BY AARON FREDERICKSON

Medicare Set-Aside Arrangements:

Submit or Not Submit?

This article provides a background on the Medicare Secondary Payer Act and Medicare set-aside arrangements (MSAs) and things that attorneys practicing in worker's compensation law should consider from the time of case opening. It gives guidelines for when an MSA is required or recommended and suggests circumstances in which stakeholders might want to submit an MSA to the Centers for Medicare & Medicaid Services.

In William Shakespeare's play *Hamlet*, Prince Hamlet of Denmark agonizes over his sanity and speaks one of the most famous lines in English literature: "To be, or not to be, that is the question!" While Prince Hamlet could not have known about the perils of the Medicare Secondary Payer (MSP) Act, he would understand the tribulation of claim handlers and attorneys as they ponder the issue of submitting a Medicare set-aside (MSA) arrangement for review to the Centers for Medicare and Medicaid Services (CMS).

The goal of the MSP Act is to ensure primary insurance plans do not shift the burden of future medical expenses onto Medicare after a settlement. While this applies to all injury-related cases, the focus of CMS policy, which started in the early 2000s, has primarily been on worker's compensation cases.[1] This includes the creation of workload review thresholds that allow attorneys and stakeholders to have an MSA submitted to the CMS for review and approval.

Although an MSA may be recommended in a settlement, submitting a case that meets the CMS review thresholds is not required. Over the years, the CMS has continued reaffirming this principle in policy memoranda. Notwithstanding this unbroken message, the CMS has complicated matters for attorneys and stakeholders seeking to comply with the MSP Act through revisions made in subsequent communications and, more recently, rulemaking related to section 111 reporting requirements found in the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007.[2]

This complex and sometimes impenetrable statutory framework of the MSP Act has resulted in confusion for attorneys as to what is required to settle their worker's compensation cases. This article provides a background on the MSP Act and things that attorneys practicing in worker's compensation law should consider from the time of case opening. It also provides the framework for what is required and when an MSA is recommended — debunking myths and urban legends that remain within the worker's compensation claims community and legal circles — and guides stakeholders on when the submission of an MSA should be considered and why the CMS lacks the legal authority it claims.

Considering Medicare's Interests in a Settlement

The MSP Act requires parties to consider Medicare's goal — to not become the primary payer after settlement of a worker's compensation claim.[3] One tool to achieve this statutory command is an MSA, which can be submitted to the CMS for review and approval. This review process is voluntary and available for parties to use when the CMS workload thresholds are satisfied.

The "requirement" to consider Medicare's interests does not mean parties are compelled to use an MSA or submit it for review. Instead, an MSA is recommended when:

- There is a reasonable expectation of Medicare eligibility in the foreseeable future, or the employee is a Medicare beneficiary at the time of settlement;
- The employee will reasonably require medical care and treatment otherwise reimbursable by Medicare after settlement; and
- The settlement closes out all future medical care — and would otherwise make Medicare the "primary payer."[4]

When these factors are present, it is essential to consider using an MSA to ensure Medicare remains the secondary payer after settlement.[5] Questions related to the submission of the MSA require legal analysis by an attorney and discussion with the client.

Understanding the Voluntary Review Process

The CMS has established workload thresholds to assist parties with MSP Act compliance.[6] Many insurance carriers routinely submit cases for review when the facts meet these thresholds. This practice has complicated settlement discussions and decision-making processes on how to proceed. Reasons include the following:

• While the CMS review and approval process is voluntary, parties *should not* attempt to settle cases with impunity.

• The CMS does not have statutory or regulatory authority to deem non-submitted MSAs as being unreasonable – Medicare's cause of action only arises in those instances in which Medicare, not a worker's compensation insurance carrier, makes payment.[7]

• The MSA is merely a contract between the CMS and the employee.[8] While the insurance carrier has "deep pockets," the employee is the target of any adverse action if the employee shifts the burden onto Medicare by seeking medical care after an injury and indicating that Medicare should be billed.

Given this vital consideration, stakeholders should recognize that not submitting an MSA does not create liability or exposure. The main target of any potential litigation is the employee.

Aaron Frederickson, William Mitchell 2002, is the founder of MSP Compliance Solutions LLC, based out of Minneapolis/St. Paul. He is licensed to practice law in Minnesota and Wisconsin and has more han 20 years of experience in worker's compensation and Medicare secondary payer compliance.

