prayed for "an order permanently enjoining Defendants . . . from enforcing the MSP provisions against CIGA with respect to government claims for reimbursement that are not 'covered claims.'" (FAC, Prayer for Relief ¶ 4; SAC, Prayer for Relief ¶ 4.) Defendants argue that this prayer for relief pertains only to legal theories that the Court previously dismissed. Indeed, CIGA sought leave to file a Third Amended Complaint to add a specific request to enjoin Medicare from seeking reimbursement for "charges . . . that are not covered by the workers compensation insurance policy of any insolvent insurer," suggesting that even CIGA recognized that the SAC's prayer for relief did not relate to the one theory still left before the Court. While the question is close, the Court concludes that CIGA is not precluded from seeking their request injunction.

"Every . . . final judgment [not obtained by default] should grant the relief to which each party is entitled, even if the party has not demanded that relief in its pleadings." Fed. R. Civ. P. 54(c). Rule 54(c) is "liberally construed," and thus the court should usually "grant whatever relief is appropriate in the case on the facts

[11] The parties have not addressed, and thus the Court does not decide, whether injunctive relief is otherwise appropriate under the traditional four-factor test. *eBay Inc. v. MercExchange, L.L.C.*, 547 U.S. 388, 391 (2006) ("[A] plaintiff seeking a permanent injunction must satisfy a four-factor test before a court may grant such relief."); *High Sierra Hikers Ass'n v. Blackwell*, 390 F.3d 630, 641 (9th Cir. 2004) (applying equitable test to a permanent injunction against an administrative agency).

proved"—"includ[ing] injunctive relief when appropriate, and even when not specifically requested." *Kaszuk v. Bakery & Confectionery Union & Indus. Int'l Pension Fund*, 791 F.2d 548, 559 (7th Cir. 1986) (citations and internal quotation marks omitted). That said, a party may nevertheless not be "entitled" to relief "if its conduct of the cause has improperly and substantially prejudiced the other party." *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 424–25 (1975). A party may be "prejudiced" if the court "grants relief not requested and of which the opposing party has no notice." *Powell v. Nat'l Bd. of Med. Examiners*, 364 F.3d 79, 86 (2d Cir. 2004); *see also Felce v. Fiedler*, 974 F.2d 1484, 1501–02 (7th Cir. 1992). This appears to be a narrow exception, however, for the Ninth Circuit has liberally construed what constitutes sufficient notice of the requested relief. *Compare Nw. Envtl. Def. Ctr. v. Gordon*, 849 F.2d 1241, 1245 (9th Cir. 1988) (plaintiff was entitled to the injunctive relief the district court awarded because it was only slightly different from the injunction prayed for in the complaint, and because plaintiff brought to the district court's attention the possibility of seeking a different injunction), *with Seven Words LLC v. Network Sols.*, 260 F.3d 1089, 1098 (9th Cir. 2001) (defendant was prejudiced by plaintiff's request for damages where it "was made after two years of litigation, after various representations that it was seeking only declaratory and injunctive relief, after a motion to dismiss, and at the eleventh hour, only days before oral argument on appeal").

Here, CIGA gave sufficient notice to Defendants that it sought to enjoin CMS from seeking full reimbursement for charges containing uncovered diagnosis codes. In its FAC, CIGA alleged multiple reasons why CMS's request for reimbursement did not constitute a statutorily-defined "covered claim," including because the payments did not fall "within the coverage of an insurance policy of the insolvent insurer," Cal. Ins. Code § 1063.1(c)(1)(A). (FAC ¶ 32.) CIGA broadly requested "an order permanently enjoining Defendants . . . from enforcing the MSP provisions against CIGA with respect to government claims for reimbursement that are not 'covered

claims.'" (FAC, Prayer for Relief ¶ 4.) CIGA similarly alleged in its SAC that it could "only pay 'covered claims' that are 'within the coverage of an insurance policy of the insolvent insurer,'" and that "Defendants seek to recover many 'conditional' payments from CIGA that are outside the coverage of the insolvent insurer's policy . . . ." (SAC ¶ 44.) CIGA also reasserted the identical request for injunctive relief present in the FAC. While the Court has since dismissed CIGA's *other* legal theories as to why CMS's reimbursement requests were not "covered claims," it is quite clear that the request for injunctive relief still applies to the lone remaining theory.

To be fair, CIGA caused a fair amount of confusion when it sought to add a *further* prayer for injunctive relief that would bar CMS from seeking reimbursement from CIGA specifically for "charges . . . that are not covered by the workers compensation insurance policy of any insolvent insurer." (ECF No. 55.) Moreover, as the Court denied leave to add such a request, Defendants could have reasonably assumed that such relief was now off the table. Nevertheless, it appears that Defendants made no such assumption. For example, in their motion for summary judgment, Defendants still attacked the Court's ability to issue this precise injunction under the APA. (Defs.' MSJ at 15 n.5.) In addition, the injunction was always the focus of (and sticking point in) the parties' settlement discussions. (Joint Report at 5; MSJ Hr'g Tr. at 12.) In fact, Defendants took the position that CIGA did not put them on notice of the contemplated injunction only after the Court requested briefing on that issue.[12] Given the Ninth Circuit's liberal approach to Rule 54(c), the Court is satisfied that Defendants were sufficiently on notice of the specific injunction CIGA now seeks, and thus would not be prejudiced if the Court granted that relief.

[12] In granting Defendants' request to move to dismiss the action as moot, the Court requested briefing on the question "[w]hether CIGA sufficiently pleaded in its Second Amended Complaint its request that the Court enjoin Defendants from seeking reimbursement for Medicare payments that are not covered by the policies that CIGA administers," and noted that "[i]t appears to the Court that the injunctive relief CIGA has requested in its paragraph 4 of its prayer for relief relates only to legal theories that the Court has already dismissed." (Minute Order at 1–2. ECF No. 84.)

2. Mandatory Appeals Process

Shortly after CIGA filed suit, CMS created an administrative appeals process that every disputed reimbursement demand must go through before judicial review. *See* 42 U.S.C. § 1395y(b)(2)(B)(viii); 80 Fed. Reg. 10,611-01; 42 U.S.C. § 405(g); *id.* § 405(h) ("No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter."). Defendants argue that dictating how CMS must calculate future reimbursement demands effectively bypasses the mandatory appeals process with respect to those demands.

The problem with Defendants' argument is that it impermissibly separates CIGA's injunctive relief claim from its substantive legal claim. The Supreme Court has made clear that § 405(h)'s prohibition on pre-exhaustion judicial review does not turn on "the 'potential future' versus the 'actual present' nature of the claim, the 'general legal' versus the 'fact-specific' nature of the challenge, the 'collateral' versus 'noncollateral' nature of the issues, *or the 'declaratory' versus 'injunctive' nature of the relief sought*." *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13–14 (2000) (emphasis added) (citations omitted). Rather, § 405(h) simply requires the substantive question over the legality of CIGA's practice to be properly before the Court for adjudication—which Defendants do not dispute. *Id.* Indeed, the purpose of the exhaustion requirement is simply to give the agency a chance to consider the legal questions presented by the dispute before an Article III court considers them. *Id.* at 13. Once this happens, it is ripe for adjudication (and remediation) by the court; there is no reason to give the agency a chance to revisit the same legal issue in *every single* future reimbursement dispute on the off chance that the agency changes its mind somewhere down the line. Nor should the exhaustion requirement be used as a pretext for a policy of "nonacquiesence" to unfavorable judicial interpretations of statutes and

regulations. *Cf. N.L.R.B. v. Ashkenazy Prop. Mgmt. Corp.*, 817 F.2d 74, 75 (9th Cir. 1987).

3. Broad Programmatic Attack

Finally, Defendants contend that CIGA is impermissibly attempting to institute wholesale change to the Medicare reimbursement program. "The Supreme Court has made clear that the APA does not allow 'programmatic' challenges to agency . . . procedures, but instead requires that there be a specific final agency action which has an actual or immediate threatened effect." *High Sierra Hikers Ass'n v. Blackwell*, 390 F.3d 630, 639 (9th Cir. 2004). For example, in *Lujan v. National Wildlife Federation*, the plaintiff alleged that a land management program implemented by the Bureau of Land Management was "rampant" with legal violations. 497 U.S. 871, 890 (1990). The Supreme Court nonetheless held that "respondent cannot seek *wholesale* improvement of this program by court decree, rather than in the offices of the Department or the halls of Congress, where programmatic improvements are normally made." *Id.* at 891 (original emphasis). Rather, judicial review must wait until "the scope of the controversy has been reduced to more manageable proportions, and its factual components fleshed out, by some concrete action applying the regulation to the claimant's situation in a fashion that harms or threatens to harm him." *Id.* Moreover, even where the plaintiff identifies specific agency actions in an administrative program that are allegedly unlawful, the plaintiff cannot use those specific actions in order to challenge the entire program. *See High Sierra Hikers*, 390 F.3d at 639; *Siskiyou Reg'l Educ. Project v. U.S. Forest Serv.*, 565 F.3d 545, 553–54 (9th Cir. 2009); *Wild Fish Conservancy v. Jewell*, 730 F.3d 791, 801–02 (9th Cir. 2013).

CIGA is not pushing for the kind of wholesale change to an entire federal program that the plaintiffs in *Lujan* were. CIGA does not seek across-the-board changes to the manner in which Medicare functions; it is attacking one discrete practice that CMS both applied to the three reimbursement demands at issue here (each of which Defendants concede constitutes final agency action) and has made

clear that it intends to apply to future reimbursement demands by CIGA. This clearly constitutes "concrete action [that] appl[ies] the regulation to the claimant's situation," as required by *Lujan*. 497 U.S. at 890. The Ninth Circuit has found challenges to comparably discrete agency conduct permissible. *High Sierra Hikers*, 390 F.3d at 639 ("High Sierra has alleged specific discrete agency actions taken by the Forest Service that have caused harm. High Sierra did not challenge the entirety of the wilderness plan, but instead challenged certain agency actions [within the larger plan], for example the grant of certain special-use permits, and the calculation of certain trailhead limits."); *Siskiyou Reg'l Educ. Project*, 565 F.3d 553–54 ("SREP has expressed more than a generalized dissatisfaction with the Forest Service's decision to limit the application of MM–1 . . . . SREP's complaint refers to specific instances of suction dredge mining operations that took place without an approved plan of operations in waterways administered by the Forest Service. . . . SREP's allegations challenge specific instances of the Forest Service's actions taken pursuant to its interpretation of MM–1, and therefore constitute more than a programmatic attack or a vague reference to Forest Service action or inaction."). Moreover, the practice that CIGA challenges fairly constitutes "agency action," which is reviewable on review of the final agency action. 5 U.S.C. § 704; *see also id.* § 551(13) (defining "agency action" as "the whole or a part of any agency rule, order, license, sanction, relief, or the equivalent or denial thereof, or failure to act"); *id.* § 551(4) (defining "rule" as "the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency"); Fraser Depo. at 34 ("Q. [D]o you know why is that part of the protocol or procedure that that approach is generally taken? A. That's always been the way that we've done it. Q. Has anyone instructed you to do it that way? A. It's just for – for what we do that's just been what we've always done.").

/ / /

V. CONCLUSION

For the reasons discussed above, the Court **DENIES** Defendants' Motion to Dismiss (ECF No. 87), **DENIES** Defendants' Motion for Summary Judgment (ECF No. 63), and **GRANTS** CIGA's Motion for Partial Summary Judgment (ECF No. 68). The Court **VACATES** all future dates and deadlines in this action, including the trial date. Within two weeks of the date of this order, the parties should submit a proposed schedule for adjudicating all remaining disputes in this action. Alternatively, if no further disputes remain, the parties should submit a proposed judgment to the Court.

IT IS SO ORDERED.

January 5, 2017

OTIS D. WRIGHT, II
UNITED STATES DISTRICT JUDGE

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1787	**Date: February 3, 2017**
	Change Request 9893

SUBJECT: New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

I. SUMMARY OF CHANGES: This change request (CR) identifies the roles the A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment MACs (DME MACs), shared systems, and Common Working File (CWF) will have for creating Liability Insurance Medicare Set-Aside Arrangement (LMSA) or No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA) records on CWF and process Medicare Secondary Payer (MSP) claims accordingly with an open set aside MSP record on CWF.

EFFECTIVE DATE: July 1, 2017 - MCS, VMS, FISS and CWF Analysis and Design; October 1, 2017 - MCS, VMS, FISS and CWF Coding and Testing
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017 - MCS, VMS, FISS and CWF Analysis and Design; October 2, 2017 - MCS, VMS, FISS and CWF Coding and Testing

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1787	Date: February 3, 2017	Change Request: 9893

SUBJECT: New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

EFFECTIVE DATE: July 1, 2017 - MCS, VMS, FISS and CWF Analysis and Design; October 1, 2017 - MCS, VMS, FISS and CWF Coding and Testing
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I. GENERAL INFORMATION

A. Background: To comply with the Government Accountability Office final report entitled MSP Additional Steps are Needed to Improve Program Effectiveness for Non Group Health Plans (GAO-12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two new set-aide processes: Liability Medicare Set-aside Arrangement (LMSA) and a No-Fault Medicare Set-aside Arrangement (NFMSA). An LMSA or NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. This CR: 1) addresses the policies, procedures, and system updates required to create and utilize an LMSA and NFMSA MSP record, similar to a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record and 2) instructs the A/B MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or NFMSA fund.

