

NEGOTIATING WITH MEDICARE AND MEDICAID

- I. **MEDICARE PROVIDES HEALTHCARE COVERAGE**
 - A. Persons 65 Years Old and Older
 - B. Certain Disabled Persons under 65
 - C. Persons with End-Stage Renal Disease

- II. **MEDICARE’S RIGHT OF RECOVERY OF CONDITIONAL PAYMENTS UNDER THE MEDICARE SECONDARY PAYER ACT (Pub.L.No. 96-499, 42 USC § 1395y(b)(2))**
 - A. Purpose of Legislation Is to Protect Medicare Financial Sustainability
 - B. Provides that “primary plans” function as the “primary payer,” and that Medicare functions as the “secondary payer” where the primary person is legally obligated to provide coverage to the beneficiary.
42 USC 1395(b); 42 CFR § 411.20
 - C. Medicare makes “conditional payments” when a primary payer cannot promptly make payment. The “condition” is that Medicare is entitled to a statutory primary right of recovery of its conditional payment.

- III. **MEDICARE’S RIGHT TO NOTICE OF PAYMENTS BY A PRIMARY PAYER UNDER THE MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007 (“MMSEA”) (Pub.L.No. 110-173, 42 USC §1395y(b)(7) and (8)).**
 - A. The MMSEA Amendments to the Medicare Secondary Payer Act.
 - 1. Impose reporting requirement on primary payers to notify Medicare of any settlement, judgment, or payment made to a Medicare beneficiary.
 - 2. These reports enable Medicare to enforce its recovery rights; otherwise, it may never know of the opportunity to obtain reimbursement.
 - 3. Primary payers must reimburse Medicare for any conditional payments made.
 - 4. Within 60 days of the primary payer’s payment, MMSEA establishes penalties for the failure to comply with the reporting requirements
 - a. \$1,000.00 per day penalty for noncompliance
 - b. direct collection of payments by Medicare

- c. private cause of action for double damages
42 USC § 1395y (b)(2)(B); 42 CFR 411.24, 411.26

5. Responsible Reporting Entities

- a. persons who fund and pay, in whole or in part, a settlement, judgment, award or other payment to a Medicare beneficiary;
- b. private insurers, self-insured entities and TPAs.

- B. Gone are the days when the plaintiff's attorney could sit back and wait to see if a Medicare demand letter arrived.

IV. SETTLEMENT WITH MEDICARE

A. Overview of the Recovery Process

- 1. If notice of the primary payment is provided to the Coordination of Benefits Contractor ("COBC"), the COBC establishes a case file.
- 2. The beneficiary and other parties associated with the case then receive a Rights and Responsibilities Letter.
- 3. The COBC initiates the Claim Retrieval Process by which all claims paid by Medicare on or after the Date of Incident are retrieved.
- 4. The beneficiary executes either a Proof of Representation or Consent to Release document.
 - a. The Proof of Representation document (e.g. attorney retainer agreement or power of attorney) must contain certain suggested or model language. It authorizes the specified person or entity to act on the beneficiary's behalf.
 - b. The Consent to Release document merely authorizes the COBC to release certain information to the specified person or entity. It does not authorize the person or entity to act on the beneficiary's behalf.
- 5. Medicare identifies claims paid or payments made and issues a Conditional Payment Notice or Conditional Payment Letter.

6. The beneficiary must respond by providing additional settlement information and may dispute claims or payments included in the Conditional Payments Notice.
7. After the disputed claims or payments are resolved, Medicare determines a final conditional payment amount and issues a Demand Letter.
8. If the beneficiary fails to respond to the Conditional Payment Notice or Letter within 30 days, Medicare will issue a Demand Letter.
9. Payment is due within 30 days of a Demand Letter.
10. Interest accrues from the date of the Demand Letter and will be assessed on day 61 if no payment is received.

B. Pre-Settlement Issues

1. No overpayment exists until a settlement is reached or a court renders judgment in favor of a beneficiary.
2. Medicare does not use the term “lien” to describe its entitlement to reimbursement. This is a common misconception. Rather, Medicare describes its payments as “overpayments” until there is an acceptance or imposition of liability. It is only then that the obligation to repay Medicare arises by operation of law.
3. Consequently, while Medicare may put beneficiaries and their counsel on notice of its recovery rights in pre-settlement correspondence, no demand for recovery may be made until a settlement has been reached or a judgment rendered. *See Medicare Secondary Payer (MSP) Manual, Chapter 7, § 50.1. (“MSP Manual”)*

C. Medicare Has Both a Priority Right of Recovery and a Right of Subrogation to Recover Conditional Payments.

1. Medicare’s right of subrogation gives it the right to recover its conditional payment from an individual or entity that the beneficiary received from a third party payment.
2. Medicare’s priority right of recovery arises under § 1862(b) of the Social Security Act. The priority right of recovery is much stronger than the subrogated right, as it takes precedence over the claims of any other party, including Medicaid. *MSP Manual, Chap. 7, § 50.5.1.*

3. The entire amount of the settlement is subject to Medicare's right of recovery. Thus, if Medicare's claim exceeds the settlement amount, it has a right to recover the entire amount, subject to a deduction for procurement costs.
4. If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:
 - a. determine the ratio of procurement costs to the total judgment or settlement;
 - b. apply the ratio to the Medicare conditional payment amounts;
 - c. subtract Medicare's share of procurement costs from the Medicare conditional payments;
 - d. the remainder is the Medicare recovery amount.

