Where They've Been and Where They're Going

Secondary Payer Lawsuits Involving Medicare Advantage Organizations

By Laura Besvinick, Julie Nevins, and Jay Yagoda

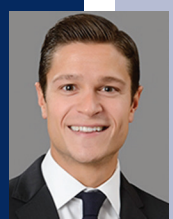
Courts are now being directly asked to discuss causes of action by "first-tier entities" and "downstream entities" for reimbursement of conditional payments, leaving the future of MSP Act litigation uncertain.

Liability insurers settle tort claims asserted against their insureds every day. The purpose of these settlements is self-evident: They attempt to compensate claimants injured as a result of the insureds' alleged negligence in exchange for certainty. The claims are fully resolved, the claimants get paid, and the insurers avoid the burden and high cost of litigation and possibly trial. However, now that approximately 19 million Medicare beneficiaries (or 33 percent) are using Medicare Advantage Plans (MA Plans) to deliver their Medicare benefits, the certainty that tort liability settlements generally brought liability insurers in decades past has waned.

The Medicare Secondary Payer Act (the MSP Act), codified in 42 U.S.C. §1395y(b), is the reason for this change. The MSP Act prohibits Medicare from paying medical expenses when another payer is responsible for the payment. Based on recent developments in the law, courts have authorized Medicare Advantage organizations (MAOs)—private sector managed care organizations that contract with the U.S. government to provide MA Plans to Medicare beneficiaries—to transform these once-settled tort liability claims into new actions that seek not just reimbursement for paid-out medical expenses, but also an award of double damages. A liability insurer that settled and paid a claim once now is potentially liable for paying the same claim again—two more times, years later.

Lawsuits against liability insurers have proliferated in jurisdictions across the nation as a result. The allegations are for-





■ Laura Besvinick is a partner in Stroock & Stroock & Lavan LLP's Insurance and Reinsurance Group in Miami, Florida. With more than 30 years' experience litigating matters in state and federal trial and appellate courts, she focuses on representing insurers in complex coverage disputes, bad-faith actions, and consumer class actions. Julie Nevins is a special counsel in Stroock's Insurance and Reinsurance Group in Miami, Florida. She has more than 15 years' experience litigating matters in state and federal trial and appellate courts and in arbitral and administrative forums, and has broad experience handling business tort cases and insurance coverage disputes. Jay Yagoda is an attorney in Miami, Florida, where he focuses his practice on commercial disputes in state and federal trial and appellate courts.

mulaic. An MA Plan enrollee was injured as a result of a tortfeasor's negligence; the tortfeasor's liability insurer settled the claim with the enrollee; and the MAO that paid all or part of the enrollee's medical expenses resulting from the injury did not receive reimbursement from the proceeds of the enrollee's settlement. The lawsuits allege that the settlement rendered the MAO's payment "secondary" (or "conditional"), subject to repayment by the liability insurer as the "primary payer" under the MSP Act. According to the lawsuits, the MSP Act permits an MAO to recover the amount paid, twice over.

When faced with these lawsuits, liability insurers often are left wondering how these payments went unreimbursed. Liability insurers report their settlements to the Centers for Medicare & Medicaid Services (CMS) and communicate with CMS about whether conditional payments are owed, but they often have no notice that an MAO paid for medical services before a settlement was finalized. The problem lies in the fact that CMS does not communicate information about payments made by MAOs to liability insurers, and unlike with traditional Medicare, there are limited mechanisms in place for liability insurers to identify MA Plan enrollees. Plaintiff attorneys have leveraged this lack of clarity into a business model for bringing suits against liability insurers on behalf of MAOs.

And the lawsuits continue to evolve. A new wave of reimbursement lawsuits brought on behalf of entities—labeled as "first-tier entities" and "downstream entities"— that supposedly contract with Medicare Advantage organizations to provide Medicare services to MA Plan enrollees has started. Although no court has recognized a cause of action by such entities for reimbursement of conditional payments, courts are now being asked to decide this issue directly, leaving the future of MSP Act litigation uncertain.

