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50 State Primer on Medicaid Recovery Laws

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This primer is part of a series of guides prepared by Hinshaw & Culbertson LLP for legal and insurance professionals.

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Introduction

50 State Primer On Medicaid Recovery Laws

This primer is intended to provide a brief introduction to Medicaid Recovery laws and act as a practical reference guide for insurance, legal, or medical service providers on Medicaid reimbursement or subrogation claims, or Medicaid compliance issues. In this highly regulated industry, it is essential to understand the individual State laws that affect reimbursement and subrogation claims.

This 3rd Edition includes both procedural and substantive changes to individual State laws since 2019, including Connecticut, Florida, Georgia, Louisiana, Maine, Michigan, Montana, New Jersey, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, and West Virginia As well, you will find a Comment on the recent United States Supreme Court decision in *Gallardo v. Marstiller* which decided whether the Medicaid Act permits states to seek reimbursement from settlement payments allocated for future medical care.

INTRODUCTION TO MEDICAID AND STATE AGENCY RECOVERY RIGHTS

Medicaid is the single largest health plan in the United States with reported enrollment totaling nearly 89 million individuals. An analysis of recent enrollment trends, published by Kaiser Family Foundation in September 2022 (https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/), showed a 25% growth during the COVID Pandemic period from February 2020 to May 2022. In fact, every state across the country realized an increase in Medicaid enrollment during the COVID period: from 15% in Connecticut to 68% in Oklahoma. KFF's analysis also found that, while enrollment numbers continue to increase, the rate recently flattened; and pre-pandemic numbers were at a downward trend from 2017 to 2019. According to KFF, COVID's effect on Medicaid enrollment may be explained by economic factors, legacy legislation like Affordable Care Act (ACA) expanding Medicaid-qualified individuals, and emergency legislation like Families First Coronavirus Response Act's (FFCRA) *quid pro quo* where states that continuously enroll Medicaid-qualified individuals receive increases in matching federal funds.

Medicaid is separate and distinct from Medicare, which is a federal health plan based on age and certain disabilities. Medicaid is a joint federal and State program that funds medical care. Low income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory Medicaid eligible groups, whereas other groups are provided optional coverage at the State's discretion such as individuals receiving home and community based services and children in foster care who are not otherwise eligible. www.medicaid.gov States are not required to participate in Medicaid; however, all States have opted to do so. The federal government covers a percentage of the medical costs that are paid by the States. In return, States must pay their portion of medical costs as well as follow the requirements the federal government has set in place for Medicaid.

State participation requirements include the following: setting requirements for eligibility determinations; collecting and maintaining information; and administering the program. If the State recovers from a liable third party, then the federal government does not have to reimburse the State. *See* FFP and Repayment of Federal Share, 42 C.F.R. § 433.140(a)(2)(2005). To receive federal Medicaid funding, States must include a provision in their Medicaid plans for recouping funds spent on behalf of Medicaid recipients from liable third parties. 42 U.S.C. § 1396a(a)(25)(A). States must take all reasonable measures to find third parties that are liable for the coverage of a Medicaid recipient's medical costs. *Id*. States must include a provision that requires Medicaid participants to sign over their rights to seek and collect payment for medical care from a liable third party to the State. 42 U.S.C. § 1396a(a)(25)(H). Recipients of Medicaid have a duty to cooperate when the proceeding is initiated by the State. 42 U.S.C. §1396k(a)(1)(C). Recipients must help identify and provide information that will help the state to pursue third parties. *Id*. Also, States must pursue reimbursement from the third party if legal liability is found, unless the cost of pursuing the reimbursement outweighs the amount of reimbursement. 42 U.S.C. § 1396a(a)(25)(B); *See also* 42 U.S.C. § 1396p(a); *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006).

Under *Ahlborn*, the State can only recover its Medicaid expenses from the portion of the settlement or judgment that is designated as medical costs. *Arkansas Dept. of Health & Human Servs.*, 547 U.S. at 280. The State cannot recover from any other portion of the settlement or judgment which means where a beneficiary/Plaintiff and a third party has a settlement which stipulates that 15% of the total award is medical expenses, the State will only have the ability to recover from that 15%. *See Id*. The practical effect of *Ahlborn* leads to the possibility that a State is not fully reimbursed. *See Id*. at 281-82.

Also, the allocation methodology discussed in *Ahlborn* could result in a liable third party and a beneficiary conspiring to reduce the total medical costs associated with the settlement. Id.at 288. Under these circumstances, the State can challenge the settlement amount in court. Further, in cases where parties or the court do not specify which portion of the settlement or judgment is allocated for medical costs, the State can negotiate with the beneficiary or ask a court to determine the appropriate amount. *Id*.

States cannot, however, establish a broad allocation provision that determines medical costs. *Wos v. E.M.A. ex rel. Johnson*, 133 S.Ct. 1391, 1402 (2013). For example, a State cannot claim that one-third of every judgment or settlement is automatically attributed to medical costs. *Id*. This is not permitted because it would then allow a State to have access to funds that are not designated for medical costs. *Id*.

In 2013, due in part to *Ahlborn* and *Wos*, as well as Medicaid eligibility expansion under The Affordable Care Act, the Social Security Act was amended for recovery of Medicaid expenditures from beneficiary liability settlements (commonly known as "Strengthening Medicaid Third Party Liability") which resolved to explicitly permit State Medicaid agencies to recover funds expended on its beneficiary from the *entire* settlement amount by removing language limiting State recovery to only "health care items or services." Strengthening Medicaid Third Party Liability recovery may have applied to practically void *Ahlborn* and *Wos*. However, prior to the effective date, the amendment permitting State's to recover from the entire settlement amount, not just heath care

items or services, was repealed as part of the Bipartisan Budget Act of 2018. Consequently, *Ahlborn* and *Wos* can be interpreted as the law of the land.

Notwithstanding, each State has different provisions for Medicaid reimbursement and recovery laws and procedures. Many States already have statutory provisions proscribing recovery to the portion of settlement allocated for medical expenses. However, other States have a general rule that allows States to recover their medical assistance costs, while some statutes do not go further by specifying that it must be from the portion deemed to be for medical expenses.

COMMENT ON *GALLARDO V. MARSTILLER*

On June 6, 2022, the United States Supreme Court decided the case of *Gianinna Gallardo v. Marstiller, Secretary of the Florida Agency for Health Care Administration*, 596 U.S. _____ (2022). The Court's 7-2 decision held that the Medicaid Act permits a State to seek reimbursement from settlement payments allocated for future medical care. Justice Thomas delivered the opinion of the Court, in which Chief Justice Roberts, and Justices Alito, Kagan, Gorsuch, Kavanaugh, and Barrett joined. Justice Sotomayor filed a dissenting opinion in which Justice Breyer joined.

A truck struck Gallardo as she stepped off her Florida school bus. She suffered catastrophic injuries resulting in permanent disability. Florida's Medicaid agency paid $862,688.77 to cover her initial medical expenses, and the agency continues to pay her medical expenses. Gallardo, through her parents, sued the truck's owner and driver, as well as the Lee County School Board seeking compensation for past and future medical expenses, lost earnings, and other damages. The parties reached a settlement for $800,000 with $35,367.52 expressly allocated as compensation for past medical expenses; however, no specific amount was allocated for future medical expenses.

The federal Medicaid Act requires States to pay for a qualifying beneficiary's medical costs and make reasonable efforts to recover (or risk losing funding) those costs from liable third parties including a mandatory assignment of rights to payment for medical support and other care (42 U.S.C. §1396k(a)(1)(A)), as well as automatically acquiring a right to certain third-party payments for health care items or services (42 U.S.C. §1396a(a)(25)(H)). The State of Florida's Medicaid Third Party Liability Act provides for a beneficiary who accepts medical assistance to automatically assign any right to third-party payments for medical care.

