SURROGATE'S COURT OF THE STATE OF NEW YORK
COUNTY OF SULLIVAN

**In the Matter of the Application of Anthony Mormile, As Administrator of the Estate of**

**Richard Mormile,**
**Deceased,**

**For Leave to Allocate and Distribute the Proceeds of an Action for the Wrongful Death of Said Decedent, and to Judicially Settle the Account.**

**Decision & Order**

**File No.: 2014-92/A**

**Appearances:** **Sullivan, Papain, Block, McGrath & Cannavo, P.C.**
**Attorneys for Petitioner Anthony Mormile**
**120 Broadway**
**New York, New York, 10271**
**By: John M. Tomsky, Esq.**

**Sullivan County Department of Family Services**
**Legal Department**
**Sullivan County Government Center**
**100 North Street**
**Monticello, New York 12701**
**By: Colleen M. Cunningham, Esq.**

**McGUIRE, J.,**

In a proceeding seeking leave to allocate and distribute the proceeds of an action for the wrongful death of Richard Mormile and to judicially settle the account; an application was brought pursuant to Order to Show Cause, by Petitioner Anthony Mormile, as Administrator of the Estate of Richard Mormile, seeking an order of this Court disallowing the claim of the Department of Family Services (DFS); awarding costs to Administrator, and for such other and further relief as the Court deems just and proper.

The decedent died on January 8, 2014, at the age of fifty (50), thereafter the Petitioner Anthony Mormile was granted Letters of Administration in Sullivan County on October 1, 2014. A wrongful death action was commenced in Orange County Supreme Court and a settlement of

that action was compromised by order dated October 19, 2016. Prior to the wrongful death action being settled, by letter dated November 13, 2015, DFS asserted a Medical Assistance lien in the amount of $27,425.44.

On or about November 23, 2016, an application for leave to allocate and distribute the net settlement was made by petition and supporting documents, which provided for the payment of the Medical Assistance lien. This Court appointed William Chellis, Esq., to be the Guardian Ad Litem for the infant distributee, Nevaeh.

Thereafter, Petitioner Administrator states in his application, upon review of the claimed lien at issue herein, discovered that the lien was not for reimbursement of medical assistance but for the premium paid for a Medicaid Managed Care plan. After trying to resolve the outstanding lien, without success, Petitioner now brings the instant application seeking an order of this Court disallowing the Medical Assistance lien. The Department of Social Services opposes the relief sought herein. The Court heard oral argument on July 18, 2017, and the matter is now deemed fully submitted.

At the request of the Court the Department provided an attorney affirmation dated July 24, 2017, detailing a breakdown of the Medical Assistance lien at issue; which covers the period commencing October 1, 2011, through May 29, 2013, and is in the amount of $27,425.44.

Initially, Petitioner Administrator argues that by letter dated September 10, 2008[1], the New York Department of Health, Office of Health Insurance Programs, sent a letter to Affinity Health Plan, a Medicaid Managed Care plan, which advises that while the Department of Health

[1] The Court was not provided with a copy of this letter as part of Petitioner's application. Petitioner references the letter in his Reply and states that it is attached to the Affirmation in Support of the Order to Show Cause as Exhibit "A", however Exhibit "A" is the Compromise Order.

and county social services districts are subrogated to any rights a Medicaid recipient has to health insurance, other medical care coverage, medical support or third party reimbursement, these rights are not transferred or delegated to the Medicaid Managed Care or Family Health Plans. The Medicaid Managed Care plan's contract only authorizes and requires a determination to be made as to whether the recipient has third party insurance. The letter states that third party health insurance does not include a personal injury award or settlement. Therefore, Petitioner Anthony Mormile argues that the Medicaid Managed Care plan would not have a lien on the estate's recovery from the tortfeasor, and likewise DFS would have no lien for the cost of the premium.

