Medicaid Third-Party Recovery: A Moving Target

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SUMMARY
The landscape of Medicaid Secondary Payer recovery continues to develop at a rapid pace. This evolution requires lawyers practicing in the areas of personal injury and worker's compensation law, and other interested stakeholders, to take note and refine their best practices to meet clients' needs. Failure to do so will result in settlement delays and costly malpractice actions.

BY AARON FREDERICKSON

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In the face of increased demands for health care and decreased Medicaid funding, states are becoming more aggressive in efforts to find and collect from potentially liable third-party payers.

Changes earlier this year to the Medicaid Secondary Payer Act are a prime example of factors that are driving the need for lawyers and entities that handle injury claims to keep Medicaid recovery rights and processes top of mind in their practices. Delays in the effective date of the Act are forcing state programs to draw firm boundaries when it comes to claim identification and recovery processes. Lawyers must implement effective best practices to balance aggressive governmental collection efforts and protection of client interests.

Medicaid Secondary Payer Act: A Primer

The Medicaid program became law in 1965 as part of President Lyndon Johnson's "War on Poverty."[1] Created to provide health care to low-income and disabled individuals, the program remained relatively the same until passage of the Patient Protection and Affordable Care Act (ACA) in 2010. Under current program guidelines, anyone who has a household income under 133 percent of the federal poverty level (roughly $25,100 for a family of four) and is under age 65 qualifies for Medicaid.[2]

To deal with funding constraints, state Medicaid programs undertook aggressive recovery efforts in injury cases. This included instances when state programs sought to recoup money paid on behalf of Medicaid recipients beyond what some believed was allowable under federal law. In *Arkansas Department of Human Services v. Ahlborn*,[3] a unanimous U.S. Supreme Court limited state Medicaid programs in their ability to recover.

The result of the decision to not allow full recovery similar to that of Medicare[4] forced states to be creative in a number of ways when addressing the ongoing solvency of their Medicaid programs. These limitations, along with continued decreased funding for Medicaid expansion built into the ACA, have prompted Medicaid agencies to seek other means to achieve their objectives.

In late 2013, a Republican-controlled Congress was deadlocked with Pres. Barack Obama and other Democrats regarding ongoing funding for the federal government. As time was running out on resolving the budget impasse, then Rep. Paul Ryan (R-WI) and Sen. Patty Murray (D-WA) reached a compromise on budget matters that kept the federal government operating.[5] One of the measures incorporated into the new law included what has become known as the Medicaid Secondary Payer Act, which took effect Oct. 1, 2014.[6] With the passage of the Act, states were to have the ability to pursue recovery of "any payment from a third party that has a legal liability to pay for care and services available under the plan."[7]

This expansive language was a godsend to state Medicaid programs but received immediate opposition from lawyers representing injured persons and insurance carriers. From a state government perspective, the expanded ability to recover in all injury-related cases allowed states to recover a greater portion of an injured recipient's settlement. However, the trial lawyers' lobby was able to convince Congress to delay the law's effective date.[8] Although the Act did eventually go into effect, on Oct. 1, 2017, its existence was short-lived when subsequent congressional action extended the matter until Oct. 1, 2019, and possibly beyond.[9]

Effect of Recent Changes on Injury-related Cases

The concept of third-party liability has taken center stage following the passage of the Deficit Reduction Act of 2005 (DRA).[10] In a nutshell, this

law directed state Medicaid programs to take a more active role in collection efforts from third parties (for example, individuals, entities, insurers, and pharmacy benefits management or programs) related to medical expenditures made on behalf of Medicaid recipients. Central to the rising concerns regarding Medicaid solvency, Congress placed additional requirements on states to make all reasonable efforts to ascertain the legal liability of third parties and streamline coordination of benefits.

The main objection to increased settlement authority by state Medicaid programs revolved around the disincentive to settle claims involving program recipients. This is based on the premise that a Medicaid program can recover from settlement proceeds beyond those related to "care and services." If more cases go to hearing or trial, there is a diminished ability of Medicaid programs to recover if the defense prevails. Plaintiff-recipients would also suffer by being deprived of the opportunity to resolve an injury claim. The merits of this argument were never resolved given the Medicaid Secondary Payer Act's brief lifespan of about six months.[11]

Notwithstanding these delays, it is important for lawyers and other interested stakeholders in injury-related cases to pay attention to the ever-changing legal landscape. Important steps to take include the following:

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• Determine a claimant's Medicaid (and Medicare) status at the onset of a claim. For lawyers representing injured parties, this should be standard practice upon intake. Defense attorneys should include questions regarding this issue in their discovery.