Under Florida's Act, the State was presumptively entitled to recover $300,000 (or 37.5% of $800,000) from Gallardo's third-party tort recovery for past and future medical expenses absent clear and convincing rebuttal evidence. Gallardo challenged the State's presumptive recovery formula in an administrative proceeding as well as in a declaratory action. The Eleventh Circuit agreed with the State of Florida that the State is not prevented from recovering from third party settlement monies allocated for future medical care. 963 F. 3d 1167, 1178.

Gallardo presented multiple arguments to limit Florida's recovery to past medical payments which were rejected by the Supreme Court. The United States submitted an Amicus brief in support of Gallardo. The Court's analysis primarily relied upon the plain text and purpose of the Medicaid Act which grants recovery rights to payment for medical care generally—without limiting a State to recover just past medical care payments provided under the state plan. Relying on *Ahlborn*, Gallardo claimed Florida's law violated anti-lien provisions in the Medicaid Act which prohibit

recovery of medical expenses from settlement monies other than past medical care. However, the Court determined that the Act's anti-lien provision does not apply where a state law, here Florida's Act, permits recovery from settlement monies representing payment for medical care. The Court also distinguished its decision in *Wos* which analyzed medical and nonmedical expenses (such as for example, lost wages), rather than past and future medical expenses.

In closing, the Court rejected two policy arguments where Gallardo raised concerns about injustice; specifically, that Florida is sharing in damages for which it has not provided compensation, and that Florida could recovery against Gallardo while no longer a Medicaid beneficiary. The Court reasoned that the Act's plain text decides these cases, not the Court's sense of fairness; and that the Act cannot be read to invoke a lifetime assignment by the State.

The *Gallardo* decision may have numerous effects on how personal injury matters involving liable third parties are assessed and resolved by interested parties, insurers and attorneys. The courts seem ready to defer to state legislatures and its administrative agencies on plain-text applications and reasonable interpretations of its recovery obligations attributable to medical under The Medicaid Act. Consequently, Gallardo may have realized a different result in Maine, Texas, or California since a one-size-fits-all recovery rule was not the holding here. State lawmakers may continue to be active in this area passing new state statutes, perhaps similar to the recently-repealed Strengthening Medicaid Third Party Liability federal law, especially where higher beneficiary populations exist and higher medical costs are realized under existing Medicaid plans. State agencies may be more active and less compromising on its recovery activities albeit clearly limited to portions of settlement for medical care, items, services, and support. Notwithstanding, courts may be able to find further reconciliation of existing federal laws on past Medicaid payments and the scope of damages in tort settlements to support the state agency's reasonable recovery efforts limited to past and future medicals from liable third party payments. A chilling effect on claims and lawsuits involving Medicaid beneficiaries is hard to foresee much less measure. Insurers and litigants must competently consider the venue's State-specific Medicaid recovery law and administrative process especially applicable liable third parties, payments, and *Ahlborn*-type hearing proceedings. Parties to tort and occupational injury cases where damages and/or benefits include medical expenses (past and future) must be conscientious of State-specific laws and diligently resolve repayment claims. Fictitious sustainable verdict values exceeding the settlement amount should be subject to scrutiny and proposed stipulations on the subject with alternative propositions could cultivate fertile grounds for compromise negotiations. The use of structured settlement tools may be increasingly useful to reasonably allocate damages, weigh the concerns of the beneficiary, third party payer and state agencies, and mitigate litigation expenses in favor of compromise.

Finally, *Gallardo* addresses Medicaid future medical recovery efforts by the States; however, similarities with Medicare Secondary Payer reimbursement efforts by the federal government are so readily apparent that the United States drew a footnote on that comparison in support of its arguments on behalf of Gallardo; i.e. "…Medicare…appears to permit a broader scope of recovery for services (both furnished and to be furnished) from a third party's liability in tort."

Gallardo sets the table in the near term on Medicaid recovery and Medicare reimbursement laws. This 50 State Primer is intended to provide useful, introductory utensils to help assess the spread.

LEAD AUTHOR

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ALABAMA

Right of Recovery

The Medicaid Agency of the State of Alabama is the single state agency charged with responsibility for administering the Alabama Medicaid Program. Code of Ala. § 22-6-7(a). If a recipient receives medical assistance under the Alabama Medicaid Program for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm or corporation then the State shall be subrogated to such recipient's rights. Code of Ala. § 22-6-6(a). The State shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery which the recipient may have against any such person, firm or corporation to the extent of the actual amount of the medical assistance payments made by the Alabama Medicaid Program. Code of Ala. § 22-6-6(a). The recipient is required to execute and deliver instruments and papers to do whatever is necessary to secure such rights and shall do nothing after said medical assistance is provided to prejudice the subrogation rights of the State. Code of Ala. § 22-6-6(a).

Legal Proceedings

In order to enforce such rights, the State may institute and prosecute legal proceedings against any such person, firm, or corporation against whom such recovery rights arise, intervene or join any action or proceeding brought by such recipient against such person, firm or corporation or compromise or settle any such claim. Code of Ala. § 22-6-6(b). No action taken by the State shall operate to deny such recipient's recovery for that portion of his damages not subrogated to the State under subsection (a) and no action of the recipient shall prejudice the state's subrogationrights. Code of Ala. § 22-6-6(b).

Written Notice

Any such recipient seeking to recover damages relating to or in any way connected with such circumstances giving rise to recovery rights who institutes any civil action against such party shall, within 10 days of filing, provide the director of the Alabama Medicaid Program and the Attorney General of Alabama a written notice, a copy of the complaint, and all amendments. Code of Ala. § 22-6-6(c).

Assignment of Rights

All medical assistance recipients under the Alabama Medicaid Program shall be deemed to have made assignment to the State of any and all rights of his to medical support or payments for medical care from any person, firm or corporation, together with the rights of any other individuals eligible for medical assistance for whom he can legally make assignment. Code of Ala. § 22-6-6.1(a). The assignment shall be effective to the extent of the amount of medical assistance actually paid by the Medicaid Agency. Code of Ala. § 6-6.1(a). The recipient shall cooperate fully with the Medicaid Agency in its efforts to secure such rights and shall execute

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and deliver all instruments and papers needed by the Medicaid agency in this regard. Code of Ala. § 6-6.1(a). Every recipient of medical assistance under the Alabama Medicaid Program shallbe deemed to have authorized all third parties, including insurance companies and providers of medical care, to release to the Medicaid Agency all information needed by the agency to secureor enforce its rights as assignee under subsection (a) of this section. Code of Ala. § 6-6.1(b).

ALASKA

Secondary Payer Status and Right of Recovery

The Department of Health and Social Services may not pay medical claims that are payable by a third party payor. Alaska Stat. Ann. § 47.05.070(a). Medical providers should attempt to collect from a third party payor before billing Medicaid. *Id.* Medical providers must present evidence of third party denial or partial payment in order to bill and receive payment by Medicaid. *Id.*

The Department will be subrogated to not more than the part of an insurance payment or other recovery by the recipient that is for medical expenses provided by the Department. Alaska Stat. Ann. § 47.05.070(b). The Department may bring an action in the Superior Court against an alleged third party payor to recover an amount subrogated to the Department for medical assistance provided on behalf of a recipient. *Id.* The amount of a claim or settlement by the recipient of medical assistance to which the Department is entitled to will be reduced by a pro rata share of the attorney fees and litigation costs. Alaska Stat. Ann. § 47.05.070(c).