Petitioner also argues that the lien should be disallowed, as it is not for monies paid for medical assistance but instead for premium's paid for a Medicaid Managed Care plan. Petitioner argues that only monies paid for medical expenses are recoverable. In support of this argument Petitioner refers to Social Services Law §104-b[2] which grants the New York State Medicaid program the right to recover payments made for medical expenses awarded in a lawsuit. Petitioner also points to the Federal law which requires Medicaid recipients, in order to qualify, assign the State and rights to payment for medical care from any third party pursuant to 42 U.S.C. §1396k[a]. Additionally, the Federal law requires that States who accept Medicaid funds to enact laws that give the State the right to recover from liable third parties for medical assistance for health care items or services provided to an individual in receipt of Medicaid pursuant to 42 U.S.C. §1396a[a][25][H]. Petitioner argues that the legislation does not provide

[2] Although the Petitioner notes Social Services Law §104[b] in the papers, there is no such subparagraph in §104 (concerning recovery from a person discovered to have property), whereas §104-b concerns, as Petitioner notes, liens for public assistance and care on claims and suits for personal injuries.

for a recovery of a Medicaid Managed Care premium, as this is not a payment for medical care, but is a payment for insurance.

Lastly, Petitioner Administrator argues that even if the premium were to be considered a medical expense by the Court, as the medical malpractice, which eventually brought about the wrongful death suit, did not cause the decedent to go on Public Assistance for health care. Petitioner noting that at the time of the malpractice the decedent was already on Medicaid and covered by the Medicaid Managed Care plan, he was already being treated for cancer.

In opposition, the Sullivan County Department of Family Services (Department), argues that the Medicaid payment to the Medicaid Managed Care plan is a payment for medical assistance and is recoverable in this situation under both State and Federal law.

In support of their argument the Department references a portion of the Federal Medicaid Act stating that States or local administering agencies are required to take all reasonable steps to ascertain the legal liability of third parties to pay for care and services available under the plan in order to qualify for the receipt of Federal funds pursuant to 42 U.S.C. §1396a[a][25][A].

The Department further contends that New York State has developed a plan to provide medical assistance to qualifying low income persons, and assistance is provided in two ways: 1.) fee-for-service (FFS) and/or 2.) by contracting with Managed Care Organizations (MCO). The Department also refers to the objective behind Medicaid, being that it is intended to be the payor of last resort and other resources are to be utilized first, to this end State plans are required to include assignment, enforcement and collection in their plans pursuant to 42 U.S.C. §1396k[a][1] and 42 U.S.C. §1396k.

For recipients of Medicaid Managed Care, like the decedent herein, the Department explains that Medicaid pays for the Managed Care Organization that arranges for the services to

be provided. The Department states that these payments are made in a monthly premium also referred to as a capitation payment.

The Department directs the Court to Social Services law §369[2][c] and 42 U.S.C. §1396 which provide that the State can recover medical assistance properly paid, and provides for the socials services official's recovery of the cost of medical assistance provided to an injured person pursuant to Social Services Law §104-b. Furthermore, it is argued, that as the Medicaid recipients are required to cooperate in identifying any third parties who may be responsible to pay for the recipient's care, and has to assign the right, to the local district to obtain the reimbursement from the responsible third party pursuant to 18 NYCRR 360-7.4.

It is also argued that Social Services Law §104-b[1], which authorizes the Departments ability to recover the amount of cash and assistance furnished, does not distinguish whether the amount of assistance furnished is provided in the form of a direct payment to a medical provider or by the payment of a monthly managed care premium.

The Department also directs the Court to 18 NYCRR 360-7.11[b][5], which provides that a social services district may impose a lien against claims and suits for personal injuries to recover the amount of Medical Assistance furnished to a person on or after the date the person was injured and if that person makes a recovery the social services district may recover the amount of Medical Assistance provided. The Department argues that the regulation does not limit recovery to amounts paid to fee-for-service providers, or prohibit recovery for payments made to Medicaid Managed Care organizations.

In support of their opposition, the Department, submits a copy of a 2002 NYS Department of Health Office of Medicaid Management Administrative Directive entitled

Medicaid Liens and Recoveries. The directive in pertinent part provides for the recovery of payments made under Medicaid Managed Care contracts are considered Medicaid correctly paid.

