SELECTED TOPICS INVOLVING
Medicare, Medicaid and Hospital Liens

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I. THE MEDICARE SECONDARY PAYER STATUTE - MSAs REQUIRED?

A. The MSP Statute

The Medicare Secondary Payer (MSP) statute allows the Centers for Medicare & Medicaid Services (CMS) to pursue damages against any entity that receives what Medicare deems "primary" payments. The list of entities who may be liable include a beneficiary provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. 42 C.F.R §411.24(g) (emphasis supplied). The purpose of the MSP statute is to ensure that CMS is not primarily responsible for payment of medical expenses for Medicare beneficiaries if another payer is available. The provisions of the MSP are found at 42 U.S.C. §1395y(b).

The MSP statute specifically provides that Medicare may not make payment on behalf of a beneficiary if, "payment has to be made under a workmen's compensation law or plan... or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." 42 U.S.C. §1395y(b)(2)(A)(ii). As a result, Medicare will look to one of these designated plans or policies as the "primary" payer for all injury or illness related medical expenses. The MSP provides that if Medicare makes a payment for which a primary plan was responsible, the payment is "conditional" and Medicare is entitled to reimbursement. 42 U.S.C. §1395y(b)(2). Additionally, the statute provides for a private cause of action for double damages for failure to provide primary

payment or appropriate reimbursement. 42 U.S.C. §1395y(b)(3)(A).

B. The Recent MMSEA Amendments

On December 29, 2007, Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) was signed and it mandates that liability insurers, including self insurers, no fault insurers and workers' compensation plans identify claimants who are entitled to Medicare benefits and then submit certain information to CMS concerning these Medicare-eligible individuals. Under the regulatory lingo, these entities are termed "Responsible Reporting Entities" (RRE). This information must be provided in the "form and manner (including frequency) specified by the Secretary" of Health and Human Services. See 42 U.S.C. §1395y(b)(8). The RRE reporting requirements include the submission of a social security number and up to five diagnosis codes which identify the injury, with the reporting to occur monthly. This information may be used by Medicare to track treatment for the rest of the beneficiary's life. The statutory language further states that the information will also be submitted "after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability)." See 42 U.S.C. §1395y(b)(8). The MMSEA includes stiff fines to be imposed on RREs who fail to comply with the reporting requirements, with a maximum fine of $1,000.00 per day for each violation.

Any Medicare beneficiary who receives payment from a "primary

plan" (including a liability insurer, workers' compensation carrier, or "self-insured entity") must reimburse Medicare within 60 days from the beneficiary's receipt of payment from that primary plan (i.e., the beneficiary/personal injury plaintiff's receipt of the settlement check from the primary plan/defendant). 42 C.F.R. §411.24(h); 42 U.S.C. §1395y(b)(2)(A). Although in practice, Medicare pursues reimbursement from the beneficiary first, it can also recover (1) from the primary plan and (2) anyone who receives payment from that plan, including attorneys. Medicare MSP Manual, CH. 7, 50.5.2.1; 42 C.F.R. §411.24(e), (g), (i); 42 U.S.C. §1395y(b)(2)(B)(iii). In fact, if the beneficiary does not repay Medicare within 60 days from receipt of a settlement or judgment, the primary payer "must" reimburse Medicare "even though it has already reimbursed the beneficiary or other party." 42 C.F.R. §411.24(i). Any payment by a tortfeasor, except under a no-fault clause in a non-automobile policy, constitutes a primary plan's payment regardless of whether there has been a determination of liability. 42 U.S.C. §1395y(b)(2)(B)(ii).

C. Limited Lien Relief

Upon request, CMS may waive recovery of conditional payments made by Medicare. See 20 C.F.R. §404.506. Under the Social Security Act, waiver of recovery may be granted where (1) the claimant is without fault and (2) recovery would either defeat the purposes of Title II or would be against equity and good conscience.

42 U.S.C. §404(b). A recovery would defeat the purposes of Title II if it caused the claimant to suffer financial hardship by depriving him "of income required for ordinary and necessary living expenses." 20 C.F.R. §404.508. A recovery would be against equity and good conscience if the claimant (1) changed his position for the worse or relinquished a valuable right because of reliance upon a notice that a payment would be made or because of the overpayment itself; or (2) was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment. Id. at §404.509(a). The claimant's "financial circumstances are not material to a finding of against equity and good conscience." Id. at §404.509(b).

D. MSAs in Liability Cases?

In the past, attorneys handling automobile injury cases have generally been aware of Medicare's interest and of necessary steps to make sure the client's interest is protected regarding past medical expenses paid by Medicare. However, there is much debate about whether the MMSEA, which will be fully effective January 1, 2010 after a gradual rollout of its various provisions, requires Medicare set-asides (MSAs) for future medical benefits. The very terms of the MSP statute provide that Medicare payments are secondary when payment has been made under an automobile liability insurance policy and this would appear to encompass future medical payments. However, Medicare Set Asides (MSAs) for future medical

expenses have always been termed "worker compensation MSAs (WCMSA)" under the regulatory scheme and required by Medicare only in the worker compensation context. The MMSEA only changes reporting requirements and does not address MSAs, which are fully addressed in other parts of the regulatory framework that are specific to the worker compensation context. The issue of MSAs in the automobile liability context is in need of further clarification by CMS.

