The MSP and the False Claims Act

By John Cattie and Bruce A. Cranner

The Government's Most Potent Recovery Tool

Parties that settle a tort claim or pay a judgment face two independent areas of potential liability to the Centers for Medicare & Medicaid Services ("CMS"). The first is liability under the Medicare Secondary Payer Statute ("MSP") 42 U.S.C. §1395y(b)(2). A second potential area of liability includes monetary exposure through the federal False Claims Act, 31 U.S.C. §§3729, *et seq*. These potential areas of liability for failure to satisfy Medicare and reimburse conditional payments made by Medicare, if satisfaction is not made, can increase the settlement cost of a settling insurer, payer, or self-insured claim by hundreds of thousands of dollars. Both potential areas of exposure will be examined in this article because both must now be carefully considered by parties. Payer settlement protocols in particular must account for the very real possibility that a False Claims Act claim may be made if Medicare's interest is not fully protected.

The Medicare Secondary Payer statute prohibits Medicare from making payments if payment has already been made or can reasonably be expected to be made by a primary payer. 42 U.S.C. §1395y(b)(2). Although Medicare makes payments when a primary plan cannot reasonably make payments promptly, any such payments are conditioned upon reimbursement when that primary plan accepts responsibility for medicals and that responsibility is evidenced in a settlement, judgment, or award. 42 U.S.C. §1395y(b)(2)(B)(ii). The reimbursement of the conditional payment is the law; the continued violation of the law requiring reimbursement can be addressed by the federal government through federal litigation for double damages against the beneficiary or plaintiff, plaintiff's counsel, and/or the liability insurer. 42 U.S.C. §1395y(b)(2)(B)(iii).

MSP Recovery Under the MSP

Under the MSP, if reimbursement is not forthcoming, the government has several methods of recovery. First, Medicare may recover its conditional payments "by direct collection or by offset against any monies it owes the entity responsible." 42 C.F.R. §411.24(d). Second, the government may bring an action for double damages against any responsible entity for repayment. 42 U.S.C. §1395y(b)(2)(B)(iii); 42 C.F.R. §411.24(c)(2). Third, the government has a separate subrogation right to recovery. 42 U.S.C. §1395y(b)(2)(B)(iv); *see also* 42 C.F.R. §422.26(a). Medicare regulations also empower CMS to "join or intervene in any action related to the events that gave rise to the need for services for which Medicare is paid." 42 C.F.R. §422.26(b). However, because most of the underlying tort litigation takes place in state courts, and those courts lack subject matter and personal jurisdiction over the Medicare program, CMS does not normally intervene in state court tort actions. *See Hoste v. Chante Creek Management, Inc.*, 246 F. Supp. 2d 784, 788-89 (W.D. Mich. 2002); *Mitchell v. Healthcare Service Corp., et al.*, 633 F. Supp. 948, 949 (N.D. Ill. 1986). Finally, the MSP double payment provisions state that if a primary payer does not pay or reimburse Medicare, the primary payer remains responsible for reimbursement. 42 C.F.R. §411.24(i). The federal government possesses the statutory ability to sue the liability insurer or the self-insured for double damages, rather than for only the amount of conditional payment.

In the words of the MSP statute, Medicare "shall be" reimbursed for medical expenses upon reaching a tort settlement involving a Medicare beneficiary. The language of the statute is mandatory, and the MSP sets forth the roles of the parties to ensure Medicare's reimbursement. The underlying goal of the MSP statute to obtain conditional payment reimbursement operates to save the Medicare trust funds in excess of $600 billion per year.

Parties to a tort settlement should avoid attempting to defeat the purpose of the MSP statute through artful pleadings that purport to recover only for pain and suffering. Tort releases issued in personal injury settlements generally release potential liabilities for all possible causes of action and Medicare will reasonably read such a release as including damages for medical expenses. Medicare requires reimbursement based on what is pled or released by the parties. Courts have reinforced Medicare's interpretation in multiple decisions. *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 899 n. 27 (11th Cir. 2003)(stating that

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courts "have uniformly concluded that a settlement agreement that includes a non-itemized element of compensation for a plaintiff's medical care is for medical expenses, even if the exact share is indeterminate."); *Mathis v. Leavitt*, 554 F.3d 731, 733 (8th Cir. 2009)(Medicare is entitled to reimbursement so long as "the settlement, which settled all claims brought, necessarily resolved the claims for medical expenses."). Attempting to avoid reimbursing conditional payments to Medicare by designating personal injury settlements as being related only to pain and suffering may give rise to CMS's right to seek double damages from the insurer or self-insured, plaintiffs' counsel, and the plaintiff or beneficiary for repayment.