B. Policy: Pursuant to 42 U.S.C. §1395y(b)(2) and §1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, Liability and No-Fault MSP claims that do not have a MSA will continue to be processed under current MSP claims processing instructions.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9893.1	The LMSA and NFMSA MSP records shall only be applied to CWF if a Liability (L) or No-Fault/Auto (D) NGHP MSP record already exists on the CWF MSP Auxiliary File.								X	BCRC, MSPSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9893.2	The Liability (L) or No-Fault/Auto (D) NGHP MSP record on CWF shall have a termination date prior to a LMSA and NFMSA record being created.								X	BCRC, MSPSC
9893.3	The LMSA and NFMSA effective date shall be the day after the Liability (L) or No-Fault/Auto (D) NGHP MSP record is closed. For example, if the L MSP record shows a 10/31/16 termination date, the effective date of the LMSA shall be 11/1/16.								X	BCRC, MSPSC
9893.4	The BCRC shall create the LMSA and NFMSA HUSP transaction on CWF.								X	BCRC, MSPSC
9893.5	CWF and the shared system maintainers shall accept and process the below two new MSP codes for use with MSP HUSP transactions and to identify a LMSA and NFMSA in the CWF MSP Auxiliary file: • "S" shall be used to identify LMSAs; and • "T" shall be used to identify NFMSAs.					X	X		X	BCRC, MSPSC, REMAS
9893.6	CWF shall create two new contractor numbers 11144 and 11145 on incoming HUSP records.								X	BCRC, MSPSC
9893.6.1	Contractor number 11144 shall be associated to incoming MSP "S" HUSP records for application on the MSP Auxiliary file.								X	BCRC, MSPSC
9893.6.2	Contractor number 11145 shall be associated to incoming MSP "T" HUSP records for application on the MSP Auxiliary file.								X	BCRC, MSPSC
9893.6.3	The shared system maintainers shall accept contractor number 11144, MSP code "S" and source code "44" on the returned 03 CWF trailer response.					X	X	X	X	
9893.6.4	The shared system maintainers shall accept contractor number 11145, MSP code "T" and source code "45" on the returned 03 CWF trailer response					X	X	X	X	
9893.6.5	CWF, and the shared system maintainers, shall accept a "44" in the source code field on the HUSP and HUSC/HUST transactions for contractor 11144.					X	X		X	BCRC, MSPSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9893.6.5.1	CWF, and the VMS shared system maintainer, shall accept a “44” in the source code field on the HUSC/HUST transactions for contractor 11144.							X	X	
9893.6.6	CWF, and the shared system maintainers, shall accept a “45” in the source code field on the HUSP and HUSC/HUST transactions for contractor 11145.					X	X		X	BCRC, MSPSC
9893.6.6.1	CWF, and the VMS shared system maintainer, shall accept a “45” in the source code field on the HUSC/HUST transactions for contractor 11145.							X	X	
9893.6.7	The CWF, and the shared system maintainers, shall only accept a “Y” Validity Indicator for HUSP transactions created by Contractor 11144 or Contractor 11145.					X	X		X	BCRC, MSPSC
9893.6.7.1	CWF shall only return a HUSP to VMS if the MSP was originated by the DME MACs.				X			X	X	
9893.6.8	CWF shall send a “Y” validity indicator for HUSC transactions for Contractor 11144 and 11145.								X	
9893.6.9	CWF shall use the following address for contractor numbers 11144 and 11145: LMSA and NFMSA P.O. Box 138899 Oklahoma City, OK 73113-8897.								X	
9893.7	CWF shall only allow Contractors 11100 and 11144 to add, update, or delete MSP records created by contractor 11144.								X	BCRC, MSPSC
9893.7.1	CWF shall only allow Contractors 11100 and 11145 to add, update, or delete MSP records created by contractor 11145.								X	BCRC, MSPSC
9893.7.2	CWF shall create and send a HUSC transaction to the shared system maintainers that processed claims for each beneficiary when either an "add," "update," or "delete" transaction is received from contractor 11100, 11144 or contractor 11145.								X	
9893.8	The Contractor Reporting of Operational Workload (CROWD) Report shall be updated to reflect Special Project “7044” as "Liability Medicare Set-aside" and Special Project number “7045” as "No-Fault Medicare Set-aside."	X	X	X	X	X	X			CROWD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9893.8.1	The A/B MACs, DME MACs and the designated shared system maintainers shall identify MSP savings for LMSAs and NFMSAs under special project 7044 and 7045, as applicable, when LMSA and NFMSA claims are processed.	X	X	X	X	X	X			
9893.8.2	MSP savings for special project 7044 shall be identified under the Liability column and savings for special project 7045 shall be identified under the No-Fault column in the MSP Savings Report and in CROWD.	X	X	X	X	X	X			CROWD
9893.8.3	MSP claims shall be considered cost avoided when a claim is returned without payment because CWF indicators indicate another insurer is primary to Medicare.								X	
9893.8.4	FISS shall create and use MSP savings type “DS” for No-Fault and "LS" for Liability when the claims process through post pay and posted to the MSP Savings file for NFMSAs and LMSAs.					X				
9893.9	CWF shall apply the same MSP consistency edit codes that it currently applies for MSP (Liability) code L (numeric code 47) to MSP code S.								X	
9893.9.1	The CWF shall apply the same MSP consistency edit codes that it now applies for MSP (Auto/No-Fault) code D (numeric code 14) to MSP code T making sure CWF has the correct MSP record associated with the claim.								X	
9893.10	The A/B MACs (A) shared system shall continue to accept claims with value code 47 and 14 for Part A claims that may be reviewed against an open “S” or “T” MSP auxiliary record.					X				
9893.11	The A/B MACs (B) and DME MAC shared systems shall continue to accept claims with insurance code 47 and 14 in association with an open “S” or “T” MSP auxiliary record.		X		X		X	X		
9893.12	The A/B MACs and DME MACs shall not make payment for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open “S” or “T” MSP auxiliary record when the claim’s date of service is on or after	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the MSP effective date.									
9893.13	The CWF shall create a new SP error code (SPXX) that shall set when an incoming HUSP transaction with MSP Code "S" or “T" is submitted and the Beneficiary MSP Auxiliary File contains an open “L" or “D” MSP occurrence that has the same effective date and diagnosis code(s). This means the LMSA or the NFMSA record cannot be created until the "L" or “D” record is closed.								X	
9893.14	The CWF maintainer shall create a new utilization error code (68XX) - “LMSA exists. Medicare contractor payment not allowed."								X	BDS
9893.14.1	The CWF maintainer shall create a new utilization error code (68XX) - "NFMSA exists. Medicare contractor payment not allowed."								X	BDS
9893.14.2	CWF shall set the new utilization error codes under the following conditions : • An open occurrence on the MSP Auxiliary file exists with a MSP code “S” or “T” and; • A Medicare contractor attempts to pay the claim; and • The diagnosis code(s) on the claim is/are related to the diagnosis code(s) on the open MSA record.								X	BDS
9893.14.2.1	The two new 68XX and 68XX utilization error codes shall not set when the LMSA or NFMSA MSP Auxiliary record contains a termination date, no matter what the date of service is, so Medicare can make a payment.								X	BDS
9893.14.3	The shared systems shall accept both of the new error codes (68XX) and (68XX) when returned with an 08 trailer.					X		X	X	
9893.14.4	Upon receipt of the utilization error code, the MAC shall deny all claims, detail line level only for Part B services, (including conditional payment claims) related to the diagnosis codes, or related within the family of diagnosis codes, on the open CWF MSP	X	X	X	X	X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	auxiliary file for MSP code “S” or “T” when there is no termination date entered for the MSP “S” or “T” record because MSA funds are not exhausted. **NOTE:** CWF be returning the two new error codes with Trailer 39 to indicate which detail line(s) on the Part B or DME claim caused the error code to set.									
9893.14.4.1	Upon denying the claim, the MAC and shared system maintainers shall create a “44” or “45” Payment Denial Indicator, Non-payment/ Payment Denial Codes, in the header of the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claims.	X	X	X	X	X	X			
9893.14.4.2	Upon denying the claim, the A/B MAC (B), the DME MACs and shared systems shall: • Populate an “S” or “T” in the MSP code field; and • Create a “44” or “45” in the HUBC and HUDC claim header transaction as well as in the claim detail pay process field.		X		X		X	X		
9893.14.4.3	Upon denying the claim, the A/B MAC (A) and shared system maintainer shall populate a “47” or “14” in the value code field.	X		X		X				
9893.15	The MACs and shared system maintainers shall apply Claim Adjustment Reason Code (CARC) 201-(Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement) with Group Code “PR” and Medicare Summary Notice (MSN) message 29.33, defined below, when denying claims based on the open “S” or “T” MSP auxiliary record.	X	X	X	X	X	X	X		
9893.15.1	The MACs and shared systems shall reflect CARC 201 and Group Code PR on outbound 837 claims and on 835 Electronic Remittance Advices (ERAs) when there is an open “S” or “T” MSP auxiliary record.	X	X	X	X	X	X	X		
9893.15.2	In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open “S” or “T” MSP record, the A/B MAC and DME MAC shall include the following Remittance Advice Remark Codes (RARCs) and MSN message as appropriate to the situation:	X	X	X	X	X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• N723—Patient must use liability set aside (LSA) funds to pay for the medical service or item. • N724—Patient must use no-fault set-aside (NFSA) funds to pay for the medical service or item. • MSN 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies). • MSN 29.33 - Su reclamación ha sido denegada por Medicare porque usted podría sacar dinero de su convenio/acuerdo para pagar por sus futuros gastos médicos y su tratamiento con medicinas recetadas relacionadas a su lesión(es).									
9893.16	CWF shall ensure that the overrideable error code 68XX and 68XX may be overridden for payment by the shared system maintainers, A/B and DME MACs, with override code N for claim lines or claims on which: • auto/no-fault insurance set-asides diagnosis codes do not apply, or are not related, or • liability insurance set-asides diagnosis codes do not apply, or are not related, or • when the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR 9009.	X	X	X	X			X	X	
9893.16.1	CWF shall allow for an override of error code 68XX and 68XX within the header of claims transaction sent to CWF so that a secondary payment on a claim can be made when benefits are exhausted in the middle of a claim billing period.	X	X	X	X	X		X	X	BDS
9893.16.1.1	When WCMSA, LMSA or NFMSA benefits are terminated or exhausted during a provider stay or physician visit and the claim is not fully paid, the A/B				X	X		X	X	BDS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MACs, DME MACs and shared system maintainers shall make a residual payment on that claim by sending the primary payer amounts to the MSPPAY module to calculate Medicare's residual payment if such services are covered and otherwise reimbursable by Medicare. **NOTE:** CR 9009 outlines policies for benefits exhausted that CWF and the SSMs shall follow for LMSAs and NFMSAs. This means the residual payment indicators identified in CR 9009 will apply as Medicare payment may be made due to MSA benefits being exhausted during a hospital stay or performed service.									
9893.16.2	A/B MACs (B) and DME MACs shall override payable lines with override code N. **NOTE**: Override code "N" is used where NGHP No-fault and liability services are involved and the service is either: • Not a covered service under the primary payer's plan; • Not a covered diagnosis under the primary payer's plan; or • Benefits have been exhausted under the primary payer's plan.		X		X					
9893.16.3	A/B MACs (A) shall override payable claims with override code N.	X		X						
9893.16.3.1	If the A/B MAC (A) is attempting to allow payment on the claim, the A/B MAC (A) shall include an "N" on the '001' Total revenue charge line of the claim.	X		X						
9893.16.4	If there is an open GHP record on CWF, the MSP claim shall be denied as it should be sent to the primary insurer first if it was not done so already. **NOTE:** CWF shall use MSP error code 6803 first in this situation.								X	
9893.16.4.1	A/B MACs (A) shall add VC 14, 15 or 47 with payment amount of $0 to WC, Liability or NF claims when rejecting the claim due to an open MSA record at CWF. **NOTE:** MACs shall also apply occurrence code 1,2,3,4 or 5, as applicable, with the effective date of the MSA in the occurrence code date when cost avoiding the claim.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9893.17	The Comprehensive Error Rate Testing (CERT) contractor shall accept the MSP codes D (14) and L (47) within the claims resolution code field.						X	X		CERT
9893.17.1	The A/B MACs and designated, shared system maintainers shall send the MSP codes D (14), E (15), for MCS, and L (47) to CERT as necessary.	X	X	X	X		X	X		CERT
9893.18	MACs and shared systems shall make payment for those services related to the diagnosis codes associated with the closed "W" “S” or “T” MSP auxiliary record for covered and reimbursable services. **NOTE:** CWF shall not send a MSP error code in this situation where the MSA record is closed.	X	X	X	X	X		X	X	
9893.18.1	For claims with dates of service between the WCMSA, LMSA or NFMSA effective and termination date, Medicare shall make a payment for covered and reimbursable services. **NOTE:** If there is an open GHP record on CWF, the MSP claim shall be denied as it should have been sent to the GHP insurer first if it was not done so already.	X	X	X	X	X	X	X	X	
9893.19	CWF and the CWF copy book shall be updated to include the two (2) byte field named “MSP Qualifier” codes “LT” and “AP” to populate the “MSP Qualifier” field for files sent to the MBDSS for generation of 270/271 to providers via HETS alerting them of the LMSA and NFMSAs.								X	HETS, MBD
9893.19.1	MACs shall update their HETS-related documentation to reflect that MSP Qualifier “LT” means Litigation (Liability) and represents an LMSA for provider education purposes.	X	X	X	X					
9893.19.2	A/B MACs and DME MACs shall update their HETS-related documentation to reflect that MSP Qualifier “AP” means Auto Insurance Policy (Auto/No-Fault) and represents a NFMSA for provider education purposes.	X	X	X	X					
9893.20	CWF shall associate “LT” in the “MSP Qualifier” field with MSP type “S" for HETS processing.								X	HETS
9893.20.1	CWF shall associate “AP” in the “MSP Qualifier”								X	HETS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	field with MSP type “T" for HETS processing.									
9893.20.2	CWF shall transmit the “LT” and/or “AP” qualifier as part of its COB file exchanges with MBDSS and NGD for HETS processing.								X	HETS, MBD, NGD
9893.20.3	MBD and NGD shall modify their systems to accept and allow in the two (2) byte field named “MSP Qualifier” the codes “LT” and “AP” to populate the “MSP Qualifier” field.									MBD, NGD
9893.20.4	MBD and NGD shall accept the “LT” qualifier to denote a LMSA MSP occurrence.									MBD, NGD
9893.20.5	MBD and NGD shall accept the “AP” qualifier to denote a NFMSA MSP occurrence.									MBD, NGD
9893.21	HETS shall transmit, in the EB04 segment of the 270/271 interface, an insurance type “LT,” which indicates a LMSA for MSP type code “S” records received from CWF.									HETS, MBD
9893.21.1	HETS shall transmit, in the EB04 segment of the 270/271 interface, an insurance type “AP,” which indicates a NFMSA for MSP type code “T” records received from CWF.									HETS, MBD
9893.21.2	HETS shall continue to transmit an insurance type “47” on outbound 271 transactions in association with “traditional” Liability records (MSP type “L” on CWF).									HETS, MBD
9893.21.3	HETS shall continue to transmit an insurance type “14” on outbound 271 transactions in association with “traditional” Auto/No-Fault records (MSP type “D” on CWF).									HETS, MBD
9893.21.4	CWF shall continue to return Value Code “47” for MSP type code “S” on the MBD and NGD extract file under MSP Code.								X	
9893.21.5	CWF shall continue to return Value Code “14” for MSP type code “T” on the MBD and NGD extract file under MSP Code.								X	
9893.22	The 1524 report shall also capture the NFMSA and LMSA when the MSA records are open in CWF and	X	X	X	X	X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	does not capture this information when the MSA records are closed.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9893.23	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, 410-786-1418 or richard.mazur2@cms.hhs.gov , Brian Pabst, 410-786-2487 or Brian.Pabst@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-0- 24
Baltimore, Maryland 21244-1850

Financial Services Group

November 15, 2018

Centers for Medicare & Medicaid Services
Computation of Annual Recovery Thresholds for Certain Liability Insurance, No-Fault Insurance, and Workers' Compensation Settlements, Judgments, Awards, or Other Payments

BACKGROUND:

The Medicare Secondary Payer (MSP) provisions of the Social Security Act prohibit Medicare from making payment where payment has been made or can reasonably be expected to be made by a primary plan. If payment has not been made, or cannot reasonably be expected to be made promptly by a primary plan, Medicare may pay conditionally, with the expectation that the conditional payments would be reimbursed, once primary payment responsibility is demonstrated.

The primary plan, such as liability insurance, no-fault insurance, or workers' compensation, often demonstrates primary payment responsibility through a settlement, judgment, award, or other payment (hereinafter, "settlement"). Accordingly, Medicare is obligated by statute to recover conditional payments it made for medical care related to the settlement. Medicare's recovery is limited to the amount of the settlement less any attorney fees or costs the beneficiary incurred to obtain the settlement.

Medicare beneficiaries, their attorneys, and primary plans report settlements to Medicare. Reporting is required so Medicare is able to determine if it made any conditional payments related to that settlement. Once reported, Medicare calculates its conditional payment amount, reduces that amount for attorney fees and costs, and issues a demand letter requiring reimbursement.

Medicare incurs costs to perform these activities. These costs include, for example, compiling related claims, calculating conditional payments, applying reductions, sending demands, and providing customer service. In addition to CMS' costs associated with pursuing recovery, Medicare does not usually recover the full amount of the conditional payments. For example, there may be reductions to the demand to account for procurement costs (attorney fees and costs) or for full or partial waiver of recovery if certain criteria are met. Implementing a threshold facilitates CMS' efficient use of its resources.

To fulfill the requirements of Section 202 of the SMART Act, in 2018, CMS reviewed all of the costs related to collecting data and determining the amount of Medicare's recovery claim. As a result of this analysis, CMS calculated a threshold for physical trauma-based liability insurance settlements. Effective January 1, 2019, CMS will maintain a single threshold for these cases, where settlements of $750 or less do not need to be reported and Medicare's conditional payment amount related to these cases did not need to be repaid.

CMS also evaluated available data related to no-fault insurance and workers' compensation settlements. Based on this data, CMS determined that it will maintain a $750 threshold for no-fault insurance and workers compensation settlements for 2019. Accordingly, settlements of $750 or less for no-fault insurance and workers' compensation will not need to be reported and Medicare's conditional payment amount related to these cases will not need to be repaid.

COST OF COLLECTION:

The CMS estimated the average cost of collection for Non-Group Health Plan (NGHP) cases (which includes liability insurance (including self-insurance), no-fault insurance, and workers' compensation) as approximately $297 per case. This cost of collection was based on the amount paid (invoices) to our Benefits Coordination and Recovery Contractors for work related to identifying and recovering NGHP conditional payments. CMS relied on data between August 2017 and July 2018. The total dollar amount paid to CMS' contractors was divided by the number of final NGHP demand letters issued during the aforementioned date range.

To determine settlement thresholds, CMS compared the estimated cost of collection per NGHP case of approximately $297 to the average liability insurance demand amount per settlement range. We then did the same comparison of the estimated cost of collection to the average no-fault insurance and workers' compensation demand amounts per settlement range.

CONCLUSION:

Based on this information, CMS determined that it should maintain a $750 threshold for 2019 so that physical trauma-based settlements of $750 or less do not need to be reported and Medicare's conditional payment amount for these settlements does not need to be repaid. For liability insurance and workers' compensation settlements, the calculated cost of collection of $297 most closely aligns, without exceeding, to the average demand amounts of $368.40 and $518.18 respectively for settlements of over $500 to $750.