Medicare and the Medicare Secondary Payer Act

To place a liability insurer's post-settlement reimbursement obligations into context first requires having a basic understanding of the Medicare program. Medicare, enacted in 1965, is a federally funded health insurance program for individuals aged 65 and older or individuals suffering from certain disabilities or battling end-stage renal disease. Parts A and B of the Medicare Act regulate the traditional fee-for-service Medicare program administered by the Centers for Medicare & Medicaid Services (CMS), a branch of the U.S. Department of Health and Human Services. Part C, added in 1997, outlines the Medicare Advantage program, which gives Medicare enrollees the option of electing to receive their Medicare benefits through private managed care organizations called Medicare Advantage organizations, or "MAOs." These MAOs contract with CMS, which pays the MAOs a fixed fee per enrollee, per capita (a "capitation"), to administer Medicare benefits to enrollees through MA Plans. In exchange, the MAOs assume all of the financial risk for treating enrollees. 42 U.S.C. §§1395w-24 to 25.

For the first 15 years that the Medicare Act existed, Medicare often acted as a primary insurer. Medicare paid for an enrollee's medical expenses even if the enrollee had overlapping insurance coverage or when a third party had an obligation to pay for the enrollee's medical expenses. In 1980, Congress enacted the MSP Act in an effort to curtail Medicare's rising costs, which, at that time, were vastly exceeding actuarial projections. Aiding in this effort, the MSP Act makes Medicare's liability secondary to other sources of payment. It does this by shifting responsibility for medical payments to other group health plans and workers' compensation and no-fault and liability insurers, which the MSP Act terms "primary plans." 42 U.S.C. §1395y(b)(2). Specifically, the MSP Act prohibits Medicare from paying for items or services if "payment has been made or can reasonably be expected to be made" by a "primary" payer. *Id.* §1395y(b)(2)(A)(ii). This prohibition effectively makes Medicare, the secondary payer, an insurer of last resort.

Only one exception to the MSP Act's prohibition exists: the "conditional payment." If a primary payer "has not made or cannot reasonably be expected to make payment with respect to the item or service promptly," Medicare is authorized to make a "conditional payment." *Id.* §1395y(b)(2)(B)(i). But because Medicare remains the secondary payer, the primary payer must reimburse Medicare for all conditional payments, "if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." *Id.* §1395y(b)(2)(B)(ii).

Under the MSP Act, the "responsibility" for reimbursement 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." *Id.* A liability insurer's settlement with a Medicare enrollee injured as a result of the insured's alleged negligence, for example, may "demonstrate[]" or trigger "responsibility" for reimbursement of conditional payments under certain circumstances.

Because Medicare remains the secondary payer, the primary payer must reimburse Medicare for all conditional payments, "if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service."

The MAOs that contract with CMS receive secondary payer status in 42 U.S.C. §1395w-22(a)(4). This provision allows, but does not require, MAOs to charge an insurer that is primarily responsible for medical expenses that the MAOs have paid on behalf of MA Plan enrollees. By regulation, MAOs "exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations." 42 C.F.R. §422.108(f).

Coordination of Benefits and Methods of Recovery

CMS coordinates benefits for traditional Medicare Part A and B claims. CMS does not coordinate benefits for Medicare Advantage claims.

Liability insurers are required to report to CMS the identity of those claimants determined to be Medicare beneficiaries.

Liability insurers are required to report to CMS the identity of those claimants determined to be Medicare beneficiaries.

See 42 U.S.C. §1395y(b)(8). However, CMS only uses this information to seek recovery of conditional payments made by traditional Medicare. CMS is required by law to administer a web-based portal that allows liability insurers to access and identify information regarding conditional payment amounts paid on behalf of Medicare beneficiaries that can be relied upon at settlement. *See id.* §1395y(b)(2)(B)(vii)(II). However, the web-based portal only includes information about conditional payments made by traditional Medicare.

