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## **Region VI of CMS Issues “Handout” to Address Industry Concerns and Liability MSAs**

On May 25, 2011, Sally Stalcup, the MSP Regional Coordinator for Region VI of the Centers for Medicare & Medicaid Services (CMS), issued a “handout” in response to recurring questions her office has received, particularly surrounding whether Medicare Set-Asides (MSAs) are required. The handout is Ms. Stalcup’s attempt to provide clarification on several issues including the use of MSAs in liability settlements. For a copy of the handout, [click here](#). Let us examine the handout’s key sections.

As an initial matter, Ms. Stalcup’s handout is simply her opinion as a Regional Administrator for CMS in Oklahoma, Texas, New Mexico, Louisiana and Arkansas. It is not meant to replace any laws or regulations and should not be considered a CMS official statement of policy.

Right off the bat, Ms. Stalcup provides two key points – [f]irst, that “the law does not require a “set-aside in any situation” and second, that CMS’ “method of choice” is the set-aside, and the agency feels it “provides the best protection for the program and the Medicare beneficiary.”

To the extent that some individuals believe MSAs are “required by law,” Ms. Stalcup’s first two points should clear up this confusion. However, what is less clear, and is discussed in two and a half pages of a three-page handout, is how concerned parties should protect their interests in attempting to obtain approval that a settlement has, in fact, sufficiently protected Medicare’s interest. Unfortunately, the answer to this question is not provided.

Ms. Stalcup’s handout does acknowledge that under existing law, Medicare shall not be billed for future services until settlement funds are exhausted by payments to providers for services that would otherwise be covered and reimbursed by Medicare.

If a set-aside of some kind is not used, how would a claimant’s future Medicare benefits be protected from some future claim challenging the use of these funds? This is not answered and as Ms. Stalcup suggests, there is no statutory solution to this question. If the parties attempt to set aside funds for future Medicare benefits, but arbitrarily designate a specific amount to be set aside, what analysis would CMS use to determine if Medicare’s interests have been met? CMS has not opined on this issue either.



Ms. Stalcup further states that Medicare payment for services is precluded, to the extent that payment has been made or can reasonably be expected to be made promptly under workers' compensation and liability insurance. She highlights the phrase "reasonably expected" by stating that "[a]nytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment or award." This statement appears to be a reference to CMS' policy concerning a primary payer's payments made on potentially disputed claims and CMS' position that once payment is made, the primary payer assumes continual payment responsibility even if it is later determined that the payer is not legally responsible for such payment.

Reviewing Ms. Stalcup's discussion of liability MSAs, she states that "...[t]here is no formal CMS review process in the liability arena as there is for Worker[s]' Compensation. However, CMS does expect the funds to be exhausted on otherwise Medicare covered and otherwise reimbursable services related to what was claimed and/or released before Medicare is ever billed. CMS review is decided on a case by case basis."

In essence, what Ms. Stalcup is saying is that a liability MSA is not required, but as stated previously, if one is not established in a settlement that forecloses future medicals, Medicare will require the entire settlement amount be exhausted before Medicare will pay for any expenses related to the injury. This is something we have known all along as well; yet, the liability industry remains resistant to accepting the fact that jeopardizing a plaintiff's Medicare benefits by not providing an MSA could result in a malpractice lawsuit against the plaintiff's attorney or perhaps a bad faith action against the carrier.

Ms. Stalcup states that with each settlement, "[e]ach attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds." Unfortunately, it is not quite that simple in reality. The parties to a settlement might not elect to establish an MSA, and will include statements to the plaintiff within the settlement documents surrounding the repercussions of not establishing an MSA, but does the plaintiff really understand that they will have to spend their entire settlement before they will get Medicare coverage related to their injury again? Do they really understand that their Medicare benefits will be cut off? On the other hand, if the parties to a settlement include an MSA as part of their settlement, and the cost of future medicals exceeds the settlement amount, what are the parties to do then? CMS has not provided guidance on this issue nor provided a framework for which MSAs would work from a practical standpoint in liability settlements.



While the handout leaves many questions unanswered, the industry is appreciative of some guidance from Ms. Stalcup and hopes to see more CMS communications that address the industry's concerns.

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