For no-fault insurance settlements, CMS will maintain the current threshold of $750, where the no-fault insurer does not otherwise have ongoing responsibly for medicals. Although the cost of collection of $297, most closely aligns with the average demand for settlements of $300 to $500, the limited number of demands for no-fault within this range represents a minimal amount of missed potential recoveries. For 2018, these missed recoveries would have totaled $16,789 (47 no-fault cases at $357.21). The cost for CMS and primary plans to alter supporting systems, documentation and to perform outreach for a reduction to a $500 threshold for this insurance type would far exceed potential recoveries for settlements in this range.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PATRICIA HARO; JOHN G. BALENTINE; JACK MCNUTT; TROY HALL, *Plaintiffs-Appellees*, v. KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services, *Defendant-Appellant*.	No. 11-16606 D.C. No. 4:09-cv-00134-DCB OPINION

Appeal from the United States District Court
for the District of Arizona
David C. Bury, District Judge, Presiding

Argued December 5, 2012
Submitted February 14, 2013
San Francisco, California

Filed September 4, 2013

Before: Barry G. Silverman, Ronald M. Gould, and Morgan Christen, Circuit Judges.

Opinion by Judge Christen

SUMMARY*

Medicare

The panel vacated injunctions entered by the district court's and reversed the district court's summary judgment order entered in favor of a nationwide class of Medicare beneficiaries in an action challenging the Secretary of Health and Human Services' practice of demanding "up front" reimbursement for secondary payments from beneficiaries who have appealed a reimbursement determination or sought a waiver of the reimbursement obligation.

The district court enjoined the Secretary from seeking up front reimbursements of Medicare secondary payments from beneficiaries who have received payment from a primary plan if they have unresolved appeals or waivers, and enjoined the Secretary from demanding that attorneys withhold settlement proceeds from their clients until after Medicare is reimbursed. The panel held that plaintiff Patricia Haro demonstrated Article III standing on behalf of the class of Medicare beneficiaries, and Haro's attorney independently demonstrated standing to raise his individual claim. However, the panel concluded that the beneficiaries' claim was not adequately presented to the agency at the administrative level, and therefore the district court lacked subject matter jurisdiction pursuant to 42 U.S.C. d 405(g). The panel reached the merits of the attorney's claim, but concluded that the Secretary's interpretation of the secondary payer

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

provisions was reasonable. The panel remanded for consideration of the beneficiaries' due process claim.

COUNSEL

Alisa B. Klein (argued) and Mark B. Stern, Attorneys; Tony West, Assistant Attorney General; Ann B. Scheel, Acting United States Attorney, United States Department of Justice, Civil Division, Washington, D.C.; William B. Schultz, Acting General Counsel; Margaret M. Dotzel, Deputy General Counsel; Janice L. Hoffman, Associate General Counsel; Carol J. Bennett, Deputy Associate General Counsel for Program Integrity; Leslie M. Stafford, Attorney, United States Department of Health and Human Services, Washington D.C., for Defendant-Appellant.

Gil Deford (argued) and Wey-Wey Kwok, Center for Medicare Advocacy, Willimantic, Connecticut, for Plaintiffs-Appellees.

OPINION

CHRISTEN, Circuit Judge:

Secretary of Health and Human Services Kathleen Sebelius appeals the district court's order certifying a nationwide class of Medicare beneficiaries and granting summary judgment in the beneficiaries' favor. Patricia Haro, Jack McNutt, and Troy Hall are named plaintiffs. John Balentine was Haro's lawyer in her underlying personal injury suit.

Before the district court, the beneficiaries raised two claims: (1) the Secretary's practice of demanding "up front" reimbursement for secondary payments from beneficiaries who have appealed a reimbursement determination or sought waiver of the reimbursement obligation is inconsistent with the secondary payer provisions of the Medicare statutory scheme; and (2) the Secretary's practice violates their due process rights. Balentine separately claimed the Secretary's practice of demanding that attorneys withhold settlement proceeds from beneficiary-clients until Medicare is reimbursed is also inconsistent with the secondary payer provisions.

The district court agreed with the beneficiaries. The court enjoined the Secretary from seeking up front reimbursement of Medicare secondary payments from beneficiaries who have received payment from a primary plan if they have unresolved appeals of their reimbursement calculations or unresolved requests for waiver of their reimbursement obligations. The district court also agreed with Balentine and enjoined the Secretary from demanding that attorneys withhold settlement proceeds from their clients until after Medicare is reimbursed. The district court did not reach the beneficiaries' due process claim.

On appeal to our court, the Secretary raises three jurisdictional arguments. First, she argues that this case is not justiciable because neither the beneficiaries nor Balentine had Article III standing. Second, she argues this case is moot. Third, she argues that the district court lacked subject matter jurisdiction over all claims in the complaint. On the merits, the Secretary maintains that her interpretation of the Medicare secondary payer provisions is reasonable.

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1291. We conclude that Haro has demonstrated Article III standing on behalf of the class of Medicare beneficiaries and that Balentine has independently demonstrated standing to raise his individual claim. But we conclude that the beneficiaries' claim was not adequately presented to the agency at the administrative level and therefore the district court lacked subject matter jurisdiction pursuant to 42 U.S.C. § 405(g). We reach the merits of Balentine's claim, but conclude that the Secretary's interpretation of the secondary payer provisions is reasonable. We therefore vacate the district court's injunctions, reverse the district court's summary judgment order, and remand for consideration of the beneficiaries' due process claim.

I. BACKGROUND

A. Statutory Background

Congress enacted the secondary payer provisions of the Medicare statute in 1980 to cut Medicare costs. *See Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir. 1995). Those provisions make Medicare secondary to other sources of insurance by forbidding Medicare payments when a primary plan—for instance, group health insurance or liability insurance—is reasonably expected to make payment for the same medical care; and by providing that certain Medicare payments are conditional and must be reimbursed. 42 U.S.C. § 1395y(b)(2)(A), (B). Conditional payments are at issue in this case.

Medicare makes a conditional payment when a primary insurer cannot reasonably be expected to pay promptly. *Id.* § 1395y(b)(2)(B)(i). If Medicare makes a conditional

payment and the beneficiary later receives payment from a primary insurer, Medicare is entitled to reimbursement. *Id.* § 1395y(b)(2)(B)(ii). Specifically, § 1395y(b)(2)(B)(ii) provides that "a primary plan [or] an entity that receives payment from a primary plan, shall reimburse" Medicare once the primary plan's responsibility has been demonstrated by a judgment or settlement. *Id.* We refer to this paragraph—§ 1395y(b)(2)(B)(ii)—as the "reimbursement provision." If Medicare is not reimbursed within 60 days after notice of the primary insurer's payment, the Secretary is entitled to charge interest on the reimbursement amount. *Id.*

The statutory scheme also creates a cause of action by which the United States may recover from a primary plan or "from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." *Id.* § 1395y(b)(2)(B)(iii). We refer to this part of the Medicare statutory scheme as the "cause of action provision." The cause of action provision allows the United States to seek reimbursement from "the beneficiary herself." *Zinman*, 67 F.3d at 844–45; *see also* 42 C.F.R. § 411.24(g) (Medicare "has a right of action to recover its payments from any entity, including a beneficiary . . . [or] attorney . . . that has received a primary payment.").

When Medicare learns that a beneficiary has received payment from a primary plan, the Secretary makes an initial determination of the amount of reimbursement due from the beneficiary. Borrowing from the Social Security Act, the Medicare Act incorporates administrative review procedures set out in 42 U.S.C. § 405(b) and judicial review pursuant to 42 U.S.C. § 405(g). *See* 42 U.S.C. § 1395ff(b)(1)(A). A beneficiary may contest the amount of reimbursement or seek waiver of any reimbursement amount. *See id.* § 1395gg.

B. Factual Background

1. Patricia Haro

Patricia Haro was injured in a car accident and Medicare paid for her medical treatment. Haro filed a personal injury claim against the tortfeasor, which eventually settled. Medicare, through the Medicare Secondary Payer Recovery Contractor,[1] sought reimbursement of $1,682.72 in a letter dated January 12, 2009. The letter informed Haro of her right to appeal the reimbursement determination or seek waiver but also stated that Haro "must" pay within 60 days and that interest would start to run if payment was not made in that period. The letter encouraged Haro to pay the amount in full, even if she decided to appeal or seek a waiver, in order to avoid interest charges.

Haro disputed the reimbursement determination by letter dated January 21, 2009. Haro's lawyer sent a second letter, on February 2, 2009. In it, he argued that the reimbursement provision did not grant the Secretary authority to seek payment from a beneficiary within 60 days of notice of the settlement if the beneficiary had appealed the reimbursement determination. The letter also argued that the Due Process Clause prohibits takings of property before there has been a determination of rights to that property.

Medicare reduced Haro's reimbursement amount to $696.13 by letter dated March 3, 2009. On March 4, 2009, likely before Haro received notice of the revised

[1] The Medicare Secondary Payer Recovery Contractor is a private contractor that collects secondary payment reimbursements on behalf of Medicare. For simplicity, this opinion refers to both entities as Medicare.

reimbursement figure, Haro sent Medicare a check for $800. Haro did not seek reconsideration of Medicare's reduced reimbursement amount and instead filed this lawsuit on March 10, 2009. Medicare reimbursed Haro $103.87 (the difference between $800 and $696.13) on April 13, 2009.

2. Jack McNutt

Like Haro, Jack McNutt was injured in a car accident and Medicare paid his medical costs. McNutt's personal injury lawsuit settled and McNutt notified Medicare of the settlement. Medicare responded with a letter requesting reimbursement of $26,487.07. The letter stated that McNutt was required to pay within 60 days of the receipt of the settlement proceeds and that interest would start to accrue if payment was not received within that time. The letter also informed McNutt of his rights to appeal and seek waiver of the reimbursement obligation. McNutt appealed the reimbursement determination.

After Medicare sent McNutt a notice of the Secretary's intent to refer the debt to the Department of Treasury, McNutt wrote a letter of "appeal," but with his letter he enclosed a check for $11,366.58, the amount he believed he owed. Medicare sent McNutt an adjusted demand. Because of McNutt's earlier payment, only $1,422.93 (including $13.36 in interest) remained outstanding. Medicare notified McNutt that his remaining reimbursement payment "should" be made within 30 days. McNutt sought reconsideration of that amount, and the Secretary acknowledged that notice of intent to refer the debt to Treasury was sent in error.[2] Medicare then

[2] The letter states that "debts pending appeal are excluded from referral to the Department of Treasury."

reduced McNutt's total reimbursement amount again, and McNutt paid the remaining balance, plus interest. His administrative appeal was still pending at the time this appeal was filed. At the administrative level, McNutt did not challenge the Secretary's practice of demanding up front reimbursement.

3. Troy Hall

Troy Hall was injured while working and Medicare paid for his injury-related medical care. After Hall settled his worker's compensation claim, he received a reimbursement demand from the Secretary. Hall appealed the Secretary's initial reimbursement calculation. Medicare reduced the reimbursement amount and determined that Hall owed nothing. At the administrative level, Hall did not object to the Secretary's practice of demanding up front reimbursement.

4. John Balentine

Attorney John Balentine represented Haro in her personal injury lawsuit and during administrative proceedings. He received a letter from Medicare similar to the letter that Haro received. It instructed him not to disburse settlement funds to his beneficiary-client until Medicare had been reimbursed, and said he would be personally liable if he did. Balentine declared that he routinely receives similar letters from Medicare.

C. District Court Proceedings

As noted above, this appeal involves two separate claims against the Secretary. First, the beneficiaries alleged that the

Secretary exceeded her authority under the Medicare secondary payer provisions by demanding payment before resolution of the beneficiaries' appeals or completion of the waiver application process. Second, Balentine alleged that the Secretary's demand that beneficiaries' attorneys withhold settlement proceeds until Medicare is reimbursed exceeds the Secretary's statutory authority. The beneficiaries also alleged that the Secretary's demand violated their due process rights. Plaintiffs sought declaratory and injunctive relief.

In the district court, the Secretary moved pursuant to Federal Rule of Civil Procedure 12(b)(1) to dismiss the complaint for lack of subject matter jurisdiction. The Secretary argued that the beneficiaries lacked Article III standing and had not exhausted their administrative remedies as required by 42 U.S.C. § 405(g). The district court concluded that Haro and McNutt had Article III standing and that, with respect to McNutt, § 405(g)'s exhaustion requirement was properly waived. The district court denied the motion to dismiss.

On cross-motions for summary judgment, the district court granted the named plaintiffs' motion and certified a class of beneficiaries who had been or would be subject to demands for reimbursement from the Secretary before their administrative appeals were exhausted. Even analyzing the Secretary's practice pursuant to the deferential standard explained in *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984), the district court determined that the Secretary's up front reimbursement requirement was inconsistent with the appeals and waiver processes. The district court therefore enjoined the Secretary from demanding reimbursement of secondary payments from beneficiaries prior to resolution of their administrative

appeals or requests for waiver. The district court also enjoined the Secretary from demanding that attorneys withhold liability proceeds from their clients pending reimbursement of disputed claims.

II. STANDARD OF REVIEW

We review a district court's determination of subject matter jurisdiction de novo. *Cook Inlet Region, Inc. v. Rude*, 690 F.3d 1127, 1130 (9th Cir. 2012). We also review an order granting summary judgment de novo. *Int'l Rehabilitative Sciences, Inc. v. Sebelius*, 688 F.3d 994, 1000 (9th Cir. 2012).

III. DISCUSSION

A. Jurisdictional Issues

On appeal, the Secretary argues that Article III's case or controversy requirement was not met in this case because neither the beneficiaries nor Balentine had standing and because the beneficiaries' claims are moot. The Secretary also maintains that the district court lacked statutory subject matter jurisdiction. Each jurisdictional argument is addressed in turn.

1. Article III Standing

a. Beneficiaries

In order to demonstrate Article III standing, a plaintiff must show: (1) a concrete injury; (2) fairly traceable to the challenged action of the defendant; (3) that is likely to be redressed by a favorable decision. *Lujan v. Defenders of*

Wildlife, 504 U.S. 555, 560–61 (1992). "In a class action, standing is satisfied if at least one named plaintiff meets the requirements." *Bates v. United Parcel Serv., Inc.*, 511 F.3d 974, 985 (9th Cir. 2007) (en banc). "[A] plaintiff must demonstrate standing for each claim" and "for each form of relief sought." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006) (internal quotation marks and citation omitted). "The standing formulation for a plaintiff seeking prospective injunctive relief" generally requires that the plaintiff's concrete injury be "coupled with 'a sufficient likelihood that he will again be wronged in a similar way.'" *Bates*, 511 F.3d at 985 (quoting *City of Los Angeles v. Lyons*, 461 U.S. 95, 111 (1983)).

"[A] plaintiff is presumed to have constitutional standing to seek injunctive relief when [the plaintiff] is the direct object of [government] action challenged as unlawful." *Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 655 (9th Cir. 2011) (citing *Lujan*, 504 U.S. at 561–62). Here, Haro was the direct object of the Secretary's allegedly overreaching collection practice. She received a letter requesting reimbursement before her administrative appeal had run its course. We therefore start with the presumption that Haro has Article III standing, on behalf of the class, to challenge the Secretary's practice. *See Mayfield v. United States*, 599 F.3d 964, 971 (9th Cir. 2010) ("When the lawsuit at issue challenges the legality of government action, and the plaintiff has been the object of the action, then it is presumed that a judgment preventing the action will redress his injury.").

We consider whether the elements of Article III standing, as articulated in *Lujan*, were satisfied at the time the complaint was filed. *Cnty. of Riverside v. McLaughlin*, 500

U.S. 44, 51 (1991). When the complaint was filed, Medicare owed Haro $103.87—the difference between the $800 she sent to Medicare in response to the first demand letter and Medicare's $696.13 final reimbursement determination. Haro had been deprived of $103.87 for approximately one month[3] and had therefore suffered a modest but concrete fiscal injury that was directly traceable to the challenged action of the Secretary. The first two prongs of the *Lujan* formulation were therefore satisfied as to the beneficiaries' claim.

The third element of Article III standing is redressability. The Secretary argues that Haro is not likely to suffer the same injury again and that she therefore cannot show that injunctive relief would redress her injury. *Lyons* suggests that Haro must demonstrate that she was likely to suffer the same injury in the future, absent injunctive relief. 461 U.S. at 105–06 (choke-hold victim lacked standing to pursue injunctive relief against police where he was unable to demonstrate likelihood of future choke-holds). But unlike the plaintiff in *Lyons*, Haro's alleged injury was ongoing at the time the complaint was filed—she was deprived of $103.87. An injunction prohibiting the Secretary from withholding reimbursement payments until after completion of the appeals process would have redressed Haro's injury. *See McLaughlin*, 500 U.S. at 51 (distinguishing *Lyons*). Because we conclude that a properly framed injunction would have

[3] Haro claims in an affidavit that she sent the $800 payment with her request for redetermination on January 21, 2009. She repeats this contention in her brief. However, the check itself was dated March 4, 2009. Moreover, a March 4 letter from Balentine to Medicare states that an $800 check is enclosed. The complaint was filed on March 10, 2009 and Medicare's reimbursement check to Haro was dated April 13, 2009.

redressed Haro's injury, Haro has demonstrated the necessary criteria for Article III standing on behalf of the class.

b. Balentine

Balentine is not part of the beneficiary class; he asserted an individual claim unique to his status as counsel for a Medicare beneficiary. Therefore, he must separately demonstrate Article III standing. *DaimlerChrysler*, 547 U.S. at 352. Because Balentine was the object of the Secretary's demand that he withhold disbursement of Haro's settlement funds, we begin with the presumption that he has standing to challenge the Secretary's action. *Los Angeles Haven Hospice*, 638 F.3d at 655 (citing *Lujan*, 504 U.S. at 561–62).

