MEDICARE COMPLIANCE AND GOVERNMENT BENEFITS PLANNING: THE ELEPHANTS AT THE MEDIATION TABLE

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I. THE FIRST STEP – YOUR ETHICAL OBLIGATIONS

A. Model Rule 1.4, which states, “[a] lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation” and “shall reasonably consult with the client about the means by which the client’s objectives are to be accomplished.”

B. The constructive or actual receipt of money from a judgment, settlement or verdict by a client may eliminate or complicate that individual’s eligibility for government benefits.

- It is imperative that a client be informed about their eligibility for government benefits and how the receipt of settlement money may impact their eligibility in the future for certain government benefits.

C. Model Rule 1.3 supports client counseling on government benefits when it speaks to “diligence” in handling an interest of the client that can be adversely affected by the passage of time.

- A client’s eligibility for government benefits should be verified at the beginning of representation in order to provide the attorney and the client to fully evaluate the benefits of proceeding with the

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litigation and what steps must be taken to properly protect those benefits should a judgment, settlement or verdict be obtained.

II. MEDICARE COMPLIANCE

A. The Medicare Secondary Payer Act (“MSP”)

Enacted in 1980 and provides, “section 1862(b)(2)(A)(ii) of the act precludes Medicare payment for services to the extent that payment has been made or can be reasonably expected to be made promptly under any of the following:

1. Workers’ compensation.
2. Liability insurance.
3. No-fault insurance.

B. 42 USC §1395y(b)(2): A primary plan or insurer’s responsibility for such payment may be demonstrated by:

1. A judgment; or
2. A payment conditioned upon the recipient’s compromise, waiver, or release of payment for items or services included in a claim against the primary plan or the primary plan’s insured.

C. When a Medicare beneficiary is injured and subsequent medical services are required, Medicare is prohibited from making payment for such medical care or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan).\(^1\)

D. This prohibition is suspended if the liability insurance plan has not made or cannot reasonably be expected to make payment promptly.\(^2\) If liability payment has not been made or cannot reasonably be expected to be made promptly, Medicare may make payment but it is made conditioned upon reimbursement once a final payment is made from the liability carrier.

- This Medicare payment is called the conditional payment and represents Medicare’s claim for recovery against the liability settlement proceeds. The total conditional payment value for litigation purposes is the amount paid by Medicare for injury related

\(^1\) 42 USC §§1395y(b)(2)(A) and (B)

\(^2\) 42 USC §§1395y(b)(2)(A) and (B)
medical care received between the time of injury and the time of settlement.

E. Upon the final resolution of the litigated matter, Medicare’s claim must be resolved or several parties run the risk being found liable for failing to properly protect Medicare’s interest. This potential liability can be found at 42 CFR §411.24 and §411.26. Together these two regulations provide Medicare with the requisite authority to seek reimbursement of their conditional payment interest from either the party making a settlement payment or any party who receives said payment.

III. MEDICARE CLAIM RESOLUTION PROCEDURE

A. Immediately notify the COBC of your representation by submitting the following:

1. Your client’s name and address.
2. DOB.
3. SSN.
4. Medicare number.
5. Date of incident.
6. Type of incident.

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3 U.S. vs. Stricker, 2010 WL 6599489 (N.D.Ala. Sep. 30, 2010). The government filed a lawsuit against various law firms representing claimants, underlying corporate defendants, and insurers. The government alleged that at the time of settlement its interests were not adequately protected as proper attention was not given to whether the settling claimants were Medicare beneficiaries [907 of the claimants were]: (1) government sought reimbursement for conditional payments, double damages; (2) Court ruled on September 30, 2010; and (3) found that the claims against the corporate defendants were barred due to the expiration of the three year statute of limitations passing and against the attorneys due to the expiration of the six year statute of limitations.

4 42 C.F.R. §411.24(e): Recovery from third parties. HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan or program, and a third party administrator.

5 42 C.F.R. §411.24(g): Recovery from parties that receive third party payments. HCFA has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

8. Your full name, address and phone number.

9. Defense counsel’s name, address and phone number.

B. This information should be sent to:

Medicare (COBC)
MSP Claims Investigation Project
PO Box 33847
Detroit, MI 48232
(800) 999-1118

C. Once the COBC possess this information, they will assign your case to the MSPRC. Once the assignment is made, then all future written correspondence should be made to the MSPRC.

D. Contacting the MSPRC

1. By telephone: For your convenience, please have HICN/ Medicare Number when calling.

MSPRC Main Number: 1-866-MSPRC-20 or 1-866-677-7220
Monday-Friday, 8:00 a.m.-8:00 p.m., eastern time
TTY/TDD Number for the Hearing and Speech Impaired: 1-866-677-7294

2. By mail.

   a. Group Health Plan (GHP) Inquiries and Checks (e.g. all GHP checks and inquiries including Congressional, FOIA, Bankruptcy and QIC/ALJ).

      MSPRC – GHP
      P.O. Box 138856
      Oklahoma City, OK 73113

   b. Non-Group Health Plan (NGHP) Inquiries and Checks (e.g. all NGHP checks and inquiries including Liability, No-Fault, Workers Compensation, Congressional, FOIA, Bankruptcy, Liquidation Notices and QIC/ALJ).

      MSPRC – NGHP
      P.O. Box 138832
      Oklahoma City, OK 73113

   c. Special Projects (e.g. all Product Liability Case Inquiries and Special Project Checks).

      MSPRC - Special Projects
      P.O. Box 138868
      Oklahoma City, OK 73113
d. Fixed Percentage Option (this address should be used when electing the Fixed Percentage option).

MSPRC - Fixed Percentage Option
P.O. Box 138880
Oklahoma City, OK 73113

e. Self-Calculated Conditional Payment Amount Option (this address should be used when electing the Self-Calculated Conditional Payment Amount option).

MSPRC - Self-Calculated Conditional Payment Amount Option
P.O. Box 138880
Oklahoma City, OK 73113

E. The MSPRC will provide you with a conditional payment summary within sixty to ninety days. Please be sure to review this document for any unrelated expenses.

F. Once you notify the MSPRC of the final settlement you will then receive a Final Demand notice from the MSPRC which you have sixty days to satisfy.

G. 42 CFR 411.37: Medicare reduces its recovery to take into account the cost of procuring (attorneys’ fees/expenses) the judgment or settlement.

H. If Medicare’s lien is larger than the settlement: Medicare will take the full settlement, less the total procurement costs, unless a court allocates the judgment to which Medicare will only recover from those monies allocated to medical expenses.

I. Medicare may grant a full or partial waiver of its recovery amount with respect to the beneficiary under two options:

1. Waiver Section 1870(c) – Financial Hardship; and

2. Waiver Section 1862(b) – “in the best interest of Medicare”

IV. CASE LAW AS TO THE RESOLUTION OF CONDITIONAL PAYMENTS

A. Please see attachment 1 to this outline for an article addressing the decisions in both Hadden v. United States, 661 F.3d 298 (6th Cir. 2011) and Bradley v. Sebelius, 621 F.3d 1330 (11th Cir. 2010).

B. Takeaway: CMS only recognizes the allocations/categorization of damages when such an allocation is accompanied by a court order on the merits of the case.

- While this position may clog up the courts and runs afoul of the general desire to preserve judicial resources, CMS stands firm in
their position as to court approved allocations being based on the merits of the case.

V. FAILURE TO COMPLY WITH MSP

A. 42 CFR 411.24: *Recovery from parties that receive third party payments.* CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

B. Double damages: The government may collect double damages against any such entity that fails to reimburse Medicare.

- Some argue this liability only extends to the defense and not the attorney as the law stipulates in the §301 Medicare Modernization Act of 2003 that double damages may be collected against a primary payer and does not list attorney under this definition.

VI. RECENT CHANGES IN MEDICARE SECONDARY PAYER COMPLIANCE

A. The MSPRC and the COBC are being consolidated into what will be called the Medicare Secondary Integration Contractor (MSPIC).

B. Medicare has implemented a $300 threshold for certain liability insurance cases. Assuming certain criteria are met when a liability insurance claim is resolved, Medicare will not recover from the recovery proceeds. Those criteria are as follows:

1. The settlement (generally defined by Medicare as including settlement, judgment, award or other payment) is related to an alleged physical trauma-based incident (as opposed to an alleged exposure, ingestion or implantation);

2. The claimant does not have any additional settlements related to the same alleged incident; and

3. Medicare has not already issued a final demand.

C. The Self Service Feature

This new automated feature will give callers the ability to get the most up-to-date Demand/Conditional Payment amounts and the dates those letters were issued without having to speak with a Customer Service Representative!

Some additional benefits of this new feature include:

1. Extended calling hours – It will be made available for additional hours outside of the MSPRC Hours of Operation!
2. Shorter wait time – Callers will no longer have to experience the wait time associated with speaking to a Customer Service Representative!

3. Unlimited number of cases inquiries on one phone call – After receiving information on a case through the Self-Service Information Feature, callers are given the option of checking multiple cases on that same call!

VII. EXPEDITED MEDICARE CONDITIONAL PAYMENT RESOLUTION PROCESS

A. This option permits certain Medicare beneficiaries to receive a final conditional payment amount from Medicare prior to settlement. Historically, Medicare’s conditional payment reimbursement process has not allowed a Medicare beneficiary or settling parties from obtaining such pre-settlement information from Medicare or its recovery contractors.

B. Eligibility: This new resolution tool can only be used where certain conditions are met. Those conditions include:

1. The liability insurance (including self-insurance) settlement must be for a physical trauma based injury (the settlement relate to ingestion, exposure, or medical implant);

2. The total liability settlement, judgment, award, or other payment will not exceed $25,000;

3. The Date of Incident must have occurred at least six months before the beneficiary or representative submits the proposed conditional payment amount to Medicare;

4. The beneficiary’s treatment must have been completed for at least ninety days prior to submitting the proposed conditional payment amount to Medicare and no further treatment can be expected. A written physician attestation or beneficiary certification in writing must be obtained that confirms that no medical treatment related to the case has occurred; and

5. The Settlement must occur within sixty days of the issuance of Medicare’s agreement with the claims amount.

VIII. CONDITIONAL PAYMENT PRACTICE TIPS

A. Indemnification against the Failure to Properly Resolve Medicare’s Conditional Payment Interest

1. Many states, such as Missouri, find it to be an ethical violation when an attorney agrees to indemnify the defense for the resolution of Medicare and other subrogated interests.
2. Missouri Formal Ethics Opinion 125: To sign such an indemnification agreement would be in violation of Rule of Professional Conduct 4-1.8(e). The opinion went on to state that it is an ethical violation to simply ask that such an indemnification be signed.