CMS does not share with MA Plans the information reported to it by liability insurers, and MA Plans do not share their claims information with CMS. *See Humana Med. Plan, Inc. v. Western Heritage Ins. Co.*, 880 F.3d 1284,1292 n.7 (11th Cir. Jan. 25, 2018) (denying rehearing en banc) (Tjoflat, J., dissenting). In fact, CMS does not track or attempt to recover payments made by private MAOs at all. Therefore, if a diligent liability insurer were to contact CMS regarding a Medicare beneficiary enrolled in an MA Plan, CMS would inform the liability insurer that any amount due and owing is zero, even if benefits were paid by an MAO.

A primary payer's obligation to reimburse CMS for conditional payments is triggered after the primary payer receives a recovery demand notice. 42 U.S.C. §1395y(b)(2)(B)(i); 42 C.F.R. §411.22(c)(2). If, after receiving a demand, the primary payer fails to pay CMS back, CMS must employ a cumbersome debt-recovery process to avail itself of the double-damages remedy. *See Western Heritage*, 880 F.3d at 1291.

Under the debt-recovery process, if the primary payer fails to reimburse CMS within 60 days of receiving notice of its responsibility to do so, the Secretary of Health and Human Services may begin to charge interest. 42 U.S.C. §1395y(b)(2)(B)(ii). After 180 days, the Secretary of Health and Human Services then refers the interest-accruing debt to the U.S. Department of the Treasury, which attempts to collect it. 31 U.S.C. §3711(g)(1)(A)–(B). If the Treasury Department's debt-collection efforts fail, it refers the debt either back to CMS or to the U.S. Department of Justice for litigation. *Id.* §3711(g)(4)(A), (C). At this point, the government may choose to litigate against a delinquent primary payer and seek double damages under the MSP Act, §1395y(b)(2)(B)(iii). But even then, a primary payer cannot be held liable until the payer "is, or should be, aware that Medicare has made a conditional primary payment." 42 C.F.R. §411.24(i)(2).

To facilitate efforts to recover the reimbursement of conditional payments, the MSP Act provides two distinct causes of action. The first, established by Congress as part of the MSP Act's initial 1980 enactment, authorizes the U.S. government to seek double damages against "any or all entities that are or were required or responsible" to make payment as a primary payer. 42 U.S.C. §1395y(b)(2)(B)(iii). The second, added to the MSP Act by Congress in 1986, allows "a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement)." 42 U.S.C. §1395y(b)(3)(A). These causes of action function in different ways.

The cause of action set forth in §1395y(b)(2)(B)(iii) can only be invoked by the federal government. The private cause of action established by §1395y(b)(3)(A) is independent of the rights reserved to the U.S. government under §1395y(b)(2)(B)(iii). The private cause of action authorizes suit for an award of double damages "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement)," but it does not include within its text any preconditions for bringing suit, such as a pre-suit notice or demand for reimbursement of conditional payments. Unlike the federal government's cause of action found in §1395y(b)(2)(B)(iii), the private cause of action found in §1395y(b)(2)(B)(ii) also places no express limitations on who can invoke the provision to assert a reimbursement claim.

The Private Cause of Action

Before 2012, the private cause of action codified in §1395y(b)(3)(A) had never been successfully invoked by an Medicare Advantage organization to recover reimbursement for conditional payments. The U.S. Court of Appeals for the Third Circuit's 2012 decision in *In re: Avandia Marketing, Sales Practices & Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012), quickly ushered in a change to the legal landscape. There, the Third Circuit held that "[t]he language of the MSP [Act] private cause of action is broad and unrestricted and therefore allows any private plaintiff with standing to bring an action[,]" including MAOs. *Id.* at 367. The court determined that an MAO could invoke §1395y(b)(3)(A) to pursue a reimbursement claim against a primary payer whose responsibility to pay for MA Plan enrollees' medical expenses was demonstrated by a settlement agreement. *Id.* at 355.

