50.12 – Applying Medicare Secondary Payer (MSP) Requirements

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The MMA (section 1860D-2(a)(4) of the Act) extended MSP requirements that are applicable to MA organizations to include Part D sponsors. Accordingly, Part D sponsors will have the same responsibilities under MSP requirements as MA plans, including the collection of mistaken primary payment from insurers, group health plans, employer sponsors, enrollees, and other entities; and the relationship between MSP rules and State laws. Part D sponsors must properly apply MSP requirements and regulations to their payments (e.g., working aged, worker's compensation (WC)).

Part D sponsors are responsible for adjudicating enrollees' claims in accordance with MSP requirements. Under CMS' adjudication logic for Part D MSP claims, the provider/pharmacy receives at least the Part D sponsor's negotiated price for the drug. Policy regarding Part D payments for MSP claims applies the following order of payment: primary insurer's payment, beneficiary cost sharing under the Part D plan, and finally the Part D plan payment. If the primary payment is greater than or equal to the Part D negotiated price, no other payment is made. If the primary payment is less than the Part D negotiated price, the beneficiary pays the lesser of either: the negotiated price minus the primary payment; or the beneficiary's cost sharing liability under the plan. This policy is supported by Federal regulations at § 411.33(e) and addressed in section 17 of the PDE Guidance available on the CMS Website. See Appendix B for the specific Web address.

A claim for a drug that should be paid as MSP may not be submitted or paid as a primary claim by the Medicare plan. Additionally, the Part D sponsor should not require the pharmacy to submit MSP claims with different 4Rx or unique BIN/PCN information than would otherwise be used for any other claim submitted to the Medicare Part D benefit.

According to statute, Medicare is the secondary payer in the following situations:

1. Employer group health plans (EGHP) MSP

   a. Working Aged G*roup* H*ealth* P*lan (GHP)* – The beneficiary is actively working and is covered under the employer's GHP or the beneficiary's spouse is

actively working and the beneficiary is covered under the spouse's employer GHP (≥20 employees; or another employer in GHP≥ 20 employees.) (42 U.S.C. §1395(y)(b)).

b. Disability with GHP – The beneficiary is actively working for a large employer and is covered under the employer's GHP, or a beneficiary's family member is actively working for a large employer and the beneficiary is covered under the family member's employer GHP (LGHP, ≥100 employees).

c. End Stage Renal Disease (ESRD) GHP – GHP (any size) is primary for the first 30 months when an individual also becomes eligible for Medicare Part A due to ESRD status. After 30 months of Part A eligibility, Medicare becomes primary.

2. Non-GHP MSP

a. W*orkers'* C*ompensation* (WC) – Beneficiary covered under WC due to job-related illness or injury.

b. Black Lung (BL) – The beneficiary has black lung disease and is covered under the Federal Black Lung Program.

c. No-Fault/Liability – The beneficiary is covered by no-fault or liability insurance due to an accident.

However, Part D sponsors should not immediately pay only as a secondary payer. The action required of the Part D sponsor is dependent on the type of other primary payer as follows:

1. For the types of Employer Group Health Plans (EGHP) listed above, the Part D sponsor will always deny primary claims that fall within the EGHP's applicable coverage dates and default to MSP. The types, as listed above, include: working aged GHP, disability GHP, and ESRD GHP for first 30 months of Medicare Part A eligibility.

2. For WC, BL, and No-Fault or Liability coverage, the sponsor will always make conditional primary payment unless the sponsor is aware that the enrollee has WC/BL/No-Fault/Liability coverage and has previously established that a certain drug is being used exclusively to treat a related injury. For example, when a beneficiary refills a prescription previously paid for by WC, the Part D sponsor may deny primary payment and default to MSP.

In all other instances, the Part D sponsor is required to make conditional primary payment then recover any mistaken payments where it should have only paid secondary to WC/BL/No-Fault/Liability coverage. For example, if a sponsor does not know whether a given drug for which it is billed is related to the covered injury, the sponsor must pay for the drug (if it is a covered Part D drug) and later recoup any amounts that the other insurance should have covered.

Part D sponsors are responsible for identifying and recovering any Coordination of Benefits (e.g. where a Part D sponsor paid for a claim and another payer should have paid), MSP-related mistaken payments and submitting associated adjustments to CMS. Recovery of payments when the sponsor determines no payment at all should have been made or the amount paid was more than it should have been should be sought from the responsible other party. Sponsors should implement processes to handle payment resolution in these situations directly with the primary payer or in limited cases with the beneficiary Any required adjustments to PDE records should be handled in accordance with the July 3, 2013 guidance from CMS entitled, "PDE Guidance for Post Point-of-Sale Claims Adjustments." This guidance is available on the CMS Website. See Appendix B for the specific Web address.