3. In Kentucky, this rule can be found at Supreme Court Rule §3.130(1.8)(e).

4. The following states do not or arguably do not permit attorneys to indemnify:
   - Arizona, Alabama, California, Florida, Illinois, Indiana, Kansas, Missouri, New York, North Carolina, Oklahoma, Ohio, South Carolina, Tennessee, Vermont, Wisconsin, Virginia

B. Lien Resolution – Client Expense

1. Outsourcing the resolution of Medicare compliance and of subrogated interests is a client expense and need not be carried by the attorney as part of his or her representation. See ABA Formal Opinion 08-451.

2. SUGGESTED LANGUAGE: We understand that current law and regulations regarding Medicare, Medicaid or private health insurance plans (healthcare providers) may require all parties involved in this matter (client, law firm defendant, and any insurance companies) to compromise, settle, or execute a release of healthcare providers' separate claim for reimbursement/lien for past and future payments prior to distributing any verdict or settlement proceeds. We agree that the law firm may take all steps in this matter deemed advisable for the handling of our claim, including hiring separate experts/case workers who assist with resolving any healthcare providers’ reimbursement claims or liens for past and/or future injury-related medical care. The expense of any such service shall be treated as a case expense and deducted from our net recovery and shall not be paid out of the law firm’s contingent fee in this matter.

C. Confidentiality Provisions in Settlement Agreements

1. In Amos v. Commissioner of Internal Revenue, T.C. Memo. 2003-329 at *5, the United States Tax Court stated that “if the settlement agreement lacks express language stating what the amount paid pursuant to that agreement was to settle, the intent of the payor is critical to that determination.”

2. MODEL LANGUAGE: While Releasees and Releasor represent that this agreement would not have been consummated absent the foregoing confidentiality covenants, Releasees and Releasor acknowledge that no portion of the settlement amount represents
consideration for the mutual promise to maintain strict confidentiality of all the terms of this agreement. Rather, the Releasees and Releasor expressly have agreed that each other’s reciprocal confidentiality is the sole consideration given in exchange for that of the other.

D. Medicare’s Name on the Check


Should a defense insurer ever suggest or require that they place Medicare’s name on the check then cite to the Pennsylvania Superior Court’s recent ruling in Zaleppa v. Seiwell in which the Court held that where there is verdict in a case, the defense is unable to withhold the payment of its judgment by either demanding that they place Medicare as payee on the settlement draft or insist that funds be escrowed until notification that any Medicare conditional payment interest doesn’t exist. See also Tomlinson v. Landers, 2009 WL 1117399 (M.D.Fla. Apr. 24, 2009).

IX. MEDICARE’S FUTURE INTEREST

1. All settlements must “adequately consider” Medicare’s interest, no shifting of Medicare to be primary payer for past and future medical care.

2. Medicare will not pay for any medical expenses related to an injury after settlement until the time the portion of the settlement allocated to future medical expenses covered by Medicare is fully exhausted.

X. THE MEDICARE SET ASIDE METHODOLOGY

A. Adopted by CMS in 1995 as preferred method to deal with WC cases.

• https://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp

B. No enforcement of MSP until CMS issues its July 2001 memo to WC primary payers.

C. As of March 26, 2012, CMS has issued twelve memos outlining the MSA process for workers’ compensation cases and only one memo on liability cases.

On September 29, 2011, CMS issued its first formal guidance: “where a beneficiary’s treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) “settlement” has been completed as of the date of the “settlement”, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to the future medcals for that particular “settlement”, satisfied.”
D. When a part of a settlement is allocated to future medical expenses, and the settlement creates a permanent burden shift of to Medicare for future injury related medical expenses, you must consider Medicare's interest as to that future cost of care.

E. MSAs are not a statutory requirement, nor were they established by any regulation. They were simply created as part of CMS memos (in compliance with MSP) and are CMS' preferred methodology for protecting Medicare's interest in a claimant's future cost of injury related medical care.

F. What exactly is a Medicare Set-Aside? Money set aside after a settlement to satisfy the Medicare Secondary Payer (MSP) statute requirements.

1. Covers future medical expenses related to the injury for which Medicare would ordinarily pay.

2. Acts like a deductible for future injury related medical care

XI. IS AN MSA IS APPROPRIATE IN A JUDGMENT, SETTLEMENT OR VERDICT?

A. Clear Allocation: If an itemized or specifically allocated portion of a settlement, judgment or other payment is made by the defense to the plaintiff in recognition of the plaintiff's future medical care, then an Medicare Set Aside should be established in order to allow for this portion of the settlement, judgment or other payment to first be exhausted before Medicare is billed for any associated services.

B. Treating Physician: If a treating physician certifies that no such future medical is necessary, then Medicare is willing to accept that no money in the settlement is being paid for future Medical care and will permit the parties to the lawsuit to finalize the settlement without establishing a Medicare Set Aside.

C. Unclear: If it is unclear as to whether any portion of a settlement, judgment or other payment is being made on account of future injury related care and/or the a treating physician is unable to certify that no future injury related care will be necessary, then the plaintiff should seek out the opinion of an objective third party to determine whether or not a Medicare set Aside is appropriate.

D. A Q&A exchange from the October 22, 2009 MMSEA teleconference held by CMS that confirmed our long-standing position on liability settlements and what the MMSEA is intended to do.

E. CMS would like for a third party objective opinion to be obtained when a question as to whether an LMSA is necessary exists.

XII. CASE LAW AND MORE

D. CMS Region 6 LMSA Memo: “Stalcup Memo” (see attachment 2)
G. First CMS LMSA Memo
H. TAKEAWAY

1. The only consistency within these decisions is each court’s recognition that MSAs are not required by statute or regulation, but rather are simply CMS’ preferred method for protecting Medicare’s interest in a client’s future cost of injury related care.

2. There is the potential to extend 42 CFR §411.37 to MSAs. Thus attorneys’ fees can be deducted from an MSA.

3. Due to the lack of clear guidance from the courts and any statutory authority for determining when, if ever, an MSA is appropriate in a judgment, settlement or verdict it is imperative that the parties involved in litigation do everything they can to document their file as to their making of a good faith effort to substantially comply with the Medicare Secondary Payer Act. Such good faith efforts can be evidenced by:

   a. An affidavit of a treating physician.

   b. Seeking out the assistance and opinion of a third party expert in the field of Medicare Compliance.

   c. A legal memo analyzing the facts of the case.

   d. A court approved allocation and ruling on the issue.

   e. A self-drafted memo analyzing the need for an MSA in the settlement, judgment or verdict.
f. The key is to document the analysis that was completed in determining Medicare’s interest via settlement documents and/or MSA.

XIII. MEDICAID AND NEEDS BASED GOVERNMENT BENEFITS

A. Failure to verify and protect a client’s eligibility for a need-based government benefit may result in the client’s loss of:
   1. SSI.
   2. Medicaid.
   3. Other government assistance or grants.
   4. Medicaid and needs based government benefits.

B. Entitlement Benefits (unaffected by settlements):
   1. SSDI — Except in a workers' compensation recovery.
   2. Medicare -- Except for set-aside requirements.

C. Needs-Based (affected by settlements):
   1. SSI.
   2. Medicaid.
   3. TANF/Food Stamps.
   4. Section 8 Housing.
   5. Medicaid and other needs based government benefits.

XIV. WHAT IS MEDICAID

A. Medicaid, or Title XIX of the Social Security Act, is a Federal-State matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low income and resources.

More info/ additional resources:

1. CMS: https://www.cms.gov/MedicaidEligibility/.

B. Became law in 1965 to assist States in furnishing medical assistance to eligible needy persons.

C. Each State

1. Establishes its own Eligibility Standards (i.e. 1634(a), SSI-Criteria, or 209(b)).

2. Determines the type, amount, duration, and scope of services.

3. Administers its own program and the policies vary considerably even among adjacent states, and thus a person eligible in one state may not be eligible in another state, and services may vary among covered persons from state to state.

D. States have the ability to determine how they will determine eligibility for Medicaid and SSI, and fall into one of three general categories:

1. 1634(a) states.

2. SSI-criteria states.

3. 209(b) states.

E. States that Follow §1634 of the Social Security Act

1. These states have a contract with the Social Security Administration to determine eligibility for Medicaid at the same time that a determination is made for receipt of SSI benefit.

2. There are thirty-two states and the District of Columbia that use this eligibility criteria for determining who will qualify:

   Alabama  Louisiana  Pennsylvania  
   Arizona  Maine  Rhode Island  
   Arkansas  Maryland  South Carolina  
   California  Massachusetts  South Dakota  
   Colorado  Michigan  Tennessee  
   Delaware  Mississippi  Texas  
   D.C.  Montana  Vermont  
   Florida  New Jersey  Washington  
   Georgia  New Mexico  West Virginia  
   Iowa  New York  Wisconsin  
   Kentucky  North Carolina  Wyoming

F. States that Require Separate Application for Medicaid

1. These states use the same criteria to determine eligibility as the criteria used by the SSI program (either age sixty-five or older, blind, or disabled, including children), but require that the individuals apply to the State separately for SSI and Medicaid.
2. There are seven states and the Commonwealth of Northern Mariana Islands that use this eligibility criteria for determining who will qualify:

- Alaska
- Nevada
- Idaho
- Oregon
- Kansas
- Utah
- Nebraska

G. §209(B) States

1. Eligibility for SSI benefits does not guarantee access to Medicaid coverage in these states.

2. These states use at least one eligibility criterion more restrictive than the SSI program’s requirements for eligibility, but may not use more restrictive standards than those in effect on January 1, 1972, and must provide for deducting incurred medical expenses from income through Medicaid Spend-down so that individuals may reduce their income to the eligibility level.

