AMETROS

Implementation and Implications of Medicare Set Asides

Advanced Workers' Compensation Seminar

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Topics of Conversation

- MSP Background & Overview
- Medicare Set Aside (MSA) Focus
- Professional Administration
- Q&A

MSP Overview

Medicare Overview

- 1965 Social Security Act
- Part A (hospital)/B (outpatient)
- Entitlement
  - Age 65
  - Disabled
    - SSDI
    - ESRD
    - ALS
- Part C
  - Medicare Advantage
  - 1997
  - Administered by private companies
- Part D
  - Prescription drug coverage
  - 2003

MSP Overview

- 1980
- The MSP Act makes Medicare secondary to all other forms of insurance and self-insurance (known as primary payers)
- Applicable to Non-Group Health Plan coverage (work comp, liability, no-fault) as well as GHP (group health plans)
- Sources:
  - 42 USC 1395y (Statute)
  - 42 CFR 411 (Regulations)
  - Also encompasses case law, policy memos, reference (WCMSA Reference Guide) and user guides
- Designed to protect an eroding Medicare trust fund

❶ Sec. 111 Reporting

❷ Conditional Payment Recovery

❸ Medicare Set Asides (MSAs)

Medicare Secondary Payer Compliance Components

Sec. 111 Reporting

1

- Medicare, Medicaid and SCHIP Extension Act of 2007
- Amendment to MSP statute to include electronic reporting requirement
- Insurance carriers and self-insureds, known as Responsible Reporting Entities (RREs), must report bodily injury claims with Medicare beneficiaries
  - Query Process (to determine eligibility)
  - ORM / ORM Termination
  - TPOC Events
- Purpose: Coordination of Benefits (COB), Recovery, and alerts Medicare to MSA
- Potential $1,000 per day, per claim, civil money penalty exists for non-compliance

Conditional Payment Recovery

2

- Payments made by Medicare, for treatment related to underlying injuries, during the pendency of the claim until the date of the settlement
- Medicare has the right to recover these payments
- The risk involves direct recovery (against the beneficiary, primary payer, claimant's attorney), interest accrual for overdue debt, collection by the U.S. Department of Treasury collection and Federal Court lawsuits for double-damages
- Recovery in workers' compensation may occur prior to a settlement once ORM is assumed

Medicare Set Asides (MSA)

3

- Any lump-sum workers' compensation settlement that includes ***future*** medicals must take into consideration Medicare's interests with respect to post-settlement medical expenses. The recommended method to protect Medicare's interests is an MSA.

- An MSA allocates funds in consideration of Medicare-covered treatment related to the industrial injury for the lifetime of the claimant

- If Medicare's interests are not taken into consideration, CMS indicates that it may:
  - Refuse to pay for industrially-related medical expenses
  - Disregard the settlement
  - Have right of recovery / subrogation

Medicare Set Aside (MSA) Focus

Regulatory Underpinnings

- 42 CFR 411.46 - Appeared in the Federal Register on October 11, 1989
- MSP Regulation under the subpart: “Limitations on Medicare Payment for Services Covered Under Workers’ Compensation”
- Distinguishes WC Settlements: Commutation of Benefits vs. Compromise
- “If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.” See 42 CFR 411.46 (a)
- “If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized.”
- Practical effect of the regulation

Patel Memo

- Issued on July 23, 2001
- **First instance where CMS codifies policy around MSAs. The foundational framework still exists nearly 20 years later.**
- Identifies regulatory authority (42 CFR 411.46)
- Distinguishes commutation vs. compromise settlements
- All memorandum have been supplanted by the WCMSA Reference Guide

Components of an MSA

1) **The Allocation**
   - Itemized listing of services, procedures and prescription drugs otherwise covered by Medicare related to the underlying industrial injuries

2) **The Funding Mechanism**
   - **Lump-Sum**
     - Beneficiary accepts single total payment. Medicare will not make payment until all funds are exhausted.
   - **Structured / Annuity**
     - Funding where payments are made to account on a defined schedule annually
     - Initial deposit ("seed money") is required to cover first surgical procedure/replacement and two years of annual payments
     - If fund is exhausted appropriately during annual period, Medicare will pay primary

3) **Method of Administration**
   - Administration of MSA funds from the interest-bearing account, including annual attestation and record-keeping
   - **Professional Administration**
     - When a company is appointed to administer the MSA
     - Per CMS, "it is highly recommended that settlement recipients consider the use of a professional administrator for their funds."
   - **Self-Administration**
     - When the beneficiary administers their own MSA