My mother has been reading, reviewing, and critiquing my articles for a long time. Sadly, she left us without taking a look at this article. Mom, I love you forever. 1 Corinthians 16:13-14.

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aaron@mspcompliancesolutions.com

MSP Act Applies to All Injury-Related Cases

The MSP Act applies to more than workers' compensation cases – it applies to all types of litigation where there is a personal injury, and the injured party is a Medicare beneficiary or will be one in the foreseeable future. These claims can include:

• Common personal injury cases – slip/falls, premises liability, or products liability where the plaintiff sustains physical or mental injuries/trauma;

• All motor vehicle accident claims;

• Construction claims where part of the lawsuit alleges a personal injury. Common claims can include asthma or other types of exposure-related ailments;

• Elder care and abuse claims. Attorneys practicing in this area should be prudent when accepting these types of cases, as the injured party will almost always be a Medicare beneficiary; and

• Employment law and contracts cases. Be on the lookout for allegations of mental or physical abuse, which could include claims for tortious interference of a business contract.

The bottom line is that an attorney handling any lawsuit that involves a "personal injury" should consider Medicare's interest in the settlement. **WL**

Common Pitfalls of the WCMSA Review Process

It is also vital that members of the claim management team and other stakeholders consider the consequences of unnecessary case submission.

• **Development Delays**. Cases submitted for review can be subjected to unnecessary development and thereby be delayed. The examples of this are numerous. The assigned CMS contractor can change how they view submissions and their components without notice and alter how service providers input data. These changes often have no support in evidence specific to a case but are based on generalized trends observed by the CMS. The result is often a string of development letters until new trends are more fully understood.[9]

• **Counter-Higher Conundrum.** Smart public policy must encourage settlement, which is contravened by CMS policy. CMS has demonstrated a willingness to consistently "counter-higher" cases submitted for review, such that the final CMS approval of an MSA is higher than what was originally proposed. In fiscal year (FY) 2020, the average submission was increased by CMS nearly 13%.[10] Over the next two years, CMS continued to increase the final approved amounts. In FY 2023 alone, the average submitted MSA versus average approved amount was 21.95%. From 2020 through 2023, CMS counter-highers required the payment of nearly an additional $1 billion, while often offering little or no evidence to support these increased allocation amounts. Because the submission process lacks an appeals process, stakeholders are denied a system that includes fundamental fairness and procedural due-process safeguards. In sum, the CMS review and approval process represents an unnecessary "tax" on settlements that should shock the conscience of all stakeholders.

• **Failing to Consider Statutes of Limitation and State Law.** Although CMS policy dictates that the CMS follow state law regarding primary liability determinations and defenses, these factors are largely ignored during review of MSA submissions. One example is the CMS's willingness to allow insurance carriers to pay the employee while liability is investigated. This process

applies to some but not all jurisdictions. Other examples include the willingness of the CMS to honor state-based statutes of limitation found in jurisdictions such as Georgia,[11] Montana,[12] and Wisconsin.[13] In other instances, CMS will inconsistently honor affirmative defenses, such as payment made by mistake of fact when considering $0 allocation submissions. This is inconsistent with court directives requiring the CMS to follow the "well-oiled machine absent a clear directive from Congress."[14]

Effective MSP Act compliance starts with efforts by all stakeholders to consider Medicare's interests and protect only their clients. While this often can start with submitting an MSA for review and approval, this step is often taken with the misunderstanding that it is the only way to protect oneself from future adverse action. This notion is not based on law and often involves paying extra to settle cases.

Section 4.3 and Non-CMS Approved Products

CMS surprised countless stakeholders in January 2022 when it released version 3.5 of the *Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide*, which included a specific section dedicated to "non-submit" allocations. In this new section, the CMS suggested that these allocations were an attempt to shift the burden under the MSP Act:

"Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program's interests are adequately protected. As such, CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement."[15]

While the CMS is entitled to state its position on the use of the *voluntary* MSA review and approval process, the mere suggestion that they are final arbiters of what is reasonable for purposes of considering Medicare's interest after settlement is a gross mischaracterization of the MSP Act.

This is not the first time, and likely not the last, that the CMS overstepped its authority by using policy manuals and reference guides to govern the MSP Act. In 2010, the CMS sought the recovery of conditional payments against the survivors in a wrongful death claim.[16] In *Bradley,* CMS sought recovery of these payments in contradiction of controlling state law based on language contained in the *Medicare Secondary Payer (MSP) Manual*. The district court judge agreed with the CMS's position but was ultimately overturned on appeal.