The demand Balentine received bears significant similarity to the demand at issue in *Los Angeles Haven Hospice*. Haven Hospice challenged a Department of Health and Human Services regulation implementing a cap on reimbursement for hospice care provided to Medicare beneficiaries. *See id.* at 649; *see also* 42 U.S.C. § 1395f(i)(2). Haven Hospice received a demand for repayment of the amount it had been reimbursed in excess of the statutory cap. *Los Angeles Haven Hospice*, 638 F.3d at 652. The Secretary maintained that the hospice did not have Article III standing to challenge the regulation or seek to enjoin its enforcement. *Id.* at 654. But this court, applying the *Lujan* presumption, concluded: "[T]he fact that the allegedly unlawful regulation was directly applied to Haven Hospice and exposed it to individual liability for the claimed overpayments, is sufficient to support its claim of Article III standing to pursue the declaratory and injunctive relief sought in the complaint." *Id.* at 655.

The demand letter the Secretary sent to Balentine represents direct application of the Secretary's interpretation of her authority under 42 C.F.R. § 411.24(g).[4] The letter states that "Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs," and that "Medicare must be paid within 60 days of receipt of the proceeds from the third party." Because 42 C.F.R. § 411.24(g) provides that Medicare "has a right of action to recover its payments from any entity, including a[n] . . . attorney . . . that has received a primary payment," the regulation subjects Balentine to individual liability. Consistent with *Los Angeles Haven Hospice*, Balentine has demonstrated Article III standing. 638 F.3d at 655.

2. Mootness

The Secretary next argues that the claims asserted in the complaint are moot.[5] A claim becomes moot "when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." *Powell v. McCormack*, 395 U.S. 486, 496 (1969) (citation omitted). It is undisputed that Haro did not challenge Medicare's final

[4] Whether we analyze 42 C.F.R. § 411.24(g) individually, or in conjunction with 42 C.F.R. § 411.24(h) is largely academic: § 411.24(h) interprets the reimbursement provision and provides that "[i]f the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days." The Secretary's interpretation of the reimbursement provision is thus similarly broad—it encompasses attorneys who have received a primary payment.

[5] Because we conclude, *infra*, that Haro is the only plaintiff who arguably presented a challenge to the practice of requiring up front reimbursement at the administrative level, we limit our analysis of the Secretary's mootness argument to Haro's claim.

reimbursement calculation and is not owed any additional refund. But the district court concluded, and the beneficiaries maintain, that the "capable of repetition, yet evading review" exception to mootness applies to their claim. *See, e.g.*, *Padilla v. Lever*, 463 F.3d 1046, 1049 (9th Cir. 2006) (en banc) (quoting *Roe v. Wade*, 410 U.S. 113, 125 (1973)).

In *Sosna v. Iowa*, 419 U.S. 393, 401 (1975), the Supreme Court held that mootness of a named plaintiff's claim after class certification does not moot the action. After incremental extension of *Sosna*,[6] the Supreme Court held that whether class certification occurs before or after a named plaintiff's claim becomes moot is immaterial. *McLaughlin*, 500 U.S. at 52 ("That the class was not certified until after the named plaintiffs' claims had become moot does not deprive us of jurisdiction."). The Court stated that where a claim is "so inherently transitory that the trial court will not have . . . enough time to rule on a motion for class certification before the proposed representative's individual interest expires . . . the 'relation back' doctrine is properly invoked to preserve the merits of the case for judicial resolution." *Id.* (citations omitted).

Here, Haro's claim expired before the district court certified the class. Her individual interest in injunctive relief expired once she was fully reimbursed—approximately one month after she filed this lawsuit—but the district court could not have been expected to rule on a motion for class certification in that period. Pursuant to the rule in *Sosna* and *McLaughlin*, expiration of Haro's personal stake in injunctive relief did not moot the beneficiaries' claim for injunctive

[6] For a comprehensive summary of this case law, see *Pitts v. Terrible Herbst, Inc.*, 653 F.3d 1081, 1086–90 (9th Cir. 2011).

relief. We conclude that the beneficiaries' claim for injunctive relief is not moot, and that Article III's justiciability requirements are satisfied.[7]

3. Statutory Subject Matter Jurisdiction

The Secretary maintains that the district court did not have subject matter jurisdiction. The complaint alleged federal question jurisdiction under 28 U.S.C. § 1331 and, alternatively, jurisdiction under 42 U.S.C. § 1395ff(b)(1)(A). The latter statute is a provision in the Medicare scheme that incorporates 42 U.S.C. § 405(g), the statute that establishes federal jurisdiction to review final decisions of the Commissioner of Social Security. The district court determined that it had subject matter jurisdiction pursuant to § 405(g).

a. The beneficiaries' claim

Federal question jurisdiction does not extend to most claims arising under the Medicare Act. The Medicare Act incorporates 42 U.S.C. § 405(h), which provides:

[7] The Secretary argues that her current practice—under which debts that have been appealed are not referred to the Department of Treasury for collections—mooted the beneficiaries' claim. But this misapprehends the nature of the beneficiaries' claim. Whether the claims are referred for collection or not, plaintiffs object to the demand for up front reimbursement. To the extent a current policy *could* have mooted the beneficiaries' claim, the voluntary cessation exception applies. *See Friends of the Earth v. Laidlaw*, 528 U.S. 167, 189 (2000) ("[A] defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice." (internal quotation marks omitted)).

> No findings of fact or decision of the [Secretary] . . . shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary] . . . , or any officer or employee thereof shall be brought under section 1331 . . . of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h); 42 U.S.C. § 1395ii.

The series of cases interpreting § 405(h) makes clear that it precludes federal question jurisdiction in this case. First, in *Weinberger v. Salfi*, 422 U.S. 749, 760–61 (1975), the Supreme Court ruled that a claim "arises under" the Social Security Act, for purposes of § 405(h), if the Social Security Act "provides both the standing and the substantive basis for the presentation of" the claim. *Salfi* held that a due process and equal protection challenge to duration-of-relationship provisions of the Social Security Act could not proceed under § 1331. *Id.* at 761.

The Supreme Court extended *Salfi* to the Medicare Act in *Heckler v. Ringer*, 466 U.S. 602, 614 (1984). There, the Court ruled that there was no federal question jurisdiction to consider a challenge to a procedure for determining Medicare benefits. The Court described the procedural claim as "inextricably intertwined" with the substantive claim for benefits, *id.*, but the Court rejected the proposition that application of § 405(h) depends on whether a claim is "procedural" rather than "substantive," *id.* at 615.

Finally, in *Shahala v. Illinois Council on Long Term Care, Inc.*, the Supreme Court explained that the broad

purpose of § 405(h) is to ensure that claims are channeled so that the agency has the first opportunity to revise its own policies:

> [T]he bar of § 405(h) reaches beyond ordinary administrative law principles of 'ripeness' and 'exhaustion of administrative remedies'—doctrines that in any event normally require channeling a legal challenge through the agency. . . . [*I*]*t demands the 'channeling' of virtually all legal attacks through the agency* [*and*] *assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying 'ripeness' and 'exhaustion' exceptions case by case.*

529 U.S. 1, 12–13 (2000) (emphasis added) (citation omitted). *Illinois Council* continued, "[t]he fact that the agency might not provide a hearing for [any] particular contention, or may lack the power to provide one . . . is beside the point because it is the 'action' arising under the Medicare Act that must be channeled through the agency." *Id.* at 23 (emphasis omitted) (citations omitted).

Here, the beneficiaries and Balentine maintain that the Secretary's interpretation of the secondary payer provisions is unlawful and that the Secretary's application of the statute's enabling regulations injured them. Because the secondary payer provisions of the Medicare Act provide the standing and the substantive basis for the beneficiaries' claim, § 405(h) precludes original jurisdiction under § 1331. *See Salfi*, 422 U.S. at 760–61; *see also Fanning v. United States*,

346 F.3d 386, 392, 399–400 (3d Cir. 2003) (district court did not have federal question jurisdiction over "class action complaint seeking to enjoin the government's attempt to obtain reimbursement of Medicare overpayments pursuant to the secondary payer provisions"). Pursuant to § 405(h), we conclude the beneficiaries' claim is subject to the requirement that it be administratively channeled.

Because the beneficiaries were required to satisfy the presentment and exhaustion requirements under § 405(g) prior to seeking judicial relief, we must first determine whether Haro fairly presented her claim at the administrative level. *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107, 1115 (9th Cir. 2003). Exhaustion is waivable, presentment is not. *Id.* (citing *Mathews v. Eldridge*, 424 U.S. 319, 328 (1976)). Only presentment is "purely jurisdictional." *Eldridge*, 424 U.S. at 328 (internal quotation marks omitted).

The Secretary maintains that § 405(g)'s jurisdictional presentment requirement was not met because none of the named plaintiffs presented to the agency the claim that the Secretary lacks authority to demand up front reimbursement. The beneficiaries rely heavily on *Eldridge* to argue that a final decision from the Secretary with respect to a claim for benefits entitles a beneficiary to raise any policy challenge in federal court, ostensibly on review of the Secretary's final benefits decision. We conclude the beneficiaries' position is inconsistent with the purpose of the channeling requirement in § 405(h) as explained by the Supreme Court in *Illinois Council*.

Eldridge involved a Social Security beneficiary who, after responding to a questionnaire, received notice that a state agency monitoring his status had tentatively concluded he

was no longer disabled. *Id.* at 323–24. Eldridge disputed one of the reports relied upon by the agency but otherwise stated that the agency had enough evidence of his disability. *Id.* at 324. The Social Security Administration accepted the agency's determination and terminated Eldridge's benefits. *Id.* Eldridge did not request reconsideration of the administration's termination of his benefits before filing a lawsuit and arguing that due process required that he be given a pretermination evidentiary hearing. *Id.* at 324–25.

Analyzing the district court's jurisdiction to adjudicate Eldridge's claim, the Supreme Court ruled that "[t]hrough his answers to the state agency questionnaire, and his letter in response to the tentative determination that his disability had ceased, [Eldridge] *specifically presented the claim that his benefits should not be terminated because he was still disabled*." *Id.* at 329 (emphasis added). The Court continued, "[t]he fact that Eldridge failed to raise with the Secretary his constitutional claim to a pretermination hearing is not controlling[,] . . . § 405(g) requires only that there be a 'final decision' by the Secretary with respect to the claim of entitlement to benefits." *Id.* Consequently, the Court concluded that "the nonwaivable jurisdictional element [of § 405(g)] was satisfied." *Id.* at 330.

The beneficiaries maintain that *Eldridge* stands for the broad proposition that § 405(g)'s presentment requirement is satisfied once a beneficiary has raised a claim for benefits. In their view, a final decision on a claim for benefits permits a beneficiary to raise *any* separate claim pertaining to the agency's procedure or policy in federal court. We disagree. In our view, the beneficiaries' reading of *Eldridge* is overly broad.

The purpose of the channeling requirement is to "assure[] the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying 'ripeness' and 'exhaustion' exceptions." *Illinois Council*, 529 U.S. at 13. This purpose would not be fulfilled if plaintiffs proceeding through the administrative channel were permitted to raise claims in federal court that were not raised before the agency. *See Lifestar Ambulance Serv., Inc. v. United States*, 365 F.3d 1293, 1298 (11th Cir. 2004) (describing administrative review as "the first step in a comprehensive statutory remedial scheme that fully empowers a reviewing court to consider and remedy any of the violations of law alleged by [a] plaintiff").

Moreover, the beneficiaries' interpretation of the presentment requirement is fundamentally inconsistent with the general rule that "[o]nce federal subject matter jurisdiction is established over the underlying case between [plaintiff] and [defendant], the jurisdictional propriety of each additional claim is to be assessed individually." *Caterpillar Inc. v. Lewis*, 519 U.S. 61, 66 n.1 (1996) (quoting 3 James Moore, *Moore's Federal Practice* ¶ 14.26, 14-116 (2d ed. 1996)). In *Eldridge*, the general rule described in *Caterpillar* was not contravened because the plaintiff's argument that he was entitled to a pretermination evidentiary hearing had direct bearing on the termination of his benefits. Notably, this case does not involve a "claim for benefits" because the beneficiaries do not challenge Medicare's reimbursement calculations. They challenge the Secretary's policy of demanding up front reimbursement, a policy that has no

bearing on the reimbursement calculations questioned by the beneficiaries at the administrative level.[8]

Finally, *Illinois Council*, a case decided twenty-four years after *Eldridge*, persuades us that the beneficiaries' interpretation of *Eldridge* is too expansive. In *Illinois Council*, the Supreme Court addressed a case bearing directly on challenges to Medicare regulations and made clear that the type of policy challenge at issue in this case *is* subject to the channeling requirement of § 405(h), and to the presentment requirement in § 405(g). *Illinois Council*, 529 U.S. at 14 ("Nor can we accept a distinction that limits the scope of § 405(h) to claims for monetary benefits.").

We decline to adopt the extraordinarily broad reading of *Eldridge* that the beneficiaries invite. We conclude that the named plaintiffs' reimbursement disputes did not provide an opportunity for the Secretary to consider the claim that her

[8] The beneficiaries also cite, *inter alia*, *Mathews v. Diaz*, 426 U.S. 67 (1976), *Briggs v. Sullivan*, 886 F.2d 1132 (9th Cir. 1989), and *Lopez v. Heckler*, 725 F.2d 1489 (9th Cir. 1984), *vacated* 469 U.S. 1082 (1984). In each of those cases, the plaintiffs were seeking monetary benefits or enrollment in a benefit program. 426 U.S. at 76–77; 725 F.2d at 1493; 886 F.2d at 1133–34. The beneficiaries in this case argue that *Briggs* and *Lopez* are particularly illustrative of a liberal presentment requirement because those cases involved challenges to the Secretary's policies. But the policies challenged in those cases, unlike the policy challenged in this case, affected the plaintiffs' receipt of monetary benefits. 886 F.2d at 1133–34 (plaintiffs "received no payments, or . . . had their payments suspended" and "sued in district court to compel the Secretary to pay their benefits"); 725 F.2d at 1493 ("Plaintiffs challenged the Secretary's termination of their benefits on the ground that the Secretary unconstitutionally refused to give effect to two decisions of this court describing the procedures the statute requires the Secretary to follow in terminating benefits.").

interpretation of the secondary payer provisions exceeded her authority. Their requests for redetermination of their respective amounts of reimbursement did not constitute presentment of their policy challenge.

i. Haro's February 2, 2009 letter was not adequate presentment.

The beneficiaries rely solely on presentation of their reimbursement disputes as evidence that they fulfilled § 405(g)'s presentment requirement, but we consider whether the requirement was otherwise satisfied. In the course of exchanging correspondence regarding the amount of reimbursement they each owed, only Haro made mention of the argument that the Secretary exceeded her authority under the Medicare secondary payer provisions by seeking up front reimbursement.

Haro requested redetermination of the amount of her reimbursement obligation by letter dated January 21, 2009, but her letter did not challenge the Secretary's authority to demand "up front" reimbursement. Haro did make a brief objection to the Secretary's reimbursement practice in a follow-up letter dated February 2, 2009. But subsequent correspondence between Haro and the Secretary memorializes that both parties ignored Haro's objection. The correspondence shows that Haro sent payment in response to the Secretary's initial demand. Medicare then reduced its reimbursement demand, determined that Haro had overpaid, and refunded $103.87 to Haro. With its refund, Medicare gave Haro notice that it was closing its file. Haro did not object to the Secretary closing her file, signaling that the parties had resolved their dispute. Approximately one month passed between the time Haro sent her February 2, 2009

follow-up letter and the time the Secretary sent a letter reducing the reimbursement amount. Approximately one additional month passed before Haro was reimbursed for her overpayment. The record does not show that either of the parties ever followed up on Haro's objection to the Secretary's practice, and neither McNutt nor Hall ever objected to the Secretary's authority to demand up front reimbursement.

Haro's letter and subsequent inaction did not afford the Secretary an "opportunity to apply, interpret, or revise" the challenged policies or regulation. *Illinois Council*, 529 U.S. at 13. Given the sequence of the parties' correspondence, Haro's silence signaled abandonment of her objection and an end to her dispute with Medicare. Haro's letter is not a basis for jurisdiction under § 405(g); treating it as such would render § 405(h)'s channeling requirement meaningless. *Cf. Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1144–45 (9th Cir. 2010).