The Department states that the purpose of Social Services Law §104-b is to ensure the tortfeasor is financially responsible in the first instance for medical costs that are the result of the tortfeasor's negligence and maintain Medicaid as the "payor of last resort". To not allow for recovery when Medicaid paid for accident-related care through a managed care plan would relieve the tortfeasor of responsibility because Medicaid provided services through a managed care plan rather than through a direct payment to a medical provider. The Department further argues that the law does not contain the additional requirement that the personal injury cause the recipient to apply for medical assistance, therefore the Department can still recover even if the recipient was already receiving Medicaid prior to the injury occurring.

Addressing the letter referenced by Petitioner Administrator, the Department states that the 2008 Department of Health letter instead stands for the proposition that the Managed Care Organization itself cannot try to subrogate from a third-party tortfeasor, the right to recover is the Department's and has not been assigned to the Managed Care Organization through contract. Instead the letter deals with the Managed Care Organization's right to pursue third party health insurance, not a personal injury award or settlement.

Finally, the Department directs the Court to a letter dated June 30, 2015, from the Director of the NYS Department of Health to the Division of Liens and Recovery addressing specifically the issue of Medicaid recoveries and Medicaid Managed Care premiums. The letter opines that in a case where Medicaid has the right to recover the cost of Medicaid furnished to a recipient, if the recipient was in Medical Managed Care, then that premium should be recovered in full. The letter further opines that the fact that the Medicaid program would have paid a

Managed Care premium regardless of whether the recipient received accident related care or not is irrelevant and nothing in Social Services Law §104-b or other recovery statutes conditions Medicaid recoveries on the program having incurred some additional expense. The letter notes that the Department can recover the amount of the premium paid in those months that the recipient received accident-related care, the full premium amount in those months, even if non accident related care was received as well, is recoverable as that is the amount Medicaid had to pay to ensure coverage.

In reply Petitioner Anthony Mormile, the Administrator of the Estate, reiterates the position that a payment for the premium for a Managed Care Organization is not payment for medical assistance, and also argues, even if it was, at no time did the decedent undergo treatment that was necessitated by acts of negligence of the tortfeasor, or the estate could have recovered in the underlying medical malpractice action. Petitioner further argues that the Medical Care Organization paid for the medical assistance not the department, and that is the organization that could have asserted a lien, but for the provisions of General Obligations Law §5-335, prohibiting them. Petitioner Administrator argues that the Department does not have a right to recover the cost of health care, loss of earnings and economic losses which have been paid for by the Managed Care Organization.

The Petitioner states that had the Department paid medical expenses, it could have asserted a lien, however it is argued that the payment of a premium for a Managed Care Organization is not a medical expense. Petitioner then recites the definition of Medical Assistance contained within Federal Law 42 U.S.C. §1396d noting that payment of MCO premiums are not included. Petitioner further directs the Court's attention to provisions of the regulations of the Department of Health (18 NYCRR §500.1) defining medical care, and Social

Services Law §364-j describing the Managed Care program, stating that these provisions show that the State recognizes that a recipient who is receiving assistance pursuant to a Managed Care Organization has received their medical assistance from the Managed Care Organization and not the Department.

Petitioner Anthony Mormile, Administrator, further argues that the Department's position that the law does not condition recovery on the program having incurred additional expense as a result of the torfeasor's actions, is not accurate. Petitioner quotes Social Services Law §104-b, in that, the purpose of that section is to ensure the tortfeasor is responsible for the costs that are the result of the tortfeasor's negligence, however in this case the premium payment was not occasioned by the tortfeasor's negligence as the decedent was already on Medicaid.

In response to the Department's arguments concerning the letter of June 30, 2015, Petitioner argues that the facts discussed therein are different from the instant case. The scenario in the letter considers recovery for premium payments in months that include both accident related care and non-accident related care or just accident related care. Petitioner argues that in the instant case there has been no accident related care and as such there should be no recovery.

The Petitioner cites *Arkansas Dept. of Health Human Services v. Ahlborn*, 547 US 268 [2006] in which the Supreme Court allowed the Department only to attach its lien to the portion of the settlement allocated to the recovery for medical expenses, the Medicaid Law only allows a lien to attach to the recovery for medical expenses. Finally, Petitioner states that the Department can only recover from the settlement the amounts for which the third party was legally liable, and as the third party was not legally liable for the decedent being on Medicaid or the payment of the Managed Care Organization premium there can be no recovery and the lien must be extinguished.