Several years later, the U.S. Court of Appeals for the Eleventh Circuit agreed with the Third Circuit's reasoning in *Avandia*. In *Humana Med. Plan, Inc. v. Western Heritage Insurance Co.*, the Eleventh Circuit held, in a two-to-one decision, that §1395y(b)(3)(A) "permits an MAO to sue a primary plan that fails to reimburse an MAO's secondary payment." 832 F.3d 1229, 1238 (11th Cir. 2016), *rehearing denied en banc*, 880 F.3d 1284 (11th Cir. Jan. 25, 2018). Addressing an MAO's standing to bring suit under the private cause of action provision, in particular, the Eleventh Circuit concluded that "[a]n MAO has a statutory right to charge a primary plan when an MAO payment is made secondary pursuant to the MSP [Act]," and consequently, "the primary plan's failure to make primary payment or to reimburse the MAO causes the MAO an injury in fact." *Id.* As in *Avandia*, the MAO in *Western Heritage* could bring suit against the liability insurer because it paid an MA

Plan enrollee for covered medical expenses in a settlement agreement and did not reimburse the MAO that paid prior medical expenses. *Id.* at 1239.

Since the decisions by the Third and Eleventh Circuits, federal district courts in other circuits have followed suit, citing "the national trend interpreting subsection (3)(A) to permit MAOs to bring private causes of action." *MAO-MSO Recovery II, LLC v. State Farm Mut. Auto. Ins. Co.*, 1:17-cv-01537-JBM-JEH, 2018 WL 340020, at *2 (C.D. Ill. Jan. 9, 2018) (permitting assignees of MAOs to bring a private cause of action under 42 U.S.C. §1395y(b)(3)(A) to recover reimbursement for conditional payments). *See also Humana Ins. Co. v. Paris Blank LLP*, 187 F. Supp. 3d 676, 681 (E.D. Va. 2016) (following *Avandia*); C*ariten Health Plan, Inc. v. Mid-Century Ins. Co.*, No. 3:14-CV-476-TAV-CCS, 2015 WL 5449221, at *6 (E.D. Tenn. Sept. 1, 2015) (same); *Collins v. Wellcare Healthcare Plans, Inc.*, 73 F. Supp. 3d 653, 665 (E.D. La. 2014) (same); *Humana Ins. Co. v. Farmers Texas County Mut. Ins. Co.*, 95 F. Supp. 3d 983, 986 (W.D. Tex. 2014) (same). Outside the Third and Eleventh Circuits, no other federal appellate court has directly addressed this question.

Whether *Avandia* and *Western Heritage* were correctly decided is beyond the scope of this article. It is worth noting, however, that the two-to-one panel decision in *Western Heritage* drew a well-reasoned dissent from Judge William Pryor, and on dissent from the denial of a motion for rehearing en banc, Judge Gerald Bard Tjoflat sharply criticized the majority panel decision. *See Western Heritage*, 880 F.3d at 1285-300 (Tjoflat, J., dissenting). As of the date on which this article was submitted, the time for seeking a petition for writ of certiorari to the U.S. Supreme Court had not yet expired.

Limited Mechanisms in Place to Identify MA Plan Enrollees

After *Avandia* and *Western Heritage* recognized an MAO's right to obtain reimbursement of conditional payments under §1395y(b)(3)(A), lawsuits brought on behalf of MAOs against liability insurers that previously settled tort liability claims proliferated across the country. These lawsuits, styled as putative class actions, alleged that an MA Plan enrollee was injured as a result of a tortfeasor's negligence; the tortfeasor's liability insurer settled the claim with the enrollee; and the MAO that paid all or part of the enrollee's medical expenses resulting from the injury did not receive reimbursement from the proceeds of the enrollee's settlement. According to the plaintiffs, the settlements rendered the MAOs' payments secondary under the MSP Act, entitling the MAOs to double-damages awards against the liability insurers for payments that the MAOs made.

