Medicare Claims, Medicaid Liens, Medicare Set-Aside Issues: What Every SNT Attorney and Trustee Needs To Know

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Medicare Claim – Medicaid Lien

- Both Medicaid and Medicare provide for liens or claims to be asserted when either Medicaid or Medicare has made a payment for services that can reasonably be expected to be made by a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no fault insurance. Medicaid's right to recover (commonly called a "lien") is governed primarily by state law. Medicare right to recover is called a claim, not a lien, and is governed solely by federal law. Medicare's claim to recover supersedes any state law right of recovery, including that of the state Medicaid program.

Subrogation

- For Medicare and Medicaid purposes, subrogation and lien issues occur when an individual receiving Medicare or Medicaid benefits is injured by a third party and Medicare or Medicaid has paid the injured party's medical expenses related to the injury prior to settlement of the lawsuit. If the injured party receives a damage award or settlement to compensate them for injuries, federal and state law require that the injured party reimburse Medicare and Medicaid from the proceeds of the damage award.

Trust Payback vs. Lien/Claim

- A Medicaid lien or Medicare claim issue should not be confused with the statutory payback provision of a first party special needs trust.

- The payback provision of a first party special needs trust requires the state to "receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total 'medical assistance' paid on behalf of the individual under a State plan under this subchapter." This requires that the state be reimbursed out of any funds remaining in trust at the termination of the trust up to the amount of medical benefits paid on the beneficiary's behalf. If the amount of the trust corpus is insufficient to reimburse the entire balance paid on behalf of the individual, then the state takes the balance of the trust corpus and absorbs the other costs.

- Medicaid lien and Medicare subrogation claim issues arise prior to the funding of the first party special needs trust in the context of a third party liability settlement. The Medicaid lien must be resolved prior to funding the special needs trust.

MEDICAID LIEN

- Federal Medicaid law requires that participating States "ascertain the legal liability of third parties ... to pay for [a beneficiary's] care and services available under the [State's] plan," to "seek reimbursement for [medical] assistance to the extent of such legal liability," to enact "laws under which, to the extent that payment has been made ... for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services," and to "provide that, as a condition of [Medicaid] eligibility ..., the individual is required ... (A) to assign the State any rights ... to payment for medical care from any third party; ... (B) to cooperate with the State ... in obtaining [such] payments ... and ... (c) ... in identifying, and providing information to assist the State in pursuing, any third party who may be liable.

Arkansas Department of Health and Human Services v. Ahlborn,

- Heidi Ahlborn was a 19-year-old college student when she was involved in a serious automobile accident on January 2, 1996, that left her severely and permanently disabled. The accident was not her fault, and she eventually filed a State court suit against the tortfeasor. In the meantime, she applied for and was given financial assistance under the Arkansas Medicaid program which had paid medical expenses of $216,645.30 as of the date of the settlement of her personal injury action.

- In the lawsuit, she claimed a number of items of unliquidated damage compensable in a personal injury suit under local law: (a) permanent injury; (b) past and future medical expenses; (c) past and future pain, suffering and mental anguish; (d) past loss of earnings and working time; and (e) permanent impairment of ability to earn in the future. The case eventually settled out of court with the defendant carrier paying $525,000 and her own underinsured motorist carrier paying $25,000. In the settlement, there was no allocation between the various elements of damage claimed in the suit.

Ahlborn

- The State's Medicaid program asserted a "lien or claim" on $215,645.30 of the settlement proceeds.
- The position of the State Medicaid agency was that it was entitled to be reimbursed the full amount of its claim from the settlement. Ms. Ahlborn's position was that the settlement was less than the full amount of her damages and that the State's reimbursement should be limited to the proportion based on the value of its claim to the whole recovery.

Ahlborn

- Both parties confirmed the underinsured carrier's conclusion that Ms. Ahlborn had suffered damages well in excess of the settlement from the tortfeasor's insurance, stipulating that an estimate of her claim as liquidated would be roughly $3,040,708.12.
- Thus, her recovery based on this settlement was approximately one-sixth of her actual damages, and the U. S. Supreme Court held that the State Medicaid agency would be limited to recovering one-sixth of its claim, or $35,581.47. The opinions at the trial, appellate and Supreme court levels made no distinction as to the source of her recovery, whether from her own car's underinsured carrier or from the tortfeasor's carrier.

