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Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

July 3, 2006

TO: All Associate Regional Administrators for Medicaid and State Operations

FROM: Gale Arden /S/
Director

RE: State Options for Recovery Against Liability Settlements In Light of U. S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*

The purpose of this memorandum is to clarify third party recovery rules and options for States in the context of the U. S. Supreme Court's decision in *Arkansas Department of Human Services v. Ahlborn* (*"Ahlborn"*). The Court ruled against the State in this case, in which the federal government had filed an *amicus* brief, holding that the federal assignment and lien provisions prohibited full recovery of the State's payments for Medicaid if the State's recovery claim exceeded the amount designated as compensation for medical items and services. States must comply with the decision in *Ahlborn.* However, States may be able to mitigate the adverse impact of the case by taking some of the actions discussed in this Memorandum. The Centers for Medicare & Medicaid Services (CMS) strongly encourages States to consider implementing mitigating strategies, and we ask that you share the information in this memorandum with the States in your region.

Background:

On May 1, 2006 the United States Supreme Court, in a unanimous decision, held that the federal Medicaid statute only permits a State to recover its payments for medical assistance from the portion of a liability settlement attributable to medical items and services. The Court further held that if the State attempted to recover from more than the portion of a settlement that the parties allocated to medical items and services, it was in violation of the federal anti-lien statute. The federal government had filed an *amicus* brief in this case on behalf of the State of Arkansas.

The case concerned a Medicaid recipient who subsequently received a tort liability settlement of $550,000. The settlement was not apportioned between medical services, loss of earnings or pain and suffering claims. Arkansas asserted a lien in the amount of $215,645 against the entire settlement amount. Ahlborn argued that Arkansas could recover only that portion of the settlement proceeds that Ahlborn determined was payment for medical expenses, as opposed to the much larger payment for lost wages or pain and suffering. Ahlborn based her argument on the federal anti-lien provision that prohibits imposition of a lien against the property of any

individual on account of medical assistance paid or to be paid on his or her behalf under a State plan. Arkansas contended that the anti-lien provision did not prevent full recovery because, as a condition of Medicaid eligibility, Ahlborn had assigned to the State her right to any settlement, judgment or award paid by a third party liable for her medical costs resulting from the accident. The State argued that those settlement proceeds remained the property of the third party tortfeasor until the Medicaid program was fully reimbursed for the funds it expended on respondent's medical care. During the course of this litigation, in order to pave the way for summary judgment, Arkansas and Ahlborn entered into a stipulation which indicated that if Ahlborn's view of the case was correct, the amount of her settlement allocated to medical expenses would be only $35,581 or approximately 16% of its total recovery claim.

The Supreme Court held that the federal assignment provision, Section 1912(a)(1)(A) of the Social Security Act (the "Act"), provides only a limited assignment from the Medicaid recipient to the State for payment for medical items and services from a liable third party. Likewise, the Supreme Court held that the statutory provisions authorizing States to recover prohibit the States from seeking anything greater than the limit of the tortfeasor's legal liability. See Section 1902(a)(25)(H) of the Act. The Court found that the limited assignment to the State prohibited full recovery, under Section 1902(a)(25)(H), of the State's payments for medical assistance if the State's recovery claim exceeded the amount attributed to compensation for medical items and services. Finally, to the extent the Arkansas State statute provided for filing a lien for full recovery of medical assistance payments, the Court found it conflicted with the Medicaid laws anti-lien provision, Section 1917(a)(1) of the Act, which prohibits the State from imposing liens against any individual prior to his death on account of medical assistance paid on his/her behalf.

What this means for Medicaid third party liability recovery programs:

Prior to the Supreme Court's decision in *Ahlborn*, CMS had interpreted the Medicaid third party liability provisions to authorize States to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws.

However, the Supreme Court also strongly noted that the States should become involved in the underlying tort litigation in order to influence the amount that is allocated in a settlement to medical items and services. Thus, the Supreme Court determined that a State's recovery rights could be protected, and the adverse consequences of the decision mitigated, by vigorous action on the part of a State to increase the amount of a settlement allocated to medical items and services. Absent such involvement, the Supreme Court found little sympathy in the State's argument that they should be able to recover from the total settlement.

While the federal government is reviewing its legislative options, it is imperative that States comply with the decision in *Ahlborn*. To assist States in determining how to proceed under the federal Medicaid third party liability recovery rules post-*Ahlborn* we provide the following:

State Actions Prohibited Under *Ahlborn:*

- The Court interpreted current federal Medicaid law to preclude the State from enforcing laws which broaden the assigned rights of a Medicaid recipient. States may only require assignment of the right to payment from a third party for healthcare (or medical) items and services.