How the allocation is derived

- The MSA allocation is a written proposal indicating Medicare-covered items / services that are related to the work injury for the life of the claimant
- Latest two years of medical / treatment records are utilized
- Payment histories (medical, prescription and indemnity) for last two years are utilized (printed within six months of the date of submission). The Rx pay history must show dose and frequency of medications
- Court / legal documents
- Independent Medical Examination (IME) reports are not considered.
- Medications are priced at the Red Book Drug Reference Average Wholesale Price (AWP)
- MSAs are allocated on a case-by-case basis, but a wide range of resources and methodologies are utilized in calculating and costing anticipated treatment
- CMS has adopted a conservative methodology
- A Rated Age may be utilized for purposes of allocating a diminished life expectancy

Review

- CMS will voluntarily review an MSA proposal in the following circumstances:
  1) The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or
  2) The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount is greater than $250,000.00.
     - A claimant possesses a "reasonable expectation" if they are 62.5 years of age or older, have applied for SSDI, applied for SSDI and been denied but anticipate appealing the decision, are currently appealing an SSDI denial, or have ESRD but do not yet qualify for Medicare.
  - Development: following submission, if additional information is required, CMS will send a development letter requesting additional documentation or information
  - A decision will be rendered:
    - Approving the amount as proposed
    - Counter-Higher: requesting additional funds be set-aside
    - Counter-lower – allowing for less funds – but this currently a rare occurrence
  - Note on CWF flag for submitted MSAs

MSA Compliance Ramifications

- **Refusal to Pay** - Right to refuse to pay for certain expenses related to the workers' compensation injury post-settlement until the entire settlement is exhausted. WCMSA Reference Guide, Sec. 3.
- **Disregard of the Settlement** - If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. See 42 CFR 411.46(b)(2).
- **Right of Recovery** - Priority right of recovery against any entity that received a portion of the settlement payment. WCMSA Reference Guide, Sec. 3.
- **Subrogation** - Subrogation right with respect to any such payment. WCMSA Reference Guide, Sec. 3.

Additional Topics

- Denied Cases
  - Considerations for review
- Non-Submits
  - What are they?
  - CMS’ position

Professional Administration

Professional Administration

- “While an individual may administer their MSA, it is highly recommended to use a professional administrator.” WCMSA Reference Guide, Sec. 17.1
- In the instance where an individual is taking frequently abused drugs, it is highly recommended they use a professional administrator. Id.
- “[C]orporate entities administering [MSA] funds after settlement who are responsible for reporting to Medicare.” See Workers' Compensation Medicare Set Aside Portal (WCMSAP) User Guide, Chapter 2.2.

Requirements for Administration

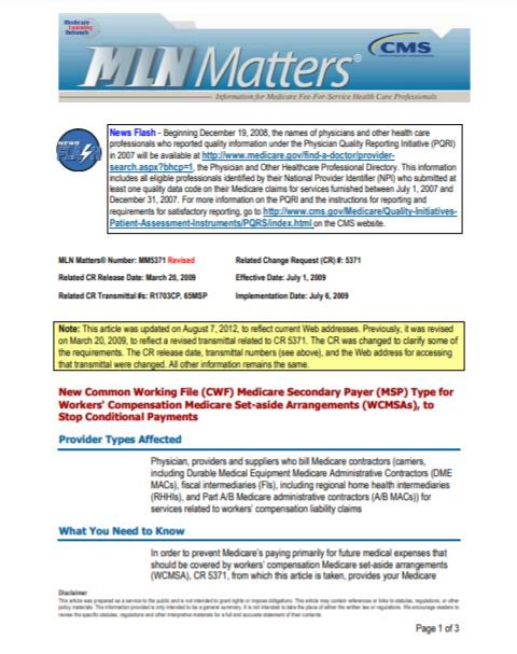
- Funds must be held in an account "separate from any other account such as personal savings or checking." WCMSA Reference Guide, Sec. 17.2.
- "It *must* be an account that earns interest and *should* be insured by the Federal Deposit Insurance Corporation (FDIC)." Self-Administration Toolkit, Sec. 2.
- "…ONLY use it to pay for medical treatment or prescription drugs related to your WC claim, and ONLY if the expense is for a treatment or prescription Medicare would cover. This is true even if you are not yet a Medicare beneficiary…" See Self-Admin Toolkit, Sec. 4 & WCMSA Reference Guide, Sec. 17.3

Requirements for Administration

- Other permissible uses for funds:
  - Cost of copying docs
  - Mailing fees/postage
  - Banking fees
  - Income tax on interest from account.