The Department is also authorized to enter into contracts for the collection of medical expenses paid by Medicaid from potential third party payors. Alaska Stat. Ann. § 47.05.070(d).

The Department has a lien upon any sum that may be due to the recipient of medical assistance from a third party payor. Alaska Stat. Ann. § 47.05.075(a). A lien is not perfected and has no effect unless a notice of filing of the lien is served by the Department upon the third party payor, personally or by registered, certified, or insured mail. Alaska Stat. Ann. § 47.05.075(b).

Beneficiary Duties

Medical assistance recipients must cooperate with and assist the department in identifying and providing information concerning potential third parties who may be liable to pay for care and services that were received by the recipient. Alaska Stat. Ann. § 47.05.071(a). When an individual applies for medical assistance, the individual assigns to the Department the applicant'srights of payment for care and services from any third party to the extent the Department haspaid medical assistance for care and services, cooperates with and assists the Department in identifying and providing information regarding potential third parties, and agree to make application for all other available third party resources that may be used to provide or pay for the costs for the cost of care or services received by the medical assistance recipient or that may be used to finance reimbursement to the state for the cost of care. Alaska Stat. Ann. § 47.05.071(b). A medical recipient may not maintain any rights to payment for medical costs as a result of a judgment or settlement for which another person may be legally obligated to pay without first making a repayment to the Department for past medical assistance services provided to or paid for on behalf of the recipient. Alaska Stat. Ann. § 47.05.073(a). The attorney

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general may only discharge a medical assistance lien if the discharge complies with federal law. Alaska Stat. Ann. § 47.05.073(c).

Attorney Responsibilities

The attorney representing a medical assistance recipient has the duty to notify the attorney general's office. Alaska Stat. Ann. § 47.05.072(a). The notice is required to include: (1) the identification of the medical assistance recipient's name, address, telephone number, and the dateof the injury or illness giving rise to the action or claim; (2) copies of the pleadings and other papers related to the action or claim; (3) the identification of each potentially liable third party, including the party's name, address, and number; (4) the identification of any insurance policy potentially responsive to the action or claim; and (5) a description of the facts and circumstances supporting the action or claim. Alaska Stat. Ann. § 47.05.072(b). The attorney shall give the attorney general's office notice within 30 days of any judgment or settlement in an action or claim by the medical assistance recipient to recover damages for an injury or illness that has resulted in the Department's providing or paying for medical assistance. Alaska Stat. Ann. § 47.05.072(c). If the medical assistance recipient is handling the action on a pro se basis, the provisions of section 47.05.072 applies as if the medical assistance recipient were an attorney representing the medical assistance recipient. Alaska Stat. Ann. § 47.05.072(d).

ARIZONA

Right of Recovery

The Arizona Medicaid system is known as the "Arizona Health Care Cost Containment System."The AHCCCS has three theories of recovery: (1) a statutory lien under Ariz. Rev. Stat. § 36- 2915(A), (2) subrogation rights under Ariz. Rev. Stat. § 12-961 – 12-964, and (3) assignment rights under Ariz. Rev. Stat. § 36-2903(F). The State can only enforce its lien on any portion of a tort settlement where medical payments were actually paid. *Southwest Fiduciary, Inc. v. Arizona Health Care Cost Containment System Admin.*, 249 P.3d 1104, 1109 (Ariz. Ct. App. 2011).

The AHCCCS is entitled to impose a lien for medical care costs on any and all claims of liability or indemnity for damages by the injured person. Ariz. Rev. Stat. § 36-2915(A). The recipient or recipient's attorney must provide written notice to the AHCCCS within twenty days after the commencement of a civil action or other proceeding to establish liability of any third party or to collect monies payable from any insurance. Ariz. Rev. Stat. § 36-2915(A). Liens may be amended to reflect current charges; however, if AHCCCS was given proper notice of a proceeding they may not amend the lien after the time of the final settlement. Ariz. Rev. Stat. § 36-2915(G).

The AHCCCS may recover by intervening or joining in any action or proceeding that is brought by the injured party. Ariz. Rev. Stat. § 12-962(B)(1). If the injured party does not bring a claim within six months after the first day on which the medical care was furnished, then the AHCCCS may institute and prosecute legal proceedings against the third person who is liable for the injury.Ariz. Rev. Stat. § 12-962(B)(2). The action may be brought in the name of the state or in the name of the injured person. *Id.* The injured person is not required to join in the action if theaction is brought in the name of the state. Ariz. Rev. Stat. § 12-962(C). The AHCCCS may also recover the cost of care from the injured person if that person has received money in a settlementor satisfaction of a judgment against a third party. Ariz. Rev. Stat. § 12-962(B)(3). Attorney'sfees and costs may be recovered if a recipient receives a settlement that has not already accounted for and deducted fees and costs. *See State ex rel. Raber v. Hongliang Wang*, 286 P.3d 1085, 1087 (Ariz. Ct. App. 2012).

The AHCCCS may recover any costs for hospitalization and medical care paid by the AHCCCS from any liable third party payors. Ariz. Rev. Stat. § 36-2903(F).

Recipients assign their right to recover medical benefits to the AHCCCS. *Id.* Subsection F only governs the coordination of medical and disability insurance benefits and does not cover assignment of liability claims. *Nationwide Mut. Ins. Co. v. Arizona Health Care Cost Containment System*, 803 P.2d. 925, 929 (Ariz. Ct. App. 1990).

ARKANSAS

Recovery against a Third Party

When the State provides medical assistance benefits, or will provide medical assistance benefits, because of injury, disease, disability, or death for which a third party is or may be liable, then theDepartment of Human Services may recover from the person the cost of benefits that were provided. Ark. Code Ann. § 20-77-301(a)(1). The Department may institute and prosecute legal proceedings against a third party who may be liable in order to enforce its rights for recovery. Ark. Code Ann. § 20-77-301(a)(2). An action brought by the Department will not bar any action that may be brought by the recipient against a third party. Ark. Code Ann. § 20-77-301(b)(1). Ina tort action the Department's amount of recovery will not be denied or reduced by any amountor percentage of fault that can be attributed to the recipient. Ark. Code Ann. § 20-77-301(d)(1).

A claim or action that is brought and prosecuted by the recipient alone will result in the award of reasonable litigation expenses and attorney's fees. Ark. Code Ann. § 20-77-302. The remaining amount will be available to the Department so they may recover the appropriate amount of benefits paid on behalf of the recipient under the medical assistance program. *Id.* If the claim or action is prosecuted by both the medical assistance recipient and the department against a third party who is or may be liable, then the court will order the payment from any judgment or award the reasonable litigation expenses incurred in the prosecution of the action or claim, togetherwith reasonable attorney's fees based solely on the services rendered for the benefit of the recipient. Ark. Code Ann. § 20-77-303. The recipient or the Department, whichever brings the claim, must provide written notice, claim by personal service, or notice through registered mail to the other party within thirty days in the event they bring an action or claim against a third party. Ark. Code Ann. § 20-77-304. The notice must contain the name of the third party and the court in which the action is brought in. *Id.* The Department or medical assistance recipient may become a party to the action at any time before trial on the facts, or may consolidate their action or claim with the other if brought independently at any time before the trial on the facts. *Id.*

Any judgment, award, or settlement in an action or claim by the medical assistance recipient to recover damages for injuries from a third party will not be satisfied without first giving the Department notice and a reasonable opportunity to establish its interest. Ark. Code Ann. § 20-77-305(a). In the event that a recipient disposes of the funds that are to be held for the benefit of the Department, the recipient will be personally liable to the Department for the amount that should have been recoverable by the Department. Ark. Code Ann. § 20-77-305(b). In the event a recipient, their guardian, an attorney, or their personal representative knowingly fails to obtain written approval from the Department before disposing of funds, that party will be liable to the Department for a penalty equal to 10% of the amount of the Department's claim, and reasonable costs and attorney's fees. Ark. Code Ann. § 20-77-305(c).

