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MEDICARE AND MEDICAID LIENS IN P.I. CASES

Referred to in the June 2006 issue, page 2

When a client's injury is caused by a tortfeasor's negligence, the need for medical treatment begins immediately and the costs begin accruing. Sometimes, the client has no medical insurance or the insurer refuses to pay for injury-related medicals.

Months or years may pass before the case is settled. In the absence of primary insurance coverage, Medicare and/or Medicaid often pay the client's medical providers for the injury-related medical costs prior to settlement. If so, statutory liens must be resolved prior to disbursement of settlement proceeds to the client. Failure to resolve the liens could subject the attorney, client, and "primary plans" to enforcement actions by Medicare and Medicaid.

MEDICARE LIENS

Medicare is a federal health care plan available to individuals who: (1) are 65 years or older; (2) have received Social Security Disability Insurance (SSDI) for at least two years; or (3) have End Stage Renal Disease (ESRD). Medicare is administered by the federal administrative agency Centers for Medicare and Medicaid Services ("CMS"). The CMS Web site, www.cms.gov/medicare, is voluminous and quite helpful.

The Medicare Secondary Payer Statute (MSP), created by the Omnibus Budget Reconciliation Act of 1980 and codified as 42 U.S.C. 1395y(b)(2), provides that Medicare will not pay for items and services for which a Medicare beneficiary has received payment or can reasonably expect payment from a "primary plan."

Primary plans include, but are not limited to, liability insurance, health insurance, no-fault insurance, automobile insurance, self insurance, employers, judgments, settlements, and compromises. Medicare's interest must be adequately considered in each of these cases. 42 C.F.R. 411.46.

Even though the MSP clearly shifts financial responsibility to an available primary plan, when a Medicare beneficiary is injured, a Medicare card is readily furnished to the Medicare participating provider. Medicare is then billed for Medicare covered services.

Medicare payments made prior to settlement are called "conditional" because the payments are made on the condition that the responsible party will ultimately pay the injury-related medical costs.

Generally, the government is granted a direct right of action to recover conditional payments from entities that are required to make payments under a primary plan, or from other entities that have received payment from such entities. 42 U.S.C. 1395y(b)(2)(B)(ii).

Entities from whom the government has a right to recover include a beneficiary (42 C.F.R. 411.23(b)) provider, supplier, physician, attorney, state agency, employer, third party administrator, or private insurer that has paid or received a third party payment. 42 C.F.R. 411.24(e) and (g). Once the beneficiary or other party receives a third party payment,

Medicare's right to demand payment begins.

Medicare must be reimbursed within 60 days of receiving such payment. 42 C.F.R. 411.24(h). CMS is entitled to interest 60 days from the date notice or other information regarding third party payment is received by CMS until payment is made. 42 C.F.R. 411.24(m)(ii). The case is referred to the Office of General Counsel for recovery 120 days after the date of the demand. 42 C.F.R. 411.24(b).

If Medicare is not reimbursed as required, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party. 42 C.F.R. 411.24(h)(i). When CMS has to recover conditional payments from the primary payer, double damages plus the original payments may be assessed. 42 C.F.R. 411.24(c)(2), *U.S. v. Sosnowski*, 822 F. Supp. 570 (W.D. Wis. 1993).

The personal injury (P.I.) lawyer in *Sosnowski* who challenged Medicare's right to recover conditional payments was not deemed a primary payer, thus avoiding double damages. However, CMS recovered $15,066.68 of the $25,000 policy limits.

The MSP lien has priority over all other parties and claims, including Medicaid. *U.S. v. Geier*, 816 F. Supp. 1332 (W.D. Wis. 1993). CMS has the right to garnish the client's Social Security and Railroad Retirement benefits, as well as federal income tax refunds. The client's future Medicare coverage may be suspended.

Unless CMS sues to recover conditional payments, recovery is reduced to take account of the cost of "procuring" the judgment or settlement if the claim is disputed and such costs are "borne" by the client. Procurement costs include attorney's fees, court costs, and expert witness fees. 42 C.F.R 411.37 details the procurement cost computation formula. Most P.I. cases meet these requirements.

