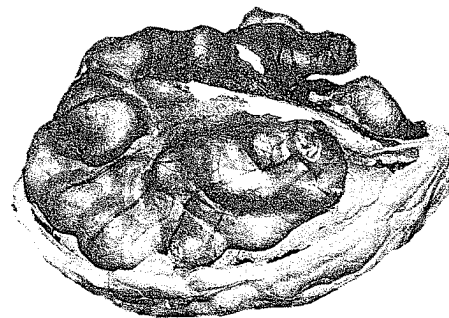


MEDICARE AND MEDICAID FOR ATTORNEYS, IN a NUTSHELL



Medicare is a purely federal program funded by participating taxpayers. It is nearly universal, and is not means-tested. Almost everyone who turns 65 is eligible for Medicare. Individuals who qualify for Social Security Disability are also eligible for Medicare when they have been disabled for 24 months. Entitlement to Social Security and Medicare benefits is not affected by income or assets. Medicare is administered by the Center for Medicare and Medicaid Services (CMS), but some CMS functions are contracted out.

Attorneys representing injured Medicare beneficiaries must deal with two exposures: (1) "Conditional payment" recoveries, *i.e.*, Medicare's "lien," or right to be reimbursed out of the proceeds of a beneficiary's liability recovery for what it has already paid in related benefits, and (2) Medicare's right to be protected from paying benefits in the future for treatment for which a third party is responsible, which is the "Medicare Set-Aside" (MSA) problem. Attorneys representing liability insurers or self-insurers must also deal with the new reporting requirements under the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

Under the Medicare Secondary Payer (MSP) provisions, 42 USC § 1395y(b)(2), Medicare has a right to recover whatever it has paid, subject to a reduction for its proportionate share of attorney's fees and costs ("procurement costs"). 42 CFR 411.37. The right is enforceable against workers' compensation, liability, and no-fault insurance or self-insurance proceeds, but not against individual tortfeasors (unless they have set money aside in a manner that rises to the level of self-insurance; compare *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003), with *United States v. Baxter*, 345 F.3d 866 (11th Cir. 2003)). The right does not have to be formally asserted in order to be enforceable, and an attorney may be held

personally liable for his failure to honor Medicare's right. The right is enforceable against any and all judgment or settlement proceeds without regard to the allocation between general and special damages and without regard to any "hit" taken by the plaintiff for comparative liability.

The recovery rights of "Medicare Advantage" plans are set forth at 42 USC § 1395-22(a)(4) and 42 CFR 422.108. According to 42 CFR 422.108, a Medicare Advantage plan exercises "the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations." It appears that, while the plan "may" assert a recovery right, there is no statutory super-lien as in Medicare itself, no special reporting requirements, no imposition of constructive knowledge of the recovery right, and no imposition of personal liability. An argument can be made that the plan must specify its recovery rights in its contract, just like a private insurer; a better argument can be made that whatever recovery rights the plan asserts are subject to procurement costs just like Medicare itself.

Under certain circumstances, it is not enough to reimburse Medicare for past benefits paid. Medicare's future exposure has to be addressed, and Medicare's interest has to be considered, even if Medicare has not yet paid any benefits. If workers' compensation is involved, then a special "Medicare Set-Aside" (MSA) has to be calculated and submitted to CMS (which administers Medicare) for approval in each of two circumstances: (1) the client is a current Medicare beneficiary and the settlement (including past settlements, and including any accompanying tort settlement) is \$25,000 or greater, or (2) there is a "reasonable expectation" of being a Medicare beneficiary within 30 months - *i.e.*, the client has applied for or received Social Security Disability or is 62.5 years old - and the settlement is \$250,000 or more.

Under the guidelines, an MSA does not have to be submitted for approval, and will not be considered for approval, except in a workers' comp situation that meets one of the two thresholds (either current beneficiary and \$25,000, or reasonable expectation of being a beneficiary within 30 months and \$250,000). But, in theory, the same statutory authority by which Medicare requires MSAs in some situations could allow it, in the future, to begin requiring MSAs in other situations as well. There are some reports that CMS is already reviewing liability MSAs in select situations, though current regulations and guidelines don't provide for this. A prudent practitioner will make sure that Medicare's interest in not being exposed to future medicals in any situation is at least "considered." This may mean nothing more than documentation of the unlikelihood of Medicare paying future medicals, and the saving of such documentation for a very long time. Or it might mean, in rare circumstances, some kind of set-aside that is not submitted for approval but is still set up.

