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7/10/2018 | Articles

Maryland Court holds that Medicare Secondary Payer Act does not preempt state law

On June 4, 2018, the United States Court of Appeals for the Fourth Circuit joined a growing number of courts around the country that have found an individual does have standing to bring suit under the Medicare Secondary Payer ("MSP") Act's private cause of action. See *Netro v. Greater Balt. Med. Ctr., Inc*., 2018 U.S. App. LEXIS 14835 (a copy of the decision can be found by clicking here). While standing to bring the action was established, the Fourth Circuit ultimately found that the facts of the case did not establish that the Defendant had failed to reimburse Medicare for conditional payments, and the district court's granting of summary judgment to Defendants was affirmed. However, this is not where the Medicare controversies in this case ended; and recently the Court of Special Appeals of Maryland, an intermediate state appellate court, addressed a question of MSP preemption of state law. A copy of the decision can be found by clicking here.

Facts

The *Netro* case began as a medical malpractice suit filed in state court against the Greater Baltimore Medical Center ("GBMC"). The case proceeded to a jury trial, with the jury finding negligence on the part of GBMC. At trial, evidence was submitted demonstrating that Plaintiffs had received medical bills from health care providers totaling $451,956.00, that the decedent was a Medicare beneficiary, and that Medicare had made conditional payments totaling $157,730.75 for claim-related care. After the judgment was entered, GBMC moved to reduce the judgment pursuant Maryland Code, Courts and Judicial Proceedings Article § 3-2A-09(d) (hereinafter "the Act."). The Act states:

(d) Medical expenses; loss of earnings.

(1) A verdict for past medical expenses shall be limited to:

(i) The total amount of past medical expenses paid by or on behalf of the plaintiff; and
(ii) The total amount of past medical expenses incurred but not paid by or on behalf of the plaintiff for which the plaintiff or another person on behalf of the plaintiff is obligated to pay.

According to the court, under Maryland law, a Plaintiff is allowed to provide evidence of the bill received by the health care provider, but the defendant is prohibited from informing the jury that a portion of the bill was written-off. This is what occurred in this case, with the Defendants filing a post-judgment motion and providing evidence that Plaintiffs' insurers, including Medicare, had taken some $62,941.70 in write offs, reducing Plaintiffs' healthcare bills that she or another entity paid or was obligated to pay from $451,956.00 to $389,014.30. Plaintiffs subsequently filed a motion in opposition to Defendant's motion for reduction based on the write-offs.

In support of their motion in opposition, Plaintiffs contended that the MSP, and its associated regulations, preempted the Maryland Act because application of the Act in the instant case lead to a lower recovery for Medicare than if the Act was not applied and that the Congressional intent of the MSP was to increase recovery "to the maximum extent possible." Namely, Plaintiffs' argument centered around Medicare's procurement cost reduction found at 42 C.F.R. § 411.37, which states that Medicare will reduce its recovery of conditional payments to take into account a party's cost for procuring a judgment or settlement if certain factors are met, including that procurement costs are incurred

because the claim is disputed, the costs are paid by the party from whom the Centers for Medicare & Medicaid Services (“CMS”) seeks recovery, and if the conditional amount paid by Medicare is less than the judgment or settlement amount. The procurement reduction is located at 42 C.F.R. § 411.37(c) and is calculated as follows:

1. Determine the ratio of the procurement costs to the total judgment or settlement payment.
2. Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.
3. Subtract the Medicare share of the procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.
   In this matter, and applying the reduction calculation outlined above, CMS would pay 40.55% of the procurement costs if the Act is applied versus the 34.90% they would have pay if the Act were not applied. This amounted to a real dollar difference of $18,500.00. However, the trial court disagreed with Plaintiffs’ motion in opposition, and the judgment was reduced to $389,014.30.

