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Health Care Law

New Developments in Medicare Maximization

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The Health Care Financing Administration (HCFA) has given providers and suppliers some relief in the tug of war that often occurs between State Medicaid programs and the Medicare program as a result of so-called "Medicare Maximization" or "Third Party Liability" (TPL) audits. These audits, which often result in large recoupments against providers and suppliers, rest on the theory that services should have been paid for by Medicare or another third party payer, rather than by Medicaid, which by law is the payer of last resort. HCFA has now clarified that States may not recoup money as a result of these audits until third party liability is established. Further, states with subrogation rights may not seek recoupment from providers, but must look directly to the Medicare program.

The Medicaid program is a joint Federal-State program, under which the federal government provides matching funds to states that account for at least 50% of the state's Medicaid budget. Therefore, if a state Medicaid program is successful in shifting the obligation to pay for services to a third party payer, such as Medicare, the Medicaid program saves money. However, this also increases the costs incurred by the Medicare program, since HCFA must pay the administrative costs of processing TPL claims.

Encouraged by a high rate of success before federal Administrative Law Judges, state Medicaid programs conduct or contract with private entities to conduct "Medicare Maximization" or "TPL" audits, to identify claims that can be billed to Medicare. The goal of these audits is to identify claims from providers such as home health agencies, skilled nursing facilities, hospices and assisted living programs for dually eligible patients that have been paid by the state Medicaid program, but which the state believes should have been paid by the Medicare program or other third party payers. The basis for these Medicaid overpayments is the language of the Social Security Act, which makes Medicaid the payer of last resort.

HCFA's letter to State Medicaid Directors and Program Memorandum "urge" Medicaid programs that have paid providers for Medicaid services for "dually eligible" patients, i.e., patients who are covered by both the Medicare and Medicaid programs, not to recoup these payments from the providers "until the extent of legal liability, if any, is established on the part of a third party (such as Medicare) to pay for the services." The relief is even more powerful in states such as Connecticut, Michigan, New York and Vermont where, as a result of various court decisions, these states have obtained the right of subrogation to pursue Medicare appeals of denied claims on behalf of dually-eligible patients. HCFA advised the Medicaid programs in these states that they cannot pursue recoupment from providers. In these four states, HCFA requires that once liability is established the Medicaid programs must recover directly from liable third parties and not from the providers. As explained in detail below, the federal regulations do more than "urge," but instead prohibit Medicaid programs from recouping from providers where third party liability has not been established. HCFA has the power to enforce these requirements through a State Plan Compliance proceeding.

In order to participate in the Medicaid program and receive matching federal funds, a state must submit a Medicaid State Plan that contains state regulations enforcing certain federally mandated State Plan requirements. The State Plan requirements authorizing recovery from liable third party payers are set forth in 42 C.F.R. §§ 433.135 to 433.153. Those federal regulations require state Medicaid programs to submit to HCFA for approval a description of the procedures to be used by the Medicaid program to identify any liable third party payers prior to Medicaid paying the claim. This is referred to in the regulations as "cost avoidance." 42 C.F.R. § 433.139. Cost

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avoidance requires the Medicaid program to establish any third party liability at the time the claim is filed by the provider with Medicaid. Thus, the Medicaid program is required to reject the claim and return it to the provider with information necessary for the provider to bill the third party. Some states have computer edits in their Medicaid billing systems that identify claims that may be covered by Medicare or other third party payers. The cost avoidance requirements prevent overpayment and recoupment actions by state Medicaid programs based on retroactive audits of old claims because the correct payer is identified before the claim is paid by Medicaid.

A state Medicaid program may request a waiver from HCFA of the cost avoidance requirement and pursue what is known as "pay and recover later" or "pay and chase." Under pay and chase the Medicaid program pays the total amount allowed under its payment schedule and later, sometimes up to six years later, seeks recovery from a third party payer such as Medicare. Usually recovery is sought by requiring a provider or supplier to submit the claims to Medicare under threat of a Medicaid overpayment. According to regulations and as reiterated in the December 3rd HCFA letter to Medicaid Directors, recovery must take place only after liability has been established. See 42 C.F.R. § 433.139(d). Problems have arisen for providers because some Medicaid programs are ignoring the cost avoidance regulatory requirements and pursing a pay and chase methodology even though they do not have a waiver to do so. In addition, some states are ignoring the requirement that recovery is permitted only after third party liability is established.

For example, when a provider is the subject of a Medicaid Maximization or TPL audit by the state Medicaid program, the state will require the provider to submit the claims to the Medicare fiscal intermediary to determine if Medicare coverage is appropriate. If the fiscal intermediary determines that the claim is too old, it will refuse to process the claim as untimely and issue a "Time Reject Notice." Under this scenario, third party liability has not been established and the state Medicaid program cannot recoup against the provider pursuant to the regulations discussed above. However, state Medicaid programs are recouping overpayments against providers in just such a scenario and triggering financial hardships, closures, and bankruptcies. In these disputes the provider becomes a bouncing ball between the Medicare program that refuses to process the claim, and the Medicaid program, which will proceed with its recoupment action even though Medicare's liability has not been established.

HCFA's December 3rd letter to the State Medicaid Directors addresses this problem by advising States not to recoup any Medicaid payments until the extent of legal third party liability, if any, is established. If Medicare refuses to process a claim as untimely, there is no determination of other third party liability. Therefore recoupment against the providers is prohibited. Although the HCFA letter "urges" states not to recoup against providers where third party liability has not been established, HCFA does have the authority to enforce compliance with its regulations. HCFA has the authority to initiate an action against a state Medicaid program for failure to comply with its State Plan requirements. HCFA is authorized to withhold its payments to a state for its Medicaid program for noncompliance with its State Plan in practice, which includes "the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement." 42 C.F.R. § 430.35. A state does have the right to an administrative appeal of HCFA's decision. Thus, although HCFA "urges" compliance, it does have the authority to implement compliance with its regulations that prohibit recoupment from a provider when third party liability has not been established.

The Medicaid programs in New England and New York State have been very active in pursing Medicare Maximization and TPL audits conducted by state auditors or contingency fee contractors, such as the Center for Medicare Advocacy or Health Systems Management, Inc.2 These organizations contract with different state Medicaid programs to identify possible third party claims, and contact providers to request that they develop and submit claims to Medicare. The requests to providers are made under the threat of a Medicaid overpayment and recoupment action. These audits are retrospective and may involve claims up to six years old. Providers are not compensated for their administrative costs in locating, developing, and submitting these claims to Medicare. The Medicaid auditors or their contingency fee contractors file "Statements of Intent to File Claims" with Medicare advising Medicare of the forthcoming claims.

The increase in TPL claims submitted to Medicare by providers and suppliers in response to Medicaid overpayments, and the increase in administrative costs to process these claims are among the reasons HCFA issued the December 3rd letter to the State Medicaid Directors and its accompanying Program Memorandum. The Program Memorandum instructs fiscal intermediaries and carriers that they are not responsible for: 1) identifying providers and suppliers of TPL claims for the state Medicaid pro-

grams; 2) requesting that the provider or supplier submit the claim; or 3) requesting additional information from the provider or supplier to develop the claim. These functions are the responsibility of the Medicaid program, or its contingency fee contractor, which files a "Statement of Intent To Files Claims" for these TPL claims.

HCFA's December 3rd letter and Program Memorandum emphasizing long standing regulations will help providers and suppliers obtain some relief from a previously no-win situation between the Federal and state governments.