ARKANSAS

Assignment of Rights

In order to be eligible for Medicaid, every Medicaid applicant must automatically assign their right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant. Ark. Code Ann. § 20-77-307(a). The assignment is considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party. Ark. Code Ann. § 20-77-307(c). Recipients of medical assistance under the Medicaid program are deemed to have authorized all third parties, such as insurance companies and providers of medical care, to release to the Department information needed by the Department to secure or enforce its rights as an assignee. Ark. Code Ann. § 20-77-308.

Insurance policies may not contain any provision that denies or reduces benefits because servicesare or will be rendered to an insured or dependent who is eligible for medical assistance underthe Arkansas Medicaid Program. Ark. Code Ann. § 20-77-309. A billing statement forwarded to recipients of medical assistance by vendors of medical care shall clearly state that reimbursementfrom the Medicaid program is contemplated. Ark. Code Ann. § 20-77-313. The Department is entitled to full reimbursement unless the portion of the third party settlement, judgment, or award is less than the full amount of the department's medical assistance claim. Ark. Code Ann. § 20- 77-315.

The third party or health insurer that is legally liable for any medical cost of an injury shall be liable to reimburse Medicaid the lesser of (1) the difference between the amount previously paid in good faith by a third party or health insurer to a recipient or health care provider for the medical cost of an injury and the full amount of the liability of the third party or health insurer, or (2) the full amount paid by Medicaid for the medical cost of an injury. Ark. Code Ann. § 20-77-306(b). The Department may request that a health insurer, who does business in the state, provides the Department with eligibility and coverage information that will enable the Department to determine which Medicaid recipients may or may not have been covered by the third party or health insurer, the period of cover, the coverage, and the name, address, and identify number of the plan. Ark. Code Ann. § 20-77-306(c). A health insurer shall pay Medicaid reimbursement claims to the same extent that the plan would have been liable had it been properly billed at the point of sale. Ark. Code Ann. § 20-77-306(d)(2). Health insurers cannot deny claims submitted by the Department based on a failure to present proper documentation of coverage at the point of sale, or if the date of submission of the claim is within three (3) years from the date on which the claimed item or service was furnished. Ark. Code Ann. § 20-77-306(d)(3). Health insurers do not have to reimburse Medicaid for any items or services that Medicaid does not or did not cover for the recipient. Ark. Code Ann. § 20-77-306(g).

CALIFORNIA

Right of Recovery

The Medicaid program in California is known as Medi-Cal. The Director of Social Services has the right to recover the reasonable value of benefits provided to an individual for which another person or insurance carrier is liable for. Cal. Welf. & Inst. Code § 14124.71(a). The State can enforce this right by instituting and prosecuting legal proceedings against the third party whomay be liable for the injury or coverage. *Id.* The proceedings may be brought in the name of the Director or in the name of the injured person. *Id.* The Director can settle and release or waive anysuch claim. Cal. Welf. & Inst. Code § 14124.71(b)(1). The Director has the option of pursuing a subrogation action on the beneficiary's assignment. Cal. Welf. & Inst. Code § 14124.71(d); *State v. Superior Court (Bolduc)*, 83 Cal.App.4th 597, 603-604 (2000).

State Cause of Action

The Director may also pursue a direct action against a third party. *Id.* The direct action is not dependent on any right the beneficiary may have. *Id.* The Director is not required to prove tort-feasor liability in order to assert its lien against settlement money in instances where the settlement is entered without express admission of fault on the part of the alleged tort-feasor. *Kizer v. Hirata*, 20 Cal. App. 4th 841, 844 (1993).

Notice Requirements

The State is not automatically entitled to the entire settlement amount, even if the claim for reimbursement exceeds the settlement. *Id.* at 258. A notice of the institution or settlement of an action for damages against a third party is required to be given to the Department when an injured party has received medical benefits from the Department of Health Care Services. Cal. Welf. & Inst. Code § 14124.79. The beneficiary or Director, whichever brings the action against a third party, has thirty (30) days to notify the other interested party about the proceeding. Cal. Welf. & Inst. Code § 14124.73(a). However, the attorney does not have a duty that requires him to provide such notice. *Brian v. Christensen*, 35 Cal. App. 3d 377, 381 (1973). A settlement or judgment will not be considered final or satisfied if the Director, who has an interest, has notbeen notified and given a reasonable opportunity to perfect and satisfy the Director's lien. Cal. Welf. & Inst. Code § 14124.76.

Allocation of Recovery Amount

The amount the State may recover in a tort settlement is the amount that is allocated for past medical expenses. *Lima v. Vouis*, 174 Cal. App. 4th 242, 260 (2009).

If the beneficiary prosecutes an action, even if jointly prosecuted by beneficiary and Director, thecourt shall first pay from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. Cal. Welf. & Inst. Code

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§ 14124.74. After this payment is complete, the court will then award an amount sufficient to reimburse the Director the full amount of the reasonable value of benefits provided on behalf of the beneficiary under the Medi-Cal program. *Id.*

The allocation of recovery is necessary to determine how much the State is owed from a settlement proceeding. *Bolanos v. Superior Court*, 169 Cal. App. 4th 744, 753 (2008). In instances where a settlement occurs, the parties or court must attempt to allocate the amount of past medical expense to determine how much the State can recover. *Id*. The Director's claim for reimbursement provided to the beneficiary, when the beneficiary brings a claim alone, will be limited to the reasonable value of the benefits minus 25% which will represent the Director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses is determined by multiplying by the ratio of the full amount of reasonable value of benefits so provided to the full amount of the judgment or settlement. *Id*. All federal statutes and regulations regarding reimbursement preempt any State statutes.

COLORADO

Automatic Lien

The Colorado Medical Assistance Act provides that when the State department provides medical assistance to or on behalf of a recipient pursuant, the State department shall have an automatic statutory lien for all such medical assistance. Colo. Rev. Stat. Ann. § 25.5-4-301(5)(a). The State department's lien may be against any judgment or settlement in a suit or claim against a third party. *Id.*

Amount of Recovery

The lien will be to the fullest extent allowed by federal law, but it may not exceed the amount of the medical assistance provided. *Id.* An award or settlement may not be satisfied without first satisfying the State department's lien. Colo. Rev. Stat. Ann. § 25.5-4-301(5)(b). The failure by any party to comply with the requirement to satisfy the Department's lien will result in that party becoming liable for the full amount of medical assistance furnished to or on behalf of the recipient. *Id.*

In cases where the action or claim is brought by the recipient alone and the recipient has a personal liability to pay attorney fees, the State department will pay its reasonable share of attorney's fees. Colo. Rev. Stat. Ann. § 25.5-4-301(5)(d). The share of attorney fees cannot exceed 25% of the State department's lien. *Id.* The State department will not be liable for costs. *Id.*

Beneficiary Duties

The State department must be given notice by an applicant when the applicant brings an action orasserts a claim against a third party. Colo. Rev. Stat. Ann. § 25.5-4-301(6). The notice must be given by personal service or certified mail within fifteen (15) days after filing the action or asserting the claim. *Id.* The failure to comply with the notice requirement will result in the recipient, attorney, or any other representative liable for the entire amount of medical assistance that was furnished to or on behalf of the recipient for the injuries which gave rise to the action or claim. *Id.*

Enforcement Action

The State department can enforce its rights in the district court of the city and county of Denver within thirty (30) days after receiving notice. *Id.* The State department will receive its costs and attorney fees incurred in the prosecution of any such action. *Id.* The State department shall be subrogated to any rights a legally responsible relative of a recipient who has agreed to provide medical support may have to obtain reimbursement from a third party or insurance carrier. Colo. Rev. Stat. Ann. § 25.5-4-301(7). All recipients of medical assistance under the Medicaid program are deemed to have authorized their attorneys, third parties which includes but is not limited to insurance companies, and providers of medical care to release to the State department

COLORADO

all information needed by the state department to secure and enforce its rights. Colo. Rev. Stat. Ann. § 25.5-4-301(8).

