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Betting on the Future: Reimagining the MSA Program

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Topics of Discussion

- **Current Challenges**
- **How the Industry is Addressing: *Focus on Non-Submit Trend***
- **Legislative, Regulatory & Policy Changes**
- **Examining the Role of Stakeholders in the Process**
- **What does a Better MSA program look like?**

Current Challenges

Current Challenges

- **CMS / WCRC Allocation Methodology**
  - What could possibly occur vs. what is likely to occur
  - Formulaic / cookie-cutter approach where certain items and services are always included and at a standard frequency / dosage/ duration regardless of clinical status or individualized pattern of treatment
  - **Specifics:**
    - **Opioids**: WCRC will oftentimes require a regimen for life expectancy at current dosage
      - Evidence has historically suggested an overfunding for opioids in WCMSAs
      - Injured-party given potentially tens of thousands of dollars for a self-pay scenario without safeguards of Part D guidelines
    - **High prescription drug costs**
      - In general, there is typically a default status to frequency and dosage for the entire life of the claimant, which can oftentimes equate to a very high allocation amount
      - Inclusion of off-label medications, i.e. Lyrica (Sec. 9.4.6.2 of Ref. Guide)

Current Challenges

- **CMS / WCRC Allocation Methodology Cont.**
  - **<u>Prescription Drug Costing Reality vs. Methodology</u>:**
    - Current guidelines create situations where there can be discrepancies in allocation amounts vs. actual costs
    - Current guidelines allow for drug to be priced at lowest generic AWP cost (WCMSA Ref. Guide, Sec. 9.4.6.1, v2.9). In certain situations, this makes it impossible for someone to obtain a particular drug at the MSA-indicated lowest AWP price in the marketplace. Example of this is Gabapentin where the lowest price per pill is $0.03. However, it is nearly impossible to find this drug at this cost in the marketplace. Another example, Celecoxib (generic Celebrex), has a lowest price of $0.62, but there was recently a significant price increase
    - In some instances, AWP can be higher, especially as it relates to brand-named drugs. Examples: Lyrica (prior to going generic) and certain classes of opioids / narcotics (ex. Oxycontin) of where allocation costs may be higher than what can be obtained, on average, in the marketplace

Current Challenges

- **CMS / WCRC Allocation Methodology Cont.**
  - **Revision Surgeries**
    - Formulaic: doesn't take into consideration what their age will be or current clinical status is when they're having the revision surgery. Claimant could be at the end-stage of their life with a potentially invasive surgery.
  - **Urine Drug Screens**
    - Defaulting to 2 per year, even if there is no history of utilization
  - **Diagnostics**
    - X-Rays / MRIs typically a standardized frequency
  - **Physical Therapy**
    - Typical default to 24 sessions or doubled if a surgery is involved
  - **Possibility of Future Procedures**
    - If there is a question, oftentimes the tie will go to CMS – even if claimant indicates they will not have the procedure – this will oftentimes drive parties to go to towards non-submit

Current Challenges
(Example Case)

- Case Study #1 - Sprain/Strain/Contusion
- 2 injuries:
  (1) Specific trauma
  (2) Repetitive trauma bilateral shoulder, back and neck sprain/strains
  - Accepted elbow fracture specific trauma AND, but all neck and back diagnoses contusions & sprain/strains
- No spine or shoulder imaging ever done – just chiropractic followed by physical therapy
- 3 months of treatment, then 4 year gap
- Treatment after gap for shoulder, back and neck sprains (more PT) disputed by carrier

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Service	Freq	Every X Yrs	# of Years	Price Per Service	Total
ORTHOPEDIC PHYSICIAN	1.00	1.00	14.0	$105.41	$1,475.74
X-RAY RIGHT ELBOW	4.00	14.00	14.0	$39.67	$158.68
X-RAY LUMBAR SPINE	4.00	14.00	14.0	$53.82	$215.28
X-RAY THORACIC SPINE	4.00	14.00	14.0	$53.28	$213.12
X-RAY CERVICAL SPINE	4.00	14.00	14.0	$53.82	$215.28
X-RAY RIGHT SHOULDER	4.00	14.00	14.0	$44.35	$177.40
X-RAY LEFT SHOULDER	4.00	14.00	14.0	$44.35	$177.40
MRI RIGHT ELBOW	1.00	14.00	14.0	$344.24	$344.24
MRI LUMBAR	1.00	14.00	14.0	$325.11	$325.11
MRI THORACIC	1.00	14.00	14.0	$325.11	$325.11
MRI CERVICAL	1.00	14.00	14.0	$324.57	$324.57
MRI RIGHT SHOULDER	1.00	14.00	14.0	$552.87	$552.87
MRI LEFT SHOULDER	1.00	14.00	14.0	$552.87	$552.87
PHYSICAL THERAPY	60.00	14.00	14.0	$109.83	$6,589.80
Total:					$11,647.47