Ahlborn

- The Court held that federal third-party liability provisions require an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.
- There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

CMS Response

- Roughly two months after the Supreme Court's Ahlborn decision was announced, the Centers for Medicare and Medicaid Services (CMS) published a memorandum "to clarify third party rules and options for States in the context" of *Ahlborn*. It characterized *Ahlborn* as: "A State's lien laws may only operate to recover from that portion of a settlement that is allocated to healthcare items or services, even if it means that Medicaid must forego full recovery of its claim

CMS Response (continued)

- The memorandum suggested two political strategies to avoid *Ahlborn's* requirement of proportional reimbursement. First, states could enact laws which provide for a specific allocation among damage items, i.e., pain and suffering, lost wages, and medical claims. Second, "[a]ccording to *Ahlborn*, federal Medicaid anti-lien law precludes the State from passing lien laws which broaden the recovery rights of the state Medicaid agency. Note, however, that the State may pass other laws which give it a priority right of recovery in tort actions.

CMS Response (continued)

- In addition to advising the States how to avoid the limitations on reimbursement to their programs under *Ahlborn*, the Agency also recommended processes to mitigate the adverse consequences of Ahlborn. These included measures designed to involve the State in the litigation process itself, presumably to maximize the "past medical expense" component of any damage award, such as laws which mandate formal joinder of a state when a Medicaid lien is at issue, requiring notice and cooperation from personal injury attorneys, and requiring state consent to any compromise involving medical expenses.

Know Your State Law

What will the future hold for injured parties and attorneys advising them? Although Edmund Burke once wrote "You can never plan the future by the past," it can reliably be predicted that States will attempt to fashion recovery plans that maximize their perceived share of injured parties' recoveries.

Medicare Secondary Payer (MSP)
vs.
Medicare Set Aside (MSA)

- Do NOT confuse Medicare Secondary Payer (MSP) rules with Medicare Set Aside Arrangements (MSA).
- Medicare Secondary Payer (MSP): Prior conditional payments made by Medicare that must be reimbursed from the settlement. Medicare is a secondary payer under the MSP regulation. A primary payer would include group health plans, liability insurance, non-fault insurance, self-insured plan. COB office.
- Medicare Set Aside (MSA) deals with future medical expenses that relate to the injury.

Medicare Secondary Payer Statute

The Medicare Secondary Payer ("MSP") statute was created by the Omnibus Budget Reconciliation Act of 1980. The purpose of the MSP statute was to ensure that Medicare was only *secondarily* responsible for paying the medical expenses of individuals covered by Medicare if they also were covered by another type of private insurance. On several occasions after its enactment, Congress expanded the reach of the MSP statute. Medicare is now secondary for a larger class of Medicare beneficiaries who have other primary sources of insurance coverage.

Primary and Secondary Payers

- Medicare serves as the back-up medical insurance plan to an injured party who cannot receive payment from a primary insurance plan. In other words, the insurance company or other responsible party remains the primary payer. As secondary payer, medical benefits are payable by Medicare only to the extent that payment has not been made and cannot reasonably be expected to be made under coverage by the primary payer. Any secondary payment made by Medicare is considered a "conditional payment" subject to reimbursement.

- If the Medicare recipient is not covered under a primary plan of insurance, the reimbursement provisions of the MSP statute are not triggered. In this situation, Medicare remains the primary medical plan.

Coordination of Benefits Office

- Questions regarding the existence of any conditional payments made by Medicare should be directed to CMS's Coordination of Benefits ("COB") Contractor. The COB Contractor will require the beneficiary's name, Medicare or Social Security number, date of the incident, nature of the injury, and name and address of the other insurance. The COB Contractor will send a "Medicare right of recovery" letter and "release of information" form for the beneficiary's signature. The COB Contractor will create a Medicare secondary payer record in the CMS database for the Medicare beneficiary.

- Under 42 C.F.R. § 411.25(a) and (b), if a third-party payer learns that Medicare has made a payment for an injured worker's medical expenses, it must notify Medicare. Nonetheless, due to the potential loss of benefits to the Medicare beneficiary and the potential liability to the attorney, counsel for the Medicare beneficiary should take the lead and contact the CMS's Coordination of Benefits ("COB") Contractor. More information about the COB can be found online at http://www.cms.gov/medicare/cob.

Medicare Claim Procurement Costs

- The amount Medicare recovers is reduced by a proportionate share of the necessary procurement costs incurred in obtaining the settlement. Procurement costs include the claimant's expenses in the underlying lawsuit, such as expert witness fees, court costs, and attorney fees.