Another incorrect presumption that should be avoided is that state courts possess authority to adjudicate Medicare's interest despite the state court's absence of subject matter jurisdiction over CMS and the Medicare claim and the lack of personal jurisdiction over the United States as a party. Again, any parties resolving cases or entering into settlements under this incorrect presumption run the risk that CMS will seek double damages from the insurer or self-insured, plaintiffs' counsel, or the plaintiff/beneficiary for repayment.

A third incorrect presumption relates to the perceived obligation of CMS to appear in a state court proceeding to defend its interest, despite CMS's sovereign immunity from suit in state court, and the federal nature of the proceedings. For discussion of these three incorrect presumptions from the government's point of view, see *Trusiak: State courts not an out on MSP,* Robert Trusiak, Assistant U.S. Attorney, dated March 25, 2010. To the contrary, parties to a settlement in litigation that involves a Medicare-enrolled beneficiary or beneficiaries have an affirmative obligation to contact CMS and secure an administrative adjudication under the MSP.

The initiation of litigation under the MSP by the federal government is generally based on the advancement of two litigation goals: deterrence and punishment. At times, the federal government has recognized that it may be necessary to pursue the double damages remedy in federal court to vindicate these goals and to deter MSP misconduct by litigants, insurers, self-insureds, plaintiffs, and/or plaintiffs' counsel. In some cases, the U.S. Attorney's Office may file suit to address all MSP-related misconduct by a party or practitioner rather than address only a single case. The U.S. Attorney's Office can do so by initiating the MSP quantification process with the Medicare Coordination of Benefits Contractor for all MSP claims involved. This practice has been used in New York to seek, for example, all personal injury settlements involving Medicare beneficiaries for periods of time from January 2000 to the present involving certain parties. The government will then consider whether to commence double damages suits against the individual plaintiffs, plaintiffs' counsel, and/or the insurers or self-insureds.

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MSP Recovery Under the Federal False Claims Act

In addition to the double damages exposure under the MSP, the government may file a claim under the False Claims Act to address fraud in a federal program such as Medicare. The False Claims Act provides for treble damages and a mandatory penalty of $5,000 to $10,000 per false claim. 31 U.S.C. §3729, *et seq.* Since Congress amended the False Claims Act in 1986, the aggregate value of False Claims Act settlements has increased exponentially each year. According to a Department of Justice report released in December 2013, the government collected $3.8 billion in *qui tam* and other settlements under the False Claims Act in 2013. Of that amount, approximately $2.6 billion came from cases from the Department of Health and Human Services, which runs CMS. Department of Justice, Civil Division, Fraud Statistics – Overview, (Dec. 23, 2013), *available at* www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Statistics.pdf.

False Claims Act liability is based in part on a party's attempt to conceal or avoid an obligation to pay the federal government. The False Claims Act defines a false claim as follows: "any person who… knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000… plus three times the amount of damages which the Government sustains because of the act of that person." 31 U.S.C. §3729(a)(1)(G). The False Claims Act permits private persons known as relators to file civil actions known as *qui tam* actions to recover damages on behalf of the government from any person who:

(1) Knowingly presents, or causes to be presented, to an officer or employee of the United States government or a member of the armed forces of the United States a false or fraudulent claim for payment or approval;
(2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.

31 U.S.C. §3729(a)(1)–(2).

The knowing avoidance by a practitioner of the obligation to repay CMS for conditional payments made to a Medicare-enrolled beneficiary constitutes a false claim. As it relates to the "knowing" or "scienter" element under the False Claims Act, knowledge includes reckless disregard or deliberate ignorance. 31 U.S.C. §3729(b). Under the False Claims Act, "specific intent" to defraud is an element in this analysis. The False Claims Act defines culpable persons as those who avoid or cause the avoidance of the obligation to pay money to the government. 31 U.S.C. §3629(a).