3. There are eleven states that fall into this category:

- Connecticut
- New Hampshire
- Hawaii
- North Dakota
- Illinois
- Ohio
- Indiana
- Oklahoma
- Minnesota
- Virginia
- Missouri

XV. KENTUCKY’S MEDICAID LAWS

A. KAR 907: http://www.lrc.state.ky.us/kar/title907.htm


XVI. WHAT IS SUPPLEMENTAL SECURITY INCOME

A. SSI is a federal program administered by the Social Security Administration (SSA), sometimes called Title XVI benefits.

B. Provides cash assistance to individuals who have limited income and resources and are either age sixty-five or older, blind, or disabled, including children.

C. The amount of cash benefit an individual receives is based on the Federal Benefit Rate (FBR) and the amount of income the individual receives. To calculate the cash benefit, an individual must subtract their countable income from the Federal Benefit Rate.
1. The Federal Benefit Rate in 2012 is $698 for a single person and $1,048 for a couple.

2. Non-excluded resources must not exceed $2,000 (or $3,000 for a couple).

3. Your countable income must be less than the FBR amount (they do not count the first $20).

XVII. SPECIAL NEEDS PLANNING

A. 42 USC §1396p: A Special Needs Trust (“SNT”) is a form of discretionary, spendthrift trust designed to preserve government benefits for a disabled or aged beneficiary. Distributions from the trust are intended to supplement public benefits, not supplant them.

B. The benefits at issue are typically needs-based benefits -- those that have limitations on the amount of resources and income the recipient may own and/or receive.

C. 42 USC §1396(d)(4)(A) Trusts

1. Separate trusts.

2. State specific.

3. Must be under sixty-five.

4. No additional funds after sixty-five.

5. Only parent, grandparent, guardian or a court can establish.

6. Mandatory Medicaid payback.

7. Need knowledgeable administrator to protect government benefits.

8. Cost varies and time consuming.

9. Need government agency approval.

D. Pooled Special Needs Trusts 42 USC §1396(d)(4)(C)

1. Master trust.

2. Nationwide.

3. Any age, but can be viewed as a transfer for less than fair market value.

4. Funds can be added anytime.
5. Individual may establish.

6. Medicaid payback may be avoided by permitting the trust to keep the assets upon the death of the beneficiary or provide to a charity or for those other disabled beneficiaries the trustee is responsible for helping.

7. Need knowledgeable administrator to protect government benefits.

8. Low cost and quick setup.

9. Need government agency approval.

E. The primary goal of a private pooled special needs trust is to preserve your client’s needs-based government benefits.

F. Does the client have a parent, grandparent or legal guardian who can establish the trust on his or her behalf? If not, a court order must be obtained to establish the trust properly.

G. Upon Termination of the SNT or Death of the Beneficiary

1. Medicaid payback required to the state.

2. Remainder passes to heirs.


H. Why Create D(4)(A) Trust?

1. Reimbursement is only for Medicaid, not all public benefits.

2. Reimbursement is based on actual Medicaid expenditures, not prevailing market costs.

3. No interest.

4. Some services not readily available in the private market.

I. Why Create a Pooled Trust?

1. Non-profit 501(C)(3) organization as trustee.

2. Must be irrevocable.

3. Beneficiary may be any age (varies state to state).

4. Medicaid asset transfer issue after age sixty-five.
5. Created and managed by non-profit association.

6. May be established by the individual.

7. Separate accounts maintained for the benefit of individuals with disabilities.

8. Modified payback provision.

XVIII. THIRD PARTY TRUSTS

A. The purpose of a third party special needs trust is to preserve public benefits for an individual or family member with physical or mental disabilities.

B. Money is provided to a disabled individual via gift or inheritance to a trust established for their benefit in order to provide for their supplemental needs.

C. Individuals with disabilities often experience difficulty with managing their own financial affairs, so by establishing a third party special needs trust the funds are administered and managed by a qualified trustee.

D. The trust must be a discretionary spendthrift trust that limits the discretion of the trustee such that he or she is prohibited to distribute principal or income to the beneficiary if such a distribution would reduce or eliminate the beneficiary’s eligibility for public benefits.

E. These can be testamentary or inter vivos trusts and can be revocable or irrevocable.

F. Medicaid is not the primary beneficiary upon termination of the trust.

XIX. ELDER LAW PLANNING

A. An expanding area of the law that largely involves long term Medicaid benefits.

B. Largest percentage of US population will soon be over age sixty-five.

C. How to preserve assets and become eligible for Long Term Care Medicaid benefits?

D. What to know and what can you do?

1. Long Term Care Insurance or Medicaid.

2. Medicare does not pay for long term nursing home care

3. Irrevocable Income Only Trusts.
4. Miller or Medicaid Qualifying Trusts.
5. Gift and return.
6. Rental agreements.
8. Spend down planning.

XX. FREQUENTLY ASKED QUESTIONS

Q. What is Social Security Income or what is referred to as Supplemental Security Income (“SSI”)?

A. SSI is a means-based federal program that provides income to certain aged, blind and disabled people. SSI is an income maintenance program for low-income individuals. The purpose of the SSI payment is to provide the recipient with income to be used for food and shelter. For 2012, the maximum amount of SSI for an individual is $698.

Q. What is the general amount of income a person can receive each month and the total amount of liquid assets that someone can own and maintain eligibility for SSI?

A. A person can receive up to $697 per month and can maintain $2,000 in liquid assets while also remaining eligible for SSI.

Q. What is a Resource?

A. Resources are defined as cash or other liquid assets or any real or personal property that the individual or the spouse owns or can convert to cash. Non-liquid assets are those that cannot be converted to cash within twenty days. Some examples include machinery, vehicles, household goods, livestock and land.

Q. What are some examples of non-countable resources?

A. Household goods and personal effects, an automobile, life insurance that does not exceed $1,500, burial plot and funds for a burial up to $1,500 per individual, and pre-paid funeral expenses.

Q. What is In-Kind Support and Maintenance (“ISM”)?

A. In-kind support and maintenance means any food or shelter that is given to you or that you receive because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water,

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7 Special Needs Trusts Handbook, by Thomas D. Begley, Jr., Angela E. Canellos, Last Updated on December 20, 2011.
sewerage, and garbage collection services. You are not receiving in-kind support and maintenance in the form of room or rent if you are paying the amount charged under a business arrangement.

Q. What happens to an SSI beneficiary when they receive In-Kind Support and Maintenance ("ISM")?

A. When a claimant or couple lives throughout a month in another person's household and receives both food and shelter from others living in the household, the government reduces the SSI payment the beneficiary is receiving by one-third. This reduction is known as the VTR or the value of the one-third reduction. When the value of the one-third reduction (VTR) applies, it applies in full or not at all. When the VTR applies, no additional in-kind support and maintenance (ISM) is countable.

**EXAMPLE:** An eligible individual and his friend live in a house the friend owns. The friend buys all of the food for the household and pays all the shelter expenses except for electricity. The friend's mother pays the electric bill each month. Based on the eligible individual receiving both food and shelter from the household and not paying his pro rata share, he is subject to the VTR. Because the VTR applies, no additional ISM will count. Therefore, the electric bill paid by someone outside the household will not count as ISM.

Q. What is Social Security Disability Income (SSDI)?

A. Unlike SSI, which is a means-tested welfare program, SSDI is an insurance program. Coverage is based upon the number of quarters of employment during which the disabled party paid taxes into social security. Whether a person is paying into social security during their employment and thus satisfying the “quarters” requirement for the benefit is different for those that are employed by an employer and those who are self-employed.

Q. What is the Definition of Social Security of Disability under Social Security?

A. It is "the inability to do any substantial gainful activity by reason of medically-determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months." In other words, the injury must prohibit the person from performing his or her previous job or any other substantial gainful activity in the national economy.

Q. Can I become eligible for Medicare after being determined to be disabled?

A. A person who has been determined to be disabled and entitled to receive SSDI benefits is also entitled to receive Medicare after two years in addition to the five month waiting period. Group health insurance should provide you with the ability to secure a COBRA policy during the twenty-nine month waiting period should you be disabled.
Q. What is Medicare?

A. Medicare is a program that pays the medical cost of a person who is eligible for the benefit. Similar to SSDI, Medicare is an insurance program and not a program that is provided to people based primarily on financial need. Medicare pays for acute care, hospitalization, limited skilled nursing care, doctor’s fees, drugs, medications used in the hospital and home care. It also provides prescription drug coverage.

Q. What are Disabled Adult Child benefits?

A. If a child who is receiving SSI and Medicaid subsequently becomes eligible for SSDI because of the disability, death, or retirement of the parent and the receipt of the SSDI payment causes a loss of the SSI payment, the child will, nevertheless, retain Medicaid so long as the child is either under the age of eighteen or is receiving benefits because he or she is a developmentally disabled child suffering from a disability that began before he/she attains age twenty-two.

Q. What happens if a loss of benefits occurs upon entitlement to child’s insurance benefits or an increase in the insurance amount?

A. If any individual who has attained the age of eighteen and is receiving Medicaid benefits on the basis of blindness or a disability which began before he or she attained the age of twenty-two and loses eligibility for the benefit because of becoming eligible for or receiving an increase in the amount of the child’s insurance benefits, such individual shall be treated as remaining eligible for Medicaid benefits so long as he or she would be eligible for benefits in the absence of such child’s insurance benefits or such increase.

Q. What is Medicaid?

A. Medicaid provides access to basic medical and hospital care, as well as prescription drugs and long-term care services. Services are available in the community as well as in institutions. Many states have waiver programs to support person with disabilities in the community.

