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Dear State Medicaid Director:

It has been brought to our attention that some States have unique laws that we believe present compelling reasons to re-examine our third party liability policy concerning tort claims. Some States authorize hospitals which participate in the Medicaid program to undertake collection efforts in order to recover the amount of benefits paid by Medicaid. The hospital files a lien representing the full amount of its charges which includes the amount Medicaid has paid the hospital. Once the lien has been perfected, the hospital is required to reimburse Medicaid. In the event that the settlement exceeds Medicaid's payment, the hospital is allowed to keep excess collections to cover its expenses. In the event that a provider determines, at some point, that it would no longer be cost effective to pursue a claim in its own behalf, the provider generally withdraws its lien and it is left up to the State to pursue the lien on behalf of Medicaid. In consideration of such State laws, we are clarifying our policies on tort claims.

We are broadening our policy interpretation which will allow States to permit providers to pursue payment in excess of Medicaid's reimbursement in tort situations as long as certain conditions are met. Specifically, States must assure that Medicaid is made whole before providers can keep any monies. Secondly, the State must assure protection to its Medicaid beneficiaries by prohibiting providers from receiving money that has been designated to go to the beneficiary. Enclosed is a detailed analysis of this policy clarification.

If you have any questions concerning this policy clarification, please contact your respective regional office.

Sincerely,

Judith D. Moore
Acting Director
Medicaid Bureau

Enclosure

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cc:

All Regional Administrators

**All Associate Regional Administrators
Division of Medicaid**

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American Public Welfare Association**

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PROVIDERS' RIGHTS TO PAYMENT - TORT CLAIMS

HCFA's policy is that once a provider bills Medicaid, it must accept Medicaid's payment as payment in **full** (42 CFR **447.15**). It then becomes the responsibility of the Medicaid agency to pursue reimbursement. Section 1902(a)(25)(B) states that where legal liability is found to exist after Medicaid payment is made "the State . . . will seek reimbursement for such assistance to the extent of such legal liability."

Furthermore, 42 CFR 433.139(d)(1), relating to circumstances where a State has a waiver (of cost avoidance), provides that the State, ". . . must seek recovery of reimbursement **from the third party to the limit of legal liability**" (our emphasis). Section 433.139(d)(2) relates to situations where the State ". . . learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid" by Medicaid. Although paragraph (d)(2) omits the emphasized language, we contend that it is implicitly contained in the reference to "reimbursement" which is simply a shortcut reference to the longer phrasing in paragraph (1). This is further supported by preamble language found in 50 Federal Register 46654 (November 12, 1985) which states that the ". . . State would pay the entire claim and then seek reimbursement from any liable third party."

There are certain circumstances whereby it is permissible for States to adopt a policy that would allow providers to accept a Medicaid payment and to subsequently return that payment to Medicaid in order to seek reimbursement from a third party. For instance, in the event that there is a third party liable for payment at the time services are rendered and the third party would have been billed had the provider **known** of its existence, the State may allow providers to return Medicaid's payment thus invoking the cost-avoidance procedures. This is supportable as a correction of an erroneous payment, since the regulation's cost-avoidance procedures could or should have been applied in the first instance. In the event that it was not until after Medicaid paid for the services that the third party was determined to be liable for payment, for example, as a result of a tort lawsuit, the statute and regulations would appear to require direct pursuit by the State.

To put this issue in perspective, we will outline the various scenarios under which a provider receives payment for services rendered to a Medicaid beneficiary. First, the provider could obtain compensation directly from the liable third party, bypassing Medicaid directly. Second, the provider could bill Medicaid, and thus is obligated to accept the Medicaid payment as payment in full for services rendered. Third, the provider could bill Medicaid, discover the existence of a third party payer, and seek to bill that third party payer after refunding the Medicaid payment to the State agency. It is this latter situation that we **now** address.