CONNECTICUT

Right of Subrogation

The Connecticut Department of Social Services has a right of subrogation to any right of recovery or indemnification that a recipient of medical assistance has against an insurer orother legally liable third party. Conn. Gen. Stat. Ann. § 17b-265(a). Whenever funds owed to a person are collected pursuant to this section and the person who otherwise would have been entitled to such funds is subject to a court-ordered current or arrearage child support payment obligation in an IV-D support case, such funds shall first be paid to the state for reimbursement of Medicaid funds paid on behalf of such person. *Id.* Remaining funds, if any, shall then be paid to the Office of Child Support Services for distribution pursuant to the federally mandated child support distribution system. *Id.* Any additional claim of the state to the remainder of such funds, if any, shall be paid in accordance with state law. *Id.*

Assignments

An applicant or recipient of medical assistance must assign to the State the right to reimbursement from third parties for medical expenses. Conn. Gen. Stat. Ann. § 17b-265(b). The Department may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to a recipient, in order to assist the provider in obtaining payment for such services. *Id.*

Notice Requirements

A provider that has received an assignment from the Department must notify the recipient's health insurer or other legally liable third parties. *Id.* A failure to notify the health insurer or other liable third party will render the provider ineligible for payment from the Department. *Id.*

DELAWARE

Right of Recovery

The Delaware Department of Health and Social Services will be subrogated against any medical care recipient, who has a cause of against another person, to the extent of any payment made by the Department on behalf of the recipient. Del. Code Ann. tit. 31, § 522(a).

State Fund and Recovery Amount

Any funds received by an individual who has received medical care, by a guardian or representative, or the individual's attorney, by means of judgment, award, or settlement of the cause of action, will be held for the benefit of the Department. Del. Code Ann. tit. 31, § 522(b). Attorney fees and litigation costs are deducted from the fund first before the payment to the Department. *Id.* The Department is required to pay its fair share of attorney fees and costs associated with the collection of the subrogated amount. *Jeffries v. Kent Cty. Vocational Tech. Sch. Dist. Bd. of Educ.*, 743 A.2d 675, 680 (Del. Super. 1999).

Beneficiary Responsibilities

After the notice of a subrogation claim, a recipient will be liable to the Department for any funds that are disposed of by the recipient, a representative, or the recipient's attorney which were meant to be held for the Department. Del. Code Ann. tit. 31, § 522(c).

Hardship Considerations

The Department has the opportunity to compromise, settle, and release a subrogated claim if theDepartment determines that collection would result in substantial hardship on the recipient. Del.Code Ann. tit. 31, § 522(d).
https://www.dmap.state.de.us/downloads/manuals/General.Policy.Manual.pdf

FLORIDA

Secondary Payer Status and Third Party Liability

Medicaid is intended to be the payer of last resort for medically necessary goods and services provided for Medicaid recipients. Fla. Stat. § 409.910(1). Medicaid must be reimbursed in full if a liable third party is discovered or becomes available after medical assistance has been providedby the state. *Id.*

Right of Recovery

Florida has enacted the Medicaid Third Party Liability Act which provides at least three mechanisms that the Agency can use to recover expenditures from third parties: (1) the Agency is statutorily granted an automatic lien for the full amount of medical assistance provided by Medicaid; (2) the Agency is automatically subrogated to any rights to third party benefits; and (3) the acceptance of Medicaid benefits results in an automatic assignment to the Agency of the recipient's rights to any third party benefits or actions. Fla. Stat. § 409.910(6)(a)-(c).

The Agency has an automatic lien for the full amount of medical assistance provided by Medicaid to the recipient for medical care provided as a result of any covered injury or illness forwhich a third party is or may be liable. Fla. Stat. § 409.910(6)(c). The lien attaches automaticallywhen recipient first receives treatment for which the Agency may be obligated to provide medical assistance under the Medicaid program. *Id.* The lien is perfected automatically at the time of attachment. *Id.* The Agency may intervene in or join any legal or administrativeproceeding as a matter of right in order to enforce its rights. Fla. Stat. § 409.910(11). Any actionby the recipient will not prejudice the rights of the Agency. Fla. Stat. § 409.910(13). Anyagreements entered into between the recipient and a third party will not impair the Agency's rights. *Id.*

State Cause of Action

The Agency also has an independent cause of action which requires the State to prove that (1) there was negligence or a defective product, (2) causation, and (3) damages. *Agency for Health Care Admin. v. Associated Indus. of Florida, Inc.*, 678 So. 2d. 1239, 1250 (Fla. 1996). Affirmative defenses are not available to defendants when the Agency brings an independent cause of action. *Id.* When the agency provides medical care under the Medicaid program, the agency is automatically subrogated to any rights that a recipient has to any third party benefit for the full amount of medical assistance provided by Medicaid. Fla. Stat. § 409.910(6)(a).

Amount of Recovery

Full Medicaid repayment takes precedent over the recipient and other creditors. The amount of recovery is limited to the legal liability and for the full amount of third party benefits, but it may not be in excess of the amount of medical assistance paid by Medicaid. Fla. Stat. § 409.910(4). Fla. Stat. § 490.910(11)(f) provides a formula to determine how much the state may recover

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froma settlement. The State's recovery is capped at half of the total settlement amount after deducting attorney's fees and costs. However, this is the default allocation.

Insurance and other third party benefits cannot contain any provision which limits or excludes payment or benefits for an individual if the individual is eligible for medical assistance from Medicaid. Fla. Stat. § 409.910(15). The agency is authorized to make appropriate settlements when trying to recover any payments. Fla. Stat. § 409.910(18). The agency is not required to seek reimbursement from a liable third party on claims for which the agency determines that the amount it reasonably expects to recover will be less than the cost of recovery, or that recovery efforts will otherwise not be cost-effective. Fla. Stat. § 409.910(19).

Reducing Medicaid Claims

A Medicaid recipient can seek a reduction of the Medicaid lien amount by providing evidence that the lien amount exceeds the amount recovered for medical expenses. *See Davis v. Roberts*, 130 So. 3d 264, 270 (Fla. Dist. Ct. App. 2013). The recovery of these benefits may be collected directly from any third party, the recipient or legal representative if they received third party benefits, the provider of a recipient's medical services if third party benefits have been recovered by the provider, or any person who has received the third party benefits. Fla. Stat. § 409.910(7).

GEORGIA

Right of Subrogation

The Department of Community Health is in charge of medical care and Medicaid reimbursement in Georgia. The Department may seek reimbursement for medical assistance from another personif that person is legally liable for the sickness, injury, disease, or disability to a recipient of medical assistance. Ga. Code Ann. § 49-4-148(a). The Department shall be subrogated, only to the extent of the reasonable value of the medical assistance paid and attributable to the injury, to the rights of the recipient of medical assistance against the person who is legally liable. *Id.*

Liens

The Department shall have a lien on monies that a medical assistance recipient receives as a result of sickness, injury, disease, disability, or death due to the liability of a third party. Ga.Code Ann. § 49-4-149(a). The Department may perfect and enforce any lien by following the procedures set forth in Georgia Code Sections 44-14-170 through 44-14-473. Ga. Code Ann. § 49-4-149(b). The Department has one year from the date the last item of medical care was furnished to file its verified lien statement. *Id.*

Beneficiary Notice Requirement

An individual who has been injured by another party, and that individual has received medical assistance benefits, shall notify the Department either by themselves or by an attorney who has actual knowledge of the receipt of said benefits. Ga. Code Ann. § 9-2-21(c).