- Funds may NOT be used to pay for:
  - Fees for trustees, custodians, or other professionals hired to help administer the account
  - Expenses for administration of the WCMSA
  - Attorney costs for establishing the WCMSA
  - Medicare premiums, co-payments, and deductibles

Potential Denial of Benefits



MLN Matters® CMS

Information for Medicare Fee-For-Service Health Care Professionals

News Flash - Beginning December 19, 2008, the names of physicians and other health care professionals who reported quality information under the Physician Quality Reporting Initiative (PQRI) in 2007 will be available at http://www.medicare.gov/find-a-doctor/provider-search.aspx?bhcp=1, the Physician and Other Healthcare Professional Directory. This information includes all eligible professionals identified by their National Provider Identifier (NPI) who submitted at least one quality data code on their Medicare claims for services furnished between July 1, 2007 and December 31, 2007. For more information on the PQRI and the instructions for reporting and requirements for satisfactory reporting, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website.

MLN Matters® Number: MM5371 Revised — Related Change Request (CR) #: 5371

Related CR Release Date: March 20, 2009 — Effective Date: July 1, 2009

Related CR Transmittal #s: R1703CP, 65MSP — Implementation Date: July 6, 2009

Note: This article was updated on August 7, 2012, to reflect current Web addresses. Previously, it was revised on March 20, 2009, to reflect a revised transmittal related to CR 5371. The CR was changed to clarify some of the requirements. The CR release date, transmittal numbers (see above), and the Web address for accessing that transmittal were changed. All other information remains the same.

New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers' Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments

Provider Types Affected

Physician, providers and suppliers who bill Medicare contractors (carriers, including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services related to workers' compensation liability claims

What You Need to Know

In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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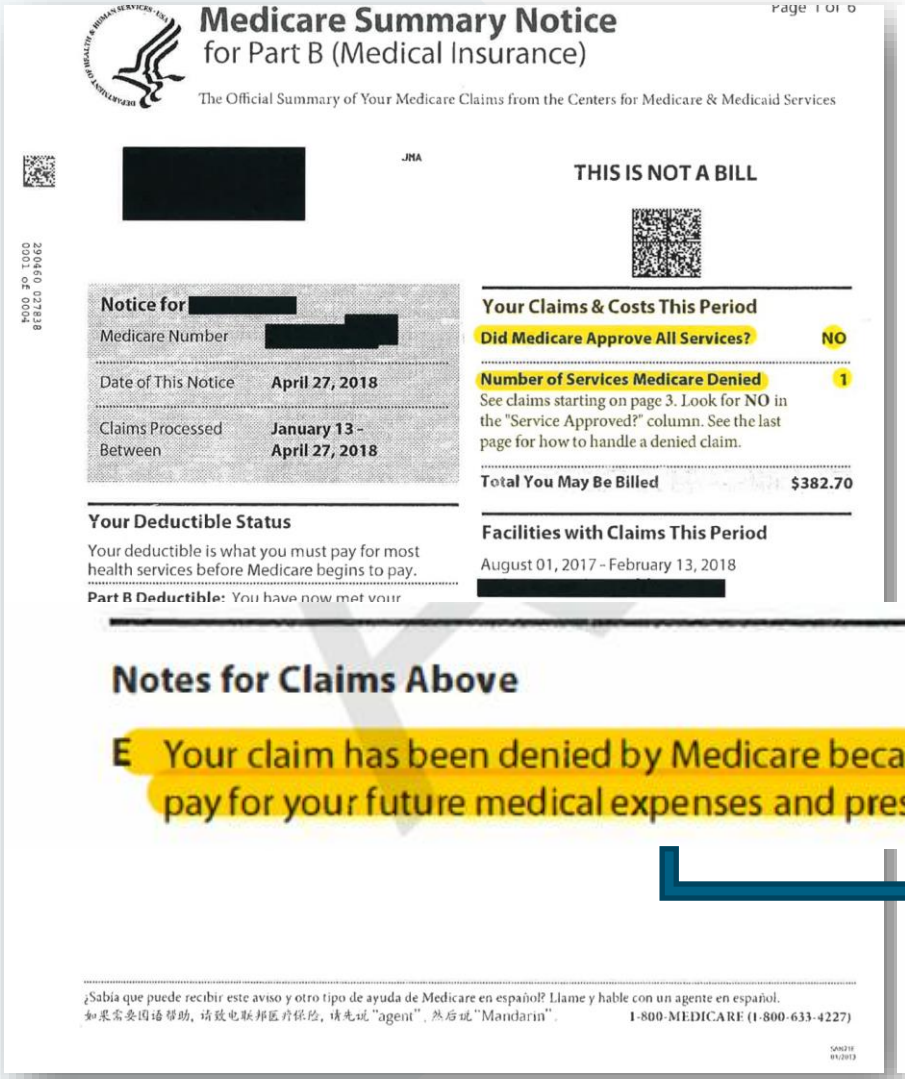
- "If payments from the WCMSA account are used to pay for services other than Medicare-allowable medical expenses related to medically necessary services and prescription drug expenses for the WC settled injury or illness, Medicare will deny all WC-injury-related claims until the WCMSA administrator can demonstrate appropriate use equal to the full amount of the WCMSA." WCMSA Reference Guide, Sec. 17.3