## Conclusions of Law

The Social Security Act established the Medicaid program which is a jointly funded Federal and State program, it pays for the medical care of indigent persons (see 42 U.S.C. §1396 *et seq.;* Social Services Law §363 *et seq.)* Medicaid is supposed to be the "payor of last resort" and the State must take reasonable steps to ascertain the legal liability of third parties to pay for the care of the plan recipients and seek reimbursement from them accordingly (see 42 U.S.C. §1396a[a][25][A], [B]). Federal and State law requires Medicaid applicants to assign to the State the right to seek reimbursement from any third party up to the amount of medical assistance paid (see 42 U.S.C. §1396k[a][1][A]; Social Services Law §366 and 18 NYCRR §360-7.4[a][4]). In New York the local social services district is subrogated, for amounts paid for medical care, to any rights a Medicaid recipient may have to a third-party reimbursement (Social Services Law §367-a[2][b]; 18 NYCRR §360-7.4[a][6]). Pursuant to this assignment the Department can either pursue an action against the third party or, as in this case, pursue reimbursement by placing a lien on the personal injury suits brought by a Medicaid recipient against the responsible party pursuant to Social Services Law §104-b. The Department's rights to recovery of the amount expended on behalf of the Medicaid recipient is the same whether done by a direct action against the third party or by asserting a lien (see generally *Calvanese v. Calvanese,* 93 NY2d 111 [1999]).

Social Services Law §104-b[1] states in pertinent part:

> "If a recipient of public assistance and care shall have a right of action, suit, claim, counterclaim or demand against another on account of any personal injuries suffered by such recipient, then the public welfare official for the public welfare district providing such assistance and care shall have a lien for such amount as may be fixed by the public welfare official not exceeding, however, the total amount of such assistance and care furnished by such public welfare official on and after the date when such injuries were incurred."

By law agencies like the Sullivan County Department of Family Services must pay the medical expenses of both injured indigents and indigents alike. "The People of the State of New York have chosen to confer this benefit upon the disadvantaged. However, the State's citizens have not sought to give indigent plaintiffs both their medical expenses and other sums which they can obtain from insurers eager to settle a claim quickly and inexpensively. This sort of double recovery at public expense is exactly what the several parts of §104 are designed to prevent [internal citations omitted]" *Kidney by Kidney v. Kolmar Laboratories, Inc.*, 68 NY2d 343 [1986]. The overriding purpose of Social Services Law §104-b which authorizes such a lien, is to facilitate recoupment of public funds by social services agencies (see *Merer by Merer v. Romoff*, 660 NYS2d 241 [Sup. Ct. New York Cty., 1997]).

Petitioner's argument, in summary, is that a premium payment/capitation payment is not a form of medical assistance and/or a payment for medical expenses as defined statutorily and is not therefore recoverable as it would be, as conceded by Petitioner, if the Department had made a direct payment to a provider for medical expenses on decedent's behalf, as a recipient of Medicaid. As an initial matter, Petitioner fails to submit case law or statutory authority specifically prohibiting recovery when a local social service agency chooses to contract with a Managed Care Organization, and provide medical assistance through the payment of a premium (capitation payment) rather than pay for services directly to a person who is eligible to received Medicaid assistance.

Pursuant to Social Services Law §364-j[1][c] a "Managed care program" is defined as

> "A statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis *to receive medical assistance services*, including case management, directly and indirectly (including by referral) from a managed care provider, including as applicable, a special needs managed care plan or a comprehensive HIV special needs plan, under this section [*emphasis added*]."

Clearly pursuant to the statutory definition of a Managed Care program it is contemplated that this is one of the ways in which medical assistance services are provided to a medical assistance recipient.

The purpose of Managed Care is to provide Medicaid health benefits through contracted arrangements between state Medicaid agencies and Managed Care Organizations that accept a set per member per month payment for providing these services, thereby managing costs, utilization and quality (see Medicaid, Managed Care, https://www.medicaid.gov/medicaid/managed-care/index.html, last visited January 17, 2018)

As of July 1, 2014, in New York state, the total number of people enrolled in any type of managed care (inclusive of beneficiaries enrolled in any Medicaid managed care program) was 4,412,837, while the total number of people enrolled in Medicaid (both beneficiaries in fee-for-service and any type of managed care) was 5,845,589 (see Centers for Medicare & Medicaid Services, Medicaid Managed Care Enrollment and Program Characteristics 2014, Spring 2016, Mathematica Policy Research, Table 1. State Medicaid Managed Care Enrollment Data Summary, as of July 1, 2014, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf ,pages 17-18, last visited January 17, 2018).