Medicare's Enforcement Rights

- ***Direct Right of Recovery:*** Medicare may pursue a direct right of recovery against any or all entities that are or were required or responsible (directly, an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan of insurance.

- A third-party payer's obligation to reimburse Medicare for such claim continues even if the third-party payer has already reimbursed the beneficiary or other party. In short, the government can make the third-party payer pay twice.

- ***Double Damages:*** The government also may collect double damages against any such entity that fails to reimburse Medicare. Under the Medicare Act of 2003, the list of entities against which the government may assert double damages is expanded to include all entities responsible for making a payment under a "primary plan" of insurance. A primary plan of insurance includes any entity that has made a payment conditioned on the recipient's compromise, waiver, or release (regardless of whether there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

Direct Cause of Action

- In addition to the action against a "primary plan," the government may pursue a direct cause of action against "any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to an entity." **An entity that receives a third-party payment includes a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer. 42 C.F.R. § 411.24(g).**

- Although a Medicare beneficiary has an affirmative duty to file a workers' compensation claim, there is no such affirmative duty for a Medicare beneficiary to attempt to collect damages against a liability insurance carrier or defendant. 42 C.F.R. § 411.24(k)(1) and (2). If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a third-party payer, and Medicare is unable to recover from the third-party payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

- Exceptions: This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary." If a claim is filed by a Medicare beneficiary against a liability insurance carrier, under 42 C.F.R. § 411.23, CMS may pursue a direct action against the Medicare beneficiary if CMS is unsuccessful in collecting because the beneficiary did not cooperate with CMS in the collection proceedings.

Unless You Want to be Named in the Lawsuit – Resolve the MSP Claim

- On December 1, 2009, the US Department of Justice, on behalf of the Secretary of Health and Human Services, filed a civil action to recover conditional payments that were made to approximately 907 Medicare beneficiaries involved in a $300,000,000 class action liability lawsuit named the Abernathy Settlement. Defendants include plaintiff attorneys, Travelers Indemnity Company, AIG, Monsanto Company, Pharmacia Corporation, and Solutia, Inc. The suit alleges that the defendants had an obligation under 42 CFR §411.25 to notify Medicare of any settlement, judgment, award or other payment that was made when the case was resolved, and to reimburse Medicare for these conditional payments at the time of settlement, but failed to do so. It also claims that it does not matter that these defendants paid out the settlement proceeds, as 42 CFR §411.24(i) allows Medicare to seek payment from the liability insurance carrier regardless of whether payment has already been made to the Medicare beneficiary. The US is seeking reimbursement of these funds along with double damages plus interest.

- *United States vs. Stricker*, Federal Dist. Court Northern Alabama, CV-09-PT-2423.
- *United States v. Harris*, Civil Action No. 5:08CV102, N.D. West Virginia

Medicare Set Asides – A Little History

- Federal Law provides Medicare which is administered through the Center for Medicare Services (CMS), expansive rights with regard to claimants who are, or will become eligible for Medicare benefits. The Medicare Secondary Payer (MSP) statute 42 U.S.C §1395y, and regulations 42 C.F.R §411.20 *et. seq.* make Medicare a secondary payer for any medical services for which payments have been made, or can reasonably be expected to be made promptly under a workers' compensation (WC) law or insurance plan.

More History

- Despite its passage in 1980, the MSP statute was seldom followed by insurance companies and until recently, it was rarely enforced by CMS.

- Medicare Prescription Drug, Improvement and Modernization Act of 2003 expanded Medicare's recovery and enforcement powers and amended the MSP statute.

CMS Solution

- On July 23, 2001, the Central Office of CMS issued written guidelines on the application of the MSP regulations to WC cases. The July 23, 2001 memo has been supplemented thirteen times with the last memo issued in 2010. A copy of all thirteen memos can be found at: http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.

Safe Harbor for WC Settlements

- The various memos issued by CMS explain the use of a Medicare Set-Aside (MSA) arrangement to prevent Medicare from making payments for medical expenses related to the "work related" injury when a primary payor has already made payment intended to cover future medical expenses.

- With a MSA arrangement, a portion of the settlement is set-aside and applied to future medical expenses which would otherwise be covered by Medicare. Only after this amount has been spent will Medicare begin to pay for medical care related to the injury.

- CMS developed a specific set of criteria for WC cases to receive pre-approval of the MSA amount.