We conclude that the beneficiaries' claim was not presented to the agency. Because presentment is a jurisdictional requirement under § 405(g), the district court lacked subject matter jurisdiction over the beneficiaries' claim.[9]

b. Balentine's claim is excepted from the channeling requirement.

Attorney Balentine brings a separate claim unique to his status as an attorney for a Medicare beneficiary. As such, we

[9] We do not address the Secretary's exhaustion argument because the beneficiaries' claim was not presented.

must separately consider whether the district court had jurisdiction to adjudicate his claim.

Between *Ringer* and *Illinois Council*, the Supreme Court decided *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). *Michigan Academy* appeared to limit the scope of the channeling requirement in § 405(h) to quantitative, benefit-amount determinations. *See id.* at 680–81. But in *Illinois Council* the Supreme Court clarified that "it is more plausible to read *Michigan Academy* as holding that § 1395ii [the provision of the Medicare statute that incorporates § 405(h) into the Medicare Act] does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all." *Illinois Council*, 529 U.S. at 19.

Because Balentine is not a Medicare beneficiary, he did not have the opportunity to present his challenge through the same administrative channel as the beneficiaries.[10] We are unaware of any other path to administrative review of the policy that Balentine challenges, and the parties cite none. Therefore, because applying § 405(h)'s channeling requirement would mean no review of Balentine's individual claim, the claim falls within the very narrow *Michigan*

[10] Subpart I of 42 C.F.R. § 405 describes the five levels of administrative review. A beneficiary first receives an initial determination. 42 C.F.R. § 405.924(b). If the beneficiary is dissatisfied, the beneficiary may request redetermination, *id.* § 405.940, reconsideration of the redetermination, *id.* §§ 405.960–.978, an ALJ hearing, *id.* §§ 405.1000–.1054, and review by the Medicare Appeals Council, *id.* §§ 405.1100–.1140. Because Balentine is not a beneficiary, he would not receive an initial determination of a reimbursement amount directed at him.

Academy exception, *see id.*, and the district court had federal question jurisdiction under § 1331 to adjudicate it.

B. The Secretary's interpretation of the reimbursement provision is reasonable.

Having determined that the district court lacked subject matter jurisdiction over the beneficiaries' claim, but that it had jurisdiction to adjudicate Balentine's claim under § 1331, we turn to the merits of the Secretary's appeal of the district court's second injunction.

The district court concluded that the Secretary's practice of demanding that attorneys withhold client funds was inconsistent with the secondary payer provisions. The reimbursement provision states that "an entity that receives payment from a primary plan, *shall reimburse* [Medicare] for any [secondary payment] if it is demonstrated that such primary plan . . . had a responsibility to make [a primary] payment," 42 U.S.C. § 1395y(b)(2)(B)(ii) (emphasis added), but it does not define "entity."

The Secretary has interpreted "entity that receives payment from a primary plan" in accordance with the statute's enabling regulations. 42 C.F.R. § 411.24(g) provides that the Secretary "has a right of action to recover its payments from any entity, including a beneficiary . . . *[or] attorney* . . . that has received a primary payment." (emphasis added). And 42 C.F.R. § 411.24(h) states that "[i]f the beneficiary *or other party* receives a primary payment, the beneficiary *or other party* must reimburse Medicare within 60 days." We review the Secretary's interpretation of the statute pursuant to the deferential *Chevron* standard. *Zinman*, 67 F.3d at 843–44.

1. Application of *Chevron*

The first step under *Chevron* is to determine "whether Congress has directly spoken to the precise question at issue." 467 U.S. at 842. The reimbursement provision does not specify whether an attorney who receives settlement proceeds constitutes "an entity that receives payment from a primary plan," and therefore Congress has not spoken to the precise issue.

"[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. If the Secretary's construction is "rational and consistent with the statute, it is a permissible construction" and will be upheld. *Zinman*, 67 F.3d at 845 (internal quotation marks omitted). We therefore consider whether the Secretary's construction of the reimbursement provision is rational and consistent with the statute.

a. There is no statutory basis to distinguish between entities that receive payment from a primary plan and end-point recipients.

An attorney who receives settlement proceeds, even as an intermediary, has "receive[d] payment from a primary plan" in a literal sense; the Secretary's interpretation of the statute is rational in this regard. But the district court concluded that there is nothing in the secondary payer provisions supporting an action against attorneys, "except to the extent they are end-point recipients of settlement proceeds." From this, we understand that the district court drew a distinction between fees earned and retained by an attorney representing a Medicare beneficiary, and funds deposited into an attorney's

trust account to be held in trust on behalf of the attorney's beneficiary-client. But the relevant statutory text broadly states that "an entity that receives payment from a primary plan[] shall reimburse" Medicare; it does not distinguish between a recipient of payment from a primary plan and an "end-point recipient" of such payment. 42 U.S.C. § 1395y(b)(2)(B)(ii). We find nothing in the statutory language to persuade us that the obligation to reimburse Medicare is limited to "end-point" recipients.

b. The 2003 amendments indicate that Congress intended a broad construction of "entity that receives payment from a primary plan."

Before 2003, the cause of action provision stated that "the United States may bring an action against any entity which is required . . . to [make a primary payment] or against any other entity (including any physician or provider) that has received payment from that entity." *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 906 (11th Cir. 2003) (quoting 42 U.S.C. § 1395y(b)(2)(B)(ii)).[11] Analyzing the previous version of the statute, the *Baxter* court applied the doctrine of ejusdem generis to conclude that "Congress intended the term 'any other entity' to be understood with reference to 'physician' and 'provider,' and to encompass only entities of like kind." *Id.* at 906. But in the wake of *Baxter*, Congress amended the statute to eliminate its reference to "physician" and "provider." The amended statute now states that the United States may recover, without limitation, "from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity."

[11] Before 2003, the cause of action provision was codified at 42 U.S.C. § 1395y(b)(2)(B)(ii), which now codifies the reimbursement provision.

42 U.S.C. § 1395y(b)(2)(B)(iii). The amended cause of action provision indicates that Congress intended a more expansive construction of "entity that has received payment from a primary plan" than the one described in *Baxter*. Because the reimbursement provision uses identical language to the amended cause of action provision, the 2003 amendments support the Secretary's position that her construction of the reimbursement provision is consistent with congressional intent. *See Bowoto v. Chevron Corp.*, 621 F.3d 1116, 1127 (9th Cir. 2010) ("identical words used in different part of the same act are intended to have the same meaning" (quoting *Comm'r v. Lundy*, 516 U.S. 235, 250 (1996)).

c. The Secretary's interpretation is consistent with the purpose of the secondary payer provisions.

"The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs." *Zinman*, 67 F.3d at 845. The Secretary's demand that attorneys who have received settlement proceeds reimburse Medicare before disbursing those proceeds to their clients certainly increases the likelihood that proceeds will be available for reimbursement. Therefore, the Secretary's interpretation of the reimbursement provision is consistent with the general purpose of the secondary payer provisions.

d. Whether the Secretary can recover from an attorney who has already disbursed settlement proceeds does not bear on the merits of the injunction.

Balentine maintains that the secondary payer provisions do not create a lien against the settlement proceeds. Therefore, he argues, the Secretary may not recover from an attorney who has already disbursed settlement proceeds. The district court agreed and ruled that the Secretary does not have a right of action against attorneys who have already disbursed settlement proceeds. But that issue is not presented on the facts of this case. The Secretary was fully reimbursed and Balentine was not sued after disbursing Haro's settlement proceeds. The complaint alleges only that the Secretary's demand that attorneys withhold funds from their clients exceeds her authority under the secondary payer provisions. The Secretary's authority to bring an action against an attorney who has disbursed the proceeds is not a controversy ripe for our review.

We conclude the Secretary's interpretation of the reimbursement provision is rational and consistent with the statute's text, history, and purpose, therefore it is reasonable and the district court's second injunction and its order on summary judgment must be reversed.

IV. CONCLUSION

The district court lacked subject matter jurisdiction over the beneficiaries' claims. The Secretary's interpretation of 42 U.S.C. §§ 1395y(b)(2)(B)(ii) and (iii) is reasonable. We therefore **VACATE** the injunctions entered by the district court and **REVERSE** the district court's summary judgment

order. We **REMAND** this case to the district court for consideration of the beneficiaries' due process claim.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF WEST VIRGINIA

UNITED STATES OF AMERICA,

Plaintiff,

v. Civil Action No. 5:08CV102 (STAMP)

PAUL J. HARRIS,

Defendant.

MEMORANDUM OPINION AND ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND DENYING AS MOOT PLAINTIFF'S MOTION TO STAY DISCOVERY

I. Procedural History

The plaintiff, the United States of America, filed a complaint against the defendant, Paul J. Harris, for declaratory judgment and money damages owed to the Centers for Medicare and Medicaid Services by virtue of third-party payments made to a Medicare beneficiary. On November 13, 2008, this Court denied the defendant's motion to dismiss under Rule 12(b)(6) of the Federal Rules of Civil Procedure. Currently before this Court is the plaintiff's motion for summary judgment, which has been fully briefed by the parties and is ready for disposition by this Court. In addition, the plaintiff has filed a motion to stay discovery pending this Court's decision on its motion for summary judgment. The defendant did not file a response. For the reasons set forth below, this Court grants the plaintiff's motion for summary judgment, and denies as moot the plaintiff's motion to stay discovery.

II. Facts

On or about May 22, 2002, Mr. James Ritchea ("Mr. Ritchea"), a Medicare beneficiary, sustained injuries when he fell off a ladder purchased from a local retailer. As a result, because Mr. Ritchea was eligible for benefits through the Medicare health care benefit program, the Centers for Medicare and Medicaid Services ("CMS") paid approximately $22,549.67 in Medicare claims submitted on behalf of Mr. Ritchea for medical services.

Thereafter, Mr. Ritchea and his wife retained the defendant, Paul J. Harris ("Mr. Harris"), as their attorney to sue the ladder retailer, alleging that the retailer was liable for Mr. Ritchea's injuries. The action was settled in July 2005, and as part of this settlement, the Ritcheas and Mr. Harris received a sum of $25,000.00.

Mr. Harris admits that he forwarded to Medicare details of this settlement payment, as well as his attorney's fees and costs. Based upon this information provided by Mr. Harris, Medicare calculated that it was owed approximately $10,253.59 out of the $25,000.00 settlement, determined by Mr. Harris's share of the attorney's fees and costs subtracted from the total medical payment. CMS informed Mr. Harris of this decision by letter dated December 13, 2005. That letter also informed Mr. Harris of the applicable appeal rights, advising Mr. Harris that if his client disagreed with the amount of overpayment, an appeal must be filed within 120 days of receipt of CMS's letter. Neither Mr. Harris nor

his clients filed an appeal and, to date, the debt has not been paid.

Now, because this amount has not been repaid to Medicare within the statutorily-required sixty-day time period, CMS claims that it is entitled to its calculated share of the settlement plus interest, and that it will not pay its full share of attorney's fees and costs. Accordingly, CMS is seeking total payment of $11,367.78 plus interest from Mr. Harris for the Medicare claims paid on behalf of the defendant's client, Mr. Ritchea.

III. Applicable Law

Under Federal Rule of Civil Procedure 56(c), summary judgment should be granted if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." The party seeking summary judgment bears the initial burden of showing the absence of any genuine issues of material fact. See Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986). "The burden then shifts to the nonmoving party to come forward with facts sufficient to create a triable issue of fact." Temkin v. Frederick County Comm'rs, 945 F.2d 716, 718 (4th Cir. 1991), cert. denied, 502 U.S. 1095 (1992) (citing Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986)).

"[A] party opposing a properly supported motion for summary judgment may not rest upon the mere allegations or denials of his

pleading, but . . . must set forth specific facts showing that there is a genuine issue for trial." Anderson, 477 U.S. at 256. The Court must perform a threshold inquiry to determine whether a trial is needed -- whether, in other words, "there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party." Id. at 250; see also Charbonnages de France v. Smith, 597 F.2d 406, 414 (4th Cir. 1979) (Summary judgment "should be granted only in those cases where it is perfectly clear that no issue of fact is involved and inquiry into the facts is not desirable to clarify the application of the law.") (citing Stevens v. Howard D. Johnson Co., 181 F.2d 390, 394 (4th Cir. 1950)).

"[T]he plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex, 477 U.S. at 322. Summary judgment is not appropriate until after the non-moving party has had sufficient opportunity for discovery. See Oksanen v. Page Mem'l Hosp., 912 F.2d 73, 78 (4th Cir. 1990), cert. denied, 502 U.S. 1074 (1992). In reviewing the supported underlying facts, all inferences must be viewed in the light most favorable to the party opposing the motion. See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986).

IV. Discussion

A. Plaintiff's Motion for Summary Judgment

Section 1395y(b)(2)(B)(ii) of the Social Security Act, commonly known as the Medicare Secondary Payer Statute ("MSPS"), states, in pertinent part, that when Medicare makes a conditional payment for medical services received as a result of an injury caused by another party, the government has a right of recovery for the conditional payment amount against any entity responsible for making the primary payment:

> Repayment required. A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the secretary under this title . . . with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

42 U.S.C. § 1395y(b)(2)(B)(ii). See also Cox v. Shalala, 112 F.3d 151, 154 (4th Cir. 1997) ("When such a conditional payment is made for medical care, the government has a direct right of recovery for the entire amount conditionally paid from any entity responsible for making primary payment.").

To recover payment, the government may "bring an action against any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service . . . under a primary plan." 42 U.S.C.

§ 1395y(b)(2)(B)(iii). Alternatively, the government "may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." Id. (emphasis added). See also Cox, 112 F.3d at 154 ("In the alternative, the government's right of recovery is subrogated to the rights of an individual or entity which has received a payment from the responsible party."). The federal regulations implementing the MSPS provide the entities in which the government can recover primary payments:

> Recovery from parties that receive primary payments. CMS has a right of action to recover its payments from any entity, including a beneficiary provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

42 C.F.R. § 411.24(g) (emphasis added).

A party who does not agree with CMS's determination of the amount of reimbursement has recourse through an administrative appeals process. "Any individual dissatisfied with any initial determination shall be entitled to reconsideration of the determination, and . . . a hearing thereon by the Secretary [of Health and Human Services] . . . and to judicial review of the Secretary's final decision after such hearing." 42 U.S.C. § 1395ff(b)(1)(A). See also 42 C.F.R. §§ 405.940, 405.960, 405.1000, 405.1100. The party has 120 days after receiving CMS's initial determination to appeal. 42 U.S.C. § 1395ff(a)(3)(C)(I).[1]

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[1]A detailed description of the appeals process can be located in Chapter 29 of the Medicare Claims Processing Manual, Appeals of Claims Decisions, at http://www.cms.hhs.gov/manuals/downloads/

In its motion, the government contends that summary judgment is appropriate because under the applicable statute and regulations, the United States is entitled to recover the amount due from Mr. Harris. Specifically, the government argues that Mr. Harris has waived any challenge to the amount or existence of the debt at issue in this suit because the time for appealing that determination has passed. In response, Mr. Harris asserts that he must be permitted to engage in discovery on the issues of liability and damages, as well as his affirmative defenses of estoppel and consortium.

This Court finds that the government is entitled to judgment as a matter of law. In this case, the Ritcheas and the defendant received a $25,000.00 settlement and primary payment in the underlying personal injury action from the ladder retailer. Because the ladder retailer took responsibility for the payment of Mr. Ritchea's medical services, demonstrated by "a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured," the government can now receive reimbursement for the medical services paid for by Medicare. 42 U.S.C. § 1395y(b)(2)(B)(iii). Furthermore, this Court holds that Mr. Harris is individually liable for reimbursing Medicare in this case because the government can recover "from any

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entity that has received payment from a primary plan," including an attorney. 42 C.F.R. § 411.24(g) (emphasis added).

Moreover, this Court agrees with the government that Mr. Harris's failure to pursue available administrative remedies precludes him from challenging CMS's reimbursement determination. As stated in Ulman v. United States, 558 F.2d 1, 7-8 (Ct. Cl. 1977):

> Where an administrative appeal is compulsory prior to invoking the aid of a court, it does not matter that the party who failed to pursue said appeal is petitioning the Court for relief or defending an action brought against him. In either situation the failure to pursue the prescribed administrative course effectively prohibits his claim or defense which could have been entertained administratively in the first instance.

In United States v. Savarese, 515 F. Supp. 533 (S.D. Fla. 1981), the government determined that the defendant physician had been overpaid approximately $108,720.42 under the Medicare program.[2] When the defendant failed to repay Medicare the alleged overpayment, a claim was filed against the defendant's estate.[3] Id. at 535. The defendant's estate did not administratively appeal the overpayment calculation. Later during suit, however, the defendant's personal representative stated that although she would not contest the amount of the alleged overpayments, she "question[ed] the allegation that Dr. Savarese . . . received

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[2]This amount was later reduced to $108,290.82 when a total of $429.60 due to the doctor was offset against the overpayment.