MEDICAID/DHH

Medicaid is a program established under federal law in which the federal and state governments share in the cost of paying for health care for poor citizens. The federal government pays for most of the costs each state incurs; in return, each state pays its share and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. Recipients of Supplemental Security Income (SSI) benefits are automatically eligible for Medicaid provided they do not exceed income and asset limits. In Louisiana, those limits are generally \$579 per month in income and \$2,000 in assets. Entitlement to SSI and Medicaid is affected by changes in income or assets. Medicaid in Louisiana is administered by the Dept. of Health and Hospitals (DHH).

By its terms, Medicaid, through DHH, has a right to recover what it has paid, including from UM and med pay proceeds. La. R.S. 46:446. Unlike Medicare, the right is enforceable against individual tortfeasors, not just insurers and self-insurers. However, the U.S. Supreme Court has ruled, in *Arkansas Dept. of Health and Human Services v. Ahlborn*, 126 S. Ct. 1752 (2006), that Medicaid is limited to that part of the plaintiff's settlement or judgment attributable to past medical specials, taking into account any reduction for comparative fault. So, for example, if the plaintiff settles or wins a judgment for a total of \$200,000 based on past medicals of \$50,000, but with a finding or stipulation that the defendant is only 50 percent at fault, then Medicaid's recovery is limited to \$25,000.

According to the statute, the plaintiff's attorney is required to serve DHH with a copy of any suit and obtain

DHH's consent to any settlement, whether or not he has received notice, and may be held personally liable if he doesn't. But *Ahlborn* has effectively eviscerated this "duty to cooperate" as well as the imposition of personal liability for not fulfilling that duty (though we need to remember we still have duties imposed by Rule 1.15(d) and (e) of the Rules of Professional Conduct). DHH does not generally allow a reduction for procurement costs, but may reduce its recovery if circumstances warrant.

While a participating Medicaid provider cannot refuse treatment, and for the most part cannot bill the patient, it appears the provider may choose to bill the third party instead of Medicaid. La. R.S. 46:446.5 (although, strictly speaking, La. R.S. 46:446.2 defines "third parties" to include only health insurers, not liability insurers or tortfeasors). What a provider clearly cannot do is bill Medicaid and then bill the patient for the balance. La. R.S. 46:437.12(a)(10); La. R.S. 46:446.5; *Miller v. Wladyslaw Estate*, 547 F.3d 273 (5th Cir. 2008). (This practice, called "balance billing," is also forbidden under Medicare, 42 USC § 1395cc(a) and 42 CFR 411.35.)

Some providers claim DHH has amended its regulations to allow balance billing though an April 2008 "Rule," but this amendment has to be considered inoperative because (1) it contradicts explicit state statutory law, La. R.S. 46:437.12(10)(a) and 46:446.5, and (2) it contradicts federal Medicaid law. *Miller v. Wladyslaw Estate*, 547 F.3d 273 (5th Cir. 2008) (where the U.S. Fifth Circuit, in a Louisiana case involving Baton Rouge General, cited a long line of cases (including *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*, 410 F.3d 304 (6th Cir. 2005)) in holding that liening tort proceeds is the same as balance billing and is illegal.

Also of concern is the effect of a tort recovery - or any acquisition of assets - on the client's continued eligibility for Medicaid, given the \$2,000 asset limit. This problem may be addressed through the creation of a Special Needs Trust and the placing of tort recovery proceeds into the trust. The funds can then be used, within the beneficiary's lifetime, for health care and other goods or services intended to enhance the Medicaid beneficiary's quality of life, and which are not provided by need-based government programs. The big drawback to a Special Needs Trust is that whatever is left in the trust at the time of the beneficiary's death (not to exceed the amount of Medicaid benefits paid to the beneficiary) passes to the state. You should not attempt to set up a Special Needs Trust yourself, or even make the determination whether a Special Needs Trust is right for your client, unless you are an expert in estate planning and government benefits. Your job is to recognize the problem, and then hire the expertise you need in order to address the problem. ■