- The issue is whether the provider could abrogate its agreement with Medicaid (under which it has, by billing Medicaid, agreed to accept the Medicaid payment as **payment in full**) and seek compensation from a third party. **This** is a matter that is governed by State contract laws. Essentially, there are two kinds of provider agreements between a provider and the Medicaid program. One is where the provider submits claims **on** an individual basis (i.e., a claim form) to Medicaid, thus participating in Medicaid for that patient. The second is where a comprehensive

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formal provider agreement is executed between the provider and Medicaid which governs the provider's responsibilities and duties. The provider is permitted to refund Medicaid and seek reimbursement from the third party payer so long as the contract or agreement does not violate existing Federal law and the intent of both parties is to abrogate the contract provisions on an individual patient basis.

In non-tort situations, if the provider seeks reimbursement from a health insurer after refunding Medicaid, the provider **will** generally receive the health insurance contract rate. There is no harm to either party since the State is reimbursed to the extent of its medical expenditures, the third party is paying what it has contractually agreed to pay, and the beneficiary is not affected in any way. Therefore, States may permit a provider to first refund the Medicaid payment, and then, seek reimbursement **from** a third party payer. This application, however, has historically extended **only** to the non-tort situation (i.e., a health insurer is the third party payer) for the reasons given below.

In the tort situation, the judgment or settlement will often contain more than just an element for medical services, such as pain and suffering or loss of consortium. Thus, the total amount will often exceed the medical expenses. **Although** the beneficiary has claim to this amount, pursuant to section 1902(a)(45) and 1912(a)(1)(A) of the Act, the beneficiary **has** assigned to the State any rights to medical support and to payment for medical care from the third party payer. Thus, the State has claim to the entire judgment or settlement amount to the extent of its total payment.

Once the full recovery amount has been identified and collected by the State, Federal law and regulations dictate the distribution of the amount collected. Based on section 1912(b) of the Social Security Act (the Act), the beneficiary is entitled to any remainder once the Medicaid program (both Federal and State share) **has** been reimbursed. In addition, section 1902(a)(25)(c) of the Social Security Act (the Act) prohibits Medicaid providers from directly billing Medicaid beneficiaries and 1902(g) establishes penalties for providers who violate this prohibition. The statute does not offer any special exceptions for liability settlements. Therefore, in a tort situation, if the provider were to reimburse the Medicaid program, and then seek reimbursement for the full amount of its charges which includes the amount Medicaid has paid **the** provider, **this** could have the effect of taking monies from the beneficiary.

As long as States assure preservation of certain principles, Federal law would not preclude the practice of providers pursuing payment in tort situations in excess of Medicaid's reimbursement. Mechanisms for securing such assurances must be **binding** on providers and could include State laws, regulations, or provider agreements. Specifically, the State must assure that Medicaid is made whole before providers can keep any monies. The State must also prohibit providers from pursuing money that has been awarded to the Medicaid beneficiary. In other words, the provider lien must be against the tortfeasor and not the general assets of the beneficiary, e.g., the provider would be entitled to reimbursement from a tort judgement or settlement when the settlement specifically distinguishes a set amount of money for medical expenses **and** then only if this amount **is** above the amount owed to Medicaid. The provider could be reimbursed only if the money has not been allotted to the beneficiary in a court judgement or settlement. This would mean that if the lien were not perfected, the tortfeasor would stand to retain the money.

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If the State does, in fact, assure protection of beneficiaries' **assets** in **this** way, then it would be permissible to allow the provider to abrogate its agreement with Medicaid and return Medicaid's payment **before** pursuing its **own** lien. Furthermore, if the State **also** authorizes the provider to act **on** behalf of the Medicaid agency, it would be permissible for the State to allow the provider **to** return Medicaid's payment **after** the provider **has** received a **settlement as long as** Medicaid is made whole. In addition, Medicaid's **rights** to pursue monies designated for pain and **suffering** and loss of consortium must be preserved. **Lastly**, in accordance with section **3907** of the "State Medicaid Manual," it is permissible for the State to compensate the provider for legitimate costs in pursuing the third party on behalf of Medicaid.

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