[3]The defendant passed away prior to reimbursing the government.

$108,290.82 in excess of the amount due him by the Medicare Program." Id. at 536. The government contended in its cross-motion for summary judgment that the decedent waived his right to judicial review of the overpayment determination because he did not utilize the administrative appeals process and that therefore, it was entitled to a judgment of a matter of law. The court agreed and held that "[d]efendant's failure to pursue administrative remedies precludes any questions regarding the amount of the overpayments received." Id. at 536.

Other courts have reached similar conclusions. See United States v. Home Health Agency, Inc., 862 F. Supp. 129, 134 (N.D. Tex. 1994) (The defendant's "failure to exhaust the administrative appellate procedure precludes it from challenging the overpayment determination which the government seeks to recover."); United States v. Total Patient Care, Inc. of Jacksonville, Florida, 780 F. Supp. 1371, 1373 (M.D. Fla. 1991) ("[T]he Court finds that defendant's failure to pursue available administrative remedies precludes judicial review of the defendant's claim concerning the propriety of the calculation of the overpayment. Exhaustion of administrative remedies is a prerequisite to any judicial review of defendant's claim under the Social Security Act.").

After careful consideration, this Court finds this authority persuasive in granting the government's motion for summary judgment. Indeed, any qualms that Mr. Harris had concerning the extent of his liability under the MSPS should have been challenged

through the administrative appeals process. By letter, dated December 13, 2005, CMS advised Mr. Harris of the amount of the reimbursement, as well as the procedures to appeal the reimbursement determination. Neither Mr. Harris nor his clients filed an appeal. Therefore, because he did not avail himself of the administrative process, Mr. Harris is now precluded from contesting the reimbursement determination that the government is seeking to recover. Accordingly, this Court finds that summary judgment in favor of the government is appropriate. See United States v. Weinberg, 2002 WL 32356399 (E.D. Pa. 2002) (granting United States partial summary judgment under MSPS and holding that United States is entitled to recover MSPS debt from beneficiary's attorney); United States v. Sosnowski, 822 F. Supp. 570 (W.D. Wis. 1993) (granting, in part, the United States' motion for judgment on the pleadings under MSPS and holding that the United States is entitled to recover MSPS debt from beneficiary and his attorney).

The judgment awarded to the government is $11,367.78, in accordance with 42 C.F.R. § 411.37(e)(2), which represents the total settlement amount minus the party's total procurement costs. The government is also entitled to recover interest on the total amount of reimbursement. See 42 C.F.R. § 405.378 ("CMS will charge interest in overpayments . . . to providers and suppliers of services."). That regulation also sets forth the rate of interest. See 42 C.F.R. § 405.378(d). Since no amount of interest has previously been presented to this Court, the parties shall confer

and attempt to agree upon the amount of interest to be awarded. The parties shall then present a stipulated amount to this Court within ten (10) days from the date of this memorandum opinion and order. If the parties cannot agree as to the amount of interest, then each party shall, within fifteen (15) days from the date of this memorandum opinion and order, present to this Court a written statement as to that party's detailed calculation of the amount of interest that that party contends shall be awarded.

B. Plaintiff's Motion to Stay Discovery

In light of this Court's holding on the plaintiff's motion for summary judgment, the plaintiff's motion to stay discovery is denied as moot.

V. Conclusion

For the above-stated reasons, the plaintiff's motion for summary judgment is GRANTED, and the plaintiff's motion to stay discovery is DENIED AS MOOT. The plaintiff is entitled to judgment in the amount of $11,367.78 plus the amount of interest thereon which will be calculated. This Court will defer entry of judgment pursuant to Federal Rule of Civil Procedure 58 until the interest has been calculated as provided above.

IT IS SO ORDERED.

The Clerk is directed to transmit a copy of this memorandum opinion and order to counsel of record herein.

DATED: March 26, 2009

/s/ Frederick P. Stamp, Jr.
FREDERICK P. STAMP, JR.
UNITED STATES DISTRICT JUDGE

PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

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No. 11-2664

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IN RE: AVANDIA MARKETING, SALES PRACTICES and PRODUCTS LIABILITY LITIGATION
GLAXOSMITHKLINE, LLC & GLAXOSMITHKLINE, PLC

HUMANA MEDICAL PLAN, INC. and HUMANA INSURANCE COMPANY, individually and on behalf of all others similarly situated,
Appellants

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APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA
(D.C. Civ. No. 10-6733 and MDL 1871)
District Judge: Honorable Cynthia M. Rufe

_____

Argued on January 24, 2012

_____

Before: McKEE, *Chief Judge*, FISHER, and GREENAWAY, JR., *Circuit Judges*.

(Opinion Filed: June 28, 2012)

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OPINION

GREENAWAY, JR., *Circuit Judge*.

Plaintiff Humana Medical Plan, Inc. and Humana Insurance Company (collectively, "Humana") brought suit against GlaxoSmithKline, L.L.C. and GlaxoSmithKline plc (collectively, "Glaxo") alleging that Glaxo was obligated to reimburse Humana for expenses Humana had incurred treating its insureds' injuries resulting from Glaxo's drug, Avandia. Humana runs a Medicare Advantage plan. Its complaint asserts that, pursuant to the Medicare Act, Glaxo is in this instance a "primary payer" obligated to reimburse Humana as a "secondary payer." The District Court dismissed the action, agreeing with Glaxo that the Medicare Act did not provide Medicare Advantage organizations ("MAOs") with a private cause of action to seek such reimbursement. Humana filed a timely appeal.

The Medicare Secondary Payer Act, in 42 U.S.C. § 1395y(b)(3)(A), provides Humana with a private cause of action against Glaxo. Even if we were to find, as Appellees suggest, that this provision is ambiguous, we would nonetheless be required to defer to regulations issued by the Centers for Medicare and Medicaid Services ("CMS"). The regulations make clear that the provision extends the private cause of action to MAOs. Accordingly, we will reverse the judgment of the District Court and remand for further proceedings.

I. BACKGROUND

Glaxo manufactures and distributes Avandia, a Type 2 diabetes drug that has been linked to substantially increased risk of heart attack and stroke. Thousands of Avandia patients have alleged various injuries resulting from their use of the drug and Glaxo has begun entering into agreements to settle these claims.[1] As part of the settlement process, where the claimant is insured by Medicare, Glaxo sets aside reserves to reimburse the Medicare Trust Fund for payments it made to cover the costs of treatment for the claimants' Avandia-related injuries.

While most Medicare-eligible individuals receive Medicare benefits directly from the government, individuals can elect instead to receive their benefits through private insurance companies that contract with the government to provide "Medicare Advantage" ("MA") plans. 42 U.S.C. § 1395w-21(a)(1). Glaxo has not, to date, included reimbursement of MA plans in the settlement agreements that it has reached with Avandia claimants enrolled in MA plans, although MAOs have paid the costs of treatment of Avandia-related injuries for these claimants.[2] Humana's MA plan provides benefits to approximately one million people, and

[1] By August 2011, when Appellants filed their brief, Glaxo had paid more than $460 million to settle these claims.

[2] An MA plan assumes full responsibility for paying the medical costs of its plan participants in exchange for a fixed annual per-participant payment from the government. § 1395w-23. This fixed, or "capitated," amount is calculated annually using a formula based on the cost of providing the required benefits that would otherwise be covered by traditional Medicare. *Id.*

Humana filed this lawsuit to seek reimbursement from Glaxo for the costs of treating its enrollees' Avandia-related injuries.

On November 17, 2010, Humana filed its class action complaint in the Eastern District of Pennsylvania.[3] Humana sought, on behalf of itself and a class of similarly-situated MAOs: (1) damages under the Medicare Secondary Payer Act ("MSP Act"), which provides a private cause of action, 42 U.S.C. § 1395y(b)(3)(A), allowing double damages for failure to reimburse a secondary payer; and (2) equitable relief in the form of an order compelling Glaxo to identify settling Avandia claimants to the MAOs that cover them.

On December 23, 2010, Glaxo filed a motion to dismiss. The District Court heard oral argument on the motion and, on June 13, 2011, granted it. In dismissing the action, the District Court noted that Part C of the Medicare Act (the "Medicare Advantage" or "MA" statute) contains its own secondary payer provision, 42 U.S.C. § 1395w-22(a)(4). *In re Avandia Mktg., Sales Practices, and Prods. Liability Litig.*, 2011 WL 2413488, at *3 (E.D. Pa. June 13, 2011). The District Court observed that this provision references the MSP Act without fully adopting or incorporating it and that its language is permissive, whereas the language of the MSP Act is mandatory. *Id.* Given the existence of the MA statute's provision, specifically relevant to MAOs, the District Court held that the private cause of action within the MSP

[3] Many suits alleging Avandia-related injuries have been filed in federal court and almost all are being coordinated for pretrial purposes in the Eastern District of Pennsylvania. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, MDL Dkt. No. 1871. This case is among them.

Act did not apply to MAOs, nor did the secondary payer provision in the MA statute create a private right of action for MAOs. *Id.* at *4. Next, the District Court analyzed whether an implied private right of action for Humana existed according to the four-part test laid out by the Supreme Court in *Cort v. Ash*, 422 U.S. 66 (1975). *In re Avandia*, 2011 WL 2413488, at *4. Although the District Court found that Humana met the first prong of the test, as it was a member of the class the statute was enacted to benefit, it found that Humana failed on the other three prongs: there was no clear legislative intent to create a remedy for Humana, it was not consistent with the legislative scheme to imply a remedy, and the cause of action was one traditionally litigated under state law. *Id.* The District Court therefore found that no implied private right of action existed.

Additionally, the District Court found that the statute's silence on the existence of a private right of action for MAOs "does not create ambiguity, but rather indicates [Congress's] intent not to create a private right of action for MAOs." *Id.* at *5. With no ambiguity in the plain text of the statute, the District Court held that the judicial deference to duly-enacted regulations required by *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc*, 467 U.S. 837, 842-43 (1984), did not come into play. Accordingly, the Court did not defer to the CMS regulation that granted MAOs parity with Medicare vis-à-vis recovery from primary payers, s*ee* 42 C.F.R. § 422.108(f). *In re Avandia*, 2011 WL 2413488, at *5.

Finally, Humana sought an order from the District Court ordering Glaxo to disclose information about settlements that Humana's enrollees entered into with Glaxo. The District Court declined to grant Humana the equitable relief it sought. It found that Humana, and not Glaxo, had

access to information about which Avandia claimants were enrolled in Humana's MA plan and that Humana could use this information to remind claimants of their obligation to disclose any settlement they might reach with Glaxo.[4, 5] *Id.*

Humana filed a timely Notice of Appeal. Humana asks this Court to determine whether the District Court erred in holding that the private cause of action in the MSP Act, 42 U.S.C. § 1395y(b)(3)(A), did not provide Humana with a cause of action here. America's Health Insurance Plans, representing the health insurance industry, filed an amicus brief in support of Humana.

II. JURISDICTION AND STANDARD OF REVIEW

The District Court had subject matter jurisdiction, pursuant to 28 U.S.C. § 1331, because interpretation of the federal Medicare Act presents a federal question. This Court has appellate jurisdiction, pursuant to 28 U.S.C. § 1291. We review de novo the decision of a district court granting a motion to dismiss, pursuant to Rule 12(b)(6). *McTernan v. City of York*, 577 F.3d 521, 526 (3d Cir. 2009). In ruling upon a motion to dismiss, "all well-pleaded allegations of the

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[4] The District Court also noted that a pending amendment to the MSP Act might arguably shift the reporting burden to Glaxo, but declined to address that question because it was not yet ripe. *In re Avandia Mktg., Sales Practices, and Prods. Liability Litig.*, 2011 WL 2413488, at *6 (E.D. Pa. June 13, 2011).

[5] Humana did not appeal the District Court's dismissal of its claim for equitable relief.

complaint must be taken as true and interpreted in the light most favorable to the plaintiffs, and all inferences must be drawn in favor of them." *Id.* (quoting *Schrob v. Catterson*, 948 F.2d 1402, 1408 (3d Cir.1991)).

III. ANALYSIS

Humana asks this Court to determine whether the private cause of action for double damages created by the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)(3)(A), provides it and other MAOs with the right to bring suit. [6] We find that the plain text of the provision sweeps broadly enough to include MAOs and that, even if we determined the statute to be ambiguous on this point, deference to CMS regulations[7] would require us to find that MAOs have the same right to recover as the Medicare Trust Fund does. We will therefore reverse the decision of the District Court.

A. The Medicare Statute

Subchapter XVIII of Chapter 7 of Title 42 of the United States Code is entitled "Health Insurance for Aged and Disabled," and is more commonly known as the Medicare

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[6] Humana repeatedly states that an MAO has "standing" to bring suit under the provision at issue. In order to avoid confusion with the doctrine of constitutional standing, s*ee Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992), this opinion avoids that term.

[7] CMS is an operating division within the Department of Health & Human Services which issues Medicare-related regulations on behalf of the Secretary of Health & Human Services.

Statute. 42 U.S.C. §§ 1395 to 1395kkk-1. The Medicare Statute divides benefits into four parts. Part A, "Hospital Insurance Benefits for Aged and Disabled," and Part B, "Supplementary Medical Benefits for Aged and Disabled," create, describe, and regulate traditional fee-for-service, government-administered Medicare. §§ 1395c to 1395i-5; §§ 1395-j to 1395w-5. Part C, inserted with the passage of the Balanced Budget Act of 1997, Pub. L. 105-33, creates the program now known as Medicare Advantage, which allows for the creation of MA plans and is described in detail below. § 1395w-21 to -29. Finally, Part D provides for prescription drug coverage for Medicare enrollees. § 1395w-101 to -154.

Part C allows Medicare enrollees to obtain their Medicare benefits through private insurers (MAOs) instead of receiving direct benefits from the government under Parts A and B. § 1395w-21(a). CMS pays an MAO a fixed amount for each enrollee, per capita (a "capitation"). The MAO then administers Medicare benefits for those enrollees and assumes the risk associated with insuring them. MAOs like Humana are thus responsible for paying covered medical expenses for their enrollees. Part C allows MAOs some flexibility as to the design of their MA plans. The MAO is required to provide the benefits covered under Parts A and B to enrollees, but it may also provide additional benefits to its enrollees. § 1395w-22(a)(1)-(3).

Part C also includes one of the two provisions that lie at the heart of this case. Entitled "Organization as secondary payer," this provision states:

> Notwithstanding any other provision of law, [an MAO][8] may (in the case of the provision of items and services to an individual under [an MA] plan under circumstances in which payment under this title is made secondary pursuant to section 1395y(b)(2)) of this title charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section--
>
> (A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or
>
> (B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

§ 1395w-22(a)(4) (the "MAO secondary payer provision").

[8] The statutory text refers to MAOs as "Medicare+Choice" organizations. For simplicity's sake, this opinion substitutes the contemporary terminology wherever that phrase appears. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2176, 42 U.S.C. §1395w-21 note ("[T]he Secretary shall provide for an appropriate transition in the use of the terms 'Medicare+Choice' and 'Medicare Advantage' (or 'MA') in reference to the program under part C of title XVIII of the Social Security Act.").

This provision (the "Part C secondary payer provision") cross-references § 1395y(b)(2) for its definitions of primary payers and its positioning of Medicare as a secondary payer. That cross-referenced provision is located within § 1395y(b), the Medicare Secondary Payer Act, enacted in 1980. It provides that Medicare cannot pay medical expenses where "payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." § 1395y(b)(2)(A)(ii). Further, a business "shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." *Id.* Glaxo, which pays out of its own pocket to settle the Avandia-related claims, is self-insured and therefore a primary payer in this instance.

The MSP Act also gives the Secretary the authority to make "conditional payments" in circumstances where a primary payer is actually responsible for the cost of medical treatment but "has not made or cannot reasonably be expected to make payment with respect to such item or service promptly." § 1395y(b)(2)(B)(i). In such a circumstance, the primary plan must subsequently reimburse the Medicare Trust Fund. § 1395y(b)(2)(B)(ii). If the primary plan fails to reimburse the Fund, "the United States may bring an action against any or all entities that are or were required or responsible . . . to make payment . . . under a primary plan." § 1395y(b)(2)(B)(iii). The government may then collect double damages, "in accordance with paragraph (3)(A)." *Id.*

Paragraph (3)(A) (the "MSP private cause of action provision") is the other provision central to this case. It states:

> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with [the requirements of the MSP Act].

§ 1395y(b)(3)(A).