- Medicare is aware of approved WCMSA instances and Coordination of Benefits occurs by way of marker in the beneficiary's Common Working File (CWF).

Potential Denial of Benefits



Medicare Summary Notice
for Part B (Medical Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

[redacted] JMA

THIS IS NOT A BILL

Notice for [redacted]
Medicare Number [redacted]

Date of This Notice April 27, 2018

Claims Processed Between January 13 - April 27, 2018

Your Claims & Costs This Period

Did Medicare Approve All Services? NO

Number of Services Medicare Denied 1

See claims starting on page 3. Look for NO in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed $382.70

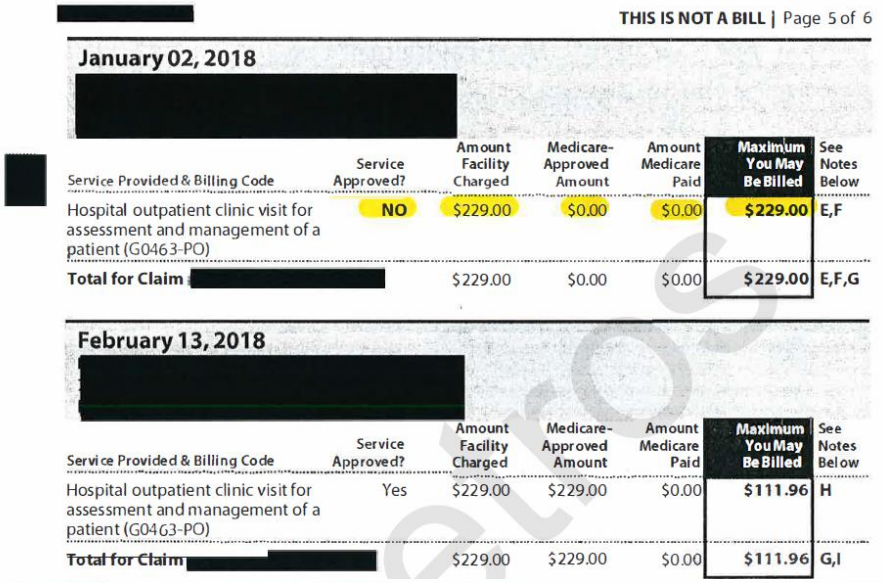
Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your

Facilities with Claims This Period

August 01, 2017 - February 13, 2018 [redacted]



[redacted] THIS IS NOT A BILL | Page 5 of 6

January 02, 2018 [redacted]

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G0463-PO)	NO	$229.00	$0.00	$0.00	$229.00	E,F
Total for Claim [redacted]		$229.00	$0.00	$0.00	$229.00	E,F,G

February 13, 2018 [redacted]

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G0463-PO)	Yes	$229.00	$229.00	$0.00	$111.96	H
Total for Claim [redacted]		$229.00	$229.00	$0.00	$111.96	G,I

Notes for Claims Above

E 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).

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要因语帮助，请致电联邦医疗保险，请先说"agent"，然后说"Mandarin"。 1-800-MEDICARE (1-800-633-4227)

E 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).

F Medicare does not pay for this item or service.

G The amount Medicare paid the provider for this claim is $0.00.