CMS may waive or compromise its claim beyond procurement costs in the following circumstances: (1) The Medicare claim exceeds the settlement amount; (2) The client has permanent injuries, lost wages or is unemployed; (3) There are unreimbursed out-of-pocket expenses; (4) The client's income is less than his/her costs of living. CMS: Information Package, Medicare Secondary Payer and Section 3418.11, Intermediary Manual, Part 3. *See* Meifert, Patty and Lewis, Robert T., "Medicare Conditional Payments: Assessing Exposure, Protecting Interests." http://www.nuquestbridgepointe.com/services/med_res/nq_focus_article-1-05.pdf.

If the client is 65 or older, Medicare will pay some or all of the presettlement injury-related medicals. If the client is under 65, Medicare will not pay injury-related medical costs until the client turns 65 or the client has received SSDI for two years, whichever occurs first. Catastrophically injured clients may become Medicare beneficiaries 30 months after the injury, triggering a conditional Medicare claim.

Do not advise your client to delay application for Social Security Disability benefits to avoid the MSP claim. Such delay could permanently disqualify your client from receiving SSDI and delay Medicare eligibility until age 65 if the client is unable to return to work.

Sometimes the client receives a different Social Security benefit, Supplemental Security Income (SSI). This benefit brings Medicaid eligibility, not Medicare. Many clients, especially catastrophically injured clients have dual eligibility. Frequently, the client, family and significant others have no idea if the Social Security benefit is SSDI, SSI or both. P.I. settlements and judgments are subject to both Medicare and Medicaid liens.

MSP CLAIM RESOLUTION

Successful and timely resolution of the Medicare lien should start long before settlement to avoid delay and interest charges. The average processing time required for CMS and the Medicare Fiscal Intermediary (the private contractor assigned to investigate and process the claim on behalf of Medicare) is generally 2 to 4 months.

The P.I. attorney can handle the many details of MSP conditional claim resolution or can use one of several private companies specializing in MSP compliance and claim resolution. Their services often include knowledgeable analysis of all Medicare charges your client received from the time of injury to judgment or settlement to eliminate non-injury Medicare covered services from the total MSP claim. Few P.I. firms have this expertise in-house.

Your first step is to determine whether your client (1) was already on Medicare when injured, (2) will turn 65 before settlement, or (3) will likely not return to work and then receive SSDI. Medicare eli-

gibility will begin 30 months after SSDI is granted by award letter. If you anticipate settlement or judgment will occur beyond 30 months, or your client is on Medicare when injured or will turn 65 before settlement, MSP compliance is an issue.

As soon as you determine that injury-related Medicare conditional payments are being made, MSP compliance is needed. Initially call (not write or e-mail) the CMS Coordination of Benefits Contractor (COBC) at 800-999-1118 and report the following information: (1) Client's Medicare number and contact information; (2) Date of injury; (3) Description of injury, preferably in ICD-9 code; (4) Name and Address of Primary Payer; (5) Name and address of your client's legal representative (you); and (6) Time frame of conditional payments made.

CMS then hands off to the fiscal intermediary (FI) assigned to the case to process claim resolution. Now submit a written request for an estimate of conditional payments to the FI with a Medicare Consent To Release Form signed by your client. The FI will provide a Medicare claim payment summary for Part A and Part B expenses. Sometimes non-injury-related expenses are incorrectly shown and are not subject to MSP compliance. Procurement costs are then deducted from Medicare payments, subject to compromise or waiver in extreme hardship cases.

MEDICAID LIENS

Unless your client is a Medicare beneficiary at the time of injury or has private major medical insurance that continues to pay the injury-related medical costs, Medicaid will be the only likely medical reimbursement source. Later, your client may become eligible for Medicare, so both Medicaid and Medicare liens must be resolved. Dual eligibility is common in catastrophic cases, such as head and spinal cord injuries.

Medicaid, Title 19 of the Social Security Act, codified as 42 U.S.C. 1396, was implemented in 1965, the same year as Medicare. It is federal and state funded (approximately 65% federal and 35% state). Medicaid is administered by the states. In Oregon, the Department of Human Services, (DHS) is the administrative agency.

Medicaid is not one program, but is a conglomeration of programs, some mandated by federal law and some created by states through the "waiver" program. The Oregon Health Plan (OHP) is a waiver program created by the Oregon Legislature and DHS. Many discrete populations are served, but most eligibles are children, aged, blind, or disabled. Eligibility is income and resource means tested.