The Medicare Statute thus creates two separate causes of action allowing for recovery of double damages where a primary payer fails to cover the costs of medical treatment. When the Medicare Trust Fund makes a conditional payment and the primary payer does not reimburse it, the United States may bring suit pursuant to § 1395y(b)(2)(B)(iii). Additionally, a private cause of action with no particular plaintiff specified exists pursuant to § 1395y(b)(3)(A) anytime a primary payer fails to make required payments.[9]

[9] Although the MSP private cause of action provision sweeps broadly, it is not so broad that it can function as a *qui tam* statute, allowing a private party to bring suit as an agent of the government to collect moneys owed to the government. Each of our sister circuits to have considered the question has rejected this interpretation. *Woods v. Empire Health*, 574 F.3d 92, 101 (2d Cir. 2009); *Stalley ex rel. United States v. Orland Reg. Healthcare System, Inc.*, 524 F.3d 1229, 1234 (11th Cir. 2008); *Stalley v. Methodist Healthcare*, 517 F.3d 911, 919 (6th Cir. 2008); *Stalley v. Catholic Health*

Exactly how broadly this latter provision sweeps will determine the outcome of this appeal.

B. Textual Arguments

1. MSP Private Cause of Action Provision

The plain text of the MSP private cause of action lends itself to Humana's position that any private party may bring an action under that provision. It establishes "a private cause of action for damages" and places no additional limitations on which private parties may bring suit. § 1395y(b)(3)(A). Accordingly, we find that the provision is broad and unambiguous, placing no limitations upon which private (i.e., non-governmental) actors can bring suit for double damages when a primary plan fails to appropriately reimburse any secondary payer.

Glaxo presents no argument that undermines this facially clear reading. The MSP private cause of action provision allows for damages where the primary plan has failed to pay "in accordance with paragraphs (1) and (2)(A)." *Id.* Paragraph (2)(A), in turn, consistently refers to payments "under this subchapter."[10] § 1395y(b)(2)(A). Glaxo contends that "payments under this subchapter" refers to payments

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Initiatives, 509 F.3d 517, 527 (8th Cir. 2007); *United Seniors Ass'n v. Philip Morris USA*, 500 F.3d 19, 26 (1st Cir. 2007).

[10] The United States Code Service uses the word "title" in place of "subchapter," favored by the United States Code Annotated. This opinion utilizes the statutory text from the latter compilation.

made by the Medicare Trust Fund and excludes payments from the MAO to private entities, which are instead "made pursuant to private contracts of insurance between the MAO and the participant." (*Id.* at 25.)

In contrast, Humana argues that because "subchapter" refers to the Medicare Act as a whole, and not in particular to Parts A or B under which the government provides benefits directly to enrollees, payments made by private providers under Parts C or D are also covered. Humana supports this assertion by highlighting other places in the Medicare Act where Congress intentionally limited the applicability of a provision to payments made under particular Parts of the Medicare Act. (Appellants' Br. 23.) These provisions refer specifically to "payment made under part A or part B of this subchapter," § 1395y(a), or payment made "under Part B of this subchapter," § 1395y(c). *See also* § 1395y(f) (requiring Secretary to establish guidelines as to whether payment may be made for certain expenses "under part A or part B of this subchapter").

This language makes clear that "subchapter" refers to the Medicare Act as a whole. Since the MSP Act and its private cause of action provision do not attach any narrowing language to "payments made under this subchapter," that phrase applies to payments made under Part C as well as those made under Parts A and B. Accordingly, that language cannot be read to exclude MAOs from the ambit of the private cause of action provision.

It is worth noting that, although the MSP Act was enacted before Part C, which created MAOs, private Medicare risk plans were authorized under 42 U.S.C. § 1395mm in 1972, before the passage of the MSP Act. Act of

Oct. 30, 1972, sec. 226(a), Pub. L. 92-603, 86 Stat. 1396. Thus, at the time it enacted the MSP Act, Congress was aware that private Medicare providers existed. Had it intended to prevent them from suing under the private cause of action provision, Congress could have done so explicitly.

2. MAO Secondary Payer Provision

Glaxo raises a number of arguments stemming from its contention that the MSP private cause of action provision cannot be read in a vacuum. Glaxo urges this Court to analyze the relationship between MAOs and the MSP Act by beginning with the MAO secondary payer provision. The plain text of the MAO secondary payer provision, Glaxo avers, makes clear that MAOs do not have a federal cause of action anywhere under the Medicare Act. Further, because this provision specifically defines the relationship of MAOs to secondary payer status and the MSP Act, it controls those relationships, and the MSP private cause of action does not apply to MAOs. [11]

In Glaxo's argument, the MAO secondary payer provision, by stating that an MAO "may . . . charge or authorize the provider of [ ] services to charge" the primary payer, gives MAOs the right to include in their policy

[11] Humana has not raised on appeal the question of whether there is some private right of action for MAOs implied in the Medicare Act, although the District Court found that no such implied right of action exists. 2011 WL 2413488, at *4. Accordingly, we are asked to determine whether the text of § 1395y(b)(3)(A) provides Humana with a cause of action and nothing further.

contracts provisions making them secondary payers in situations in which a primary payer would be liable under the MSP Act. § 1395w-22(a)(4). It does not, however, provide a federal remedy for the enforcement of that right. *See Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (stating that statute does not create private cause of action unless Congress intended "to create not just a private right but also a private remedy"). At oral argument, Glaxo asserted that this provision was intended to preempt state law that could preclude an MAO from positioning itself as a secondary payer, as certain personal injury laws might.

Under the interpretation urged by Glaxo, no rights to reimbursement are granted to an MAO by the Medicare Act. Instead, such rights can be secured by the MAO's contract with an individual insured; that is, the insurance policy. This policy may define an MAO as a secondary payer, according to the definition contained in the MSP Act, and it may also contain rights of reimbursement and subrogation.[12] Then, if a primary payer were to fail to reimburse the MAO, the MAO could sue to enforce its contractual rights in state court. It could be made whole either by recovering from the primary payer through subrogation or, if the insured has received payment from the primary payer, from the insured directly.

The District Court accepted this interpretation of the MAO secondary payer provision. 2011 WL 2413488, at *4;

[12] As the District Court noted, the policy might also create an obligation for the insured to inform the MAO of any primary insurance coverage, including tort settlements where the tortfeasor qualifies as a primary payer. *In re Avandia*, 2011 WL 2413488, at *4 n.40.

see also Parra v. PacifiCare of Arizona, Inc., Civ. No. 10-008, 2011 WL 1119736 (D. Ariz. Mar. 28, 2011) (finding Congress did no more than provide MAOs with "right to charge and/or bill a beneficiary for reimbursement, notwithstanding and [sic] state law or regulation to the contrary"). It is important to remember, though, that Humana does not contend that § 1395w-22(a)(4) endows it with a private right of action. Instead, it hangs its hat entirely on the MSP Act provision. Thus, § 1395w-22(a)(4) is relevant only inasmuch as it assists us in interpreting the MSP private cause of action provision, and we are not persuaded that it undermines the meaning of the plain text of that provision.

Glaxo further contends that the reference to § 1395y(b)(2) in the MAO secondary payer provision, far from incorporating the entirety of the MSP Act into Part C, in fact makes clear that *only* the definition of a primary payer from the MSP Act is incorporated there. (Appellees' Br. 21-22.) This argument is unavailing for the same reason—Humana is not arguing that the MAO secondary payer provision provides a cause of action through its reference to the MSP Act, but that the language of the MSP private cause of action is itself broad enough to encompass an MAO such as Humana, regardless of the existence of § 1395w-22(a)(4). In order to find these arguments persuasive, we would need to determine that, although private insurers providing Medicaid services could have brought suit under the MSP private cause of action provision before the enactment of the MA secondary payer provision, once that text became law, the MSP private cause of action was closed to them. We will not reach this conclusion.

Glaxo's final argument based on the text of the MAO secondary payer provision is that the permissive nature of the language there (an MAO "may" charge a primary plan), in contrast to the mandatory nature of the language in the MSP Act ("Payment under this subchapter may not be made. . .") means that MAOs cannot be authorized to bring suit under the MSP private cause of action. § 1395w-22(a)(4); § 1395y(b)(2)(A). Glaxo reads far too much into this distinction. No MAO, acting rationally, would decline to position itself as a secondary payer in order to charge primary payers where appropriate. Accordingly, the fact that Congress employs permissive language when establishing rules for private, market-driven entities and mandatory language when creating rules for the Secretary, a federal official over whom Congress exercises control, has no effect on the proper interpretation of MSP private cause of action.

In short, there is nothing in the text or legislative history of the MA secondary payer provision that demonstrates a congressional intent to deny MAOs access to the MSP private cause of action.

3. Court Decisions

None of the decisions cited by Glaxo or the District Court provide us with sufficient reason to conclude that, in contravention of the plain text of the MSP private cause of action provision, an MAO may not bring suit under it. The District Court found that no federal private cause of action exists under the MSP Act by relying on two cases, neither of which had plaintiffs who made an argument based on the MSP Act provision at issue here.

In *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003), the Sixth Circuit considered the argument of Care Choices, a Medicare-substitute HMO, that it had an implied federal private right of action allowing it to recover the cost of an insured's medical expenses, where the participant had collected damages from the tortfeasor who had injured her. That court declined to find an implied private right of action in the provision allowing Care Choices to occupy secondary-payer status. In so doing, it compared the language of the MSP Act private cause of action provision with § 1395mm(e)(4),[13] finding the contrast to support its holding that § 1395mm(e)(4) was not intended to create any private right of action. *Id.* at 790. Whether Care Choices could have brought suit as a private actor under the MSP Act was neither raised nor addressed and thus the decision of the United States Court of Appeals for the Sixth Circuit cannot guide us here.

Similarly, in *Nott v. Aetna U.S. Healthcare Inc.*, 303 F. Supp. 2d 565 (E.D. Pa. 2004), the court considered whether § 1395mm(e)(4) or § 1395w-22(a)(4) created a federal scheme for enforcement of a Medicare-substitute HMO's subrogation rights that would completely preempt conflicting state laws. The *Nott* court noted explicitly that § 1395y(b)(2)(B)(ii), the government's cause of action for reimbursement, was not implicated in the case, *id.* at 570, and it nowhere mentioned

[13] Because Care Choices was a Medicare-substitute HMO and not an MAO, the relevant, private-insurer-specific secondary payer provision was not § 1395w-22(a)(4), but rather § 1395mm(e)(4), which contains nearly identical language. The two provisions are logically subject to the same interpretation.

the § 1395y(b)(3)(A) private cause of action. Relying substantially on *Care Choices*, it held that "[t]here is no federal cause of action created by either subsection" and thus no preemption. *Id.* at 571.

Once again, because the decision does not discuss whether a private insurer providing Medicare services can bring suit under the MSP private cause of action, it is of limited relevance here.[14]

In contrast, the decision of the Court of Appeals for the Sixth Circuit in *Bio-Medical Applications of Tenn., Inc. v. Central States Health and Welfare Fund*, 656 F.3d 277 (6th Cir. 2011), does specifically consider the MSP private cause of action provision. There, the court held that the "demonstrated responsibility" provision of the MSP[15] applied

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[14] For the same reasons, *Parra v. PacifiCare of Arizona, Inc.*, cited by Glaxo and the District Court, is also inapposite. 2011 WL 1119736 (D. Ariz. Mar. 28, 2011). This unreported decision adopts a magistrate's report and recommendation finding no implied private right of action in the MAO secondary payer provision. The report and recommendation relied heavily on *Care Choices*, and neither that decision nor the decision of the district court addressed the argument that an MAO could bring suit under the MSP private cause of action provision.

[15] "A primary plan . . . shall reimburse [the Trust Fund] for any payment made by [Medicare] . . . with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." § 42 U.S.C. § 1395y(b)(2)(B)(ii)

only to situations in which the primary payer was a tortfeasor and not to the case before it, in which the primary plan was actually a primary insurer. *Id.* at 290-91. In explicating this point, it noted that a tortfeasor could be held liable as a primary payer under the MSP Act only when Medicare sues for reimbursement from a primary plan and not when the plaintiff is a private party. *Id.* at 292-93. It buttressed this distinction between Medicare and private parties with a number of arguments from the statute's text and legislative history.[16] *Id.* at 292. However, the private party bringing suit in *Bio-Medical* was neither an MAO nor a Medicare-substitute HMO, and the court there did not consider how such an entity would fit into the dichotomy it described. As the remainder of this opinion will demonstrate, we believe that denying an MAO the rights to recovery provided to Medicare would undermine the very purpose of the MA program and that Congress did not intend this result.

C. Legislative History and Policy

Although we find the text of the statute to be unambiguous, we nonetheless include here a discussion of the

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[16] These reasons include, *inter alia*, that the demonstrated responsibility provision's "text places a condition only on when primary plans must reimburse Medicare; it does not mention when plans must pay private parties," that "the structure of the Act suggests that the provision is limited to the reimbursement of Medicare," and that "the predominant legislative backdrop was Medicare's (not private parties') failed attempts to bring lawsuits against tortfeasors." *Bio-Medical Applications of Tenn., Inc. v. Central States Health and Welfare Fund*, 656 F.3d 277, 292 (6th Cir. 2011).

legislative history and policy rationales that support our conclusion.

Congress's goal in creating the Medicare Advantage program was to harness the power of private sector competition to stimulate experimentation and innovation that would ultimately create a more efficient and less expensive Medicare system. *See, e.g.*, H.R. Rep. No. 105-217, at 585 (1997) (Conf. Rep.) (stating that MA program was intended to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options"). It was the belief of Congress that the MA program would "continue to grow and eventually eclipse original fee-for-service Medicare as the predominant form of enrollment under the Medicare program." *Id.* at 638. The MA program was thus, like the MSP statute, "designed to curb skyrocketing health costs and preserve the fiscal integrity of the Medicare system." *Fanning v. United States*, 346 F.3d 386, 388 (3d Cir. 2003).

It would be impossible for MAOs to stimulate innovation through competition if they began at a competitive disadvantage, and, as CMS has noted, MAOs compete best when they recover consistently from primary payers. Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19678, 19797 (Apr. 15, 2010). When they "faithfully pursue and recover from liable third parties," MAOs will have lower medical expenses and will therefore be able to provide

additional benefits to their enrollees.[17] *Id.* If Medicare could threaten recalcitrant primary payers with double damages and MAOs could not, MAOs would be at a competitive

[17] CMS explains this mechanism more fully elsewhere:

> We note that MAOs claim expenses related to MSP recoveries as part of their administrative overhead. MA organizations that faithfully pursue and recover from liable third parties will have lower medical expenses. Lower medical expenses make such plans more attractive to enrollees. The lower the medical expenses in an MA plan, the higher the potential rebate. The rebate is calculated as the difference between the cost of Medicare benefits and the benchmark for that plan. The benchmark is a fixed amount. Therefore, as the cost of Medicare benefits go down (with the benchmark remaining constant), the larger the rebate. Therefore, as more MSP dollars are collected or avoided, medical expense go down and rebates go up, allowing the sponsoring MA organization to offer potential enrollees additional non-Medicare benefits funded by rebate dollars. Such non-Medicare benefits include reductions in cost sharing. Since cost sharing is generally expressed as a percentage of medical costs, such cost sharing will also be proportionally lower as overall medical costs go down—providing MA organizations offering such plans with an additional competitive edge.

Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54634, 54711 (proposed Oct. 22, 2009).

disadvantage, unable to exert the same pressure and thus forced to expend more resources collecting from such payers. It is difficult to believe that it would have been the intent of Congress to hamstring MAOs in this manner.

Although the legislative history is nowhere explicit that MAOs may bring suit for double damages under the MSP private cause of action or using any other provision, it does make clear that MAOs were intended to enjoy a status parallel to that of traditional Medicare:

> Under original fee-for-service, the Federal government alone set legislative requirements regarding reimbursement, covered providers, covered benefits and services, and mechanisms for resolving coverage disputes. Therefore, the Conferees intend that this legislation provide a clear statement extending the same treatment to private [MA] plans providing Medicare benefits to Medicare beneficiaries.

H.R. Rep. No. 105-217, at 638.[18]

Our sister circuits have determined that the MSP Act provides traditional Medicare with a cause of action for double damages "[i]n order 'to facilitate recovery of conditional payments.'" *Stalley v. Methodist Healthcare*, 517

[18] Because Congress clearly intended there to be parity between MAOs and traditional Medicare, we find additional support for our decision in § 1395y(b)(2)(B)(iii), the government's cause of action for recovery from primary payers, which also provides for double damages.

F.3d 911, 915 (6th Cir. 2008) (quoting *Glover v. Liggett Group, Inc*., 459 F.3d 1304, 1307 (11th Cir. 2006)). We see nothing in the text or legislative history of the statute to imply that Congress did not intend to facilitate recovery for MAOs in the same fashion.