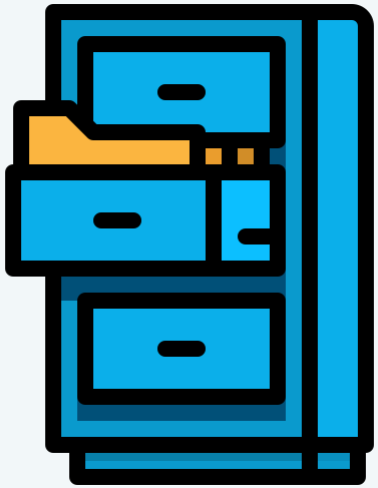
H $111.96 of this approved amount has been applied toward your deductible.

I This information is being sent to [redacted] Send any questions regarding your benefits to them.

Potential Denial of Benefits

Claim Data Category	2018	2019	2020	3 Year Average
WCMSA Denied Claims*	35,980	36,060	30,720	34,253
Total unpaid Claims (in Dollars)*	$19M	$14.3M	$11.8M	$15M
Individual Beneficiaries Affected	11,570	11,150	12,480	12,733
Average # of Denials per Beneficiary	5	5	6	5
Average Cost of Denied Claims	$1,729	$2,569	$2,830	$2,376

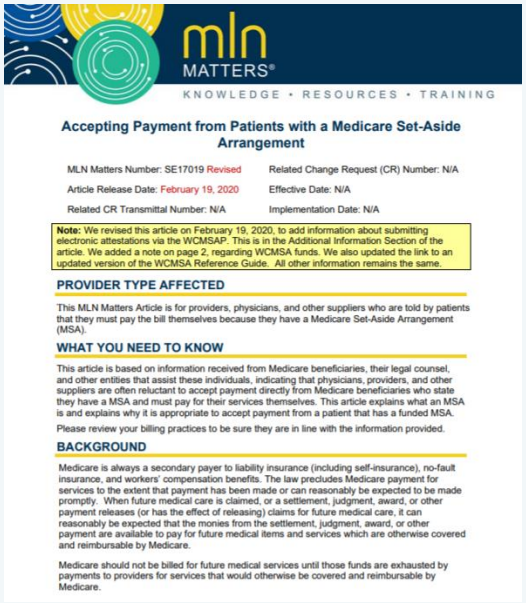
Record Keeping



- To validate funds are spent appropriately, Medicare suggests that the following records are retained for each transaction:
  - Transaction date
  - Check number (if any, or transaction number if present)
  - “Payable to” or health care provider name
  - Date of service
  - Description (procedure, service, or item received; deposit; interest; other allowable expense)
  - Amount paid

- Other records to be kept for possible review by Medicare are
  - Itemized receipts for each transaction
  - Bank statements
  - Tax records

Providers Accepting Payment



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Accepting Payment from Patients with a Medicare Set-Aside Arrangement

MLN Matters Number: SE17019 Revised | Related Change Request (CR) Number: N/A

Article Release Date: February 19, 2020 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

Note: We revised this article on February 19, 2020, to add information about submitting electronic attestations via the WCMSAP. This is in the Additional Information Section of the article. We added a note on page 2, regarding WCMSA funds. We also updated the link to an updated version of the WCMSA Reference Guide. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

WHAT YOU NEED TO KNOW

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what an MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

BACKGROUND

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

- Providers are not obligated to receive payment from an WCMSA account / professional administrator at a specific fee schedule or rate.
- Providers are set-up to accept insurance!
- Benefits of having a professional administrator.

Attestation

- Attestations must be sent to the Benefits Coordination & Recovery Center (BCRC) annually within 30 days of the anniversary of settlement
- Additional attestation reports must be provided if structured or lump sum account has permanently exhausted, or if structured account has temporarily depleted. Proper attestation is critical with annuitized MSAs.
- Annual attestation/signed statement to Medicare's Benefits Coordination & Recovery Center (BCRC) stating that funds have been used correctly. Includes:
    - Total spent for medical services
    - Total spent for prescription drugs
    - Grand total of expenditures
    - Total of interest income the account earned
    - Balance of WCMSA account at the end of the calendar year
- When funds are exhausted Medicare requires final attestation and Medicare will determine if they are satisfied that the right amount of money has been spent appropriately.
- Note on electronic attestation

Benefits

- Extends the life of the funds of the MSA through savings by leveraging medical network platforms. Realization of savings ensures the MSA fund is extended. Savings can occur in all spend categories, including prescriptions drugs, provider/hospital, durable medical equipment, and home healthcare.
- Coordinates care and billing with providers.
- It provides security to the settling parties that the funds will be spent in accordance with CMS guidelines, including attestation and communication with Medicare in the event there's an issue.
- The injured worker also has a resource in the professional administrator that they can turn to when they have questions and need assistance in coordination of care.