Q. What is a Medicaid waiver program?

A. The purpose of Medicaid Waiver programs is to provide Medicaid coverage for long-term care services in the community. The intent of the waiver program under federal law is to allow states the flexibility in operating their Medicaid programs. The majority of waiver programs allow the states to disregard Medicaid provisions in order to deliver long-term care services in the community. For example, a waiver program may disregard the amount of income or assets a disabled person or their family members may possess. This is a great benefit to provide disabled individuals and their families to obtain care outside the confines of a residential facility.

Q. What is a special needs trust?
A. A Special Needs Trust ("SNT") is a form of discretionary, spendthrift trust designed to preserve government benefits for a disabled or aged beneficiary. Distributions from the trust are intended to supplement public benefits, not supplant them.

There is no age restriction under this exception. However, a transfer of resources to a trust for an individual age sixty-five or over may result in a transfer penalty. However, if the trust is not countable as a resource, money or property transferred by the individual into the trust is a transfer of resources that is subject to the period of ineligibility unless an exception applies (SI 01120.203 – Exceptions to Counting Trusts Established on or After 01/01/00 and SI 01150.121 -- Exceptions – Transfers to a Trust).

Q. Are there different types of special needs trusts?

A. Yes, there are first party private and pooled special needs trusts as well as third party Trusts.

Q. What is a first party private special needs trust?

A. Private special needs Trust found at 42 USC §1396(d)(4)(A) trusts are:

- Separate Trusts
- State Specific
- Must be under sixty-five
- No additional funds after sixty-five, unless through a previously established structured settlement annuity
- Only parent, grandparent, guardian or a court can establish
- Mandatory Medicaid Payback
- Need knowledgeable administrator to protect government benefits
- Cost varies and time consuming
- Need government agency approval

Q. What is a pooled special needs trust?

A. Pooled special needs trusts, found at 42 USC §1396(d)(4)(C), are:

- Master Trust
- Nationwide
- Any age, but can be viewed as a transfer for less than fair market value
- Funds can be added anytime
- Individual may establish
- Medicaid payback may be avoided by permitting the trust to keep the assets upon the death of the beneficiary or provide to a charity or for those other disabled beneficiaries the trustee is responsible for helping
- Need knowledgeable administrator to protect government benefits
- Low cost and quick setup
- Need government agency approval
Q. What is a third party special needs trust?

A. A trust that is established by a third party with assets of the third party for the benefit of a person with a disability. There is no requirement that the state Medicaid agency be paid back for expenses paid during the trust beneficiary’s lifetime upon the beneficiary’s death. The assets of the trust must not be made available to the beneficiary and income should never be distributed to the beneficiary or risk jeopardizing the beneficiary’s eligibility for needs-based benefits.⁸

Q. Do disbursements for in-kind support and maintenance (“ISM”) Cause a disqualification for benefits?

A. No. ISM will cause a reduction, most likely by one-third.

Q. What are the Questions to Ask when establishing a SNT?

A. The Following:

- Does the client want to determine the trustee, financial manager, and the terms of trust administration?
- Does the Trustee require a minimum deposit for their trust services?
- Do they have experience with SNT administration?
- What are the fees for administration?
- Does the Trust keep the money after paying the state back?
- Do you use a corporate trustee?
- Will the Trustee travel to the beneficiary?
- What is your disbursement process like?

Q. What are some additional special needs trust considerations?

A. The primary goal is to preserve your client’s needs-based government benefits. Learn if the client has a parent, grandparent or legal guardian who can establish the trust on his or her behalf? If not, a court order must be obtained to establish the trust properly. All disbursement decisions are based on what is in the best interest of the beneficiary.

Q. What happens upon termination of the SNT or death of the beneficiary?

A. Any money/property left in the trust will first go to pay back the State Medicaid for all of the expenses paid for on behalf of the Medicaid beneficiary during the time the trust was in existence. Any and all remaining money/assets/property in the trust after reimbursing the state passes to beneficiary heirs or to the individual listed in the trust agreement.

⁸ Id.
Q. Should I provide Trustee with some discretion to protect or eliminate a beneficiary’s eligibility for benefits?

A. It depends. If the intention is for the ability for the beneficiary to lose eligibility for public benefits if it is in his or her best interest, then language should be added to the trust that provides the trustee with the discretion to make a distribution even if the distribution causes a reduction or a loss of some public benefits because that result may be in the beneficiary’s best interest.

Q. What is a Medicare Set Aside?

A. A MSA (or Medicare Set-Aside Account) is required because Medicare maintains an interest in the costs associated with a Medicare beneficiary’s injury related medical care and this interest may need to be protected depending on the terms of the settlement. Federal law requires all parties to "consider Medicare’s interests" in third party settlements. Under §1862(b)(2) of the Social Security Act (42 U.S.C. §1395y(b)(2)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan).

This means that Medicare could deny paying for a client’s future medical care should he or she fail to properly consider and protect its interest in his or her settlement. One way to consider and protect Medicare is by following their guidelines as set forth by CMS (the Center for Medicare and Medicaid Services), which most often entails the establishment of an MSA. Medicare’s ability to ensure that their interests are properly protected is not limited to just the Medicare beneficiary, but rather to anyone that receives any portion of a third party payment either directly or indirectly (42 CFR §411.24). Below are descriptions of the types of MSAs and how they are used in individual situations.

Q. Why must I consider a Medicare Set Aside?

A. Federal law requires all parties must “consider Medicare’s interests” in third party settlements where Medicare conditionally paid for injury-related care. Under 42 U.S.C. §1395y(b)(2), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan).

In light of 42 USC §1395(y)(b)(2) and 42 CFR §§411.43-46, the regulations that further define how that statue is to be applied, it is clear that the liability for medical expenses incurred due to work-related injuries should not be shifted to Medicare from the responsible party or workers’ compensation carrier. In furtherance of this position, starting in 2001 the Centers for Medicare and Medicaid Services (“CMS”) began releasing memoranda that formalized the procedures for how Medicare’s interest should be properly protected in workers’ compensation cases. In these memoranda, CMS opined that the recommended

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9 42 C.F.R. §§411.46 and 411.47.
method to protect Medicare's interests is a Medicare Set-aside Arrangement, which allocates a portion of a workers' compensation settlement for future medical expenses. These types of funds can either be administered professionally through a Medicare Set Aside administrative company or privately by the client him or herself.

Q. Are Medicare Set Asides required by law?

A. No. CMS created the MSA as their approved methodology for protecting Medicare's interest in settlements involving a Medicare beneficiary who receives settlement money on account of future injury related medical care. That said, the Medicare Set Aside was created simply by memoranda from CMS and cannot be found in any Statute or Regulation.

Q. Should I ask for CMS to review my Medicare Set aside?

A. If the WC settlement closes out future medicals, then a Medicare Set Aside proposal may be submitted to CMS for review in the following situations: (1) the claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000; OR (2) the claimant has a “reasonable expectation” of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

Q. Should I seek CMS approval from a Medicare Set Aside in a liability settlement?

A. Due to the lack of guidance from CMS on liability cases, the legal community is left to decide how best to remain compliant with 42 USC §1395y(b)(2), while not over-reacting and establishing an MSA unnecessarily. MSAs are simply CMS’ preferred methodology for protecting Medicare’s future interest and are not required by law.

Thus, in every case in which a Medicare beneficiary is involved, some attention must be paid to determining what, if any, interest Medicare possesses in that case. The author’s rule of thumb is as follows: IF there is going to be a permanent shift of the burden for paying for the Medicare beneficiary’s future injury-related medical expenses from the liability insurance policy or plan to Medicare; AND the settlement contemplates a definitive allocation of settlement money to the plaintiff’s future injury-related medical care, then this author would recommend establishing an MSA or at a minimum obtaining an objective third party opinion about the need to protect Medicare’s interest in the plaintiff’s future cost of injury related care via an MSA.

If either answer to the above is no, then a claimant cannot be reasonably expected to set aside any money to protect Medicare’s interest in the injured plaintiff’s future cost of care, because no settlement money is actually being paid or received in consideration of that care. Finally, if the answer to either question is difficult to determine, then the default action should always be to obtain a third party opinion on the matter in order to fully protect the attorney and his or her
client's current and future eligibility for Medicare. It is inevitable that an attorney will come across a case in the near future with some issues concerning how to properly protect Medicare’s interest. That said, this author is hopeful that the information contained above provides a little light at the end of that dark Medicare compliance tunnel.
**Ethical Considerations**

- Model Rule 1.4, which states, “[a] lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation” and “shall reasonably consult with the client about the means by which the client’s objectives are to be accomplished.”

- Model Rule 1.3 supports client counseling on structured settlements and government benefits when it speaks to “diligence” in handling interest of the client that can be adversely affected by the passage of time.

**Medicare Compliance**

- **Past Interests**
  - Represented by Conditional Payments (“CPs”) paid by Medicare for care received from date of injury to date of settlement

- **Future Interests**
  - Medical expenses paid on behalf of the claimant from date of settlement forward
    - Represented by a Medicare Set-Aside arrangement
Medicare Compliance

- 42 USC 1395y(b)(2): A primary plan or insurer’s responsibility for such payment may be demonstrated by:
  - A judgment; or
  - A payment conditioned upon the recipient’s compromise, waiver, or release of payment for items or services included in a claim against the primary plan or the primary plan’s insured.

Medicare Compliance

- Immediately notify the COBC of your representation by submitting the following:
  - Your client’s name and address
  - DOB
  - SSN
  - Medicare number
  - Date of incident
  - Type of incident
  - Injury description
  - Your full name, address and phone number
  - Defense counsel’s name, address and phone number

Medicare Compliance

- This information should be sent to:

  Medicare (COBC)
  MSP Claims Investigation Project
  PO Box 33847
  Detroit, MI 48232
  (800) 999-1118
Medicare Compliance

- CONTACTING THE MSPRC

- By Telephone

✔ MSPRC Main Number: 1-866-MSPRC-20 or 1-866-677-7220
✔ Monday - Friday, 8:00 a.m. - 8:00 p.m., eastern time

Medicare Compliance

- CONTACTING THE MSPRC

- By Mail

✔ Non-Group Health Plan (NGHP)
  ✔ (e.g. all NGHP checks and inquiries including Liability, No-Fault, Workers Compensation, Congressional, FOIA, Bankruptcy, Liquidation Notices and QIC/ALJ)
MSPRC – NGHP
P.O. Box 138832
Oklahoma City, OK 73113

Medicare Compliance

- The MSPRC will provide you with a conditional payment summary with 60–90 days

✔ Be sure to review this document for any unrelated expenses

✔ Once you notify the MSPRC of the final settlement you will then receive a final demand which you have 60 days to satisfy

✔ 42 CFR 411.37: Medicare reduces its recovery to take into account the cost of procuring (attorneys fees/expenses) the judgment or settlement.
Medicare Compliance

- If Medicare’s lien is larger than the settlement:
  - Medicare will take the full settlement, less the total procurement costs, unless a court allocates the judgment to which Medicare will only recover from those monies allocated to medical expenses.