The Preemption Appeal

Plaintiffs immediately filed an appeal on the issue of preemption. Defendant submitted a motion to dismiss for lack of standing, arguing that Plaintiffs did not have standing to defend the rights of Medicare, which was easily dismissed. The court held that Plaintiffs did have standing because the judgment was impacted depending on whether or not the Act was applied to reduce the bills.

In furthering their preemption argument, Plaintiffs put forth numerous citations documenting the “paramount purpose” of Congress in passing the MSP was to ensure that the Medicare Program was reimbursed for conditional payments “to the maximum extent possible.” However, the court disagreed with Plaintiffs’ interpretation of the congressional intent, citing the Federal Register, which states that “Congress intended that the MSP provisions be construed to make Medicare a *secondary payer* to the maximum extent possible,” not that the Medicare Program be reimbursed to the maximum extent possible. *Netro* at 17 (citing 71 Fed. Reg. 9466, 9467 (February 24, 2006)). The court further cited to 42 C.F.R. § 411.21, which states “Secondary payments mean payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.” With this in mind, the court held that the Act did not offend the MSP because the MSP and its accompanying regulations would still see the Medicare Trust reimbursed for 100% of the conditional payments, irrespective of whether Medicare paid a higher portion of the procurement cost.

Additionally, the court instructed that the adoption of the procurement regulations showed the intent of Congress was not to ensure recovery of conditional payments to the maximum extent possible because allowing for reduction of the conditional payment owed based on a pro-rata share of procurement costs would certainly lead to instances of Medicare not recovering to the maximum extent possible. The court provided further evidence that the MSP had not preempted the Act by pointing out the paradoxical result that would be reached if CMS brought suit in their own right to recover conditional payments, as authorized by 42 U.S.C. § 1395y(b)(2)(B)(ii). In the instance of a direct recovery action by CMS, the Act would not apply and CMS would collect the full amount of their conditional payments with no reduction for procurement costs or write-offs under the Act. The court found that it would be illogical that the MSP would preempt the Act in the context of the private cause of action, but not in the context of a direct recovery from CMS.

Analysis

At its heart, this case is about one issue: how primary payer status is determined. A careful reading of the MSP most often makes this an easy determination. 42 U.S.C. § 1395y(b)(2)(B)(ii), which outlines the responsibilities of a primary plan (payer) to reimburse Medicare, states that:

> A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of

liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

This confirms that a primary payer's obligation to reimburse Medicare stems from the underlying claim, and primary payer status is determined only when a judgment, award, compromise, waiver, or release is finalized. By its own wording, the MSP is deferential to the underlying claim to establish primary payer status. Often, in the context of conditional lien payments, arguments must be put forth to establish that a debtor's primary payer obligation cannot be expanded to create repayment obligations outside the scope of the underlying claim. This case stands for the same principle. The Maryland Act is a valid mechanism under state law by which a party to litigation may reduce their owed damages.

It is true that the primary reason for the enactment of the MSP was to save the Medicare program money. However, nothing about the Maryland Act frustrated the MSP's purpose. Because the trial court's judgment and the payment of the award to the Plaintiffs established GBMC as primary payers, and thus Medicare as secondary payers, the question of "preemption" was a relatively simple one. The doctrine of preemption applies when one of the two is true: (1) when the state law "sharply interferes" with or is directly contrary to federal law, or (2) when it is a physical impossibility to comply with both the federal and the state law. The Maryland Act did not "sharply interfere" with the MSP, nor was it impossible to comply with both the Act and the MSP. Medicare's right to reimbursement for its expenditures was still paramount over any other claim in the case. Whether or not the Act was applied, Medicare was still owed $157,730.75 for their conditional payments. Once it became clear that Medicare's recovery was unchanged whether the Act was applied or not, Plaintiffs' preemption argument was reduced to a novel facade put forth in a final effort to maximize their damages.

The Dickie, McCamey & Chilcote Medicare Compliance Group is available to help your organization with all aspects of MSP compliance. If you have any questions regarding the information outlined above or any other inquiries, please feel free to contact us.

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