Therefore, just over 75% of all Medicaid enrollees in 2014, in New York State, were in some form of managed care. It would therefore fly in the face of reason and be against public policy to not treat the reimbursement of the medical expenses for a Medicaid recipient differently just because the local state agency took a financially prudent course of action in providing

medical assistance in that manner, to do so would preclude recovery in a potentially voluminous amount of cases.

Therefore, this Court determines that the Department is not foreclosed from enforcing their lien upon the basis that medical assistance was provided to the decedent by way of a capitation payment to a Managed Care Organization.

Petitioner Administrator thereafter argues that even if this Court were to consider the premium payment as a medical expense, as the decedent was already on Medicaid and being treated for cancer, at the time of the medical malpractice, which eventually brought about the wrongful death suit, the lien cannot attach to the settlement as the decedent did not undergo treatment that was necessitated by acts of negligence of the tortfeasor. Essentially, Petitioner argues that, as there has been no accident related care, that the tortfeasor could be liable for, there should be no recovery.

In *Calvanese v. Calvanese,* 93 NY2d 111, in 1999 the Court of Appeals held that a Medicaid lien filed pursuant to Social Services Law §104-b may be satisfied out of the entire proceeds of a Medicaid recipient's personal injury settlement, not just the portion that was allocated to past medical expenses. The Court of Appeals specifically rejected the argument that recoupment is limited to that portion of the settlement allocated to past medical expenses, the lien is recoverable even in the absence of any specific amount attributed to repayment of the lien (see also *Gold v. United Health Servs. Hosps.* 261 AD2d 123 [3rd Dept. 1999]).

However, the United States Supreme Court, in 2006, issued *Arkansas Dept. of Health & Human Servs. V. Ahlborn*, 547 US 268 [2006] which held that a state could not enforce liens on settlements, judgments, or awards of monies to Medicaid recipients beyond the portion of the settlement which was for actual medical costs received. The United States Supreme Court found

that the federal anti-lien provisions contained within 42 U.S.C. §1396p[a] affirmatively prohibit the state from asserting a lien on the property of Medicaid recipients prior to their death, and the statutory exceptions to that provision[3], allowing for states to enforce liens on settlements, judgments or awards of monies to Medicaid recipients, is restricted to the portion of the settlement which is for reimbursement for actual medical costs received prior to the recipients death (see *Arkansas Dept. Health & Human Servs. v. Ahlborn, Ibid).* In *Ahlborn, Id.,* the parties had already stipulated that the total settlement amounted to one sixth of the reasonable value of the claim and the portion of that sum that should be allocated to repayment of medical expenses prior to the Supreme Court considering the legal issues presented therein (*Ibid* at 274).

Thereafter, the Courts in New York began to address the meaning of *Ahlborn, Id.* In *Lugo ex rel. Lugo v. Beth Israel Medical Center*, 13 Misc.3d 681 [Sup. Ct. New York Cty, 2006] (a medical malpractice action was settled on behalf of an infant and the Department of Social Services had asserted a lien against the settlement proceeds) the Court, in being asked to decide if the same formula as that utilized in *Ahlborn* could be used in order to obviate the need for a hearing on what portion of the settlement was to be allocated to medical expenses, determined that:

> "A court determination is necessary to confirm the full value of the case and the value of the various items of damages, including plaintiff's injuries and how they compare to verdicts awarded in other cases. The parties are also entitled to be heard on the fair allocation of the settlement proceeds." *Ibid* at 688–689.

[3] See 42 U.S.C. §1396a[a][25][A] proving that there is a "[...] legal liability of third parties [...] to pay for care and services available under the plan [...]" and 42 U.S.C. §1396k[a][1][A] providing that a recipient is required to "[...] assign the State any rights [...] to any payment from a third party that has a legal liability to pay for care and services available under the plan".