According to the court of appeals, the CMS declined to participate in the state

MSP Act: A Brief History

• **1965:** President Lyndon Johnson created the Medicare program. Medicare was the primary payer for all beneficiaries – even if other forms of insurance were available, such as worker's compensation, no-fault/automobile, and liability.

• **1980:** President Jimmy Carter signed the MSP Act into law to contain costs and keep the Medicare Trust Fund solvent. Medicare was now a "secondary payer" regardless of liability in workers' compensation, no-fault/automobile, or liability plan claims.

• **2001:** The CMS started to issue a series of policy memoranda regarding a primary payer's responsibilities under the MSP Act. Stakeholders were again warned that forcing Medicare to assume primary payer status could result in adverse action.

• **Present:** The CMS continues to struggle with the enforcement of the MSP Act. This has confused effective compliance.

Now is the time to understand the MSP Act and implement best practices. **WL**

probate court proceedings and cited "no statutory authority, no regulatory authority, and no case law authority, merely relied upon the language contained in one of its many field manuals and declined to respect the decision of the probate court." In reversing the lower court, the court of appeals noted that "the Secretary's position is unsupported by the statutory language of the MSP and its attending regulations. The Secretary's *ipse dixit* contained in the field manual does not control the law. The district court also erred in relying upon the advisory language contained in a field manual as the rationale for its opinion upholding the actions of the Secretary." The court was also skeptical of the CMS's position because the policy would have a "chilling effect on settlement," which is contrary to the well-established public policy of promoting settlement.[17]

The new policy announcement also directly contradicted policies contained within that same version of the *Guide* in sections 4.2 and 8.0.

"There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval."[18]

It also confused countless stakeholders on issues concerning the inability to have cases that did not fall within established review thresholds reviewed. While the CMS quickly backtracked on this erroneous policy, confusion remains.[19]

Deciding Whether to Submit an MSA

There is no one right or wrong answer to the question of whether to submit a case to the CMS for review and approval under the WCMSA process. Attorneys should be proactive when consulting with and receiving direction from clients and be an advisor and counselor at law. Submission sometimes is necessary when it is presented as a dealbreaker during the settlement negotiation process.

Submitting a case to the CMS for review should not be undertaken merely because the case falls within the workload review criteria. Attorneys should always consider the following factors when discussing submission:

• Submission of an MSA is never required – the process is 100% voluntary.

• Submission under the WCMSA review process does not provide a legal safe harbor under the MSP Act. The CMS's warning to this effect predates the development of the *WCMSA Reference Guide*.[20] At a maximum, the voluntary review process provides "certainty" (whatever that means).[21]

• CMS policy, as outlined in the *WCMSA Reference Guide*, is not law, and sometimes contradicts the law.

The bottom line is that attorneys must understand the MSP Act and correctly explain it to their clients. Any discussion regarding submission must include a review of the goals and objectives that might or might not be achieved through CMS review.

Conclusion

To have or not have CMS review; that is the question! CMS review might provide parties with certainty, but this result might be accompanied by unnecessary and unexpected delays. It also comes at a high cost to the insurance carrier without benefiting the injured party. Attorneys should not submit MSAs merely because a case falls within the CMS review thresholds.

The CMS review and approval process is well intentioned but is being used to promote a one-size-fits-all approach that relies on agency interpretations that skirt the far edges of the MSP Act. It is also designed to meet agency objectives but lacks procedural-due-process safeguards that prey on fear – promoting the irrational fear of being reasonable. Submitting an MSA under the voluntary review and approval process without thoughtful discussion and consideration will result in paying more money to resolve fewer cases. Forcing parties into a voluntary process through other means is also inconsistent with well-established public policy that should encourage settlements, not dissuade them.

The MSP Act calls upon parties to consider Medicare's interests in their settlements, but parties should not be forced to do the CMS's bidding. By undertaking good-faith efforts that consider Medicare's interests, attorneys can comply with the MSP Act and fulfill any professional and ethical obligations. **WL**

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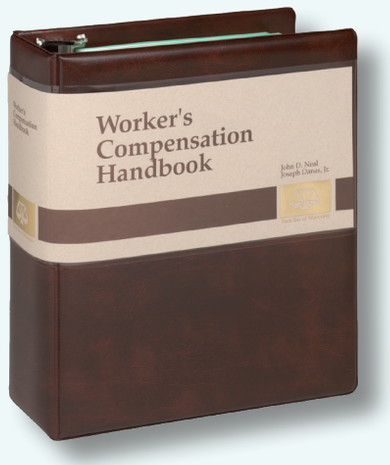

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ENDNOTES

[1]42 U.S.C. § 1395y(b)(2). CMS policy was initially referenced in a series of policy memoranda, which was later consolidated into section 1.0 (About This Reference Guide) of the *Workers' Compensation Medicare Set-aside Arrangement (WCMSA) Reference Guide*: "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures."