Many of the liability insurers had the same reaction to these lawsuits: what Medicare Advantage organization? Although federal regulations require MAOs to identify and coordinate benefits with primary payers, *see* 42 C.F.R. §422.108(b), it was not uncommon for the liability insurers' claim files to show no evidence of bills submitted by MAOs on behalf of their MA Plan enrollees or demands by those MAOs for reimbursement of conditional payments. Having seen neither bills nor demands for repayment by any MAOs, liability insurers were surprised to learn, in some cases years after a settlement, that they potentially could face double-damages liability under §1395y(b)(3)(A)— on a classwide basis, no less—for failing to reimburse payments for medical expenses that they never knew existed. What's more is that these liability insurers had already paid these claims once before, via settlement.

And this precarious situation could arise even for the most diligent of liability insurers that responsibly coordinate benefits with, and report to, CMS. CMS does not track or attempt to recover payments made by private MAOs at all. Further, CMS' communications about conditional payments do not include information about conditional payments made by MAOs and do not expressly advise the recipient that the information is limited to traditional Medicare.

Why does this create a problem? Liability insurers take their obligation to satisfy all Medicare liens prior to settlement seriously. Yet unlike CMS, which administers traditional Medicare, MAOs do not have a central clearinghouse to determine how much, if anything, is owed on a beneficiary's behalf. Nor can liability insurers rely on CMS to gather conditional payment reimbursement information. CMS does not provide data to a liability insurer about what an MAO may have paid on a beneficiary's behalf, nor does CMS inform the liability insurer whether the beneficiary is enrolled in an MA Plan. This can leave liability insurers that have a duty to settle liability tort claims reasonably searching, essentially in the dark, for MA Plans that may require reimbursement as secondary payers.

Many of the liability insurers had the same reaction to these lawsuits: what Medicare Advantage organization?

This predicament calls into question whether liability insurers should be subject to claims for double damages under §1395y(b)(3)(A). In their putative class actions, the plaintiffs have said that the answer to this question is "yes." But the answer, of course, is not so simple.

In *Western Heritage*, for example, the Eleventh Circuit stated that in cases that were litigated in court before settlement, the liability insurers would have had constructive notice of an MAO's payment because ordinary discovery tools can be used to obtain the information easily. *See* 832 F.3d 1229, 1239 (11th Cir. 2016) (citing Fla. R. Civ. P. 1.280(b)(2)). What remains unclear after *Western Heritage* is whether its logic extends to cases in which a liability insurer settles a claim pre-suit and without the benefit of discovery, particularly when an MAO does not make any effort to coordinate benefits on behalf of its MA Plan enrollee. Many of the cases that plaintiff attorneys have pursued fall into this category.

In a decision predating *Western Heritage*, the U.S. District Court for the Eastern District of Louisiana took another approach to this issue. In *Collins v. Wellcare Healthcare Plans, Inc.*, 73 F. Supp. 3d 653, 669 (E.D. La. 2014), the district court ruled that §1395y(b)(3)(A) "does not automatically afford a right to double damages." Instead, the court held, "a primary plan must *fail* to provide reim-

bursement in order to afford an MAO the right to pursue double damages. Failure connotes an active dereliction of a duty, and the award of double damages is intended to have a punitive effect on plans who intentionally withhold payment." *Collins*, 73 F. Supp. 3d at 669-70 (original emphasis). There, it was clear that the parties knew that an MAO had made conditional payments before a tort settlement was reached, and post-settlement, the beneficiary actually "placed the money claimed by [the MAO] into a trust" and "did not conceal the money or spend the money, but rather separated the funds until a court determined which party had a rightful claim over the funds." *Id.* at 670. These facts led the court to conclude that the MAO was not entitled to an award of double damages. *Id.*

By regulation, Medicare Advantage organizations do have an obligation to identify and coordinate benefits with primary payers.