In most states, all Medicare part A and part B services are also covered by Medicaid. In addition, Medicaid covers all levels of long-term care with no covered-stay limitations, including home care in some states, like Oregon. Medicaid also covers prescription drugs, attendant care, vision, dental, chiropractic services, and medical transportation.

Unlike Medicare, which is based primarily on federal authority, Medicaid law has the following sources of authority: (1) 42 U.S.C. 1396; (2) 42 C.F.R. 430 et seq.; (3) Federal SSI statutes and regulations in most states; (4) CMS State Medicaid Manuals and Transmittals; (5) State statutes and administrative rules; (6) State administrative hearing opinions; (7) State attorney general advisory memos; (8) Federal case law; and (9) State case law.

Although the states are mandated to administer Medicaid in a manner that is no more restrictive than federal law, state interpretations vary greatly, producing vast program administration differences between states. CMS can and does approve state-specific Medicaid waivers that add or subtract covered services or eligible populations and sometimes rewrite basic eligibility rules of 42 U.S.C. 1396p. The Oregon Health Plan is an example of a waiver program.

The states were given significant options regarding asset and income protections when 42 U.S.C. 1396p was implemented on October 1, 1988. State budget deficits have produced many Medicaid budget cuts by states. Most recently, the Deficit Reduction Act (DRA) of 2005, Public Law No. 109-171, signed by the President on February 8, 2006, significantly amended 42 U.S.C. 1396p and eligibility provisions concerning asset transfers, treatment of annuities, and home equity in excess of $500,000. Most of Oregon's new and amended administrative rules implementing DRA will be effective July 1, 2006.

Medicaid lien provisions are found at 42 U.S.C. 1396a(a)(25) and 42 U.S.C. 1396k, (1396k) and require that, as a condition of eligibility, a Medicaid recipient must assign to a state Medicaid agency "…rights to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party." 42

U.S.C. 1396k(1)(A). Further, the recipient must cooperate with the state Medicaid agency "…in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan…." 42 U.S.C 1396k(1)(C).

However, federal and DHS authority exists putting limits on how much of the settlement proceeds can be applied to satisfy the 1396k claim. On May 1, 2006, the United States Supreme Court in *Arkansas v. Ahlborn*, 547 U.S. _____, 126 S. Ct. 1752, (U.S. 2006), struck down an Arkansas statute that allowed the Medicaid agency to automatically impose a lien on the entire settlement amount, not just the portion of the settlement that represents medical costs.

Affirming the Eighth Circuit's reversal of the District court, the *Ahlborn* opinion held that when the state's 1396k lien exceeds the portion of the settlement that represents medical costs and is satisfied from other damages such as pain and suffering, lost wages, and loss of future earnings, the state statute contravenes 42 U.S.C. 1396p(a), the anti-lien provision, and is unenforceable.

The Court went on to discuss the issue of settlement manipulation by the parties to a tort suit to reduce the 1396k claim. "Even in the absence of such a post-settlement agreement, the risk that parties…will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." Id. at 1765.

ORS 416.510 to 416.610 and OAR 461-195-0301 to 461-195-0350 create the statutory and administrative mechanisms for identifying, perfecting, collecting, and reducing the 1396k claim on settlement proceeds. On January 1, 2006, DHS updated the OAR provisions regarding 1396k claims, predating *Ahlborn*. Thus, the provisions of ORS 416.540(1) and OAR 461-195-0305(1) that include "all assistance received" from the date of injury to the date of judgment or payment in the 1396k lien amount to be recovered do not comply with *Ahlborn*.

If a Medicaid recipient received injury-related OHP benefits, ORS 416.540(3), ORS 416.610, and OAR 461-195-0321 allow DHS to assign the 1396k claim for OHP payments to a participating prepaid managed care health care services organization (PMCO), such as CareOregon, for resolution.

ORS 416.540(2) and OAR 461-195-0305(3) provide that the 1396k lien will not attach to the amount of any judgment, settlement, or compromise to the extent of the attorney fees, costs, and expenses incurred to obtain the award and personal injury protection (PIP) pursuant to ORS 742.520. If the injured party paid or is personally liable for injury-related medical costs out-of-pocket, the lien will also not attach to such payments. OAR 461-195-0305(4).