Current Challenges

- Case Study #2 – Revision surgery
- 9/27/16 total knee replacement
- PSD 2/1/19
- 13 year life expectancy

Service	Freq	Every X Yrs	# of Years	Price Per Service	Total
PHYSICIAN, ORTHOPEDI	2.00	1.00	13.0	$81.20	$2,111.20
PHYSICAL THERAPY	60.00	13.00	13.0	$142.50	$8,550.00
X-RAY, KNEE	1.00	1.00	13.0	$101.80	$1,323.40
MRI, KNEE	3.00	13.00	13.0	$1,303.28	$3,909.84
REVISION TOTAL KNEE	1.00	13.00	13.0	$39,293.28	$39,293.28
Total:					$55,187.72

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Current Challenges
(Example Case)

- **Case Study #3**
- Industrial lumbar injury – 68 year old male
- Relatively conservative treatment, including doctor's visits, diagnostics and injections. No surgical intervention recommended.
- Prescription drug regimen includes medicines for pain, spasms and GI distress. One of the pain medicines is Celecoxib (generic Celebrex). Redbook AWP has this at $0.62 per pill and this is what it was allocated for in the MSA.
- Injured party is not able to obtain Celecoxib at this price in the marketplace – in reality the drug is around $7.50 per pill

Current Challenges

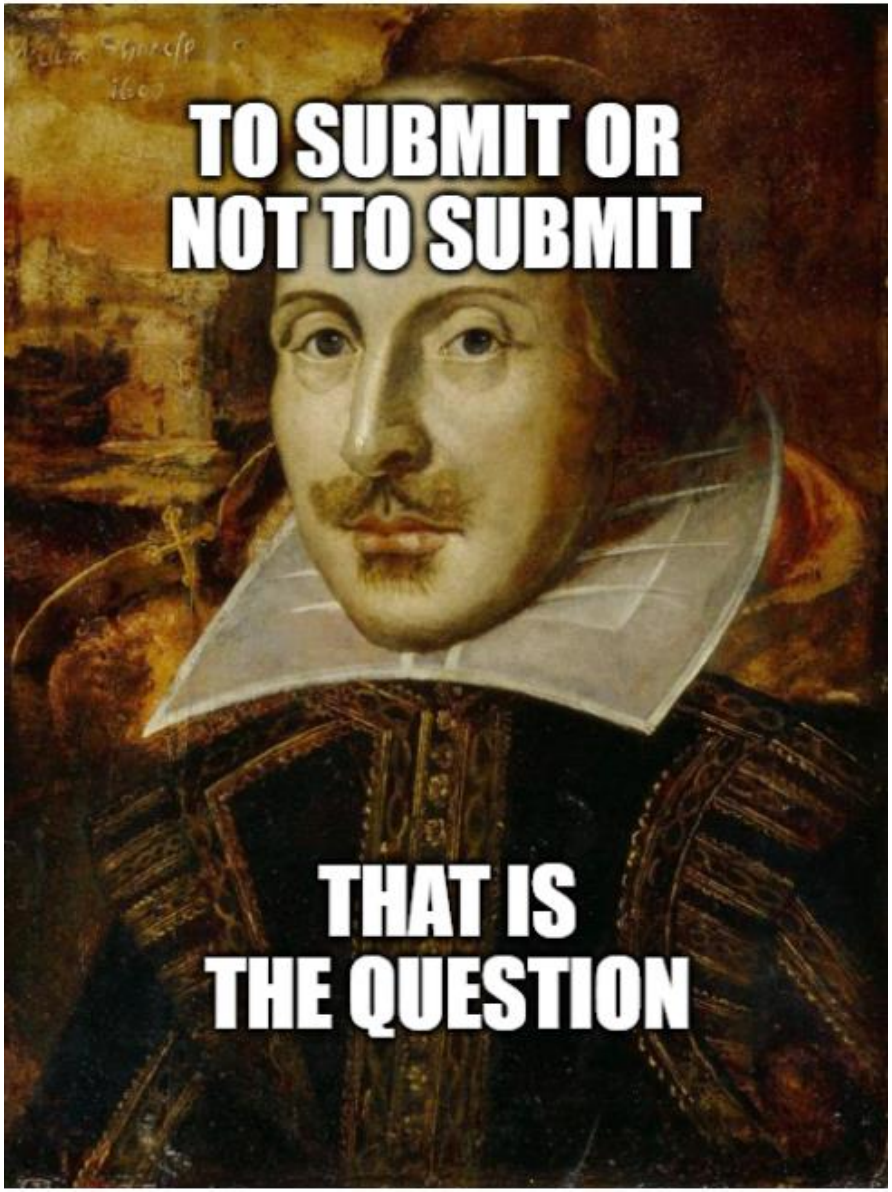
- **Medicare Denying Reimbursement**
  - Since July 1, 2009, Medicare has had the ability to flag the Common Working File (CWF) with MSP codes to deny "payment for items or services that should be paid out of an individual's WCMSA funds." See MLN Matters® Number: MM5371 Revised.
  - "[T]he contractor must ensure that Medicare makes no payments related to the WC injury until the WCMSA has been used up. This is accomplished by placing an electronic marker in CMS' systems used to pay or deny claims. That marker is removed once the beneficiary can demonstrate the appropriate exhaustion of an amount equal to the WCMSA plus any accrued interest from the account." WCMSA Ref. Guide, (v2.9). Sec. 18.
  - Recent instances of Medicare denying payment when they believe the WCMSA was *not* exhausted (even though actually it was) by way Medicare Summary Notice (MSN) referencing denial of payment 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)."