    - The Court interpreted current federal Medicaid law to preclude the State from enforcing laws which broaden the recovery rights, *vis a vi*s Medicaid beneficiaries, of the State Medicaid agency. A State may only recover from the amount of a third party payment to a Medicaid recipient that is allocated to healthcare (medical) items and services. **However, note that State tort or insurance liability provisions are a matter of State law and could be utilized to mitigate the adverse affects of the decision.** For example, a State can enact laws which provide for a specific allocation amongst damage, i.e., pain and suffering, lost wages, and medical claims. The State may also require that cases can only be compromised with the consent of the State.

    - A State's lien laws may only operate to recover from that portion of a settlement that is allocated to healthcare items or services, even if it means that Medicaid must forego full recovery of its claim. According to *Ahlborn,* federal Medicaid anti-lien law precludes the State from passing lien laws which broaden the recovery rights of the State Medicaid agency. Note however, that the State may pass other laws which give it a priority right of recovery in tort actions.

State Actions Which Would Mitigate the Adverse Consequences of *Ahlborn*:

- In order to protect the Medicaid program's interest in the allocation of settlement monies to medical items and services it is extremely important for States to be involved in the litigation and settlement process.

- States may pass laws which require mandatory joinder of a State when a Medicaid lien is at issue. The States may also want to strengthen their laws regarding the duty of attorneys to notify and cooperate to include provisions which could render voidable any settlement of which the State was not notified and given an opportunity to present its recovery claim for medical assistance paid. These actions are consistent with the federal Medicaid laws.

- As part of its governance of tort and insurance law, the State may enact laws which define tort rights of action, judicial procedures and settlement standards in State courts. For example, a State could enact laws which give priority to the repayment of medical expenses, only permit compromising a claim with the State's consent, or any other laws which ensure that the State will have an opportunity to fully recover its expenditures.

- The States may use the cost effectiveness criteria set forth in Section 1902(a)(25)(B) of the Act in determining which liability case settlements they should pursue for recovery of Medicaid claims. For example, where a Medicaid recipient decides not to pursue a claim, depending on the amount of the claim, the State Medicaid agency may determine that it is not cost-effective to pursue its direct right of recovery against the potentially liable party. States that choose this option should use the State plan process to adopt a threshold or other guidelines for determining whether to seek reimbursement. These actions are consistent with the federal Medicaid law.

- As part of its State plan, the State may determine that it is more cost-effective to pursue a lesser amount than the full cost of care in order to avoid litigation. Cost-effectiveness must be determined on a case by case basis. For example, the State could reduce the amount of its claim which becomes the amount of reimbursement that the State can reasonably expect to recover. However, in order to do so, a State must amend its State plan to include cost effectiveness criteria such as the following:

a. Factual and legal issues of liability as may exist between the Medicaid recipient and the liable party; and

b. Total funds, e.g., policy limits, available for settlement; and

c. An estimate of the cost to the Medicaid program of pursuing its claim.

See the attached copy of general cost effectiveness criteria and Washington's State plan concerning third party liability and cost-effectiveness.

- The Medicaid statute does not require the State to repay the federal government its full federal share, i.e., the total amount the federal government expended, where the State has determined that it is not cost-effective to attempt to recover the full cost of care from a recipient's settlement. What the Medicaid statute does require is that the federal share of the State's <u>actual</u> recovery amount be repaid to the federal government. Such an action is not considered a compromise of the federal share for purposes of third party liability recovery. These actions are consistent with the federal Medicaid laws and the federal share would be based on the amount that is actually recovered by Medicaid.

Attachments (2)
Fact Sheet—June 2000
Washington SPA 99-07

PURSUING TORT RECOVERIES

FACT SHEET

June 2000

Under section 1902(a)(25) of the Social Security Act (the Act), in either an out-of-court settlement or a court judgment, the State must do all in its power to obtain full restitution of the amounts expended on the beneficiary's behalf. Judgments or settlements will often contain more than just payment for the cost of medical care, such as pain and suffering or loss of consortium. Although the beneficiary may have been awarded a certain amount, pursuant to sections 1902(a)(45) and 1912(a)(1)(A) of the Act, the beneficiary has assigned to the State any rights to payment for medical care from any third party payer. Thus, the State has claim to the entire judgment or settlement amount to the extent of such legal liability.

Federal law and regulations do not permit a compromise, settlement, or release of any claim in whole or in part, allowing a Medicaid beneficiary to retain any funds, so long as the Federal government has not been reimbursed its share of the amount recovered by Medicaid. Some States contend that beneficiaries are unwilling to cooperate in recovery actions where they will not receive a share of the settlement/judgment. We offer three options that States may use that could result in monies being distributed to the beneficiary. States are not obligated to elect any of these options.