Medicare Compliance

Failure For Non-Compliance:

- See 42 CFR 411.24 Recovery from parties that receive third party payments.
  - CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

- Double Damages: The government may collect double damages against any such entity that fails to reimburse Medicare.

Medicare Compliance

Conditional Payment Case Law Update

- Vernon Hadden v. United States of America
- Bradley v. Sebelius decisions.

- Takeaway: CMS only recognizes the allocations/categorization of damages when such an allocation is accompanied by a court order on the merits of the case.

  - Try Administrative Remedies/Pre-settlement Compromise
  - Try securing assistance of third party lien resolution expert
  - Petition Court for approval of allocation and ensure that approval is based on the merits of the case.
Medicare Compliance

- Medicare has implemented a $300 threshold for certain liability insurance cases.

- Criteria for $300 Threshold:
  - The settlement (generally defined by Medicare as including settlement, judgment, award or other payment) is related to an alleged physical trauma-based incident (as opposed to an alleged exposure, ingestion or implantation);
  - The claimant does not have any additional settlements related to the same alleged incident; and
  - Medicare has not already issued a final demand.

Medicare Compliance

- The Self Service Feature. This new automated feature will give callers the ability to get the most up-to-date Demand/Conditional Payment amounts and the dates those letters were issued without having to speak with a Customer Service Representative!

- Some additional benefits of this new feature include:
  - Extended Calling Hours – It will be made available for additional hours outside of the MSPRC Hours of Operation!
  - Shorter Wait Time – Callers will no longer have to experience the wait time associated with speaking to a Customer Service Representative!
  - Unlimited number of cases inquiries on one phone call – After receiving information on a case through the Self-Service Information Feature, callers are given the option of checking multiple cases on that same call!
  - The Self-Service Information Feature is scheduled to go live September 30, 2011!
NEW CONDITIONAL PAYMENT RESOLUTION OPTION:
This option permits certain Medicare beneficiaries to receive a final conditional payment amount from Medicare prior to settlement.

This new resolution tool can only be used where certain conditions are met. Those conditions include:

✓ The liability insurance (including self-insurance) settlement must be for a physical trauma based injury (the settlement relate to ingestion, exposure, or medical implant);

✓ The total liability settlement, judgment, award, or other payment will not exceed $25,000;

The Date of Incident must have occurred at least six months before the beneficiary or representative submits the proposed conditional payment amount to Medicare;

The beneficiary's treatment must have been completed for at least 90 days prior to submitting the proposed conditional payment amount to Medicare and no further treatment can be expected. A written physician attestation or beneficiary certification in writing that no medical treatment related to the case has occurred (see below); and

Settlement must occur within 60 days of the issuance of Medicare’s agreement with the claims amount.

Requests for Indemnification

Indemnification Against Conditional Payments

Many states, such as Missouri, find it to be an ethical violation when an attorney agrees to indemnify the defense for the resolution of Medicare and other subrogated interests.

✓ Missouri Formal Ethics Opinion 125: To sign such an indemnification agreement would be in violation of Rule of Professional Conduct 4-1.8(e).

✓ The opinion went on to state that it is an ethical violation to simply ask that such an indemnification be signed.

In Kentucky, this rule can be found at Supreme Court Rule §3.130(1.8)(e).
Lien Resolution – Client expense

- Outsourcing the resolution of Medicare compliance and of subrogated interests is a client expense and need not be carried by the attorney as part of his or her representation. See ABA Formal Opinion 08-451.

Confidentiality

All too often, attorneys overlook the importance of confidentiality or -- more importantly -- the consideration being paid in return for said confidentiality.

- Amos v. Commissioner of Internal Revenue, the United States Tax Court stated:

  ✓“if a settlement agreement lacks express language stating what the amount paid pursuant to that agreement was to settle, the intent of the payer is critical to that determination.” 2003 WL 22839795 (U.S. Tax Ct. 2003).

Medicare Compliance

What about those Medicare Set-Asides…
Medicare Compliance

CMS States:

- All settlements must “adequately consider” Medicare’s interest, no shifting of Medicare to be primary payer for past and future medical care.

- Medicare will not pay for any medical expenses related to an injury after settlement until the time the portion of the settlement allocated to future medical expenses covered by Medicare is fully exhausted.

Medicare Compliance

What exactly is a Medicare Set-Aside?

- Money set aside after a settlement to satisfy the Medicare Secondary Payer (MSP) statute requirements

- Covers future medical expenses related to the injury for which Medicare would ordinarily pay.

- Acts like a deductible for future injury related medical care

Medicare Compliance

- MSA Method

  - Adopted by CMS in 1995 as preferred method to deal with WC cases

  - No enforcement of MSP until CMS issues its July 2001 memo to WC primary payers

  - As of March 26, 2012 CMS has distributed twelve memos outlining MSA process when settling WC cases and only a single memo on liability cases
Medicare Compliance

- Worker Compensation Settlement

- If case involves a Medicare beneficiary or someone with a reasonable expectation of becoming a Medicare beneficiary in the next 30 months (Social Security Disability Income beneficiary), AND

Medicare Compliance

- Settlement involves a permanent burden shift to Medicare for future injury related Medical care, THEN

- An Medicare Set Aside should be established

- SHOULD CMS APPROVAL BE OBTAINED?

Medicare Compliance

- On September 29, 2011 CMS issued its first formal guidance:

  ✓ "where a beneficiary’s treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) “settlement” has been completed as of the date of the “settlement”, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to the future medicals for that particular “settlement”, satisfied."
Medicare Compliance

- The Takeaway of the September 29, 2011 CMS Liability MS Memo:
  - Allocation to future damages and client is a Medicare beneficiary or possess reasonable expectation of being on Medicare within 30 months = MSA
  - Treating physician says no future injury related care necessary = No MSA
  - If it is unclear then the opinion of an objective third party should be obtained to determine whether or not a Medicare set Aside is appropriate.

Medicare Compliance

Case Law and CMS Memo Update:

- Finke v. Hunter’s View, LTD: Minnesota Federal District Court
- Hinsinger v Showboat Atlantic City: New Jersey Superior Court
- Big R Towing, Inc. v. Benoit, ET AL.: US District Court District of Louisiana
- CMS Region 6 LMSA Memo: “Stalcup Memo” (see attachment 2)
- Schexnayder v. Scottsdale Insurance Company: US District Court District of Louisiana
- Smith v. Marine Terminals
- First CMS LMSA Memo

Medicare Compliance

CASE LAW TAKEAWAY:

- Only consistency in opinions is that MSAs are not required by statute or regulation, but rather are simply CMS preferred method for protecting Medicare’s interest in a client’s future cost of injury related care.
Medicare Compliance

FINAL MSA TAKEAWAY:

- The parties involved in litigation should make a good faith effort to substantially comply with the Medicare Secondary Payer Act.
  - An affidavit of a treating physician
  - Seeking out the assistance and opinion of a third party expert in the field of Medicare Compliance
  - A legal memo analyzing the facts of the case

Medicare Compliance

- A court approved allocation and ruling on the issue
- A self-drafted memo analyzing the need for an MSA in the settlement, judgment or verdict.
- The key is to document the analysis that was completed in determining Medicare’s interest via settlement documents and/or MSA

Medicaid and Needs Based Government Benefits

Entitlement (unaffected by settlements):
- SSDI
  - Except in a WC recovery
- Medicare
  - Except for set-aside requirements

Needs-Based (affected by settlements):
- SSI
- Medicaid
- TANF/Food Stamps
- Section 8 Housing
Medicaid and Other Needs Based Government Benefits

Medicaid

- Is a joint federal and state medical benefit beginning in 1965 to assist states in furnishing medical assistance to those in need.

Medicaid and Other Needs Based Government Benefits

- Each state:
  - Establishes its own Eligibility Standards (i.e. 1634(a), SSI-Criteria, or 209(b))
  - Determines the type, amount, duration, and scope of services
  - Sets the rate of payment for services
  - Administers its own program

- Kentucky Medicaid is based upon §1634 of the Social Security Act

Medicaid and Other Needs Based Government Benefits

Kentucky Medicaid

- §1634 of the Social Security Act: These states have a contract with the Social Security Administration to determine eligibility for Medicaid at the same time that a determination is made for receipt of SSI benefit.

- Kentucky’s Medicaid Laws:
  - [http://www.lrc.state.ky.us/kar/title907.htm](http://www.lrc.state.ky.us/kar/title907.htm)
Indiana is a Section 209(b) State

- One eligibility criterion for Medicaid eligibility is more restrictive than the SSI program’s requirements for eligibility. (Countable Resource limit is $1,500)

Medicaid and Other Needs Based Government Benefits

Supplemental Security Income

- SSI is a Federal program administered by the Social Security Administration (SSA), and is sometimes called Title XVI benefits
  - Provides cash assistance to individuals who have limited income and resources and are either age 65 or older, blind, or disabled, including children

Medicaid and Other Needs Based Government Benefits

- The amount of cash benefit an individual receives is based on the Federal Benefit Rate (FBR) and the amount of income the individual receives. To calculate the cash benefit, an individual must subtract their countable income from the Federal Benefit Rate
  - Your non-excluded resources must not exceed $2,000 (or $3,000 for a couple)
  - Your countable income must be less than the FBR amount (they do not count the first $20)
A Special Needs Trust ("SNT") is a form of discretionary, spendthrift trust designed to preserve government benefits for a disabled or aged beneficiary. Distributions from the trust are intended to supplement public benefits, not supplant them.