Current Challenges

- **Denied Claims**
  - In certain instances, there are more stringent requirements around development (i.e. requesting medical records) and approval in wholly denied / controverted claims
- **No Formal Appeals Process**
  - Even though submission is a voluntary procedure, there should be additional avenues (beyond Re-Review) for an aggrieved party to contest CMS's initial determination beyond mathematical errors and missing documentation
  - Commend CMS for adding the Amended Review process, though it still precludes many older cases

Current Challenges

- **The Submission Conundrum**
  - Encapsulated in selected verbiage from the Reference Guide
  - "...voluntary, yet recommended, WCMSA amount review process is the only process that offers both Medicare beneficiaries and Workers' Compensation entities finality, with respect to obligations for medical care required after a settlement, judgment, award, or other payment occurs. When CMS reviews and approves a proposed WCMSA amount, CMS stands behind that amount. Without CMS' approval, Medicare may deny related medical claims, or pursue recovery for related medical claims that Medicare paid up to the full amount of the settlement…" (Sec. 4.2).
  - "If the parties to a WC settlement stipulate a WCMSA amount but do not receive CMS approval, then CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses related to the WC work-related injury, even if they would ordinarily have been covered by Medicare." (Sec. 8).
  - "Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA. " (Sec. 10.5).



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How the Industry is Addressing: Focus on Non-Submit Trend

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The Trend of Submission Alternatives

- **The procedure where a WCMSA will <u>not</u> be submitted to CMS notwithstanding the fact that it otherwise meets current voluntary review thresholds.**

- **Attributes of a non-submit:**
  - **Non-submission**
  - **Alternative costing methodology**
  - **Insurance / indemnification**
  - **Professional Administration**

- **Drivers behind the trend:**
  - ***Much of what was discussed on previous slides:***
    - **CMS allocation methodology**
    - **Higher overall allocation costs**
  - **New product in industry**
  - **Employer / insurer & vendor recommendation**
  - **Faster resolution**

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CMS's Position on Non-Submits

- **WCMSA Reference Guide (Sec. 8):** "If the parties to a WC settlement stipulate a WCMSA amount but do not receive CMS approval, then CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses related to the WC work-related injury…"

- **When alerted to a non-submit:**
  - **CMS has responded in writing that:**
    - **It maintains a right of recover up to the total value of the settlement and that it can initiate recovery on any future related Medicare claims.**

CMS's Position on Non-Submits

Selected portions of MSP Regulations
§ 411.46 Lump-sum payments.
(a)*Lump-sum commutation of future benefits.* If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.
(b)*Lump-sum compromise settlement.*
(2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.
(d)*Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement* -
(1)*Basic rule.* Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.
(2)*Exception.* If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

CMS's Position on Non-Submits

§ 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.

(a)*Determining amount of compromise settlement considered as a payment for medical expenses.*

(1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

(2) If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:

(i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.

(ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.

