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Navigating Through the Fog: Medicare, Future Medicals & Liability Settlements

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The extent to which settling parties must consider Medicare's interests in medicals in a liability settlement continues to be unclear. Since 2001, the Centers for Medicare and Medicaid Services (CMS) has pursued incremental steps that have yielded a voluntary Medicare Set-Aside (MSA) review and approval process for workers' compensation, a mandatory reporting requirement of almost all liability, workers' compensation and no-fault settlements with Medicare claimants, and a comprehensive Medicare conditional payment process with dedicated recovery contractors.

Since 2012, CMS has signaled its intention to expand its voluntary MSA review and approval process, but has not yet provided specific guidance regarding the consideration of post-settlement future medicals in a liability case. In fact, the agency has twice withdrawn proposed rules from review by the White House Office of Information and Regulatory Affairs (OIRA), most recently in October 2022. (OIRA review and approval is required before a proposed rule is published.)

This paper explores CMS authority to regulate in this area. In addition, there is guidance for the liability practitioner in regard to considering Medicare's interests when CMS has yet to articulate a clear set of guidelines.

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CMS Authority

Over two decades ago workers' compensation attorneys went to CMS with concerns about CMS's apparent authority under the Medicare Secondary Payer (MSP) Act to deny payment for post-settlement injury-related medical care when the settlement closed out medical benefits.Practitioners encouraged CMS to implement a review process that would approve a portion of the workers' compensation settlement to fully protect Medicare's interest, rather than assuming the entire settlement is available to pay future medicals.

The MSA review and approval process that CMS subsequently created provides certainty for workers' compensation parties to settle cases without fear that Medicare will require more funds than what was allocated in the MSA to pay for future medical. CMS approval ensures that Medicare will step in to pay for future medicals if an MSA is properly exhausted.

Accordingly, the question for liability practitioners is whether CMS has the authority to deny payment for injury-related medical care or seek recovery for payments made after a liability settlement. If so, some liability practitioners can be expected to ask CMS for a review process to ensure that only a portion of the settlement is allocated to future medicals.

CMS AUTHORITY UNDER THE MSP ACT

CMS cites the following provision under the MSP Act as its basis to deny payment for post-settlement medical, whether workers' compensation, no-fault or liability:

> Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that . . .
> . . . (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. 42 U.S.C. § 1395y(b)(2)

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CMS ANPRM PROVIDES INSIGHT INTO CMS'S INTERPRETATION OF ITS AUTHORITY

Although subsequently withdrawn, the June 15, 2012 Advanced Notice of Proposed Rulemaking (ANPRM) gives insight into CMS's position regarding responsibility for payment of medical care post liability settlement and its authority to either deny payment for injury-related medical care or seek reimbursement for injury-related payments made:

> Primary payment responsibility on the part of workers' compensation, liability insurance (including self-insurance), and no-fault insurance is generally demonstrated by settlements, judgments, awards, or other payments. When a "settlement" occurs, the "settlement" is subject to the MSP statute because a "payment has been made" with respect to medical care related to that "settlement." By law, Medicare is subrogated to any right of an individual or any other entity to payment for items or services under a primary plan, to the extent of Medicare's payments for such medical items and services. Moreover, section 1862(b)(2)(B)(iii) of the Act provides a direct right of action to recover Medicare's conditional payments. This direct right of action, which is separate and independent from Medicare's statutory subrogation rights, may be brought to recover conditional payments against any or all entities that are or were responsible for making payment for the items and services under a primary plan. The government may also recover under the direct right of action from any entity that has received payment from a primary plan or the proceeds of a primary plan's payment to any entity.
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> Under its rights of subrogation and direct right of action, Medicare recovers for conditional payments related to the "settlement," regardless of when the items and services are provided. Further, Medicare is prohibited from making payment when payment has been made (that is, if the beneficiary obtains a "settlement"). Medicare remains the secondary payer until the "settlement" proceeds are appropriately exhausted. It is important to note that the designation future medical care ("future medicals") is a term specifically used to reference medical items and services provided after the date of "settlement."

