Survey: Medicare Secondary Payer (MSP) Compliance Lacks Transparency and Control

Introduction

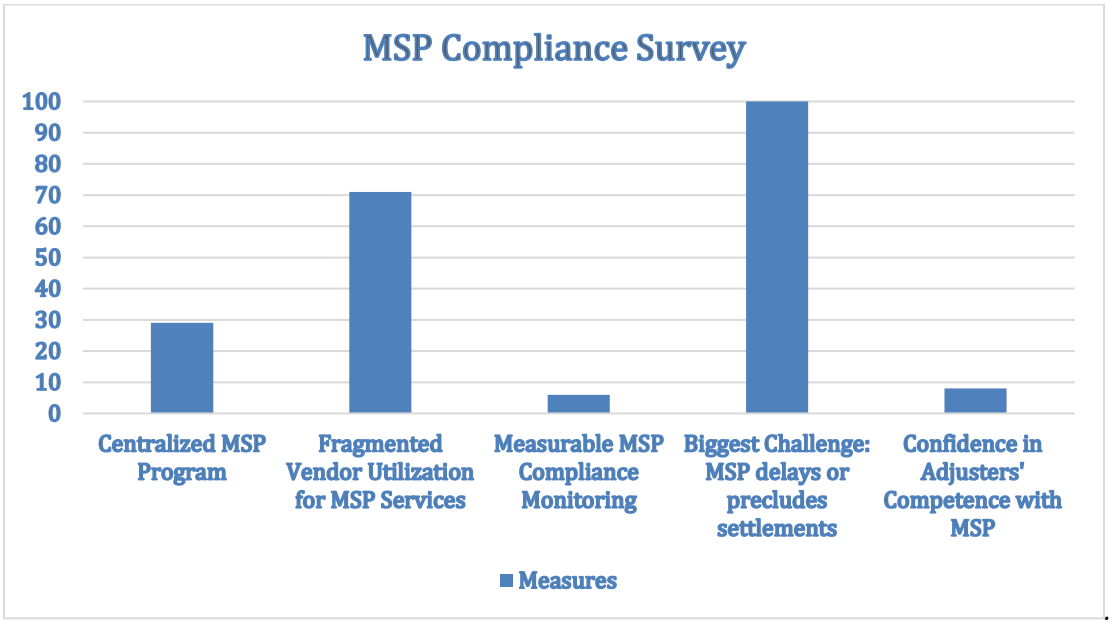
This paper discusses the current state of Medicare secondary payer (MSP) compliance within the property and casualty (P&C) industry. Our payer survey findings show payers view MSP compliance as unmanaged and out of control. MSP compliance is excessively costly. The time has come for a data-driven or analytic-powered approach to compliance which leaders of the future will embrace. An analytic-powered approach uses high-quality data and strong algorithms to augment human decision-making in the process.

Medicare Secondary Payer

Medicare was implemented in 1965 as the primary payer for medical claims involving Medicare beneficiaries not covered by workers' compensation (WC), federal black lung, or veteran's administration benefits. In 1980, In an attempt to collect as much money for the Medicare trust fund through rulemaking, Congress enacted the Medicare secondary payer act expanding Medicare's recovery to; group health and non-group health plans or self-insurance for liability, automobile and no-fault. Including all plans under those P&C lines that paid for any medical or personal injury, sweeping in travel insurance, medical payments coverages under commercial and personal property plans as well as plans that typically do not pay for a bodily injury such as treatment for medical professional liability, director and officer and errors and omission policies. Medicare has a right to both reimbursement for Medicare dollars paid, and recovery of payments Medicare might make in the future, where another primary plan exists.

Primary Payer Survey

We randomly and confidentially surveyed 36 non-group health primary payers, including carriers, third-party administrators, state funds and self-insured entities, to learn about their MSP compliance programs. The table presents the results.



Companies surveyed agree 100% that MSP compliance delays or interferes with claims settlements. However, few have a formal monitoring process (4%), a fragmented vendor panel is used (71%), and few (30%) have a centralized program, such as an internal department or individual responsible for the oversight of MSP compliance. Most compelling is that 92% of companies surveyed do not have any confidence that their adjusters or claim handlers are capable enough to identify the risk or execute on MSP compliance at the time of settlement. These results clearly reveal a clear absence of risk management or quality measures for identifying, controlling or monitoring MSP compliance. Further, most payers do not establish internal best practices, relying heavily instead on external MSA vendor suggested best practices.

Discussion

Why do primary payers remain uncomfortable with MSP after 15 years of experience? To answer this question, let's look at some background.

On July 23, 2001, Medicare released a memo to all regional administrators to answer questions raised as to how to evaluate Medicare's future interests for WC settlements. The memo did not detail any specific methodology for forecasting future medical care.

Following the release of this memo, the first Medicare Set Aside (MSA) companies emerged to produce formalized MSA reports. These early companies cobbled together a mix of approaches used in the practice of Life Care Planning as used for the valuation of future medical costs for litigated claims. This untested, short-cut approach was sold as a solution to non-group health plans and third party administrators to satisfy Medicare's requirements for MSAs. Thus, a small cottage industry established claims best practices for MSAs. Vendors have defined the requirement to not only prepare, but to submit MSAs to Medicare for review and approval, a voluntary process under the Act, that has become a WC claims best practice.