The District Court determined that providing MAOs with a right of action would not advance the program's cost-savings aim because "payments to the MA from the Medicare trust fund are capitated annually, shifting the economic risk of excessive medical expenses from the government to the MA organization." 2011 WL 2413488, at *4. As we have explained elsewhere, "[t]he Government pays MA plan participants a set amount of money based on the plans' enrollees' risk factors and other characteristics rather than paying them a fee for specific services performed." *U.S. ex rel. Wilkins v. United Health Grp., Inc.*, 659 F.3d 295, 300 n.4 (3d Cir. 2011). This capitation rate is based in part on the "adjusted average per capita cost" to the Medicare Trust Fund of covering a traditional Medicare participant in that year. 42 U.S.C. § 1395w-23(c)(1)(D); § 1395mm(a)(4) (defining "adjusted average per capita cost" as "average per capita amount that the Secretary estimates in advance . . .would be payable in any contract year for services covered under parts A and B of this subchapter. . . if services were to be furnished by other than an eligible organization").

The District Court's logic on this point is flawed for several reasons. If an MA plan provides CMS with a bid to cover Medicare-eligible individuals for an amount less than the benchmark amount calculated by CMS, it must use seventy-five percent of that savings to provide additional benefits to its enrollees. 42 U.S.C. §§ 1395w-24 (b)(1)(C)(i),

(b)(3)(C), (b)(4)(C).[19] The remaining twenty-five percent of the savings is retained by the Medicare Trust Fund. Accordingly, when MAOs spend less on providing coverage for their enrollees, as they will if they recover efficiently from primary payers, the Medicare Trust Fund does achieve cost savings.[20]

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[19] The "Beneficiary Rebate Rule" provides in full:

> The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent (or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012) of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

42 U.S.C. § 1395w-24(b)(1)(C)(i). In 2012, the federal government began to retain a larger portion of the savings and the rebate proportion became tied to assessments of MAO quality. § 1395w-24(b)(1)(C)(i).

[20] Our decision here unquestionably results in cost savings for the Medicare Trust Fund because our holding on the meaning of the private cause of action will apply equally to private entities that provide prescription drug benefits pursuant to Medicare Part D. *See* 42 U.S.C. § 1395w-151(b) (requiring that provisions relating to the MA program and MAOs be read to include part D plans). Because Part D prescription drug plans explicitly share gains and losses with the federal government, 42 U.S.C. § 1395w-115(e), the Medicare Trust

Further, cost savings for the Medicare Trust Fund was not Congress's only goal when it created the MA program. Congress structured the program so that MAOs would compete for enrollees based on how efficiently they could provide care to Medicare-eligible individuals. When, by recovering from primary payers, MAOs save money, that savings results in additional benefits to enrollees not covered by traditional Medicare. Thus, ensuring that MAOs can recover from primary payers efficiently with a private cause of action for double damages does indeed advance the goals of the MA program.

We recognize that only Congress can create private rights of action and that "[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy." *Sandoval*, 532 U.S. at 286 (2001) (citation omitted). The analysis here of text and legislative history lies strictly within the bounds of that task. Our understanding of the policy goals of the MA program merely buttresses what we have already found in the text of the Medicare Act: MAOs are not excluded from bringing suit under the MSP private cause of action.

D. *Chevron* Deference

Although we hold the text of § 1395y(b)(3)(A) to unambiguously provide Humana with a private cause of action, we recognize that a declaration that the language of the Medicare Act is clear may be counterintuitive. After all,

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Fund unquestionably loses money if these private entities recover less from primary payers.

the Medicare Act has been described as among "the most completely impenetrable texts within human experience." *Cooper Univ. Hosp. v. Sebelius*, 636 F.3d 44 (3d Cir. 2010) (quoting *Rehab. Ass'n of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994)). We therefore find that, even if the statute's text were deemed to be ambiguous, we would apply *Chevron* deference and would reach the same conclusion.

The Supreme Court in *Chevron* established a two-part test for determining when a federal court ought to defer to the interpretation of a statute embodied in a regulation formally enacted by the federal agency charged with implementing that statute. 467 U.S. at 842-43. First, the court must determine whether Congress's intent on the issue is clear — if so, it must abide by that intention, regardless of any regulations. If the statute is unclear, that is, "silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. We defer to the agency's regulations "unless they are arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 844.

CMS "has the congressional authority to promulgate rules and regulations interpreting and implementing Medicare-related statutes." *Torretti v. Main Line Hosps., Inc.*, 580 F.3d 168, 174 (3d Cir. 2009); *see also* 42 U.S.C. §1395hh(a)(1) ("The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter."); 42 U.S.C. § 1395w-26(b)(1) ("The Secretary shall establish by regulation [ ] standards . . . for [MA] organizations and plans consistent with, and to carry out, this part."). Thus, we must accord *Chevron* deference to regulations promulgated by CMS.

CMS regulations state that an "MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." 42 C.F.R. § 422.108. The plain language of this regulation suggests that the Medicare Act treats MAOs the same way it treats the Medicare Trust Fund for purposes of recovery from any primary payer. In this circumstance, we are bound to defer to the duly-promulgated regulation of CMS.

Later CMS statements lend further support to this understanding of the rule. In attempting to predict the savings generated for MAOs as a result of their secondary payer status, CMS "assume[d] a similar MSP rate for MA enrollees as obtains in original Medicare." Policy and Techinical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54634, 54711 (proposed Oct. 22, 2009). If MAOs lacked the recovery mechanism available to "original" Medicare, this assumption would be facially invalid.

Additionally, a recent memorandum from CMS specifically responded to decisions of the federal courts holding that MAOs were not "able to take private action to collection for [MSP] services under Federal law because they have been limited to seeking remedy in State court." Ctrs. for Medicare & Medicaid Svcs., Dep't of Health and Human Svcs. Memorandum: Medicare Secondary Payment Subrogation Rights (Dec. 5, 2011). This memorandum clarified that CMS itself understood § 422.108 to assign MAOs "the right (and responsibility) to collect" from primary

payers using the same procedures available to traditional Medicare.[21] *Id.*

Glaxo argues that this regulation does not directly interpret the MSP private cause of action because the Secretary exercises the right to recover pursuant to § 1395y(b)(2)(B)(iii), which allows the United States to "bring an action against any or all entities that are or were required or responsible . . . to make payment . . . under a primary plan." The government may then collect double damages, "in accordance with paragraph (3)(A)," the MSP private cause of action. *Id.* Glaxo's logic suggests that the regulation would allow MAOs to exercise rights to recovery under the government's cause of action, contrary to the plain language of the statute. However, given the cross-reference within § 1395y(b)(2)(B)(iii), the statute itself equates the United States' right to recover with a private party's right to recover. Thus, the regulation refers, ultimately, to the private cause of action in § 1395y(b)(3)(A) and deference to it supports Humana's right to bring suit under that provision.

IV. CONCLUSION

The language of the MSP private cause of action is broad and unrestricted and therefore allows any private plaintiff with standing to bring an action.[22] Since private

[21] The memorandum also noted that these same rights, responsibilities, and procedures apply to Part D prescription drug plan sponsors via 42 C.F.R. § 423.462.

[22] Because we find that Humana had the right to sue in federal court pursuant to § 1395y(b)(3)(A), we need not address its

health plans delivered Medicare services prior to the 1980 passage of the MSP Act, Congress was certainly aware that private health plans might be interested private parties when it drafted the cause of action, and it did not exclude them from that provision's ambit. That decision is logically consistent because affording MAOs access to the private cause of action for double damages comports with the broader policy goals of the MA program. Further, even if we were to find the statutory text to be ambiguous on the issue, *Chevron* deference to CMS regulations, which grant MAOs parity with traditional Medicare, would require us to find in favor of Humana here.

For all these reasons, we will reverse the District Court's dismissal of the complaint, pursuant to Rule 12(b)(6), and remand for further proceedings consistent with this opinion.

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argument that the District Court also had jurisdiction pursuant to the Class Action Fairness Act, 28 U.S.C. § 1332(d).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9893 Revised	**Related Change Request (CR) #: CR 9893**
Related CR Release Date: May 10, 2017	**Effective Date: October 1, 2017**
Related CR Transmittal #: R1845OTN	**Implementation Date: October 2, 2017**

New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

Note: This article was revised on May 10, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background

CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, Liability and No-Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key Points of CR9893

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim's date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code "PR" will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.

- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or

- Liability insurance set-asides diagnosis codes do not apply, or are not related, or

- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in **CR9009**.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an "N" on the '001' Total revenue charge line of the claim.

Additional Information

The official instruction, CR9893, issued to your MAC regarding this change, is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1845OTN.pdf**.

The GAO report related to this issue is available at **http://www.gao.gov/products/GAO-12-333**.

CR9009 is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R113MSP.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.

Document History

Date of Change	Description
May 10, 2017	The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.
February 17, 2017	Initial article released

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Financial Management and Fee for Service Operations, Region VI

May 25, 2011

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This specific handout was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain certain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. It is intended to provide consolidated guidance to those attorneys, insurers, etc., working liability, no-fault and general third party liability cases for any Medicare beneficiary residing in Oklahoma, Texas, New Mexico, Louisiana and Arkansas and is not to be considered a CMS official statement of policy.

If the Medicare beneficiary involved in your case is not a resident of one of these states, please contact the appropriate Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer Regional Office (MSP RO). If you do not have that information please contact Sally Stalcup (contact information below) for that information.

Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law requires that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law.

Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

Section 1862(b)(2)(A)(ii) of the Social Security, Act [42 USC 1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines the term "liability insurance". Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment, award ,y are not funded there is no reasonable expectation that third party funds are available to pay for those services.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8) add reporting rules and do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment. The new provisions do NOT require a set-aside when there is a recovery for future medicals, in fact this legislation does not address that subject. This legislation is unofficially known as "Mandatory Insurer

Reporting" because it does just and only that. It specifies the entity mandated to report a settlement/judgment/award/recovery to Medicare and addresses specifics of that issue.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation. **However,** CMS does expect the funds to be exhausted on otherwise Medicare covered and otherwise reimbursable services related to what was claimed and/or released before Medicare is ever billed. CMS review is decided on a case by case basis.

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review on the merits of the case. A review of the merits of the case is a review of the facts of the case to determine whether there are future medicals - not to determine the proper allocation of funds. If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the Court's designation.

While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc, we are frequently asked how one would 'know'. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any Medicare covered otherwise reimbursable, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is by no means all inclusive.

We use the phrase "case related" because we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare's right of recovery, and the prohibition from billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) of the Social Security Act.

"Otherwise covered" means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust funds. For example, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate. We include the designation of "otherwise reimbursable" because Medicare does not pay for services that are not medically necessary even if the specific service is designated as a covered service and Medicare does not pay primary when Group Health Plan insurance has been determined to be the primary payer.

At this time, the CMS is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. We do however urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.

CMS does not review or sign off on counsel's determination of whether or not there is recovery for future medical services and thus the need to protect the Medicare Trust Funds and only in limited cases do they review or sign off on counsel's determination of the amount to be held to protect the Trust Funds.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation, however Regional Offices do review a number of submitted set-aside proposals. On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the "set-aside" aspect of that request we only need to state that IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Funds must be protected. If there was/is no such funding, there is no expectation of 3rd party funds with which to protect the Trust Funds. Each attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should to see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them to protect the Medicare Trust Funds. It will also be part of their report to Medicare in compliance with Section 111, Mandatory Insurer Reporting requirements.

Medicare educates about laws/statutes/policies so that individuals can make the best decision possible based on their situation. This is not new or isolated to the MSP provisions. Probably the best example I can give is the 2008 final rule adopting payment and policy changes for inpatient hospital services paid under the Inpatient Prospective Payment System. That final rule also adopted a number of important changes and clarifications to the physician self-referral rules sometimes known as the Stark provisions. The physician self-referral law prohibits physicians from referring Medicare and Medicaid patients to certain entities with which the physician or a member of their immediate family has a financial relationship. Exceptions apply. Requests for determinations as to whether or not the physician met the exception criteria, or whether or not their situation was covered by this prohibition poured in. CMS/Medicare did not and continues to make no such determinations. It is the responsibility of the provider to know the specifics of their situation and determine their appropriate course of action.

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Accepting Payment from Patients with a Medicare Set-Aside Arrangement

MLN Matters Number: SE17019 Reissued
Related Change Request (CR) Number: N/A
Article Release Date: November 8, 2017
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Note: This article was reissued on November 8, 2017, to clarify information. The title of the article was also changed to better reflect the information.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

WHAT YOU NEED TO KNOW

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what a MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

BACKGROUND

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

A MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate a MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before Medicare will pay for treatment related to the claimed injury, illness, or disease.

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA **if**:

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare Set-Aside amount.

PROVIDER ACTION NEEDED

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

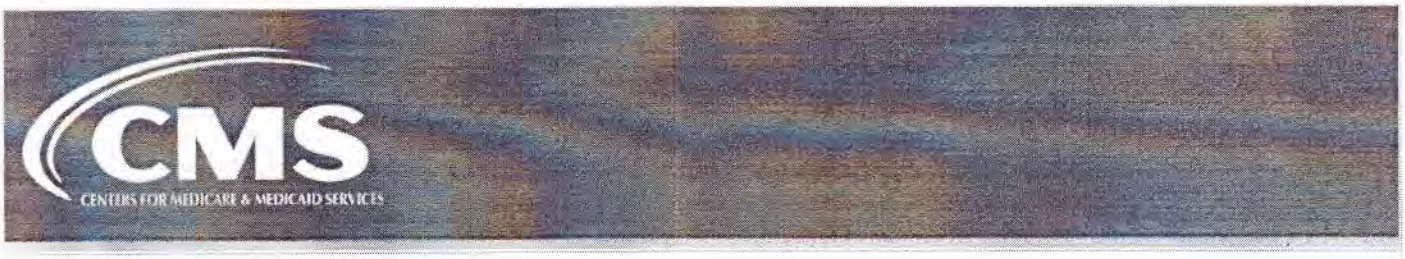
ADDITIONAL INFORMATION

If you have any questions, please contact your Medicare Administrative Contractor (MAC) at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
November 8, 2017	The article was reissued to clarify information in the initial release. The title of the article was also changed to better reflect the information.
October 3, 2017	Rescinded
September 19, 2017	Initial article issued

From: Centers for Medicare & Medicaid Services <cmslists@subscriptions.cms.hhs.gov>
Sent: Thursday, October 26, 2017 2:06 PM
To:
Subject: Consideration for Expansion of Medicare Set-Aside Arrangements (MSA)



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.

Department of Justice

U.S. Attorney's Office

Eastern District of Pennsylvania

FOR IMMEDIATE RELEASE

Monday, June 18, 2018

Philadelphia Personal Injury Law Firm Agrees to Start Compliance Program and Reimburse the United States for Clients' Medicare Debts

PHILADELPHIA – U.S. Attorney William M. McSwain announced today that a Philadelphia personal injury law firm, Rosenbaum & Associates, and its principal, Jeffrey Rosenbaum, Esq., have entered into a settlement agreement with the United States to resolve allegations that they failed to reimburse the United States for certain Medicare payments the government had previously made to medical providers on behalf of firm clients who sought medical care.

The government's investigation arose under the Medicare Secondary Payer provisions of the Social Security Act, which authorizes Medicare, as a secondary payer, to make conditional payments for medical items or services under certain circumstances. When an injured person receives a settlement or judgment, Medicare regulations require entities who receive the settlement or judgment proceeds, such as the injured person's attorney, to repay Medicare within 60 days for its conditional payments. If Medicare does not receive timely repayment, these same regulations permit the government to recover the conditional payments from the injured person's attorney and others who received the settlement or judgment proceeds.

At various points before March 2017, Medicare made conditional payments to healthcare providers to satisfy medical bills of nine of the firm's clients, at least one of whom had declared bankruptcy. Between May 2011 and March 2017, Medicare demanded repayment of the Medicare debts incurred from those conditional payments.

Under the terms of the settlement agreement, Rosenbaum agreed to pay a lump sum of $28,000. Rosenbaum also agreed to (1) designate a person at the firm responsible for paying Medicare secondary payer debts; (2) train the designated employee to ensure that the firm pays these debts on a timely basis; and (3) review any outstanding debts with the designated employee at least every six months to ensure compliance. In addition, Rosenbaum acknowledged that any failure to submit timely repayment of Medicare secondary payer debt may result in liability for the wrongful retention of a government overpayment under the False Claims Act.

This settlement agreement should remind personal injury lawyers and others of their obligation to reimburse Medicare for conditional payments after receiving settlement or judgment proceeds for their clients. "When an attorney fails to reimburse Medicare, the United States can recover from the attorney—even if the attorney already transmitted the proceeds to the client," said U.S. Attorney William M. McSwain. "Congress enacted these rules to ensure timely repayment from responsible parties, and we intend to hold attorneys accountable for failing to make good on their obligations."

The case was handled by Assistant U.S. Attorney Michael S. Macko, with assistance from the United States Department of Health and Human Services, Office of the General Counsel, Region III.

Component(s): USAO - Pennsylvania, Eastern