The most notable aspect of this statement is CMS's position that it remains the secondary payer "until the 'settlement' proceeds are appropriately exhausted." If this is an appropriate interpretation of the agency's authority, then a CMS-approved LMSA would provide for

an amount less than the full settlement amount to be allocated to future medical care, just as a Workers' Compensation MSA (WCMSA) does.

There has been litigation as to whether an LMSA or some other allocation of future medical care is a necessary element of the settlement. In Stillwell v. State Farm Fire and Casualty Co., 2021 WL 4427081 (M.D. Fla., September 27, 2021), the plaintiff asserted that a settling party must consider Medicare's interest by creating an MSA, segregating part of the settlement for future medicals, paying part of the settlement into the Medicare Trust Fund or some other alternative proposed to CMS. The court found that there is no law requiring any of these mechanisms. Further, the court held that it is left to the executive or legislative branch, not the judiciary, to establish a rule or approval mechanism. In addition, the court noted that Stillwell is the primary payer for post-settlement medical expenses.

It is uncertain whether CMS currently denies payment for post-settlement medical expenses or seeks conditional payment recovery for post-settlement payments that Medicare has made in liability cases. A 2022 study by Ametros found that CMS was denying post-settlement medical payments when a CMS-approved WCMSA existed. However, this study did not address liability settlements.

We do know CMS is notified of liability settlements that involve Medicare beneficiary claimants through the Section 111 Mandatory Insurer Reporting process (with the exception of physical trauma liability settlements of $750 or less, which are not reportable).

Therefore, questions remain over CMS's authority to deny payment or seek reimbursement for post-liability settlement injury-related medical. Further, even if settling parties are open to some type of allocation for future medical, the courts are unwilling to provide a mechanism as to how this should be done.

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CMS LMSA Review Policy

Without judicial interpretation of CMS's authority and a methodology to allocate a portion of the settlement to future medical, we are left with official CMS guidance. Unfortunately, few CMS memos or policy announcements address the issue of LMSAs.

Since 2001 when the WCMSA review process was introduced, a few of the 10 CMS Regional Offices have also voluntarily reviewed LMSAs. However, there has never been an official CMS policy on consideration of future medicals in liability settlements. The following is a review of official CMS actions regarding LMSA reviews:

9/30/2011 - CMS Memo provides criteria for when a CMS Regional Office will ***not*** review an LMSA, namely a physician certifies in writing that injury-related treatment has been completed as of the date of settlement and no future medical care will be required.

6/15/2012 – CMS issues an Advanced Notice of Proposed Rulemaking (ANPRM) announcing its intent to issue formal regulations regarding considering Medicare's interest in future medicals stemming from a liability settlement. The ANPRM provides several options for considering Medicare's interests. A comment period begins with stakeholders providing comments to CMS.

10/2014 – CMS withdraws the ANPRM.

6/8/2016 – CMS announces that it is considering expanding its voluntary WCMSA review process to liability and no-fault insurance. The statement indicates CMS will work closely with the stakeholder community to identify how best to implement this.

Early 2017 – CMS announces an RFP for the new Workers' Compensation Review Contractor (WCRC), which includes an optional provision to expand MSA reviews to liability as early as 7/1/2018.

12/2018 – On behalf of CMS, OIRA posts a Notice of Proposed Rulemaking (NPRM) entitled "Miscellaneous Medicare Secondary Payer Clarifications and Updates" (later changed to "Medicare Secondary Payer and Future Medicals"). It was generally understood that the proposed rule, to be issued in September 2019, would address future medicals in liability settlements.

3/1/2022 – CMS submits its proposed rule to OIRA for regulatory review before publication.

10/13/2022 – The proposed rule is withdrawn before publication.

What's Next?

Will a proposed rule around LMSAs will be reworked and resubmitted to OIRA for consideration soon or is CMS is closing out regulations around liability settlements and future medicals for the foreseeable future? It's not clear.

If CMS continues down the road of LMSAs, it will have to address the following in its review policy:

- Review thresholds
- Allocation of the MSA based upon a compromise formula
- Documentation required to submit a LMSA proposal to CMS
- Whether the LMSA review will occur pre- or post-settlement
- Timeline for LMSA policy implementation
- Multiple defendants and mass tort settlements
- Pricing of medical in an LMSA (usual and customary versus Medicare rates)

Through its involvement with the National Medicare Secondary Payer Network (MSPN), Tower MSA Partners plans to discuss with CMS the expansion of MSA reviews to liability. The organization's goal is to ensure that any process is one that reasonably balances the interests of the settling parties with those of Medicare.