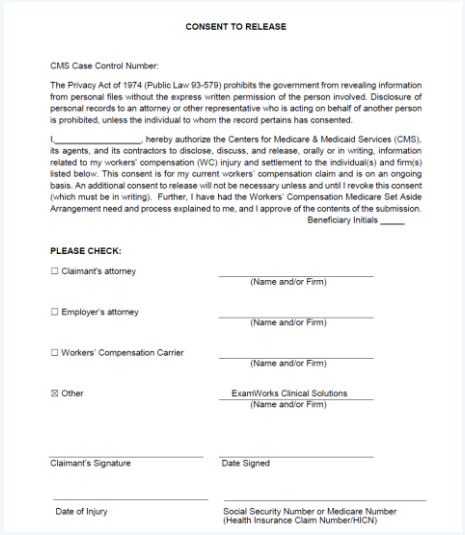
Upon Death of an Individual

- Frequently Asked Questions section from WCMSA decision letter, at #10, which indicates:
  - "What Happens to the WCMSA if I pass away before the money is used up? It depends on the terms of your settlement. If there are remaining funds in the WCMSA account, some settlement will allow your estate to retain the funds while others require the funds to be returned to the workers' compensation plan. CMS follows either the settlement agreement or your state's estate guidelines…"

- "Often, the settlement itself will dictate the appropriate dispersal of funds upon the death of the claimant and settlement of care-related expenses. This may involve holding the WCMSA open for some period after the date of death, as providers, physicians, and other suppliers are permitted to submit their initial bill to Medicare for a period of 12 months after the date of service." See WCMSA Reference Guide, v3.2, Sec. 19.2.

- With respect to where funds may pass upon the death of an individual is entirely up to the parties to a settlement.

CMS CTR



CONSENT TO RELEASE

CMS Case Control Number:

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I,_____, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents, and its contractors to disclose, discuss, and release, orally or in writing, information related to my workers' compensation (WC) injury and settlement to the individual(s) and firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release will not be necessary unless and until I revoke this consent (which must be in writing). Further, I have had the Workers' Compensation Medicare Set Aside Arrangement need and process explained to me, and I approve of the contents of the submission.

Beneficiary Initials ____

PLEASE CHECK:

☐ Claimant's attorney _____ (Name and/or Firm)

☐ Employer's attorney _____ (Name and/or Firm)

☐ Workers' Compensation Carrier _____ (Name and/or Firm)

☒ Other ExamWorks Clinical Solutions (Name and/or Firm)

_____ Claimant's Signature

_____ Date Signed

_____ Date of Injury

_____ Social Security Number or Medicare Number (Health Insurance Claim Number/HICN)

- As of April 1, 2020, CMS now requires an updated Consent to Release (CTR) form, including new language
- Requires language, "indicating that the beneficiary reviewed the submission package and understands the WCMSA intent, submission process, and associated administration." WCMSA Reference Guide, Sec. 10.2.
- This will place increased responsibility on claimant and their attorney

Professional Administration with Annuitized MSAs

- In the case of a Medicare Set Aside (MSA), it can "be established as a structured arrangement, where payments are made to the account on a defined schedule to cover expenses projected for future years." See WCMSA Reference Guide, Sec. 5.2. The first two years of the annual amount are included along with the first surgery and related costs (per body part), then followed by annual deposits.

- If funds for an MSA are temporarily exhausted in any given year, Medicare will pay for related expenses until the next annual payment. See Self-Administration Toolkit for Workers' Compensation Medicare Set-Aside Arrangements, Sec. 11.

- Benefits of Annuity / Structured Settlement

- Importance of attestation reporting

Utilizing Professional Administration When There's a Barrier to Settlement

Injured Worker is worried offer (including MSA) is too little to cover future medical care

Injured Worker is frustrated with prior approvals and utilization review

Injured Worker does not want to handle their future medical care – too complex

Injured Worker is concerned about MSA attestation reporting and losing their Medicare Benefits

Moral & Ethical Obligations

- The average amount of an MSA is approximately $100,000

- Is it the right thing to do to give an individual this amount of money:
  - With the risk they could lose their Medicare benefits?
  - With the expectation they can comply with complicated CMS obligations?
  - With the potential they're taking drugs that have the propensity for abuse / misuse?

Thank you!

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