

CMMS Payer of Last Resort Regulation Interpretation

The Center for Medicare and Medicaid Services (CMMS) is the regulatory agency overseeing both Medicare and Medicaid implementation. As you know, the regulations they publish have the full effect of the law. While my offices have not participated with either Medicare or Medicaid for nearly 2 decades, many providers and facilities we refer to do participate.

With personal injury cases there has been a growing concern from providers and attorneys regarding the issuance and honoring of a letter of protection (LOP) on Medicaid insured individuals. Doctors believe that they have the right not to accept patients for care in their private practices, even if they are a Medicaid provider. Their position is that they will only accept those patients under a LOP and wait for settlement in keeping with their interpretation of the “payer of last resort” verbiage. While many attorneys are pleased with that position, others are concerned that it breaches their fiduciary responsibilities to their client to issue or honor a LOP for a provider that has a contract with CMMS.

The State Plans for Medical Assistance law (42 U.S. Code § 1396a (25)(c and d)) suggests that Medicaid enrolled providers cannot refuse to furnish care because of a third parties liability and that they may not seek to collect from the individual (or any financial responsible relative or representative of the individual). However, this is in direct contradiction to the [Deficit Reduction Act of 2005](#) which reads as follows:

*“By law, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as “third party liability” or TPL. Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, **settlements from a liability insurer**, workers’ compensation, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute). Third party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State plan” (bold added).*

Medicare and the Medicare Secondary Payer regulations state that:

“§40 - Liability Insurance (Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06) Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), **Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan.** (bold added)

In actual practice, we all know that doctors and facilities practically always refuse to attend to patients that are in medical legal cases. This includes private practitioners and even hospital clinics. Since nearly every medical provider and hospital is a participant of Medicaid, it seems empirically evident that either the law is not enforced or the regulatory implementation is interpreted differently. From my perspective, the Deficit Reduction Act is extraordinarily clear. This issue has been addressed in the courts with some interesting perspectives that I will outline.

Gianetti v. Siglinger: In this case a surgeon billed the patient’s carrier and then, upon discovering that there was a pending law suit attempted to balance bill the patient. The appellate court supported the lower court ruling that the doctor had a contractual agreement with the carrier and therefore was not allowed to balance bill the patient and then

lien the case. At first glance this may seem relevant but it is different from the Medicaid scenario in which the regulation indicates that the third parties are first responsible before Medicaid makes any payment. This doctor submitted a bill to the contracted carrier and accepted payment and therefore both the doctor and carrier had fulfilled their obligations. The doctor had no right to then balance bill the patient when he already accepted the contracted fee.

Evanston Hospital v V Hauck W: In this case Evanston Hospital, upon discovering that there was a recovery from a law suit, attempted to refund Medicaid for a payment made years earlier claiming that it erred by billing Medicaid and that Medicaid should have been the payer of last resort. This is similar to the Connecticut case above in which a bill was submitted and paid in accordance with the contract. The difference is that the trial judge stated “...*the hospital could have simply forsaken Medicaid and taken its chances that Hauck would somehow come up with the money to pay the bills himself.* By *opting* for reimbursement from Medicaid, Evanston Hospital bought certainty. It purchased a guarantee of partial payment in lieu of possibly full payment or possibly no payment at all. Risk-averse companies that are owed money (or which do not want the hassle) make this same deal all the time with collection agencies--something secure is traded for a crack at a higher sum.” (Bold added). In other words, the judges interpretation was that the provider could bill Medicaid or lien the case, but not both. Once a claim was submitted to Medicaid and the check accepted there was no further right for the hospital to seek payment, either by returning the money or balance billing.

The question as it relates to your clients is “Can a medical provider forego Medicaid payments for a person who is eligible in the hope that such medical provider could obtain a better recovery of his/her medical fees down the road as a part of tort recovery?” I believe that the answer is **YES** for reasons previously stated as well as the following:

Lizer v. Eagle Air Med Corporation, 308 F.Supp.2d 1006, 1010 (D.AZ 2004). “The Seventh Circuit, in particular, emphasized the fact that providers may choose to not accept funds from Medicaid if they wish to preserve their right to seek their entire customary charge.”

Miller v. Gorski Wladyslaw Estate, 547 F.3d 273 (5th Cir. 2008). The court rejected a contention that the hospital was precluded from seeking to enforce the lien by Medicaid rules that prohibited medical providers from billing Medicaid patients for any unpaid balance of medical bills (42 U.S.C.A. § 1396a(a)(25)(C)), where the hospital never billed or accepted payment from Medicaid. And, the court stated that Medicaid rules allow health care providers to make a calculated choice to receive payment from Medicaid, or to seek to recover the customary charge from the patient.

This is also covered in a comprehensive **ALR Article on the issue of Balance Billing**. Section 11 of the ALR Article, specifically indicates that it would be acceptable for a medical provider to forego Medicaid payments.

In summary, while the laws and the resulting regulations are rarely perfectly in alignment it seems perfectly reasonable that a doctor or health care facility can, at its discretion, bill Medicaid and accept payment as payment in full OR exercise a lien and obtain a LOP to secure the full fee; the latter resulting in increased remuneration but also greater risk of not getting paid at all.

I believe that doctors, patients and their attorneys are all best served when the full fee is paid to the provider. There is no collateral source reduction at verdict, doctors are enthusiastic and engaged more when they know their fees will be paid in full (rather than below their costs), clients get better quality care, settlements are maximized and the attorney and patient are better compensated for their efforts and injuries.