D. Medicare Can Recover Against a Variety of Persons.

1. beneficiary
2. supplier
3. attorney - see *United States v. Baxter*, 345 F3d 866 (11th Cir. 2004); *United States v. Harris*, 2009 WL 891931 (N.D.W. Va 2009)(plaintiff's attorney held liable for conditional payment)
4. private insurers
5. provider
6. physician
7. state agency

E. Medicare is entitled to recover only the amount of charges related to the subject incident. In cases involving pre-existing and subsequent conditions and other complex medical histories, take care to sort out charges which are unrelated to the incident.

F. Settlement Designations and Allocations

1. Medicare is entitled to recover its conditional payments without regard to how a settlement agreement or judgment characterizes the beneficiary's damages.
2. Liability payments are deemed to have been made with respect to medical services related to the injury even when the settlement does not expressly include an amount for medical expenses.
3. The only circumstance in which Medicare will accept a designation or allocation of liability payments for nonmedical losses is when payment is based on a court order on the merits of the case which specifically designates amounts for pain and suffering or other amounts not related to medical services. MSP Manual, § 50.4.4.

G. Medicare Has Authority to Waive, Compromise, Terminate, or Suspend its Right of Recovery.

1. The right to compromise claims for less than the full amount arises under the Federal Claims Collection Act of 1966 (31 USC § 3711) §§ 1870(c) and 1862(b) of the Social Security Act.
2. Each section sets forth different criteria by which to compromise, waive, suspend, or terminate Medicare's claim.
3. Medicare contractors have authority to consider requests for waivers under § 1870(c) of the Act.

H. Requests for Waivers Under § 1870(c)

1. The contractor must determine whether the beneficiary meets the criteria for waiver determinations under § 1870(c) of the Social Security Act (42 CFR § 405.355 and 20 CFR 404.506-512). Medicare may waive all or any part of its recovery where an overpayment has been made with respect to a beneficiary:
 - a. Who is without fault, and
 - b. When recovery would either
 - (i) defeat the purposes of the Social Security Act, or

- (ii) be against equity and good conscience.
- 2. “Defeat the purposes” of the Social Security Act means that recovery would cause financial hardship by depriving a beneficiary of income required for ordinary and necessary living expenses. MSP Manual, §§ 50.6.2 and 50.6.5.
- 3. Ordinary and necessary living expenses include:
 - a. fixed living expenses, such as food, clothing, rent, mortgage payments, utilities, insurances, taxes, installment payments, etc.
 - b. medical, hospitalizations and similar expenses not covered by Medicare or other insurer;
 - c. expenses for the support of others for whom the beneficiary is legally responsible; and
 - d. other miscellaneous expenses which may reasonably be considered necessary to maintain the beneficiary’s current standard of living.
- 4. “Be against equity and good conscience” requires Medicare to consider:
 - a. The degree to which the beneficiary contributed to causing the overpayment;
 - b. The degree to which Medicare contributed to causing the overpayment;
 - c. The degree to which recovery would cause undue hardship for the beneficiary;
 - d. Whether the beneficiary would be unjustly enriched by a waiver; and
 - e. Whether the beneficiary changed their positions to their material detriment as a result of receiving the overpayment or as a result of relying on erroneous information supplied by Medicare.

See MSP Manual § 50.6.5.2

- 5. Factors to consider in determining if a full or partial waiver is warranted on the basis of insufficiency of assets to repay Medicare:
 - a. The amount of any out-of-pocket expenses, i.e., those medical expenses for which a beneficiary has paid or is responsible to pay for

injuries directly related to the incident and which are not covered by Medicare, insurance, settlement proceeds, or court-awarded damages.

- b. Examples of out-of-pocket expenses include housing renovations to accommodate the beneficiary for accident related injuries, prescription medications needed as a result of the injury, private duty nursing care not covered by Medicare, coinsurance and deductibles not covered by supplemental insurance.
- c. Other factors:
 - (i) Age of beneficiary
 - (ii) Assets
 - (iii) Monthly income and expenses
 - (iv) Physical or mental impairments

6. Waiver Indications

- a. Indications that support granting full or partial waiver include:
 - 1. Medicare's recovery exceeds settlement amount;
 - 2. beneficiary sustained permanent injuries, lost wages, or became unemployed;
 - 3. non-covered out-of-pocket accident related expenses; and
 - 4. beneficiary's living expenses are equal to or higher than income.
- b. Indicators that support denying waiver include:
 - 1. Medicare asserted its right to recover before the settlement proceeds were disbursed;
 - 2. beneficiary receives a large settlement;
 - 3. beneficiary's income exceeds ordinary living expenses;

4. after repaying Medicare and out-of-pocket medical costs, the beneficiary will be left with a substantial amount of the settlement proceeds; and
5. beneficiary has substantial assets.

