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Q & A

Recoupment Following an Adverse Medicaid Appeal

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Q. After my client's services were terminated by the Medicaid managed care plan, she appealed. At her request, her benefits were continued during the pendency of the appeal. The client lost the hearing, and the plan is now seeking to recover the amounts it paid while the hearing was pending. Is this legal?

A. Maybe. The federal Medicaid regulations authorize the state Medicaid agency to recover the cost of medical assistance provided during the pendency of the administrative hearing. *See* 42 C.F.R. § 431.230(b). The enrollee would not be liable for all services provided during this time period, but only for the services continued because of the appeal. However, beginning in July 2017, if a state Medicaid agency does not exercise its recoupment authority for its Fee-For-Service program, it may not permit Managed Care Organizations, Pre-paid Inpatient Health Plans, or Pre-paid Ambulatory Health Plans to exercise that authority either. *See* 42 C.F.R. § 438.420(d). Thus, your client's plan may only collect from her to the extent and in the manner authorized by the state.

Discussion

Medicaid applicants and recipients have rights to notices and administrative hearings when their claims for medical assistance are denied or not acted upon with reasonable promptness. These rights are found in the Medicaid Act and regulations, *see* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250, and are guaranteed by the Due Process Clause of the United States Constitution, *see* U.S. Const. amend. XIV, § 1; *see also Goldberg v. Kelly*, 397 U.S. 254, 266 (1970). *Goldberg* holds that public benefits recipients, such as Medicaid recipients, have the constitutional due process right to receive an effective notice and hearing before benefits may be terminated. *Id.* at 267; *see also Mathews v. Eldridge*, 424 U.S. 319 (1976). Medicaid regulations explicitly implement the protections guaranteed by *Goldberg*. *See* 42 C.F.R. § 431.205(d).

[1] Thank you to Victor Gonzalez, 3L at Cardozo Law School, for his assistance with this Q&A.

Under both *Goldberg* and the Medicaid regulations, the essential elements of "due process" are an adequate written notice and the opportunity to challenge the state action before an impartial decision maker. *Goldberg*, 397 U.S. at 267; 42 C.F.R. §§ 431.210-431.240. Thus, when the state is going to terminate, reduce, or suspend a service that an enrollee has been receiving through the Medicaid program, special protections arise. In general, the state must send the enrollee an advance notice with information about the pending action at least 10 days prior to the time of the anticipated action. *See* 42 C.F.R. §§ 431.210-431.211 (requiring 10-day advance notice and describing required content of the notice). An enrollee who requests a hearing prior to the effective date of the adverse action generally has the right to receive continued benefits (also called "aid paid pending") at the previously authorized level pending the results of the hearing. *Id.* § 431.230.

If the decision is favorable to the claimant or if the agency decides in her favor prior to the hearing, corrective payments must be made retroactive to the date that the incorrect action was taken. *Id.* § 431.246. On the other hand, if the state's decision is affirmed, the state may recover the costs of the continued benefits from the recipient. According to 42 C.F.R. § 431.230(b),

> If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

The federal Medicaid agency, the Centers for Medicare & Medicaid Services (CMS), has further clarified the recovery policy in its State Medicaid Manual, informing states:

> A. You may recover from the recipient money you paid for services provided the recipient if:
>
> > The services were provided as a result of … [the recipient requesting continued Medicaid services], and
> >
> > The recipient's appeal is unsuccessful.
>
> B. Inform the recipient of this provision at the time a hearing is requested if you employ recovery.

CMS, State Medicaid Manual § 2904.2, https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html (last updated Sept. 8, 2005); *see also* Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 41,064 (June 14, 2002) (stating enrollees liable for the costs of appealed services "from the later of the effective date of the notice of intended action or the date of the timely-filed appeal, through the date of the denial of the appeal.").

The right to continued benefits applies regardless of whether the enrollee is receiving benefits in a Fee-For-Service (FFS) setting (including a primary care case management system) or through a Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP) or Pre-paid Ambulatory Health Plan (PAHP). *See* 42 C.F.R. § 438.420 (requiring the grievance systems of Medicaid-participating MCOs, PIHPs, and PAHPs to include continued benefits). Regarding pre-paid managed care settings, newly finalized federal regulations provide:

> [T]he MCO, PIHP, or PAHP . . . may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b). . . .

Id. § 438.420(d); *see also Id.* § 438.404(b)(6) (requiring the MCO, PIHP, or PAHP notice to explain "[t]he enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services."); *see also* Medicaid Managed Care, 81 Fed. Reg. 27498, 27638 (May 6, 2016) (preamble) ("[S]tates should have monitoring mechanisms in place to ensure that their managed care plans are not taking punitive or negative actions against enrollees nor engaging in excessive or abusive recoupment practices."). The regulations will apply for contract periods that begin on or after July 1, 2017.

Thus, the state Medicaid agency and participating plans are authorized to recoup Medicaid benefits paid pending an administrative appeal that is resolved adverse to the recipient. However, recoupment is not mandatory. "The use of the word may in the regulation [431.230(b)] clearly neither mandates such recovery nor precludes [the department] from adopting other methods of recovery. . . ." *Centennial Spring Health Care Ctr. v. Commw. of Pa.*, 541 A.2d 806, 810 (Pa. Commw. Ct. 1988);[2] *see also* Medicaid Managed Care, 81 Fed. Reg. 27498, 27633 ("[T]he decision to hold the beneficiary financially liable for such services [continuation of benefits resulting in a final adverse decision] is left to the state under § 431.230(b) and that decision would be applied equally to FFS and managed care programs.").