The U.S. Court of Appeals for the Sixth Circuit has not endorsed this approach. In *Bio-Medical Applications of Tennessee, Inc. v. Central State Southeast & Southwest Areas Health & Welfare Fund*, 656 F.3d 277, 294 (6th Cir. 2011), the Sixth Circuit rejected the argument that the word "fails," as used in §1395y(b)(3)(A), means that a primary payer "has been told" to pay "and refused." Without much reasoning, the Sixth Circuit concluded that "this argument stretches the word 'fails' far beyond both its legal and common meanings," which do not require "obstinacy." *Bio-Med.*, 656 F.3d at 294. Consequently, the law governing the notice required to assert a claim for double damages against an insurer that "fails" to pay remains unsettled. The notice question also affects the statute of limitations inquiry. *Cf.* 42 U.S.C. §1395y(b)(2)(B)(iii) (requiring the federal government to bring a reimbursement action "not later than 3 years after the date of the receipt of notice of a settlement, judgment award, or other payment made" by the liability insurer to CMS).

By regulation, Medicare Advantage organizations do have an obligation to identify and coordinate benefits with primary payers. *See* 42 C.F.R. §422.108(b). But there is no available data to show how often they comply with this regulation or what mechanisms MAOs put in place to enforce their recovery rights under the MSP Act. And to date, no court has required MAOs to comply with the safeguarded, debt-recovery process that CMS follows in its efforts to collect conditional payments. MAOs will likely continue to maintain that they have the same recovery rights as does traditional Medicare under the MSP Act, even if none of the procedures that CMS employs for recovery are followed (or required).

Faced with the challenge of determining whether a Medicare beneficiary is or has been an MA Plan enrollee, liability insurers seeking to settle tort claims before (or even after) an action is filed in court may find it helpful to consider the following practical suggestions to minimize risk:

1. Do not take a claimant's word for it. Many MA Plan enrollees are unaware that they are in MA Plans and consider MAOs as ordinary health-care providers and not a Medicare provider.
2. Make every effort to obtain all of a claimant's medical billing records related to a particular claim and review the bills thoroughly before reaching a settlement. If CMS has indicated that no Medicare lien exists, and the claimant is a Medicare-eligible individual who has undergone claim-related medical treatment, investigate whether an MA Plan is involved. References in medical bills to payments made by or billed to private insurers may serve as an indication that the claimant is enrolled in an MA Plan.
3. A release may not immunize a liability insurer from a future lawsuit. Many liability insurers include a release provision in their settlement agreements that place the obligation upon the claimants to reimburse Medicare for any conditional payments demanded by CMS. These provisions generally do not contemplate liens held by MAOs and do not specifically reference MAOs. However, even if a release does require claimants to reimburse MAOs specifically for any conditional payments that the MAOs demand, serious questions remain about whether liability insurers can rely on such provisions as a defense to reimbursement lawsuits brought by MAOs under §1395y(b)(3)(A). This is because MAOs are authorized to recover reimbursement from liability insurers directly, without regard to a claimant's reimbursement obligations. *See* 42 U.S.C. §1395w-22(a)(4)(A)–(B) (authorizing MAOs to charge liability insurers or MA Plan enrollees for conditional payments); 42 C.F.R. §422.108(d)(1)–(2) (same).
4. Liability insurers have an obligation to act in good faith to reach prompt, fair, and equitable settlements when the liability of their insureds is reasonably clear. Accordingly, liability insurers may find it beneficial to investigate whether claimants are enrolled in MA Plans early on in the settlement process to comport with obligations that they owe to their insureds while simultaneously satisfying the requirements of the MSP Act.

A New Theory of Reimbursement Recovery

Leveraging the uncertainty on this front, plaintiff attorneys have attempted to create a cottage industry out of filing cookie-cutter, class action complaints for double damages against liability insurers. While some of these first-wave putative class action cases continue to wend their way through U.S. courts, presumably with a goal of class certification and high-dollar double-damages recoveries, many have been dismissed on standing grounds due to defective assignments.