See MSP Manual, § 50.6.5.4.

I. Requests for Waivers under §1862(b) of the Social Security Act

Medicare has the authority to waive MSP liability recovery if doing so would be “in the best interests of the program.” MSP Manual, § 50.7.1.

J. Medicare and Other Federal Agencies Have Authority to Compromise, Suspend, or Terminate Collection of Their Claims under the Federal Claims Collection Act

1. The cost of collection does not justify the enforced collection of the full amount of the claim;
2. The beneficiary is unable to pay within a reasonable time; or
3. The chances of successful litigation are questionable, making it desirable to seek a compromised settlement.

See MSP Manual, § 50.7.2.

VI. Appeal Rights in the Event the Waiver Request is Rejected:

A. Appealable initial determinations:

1. the existence of the overpayment;
2. the amount of the overpayment;
3. a less than fully favorable determination of the § 1870(c) waiver request.

B. The beneficiary must be given notice of the right to appeal in the initial determination letter.

C. The appeal must be considered by a person other than the one who made the initial determination.

- D. The beneficiary may also appeal to an ALJ any unfavorable recommendation or review determination. The beneficiary has 60 days to request the ALJ hearing.

See generally MSP Manual, § 50.8.

VII. Summary of Matters Considered by Medicare in Connection with Requests for Waivers

- Beneficiary is without fault and pursuing recovery is contrary to the purposes of Medicare
- Beneficiary must demonstrate hardship
- Equity and good conscience dictate waiver
- Beneficiary's inability to pay
- Legal and factual issues warrant compromise
- Amount at issue is too small
- Amount of recovery is low or probability of recovery is low
- Out of pocket expenses, in and directly related to the incident were not covered by insurance
- Age, assets, monthly income and expenses, and physical or mental impairment
- Expenses for the support of others for whom the beneficiary is legally responsible
- Other reasonable and necessary expenses to maintain the beneficiary's current standard of living
- The beneficiary's share of fault for Medicare making an overpayment
- Medicare and/or its contractor's share of fault in the overpayment
- Undue hardship
- Unjust enrichment of the beneficiary resulting from waiver or adjustment of Medicare's recover amount
- Promissory estoppel by the beneficiary relying on incorrect information provided by Medicare

- Whether Medicare’s recovery amount exceeds the amount of the settlement
- The extent of the beneficiary’s injuries, lost wages, or future employment.

VIII. MEDICARE SET-ASIDE ARRANGEMENTS (“MSAs”)

- A. The duty to set aside settlement funds to pay for the beneficiary’s related future medical treatment is implied in the Medicare Secondary Payment Act. The Act requires that the parties take Medicare’s interests into account in negotiating a settlement.
- B. Medicare has not yet issued regulations regarding MSAs in liability situations (although it has done so with regard to workers’ compensations claims).
- C. Nor is there in place a formal program to review and pre-approve MSAs. The regional offices may, in their discretion, voluntarily establish such programs.

IX. SETTLEMENT WITH MEDICAID

- A. Federal regulations require the Alabama Medicaid Agency and other states’ Medicaid programs to make provisions for handling recoupments and recoveries. *Ala. Admin. Code*, Chapter 33, Rule No. 560-X-33.01.
- B. One of the purposes of recoupment is to recover benefits correctly paid but recoverable by law. *Ala. Admin. Code*, Chapter 33, Rule No. 560-X-33.02.
- C. Recoupment is carried out by using various administrative, civil, and criminal methods:
 - 1. Direct reimbursement by the recipient to the Alabama Medicaid Agency.
 - a. the Agency typically sends a demand letter to the recipient at the time the expected amount of recoupment is identified.
 - b. the demand letter must outline the allegations and state the amount of reimbursement and the specific dates when overpayment of recoverable benefits occurred.
 - c. the recipient must be offered the opportunity to present evidence to rebut the allegations or to submit the reimbursement.
 - d. if no rebuttal is offered, the original assessment will be presumed correct.

- e. legal proceedings will be initiated if reimbursement is not received.
- 2. Time payment by the recipient on terms acceptable to the Agency.
 - a. the reimbursement amount is due immediately.
 - b. the Agency may allow a time payment plan not to exceed two years.
- 3. Recovery of erroneous payments by withholding payments to a recipient;
- 4. Liens on real property of recipients;
- 5. Administrative sanctions in cases involving fraud or abuse. Sanctions may involve one or more years of ineligibility until full restitution is made.
- 6. Civil actions through the courts, where the above procedures have not resulted in a satisfactory resolution;
- 7. Criminal proceedings in cases involving strong indications of fraud.

See, Ala. Admin. Code, Chapter 33, Rule No. 560-X-33.03 and 04.