If the sponsor has established it should pay only secondary for a Part D enrollee and receives a primary claim, the sponsor should not pay the primary claim. Rather, receipt of the primary claim should prompt the sponsor to question whether MSP requirements continue to apply. If MSP is no longer applicable, this information should be reported to the *BCRC* via ECRS to update CMS. *Additionally, since many primary payers pay claims based on a specific drug/condition, the Part D plan should not require a different 4Rx for MSP claims than primary claims.*

Similarly, absent information on the COB file that Part D is secondary for a Part D enrollee, should the sponsor receive a secondary claim, the claim cannot be paid. Instead, the sponsor should determine if the enrollee has coverage that is primary to Medicare and, if so, report this information to the *BCRC* via ECRS to update CMS. *If the sponsor has determined that it is has paid out of order, the sponsor should coordinate the benefits directly with the other payers without requiring the pharmacy to resubmit the claim or take back funds from the pharmacy.*

The following sections provide clarification regarding a limited number of MSP situations; however, Part D sponsors are required to apply all MSP requirements, whether or not they are specifically mentioned here.

50.12.1 – Workers' Compensation

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Medicare may not pay for any item or service when payment has been made, or can reasonably be expected to be made, for such item or service under a WC law or plan of the United States or any State. CMS recognizes that diagnostic information is not collected at the point of sale, however, Part D sponsors are expected to make good faith efforts to identify claims associated with WC.

It is imperative that Medicare's interests be protected when parties enter into WC settlements. One method of protecting Medicare's interest in a WC situation is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medicals and future prescription drug expenses. "Future medicals and future prescription drugs" are those services and items provided after the final WC settlement. CMS recommends Medicare beneficiaries (and individuals who expect to

become entitled to Medicare within 30 months of receiving a WC settlement) who are parties to WC settlements, judgments or awards submit WCMSA proposals to CMS for review prior to settlement to ensure Medicare's interests are considered. CMS reviews WCMSA proposals for Medicare beneficiaries with WC settlements greater than $25,000 and for individuals who are within 30 months of Medicare entitlement and possess a WC settlement greater than $250,000. Based on this review, CMS will either concur with the proposal or determine a different amount deemed adequate in order to protect Medicare's interest. Additional information regarding CMS' WCMSA policies, procedures and guidelines is available on the CMS Website; refer to Appendix B for the specific Web address.

WCMSA funds are administered by the claimant or a professional administrator employed by the workers' compensation employer, carrier or the claimant. CMS keeps a record of the WCMSA amount determined by CMS to be adequate to protect Medicare's interests with regard to the claimant's future medical treatment and/or prescription drug expenses. The claimant/professional administrator is responsible for submitting an annual attestation form or professional accounting to the Medicare contractor. This document attests that the claimant has appropriately expended the WCMSA funds for that year.

In order to assist the Part D sponsors in making proper payments to WCMSAs, at the end of 2009, CMS began including costs related to prescription drugs in its settlements and reporting WCMSAs under a distinct non-GHP MSP cost on the COB file. The WCMSA amount reported on the COB file is the combined amount for future medicals and future prescription drug costs related to the WC injury. In addition, the file will include the administrator's name, address and telephone number, the WCMSA settlement date, the total prescription drug settlement amount, and an indicator specifying whether prescription drug costs are included in the WCMSA amount.

Beginning in 2010, if the COB file record received from CMS indicated prescription drugs are included in the WCMSA, Part D sponsors continued to make conditional primary payment under Part D and promptly contact the administrator to determine which claims should not be paid for under Part D. Once the Part D sponsor established that a certain drug was included in the set-aside, the sponsor set appropriate point-of-sale edits, denied payment and rejected the claim for billing to the primary payer.

Exhaustion of the combined WCMSA amount includes both services (i.e., future prescription drug treatment and future medicals). For example, if the total WCMSA amount provided to the Part D sponsors is $10,000, this amount can include $7,000 for future prescription drug treatment and $3,000 for future medical expenses. However, Part D sponsors must understand that although the total WCMSA amount is $10,000, the final actual expenditures could be $6,000 for future prescription drug treatment and $4,000 for the future medical expenses, which will still appropriately exhaust the WCMSA.

The Part D sponsors do not have the ability, via ECRS, to report the exhaustion of a WCMSA fund. The beneficiary is provided paperwork, in the WCMSA approval package, to complete and mail to the MSPRC when WCMSA funds have been exhausted. Once the documents are received, the MSPRC will then take the steps necessary to notify the *BCRC*

of this development. The CMS Regional Offices also have the ability, via ECRS, to report the exhaustion of WCMSA funds. Once the entire CMS-approved WCMSA has been properly exhausted, the Medicare Part D plan sponsor resumes responsibility for paying claims for covered Part D drugs.

50.12.2 – Flexible Savings Accounts (FSAs), Health Savings Accounts (HSAs), Archer Medical Savings Accounts (MSAs), and Health Reimbursement Accounts (HRAs)

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HSAs, FSAs, and MSAs

Part D sponsors should not require enrollees to use the funds in their FSAs, HSAs, or MSAs before making payments when the group health plans attached to those accounts are primary under the MSP laws. However, note that an enrollee would only have an FSA or HSA when these accounts are carried over from an employee health plan. An enrollee may have an MSA at any time; it is similar to the plan attached to an HSA, but is offered exclusively to Medicare beneficiaries.

HRAs

However, under the MSP group health plan laws (e.g., when an enrollee with current employment status has an HRA through his employer), sponsors should make secondary payments after HRA funds are used.

When an enrollee is non-working, an HRA is secondary to Medicare, but drug costs paid or reimbursed from the HRA are not TrOOP-eligible.