The benefits at issue are typically needs-based benefits—those that have limitations on the amount of resources and income the recipient may own and/or receive.

42 USC 1396p – Special Needs Trusts

42 USC 1396(d)(4)(A) Trusts

- Separate Trusts
- State Specific
- Must be under 65
- No additional funds after 65
- Only parent, grandparent, guardian or a court can establish
- Mandatory Medicaid Payback
- Need knowledgeable administrator to protect government benefits
- Cost varies and time consuming
- Need government agency approval

42 USC 1396p – Special Needs Trusts

42 USC 1396(d)(4)(C) Trusts

- Master Trust
- Nationwide
- Any Age
- Funds can be added anytime
- Individual may establish
- Individual may establish
- Medicaid payback may be avoided
- Need knowledgeable administrator to protect government benefits
- Low cost and quick setup
- Need government agency approval
42 USC 1396p – Special Needs Trusts

- The primary goal is to preserve your client’s needs-based government benefits

- Does the client have a parent, grandparent or legal guardian who can establish the trust on his or her behalf?

  - If not, a court order must be obtained to establish the trust properly

42 USC 1396p – Special Needs Trusts

- All disbursement decisions are based on what is in the best interest of the beneficiary

- Upon termination of the SNT or death of the beneficiary:
  - Medicaid payback required to the State
  - Remainder passes to heirs
  - [https://secure.ssa.gov/apps10/poms.nsf/in x/0501120199/opendocument](https://secure.ssa.gov/apps10/poms.nsf/inx/0501120199/opendocument)

42 USC 1396p – Special Needs Trusts

What is a pooled trust?

- Non-profit 501(C)(3) organization as trustee

- Assets of beneficiary are “pooled” together for investment purposes
42 USC 1396p – Special Needs Trusts

- Must be irrevocable
- Beneficiary may be any age, but... Medicaid asset transfer issue after age 65
- Modified payback provision – money can stay in trust at death

Third Party Trusts

- The purpose is to preserve public benefits for an individual or family member with physical or mental disabilities.
- Money is provided to a disabled individual via gift or inheritance to a trust for the benefit of disabled individual
- Provide for their supplemental needs.

Third Party Trusts

- The trust must be a discretionary spendthrift trust that limits the discretion of the trustee such that he or she is prohibited to distribute principal or income to the beneficiary if such a distribution would reduce or eliminate the beneficiary’s eligibility for public benefits.
- These can be testamentary or inter vivos trusts and can be revocable or irrevocable.
- Medicaid is not the primary beneficiary upon termination of the trust.
Elder Law Planning

- What is it?
  - An expanding area of the law
  - Largest percentage of US population will soon be over age 65
  - How to preserve assets and become eligible for Long Term Care Medicaid benefits

Elder Law Planning

- What to know and what can you do?
  - Long Term Care Insurance or Medicaid
  - Medicare does not pay for long term nursing home care
  - Irrevocable Income Only Trusts
  - Miller or Medicaid Qualifying Trusts
  - Gift and Return
  - Rental Agreements
  - Resource Assessment Planning for Community Spouse
  - Spend Down Planning

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- Email Addresses:
  - pwayne@wyattfirm.com
  - iyussman@wyattfirm.com
CLIENT HEALTHCARE AND BENEFIT QUESTIONNAIRE

Case Intake Section 1: Personal Information and Medical Care

1. Injured Person’s Name______________________________________________
   Date of Birth:______________________________________________________
   Spouse and Date of Marriage (if applicable)______________________________

2. Injured Person’s Social Security No.____________________________________

3. Address:______________________ ___________________________________
   Phone:__________________________ _ Cell:______________________________
   Email:__________________________ _________________________________

4. If minor, list parents and siblings; names, dates of birth and current addresses. If
   adult, list children’s names, dates of birth and current addresses.

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<th>Names</th>
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5. Does the spouse or any dependents have a legal claim such as loss of
   companionship, as a result of the primary injured claimant? Yes_____ No_____

6. What is the date of injury?______________________________________________
   Nature of injury/current prognosis:__________________________________________
   Is the injury an aggravation of a pre-existing condition? Yes_____ No_____
   If so, describe the pre-existing condition:____________________________________
7. Is the injured person disabled: Yes_____ No_____  
If disabled, then what type of disability? (check all that apply)  
_____ Traumatic Brain Injury  
_____ Spinal Cord Injury  
_____ Developmentally Disabled  
_____ Bi-Polar/Mental Health Problems  
_____ Cerebral Palsy  
_____ Alzheimer’s  
_____ Physically Disabled  
_____ Kidney Dialysis  
_____ Schizophrenia  
_____ Other (please specify):________________________________________  

8. List any pre-existing medical conditions, such as immunity disorders, cardiovascular disorders, cancer, obesity, hypertension, diabetes, HIV, etc.  
________________________________________________________________  
________________________________________________________________  
________________________________________________________________  

9. Does the injured person have health insurance or other health coverage?  
Yes_____ No_____  
If so, what type? (check all that apply)  
Private Insurance –  
Insurer:________________________ ID Number____________________  
Employee Health Plan – Employer___________________________________  
If so, is it the official Employee Plan or Supplemental Insurance presented to you at work?________________________ ID Number____________________  
Medicare – Month/Year the injured person became entitled____________  
Parts: A  B  C  D  ID Number____________________
*If Part C, Insurer providing coverage______________________________

HIC#__________________________________________________________

Medicaid – Month/Year the injured person became entitled____________

ID Number_____________________________________________________

Veterans’ Benefits – Facility providing care__________________________

ID Number_____________________________________________________

TRICARE (Branch of Service____________________ Status__________)

Facility providing care___________________________________________

ID Number_____________________________________________________

Other___________________________________________________________

ID Number_____________________________________________________

How long has the injured person been covered?_____________________

How much has the coverage paid in care related to the injury?__________

If private insurance or an employee health plan, what is the lifetime cap?_______

________________________________________________________________

List current medical needs that are not covered_______________________

________________________________________________________________

If the injured person is a dependent minor and covered by a parent’s private
health insurance, at what age will the coverage terminate?______________

**Ensure that the attorney has copy of the injured person’s insurance/
benefit card.

10. What medication is the injured person receiving and what is the cost to the
injured person?___________________________________________________

________________________________________________________________
11. Where is the injured person currently living? __________________________________________

________________________________________________________________

12. Is anyone in the injured person’s immediate family disabled? Yes____ No____

If so, please list name, relationship and nature of disability of family member________________________________________________________

________________________________________________________________

Is anyone at risk of becoming disabled due to a medical condition or family history of illness? Yes____ No____

If so, please list name, relationship and nature of medical condition of family members, or nature of illness in family________________________________

________________________________________________________________

13. List any other government assistance that the injured person receives or has applied for________________________________________________________

________________________________________________________________

14. List all forms of government assistance which have been denied or discontinued to the injured person, including approximate dates:

________________________________________________________________

________________________________________________________________

________________________________________________________________

Case Intake Section 2: Income Information

Does the injured person have any source of other income:

Pension  $_____________________ per month

Interest  $_____________________ per month (avg)

Dividends $_____________________ per month (avg)

Other Income  $_____________________
Is the injured person the recipient of any gifts of cash or property:

If so, please list the gift and the date of the gift:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Case Intake Section 3: Government Assistance

Depending on the state, the program names and program availability will differ. If the injured person receives assistance similar to the programs listed below, please check the box and specify (if applicable) the specific program name in the paragraph below.

You should inquire early about whether or not the family has applied for any of these programs. Certain programs, like Medicaid Waiver, “waive” the federal requirements that the parents be impoverished in order for the child to receive Medicaid. SUCH PROGRAMS COULD HAVE A TWO TO FOUR YEAR WAITING LIST. Applying early could help avoid many issues regarding eligibility if the case eventually settles years from now.

1. Please indicate all forms of government assistance that the injured person receives:

   Social Security
   ○Yes  ○No  ○Not Sure
   Supplemental Security Income (SSI)
   ○Yes  ○No  ○Not Sure
   Social Security Disability Income(SSDI)
   ○Yes  ○No  ○Not Sure
   Institutional Care Program (Long Term Nursing Home Care)
   ○Yes  ○No  ○Not Sure
   Medically Needy Program
   ○Yes  ○No  ○Not Sure
   MEDS-AD
   ○Yes  ○No  ○Not Sure
   Medi-Kids
   ○Yes  ○No  ○Not Sure
   Protected Medicaid
   ○Yes  ○No  ○Not Sure
   Home or Community Based Medical Waiver Programs
   ○Yes  ○No  ○Not Sure
   Home Care for the Elderly and Disabled
   ○Yes  ○No  ○Not Sure
   Food Stamps
   ○Yes  ○No  ○Not Sure
Case Intake Section 4: Special Needs

1. Does the injured person need assistance with any of the 5 ADLs (Activities of Daily Living)?
   
   1. Eating  Yes____ No____
   2. Bathing  Yes____ No____
   3. Clothing  Yes____ No____
   4. Toileting Yes____ No____
   5. Transportation Yes____ No____

2. Who currently provides for the injured person?
   
   Self  Yes____ No____
   Parent  Yes____ No____
   Son or Daughter  Yes____ No____
   Caregiver  Yes____ No____
   Guardian  Yes____ No____
   Facility  Yes____ No____
   Other _____________________________________________________________

3. Does the injured person have additional legal representative? Yes____ No____

If yes, list the representative’s name, address, telephone number, and relationship to the injured person.

Name___________________________________________________________
Address_______________________________________________________
Telephone______________________________________________________
Relationship____________________________________________________
Please circle the description that best describes the current legal relationship:

- Legal Guardian
- Payee
- Conservator Representative
- Power of Attorney

4. If settlement is achieved, how would the injured person like to see the proceeds used to improve the injured person’s quality of life?