- MSA arrangements have become standard practice for addressing Medicare's interest in a WC settlement even though there is no case law or statutory authority to require a MSA.

- The MSA memos are considered a "safe harbor" process for WC settlements where future medical expenses are being settled by the carrier. Medicare's pre-approval of a WC settlement and set aside calculation eliminates the risk of a future denial of Medicare benefits, and assures the parties that Medicare's interests have been "reasonably considered."

Calculating the Set Aside Amount in a WC case

In WC cases, CMS uses the following criteria to determine if the proposed set-aside amount is reasonable:

- Date of Medicare entitlement
- Basis of Medicare entitlement
- Type and severity of injury or illness
- The Beneficiary's rated age and life expectancy
- Permanent partial or permanent total disability
- Prior medical expenses
- Amount of settlement allocated to indemnity and future medical expenses
- Whether commutation is for claimant's full life expectancy
- Prescription drug costs

CMS will require additional documentation in support of the proposed set-aside amount. Documentation will include settlement agreements, life care plan, rated age, and medical records. The plan will be submitted to the CMS Regional office for review and approval. Once approved, Medicare will not make any payments for medical expenses associated with the claimant's injury until the set-aside amount is exhausted.

SCHIP HAPPENS!!!

Why All the Concern About MSAs for PI Cases Now?

- Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) amended the Medicare Secondary Payer (MSP) provisions of the Social Security Act (Section 1862(b) of the Social Security Act; 42 U.S.C. 1395y(b)) to provide for mandatory reporting for group health plan arrangements, liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

The New MMSEA Statute Says Nothing About MSAs

- Despite considerable urban legend to the contrary, the MMSEA statute does not contain any new guidance or requirements related to MSAs.
- The MMSEA statute requires Responsible Reporting Entities (RREs) to report certain information regarding settlements with Medicare beneficiaries to the Secretary of Health and Human Services. **The sole purpose of Section 111 of the MMSEA is to ensure that settling parties fully comply with the Medicare Secondary Payer requirement** – that is, **past** Medicare payments must be verified and resolved in all liability, workers' compensation and no-fault settlements.
- Fines and penalties for not reporting.
- This new law (to date) has nothing to do with identifying Medicare-covered future costs of care, which leads to MSA issues and analysis. At the same time, the fact that the MMSEA statute says nothing about MSA rules for PI cases is not legal authority for the proposition that a MSA is not required in a PI case.
- Some commentators believe that CMS will eventually use this information to determine if future injury related medical expenses are being paid by Medicare. Prior to MMSEA, CMS could not track these cases.

Medicare Set Aside in Personal Injury Cases

- Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. **Anytime a settlement, judgment or award provides funds for future medical services**, it can reasonably be expected that those funds are available to pay for Medicare covered future services **related to what was claimed and/or released in the settlement, judgment, or award.** Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered by Medicare. Sally Stalcup, Region 6, MSP Regional Coordinator, UTSNT 2007 Conference, *Medicare Set- Asides*, February 2007.

Medicare Set-Asides - - -

(CMS) uses the phrase "case related" because they consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare's right of recovery, and the prohibition from billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) of the Social Security Act.

Medicare Set-Asides - - - Cont.

- While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, we are frequently asked how one would 'know.' Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any otherwise Medicare covered, case related future medical services:
  - Does the case involve a catastrophic injury or illness?
  - Is there a Life Care Plan or similar document?
  - Does the case involve any aspect of Workers' Compensation?

This list is by no means all inclusive.

When Do You Need to Consider using a MSA

- Triage your liability cases and determine which cases have a potentail MSA issue:
- Is the plaintiff currently receiving Medicare or is there a "reasonable expectation" that the plaintiff will receive Medicare within 30 months? A reasonable expectation of Medicare eligibility will occur if any of the following situations apply:
  - (a) The individual has applied for Social Security Disability Benefits;
  - (b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
  - (c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
  - (d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
  - (e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.
- If a workers compensation claim is being settled in a third party liability case.

No MSA Required When

1. Currently, not a Medicare beneficiary or likely to be a Medicare beneficiary within the next 30 months, then no MSA issue.

2 30 If the claimant will be a Medicare beneficiary in the next months and the total settlement is less than $250,000, then CMS does not require the set aside be submitted for approval. Still must consider Medicare's interest, but do not need to submit to CMS for approval. For a current Medicare beneficiary, total settlement must be less than $25,000 before no submittal is necessary.