The potential for federal False Claims Act exposure in MSP litigation involving any type of historical conduct is sig-

nificant. According to former Assistant U.S. Attorney Robert Trusiak, in an open letter written to the Western New York bar, the words of the MSP statute provide that Medicare "shall be reimbursed for the medical expenses upon a tort settlement involving a Medicare beneficiary." Letter, *Trusiak: State courts not an out on MSP*, Robert Trusiak, Assistant U.S. Attorney, dated March 25, 2010. The federal government's "commencement of suit for the failure to secure an administrative adjudication from CMS concerning the existence and/or amount of the repayment obligation" shares the two important litigation goals of "deterrence and punishment." *Id.* As explained by Trusiak:

> It may be necessary for the United States to pursue its double damage remedy in federal court to vindicate these litigation goals of deterring MSP misconduct by others and punishing MSP violations for the continued recklessness in failing to pursue an administrative adjudicatory. It is important to recognize any federal double damages suit will address the panoply of MSP misconduct by the practitioner rather than address only a single case.

A doctor, hospital, skilled nursing facility, therapist, or durable medical equipment provider submits Medicare claims for reimbursement via a claim form for individual providers. Courts have determined that each claim form (*e.g.*, Form UB92 or HCFA 1500) may constitute a claim within the meaning of the False Claims Act. See 31 U.S.C. §3729(b)(2); *see also United States v. Krizek*, 111 F.3d 934, 940 (D.C. Cir. 1997). In a case involving multiple providers and multiple claim forms, each provider submitting claims for medical treatment of the Medicare-enrolled beneficiary or plaintiff could constitute a false claim subject to the mandatory penalty of $5,000–$10,000 per false claim, in addition to treble damages. Likewise, a large tort settlement involving multiple plaintiffs who are Medicare beneficiaries may give rise to multiple claims under the False Claims Act.

The False Claims Act also contains a whistleblower provision. 31 U.S.C. §3730(b). A whistleblower may file a False Claims Act lawsuit under seal and may participate in any monetary recovery. *See* 31 U.S.C. §§3730(b)–(d). In addition, the False Claims Act gives rise to actions by private persons to file civil actions known as *qui tam* actions to recover damages on behalf of the government. *See* 31 U.S.C. §3729(a)(1)–(2). Therefore, conduct of counsel or other parties to advocate or engage in avoidance of obligations under the MSP may serve to invite a False Claims Act action by a whistleblower or a *qui tam* action.

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Finally, timing of the reimbursement to Medicare is important and compliance with the 60-day requirement for Medicare to be reimbursed should be strictly followed. Medicare possesses the legal authority to bring direct actions, including a False Claims Act action against any primary plan, to include an insurer or self-insured, which is responsible to make payment under the MSP. As the following cases indicate, it is in the best interest of the parties and consistent with the intent of Congress for all parties to work together cooperatively to maximize MSP reimbursement in a timely manner and avoid expensive and unnecessary litigation from the government for failure to comply.

Past Cases Under the False Claims Act: *Krizek*

Previously, the federal government has used the False Claims Act to obtain Medicare and Medicaid-related reimbursements. The False Claims Act is violated where one "knowingly" submits a false claim to the government. 31 U.S.C. §3729(b). A defendant may be deemed to have knowingly violated the Act if he or she acted with "reckless disregard as to the truth or falsity of the information." *Id.*

In the case of *United States v. Krizek*, the government brought a False Claims Act action against a psychiatrist and his wife for submitting false claims for services to Medicare and Medicaid patients. *United States v. Krizek*, 909 F. Supp. 32, 33 (D.D.C. 1995). The claims were false because they were billing for services to patients that totaled more than 24 hours in a single day. *Id.* at 33–34. The district court determined that the appropriate average day for a psychiatrist, as established by a Special Master, was nine hours. The district court originally found the defendants were presumptively liable for 114 false claims. Upon motions of the parties, the district court modified the earlier decision, finding the psychiatrist and his wife (who processed the billings) were presumptively liable for 11 claims.

The court ordered the defendants to repay the government for all that was paid to them on these invalid claims. *Id.* at 33. The court found the defendants liable under the False Claims Act for triple the amount of the unjustified payments made to them, plus fines between $5,000 and $10,000 for each claim. *Id.* The total fines were $110,000 for 11 false claims.