Amount of Recovery

The Department commissioner may compromise, settle, and execute a release of any such claim or waive, expressly, any such claim, in whole or in part, for the convenience of the Department. *Id.* The Department's lien shall not affect the priority of any attorney's lien. *Id.*

Duty of Third Party Payer

Insurers must cooperate with the Department in determining whether a person who is a recipient of medical assistance may be covered under that entity's health benefit plan. Ga. Code Ann. § 49-4-148(b)(1).

Assignment

A recipient of medical assistance who receives medical care for which the Department may be obligated to pay shall be deemed to have made an assignment to the Department of any rights of such person may have to any payments for the medical care from a potentially liable third party. Ga. Code Ann. § 49-4-149(d).

HAWAII

Right of Recovery

The Department of Human Services has the right to recover from a liable third party the full extent of costs of medical assistance payment furnished, or to be furnished, by the department to a claimant. Haw. Rev. Stat. Ann. § 346-37(c). The Department is subrogated to all rights or claims that a claimant has against the third person for medical assistance. Haw. Rev. Stat. Ann. §346-37(d). In order to enforce its rights, the Department may intervene or join in any action or proceeding brought by a claimant against the third party. *Id.*

State Cause of Action

The Department may initiate and prosecute legal proceedings against the third party for injury, disease, or death if the action or proceeding has not been commenced within six months after the first day on which medical assistance was furnished. *Id.* The Department may bring the suit alone in its own name or in the name of a claimant, or the Department may bring the suit in conjunction with the claimant. *Id.*

Amount of Recovery

Payments cannot exceed the full extent of the costs of medical assistance furnished or to be furnished by the department. *Id.* The Department has the right to recover up to the full amount ofthe costs of medical assistance from a settlement, award, or judgment. Haw. Rev. Stat. Ann. § 346-37(f). The Department may settle or compromise its reimbursement rights for less than the full amount due or enter into any agreement with claimant, claimant's attorney, or claimant's representative for the distribution of proceeds from a suit or settlement. Haw. Rev. Stat. Ann. § 346-37(o).

Beneficiary Duty to Inquire and Notice

An attorney representing a claimant or a third person must make reasonable inquiries as to whether the claimant has received or is receiving from the Department medical assistance relatedto the incident involved in the action. Haw. Rev. Stat. Ann. § 346-37(e). If the claimant, claimant's attorney, or claimant's representatives have received from the Department actual notice of its right to reimbursement or if they have reason to know that the claimant has received or is receiving from the Department medical assistance related to the incident, then the claimant, claimant's attorney, or representative must give to the Department a timely written notice on any claim or action against a third person. *Id.* The claimant or the claimant's attorney may contact theDepartment at any time during the pendency of any claim in order to ascertain the full amount of the costs of medical assistance made. *Id.* The Department must provide the cost of medical assistance made in a reasonable time. *Id.* The claimant's attorney, if the attorney has received actual notice from the Department of a lien or has reason to know a lien exists, or the claimant if not represented by an attorney who has received actual notice of the lien must notify

HAWAII

the Department immediately upon obtaining a judgment or reaching a settlement in order to ascertain and satisfy the Department's right to reimbursement for costs of medical assistance. *Id.*

IDAHO

Right of Recovery

The State Department of Health and Welfare will be subrogated to the rights of the recipient of medical assistance if that recipient is entitled to recover any or all such medical expenses from any third party or entity. Idaho Code Ann. § 56-209b(3). The Department will be subrogated to the extent of the amount of medical assistance benefits paid by the Department as the result ofthe occurrence giving rise to the claim against the third party or entity. *Id.*

Beneficiary Duty to Notify

Recipients that pursue a claim against a third party or entity through litigation or a settlement must notify the Department. Idaho Code Ann. § 56-209b(4). A failure to notify the Department of such claim may result in the Department recovering the amount of any public assistance obtained by the recipient while the recipient pursued such claim. *Id.*

Amount of Recovery

Recipients that recover funds, either by settlement or judgment, from a third party shall reimburse the Department to the extent of the funds received in settlement minus attorney's fees and costs, the amount of the medical assistance benefits paid by the Department on his behalf asa result of the occurrence giving rise to the need for medical assistance. *Id.*

The Department has priority to any amount received from a third party or entity which can reasonably be construed to compensate the recipient for the occurrence giving rise to the need formedical assistance, whether the settlement or judgment is obtained through the subrogation right of the Department or through recovery by the recipient, and whether or not the recipient is made whole by the amount recovered. Idaho Code Ann. § 56-209b(5).

If a recipient incurs the obligation to pay attorney's fees and costs for the purpose of enforcing a monetary claim to which the Department has a right under this section, the amount which the Department is entitled to recover shall be reduced by an amount which bears the same relation to the total amount of attorney's fees and costs actually paid by the recipient as the amount actually recovered for medical expenses paid by the Department. Idaho Code Ann. § 56-209b(6).

State Directed Payment Instruction

The Department may notify and instruct a third party to make payment directly to the Department prior to any amount being distributed to the recipient. *Id.* Any third party or entity who distributes funds in violation of such notice shall be liable to the Department for the amount of the reimbursement. *Id.*

ILLINOIS

Right of Recovery

The Illinois Department of Healthcare and Family Services (DHCFS) has the right to recover from a third party person or carrier the reasonable value of medical benefits provided to a beneficiary under Medicaid. 305 Ill. Comp. Stat. 5/11-22b(b). The Department has a subrogation right to any right of recovery a Medicaid recipient may have under the terms of any private or public health care coverage or casualty coverage, including coverage under the Workers' Compensation Act. 305 Ill. Comp. Stat. 5/11-22a.

In order for the Department to enforce its subrogation right, the Department may do any of the following: (i) intervene or join in an action or proceeding brought by the recipient, his or her guardian, personal representative, estate, dependents, or survivors against any person or public orprivate entity that may be liable; (ii) institute and prosecute legal proceedings against any person or public or private entity that may be liable for the cost of such services; or (iii) institute and prosecute legal proceedings, to the extent necessary to reimburse the Illinois Department for it costs. *Id.*

When the Department perfects its lien upon a judgment, the Department will be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interestand other accruing costs as in the case of other executions. 305 Ill. Comp. Stat. 5/11-22b(h).

Amount of Recovery

The Department can compromise or settle and release any claim for benefits provided, or waive any such claims for the benefits provided in whole or in part for the convenience of the Department or if the Department determines that collection would result in undue hardship upon the person who suffered the injury. 305 Ill. Comp. Stat. 5/11-22b(2).

If the action is prosecuted by the beneficiary and the Department, the court will first pay from any judgment the reasonable litigation expenses incurred in preparation and prosecution of such action together with reasonable attorney's fees for the plaintiff's attorneys based solely on the services rendered for the benefit of the beneficiary. 305 Ill. Comp. Stat. 5/11-22b(e). After this payment is made, the court will use the remaining amount of the judgment to sufficiently reimburse the Department the full amount of benefits paid on behalf of the beneficiary. *Id.* No judgment or settlement by a beneficiary to recover damages for injuries will be satisfied if the Department has an interest and is not given a reasonable opportunity to perfect and satisfy itslien. 305 Ill. Comp. Stat. 5/11-22b(g).