OPTION I - APPLYING COST EFFECTIVENESS CRITERIA

Section 1902(a)(25)(B) includes a cost effectiveness aspect to any third party recovery. Specifically, the statute states:

> "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability."

By applying 1902(a)(25)(B) as a basis, a State may determine that it is more cost-effective to pursue a lesser amount than the full cost of care in order to avoid either full litigation or the State pursuing the claim itself. In other words, the State could reduce the amount of its claim which becomes the "amount of reimbursement that the State can reasonably expect to recover." Thus, the State may pursue a reduced claim to the extent that it is cost-effective to do so. The Federal share would be based on the amount that is actually recovered by Medicaid.

While a State may forego recovery efforts where it can be shown that such efforts would not be cost-effective, it may not operate under rules which, in every case, allow beneficiaries to retain third party liability payments where the Federal share of Medicaid expenditures has not been reimbursed. Cost-effectiveness is to be determined on a case-by-case basis. The State plan must describe the process by which the Medicaid agency determines that seeking full recovery of reimbursement would not be cost-effective.

OPTION 2 - ALLOWANCE FOR ATTORNEY FEES AND COSTS

Attorney fees and litigation costs may be deducted prior to reimbursement to the Medicaid program. Although a State may choose to pay its share of the costs for attorney fees, it is not obligated to do so. The State may decide that the attorney fees will be deducted off the top and that the State will seek full recovery based on the remaining amount to be distributed. The following example illustrates a situation where the State **does not** share the costs.

State Does Not Share in Attorney Fees and Costs

Medicaid Lien Amount	$140,000
Amount of Third Party (TP) Payment	$200,000
Attorney Fees and Costs	- 50,000
Amount to be Distributed	$150,000

Using this method, the $150,000 should be distributed as follows:

Medicaid Net Recovery (no adjustment)	**$140,000**
Potentially Available to Beneficiary	**$ 10,000**

While the Federal law does not mandate that States do so, it does allow States the flexibility to share a proportionate cost of legitimate attorney fees and litigation and witness costs. The amount of the reduction is calculated by the application of the ratio of the amount recovered by Medicaid to the entire third party payment amount and then multiplied by the amount of attorney fees. The following example illustrates a situation where the State **does** share the costs.

State Shares in Attorney Fees and Costs

Medicaid Lien Amount	$140,000		
Amount of TP Payment			$200,000
Medicaid's Share	$140,000		
Beneficiary's Share	$ 60,000		
Attorney Fees and Costs			- 50,000

Medicaid's share is 70% of the TP payment
($140,000 divided by $200,000 = 70%)

Medicaid pays 70% of attorney fees
($50,000 x 70% = $35,000)

Medicaid's Share of Attorney Fees	$35,000

Beneficiary's share is 30% of the TP payment ($60,000 divided by $200,000 = 30%)		
Beneficiary pays 30% of attorney fees ($50,000 x 30% = $15,000)		
Beneficiary's Share of Attorney Fees	$15,000	
Amount to be Distributed		$150,000
Medicaid's share of the TP payment minus attorney fees ($140,000 - $35,000 = $105,000)		
Medicaid's Net Recovery		**$105,000**
Beneficiary's share of the TP payment minus attorney fees ($60,000 - $15,000 = $45,000)		
Potentially Available to Beneficiary		**$ 45,000**

Federal financial participation is available to share in attorney fees and cost. In the above example, the State would be required to return the Federal share based on the $105,000 that Medicaid recovered after adjusting for attorney fees and costs.

Applying this methodology, if the Medicaid lien amount is equal to or greater than the third party payment amount, the attorney's fees are paid from Medicaid's share and there is nothing left to disburse to the beneficiary. For example, if the Medicaid lien amount were $200,000 or greater and the third party payment is $200,000, the attorney's fees would be deducted from the $200,000 and the remaining $150,000 would go to Medicaid.

OPTION 3 - COMPROMISING THE STATE SHARE

The Federal government is to be made "whole" to the extent of its share of the amount recovered by the State. To the extent that a State wishes to give part or all of its portion of the Medicaid recovery to the beneficiary, nothing prevents the State from doing so as long as it does not impinge upon the Federal share of the amount recovered by Medicaid.

If in spite of its best efforts, a lesser amount is obtained/awarded, the State should be found in compliance with Federal requirements as long as it has followed HCFA's policy and has documented its efforts explaining why less than full recovery has been accepted.