The confusion and abject fear created by the MSA issue is apparent from a review of legal industry publications. A recent article in a defense publication takes the position, without conviction, that MSAs are required:

> There has been much speculation about the visibility Section 111 creates into whether or not parties to a claim are complying with CMS's existing MSP policies. An example of this would be a settlement of a claim without the appropriate preparation of a Medicare set-aside arrangement. The Medicare Secondary Payer statute is clear in stating that the parties to a settlement must take Medicare's interest into consideration when resolving a claim. Policy memoranda dictate that WCMSAs for settlements meeting particular criteria be submitted to CMS for approval. The Section 111 reporting data will enable Medicare to identify instances in which these procedures are not followed. Any settlement entered into with a Medicare beneficiary is a reportable event under Section 111, if it releases the primary payer from medical liability and exceeds CMS's low dollar reporting threshold. CMS would simply need to cross-reference the list of beneficiaries whose settlements exceeded $25,000.00 as reported under Section 111, and determine whether a WCMSA was submitted to CMS for approval to understand which parties are in compliance with its policies and which are not.

> Consequently, it is imperative that parties ensure that they are well versed with CMS rules and regulations surrounding conditional payments and Medicare set-aside arrangements to avoid potential settlement disputes.
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> "The Next Chapter in Medicare Compliance," For the Defense, June 2009.

A recent ALAJ publication vehemently argues, with no support, that MSAs are not required:

> It has come to our attention that some defense firms and insurance providers are now claiming that CMS requires MSAs in liability cases pursuant to Section 111 resporting requirements included in the Medicare, Medicaid & SCHIP Act of 2007 (MMSEA), Public Law No. 110-173. This is **false**. Section 111 contains reporting requirements for responsible reporting entities (1) (RREs) only. Section 111 does not impact or change the requirements for plaintiff's attorneys.
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> See, ALAJ release, attached hereto as Exhibit 1.

E. CMS Enforcement and *Res Judicata*

Medicare has exhibited its willingness to pursue attorneys to recover conditional payments and great care must be taken in response to CMS correspondence. In U.S. v. Harris, 2009 WL 891931 (N.D. W.Va. 2009), an attorney settled a client's injury case for $25,000.00. Medicare calculated that it was owed $10,253.59 out of the settlement (calculated by subtracting procurement costs from the total settlement as set forth in 42 C.F.R. §411.37(e)(2)) and sent the attorney a letter to this effect. The CMS letter advised the attorney of its administrative decision and of appeal rights from

this decision. No appeal or other action was taken in response to the letter. The U.S. v. Harris court held that the attorney was barred from relitigating the issue because the CMS administrative determination was final.

II. MEDICAID - THE AHLBORN DECISION

Medicaid is a federally funded, state administered program and thus, recovery of Medicaid payments is governed by State law within the confines of federal parameters. Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268, 275 (2006). The above discussion of Medicare is not applicable to Medicaid.

In Ahlborn v. Arkansas Dept. of Health & Human Services, 126 S.Ct. 1752 (2006), the United States Supreme Court held that an Arkansas statute automatically imposing a Medicaid lien on the entire amount of the tort settlement proceeds was not authorized by federal Medicaid law. The Ahlborn court further held that the anti-lien provision of federal Medicaid law pre-empted and otherwise precluded the Arkansas statutes encumbrance or attachment of proceeds related to damages other than medical costs. In Ahlborn, a plaintiff in a tort action sustained a severe injury, including brain damage, as the result of a car accident. The Ahlborn plaintiff became eligible for Medicaid and Medicaid paid medical providers $215,645.30 on her behalf. The case against the tortfeasor later settled for $550,000.00, which was not allocated between categories of damages. The Arkansas Medicaid Agency sought

to assert a lien against the settlement proceeds for the full amount it had paid.

The Ahlborn plaintiff filed a declaratory judgment action in federal court seeking a declaration that the State's Medicaid lien violated federal law insofar as its satisfaction would require depletion of compensation for her other injuries other than past medical expenses. The parties stipulated that the settlement amounted to approximately 1/6 of the reasonable value of Ahlborn's claim and thus ADHS would be entitled to only the portion of the settlement ($215,645.30 x 1/6 = $35,581.47) that constituted reimbursement for medical payments made. The Supreme Court held that "non medical costs, such as pain and suffering, was not medical cost and therefore not subject to a subrogation lien." Accordingly, the ADHS would be entitled to $35,581.47, the portion of the settlement that constituted reimbursement for medical payments.