• Place the correct state agency on notice regarding potential Medicaid claims. All states have a third-party-recovery practice codified into statute or administrative rule.

• Keep the state Medicaid program apprised of case developments, including settlement.

Fighting Back via Strict Enforcement and Compliance

The pressure on states to maintain a solvent Medicaid program while being constrained in recovery options presents challenges for everyone involved in the third-party-recovery process. Ongoing delays are not helping the situation. These challenges for Medicaid programs are compounded by many factors, mainly the following:

• Federal mandates that require proactive recovery efforts and compliance with program requirements;

• Decreased funding for Medicaid expansion starting Jan. 1, 2017, as designated under the ACA (before suggested funding cuts from the Trump administration); and

• Increased efforts by plaintiffs' and defense attorneys to have state Medicaid programs pay for medical services related to injury claims and then settle their claims – a "pay and chase" mentality not permitted when it comes to Medicare beneficiaries.[12]

Administrators of Medicaid programs are drawing a line in the sand as they enforce federal mandates concerning third-party liability and attempt to maintain the integrity of their programs. Notwithstanding the ongoing delays on the federal level, rules have been implemented to support the mission of providing better care.[13] While third-party-recovery matters are not specifically addressed, key changes will allow states to enhance the recipient experience and promote accountability and transparency.[14]

Primary Payer Identification and Recovery Efforts. State programs have generally been required to use data-match processes in third-party-liability situations. Initial efforts were limited to the initial application and redetermination process. In 1987, third-party-identification efforts were expanded to require states to incorporate these practices for all worker's compensation and motor vehicle accident claims.[15] Given advancements in technology, states have a greater ability to identify settlements involving Medicaid recipients and make recovery claims.

An example is Rhode Island's Medical Assistance Intercept System (MAIS).[16] Under this innovative program, Rhode Island is taking the following steps to recover money paid to beneficiaries in injury claims:

• Electronically match Rhode Island Medicaid recipients with liability and worker's compensation insurance claims;

• Provide insurance companies and lawyers the option of doing a data match through either the Insurance Services Office (ISO) Claim Search or the MAIS interactive lookup system;

• Intercept payments of $500 or more for reimbursement to the Rhode Island's Medicaid Program in worker's compensation and personal injury cases; and

• Require all insurance companies doing business in Rhode Island to participate in the MAIS program.

Payment Integrity While Playing "Pay and Chase." Like Medicare, Medicaid is a payer of last resort.[17] Given this role, medical bills are often submitted to these programs without consideration to liability. The result is Medicaid programs end up paying for medical expenses that instead should be processed and paid by private insurance. The responsibility then falls on these governmental programs to

investigate and seek repayment from the liable third party.

Recent studies by the federal government have examined the effectiveness of state Medicaid programs and their recovery processes. According to a 2013 report from the U.S. Department of Health and Human Services – Office of Inspector General, programs are doing a better job using technology and data-match systems to be reimbursed for funds incorrectly paid.[18] According to this report, savings through recovery increased from $34 billion in 2001, to over $71 billion in 2011. This 114 percent increase was attributed mainly to better processes and third-party cooperation through the assistance of technology. A later examination by the U.S. Government Accountability Office confirmed continued progress into 2015 but laid the groundwork for areas of growth and opportunity outside Congressional intervention.[19]

States have taken notice and are leading in the area of effective recovery models. An example is West Virginia's attempt to further clarify Medicaid's priority rights when recovering in all injury cases. Under recent legislation that went into effect July 1, 2018, it can be argued the West Virginia Medicaid program is in a better position to negotiate settlements in injury cases involving recipients. This is based on statutory changes that require a trial court to "give due consideration to the department's interests in maximizing recovery for purposes of the operation of the Medicaid program" in instances when an injury case settles but a dispute remains as to what percentage of the case involves Medicaid reimbursement.[20]

Proposed Legislation Could Ease Burden on the States

Current legislation in Congress could resolve some of the problems state Medicaid programs face related to recovery and collections.[21] The proposal, if enacted, will do the following:

• Expand the definition of a "responsible third party" to include health insurers such as the TRICARE program;

• Expand the ability of a state Medicaid program to recover from a contracting health insurer in terms of third-party-recovery efforts;

• Remove the ability of a responsible third party to deny repayment of certain claims based on the failure to obtain prior authorization;

• Require a quicker response by a responsible third party to respond to a state's inquiry regarding a claim for payment; and

• Apply Medicaid third-party-liability requirements to the Children's Health Insurance Program (CHIP).