Guidance for Settling Parties and LMSAs

Without a CMS LMSA review policy or process, what should settling parties do? Tower MSA recommends the following:

- Identify whether the claimant is a Medicare beneficiary or has a reasonable expectation of Medicare eligibility within 30 months. (With workers' compensation settlements, CMS is particularly interested in the 30-month window in consideration of future medicals). A reasonable expectation of Medicare eligibility is defined as follows:
  - The claimant has applied for Social Security Disability Benefits
  - The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision

  - The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits
  - The claimant is at least 62 years and 6 months old
  - The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

- If the claimant is Medicare eligible or has a reasonable expectation of Medicare eligibility within 30 months, determine need for future injury-related medical care. Is this claimed in the settlement demand or alleged in the pleadings?
- If there is a necessity for future injury-related medical care, will this burden likely be shifted to Medicare? (For example, does the claimant have a source other than Medicare to pay for future injury-related medical care, e.g., a group health plan?)
- If the burden of future injury- related medical care will likely be shifted to Medicare, then determine if there are sufficient settlement funds to allocate a portion of the settlement to fully fund future medicals. If there are, consider an LMSA as part of the settlement. If there are insufficient funds to fully fund future medicals, then consider apportionment of the future medical allocation in relation to other damages allocated in the settlement.
- Document the steps taken to consider Medicare's interest in the file and settlement/release. If an LMSA or other type of allocation for future medical has been included in the settlement, ensure the plaintiff is aware of their responsibilities in utilizing those funds for future medical expenses. Similarly, if the LMSA has been apportioned, document the reasons why such a reduction was taken. If no LMSA or allocation for future medicals has been included in the settlement, then ensure the plaintiff is aware of the potential implications for future payments by Medicare for injury-related medical care. Also, document the reason that no such allocation has been included in the settlement/release.
- In addition to the future medical considerations, remember to investigate and resolve Medicare conditional payments, including payments made through Part C Medicare Advantage Plans.

Ultimately, with the lack of CMS guidance, determining whether to include an LMSA as part of settlement is a risk management decision left to the primary plan (insurance carrier or self-insured entity) and the plaintiff and their attorney. Tower MSA Partners can provide consultation to all parties to help them understand CMS's claimed authority under the MSP Act and recommendations for considering Medicare's interests within this authority. Please contact Tower MSA Partners at (888) 331-4941 or info@towermsa.com for a consultation.

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CHIEF COMPLIANCE OFFICER

Daniel M. Anders, Esq. is an expert in Medicare Secondary Payer (MSP) compliance and Medicare Set-Aside (MSA) preparation. As Chief Compliance Officer for Tower MSA Partners, Dan oversees all aspects of regulatory compliance associated with the MSP status and local, state and federal laws. His responsibilities include ensuring the integrity and quality of Tower's services and products.

With more than 20 years of experience working with employers, insurers, third-party administrators, attorneys and claimants, Dan provides education and consultation to Tower's clients on all aspects of MSP compliance. He has presented at industry conferences, including the National Workers' Compensation & Disability Conference & Expo and the WCI Conference, and written numerous articles and posts for Tower's MSP Compliance blog on MSAs and compliance issues. Dan is a subject matter expert in this area and has been interviewed and written articles for insurance/workers' compensation publications.

An Illinois-licensed attorney, Dan also holds the Medicare Set-Aside Consultant Certified (MSCC) and Certified Medicare Set-Aside Professional (CMSP) credentials. In 2021 he served as President of the National Medicare Secondary Payer Network (MSPN) where he continues to serve on the board. He previously served as Senior Vice President of MSP Compliance for ExamWorks Compliance Solutions and he has extensive litigation experience from his earlier position with the Chicago law firm of Wiedner & McAuliffe.

Dan earned his Juris Doctor degree from Chicago-Kent College of Law and his bachelor's degree from Loyola University Chicago.

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