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________
Social Security Administration
Consent for Release of Information

TO: Social Security Administration

*Name __________________________  *Date of Birth __________________________  *Social Security Number __________________________

I authorize the Social Security Administration to release information or records about me to:

*NAME __________________________

*ADDRESS __________________________

*ADDRESS __________________________

*ADDRESS __________________________

*I want this information released because: __________________________

There may be a charge for releasing information.

*Please release the following information selected from the list below:

☐ Social Security Number
☐ Current monthly Social Security benefit amount
☐ Current monthly Supplemental Security Income payment amount
☐ My benefit/payment amounts from ____________ to ____________
☐ My Medicare entitlement from ____________ to ____________
☐ Medical records from my claims folder(s) from ____________ to ____________

If you want SSA to release a minor’s medical records, do not use this form but instead contact your local SSA office.

☐ Complete medical records from my claims folder(s)
☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) __________________________

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. §16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: __________________________  *Date: __________________________

Relationship (if not the individual): __________________________  *Daytime Phone: __________________________
Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor’s non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-70500-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete the Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for “all records” or the “entire file.” You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. §552a(b) of the Privacy act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information for our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person’s eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.

You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.
# Social Security Administration Form Approved

Please read the instructions before completing this form. OMB NO. 0960-0527

<table>
<thead>
<tr>
<th>Name (Claimant) (Print or Type)</th>
<th>Social Security Number</th>
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<td>Wage Earner (if Different)</td>
<td>Social Security Number</td>
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**Part I**

**APPOINTMENT OF REPRESENTATIVE**

I appoint this person, **Linda L. Cambron**, to act as my representative in connection with my claim(s) or asserted right(s) under:

- [ ] Title II
- [ ] Title XVI
- [ ] Title XVIII
- [ ] Title VIII
- [RSDI] (Medicare Coverage)
- [SSI] (Medicare Coverage)
- [SVB] (Medicare Coverage)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

- [ ] I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

- [ ] I appoint, or I now have, more than one representative. My main representative is **Jefferey M. Yussman**

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<th>Signature (Claimant)</th>
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**Part II**

**ACCEPTANCE OF APPOINTMENT**

I, ____________________________________, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative’s copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one:

- [ ] I am an attorney.
- [ ] I am a non-attorney eligible for direct payment under SSA law.
- [ ] I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney.  [ ] YES  [ ] NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

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<th>Signature (Representative)</th>
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**Part III**

**FEE ARRANGEMENT**

*(Select an option, sign and date this section.)*

- [ ] Charging a fee and requesting direct payment of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

- [ ] Charging a fee but waiving direct payment of the fee from withheld past-due benefits – I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

- [ ] Waiving fees and expenses from the claimant and any auxiliary beneficiaries – By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

- [ ] Waiving fees from any source – I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

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Form SSA-1696-U4 (03-2011) ef (03-2011) REPRESENTATIVE COPY

55
AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION

I, HARRY (Date of Birth _______________________), intend to comply, now and in the future, with all requirements set forth in the Standards for Privacy of Individually Identifiable Health Information, known as the Privacy Rule which implements the privacy requirements of the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA so that the information described below will be freely available to those described below. All provisions hereof will be construed in accordance with that intent.

I hereby authorize each Covered Entity identified below to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

1. Identity of Person or Class of Persons Authorized to Make Disclosure. I hereby authorize all covered entities as defined in HIPAA, and all other health care providers, health plans, and health care clearinghouses, including but not limited to each and every doctor, psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other medical provider or agent thereof having protected health information (as that term is defined in HIPAA), each being referred to herein as a Covered Entity.

2. Description of Information to Be Disclosed. To disclose the following information: All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure will include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

3. Person or Class of Persons to Whom the Covered Entity May Disclose the Above Described Protected Health Information. The above described information will be disclosed to SALLY and/or ____________________________ (each is known herein as an Authorized Person) upon written request of an Authorized Person.

4. Purpose of Disclosure. At my request.

5. Termination. This authorization will terminate on my written revocation actually received by the Covered Entity. Proof of receipt of my written revocation may be either by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the Covered Entity. Such revocation will be effective upon the
actual receipt of the notice by the Covered Entity except to the extent that the Covered Entity has taken action in reliance on this Authorization.

6. **Re-Disclosure.** By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Authorized Person and the information once disclosed will no longer be protected by the rules created in HIPAA. No Covered Entity will require my authorized persons to indemnify the covered Entity or agree to perform any act in order for the Covered Entity to comply with this authorization.

7. **Acknowledgement of Right to Treatment.** I understand and hereby acknowledge that a Covered Entity may not condition my receipt of health care upon my execution of the Authorization, and I may refuse to sign this Authorization if I wish to do so.

8. **Instructions to My Authorized Persons.** My Authorized Persons will have the right to bring a legal action in any applicable form against any Covered Entity that refuses to recognize and accept this authorization for the purposes that I have expressed. Additionally, my Authorized Person is authorized to sign any documents that the authorized person deems appropriate to obtain the protected medical information.

9. **Revocation.** This authorization may be revoked in writing by me at any time, except to the extent that a Covered Entity has taken action in reliance on it.

10. **Valid Document.** A copy or facsimile of this original authorization will be accepted as though it was an original document.

11. **My waiver and release.** I hereby release any Covered Entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my Authorized Person. I also specifically prohibit my Authorized Person, or any other person designated as my agent in any capacity from filing a complaint of any kind against any Covered Entity that complies with the directions of my Authorized Person hereunder to the extent that such a complaint purports to charge said Covered Entity with any violation of the Privacy Rules or other Federal or State laws related to disclosure of medical records as a result of their compliance with said directions.

12. **Application in any State Where I Receive Treatment.** It is my intention that this Authorization and my wishes be honored in __________________________ and anywhere else where I am a resident or receiving treatment.

Signed on __________________________, 20___.
COMMONWEALTH OF KENTUCKY   )  :SS
COUNTY OF JEFFERSON   )

Subscribed, sworn to, and acknowledged before me by HARRY on
______________________________, 20___.

My commission expires: ________________________________.

_________________________________
Notary Public

THIS INSTRUMENT PREPARED BY:

_________________________________
WYATT, TARRANT & COMBS LLP
500 West Jefferson Street, Suite 2800
Louisville, KY 40202-2898
502.589.5235
AN UPDATED PERSPECTIVE ON HADDEN vs. UNITED STATES OF AMERICA

After much anticipation, the Sixth Circuit Court of Appeals ("Sixth Circuit") finally issued its opinion in Vernon Hadden vs. United States of America. The ruling, however, is far different from the Eleventh Circuit’s decision in Bradley vs. Sebelius,¹ and does little to resolve the confusion over how best to address Medicare’s conditional payment interest in litigation. While some initially believed the Hadden decision to cause a circuit split with respect to Medicare’s right to seek reimbursement of its conditional payment interest, it is unlikely that the Supreme Court will agree.²

In short, the ruling by the Sixth Circuit indicates that if a Medicare beneficiary makes a claim against a primary plan,³ and later receives a payment from this plan in exchange for a release from that claim, then the primary plan is deemed “responsible”⁴ under 42 USC 1395y(b)(2)(ii) for the conditional payments made by Medicare on behalf of the beneficiary. Once a primary plan is deemed “responsible,” Medicare is entitled to seek recovery of its conditional payments from either the primary plan or any entity that receives payment from the primary plan, which is most often the Claimant/Medicare beneficiary. It is worth mentioning that while the ruling seems to indicate that Medicare can recover the full amount of its conditional payment amount regardless of the amount of the settlement payment made by the primary plan to the claimant, such is not permissible under the law. 42 CFR §411.37 limits Medicare’s recovery of its conditional payment interest to the total payment amount from the primary plan less procurement costs.⁵

FACTS: In August 2004, Vernon Hadden was standing near a traffic circle in Kentucky when he was struck by a vehicle owned by Pennyrile Rural Electric Cooperative

¹ The court found in favor of a Florida probate court’s determination that Medicare was only entitled to recover $787.50 out of a gross settlement of $52,500. The court calculated this figure based upon Medicare’s contribution to the total value of damages, if the said damages were recoverable. The court found that the total value of the case was actually $2,528,875.08, and that much like how the plaintiffs were unable to collect the full value of damages incurred, Medicare was also not entitled to recover its full $38,875.08 conditional payment interest.
² Under the MSP laws (42 U.S.C. § 1395y(b)), Medicare does not pay for items or services to the extent that payment has been, or may reasonably be expected to be, made through a no-fault or liability insurer or through Workers’ Compensation (WC). Medicare may make a conditional payment when there is evidence that the primary plan does not pay promptly, conditioned upon reimbursement when the primary plan does pay. Once the Medicare Secondary Payer Contractor (MSPRC) has information concerning a potential recovery situation, it will identify the affected claims and begin recovery activities. Insurers/WC carriers (as applicable), beneficiaries, and representatives/attorney(s) are required to recognize the obligation to reimburse Medicare during any settlement negotiations.
³ Primary plan means, when used in the context in which Medicare is the secondary payer, a group health plan or large group health plan; a workers’ compensation law or plan; an automobile or liability insurance policy or plan (including a self-insured plan); or no-fault insurance plan.
⁴ Pursuant to 42 CFR 411. 22, “responsibility” can be demonstrated by a judgment, settlement or verdict.
⁵ Procurement costs are the costs incurred in procuring a judgment, settlement or verdict.
Corpora/g415on (“Pennyrile”). Mr. Hadden’s medical bills totaled $82,036.17 and were paid by Medicare because he was a Medicare beneficiary. As a result of the accident, Mr. Hadden also chose to sue Pennyrile, demanding compensation for all of his medical expenses as well as other damages. Pennyrile eventually paid Mr. Hadden $125,000 in exchange for a full release of his claims against them.

According to Mr. Hadden, the accident was primarily the fault of an unidentified motorist who caused the Pennyrile truck to swerve into him. Mr. Hadden’s position was that the unidentified motorist was 90% at fault for the accident while Pennyrile was 10% at fault. Thus, the payment of $125,000 by Pennyrile to Mr. Hadden represented compensation for only 10% of his total medical expenses, or approximately $8,000. The case found its way to the Sixth Circuit after the administrative law judge and the district court found in favor of Medicare and ruled that Mr. Hadden was not entitled to a reduction in the Medicare conditional payment amount, but rather Medicare was entitled to receive the full amount that it demanded, which was $62,338.07.