Passage of this measure remains uncertain. Until then, states will need to take aggressive action within the narrow confines of existing laws and regulations to recover as much as possible in all injury-related cases. Failure to do so will result in programs hovering on the brink of solvency, further complicated by increasing enrollment and expansion that cross the line.

Using Medicaid Set-asides in Third-party Recovery

Given the increasing pressures on Medicaid programs, state Medicaid programs might need to explore using claims for future medicals and set-asides, which are common under Medicare recovery efforts.

Under the federal framework establishing the Medicaid program, a recipient of benefits is required to assign his or her rights as a condition of eligibility to the program.[22] When making this assignment, state programs are given the same rights as the person benefiting from the program. This includes the right "to medical support and to payment for medical care from any third party."[23] While the argument is circular, if the recipient is settling an injury-related case that contemplates the need for future medical care and treatment related to the claim, something to be considered in the settlement is the need for the future interests of Medicaid and continued program solvency.

There is support for this argument in the limited, but continuing to evolve, case law regarding Medicaid compliance and coordination of benefits. One example comes from *Neal v. Detroit Receiving Hospital*,[24] in which the Michigan Court of Appeals reviewed a settlement involving the recovery rights of the Medicaid program in the context of a personal injury claim. Meridian Health Plan of Michigan[25] covered $298,869.19 in medical benefits. Due to contractual discounts, the Medicaid

Wisconsin's Medicaid Third-party Recovery Process

The Wisconsin Department of Health Services (DHS) contracts with Health Management Systems Inc. (HMS) for Medicaid third-party-recovery efforts. The role of HMS is to identify, manage, and recover when the Medicaid programs pays for medical care and treatment for injured individuals. Information related to their processes is at www.wicasualty.com/wi/recovery.asp.

Medicaid beneficiaries, their lawyers, or insurance claim handlers involved in an injury-related case involving a beneficiary are asked to make immediate report to HMS. This can be accomplished by downloading, completing, and submitting a subrogation recovery information form, along with applicable authorizations. Additional information requested should include information about preexisting conditions, treatment information, and bills related to these services. HMS should respond with an interim or final statement about 10 business days after it receives the form.

The DHS has a right of recovery under federal law and Wis. Stat. sections 49.89 and 102.27. **WL**

program paid providers $110,283.19. The parties eventually reached a confidential agreement. Under the terms of this settlement, there was an apportionment of settlement assigned to damages: 55 percent for noneconomic damages; 40 percent for economic damages (loss of earning capacity, attendant care, and household services); and 5 percent for medical expenses.[26]

While the parties included Meridian in settlement negotiations, they did not agree on reimbursement to the program. Meridian sought payment for 100 percent of the amounts it had paid for the plaintiff's medical care and treatment. After failure to reach settlement, the program brought an action and was awarded the full amount. The plaintiff filed an appeal.

While the reviewing court limited recovery consistent with *Ahlborn*, the *Neal* court noted there was sympathy for the program and its ability to recover consistent with the assignment-of-rights provisions found in federal law. While the program's recovery was limited to the "payment of medical care," an argument can be made via case *dicta* that future medical expenses should be considered.[27]

Support for future medicals in Medicaid third-party recovery could also come from the Medical Care Recovery Act.[28] Under this federal law, states via the federal government could make the argument they are entitled to reimbursement for the "reasonable value of the case and treatment" furnished in injury-related cases, which includes future medicals.[29] This argument could be coupled with agency deference given to recovery tools such as Medicare set-asides.[30] While much discussion would need to take place before developing such policy, it is conceivable states may take the time and effort required to construct a policy concerning future medicals that would survive judicial review and scrutiny.

Conclusion

The increasing cost of health care and recovery limitations placed on programs have resulted in states taking a hard line to meet the challenges of an expanding group of Americans receiving Medicaid benefits. These circumstances and changes regarding Medicaid Secondary Payer and third-party liability issues should force all interested stakeholders to pay attention and adopt proactive best practices when handling injury claims. Failure to do so can result in adverse governmental action and malpractice claims. These efforts must also include a willingness on the part of all stakeholders to keep the solvency of Medicaid programs in mind as they navigate their cases through the perils of settlement and litigation. **WL**

ENDNOTES

[1]Amendments to the Social Security Amendments of 1965, Pub. L. No. 89-97, as codified in 42 U.S.C. §§ 1396 *et seq.*

[2]www.federalregister.gov/documents/2017/01/31/2017-02076/annual-update-of-the-hhs-poverty-guidelines.