The government appealed the district court's finding of only 11 false claims to the D.C. Circuit. The government's original complaint alleged that in a six-year period, the psychiatrist and his wife submitted 1,002 false or unlawful claims. *United States v. Krizek*, 111 F.3d 934, 936 (D.C. Cir. 1997). The government's initial claim was for $81 million in damages. The government argued that the district court disregarded the factual findings of the Special Master in imposing liability on only 11 claims. *Id.* at 938. However, the D.C. Circuit Court of Appeals found that the district court's ruling was not inappropriate, but that a remand was required. The D.C. Circuit determined that the definition of a claim in this instance was the applicable form, which, in this case, was the HCFA form. Therefore, each submission of a HCFA form by the psychiatrist and his wife was a separate claim.

The court noted that the False Claim Act defines a "claim" to include

> Any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides a portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

31 U.S.C. §3729(c).

On remand, the district court evaluated the evidence and found the defendants had committed three False Claims Act violations for those days where billings to Medicare and Medicaid patients exceeded 24 hours in a given 24-hour period. *United States v. Krizek*, 7 F. Supp. 2d 56, 60 (D.D.C. 1998). The court fined the defendants $10,000 per violation, or a total of $30,000.

Other examples of the federal government's actions under the False Claims Act can be found in *United States v. Pfizer*, 2009 WL 145682 (E.D. N.Y. 2009), which deals with a relator's claims under the False Claims Act that a drug manufacturer's marketing of the drug Lipitor for an off-label use violated the federal False Claims Act. Other relators have brought *qui tam* actions against Pfizer for other drugs. *See United States v. Pfizer*, 881 F. Supp. 2d 217, 219 (D. Mass 2012).

Even if the government does not pursue parties for failing to reimburse Medicare in tort settlements, the whistleblower provision of the False Claims Act can give rise to *qui tam* litigation on behalf of the government against the parties. *Qui tam* litigation can be lucrative for a whistleblower, who is paid a portion of the money collected from the lawsuit for the government. For example, a Houston hospital paid $15.5 million to settle a *qui tam* case brought by a whistleblower that exposed the hospital's practice of billing Medicare and Medicaid for patients whose treatment was not covered. Robert E. McCaslin, Jr., was an employee in the billing department of Harris County Hospital. He filed suit to expose the hospital's practice of billing Medicare and Medicaid for patients who were involved in automobile accidents, rather than waiting for the responsible party's auto insurance to pay. The hospital was also billing Medicare and Medicaid for the treatment of inmates, which was not allowed. *See United States, ex rel. Robert E. McCaslin, Jr., et al. v. Harris County Hospital District*, Case No. H-03-4438 (S.D. Tex.), available on PACER.

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In a case involving multiple providers and multiple claim forms, each provider submitting claims for medical treatment of the Medicare-enrolled beneficiary or plaintiff could constitute a false claim subject to the mandatory penalty of $5,000–$10,000 per false claim, in addition to treble damages.

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Two such actions had been filed in the Western District of New York. One matter involves attorney Michael Hayes as the relator in an action seeking recovery from several tortfeasors alleging that their practice of resolving insurance claims using boilerplate release language violates the MSP. The other matter involves Kent Takemoto, the head of an MSP vendor, as the relator in an action seeking recovery from several tortfeasors alleging that their failure to address conditional payments and future medical obligations violates the MSP. *See United States, ex. rel. Kent Takemoto v. ACE Ltd., et. al.*, Case No. 1:11-cv-00613-WMS (W.D. NY), available on PACER. Both actions highlight clear and present dangers facing primary plans or payers in the MSP compliance context.

MSP Cases Under the False Claims Act: *Hayes*

The complaint in *United States, ex. rel. J. Michael Hayes v. Allstate Insurance Company, et al.*, names over 20 liability insurance carriers and trucking companies that self-insure. Hayes alleged that the named defendants concealed and ignored MSP reimbursement obligations by utilizing general releases and broad, boilerplate indemnification clauses when resolving liability insurance claims. *See United States, ex. rel. J. Michael Hayes v. Allstate Insurance Company, et. al.*, Case No. 1:12-cv-01015-WMS (W.D. NY), available on PACER. By not specifically agreeing to certain MSP reimbursement provisions, and then asking for and receiving a broad, boilerplate indemnification with respect to those MSP reimbursement obligations, Hayes alleged that the defendants knowingly and improperly avoided their MSP reimbursement obligations.