Alternative Costing Methodologies

- **Evidence Based Medicine**
  - **Sometimes utilized in conjunction with other terms and/or designations:**
    - **Standards of Care; Patient-Focused; Data and Research-Driven Treatment**
    - **Referenced in conjunction with specific published guidelines: ODG, ACOEM**
- **How does this differ from CMS's / WCRC's methodology as it relates to submitted-MSA allocations?**
- **What are some of the positive hallmarks typically seen:**
  - Probable and Likely vs. Possible and Speculative
  - Weaning of prescription drugs
  - Reliance on treatment guidelines
  - If there is a vague recommendation for procedure, typically excluded even though in submission paradigm it may have been included
- **Potential misuse:**
  - Could be used under the guise as a wholesale and arbitrary elimination of items / services for the sole purpose to lower allocation amount not based upon medical evidence

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Legislative / Regulatory Proposals

HR 4161

- **This is similar legislation that has been proposed before**
- **Highlights:**
  - Codify definitions and terms – including MSA
  - Allows for proportional adjustment in denied / disputes cases
  - Places timeframes around a voluntary MSA approval process
  - Sets up a formalized appeals process for an aggrieved party
  - Direct deposit option for MSA funds
  - Increased deference to state workers' compensation law

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October Proposed Rule

- **“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.”**

- **What’s this mean? LMSA-specific?**

- **Will we see it in October?**

Legislative
Regulatory & Policy Reform

- What additional legislative, regulatory or policy reforms are needed?
- What is the best mechanism to achieve the required changes – each avenue (legislative, regulatory or policy) has its own implications and is provided different weight and channels for scrutiny or challenge.
- Is it best that the MSA program is sub-regulatory? Should it be legislated?

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Examining an Expanded Role for Stakeholders in the Process

Claimant | Claimant's Attorney | Defense Attorney | Court | Carrier / Self-Insured | MSA Vendor | CMS

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Claimant / Injured Party

- Historically, this stakeholder has been largely uninvolved in the MSA process.
- The injured party is the one that has to live with this MSA for the rest of their life, and it affects them arguably to the greatest extent of any party, yet they have the smallest role in the process.
- What should their role be, if any?
- Should an injured party have any say in the sufficiency or adequacy of an allocation amount or what items/services are contained in it?
- Should an injured party have a say in whether an MSA is submitted to CMS or not?
- If YOU (yes, you in the audience here), knowing what you know about MSAs, were injured and had an MSA, would you want to review it prior to a settlement?

Claimant's Attorney

- Should all claimant's attorney thoroughly review the MSA and provide feedback related to its adequacy?
- Is there a duty to review the MSA with their client?
- What should the role be of the claimant's attorney vis-à-vis the MSA and MSA process?
- How can they put their client in the best position post-settlement?
- Is there an opportunity for increased education to the injured party?

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Defense Attorney

- **Should the defense attorney review the MSA and weigh options around submission?**
- **What is the ideal role that the defense attorney should play?**
- **What expanded role should they play as intermediaries / liaisons with the vendor / submitter and court?**

Court

- **Should the courts review an MSA to determine if it is fair, reasonable and in the best interest of the parties?**
- **Should a judge ensure that the claimant understands how the MSA will affect them, their benefits and treatment?**
- **What other expanded role could / should the courts play?**

Carrier/Self-Insured

- If they don't already, should claims payers / employers take a more proactive role in in the MSA process?

- Should they provide direction in regards to specific costs, amount of overall allocation or items and services to be included?

- Should this stakeholder be the entity that is driving the submit / non-submit discussion?

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MSA Vendor

- What is the central role a vendor / allocator / submitter plays in the process, recognizing that there's both medical and legal aspects involved?

- What direction should/shouldn't the vendor take from other stakeholders with respect to the allocation (either amount or items / services included or excluded)?

- What obligations does the vendor have towards the claimant / injured party?

CMS

- Commend CMS on being increasingly engaged with stakeholder community
- What is CMS's role with regard to the MSA program and combating the opioid epidemic?
- In general, is CMS transparent enough?
- Should CMS adopt a codified and published comprehensive allocation methodology?
- What other outreach to the stakeholder community should be done?

What does a Better MSA Program Look Like?

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Elements of a Better MSA Program (General)

- Takes all interested stakeholders' interests into consideration (and protects them), especially the injured party's - not *only* Medicare's
- Allocations aren't excessive
- Predictability (methodology and process)
- Certainty / finality
- Balanced fairness for all stakeholders
- Less adversarial
- Elimination of distrust
- Civility, collegiality and kindness between stakeholders

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Elements of a Better MSA Program
(Specific)

- Appeals process for aggrieved parties
- Examples from CMS of when an MSA is not required or necessary
- A costing and allocation methodology that is based upon what is likely to occur and non-speculative, which removes arbitrary formulaic approaches and which is informed by established guidelines and actual clinical status
- Streamlined approval process for wholly denied claims
- Adoption of Part D / CDC guidelines for opioids and narcotics

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Elements of a Better MSA Program
(Specific)

- **Acknowledgement of underlying state law and its limits, defenses, etc.**
- **Alternative to AWP which is more in line with reality**

- **What do you think?**

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Thank You!

Amy, Kim & Shawn