Tucker Ellis LLP

CLIENT ALERT

# MEDICARE SECONDARY PAYER LIABILITY SET-ASIDES: HAS THE TIME FINALLY COME?

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The time to make set-aside accounts a component of liability settlements is quietly drawing near. Earlier this year Medicare issued a written notification instructing its Medicare Administrative Contractors (MACs) – the entities that act as Medicare's agents to process providers' claims for services – how to process claims and payments in cases where a set-aside arrangement has been created in Liability and No-Fault Insurance cases. That instructional MAC Guidance, which appears on the CMS Online Manual website, takes effect on October 1, 2017.

### BACKGROUND ON THE SET-ASIDE PROCESS

Medicare's notification to its MACs is a subtle but notable development in an evolving set of processes and procedures to protect Medicare's interest in recovering past and future conditional payments, as mandated by the Medicare Secondary Payer (MSP) Act. The use of a set-aside arrangement – segregating funds to pay for future medical care – has long been a common feature of the workers' compensation claims process. But the need, let alone requirement, for set-asides when settling or paying liability claims has been less clear. For years, it has been a topic of interest and concern to parties, counsel, and insurers responsible for evaluating, negotiating, and resolving liability claims, especially with the advent of the MMSEA program that requires defendants, liability insurers, and other "responsible reporting entities" to report to Medicare whenever a liability settlement, judgment, award, or other payment is made to a Medicare beneficiary. The MMSEA User Guide includes a brief overview of the MSP Act, but does not expressly address the use of set-asides to protect Medicare's interests in cases with "future medicals." Commentary offered during MMSEA Town Hall Calls has been vague and not entirely reassuring. (See, e.g., MMSEA Town Hall Transcript, 09/30/2009, pp. 25-26: "For liability situations as I said, the underlying obligation is the same if you wish to pursue CMS approval of a liability set-aside, your avenue approach is through the applicable regional office. Whether or not they agree to review . . . if they decline to review it, that doesn't provide any type of safe harbor"; and Town Hall Transcript 03/24/2009, p. 23.)

A formal regulatory directive appeared forthcoming in 2012 when CMS issued an Advance Notice of Proposed Rulemaking, "Medicare Program; Medicare Secondary Payer and 'Future Medicals'" CMS-6047-ANPRM, RIN 0938-AR43 (77 Fed. Reg. 35917 (June 15, 2012)). At that time, CMS outlined several potential options for beneficiaries to address their liability for future medicals, but after receiving comments, the rule was quietly withdrawn from the regulatory agenda in October 2014.

It is this administrative backdrop that makes the highly technical directive to the MACs to establish claim payment processes for Liability Insurance Medicare Set-Aside Arrangements (LMSAs) and No-Fault Insurance Medicare Set-Aside Arrangements (NFMSAs) so intriguing, and raises new questions about the role a Medicare Set-Aside can have in resolving liability cases and claims.

### CMS DIRECTIVE TO ESTABLISH TWO NEW SET-ASIDE PROCESSES

CMS explains that the new set-asides are intended to comply with a March 2012 Government Accountability Office (GAO) final report with the telling and admonishing title "Medicare Secondary Payer: Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans." The GAO report described the comparatively well-developed system that Medicare uses to process Workers' Compensation Medicare Set-Aside Arrangements (WCMSA), which includes a web-based portal allowing registered users – such as beneficiaries, attorneys, and insurance companies – to directly enter WCMSA case information, upload documentation, and receive up-to-date status information electronically. (GAO-12-333 at 24-25). By contrast, "CMS has issued very little guidance related to liability MSAs and NGHP [Non-Group Health Plans] stakeholders reported inconsistent handling of liability MSAs." (*Id.* at 33.)

From GAO's perspective, the policy rationale for use of LMSAs is compelling, and it strongly advocated for more effective use of LMSAs by observing:

> To help prevent Medicare from making future payments related to MSP situations involving NGHPs, when an individual is expected to have future medical expenses (including Medicare-covered drug expenses) related to his/her accident, injury, or illness, CMS states that all parties involved in negotiating a resolution of those situations are responsible for protecting Medicare's interests. One way to accomplish this is through a Medicare set-aside arrangement ….

GAO-12-333 at 6.

Thus it is no surprise that the 2017 MAC Guidance begins with a similar strongly worded policy statement:

> Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment 'has been made' for such items or services through use of LMSA or NFMSA funds. However, Liability and No-Fault MSP claims that do not have a MSA will continue to be processed under current MSP claims processing instructions.

While the Guidance tells contractors what to do when a LMSA does exist, the Guidance offers no express criteria or formula for the litigation community as to whether, when, or how to create a set-aside account in any given case; however, the Guidance does hint at what the process may eventually be. According to the MAC Guidance, Medicare's Benefits Coordination & Recovery Center (BCRC), which helps to collect information to coordinate benefits for Medicare beneficiaries on behalf of CMS, will be charged with creating the LMSA and NFMSA transaction in the CMS "common working file" system. (The CWF is a coordinated database that contains complete claim history and entitlement information, including MSP data, for all beneficiaries.) Since BCRC is also the entity responsible for the recovery of amounts owed to the Medicare program as a result of settlements, judgments, awards, or other payments by liability insurance, this suggests that LMSAs may soon become an element of the conditional payment recovery process, and may be a point of negotiation between BCRC, the beneficiary, and the representative when it comes time to resolve cases and issue Final Demand Letters.