3 Medicare set aside issues do not apply to Medicaid beneficiaries.

4. Damages are not being paid for a personal injury claim.

Medicare Set-Aside Options

- Medicare Set-Aside Trusts (MSATS)
  - Formal Trust with Trustee
  - Fiduciary rules apply
  - Trustee may hire third party administrator
  - Usually for large accounts or used in combination with SNT
- Medicare Set-Aside Custodial Accounts
  - Administered by Custodian
  - Less formal, smaller accounts
- Self-administered accounts
  - Administered by Claimant, no agreement necessary
  - Same accounting rules apply
  - Most claimants will not comply

Working with MSAs

- Usually funded with a qualified structured annuity with initial seed money;
- Usually administered by a third party administrator;
- For the life of the beneficiary;
- Used to pay Medical expenses related to the injury that Medicare would reimburse;
- Must include prescription drug coverage;
- Must provide accountings to CMS;
- Cannot pay fees and cost to establish the MSA from set aside amount.
- MSA is a countable resource for Medicaid/SSI purposes. If Medicaid/SSI eligibility is required, the MSA must be administered as a subtrust of SNT.

Funding a MSA

- A Medicare Set-aside Arrangement can be established as a structured arrangement, where payments are made to the arrangement on a defined schedule to cover expenses projected for future years. In a structured Medicare set-aside arrangement, monies are apportioned over fixed or definite periods of time. In such cases, Medicare will not agree to cover the beneficiary if there is no verification that the funds apportioned in the arrangement have been exhausted. Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the Medicare set-aside arrangement.

Calculating Seed Money

- (1) The seed money for the Medicare Set-aside Arrangement must include an amount equal to the amount of monies calculated to cover the first surgery procedure and/or replacement and two years of annual payments.
- (2) The remainder of the approved amount should be divided by the remainder of the claimant's life expectancy (or a shorter defined period of time if CMS has agreed to a shorter time period).
- (3) Subsequent annual deposits into the Medicare Set-aside Arrangement are to be based upon a set "anniversary date" which cannot be more than one year after the settlement date. In a structured Medicare set-aside arrangement, if funds are not exhausted during a given period, then the excess funds must be carried forward to the next period. The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.
- **Example:** A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2009 the injured individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2010. Therefore, in 2010 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2010. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

Set Aside Example

Calculating Seed Money for MSA's				
Claimant: John Doe				
Step 1	Total estimated future medical services covered by Medicare			$ 199,130.04
Step 2	Identify cost of first surgery and first procedure/replacement			$ -
Step 3	Subtract Step 2 from Step 1			$ 199,130.04
Step 4	Divide above by Life Expectancy to get annual costs	LE	44	$ 4,525.68
	Multiply annual costs by 2		2	$ 9,051.37
Step 5	Seed money to be deposited upon settlement is equal to the sum of Steps 2 and 4			$ 9,051.37
Step 6	Subtract seed money from total Set Aside Amount (Step 1) and divide by life expectancy minus 1 to calculate minimal annual deposit for the balance of claimant's life.			$ 190,078.67
	Life Expectancy – 1	1	43	$ 4,420.43
Total Seed Money				**$ 9,051.37**
Annual Deposits				**$ 4,420.43**

Funding a MSA

- **Example:** A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2009 the injured individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2010. Therefore, in 2010 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2010. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

MSA Administration Fees

- Administrative fees/expenses for administration of the MSA and/or attorney costs specifically associated with establishing the MSA cannot be charged to the set-aside arrangement. The CMS will no longer be evaluating the reasonableness of any of these costs because the payment of these costs must come from some other payment source that is completely separate from the MSA funds.
- Since the cost to administer the MSA cannot be paid from the MSA account, a separate structured annuity is purchased to fund annual administration fees.

MSA Administration Rules

- A MSA should be placed in an interest bearing account. MSAs should also be administered by a competent administrator (the representative payee, a professional administrator, etc.). When a claimant designates a representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties must include that information in their Medicare set-aside arrangement proposal to CMS.**(Ref: 10/15/04 Memo Q2)**

- In addition, the claimant may self-administer his or her own MSA, if permitted under State law. Claimant should submit an annual self-attestation form when monies have been exhausted. **(Ref:4/21/03 Memo Q8)**

- In professional administrative situations, the administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the CMS Medicare contractor responsible for monitoring the individual's case. Additionally, the Medicare contractor is responsible for verifying that no payments from Medicare are made for medical expenses related to the injury or illness/disease until the MSA is exhausted