Beneficiary Duty to Notify

ILLINOIS

If either the beneficiary or the Department brings an action against a third party or carrier, the beneficiary or the Department should notify the other within 30 days of the filing. 305 Ill. Comp. Stat. 5/11-22b(d).

INDIANA

Right of Recovery

The Indiana Medicaid system, administered by the Office of the Secretary, provides that the State will pay medical expenses on behalf of an eligible person. Ind. Code § 12-15-1-1. An individual who applies for or receives Medicaid automatically assigns to the State their rights to medical support and other third party payments for medical care. Ind. Code § 12-15-2-16.5. In a case where the recipient asserts a claim against a third party or insurer and receives recovery, whether by judgment, compromise, or settlement, the Office has a lien against the person in the amount paid by the Office to the extent of the other person's liability for medical expenses. Ind. Code § 12-15-8-1-2. The Office is authorized to contract with another State agency or other persons to administer any part of its Medicaid program. Ind. Code § 12-15-30-1.

Perfecting State's Lien Interest and Notice Requirements

A lien is not effective unless the office, before the party alleged to be liable has concluded a finalsettlement with the injured party, takes the following actions: (1) files in the Marion County circuit court a written notice stating the notice of the eligibility of the injured for Medicaid, the name and address of the injured, and the name of the person, firm, limited liability company, or corporation alleged to be liable to the injured person; and (2) sends to the person, firm, limited liability company, or corporation alleged to be liable, by registered or certified mail, a copy ofthe notice required by subdivision (1), with a statement of the date of filing of the notice. Ind. Code § 12-15-8-3. Additionally, the Office should send a copy of the notice required by Section 3 to the injured party for whom the Office has paid medical expenses, an insurance carrier that may be ultimately liable, and the attorney for the injured person. Ind. Code § 12-15-8-4. The Office must provide an itemized statement of the medical expenses paid by the Office within twenty-one (21) days after filing of the notice. Ind. Code § 12-15-8-5.

State Cause of Action

The Office may, in order to perfect a lien or on behalf of the injured, initiate and prosecute an action or a proceeding against a person, firm, corporation, or limited liability company who may be liable to the injured person. The Office may only initiate the action or proceeding if the injured person has not initiated legal proceedings against the potentially liable party and the time remaining under the statute of limitations for the action or proceeding is not more than six months. Ind. Code § 12-15-8-6.

Amount of Recovery

The Office must pay a pro rata share of all costs and reasonably necessary expenses if the Office recovers money under a lien as a result of a claim asserted by the injured. Ind. Code § 12-15-8-7.The pro rata share of costs includes deposition costs, witness fees, and other costs and expenses that are considered reasonably necessary. *Id.* Additionally, the Office will be

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responsible for attorney's fees as well. Ind. Code § 12-15-8-8. The Office will pay attorney's fees in the amount of 25% of its recovery under the lien if the claim was collected without initiating legal proceedings. Ind. Code § 12-15-8-8(c)(1). If, on the other hand, the Office's recovery under the lien was collected by initiating legal proceedings, then the office shall provide 33.3% of its recovery for attorney's fees. Ind. Code § 12-15-8-8(c)(2).

Waiver of Recovery

The Office may choose to waive its right to assert a lien. Ind. Code § 12-15-8-9(a). If the Office chooses to do so, then they will not be liable for any pro rata share of costs. Ind. Code § 12-15-8-9(b).

IOWA

Right of Recovery

The Iowa Department of Human Services is responsible for administering and recovering Medicaid. In order for an individual to be eligible for medical assistance, they must assign to theDepartment any rights to payments of medical care from any third party, cooperate with the department in obtaining payments, and cooperate with the Department in identifying and providing information to assist the Department in pursuing any third party who may be liable to pay for medical care. Iowa Code § 249A.54(1). "Third party" means "an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease, or disability by or on behalf of an applicant for or recipient of assistance under the medical assistance program." Iowa Code § 249A.54(6). A settlement, waiver, or release does not defeat the Department's lien except pursuant to the written agreement of the Director. Iowa Code § 249.54(2).

Amount of Recovery

The Department has a lien upon all monetary claims which the recipient may have against third parties when the Department has made a payment for medical care or expenses. Iowa Code § 249A.54(2). Attorney fees and costs shall be deducted from the total judgment or settlement before the Department is reimbursed. Iowa Code § 249A.54(5). One-third of the remaining balance shall be deducted and paid to the recipient. *Id.* The Department will then be paid from the remaining balance after the two previous payments have been deducted. *Id.* An attorney acting on behalf of a recipient of medical assistance for the purpose of enforcing a claim upon which the Department has a lien shall not collect from the recipient any amount as attorney fees which is in excess of the amount which the attorney would customarily collect on claims not subject to the relevant Medicaid third party recovery section. *Id.*

Notice Requirements

The Department must file a notice of lien with the clerk of the district court *and* with the recipient's attorney. *Id.* The notice of the lien shall be filed before the third party has concluded afinal settlement with the recipient, recipient's attorney, or other representative. *Id.*

Applicants for medical assistance must notify the department of any claims against third parties upon submitting an application. Iowa Code § 249A.54(3). Recipients of medical assistance shall notify the Department of any possible claims when those claims arise. *Id.* Any attorney who represents an applicant or recipient of medical assistance shall notify the Department of the claimof which the attorney has actual knowledge, prior to filing a claim, commencing an action, or negotiating a settlement offer. *Id.*

IOWA

State Cause of Action

The Department may enforce its lien by a civil action against any liable third party. Iowa Code §249A.54(7).

KANSAS

Secondary Payer Status and Right of Recovery

Payment by the Secretary is secondary to any other insurance coverage or third party with a legal obligation to pay such medical expenses to or on behalf of the recipient. Kan. Stat. § 39-719a(a). The Secretary may recover from the recipient or a third party when medical assistance has been paid by the Secretary and a third party has a legal obligation to pay such medical expenses to or on behalf of the recipient. *Id*. The Secretary will be subrogated to the rights of the recipient. *Id*.

Amount of Recovery

Unless otherwise agreed, the court shall fix attorney fees. Kan. Stat. § 39-719a(b). The fees shall be paid proportionately by the Secretary and the injured person. *Id*. The proper amounts will be determined by the court. *Id*. Attorney fees paid by the Secretary should not exceed one-third (1/3) of the medical assistance recovered for cases settled prior to trial. *Id*. Attorney fees shall not exceed two-fifths (2/5) of medical assistance recovered in cases when a trial is convened. *Id*. In the event of comparative negligence, the Secretary's right of subrogation will be reduced by the percentage of negligence attributable to the injured person. Kan. Stat. § 39-719a(c).

Assignments and Attorney Appointment

Individuals who apply for or receive medical assistance under a medical care plan in which federal funds are expended, any accrued, present or future rights to support and any rights to payment for medical care from a third party of an applicant or recipient and any other family member for whom the applicant is applying shall be deemed to have been assigned to the Secretary on behalf of the state. Kan. Stat. §39-709(g)(1)(A).. The assignment automatically becomes effective upon the date of approval for such assistance without the requirement that any document is signed by the applicant or recipient. *Id*. Medical assistance applicants and recipients also agree to appointing the Secretary, or the secretary's designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments, representing payments received by the Secretary on behalf of any person applying for, receiving or having received such assistance. *Id*. The limited power of attorney is effective from the date the Secretary approves the application for assistance and it remains in effect until the assignment has been terminated in full. *Id*. Any amount that is designated as medical support shall be retained by the Secretary for repayment of the unreimbursed portion of assistance. *Id*.