OAR 461-195-0325 provides that DHS and a PMCO "may distribute" to the recipient 25% of the net settlement if the lien amount is more than 75% of the net settlement. If a PMCO holds the only lien through assignment by DHS, the PMCO "must distribute" 25% of the net settlement to the recipient. OAR 461-195-0325(2)(d).

If the injured party is a minor, ORS 416.580(3) and OAR 461-195-0350(2) mandate that no payments shall be made to the minor's guardian or conservator or to DHS until a hearing has taken place to determine the sum needed for the minor's "complete physical rehabilitation" and the court has issued an order pursuant to ORS 416.590. In practice, this requirement is rarely observed or followed. ORS 416.590(1) and OAR 461-195-0350(1) provide that the 1396k lien shall not attach to the amount needed for the rehabilitation.

ORS 416.600 and OAR 461-195-320 detail the procedures to request a full or partial release of the state's share of the DHS lien (but not the federal share) when a recipient will incur additional medical, surgical, or hospital expenses or will require additional assistance after settlement, judgment, or compromise. Such release is purely discretionary by DHS and will not be considered before a binding judgment, settlement, or compromise is reached by the parties. OAR 461-195-0320(3).

ORS 416.570 and OAR 461-195-0305(2) provide that the person or public body, agency, or commission bound by the judgment, settlement, or compromise, shall, within 10 days, inform the DHS Personal Injury Liens Unit. If DHS is not timely notified, the 180-day limitation in ORS 416.580(1) does not begin to run until actual notice is received. DHS must be paid before funds are released to the recipient and DHS shall have a cause of action against all bound parties if funds are released without satisfying the 1396k lien. ORS 416.580(1), ORS 416.610, and OAR 461-195-0305(5).

MEDICAID CLAIM RESOLUION

First, determine the source of all medical reimbursement for your client's injury. If your client receives a monthly medical card from the county or state, Medicaid is involved. To expedite claim resolution, contact DHS to begin the process of identifying injury-related medicals paid by DHS. Request a summary of payments to identify payments not injury-related. Non-injury-related reimbursement is not subject to the 1396k claim. 42 U.S.C. 1396p(a).

Calculate a preliminary "net settlement" figure pursuant to OAR 461-195-0301(7) as follows: the amount of the judgment, settlement, or compromise minus attorney fees, costs, personally incurred medicals, and PIP coverage. After deducting non-injury-related Medicaid reimbursement from the summary provided by DHS, apply the 75/25 rule pursuant to OAR 461-195-0325.

If your client is a minor and can be "completely rehabilitated," petition the probate court in the county where the minor lives to determine the sum that will be needed for complete physical rehabilitation pursuant to OAR 461-195-350. Ask DHS to compute the federal share of the amount of the claim that must be paid.

If a trial court is involved, you may want to consider obtaining an order setting out the amount of damages for medical costs, pain and suffering, lost wages, future earnings, and so forth. Provide notice to DHS prior to court approval. Obtain certified copies of the order to present to DHS. If a trial court is not involved and the client is a minor or incapacitated adult, present an order setting out the nature of damages and provide DHS notice through the required conservatorship jurisdiction.

After the 1396k claim has been resolved and the net proceeds are ready for distribution to the client or the client's guardian or conservator, be aware that receipt of proceeds in excess of $2,000 will disqualify the injured party from continued Medicaid and SSI (Supplemental Security Income) eligibility. In cases involving catastrophic injuries, loss of these two benefits may result in immediate interruption of health care coverage and access, rapid spenddown of settlement proceeds, loss of future quality of life for the client, and potential liability for P.I. attorneys.

In many cases, the creation of a special needs trust pursuant to 42 U.S.C. 1396p(d)(4)(A) to receive all proceeds – whether lump sum, structured annuity, or both – will preserve eligibility for both Medicaid and SSI. If the client is a minor or an incapacitated adult, prior court approval of the settlement and creation of the special needs trust is required through a court-appointed conservatorship. P.I. settlement and conservatorship documents must provide that all proceeds shall be paid directly to the trustee of the special needs trust to avoid possible SSI and Medicaid penalties and disqualification for transfer of assets.

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