While conventional MSA methodology may have offered a solution fifteen years ago, it is time to re-assess the industry's approach. MSP compliance, as it has evolved, has outgrown existing models. Primary payers deserve to have much greater confidence and control. Primary payers can and should develop internal best practices for Medicare Secondary Payer. We believe a data-driven approach will increase payer confidence, create transparency in the MSP process and lower costs.

Data is Power! An Analytic-Powered Approach to MSP

Analytic-powered or data-driven decision management (DDDM) is an approach to governance, using data that has been appropriately gathered and verified to make business decisions. The technique has been around since the early days of the computer in the 1950's when data was first mined and extracted for analysis. Today, business intelligence has advanced to offer technology based dashboards that display data, in an organized form, for analysis and decision making. These tools no longer require an expensive IT staff to gather and analyze information. The quality of the data and effectiveness of the analysis are the foundations for a successful data driven solution. Using data intelligence, primary payers can identify, manage and control MSP exposure and make decisions about managing MSP compliance risks.

The table below compares the analytic-powered approach to the conventional approach.

Analytic-Powered Approach to MSAs	Conventional Approach to MSAs
Robust claims data warehouse	No data warehouse
Standardized process	Subjective, no standardization
Reproducible	Not reproducible, each claim is different
Reliable, Consistent	Inconsistent, variable
Valid	Invalid, guess work
Reduces, eliminates errors	Generates human errors
Data is Verified	No evidence methodology is accurate
Analytic tools to enhance decision-making	No analytic tools for decision-making

The difference between an analytic-powered and a conventional approach to Medicare Set Asides is dramatic. An analytic-powered approach relies upon a robust claims data warehouse of real medical transactions for bodily injuries over time. A standardized digital platform with algorithms and tables is applied. Given the same exact set of medical claim variables, an outcome will be the same every time. It offers tighter security standards, HIPAA (PHI/PII) protection with fewer hands touching the files. It remains in the hands of a payer's internal professionals and can stay within the confines of its IT structure.

Case Study Comparison

We analyzed the experience of a primary payer who sent the same set of medical records, for a given claim involving a Medicare beneficiary, to 5 different MSA preparers. The primary payer received five different MSA forecasts as follows:

MSA Sample	*Preparer Source*	*Total MSA Amount*	*Key Differences*
MSA #1	Certified Life Care Planner (CLCP)	$83,742.36	Future care includes possible complications
MSA #2	RN, Medicare Set Aside Consultant Certified (MSCC)	$68,563.50	Uses incorrect, outdated fee schedule pricing
MSA #3	Attorney Firm	$76,582.36	Medications inappropriately allocated
MSA #4	Claims Adjuster	$39,879.42	Does not include a medically necessary surgery, recommended by authorized treating physician
MSA #5	Analytic-Powered	$54,672.00	Uses accurate, standardized platform and verified data points based on 423 claims having the same medical condition and variables

Conventional methods are subjective, non-standardization, and therefore variable in nature and lack transparency. The same medical variables or medical claims record information can be reviewed by five different people and interpreted differently by each person; the same variables

are not reproducible or consistent. Today's conventional methods increase the complexity of future care analysis and vendor dependency.

An analytic-powered approach offers exceptional return on investment of time and redeployment of labor. When one compares an analytic-powered MSA report to conventional methods for an identical case, the analytic- powered method used one thirty-sixth (1/36) the amount of human time and completed the report within 15 minutes. These reports are not submitted to CMS for review and approval because of the strength of the data and CMS guidelines that supports the proposal are irrefutable.

A data-driven approach will not only drastically improve the quality, reliability and validity of an MSP program. It will provide the platform for a company's internal program, offering transparency and control that will cut the overall total cost of MSP compliance by 50% or more.

"Non-Group Health Plans and self- insureds are frustrated by the world of Medicare Set-Asides. This frustration has led to attempts to change the policy guidance in Congress, numerous meetings with CMS, and searches for new solutions. Some of the "Best in Class" have determined that the only way to secure superior outcomes is to control the process, bringing it inside their organizations and using data to secure superior results, thereby affording themselves an advantage in the marketplace." Peter R. Foley C.P.C.U., C.I.C, Principal at C.L.A.I.M.S, LLC and former Vice President, Claims Administration, American Insurance Association.

Conclusion

Our survey of 36 companies exposes the failure of the current state of MSP compliance and highlights the need for disruptive and revolutionary change. As future guidance for MSP compliance is released, there is a real risk of greater complexity in the execution of a solution for primary payers and third party administrators who rely on conventional practices. The time has come for primary payers to own and develop their internal best practices for MSP compliance establishing alignment between the obligation to protect Medicare and close claims. The future is here for a data-driven solution that is streamlined, efficient and compliant with the intent of the MSP Act.

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