But plaintiff attorneys have been undeterred by the dismissals. In 2017, a second wave of putative class action reimbursement-recovery lawsuits were instituted against liability insurers that settled tort claims with MA Plan enrollees under §1395y(b)(3)(A). In this new round of litigation, the plaintiffs now purport to assert assigned claims on behalf of "first-tier entities" and "downstream entities" that contract with MAOs to provide Medicare services to MA Plan enrollees. The plaintiffs assert that these first-tier and downstream entities include management service organizations (MSOs) and independent physician associations (IPAs).

Of course, MSOs and IPAs are not MAOs. MSOs are entities that assist physicians with the non-medical aspects of running a medical practice, such as financial management, human resources and personnel management, and coding, billing, and collection services. Likewise, IPAs are entities organized and owned by a network of independent physician practices that "negotiate with health insurance carriers and other health care payor organizations to establish arrangements for their member physicians to be considered preferred providers by the payers." *Pfenninger v. Exempla, Inc.*, 116 F. Supp. 2d 1184, 1187–88 (D. Colo. 2000). Unlike MAOs (or traditional Medicare, for that matter), MSOs and IPAs do *not* make conditional payments of medical expenses on behalf of Medicare beneficiaries. If anything, they are middlemen that receive payments *from* MAOs for the services that they provide, in accordance with their contracts with MAOs. *See* 42 C.F.R. §422.520(b)(1)–(2); Ctrs. Medicare & Medicaid Servs., Medicare Advantage Contract Amendment (issued Oct. 5, 2012).

Similar to traditional Medicare, MAOs certainly are authorized under the Medicare Act to contract with and pay third-party health-care providers to treat Medicare enrollees. *E.g.*, *Tenet Healthsys. GB, Inc. v. Care Improvement Plus S. Cent. Ins. Co.*, 875 F.3d 584, 587 (11th Cir. 2017) (observing that MAOs are permitted to contract with and pay third-party providers to treat Medicare enrollees); *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555, 559 (5th Cir. 2004) (same). *See also* 42 U.S.C. §1395w-25(b)(4). However, these new lawsuits have not explained how MSOs and IPAs, which generally provide non-clinical administrative services to health-care providers, themselves qualify as health-care providers that contract with MAOs. These lawsuits do not explain how MSOs and IPAs are entitled to reimbursements for conditional payments made by MAOs, even if they do contract with MAOs. Finally, these lawsuits do not identify any of the MAOs that allegedly contract with MSOs and IPAs in the first place.

The Eleventh Circuit has recognized that §1395(b)(3)(A) "permits *an MAO* to sue a primary plan that fails to reimburse an MAO's secondary payment." *Western Heritage*, 832 F.3d at 1238 (emphasis added). This cause of action "is not a *qui tam* statute but is instead only available when the plaintiff has suffered an injury in fact." *Id.* In various dismissal motions, the liability insurers have taken the position that the plaintiffs cannot allege any injury in fact under §1395(b)(3)(A) on behalf of MSOs and IPAs because those entities do *not* make payments to MA Plan enrollees that are due to be reimbursed, regardless of whether MSOs and IPAs are considered first-tier entities, downstream entities, or otherwise.

The liability insurers' position has support in the MSP Act and its implementing regulations. The provisions of the MSP Act and the implementing regulations provide secondary payer rights exclusively to CMS and MAOs. *See, e.g.*, 42 U.S.C. §1395w22(a)(4); 42 C.F.R. §422.108(f). No provision of the MSP Act, or any regulation that interprets and implements the MSP Act, states that management service organizations, independent physician associations, or any other types of first-tier or downstream entities are entitled to bring a cause of action under the MSP Act. To date, no court has recognized a cause of action by MSOs or IPAs for reimbursement of conditional payments under §1395(b)(3)(A) that is analogous to the cause of action that MAOs are permitted to bring under *Avandia* and *Western Heritage* (as asserted in the first wave of reimbursement actions). And one court recently dismissed, with prejudice, for lack of standing a putative class action premised on the alleged assignment of MSP Act reimbursement claims by entities not alleged to be MAOs or health-care providers. *See MSP Recovery Claims, Series, LLC v. ACE American Ins. Co.,* Case No. 17-cv-23749 (D.E. 54) (S. D. Fla. Mar. 9, 2018).