[2] *Centennial Spring* challenged a state regulation that required nursing facilities to maintain services at the prior-approved level of care during the pendency of a recipient's appeal of a Departmental decision to change the level of care. During the pendency of the appeal, the Department would pay the facility at the rate established for the prior level of care. However, if the recipient lost the appeal, the Department would recover from the facility any payments in excess of the amount that would have been made had the action not been appealed. A divided court rejected the facility's arguments that it was unreasonable for the Department to recoup overpayments from providers who did not participate in and had no control over recipient appeals and that 42 C.F.R. § 431.230(b) authorized recovery only from recipients, not providers. The majority held the regulation was reasonable because it protected the Department from paying for unnecessary care and was "simply a means of recouping overpayments to which the providers were not entitled in the first place." 541 A.2d at 810.

Moreover, Medicaid managed care plans cannot use recoupment policies that are different from those of the state. A recently enacted final rule, § 438.420(d), clarifies that if a state does not exercise its recoupment authority under § 431.230(b) for its Fee-For-Service (FFS) program, Managed Care Organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), or Pre-paid Ambulatory Health Plans (PAHPs) are not permitted to do so. Additionally, the final rule provides that MCO's, PIHP's, and PAHP's ability to recoup payment from the enrollees following a final adverse decision must be addressed in the contract and consistent across all managed care plans, likely since they would be treated as FFS programs for this purpose.[3]

At least one court has found that the recoupment policy balances equities between the enrollee and the state: Cutting services to an individual can result in unjustifiably forcing them to forego necessary care; therefore, services can be continued while a hearing is pending. Recoupment affords the state some level of equity, however, if it is determined later that the services were properly terminated. *See Olson v. Wing*, 281 F. Supp. 2d 476, 489 (E.D.N.Y. 2003) (preliminarily enjoining state to inform recipients about rights to continued benefits, finding balance of equities tipped in plaintiffs' favor because recoupment regulation allowed state to obtain some relief even though "limited resources" of recipient population made it "unlikely that defendants will be able to recoup their costs in most cases"); *see also Goldberg*, 397 U.S. at 264 (finding recipients should be able to have their basic needs meet during pendency of hearing).

Recommendations and Conclusions

Recovery has long been an option for state Medicaid programs. Nevertheless, there is very little administrative guidance and case law on point. This is probably because the low income, judgment-proof status of most Medicaid recipients makes it likely that state agencies would spend more resources to engage in recoupment than they would collect. If, however, your state and/or its contracting agents (e.g. MCOs) are committed to engaging in recovery, the following protections should apply:

1. <u>The state should be allowed to conduct post-hearing recovery only if there is a written policy that is clearly announced and equitably applied.</u> Clearly written and evenly applied policies apply to and among Medicaid-participating MCOs, PIHPs, PAHPs, and FFS programs.

2. <u>The recipient should be properly informed.</u> When benefits are being reduced, terminated, or suspended, the state and its managed care contractors should not recoup amounts for any benefits paid to the individual unless and until she has been adequately informed and thereafter requested continued benefits. Additionally, denial

[3] The rule does not mention Primary Care Case Manager (PCCM) programs, which are funded through Fee-For-Service payments, and thus have been subject to the state recoupment practices all along.

and termination notices must be made available in prevalent non-English languages, as well as in alternative formats.

The state's potential right to recovery should not be used a "weapon" to discourage appeals. The notice of recovery must be accurate but not written so as to incorrectly discourage a recipient from exercising her fair hearing rights. For example, it would be objectionable for a state or its MCO, PIHP, or PAHP to include the following wording on a notice that was otherwise prepared using a 12 point regular font:

You may choose to maintain your benefits pending the appeal, but if you lose the appeal, we will recoup the full amount of the benefits we paid.

NHeLP has objected to similar notices, arguing that they are overbearing and may cause individuals to forego their fair hearing rights.

3. The state's right to receive federal funding should be explicitly mentioned. When a Medicaid enrollee exercises his right to continued benefits, the state obtains the right to receive federal financial participation for "payments for services provided pending a hearing decision." 42 C.F.R. § 431.250(a). This means that continued benefits are cost effective for the state, whether they are delivered through a FFS program or managed care.

4. When the state or its MCO, PIHP, or PAHP is pursuing recovery, the individual should be allowed to present evidence to show why equity favors a full or partial waiver of the recovery. Low-income, judgment-proof individuals are simply unable to repay the assistance provided to them pending appeal or, if forced to make the repayment, will be deprived of income required for subsistence living expenses. The extenuating circumstances for people with disabling or chronic conditions can be particularly compelling.

Equitable concerns may also arise in managed care settings when the MCO (or PIHP or PAHP) has entered into a contract with the state to accept a prepaid, monthly amount of Medicaid payment per member per month (a "capitation" payment). In these situations, there may be an argument over the amount that can be recovered, that is whether the recipient can be required to repay the costs of the services received pending appeal or the amount of the capitation payments the state paid to the MCO, PIHP, or PAHP pending appeal. To date, published cases have raised, but not clearly decided, this issue only in the third party liability context (involving, for example, state recovery from the proceeds of a medical malpractice action). *See Tristani v. Richman*, 609 F Supp. 2d 423, 459-61 (W.D. Pa. 2003); *E.D.B. ex rel. D.B. v. Clair*, 987 A.2d 681, 692 (Pa. S. Ct. 2009).

5. When the client has been denied benefits due to a systemic violation of federal or state law by the state or its agents, aggressive recoupment policies by the state agency or MCOs, PIHPs, or PAHPs should be considered when making the choice of forum decision. Depending on the factual circumstances and the relevant Medicaid provisions, you may decide not to exhaust administrative remedies but rather to file a case in state or federal court and seek immediate injunctive relief requiring the agency to maintain the plaintiffs' services while the case is being heard. The administrative recoupment regulations would not apply in these circumstances, and the state will receive federal financial participation for services ordered by the court, 42 C.F.R. § 431.250(b).