## RESOURCES AND NEXT STEPS

The mechanisms that CMS frequently uses to communicate changes in process and policy to the MSP and MMSEA communities are silent about the new set-aside processes. The BCRC's "Rights and Responsibilities" letter issued to beneficiaries upon first notice of a new liability claim does not yet mention the potential creation of a set-aside account.

Some examples of the liability set-aside process can be found in judicial orders and opinions when courts have been asked to review LMSAs in a post-settlement hearing. These orders provide a helpful template to follow if parties seek court approval: The court conducts a hearing on the record, takes testimony and evidence from the plaintiffs, treating physicians, and life care planners to establish the reasonableness of a proposed set-aside arrangement and issues findings of fact and conclusions of law directing the funding, ownership, distribution process, and auditing of set-aside accounts.

## SUGGESTIONS FOR USE OF MEDICARE SET-ASIDES IN THE SETTLEMENT PROCESS

Pending more formal CMS directives, we can draw upon accumulated agency publications, policy statements, proposed rulemaking, and court opinions to offer the following observations and forecast the role LMSAs may take in the case management and settlement process:

1. Clients and counsel should work proactively, in preparation for settlement negotiations, to identify cases that would benefit from a MSA. A MSA could be a responsible and secure element when settling cases with Medicare beneficiaries where future medical care and/or drug therapy related to the liability event are undisputed and will otherwise be paid by Medicare.
2. There is no established formula for determining a percentage of a total settlement that should be allocated to a set-aside account, but, borrowing from the checklists used in establishing WCMSAs, the key documents for review will include: life care plans, medical records, future treatment plans, and life expectancy estimates and rated ages. Life Care Planners and Structure Settlement consultants may provide a helpful and principled guide to a fair allocation of liability settlement proceeds to be set aside to pay for future medicals.

3. Nor is there a formal CMS review process in the liability arena as there is for workers' compensation; thus, it is unclear if CMS Regional offices will increase their role in reviewing liability set-aside arrangements, and, if so, at what levels. Typically, WCMSAs are reviewed only if they exceed a certain minimum threshold (i.e., $250,000). In May 2011, the U.S. Attorney for the Western District of New York issued a Liability Set-Aside Review Protocol that required the value of the agreed settlement to equal or exceed $350,000.
4. A set-side account can be managed by various parties, including the beneficiary or a third-party administrator, such as a bank or an attorney. Courts have allowed the funds to be self-directed by the beneficiary or a responsible family member, but clients should fully understand that these are special purpose accounts, and the propriety of all deposits, withdrawals, and payments may be subject to audit. (For example, the administrator of a WCMSA, often the beneficiary's attorney, must submit an annual accounting of the set-aside funds to Medicare until the funds are exhausted.)
5. While a LMSA is in existence, CMS will decline payment to health care providers for products and services related to the diagnosis code (or related within the family of diagnosis codes) associated with the injury for which the settlement was paid. This underscores the importance of the accurate use of ICD-9 and ICD-10 diagnosis codes when submitting MMSEA reports. In denying payment, the Remittance Advice may include an explanatory message such as: "Your claim has been denied by Medicare 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)."
6. Once the LMSA benefits are terminated or exhausted, Medicare will resume making payments on covered claims.
7. MSAs can work to a defendant's strategic advantage in negotiating settlements. The defendants can take the plaintiff's life care plan, ascertain how much money is needed to fund it for future medical care, and offer to fund that future care with an annuity, which would cost far less than the amounts quoted in the life care plan. Taking a proactive approach can knock the economic legs out from under an otherwise inflated demand. So if a MSA has to be done, it may be best for the defense to embrace the concept and make it a strategic part of the negotiation.

## CONCLUDING COMMENTS

On June 8, 2016, CMS posted a note on its Coordination of Benefits & Recovery webpage indicating that it was "considering" expanding its voluntary MSA review process to include the review of proposed liability insurance, and stating that CMS would "work closely with the stakeholder community to identify how best to implement this potential expansion." It appears that the expansion process has quietly evolved, and the utilization of LMSAs may be here sooner than we think. Beneficiaries, liability insurers, self-insured entities, and their respective counsel should begin to anticipate and prepare for a new phase of the Medicare recovery process.

For more information on this topic, please see the Medicare Learning Network's article in *MLN Matters* (June 9, 2017).

## ADDITIONAL INFORMATION

As additional guidance and directives become available from Medicare or any of the MACs on the LMSA process, Tucker Ellis will review and advise. In the meantime, we welcome any questions, comments, or concerns as you move forward in your claims handling process. Please contact:


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