Hayes relied on a basic assumption in making his argument. When agreeing to settle a case, they are the primary plan or payer who has accepted responsibility for the claimant's medical expenses. In so doing, the primary plan or payer has an obligation to ensure that CMS is reimbursed for any conditional payments made. According to *Hayes*, this is an obligation that cannot simply be assigned to the claimant and counsel for them to address if or when the issue arises post-settlement.

Hayes asserted that, in drafting and executing settlement releases in this manner, the defendants knowingly made or caused to be made a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government. 31 U.S.C. §3729(a). According to Hayes, the conditional payment reimbursement obligation is one that meets the definition of "obligation" in the False Claims Act. 31 U.S.C. §3729(3)(b)(3). As one that has knowledge of the false or fraudulent claim, the False Claims Act allowed Hayes to recover. 31 U.S.C. §3730. With no bar to recovery, Hayes sought no less than $5,500 and no more than $11,000 for each such claim, plus three times the amount of damages sustained by the federal government due to the false or fictitious claims. 31 U.S.C. §3729(a)(1). In short, the dam-

ages alleged and sought by Hayes under the False Claims Act are significant and should be taken seriously by any tortfeasor. While the action was dismissed with prejudice just prior to this article's publication, one can expect these issues to be revisited in the near future.

MSP Cases Under the False Claims Act: *Takemoto*

Takemoto presents a slightly different (and perhaps more troubling) argument for a tortfeasor. In *United States, ex. rel. Kent Takemoto v. ACE Ltd., et al.*, Case No. 1:11-cv-00613-WMS (W.D. NY), Takemoto argued that because the defendants did not affirmatively address certain MSP reimbursement obligations, they defrauded the federal government. *See United States, ex. rel. Kent Takemoto v. ACE Ltd., et al.*, Case No. 1:11-cv-00613-WMS (W.D. NY), available on PACER. Takemoto is an executive who has worked for several MSP compliance companies since 2002. In soliciting business from several liability insurance carriers and self-insured entities, Takemoto perceived a high level of non-compliance with satisfying MSP reimbursement obligations, especially in the context of future medicals.

In his complaint, Takemoto detailed his interactions with each of the 18 named defendants, which include large liability insurance carriers and Fortune 500 companies. He asserted that defendants have "routinely, flagrantly[,] and fraudulently refused to meet their obligations under the MSP and analogous Medicaid rules." These violations, in his opinion, ranged from failing to assess whether a claimant is enrolled in Medicare or Medicaid programs to failing to inform the federal government that a defendant was liable post-settlement with respect to payment for certain liability, no-fault, or workers' compensation injuries, causing the federal government to make payment erroneously. In so doing, he alleged that defendants "inflicted many millions of dollars in damages upon the federal treasury."

Takemoto asserted that, in drafting and executing settlement releases in this manner, the defendants have knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money to the federal Government. 31 U.S.C. §3729(a)(1)(G). He alleged that every time a defendant knew or should have known of a debt to CMS and did not repay or ensure claimant repaid CMS, then the tortfeasor violated 31 U.S.C. §3729(a)(1)(G). Takemoto alleged that defendants were aware of their obligation to make payments and avoided that obligation in the past medicals context for conditional payments as well as the future medicals context. As one that has knowledge of the false or fraudulent claim, the False Claims Act allowed Takemoto to recover. 31 U.S.C. §3730. With no bar to recovery, Takemoto sought no less than $5,500 and not more than $11,000 for each such claim plus three times the amount of damages sustained by the federal government due to the false or fictitious claims. 31 U.S.C. §3729(a)(1).