ANALYSIS:  The Six Circuit found:

Under §1395y(b)(2)(B)(ii) as amended, if a beneficiary makes a “claim against a primary plan” and later receives “payment” from the plan in return for a “release” as to that claim, then the plan is deemed “responsible” for payment of “the items and services included in” the claim. Consequently, the scope of the plan’s “responsibility” for the beneficiary’s medical expenses – and thus of his own obligation to reimburse Medicare – is ultimately defined by the scope of his own claim against the third party. This is true even if the beneficiary later “compromises” as to the amount owed on the claim and if the third party never admits liability. As a result, a beneficiary cannot tell a third party that it is fully responsible for all of his medical expenses and later tell Medicare that the same party was responsible for only 10% of those expenses.

Based upon this finding, the Sixth Circuit took the position that Mr. Hadden was responsible for reimbursing Medicare in full because he made a claim against Pennyrile for the full value of his medical expenses. Therefore, because Mr. Hadden demanded payment of his medical expenses in full, he must then reimburse Medicare for those same expenses in full. Had Mr. Hadden obtained a court approved allocation on the merits of the case,7 as in Bradley vs. Sebelius, perhaps a different outcome could have been possible. But here, Mr. Hadden elected to argue that Medicare’s right of recovery should be reduced based upon a theory of equitable apportionment and the court was unwilling to agree.

Not only did the court disagree with Mr. Hadden’s argument of equitable apportionment, but the court also appeared to set precedent that whenever a plaintiff, who is a Medicare beneficiary, claims all of his medical expenses as part of his damages, Medicare’s entire conditional payment interest must be paid in full regardless of the amount of insurance coverage that is available. The possibility of such a result is absurd and in contradiction to 42 CFR §411.37. This statute limits Medicare’s right of recovery to the full amount of the payment made by the primary plan less procurement costs, even in cases where Medicare’s conditional payment amount exceeds the judgment or settlement amount. The court’s failure to recognize this limitation is unacceptable 7

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6 Medicare’s total conditional payment interest was $82,036.17, but this amount was reduced by attorney’s fees and costs pursuant to 42 CFR 411.37. This led to Medicare’s final conditional payment demand being $63,338.07. That said, the case states that the total medical expenses were $82,036.17, the same as Medicare’s conditional payment amount. This seems to be in error, as Medicare does not generally pay Medical bills in full, but rather at a reduced rate.

7 The Medicare Secondary Payer Manual states that Medicare will only accept an allocation of damages when the allocation is approved by a court based upon the merits of the case. When such an allocation is obtained, Medicare will only seek to recover its interest from the medical expense allocation of the settlement, judgment or verdict.
and its ruling will now only cause more confusion in an area full of misunderstanding.

Sixth Circuit Judge, Helen White, beautifully captures the problem with the Sixth Circuit’s failure to acknowledge the limitation on Medicare’s right of recovery by stating:

The majority concludes that if it is demonstrated that the primary plan had a responsibility to make payment with respect to an item or service paid for by Medicare, then the primary plan or an entity receiving payment from the primary plan is liable to the Secretary [Medicare] for the full amount the Secretary [Medicare] paid with respect to the item or service, without regard to the amount paid to the entity receiving payment from the primary plan... If the provision means what the majority says it means, i.e. responsibility means full responsibility for the item or service, then a tortfeasor who settles for less than the amount paid by Medicare is liable to the Secretary [Medicare] for the difference, regardless of the extent of the tortfeasor’s liability for the injuries with respect to which the medical expenses were incurred.

CONCLUSION: It appears the court simply wanted to rule that whenever a primary plan is deemed “responsible,” this plan or any entity that receives payment from the primary plan must then reimburse the Center for Medicare and Medicaid Services for Medicare’s conditional payments. In this case, Medicare’s conditional payment amount was less than the full amount of the settlement and no court approved allocation of the settlement payment was obtained. Thus, because Medicare will only limit its right of recovery when trying to recover from a settlement, judgment or verdict that is allocated by a court based upon the merits of a case, Medicare argued that it was entitled to receive full reimbursement of its conditional payment interest and the court agreed. Unfortunately, in ruling in favor of Medicare, the court failed to acknowledge that Medicare’s right of recovery cannot exceed the total amount of the settlement, judgment or verdict less procurement costs. By failing to acknowledge the scope of Medicare’s recovery right under 42 CFR §411.37, this ruling now only adds to the confusion associated with Medicare compliance.

The biggest difference between the ruling in Bradley vs. Sebelius and Vernon Hadden vs. United States of America, is that Bradley vs. Sebelius involved a settlement that was allocated by a court based upon the merits of the case, while Hadden vs. United States of America did not. Hadden’s argument was that Medicare’s right of recovery interest should be limited based purely on a theory of equitable apportionment. While there is no way to know how the court in Hadden vs. United States of America would potentially rule on a case involving a court approved allocation, its highly likely that if Mr. Hadden had obtained such an allocation that he would have found himself in a far greater position.

TAKEAWAY: When comparing the rulings from Hadden vs. United States of America and Bradley vs. Sebelius it is clear that obtaining a court approved allocation of a settlement, judgment or verdict is far more effective in limiting Medicare’s right of recovery than relying upon an argument of equity. That said, there is no exact science to obtaining a court approved allocation of a settlement, but it is critical that the facts of the case be presented to the court prior to approval being obtained. It is also imperative that a court approved allocation be based upon the facts and merits of the case and not merely a judge’s rubberstamping of a proposed order. Furthermore, it is always advisable to provide notice to Medicare of an allocation hearing so that it is afforded the opportunity to attend and argue its position should it so desire. State law determines the property right (the tort claim) upon which a person can sue and Medicare must abide by a state court’s interpretation of that right and associated damages. The state court if used properly can be the most effective methodology to limiting Medicare’s right of recovery.
In light of *Hadden vs. United States of America* and *Bradley vs. Sebelius*, it is now more important than ever that Medicare’s conditional payment interest be determined as early as possible. Without knowing Medicare’s conditional payment interest, it is difficult for both the attorney and/or the client to fully evaluate the benefits of litigation, especially if Medicare’s conditional payment amount is large and the interest limits are small. A client does not want to go through the process of litigation only to find out they helped reimburse Medicare, but did very little to satisfy their own interests.

If Medicare’s interest is substantial and the insurance is limited, then the client and his/her attorney should consider the following:

1. Outsourcing the resolution of Medicare’s interest to a provider who focuses on Medicare Compliance;

2. Obtaining a pre-settlement compromise or waiver (based upon hardship) with Medicare;

3. Petitioning the court, like in *Bradley vs. Sebelius*, for an allocation of settlement/verdict proceeds, which will help limit Medicare’s right of recovery to the settlement proceeds allocated to medical damages; and

4. Exhausting all the administrative remedies available to reduce Medicare’s interest in a claim.

For additional information or to discuss your estate plan, contact:

**Peter H. Wayne, IV** is a member of Wyatt’s Special Needs and Government Benefit Analysis practice. Mr. Wayne focuses his practice on the evaluation of applicable government benefits, special needs, and Medicare set-aside trusts as well as settlement planning. He also works with the Firm’s Health Care Service Team on issues relating to Medicare and Medicaid compliance. For additional information, visit www.wyattfirm.com.

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If the Medicare beneficiary involved in your case is not a resident of one of these states, please contact the appropriate Centers for Medicare & Medicaid Services' Medicare Secondary Payer Regional Office. If you do not have that information please contact Sally Stalcup (contact information below) for that information.

The law does not require a "set-aside" in any situation. The law requires that the Medicare Trust Fund be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law.

Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

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. This also governs Workers' Compensation. 42 CFR 411.50 defines 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 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. If they are not funded there is no reasonable expectation that third party funds are available to pay for those services.

There is no formal CMS review process in the liability arena as there is for Workers' Compensation. However, CMS does expect the funds to be exhausted on otherwise Medicare covered services related to what was claimed/released before Medicare is ever billed. CMS review is decided on a case by case basis.
The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded.

While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc., 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.

We use the phrase "case related" because we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payments 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.

"Otherwise covered" means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust fund. For example, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate.

At this time, the Centers for Medicare & Medicaid Services (CMS) is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. We do however urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.

CMS does not review or sign off on counsel's determination of whether or not there is recovery for future medical services and thus the need to protect the Medicare Trust Fund and only in limited cases do they review or sign off on counsel's determination of the amount to be held to protect the Trust Fund.

There is no formal CMS review process in the liability arena as there is for Workers' Compensation, however Regional Offices do review a number of submitted set-aside proposals. On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the "set-aside" aspect of that request we only
need to state that IF there was/is funding for otherwise covered future medical services related to what was claimed/released, the Medicare Trust Fund must be protected. If there was/is no such funding, there is no expectation of third party funds with which to protect the Trust Fund. Each attorney is going to have to decide, based on 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 Fund. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them to protect the Medicare Trust Fund. It will also be part of their report to Medicare in compliance with Section 111, Mandatory Insurer Reporting requirements.

Medicare educates about laws/statutes/policies so that individuals can make the best decision possible based on their situation. This is not new or isolated to the Medicare Secondary Payer provisions. Probably the best example I can give is the 2008 final rule adopting payment and policy changes for inpatient hospital services paid under the Inpatient Prospective Payment System. That final rule also adopted a number of important changes and clarifications to the physician self-referral rules sometimes known as the Stark provisions. The physician self-referral law prohibits physicians from referring Medicare and Medicaid patients to certain entities with which the physician or a member of their immediate family has a financial relationship. Exceptions apply. Requests for determinations as to whether or not the physician met the exception criteria, or whether or not their situation was covered by this prohibition poured in. CMS/Medicare did not and continues to make no such determinations. It is the responsibility of the provider to know the specifics of their situation and determine their appropriate course of action.

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