[2]Aaron Frederickson, *A Moving Compliance Target: Worker's Compensation Medicare Set-asides*, Wis. Law., March 2023; Medicare Program; Medicare Secondary Payer and Certain Civil Money Penalties – CMS-6061, 88 Fed. Reg. 70363 (Dec. 11, 2023) (codified at 42 C.F.R. ch. 402 and 45 C.F.R. ch. 102).

[3]The Medicare Secondary Payer Act was passed by Congress and signed into law by President Jimmy Carter under the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, on Dec. 5, 1980. It is codified at 42 U.S.C. § 1395y(b)(2).

[4]*See* 42 C.F.R. § 411.46. While this regulation specifically refers to only worker's compensation settlement, the MSP Act does specifically reference and apply to all worker's compensation, personal-injury, and no-fault cases.

[5]*WCMSA Reference Guide*, v3.9, § 3.0 (What Are Workers' Compensation Medicare Set-Aside Arrangements?) at 4 (May 15, 2023).

[6]*Id.* §§ 8.0 (Should CMS Review a WCMSA?), 8.1 (Review Thresholds). The CMS cautions parties to monitor for changes in the specified review-threshold amounts. The thresholds have not changed since May 11, 2011.

[7]Representatives from the CMS have failed to provide any statutory citation that gives them actual or de facto authority to be the final arbiters of whether an MSA allocation is "reasonable" under the MSP Act. Questions submitted to CMS representatives at townhall-style events are through controlled moderation. It remains to be seen if changes related to section 111 reporting under the non-group health plan responsible reporting entities expansion, set to take effect April 4, 2025, will be the ace in the CMS's hole. Under this reporting framework, new data fields will be added to the S111 Claim Input File to include an MSA dollar amount. The CMS has already warned that stakeholders' claims for which an MSA is not submitted will receive a higher level of scrutiny.

[8]This analogy was explicitly used at the CMS's townhall meeting on Feb. 17, 2022, by CMS health insurance specialist John Jenkins. As of the date of publication of this article, the CMS had not released an official transcript of this event.

[9]The CMS released operating rules to stakeholders on Oct. 27, 2008, and Apr. 22, 2010. These documents were received after protracted battles under Freedom of Information Act requests. Because the document was extensively redacted, the CMS failed to give stakeholders complete transparency. This has led many to conclude the "devil is in the details."

[10]Workers' Compensation Medicare Set-aside (WCMSA) Fiscal Year Statistics: 2020-2023 (Dec. 2023), https://www.cms.gov/files/document/workers-compensation-medicare-set-aside-wcmsa-fiscal-year-statistics-2023.pdf.

[11]Ga. Code Ann. §§ 34-9-200, 34-9-200.1 (West, Westlaw, current through legislation passed at 2023 Reg. Sess. of Ga. Gen. Assemb.).

[12]Mont. Code Ann. §§ 39-71-704, 39-71-717 (West, Westlaw, current through end of 2023 Sess. of Mont. Legis.).

[13]Wis. Stat. § 102.17(4)(b).

[14]*Caldera v. Insurance Co. of Pa.*, 716 F.3d 861, 867 (5th Cir. 2013).

[15]*WCMSA Reference Guide*, v3.5, § 4.3 (The Use of Non-CMS-Approved Products to Address Future Medical Care) at 6-7 (Jan. 10, 2022)

[16]*Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010).

[17]*Id.*

[18]*WCMSA Reference Guide*, v3.9, § 8.0 (Should CMS Review a WCMSA?) at 9.

[19]*WCMSA Reference Guide* v3.6 (March 15, 2022) was released following the CMS townhall meeting on Feb. 17, 2022.

[20]July 11, 2005 and April 25, 2006, CMS Memoranda of Gerald Walters, Director – Financial Services Group, Office of Financial Management.

[21]*WCMSA Reference Guide*, v3.9, § 2.3 (Past and Future Medical Services) at 4. **WL**