In reality, if the complaints brought on behalf of MSOs and IPAs in this second wave of reimbursement recovery litigation allege that MAOs have failed to make full payments to them, then the MSOs and IPAs should seek to recover damages from the MAOs under their contracts. Their contractual relationship should not give MSOs and IPAs a right to recover from third-party liability insurers under the MSP Act. To that end, the U.S. District Court for the Southern District of Florida recently remanded a breach-of-contract case brought by a downstream entity against an MAO for reduced, delayed, and ignored payments, based on the fact that the downstream entity's "claims [did] not arise under the Medicare Act." *See* Order on Motion to Remand, *Provident Care Mgmt., LLC v. Wellcare Health Plans, Inc.*, No. 16-cv-61873-BLOOM/Hunt (S.D. Fla. Feb. 1, 2018).

For their part, the plaintiffs in these actions have relied on *Michigan Spine & Brain Surgeons, PLLC v. State Farm Mutual Auto. Insurance Co.*, 758 F.3d 787 (6th Cir. 2014), for the proposition that MSOs and IPAs do have standing to bring reimbursement suits against liability insurer under §1395y(b)(3)(A). But *Michigan Spine* involved a claim for payment against a health plan by a physician group, not, as in this second wave of litigation, claims for reimbursement against third-party liability insurers. 758 F.3d at 790. The Sixth Circuit held that "[p]roviders of medical care can sue primary plans who fail to pay under the [MSP Act's] private cause of action provision." *Id.* However, in making this statement, *Michigan Spine* did not mention MSOs, IPAs, first-tier entities, or downstream entities, much less recognize their ability to stand in the shoes of an MAO to pursue a claim for reimbursement under §1395y(b)(3)(A).

While some of these first-wave putative class action cases continue to wend their way through U.S. courts, presumably with a goal of class certification and high-dollar double-damages recoveries, many have been dismissed on standing grounds due to defective assignments.

Secondary Payer, continued on page 81

Secondary Payer, from page 55

At this juncture, and without a definitive decision from any court on this specific question, the nature and extent of reimbursement recovery rights of MSOs or IPAs (or first-tier or downstream entities) under §1395y(b)(3)(A) remains unsettled. Liability insurers defending against this new round of lawsuits will do well to argue that such claims simply do not exist. But given the limited mechanisms in place to identify whether a claimant is even enrolled in an MA Plan, it may become an even greater challenge for liability insurers to identify if and when an MAO provided service to the claimant through a private contract with a first-tier or downstream entity that is now alleged to have the same recovery rights under the MSP Act as MAOs.

Conclusion

Settlements remain an effective and efficient (and sometimes necessary) tool for resolving tort liability claims. *Avandia* and *Western Heritage* have ushered in a change to the way that liability insurers should think about approaching and finalizing those settlements. Because courts have authorized MAOs to bring recovery causes of action against liability insurers to collect reimbursement of conditional payments, even years after settlements, liability insurers may take steps to identify claimants enrolled in MA Plans before reaching settlements to minimize their future exposure to double-damages awards.

As MSP Act reimbursement actions wend their way through courts around the country, the plaintiffs' theories of recovery continue to evolve. For the time being, the new theory of recovery focuses not on the reimbursement rights of MAOs, but on the reimbursement rights of first-tier and downstream entities that allegedly contract with MAOs to provide services to MA Plan enrollees. Although neither the MSP Act nor its implementing regulations grant first-tier and downstream entities the right to stand in the shoes of MAOs to pursue these reimbursement actions, courts are now being asked to decide this very question head on. How this question is decided will undoubtedly affect the next wave of MSP Act litigation brought against liability insurers. FD