Takemoto, in the authors' opinion, presents a more serious challenge to modern claim handling cost containment protocols than Hayes. Takemoto's claim was partly based on the alleged failure of payers to ensure the protection of Medicare's interests at an institutional level. His claim implied that sophisticated payers, such as insurance carriers and large self-insured entities, must have protocols built into their risk/claims systems to police the repayment of Medicare and compliance with the MSP and Sec. 111. Indeed, his False Claims Act theory ignores the obligation of the claimant to protect Medicare and puts the onus on the payers exclusively. Unfortunately, CMS and the Justice Department may share his world view and may also assert that it is ultimately the payers who must ensure compliance with the MSP; this is convenient, of course, since it is the payers and not the beneficiaries who can respond financially to a False Claims Act suit. Consider *Takemoto* a wake-up call: payers, particularly insurance carriers, should by now have robust MSP/Sec. 111 compliance protocols in place to ensure that Medicare beneficiary claimants are identified, mandatory reporting is done, and MSP reimbursement is made. Such protocols should also include the requirement that settling claimants take steps to protect Medicare's interests in the future.

Scope of Discovery in Defending False Claims Act Allegations in the MSP Context

We anticipate that any MSP and federal False Claims Act cases (such as *Hayes* and *Takemoto*) will involve dozens of defendants and, potentially, thousands of claims. But, the essential fact at the core of any MSP/False Claims Act case is the status of Medicare's reimbursement in the subject tort or workers' compensation settlements. Thus, identifying cases involving Medicare beneficiaries whose cases have been settled, whether in tort or workers' compensation, and determining if Medicare has been repaid, is the overarching goal of discovery. Each side will have a huge stake in this process because, of course, if Medicare has been timely repaid and protected, no false claim occurred.

In such cases we expect that the *qui tam* relator (or the Justice Department) prosecuting the false claims will seek to discover the name and demographic information relating to all cases settled by the defendant. Expect Requests for Production of Documents propounded to the defendants seeking the names, demographic information, and specific settlement information relating to all settlements or payments of judgments involving Medicare beneficiaries. Armed with a list of settled beneficiary cases, both sides will need to determine if Medicare was reimbursed for each case. If not, why? For example, if the settlement funds disbursed by the payer to plaintiffs' counsel who agreed to reimburse Medicare and failed to do so, why? Or, conversely, if reimbursement of Medicare by the payer directly was part of the settlement, was that payment made or not? This will be challenging. In any False Claims Act and MSP case, determining the status of reimbursement to Medicare will be a task most efficiently assigned to lien resolution professionals. The list of settled cases and their reimbursement "status" will be "Exhibit A" and must be absolutely accurate and capable of presentation to the court virtually without objection.

Additional discovery in such cases will involve determining if Medicare's interest in the future has been protected and if there is documentation of actual collu-

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sion between the settling parties to defraud Medicare by transferring the obligation for future medical care to Medicare. Such conduct may also lead to False Claims Act liability. We are very concerned about cases involving alleged pre-1980 exposure to asbestos or other substances where the assumption that the claimant's exposure was exclusively before December 1980 may lead the parties to defer reimbursement to Medicare; there is the real possibility that many of the pre-1980 exposure cases involved some post-1980 exposure and Medicare would, therefore, be owed reimbursement. In any false claim case involving mass tort exposure settlements, the parties will need to discover what proof was known to the settling parties about the dates of exposure when the claim was resolved.

The cost of this additional discovery is certain to be substantial. In order to expedite the matter in a way that minimizes this extraordinary cost, the parties, and in particular defendants, should consider working with a healthcare compliance company or other third party who has experience in identifying and verifying claimants' Medicare enrollment statuses as well as possessing the bandwidth to tackle such an extraordinary project. Working collaboratively with a third party in this area allows the parties to focus on the legal issues at hand in the false claim cases while the third party addresses concerns from the operational perspective. Be mindful that the third party of your choosing should be well-versed at verbalizing reimbursement arguments under the MSP and enjoy a good working relationship with CMS in order to ultimately vindicate your client. With treble damages or more staring at your client, it would not be the time to attempt to go it alone without the proper team assembled.

Conclusion

The Medicare program and CMS possess the legal authority to bring direct actions against any primary plan, including an insurer or self-insured, which is responsible to make payment as a primary payer under the MSP if the primary payer fails to reimburse Medicare for its conditional payments. Further, Medicare is to be reimbursed within 60 days of payment by the primary plan or interest may be imposed. This discussion regarding the False Claims Act is intended to make practitioners aware that the government's analysis of a primary payer's MSP liability will be a plenary analysis that involves the assessment of several laws. However, primary payers should be mindful of the singular focus of the government to obtain MSP compliance, especially in tort settlements.