Christine Hummel, Esq.
Hummel Consultation Services
Post Office Box 148
Ferdinand, Indiana 47532-0148
Phone: 603-758-1410
Fax: 978-338-8116
Email: christine@hummelcs.com
Website: http://www.hummelcs.com

Copyright © 2023 Hummel Consultation Services. No unauthorized duplication or dissemination is permitted. The information contained herein is informational only and does not constitute legal advice, nor should this information be solely relied upon in any case. Every case is unique and requires individual review regarding MSP compliance. Medicare changes its policies frequently and without warning, which may impact the information contained herein.

Medicare Set Aside Presentation Outline

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." NOTE: This NPRM was formally withdrawn by CMS on October 13, 2022.

NOTES: _____

_____

_____

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 1 to 3 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. An MSA should still be done even if the CMS review thresholds are not met.

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 72 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.

NOTES: _____

_____

_____

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.

NOTES: _____

_____

_____

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. NOTE: $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.

NOTES: _____

_____

_____

_____

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.

f. NOTE: As of January 2022 "Evidenced Based" MSA allocations are not recommended or approved by CMS. This clarification was published by CMS in the January and March 2022 WCMSA Reference Guides.

NOTES: _____

_____

_____

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)

NOTES: _____

_____

_____

_____

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.

NOTES: _____

_____

_____

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. On February 18, 2020 CMS published a notice of proposed rulemaking in the Federal Register outlining the civil money penalties that will be assessed against insurance providers and self-insured entities that fail to properly report settlement information.

e. April 27, 2020 Rhode Island Case: Ruiz v. Rhode Island: Court determined steps taken by the defendant to verify the plaintiff's Medicare status were adequate to show a good faith effort to comply with the law.

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

NOTES: _____

_____

_____