The Ahlborn case has significant implications for any future settlement involving a Medicaid lien. It is mandated that Medicaid be put on notice of any claim and that equitable principles will apply to the lien. See, Smith v. Alabama Medicaid Agency, 461 So.2d 817 (Ala. Civ. App. 1984)(the court held that federal statute does not require or even suggest 100% recovery and whether "equitable principles be applied to determine Medicaid's right of recovery and such would depend on the facts of the each case"). Commentators suggest that the litigant add Medicaid as an

indispensible party and continue to otherwise notify Medicaid that you will be asking the court to perform an Ahlborn calculation. Once the judge has been made fully aware that Medicaid is on notice, you should ask the Judge to set the reasonable value of the claim and determine the percentage the Medicaid lien represents toward the total value. Once this has been determined, Medicaid must accept only the portion of the settlement that represents the proportional value of the lien towards the total settlement.

III. HOSPITAL LIENS

The hospital lien statute, set forth at Ala. Code § 35-11-370 (1975), provides:

> *Any* person, firm, *hospital* authority or corporation operating a hospital in this state *shall have a lien for all reasonable charges for hospital care, treatment* and maintenance *of an injured person who entered such hospital within one week after receiving such injuries, upon any and all actions, claims,* counterclaims and demands accruing to the person to whom such care, treatment or maintenance was furnished, or accruing to the legal representatives of such person, and upon all judgments, settlements and settlement agreements entered into by virtue thereof on account of injuries giving rise to such actions, claims, counterclaims, demands, judgments, settlements or settlement agreements and which necessitated such hospital care, subject, however, to any attorney's lien." (Emphasis added.)

In Board of Trustees of University of Alabama v. American Resources Ins. Co. 2008 WL 1919904 (Ala. 2008), the Alabama Supreme Court issued an opinion that extensively discusses the Alabama

statutory scheme regarding hospital liens. In Board of Trustees, a plaintiff was severely injured in an automobile accident and lingered in a hospital for approximately one month before dying. The plaintiff filed a personal injury action before death and then later his estate amended the complaint to add a wrongful death action.

The parties to the lawsuit later agreed to settle the plaintiff's claim for the sum of $750,000.00, with the plaintiff and his counsel being responsible for payment of hospital liens exceeding $450,000.00. The parties also agreed to dismiss with prejudice the personal injury action and to allow the case to be dismissed with prejudice with the complaint only stating a claim for wrongful death. Once the hospitals learned of the settlement, they sought to intervene in the underlying action to prevent dismissal of the injury claim. This was denied.

The Alabama Supreme Court cited Ala. Code §35-11-372 (1975) and held that the dismissal with prejudice of the personal injury claim was part of the settlement and thus did not impair the lien. The Board of Trustees court stated as follows:

> Thus, under §35-11-372, once the hospital has perfected its lien, no settlement is valid against that lien unless that hospital consents to the settlement. The statute further provides the hospital with a cause of action if its lien is, in fact, impaired.

The various defendants to the subsequent suit brought by the hospitals included the insurance company for the tortfeasor and plaintiff's counsel, who were subject to liability by the Board of Trustees decision.

The Board of Trustees court also reviewed the actual liens filed by the hospitals and found that they did not comply with the explicit terms of the statute and thus were not "perfected." However, because the defendants to the action had actual notice of the lien, the Board of Trustees court held that actual perfection was not required and that the lien was still valid.

The Board of Trustees decision has wide-ranging implications. Prior to this decision, the common wisdom was that a personal injury suit should be filed if humanly possible before death. However, based upon the decision in Board of Trustees, this can create a huge lien, which would not otherwise exist. The Board of Trustees court reiterated that under Ala. Code §6-5-410(c) (1975), "... a hospital lien does not attach to the proceeds of a wrongful death settlement." Thus, if the only claim brought in an underlying action is a claim for wrongful death, a hospital would not have a lien. Once the personal injury action is filed, the parties to the action are unable to escape the lien, no matter what action they take, even if the hospital lien has not been perfected.

In Univ. of South Alabama Hospitals v. Roberts, 2009 WL 3245810 (Ala.Civ.App. Oct. 9, 2009), the Court of Civil Appeals reversed a

decision from Mobile County Circuit Court reducing the amount of a hospital lien. In Blackmon, a personal injury case was settled and post-settlement the plaintiff and USA Hospital litigated in the trial court regarding the amount of the hospital lien. The crucial issue was determining whether the charges were reasonable based upon the language in the hospital lien statute allowing a lien "for all reasonable charges." Ala. Code §35-11-370 (1975). The plaintiff presented evidence in the trial court that the hospital routinely accepted less than full payment from third parties, including Blue Cross, Medicare and Medicaid and the trial judge reduced the amount of the lien. The hospital presented witnesses at the trial court hearing who testified that the charges were reasonable. The Blackmon court found there was no evidence that the charges were not reasonable and thus the hospital was entitled to the full amount of the lien, per the terms of the statute.