[3]547 U.S. 268 (2006).

[4]*Hadden v. United States*, 661 F.3d 298 (6th Cir. 2011). Central to the court's holding was a reliance on the Center for Medicare and Medicaid Services' (CMS) policy interpretations of Hadden's "demonstrated responsibility" to reimburse Medicare under 42 U.S.C. § 1395y(b)(2)(B)(ii), and amendments to the Act in 2003. Many observers have criticized this acceptance of CMS policy via *Chevron* deference on the ground it does not promote settlements but instead encourages litigation. The author is not aware of any legal studies that demonstrate such correlation exists. These are the same arguments opponents of the Medicaid Secondary Payer Act use when advocating for delays in the law's implementation.

[5]Bipartisan Budget Act of 2013, Pub. L. No. 113-67, § 202, as amended in 42 U.S.C. § 1396a(a)(25) and 42 U.S.C. § 1396k(a)(1)(A).

[6]*Id.*

[7]Pub. L. No. 113-67, § 202. Amendments to 42 U.S.C. § 1396k(a)(1)(A) were only briefly in effect in late 2017 and early 2018, as discussed herein.

[8]Pub. L. No. 113-67, § 202 – amendments to the Bipartisan Budget Act of 2013. These provisions were to take effect on Oct. 1, 2014, but were delayed two years per section 211 of the Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, which extended the effective date until Oct. 1, 2016. Section 220 of the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, extended the effective date until Oct. 1, 2017.

[9]Pub. L. No. 115-123, § 53102 – amendments to the Bipartisan Budget Act of 2013. 42 U.S.C. § 1396k(a)(1)(A), as it currently reads, limits Medicaid recovery to only "… medical care from any third party."

[10]Enhancing Third Party Identification and Payment, Pub. L. No. 109-171, § 6035, as codified at 42 U.S.C. § 1396a(a)(25); *see also* 42 C.F.R. § 433.135.

[11]Pub. L. No. 115-123, § 53102.

[12]*See generally* 42 U.S.C. § 1395y(b)(2).

[13]CMS-2390-F; Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability.

[14]*See generally* 42 C.F.R. § 438, 42 C.F.R. § 457.

[15]42 C.F.R. § 433.138 *et seq.*

[16]The statutory authority for MAIS is found under R.I. Gen. Laws § 27-57.1-1. The program applies to any domestic insurer or insurance company authorized to issue policies of liability insurance or worker's compensation insurance.

[17]*United States ex rel. Digital Healthcare Inc. v. Affiliated Comput. Servs.*, 778 F. Supp. 2d 37, 48 (D.D.C. 2011); CMS, *State Medicaid Manual*, Pub. No. 45, ch. 3, §3900.1.

[18]*Medicaid Third-Party Liability Savings Increased, But Challenges Remain* (OEI-05-11-00130).

[19]*Medicaid – Additional Federal Action Needed to Further Improve Third-party Liability Efforts* (GAO-15-208).

[20]W. Va. Code § 9-5-11(b)(6), (d)(3)(B). The bill as originally submitted (WVa. H.B. 4392 - *Relating to Medicaid Subrogation Liens of the Department of Health and Human Resources*) sought to provide the Medicaid program with full reimbursement rights, but this provision was not included in the final bill as enacted.

[21]H.R. 938 - Medicaid Third Party Liability Act (115th Congress).

[22]42 U.S.C. § 1396k; 42 C.F.R. § 433.145.

[23]42 C.F.R. § 433.145(a)(1).

[24]319 Mich. App. 557 (2017).

[25]Meridian Health Plan (MHP) is a Medicaid managed care organization in the state of Michigan.

[26]*Neal*, 319 Mich. App. at 561-62.

[27]*Id.* at 565, 575-77.

[28]42 U.S.C. § 2651.

[29]42 U.S.C. § 2651(a).

[30]*See Glover v. Philip Morris USA*, 380 F. Supp. 2d 1279, 1290 (M.D. Fla. 2005), *aff'd sub nom, Glover v. Liggett Grp. Inc.*, 459 F.3d 1304 (11th Cir. 2006); *O' Connor v. Mayor & City Council of Baltimore*, 494 F. Supp. 2d 372, 374 (D. Md. 2007). **WL**

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