KENTUCKY

Right of Recovery

"Recipient" means any person who has received medical services provided by the Office for Children with Special Health Care Needs or who has received medical services paid for on his behalf by the office; KRS § 200.495(1). The Office shall automatically be subrogated to any rights the recipient has to third-party payment for medical services. KRS § 200.499(1). A recipient of medical services provided by the Office or paid for by the Office shall be deemed to have provided the Office the authority to release medical information with respect to such medical services for the purposes of obtaining reimbursement from a third party. KRS § 200.499(3). In recovering any payment in accordance with § 200.499, the Commission is authorized to make appropriate settlements.

Amount of Recovery

The Office shall recover the full cost of medical services provided to a recipient and shall recover any payments made for medical services on his behalf directly from the following: (a) any third party liable to make a medical benefit payment to the provider of the recipient's medical services or to the recipient under the terms and provisions of any contract, health insurance policy, health insurance plan, settlement, or award; (b) the recipient, if he or she has received third party payments for medical services that have been provided to him; or (c) the provider of the recipient's medical services if third party payment for medical services has been recovered by the provider. KRS § 200.499(2)(a)-(c).

State Cause of Action

In order to enforce its subrogation rights under § 200.499, the Office may institute, intervene in, or join any legal proceeding against any third party against whom recovery rights arise. KRS § 200.499(5). No action taken by the Office shall operate to deny the recipient recovery for that portion of his damage not subrogated to the Office, and no action of the recipient shall prejudice the subrogation rights of the Office. KRS § 200.499(5).

Beneficiary Notice Requirement

An applicant for or recipient of medical services provided by or paid for by the Office for Children with Special Health Care Needs shall inform the Office of any rights that the applicant or recipient has to third party payments for medical services at the time of initial application for services or at any time thereafter when such third party payment should become available. KRS § 200.499(1).

State Lien Interest

When the Office provides, pays for or becomes liable for the medical services, and their costs, of a recipient, it shall have a lien for the full amount of the cost of such medical services upon

KENTUCKY

any and all causes of action which accrue to the recipient or to his legal representatives, as a result of sickness, injury, disease, disability, or death due to the liability of a third party which necessitated the medical service. KRS § 200.499(6). The Office shall have one (1) calendar year from the date when the last item of medical services relative to a specific accident or spell of illness was provided or paid for in which to file its verified lien statement. The verified lien statement must be filed with the clerk of the Circuit Court in the recipient's county residence, and the lien statement must contain the following:

1. The name and address of the recipient of medical services;

2. The date of the injury or accident;

3. The name and address of the vendor or vendors furnishing medical service to the recipient;

4. The date of the medical services;

5. The amount claimed to be due the Office for the medical services provided or paid for; and

6. To the best knowledge of the Office, the names and addresses of all persons or corporations claimed to be liable for damages arising from the injuries. KRS § 200.499(6).

The Office's failure to file a lien shall not affect the Office's subrogation rights provided for in subsection (1) of § 200.499. KRS § 200.499(6).

LOUISIANA

Third Party Liability

Through the Department of Health and Hospitals, the State shall do the following: (1) undertake all reasonable measures to ascertain the legal liability of third parties, including the collection of sufficient income to enable the Department to pursue claims against such third parties, and (2) seek reimbursement for such assistance to the extent of such legal liability 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 Department can reasonably expect to recover exceeds the cost of such recovery. LSA-R.S. 46-446.2(c)(1)-(2). To the extent that payment for covered expenses has been made by Medicaid for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the State is deemed to have acquired the rights of the individual to payment by any other party for those health care items or services. LSA-R.S. 46-446.2(D).

Right of Recovery

When an injury has been sustained or an illness or death incurred by any person under circumstances creating in a third person or legal entity a legal liability or obligation to pay damages or compensation to that person or to his spouse, representative, or dependent, the Department shall have a cause of action against such third party to recover the medical assistance payments the Department has paid or is obligated to pay on behalf of the injured, ill, or deceased person in connection with the injury, illness, or death. LSA-R.S. 46:446(B). The Department, a Medicaid managed care organization, or both, may intervene in a suit filed by or on behalf of the injured, ill, or deceased person or his spouse, representative, or dependent against such third party to recover the medical assistance payments the Department, Medicaid managed care organization, or each, has paid or is obligated to pay on behalf of the injured, ill, or deceased person in connection with said injury, illness, or death. LSA-R.S. 46-446(B).

Written Notice

Any person or his spouse, representative, or dependent who files suit for the recovery of damages or compensation as the result of an injury, illness, or death for which medical assistance payments in whole or in part have been paid by the Department, a Medicaid managed care organization, or both, for which the Department, Medicaid managed care organization, or each, has an obligation to pay, shall at the time suit is filed cause a copy of the petition to be served on the Department, Medicaid managed care organization, or both, in the manner prescribed by Article 1313 of the Louisiana Code of Civil Procedure. LSA-R.S. 46-446(C). The person filing suit shall be responsible to the Department, Medicaid managed care organization, or both, to the extent of the medical assistance payments received, interest, and attorney fees if he fails to have service made upon the department, Medicaid managed care organization, or both. LSA-R.S. 46-446(C). The person will also be responsible to the Department, Medicaid managed care organization, or both, if he compromises his claim without giving the Department, Medicaid

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managed care organization, or both, written notice at least thirty days before the compromise is affected. LSA-R.S. 46-446(C). The written notice must include the name and date of birth of all injured or ill recipients and the name and address of the party or parties potentially liable for damages or compensation. LSA-R.S. 46-446(C).

Pleadings

Pleadings filed on behalf of the Department or Medicaid managed care organization shall be accompanied by an itemized statement of its monetary claim, and when accompanied by an affidavit to the correctness thereof to the best of the affiant's knowledge and belief, such itemized statement shall be accepted as prima facie proof of the amount, purpose, and necessity of such payments. LSA-R.S. 46-446(D).

Compromise

No compromise of any claim referred to in Subsections B and C of LSA-R.S. 46-446 shall be binding upon or affect the rights of the Department or a Medicaid managed care organization against a third party if the Department or Medicaid managed care organization has notified against such third party in writing of the amount of its claim prior to the date the compromise settlement is made. LSA-R.S. 46-446(E). The notice provided for may be directed to either the third party or his agent. LSA-R.S. 46-446(E).

Privilege for Reimbursement of Medicaid Payments

The Department and a Medicaid managed care organization shall have a privilege for the medical assistance payments made by the Department or Medicaid managed care organization on behalf of an injured or ill Medicaid recipient on the amount payable to the injured recipient, his heirs, or legal representatives out of the total amount of any recovery or sum had, collected, or to be collected, whether by judgment, settlement, or compromise, from another person on account of such injuries, and on the amount payable by any insurance company under any contract providing for indemnity or compensation to the injured person. LSA-R.S. 46-446(G). The privilege of an attorney shall have precedence over the privilege created in this paragraph. LSA-R.S. 46-446(G). This created privilege shall become effective if, prior to the payment of insurance proceeds, or to the payment of any judgment, settlement, or compromise, and if known, the name of the person alleged to the liable to the injured person on account of the injuries received, is mailed by the Department, a Medicaid managed care organization, or an attorney or agent of either, by certified mail, return receipt requested, to the injured person, to his attorney, to the person alleged to be liable to the injured person on account of the injuries sustained, to any insurance carrier which has insured such person against liability, and to any insurance company obligated by contract to pay indemnity or compensation to the injured person. LSA-R.S. 46-446(H). The privilege shall be effective against the persons given notice according to the provisions, and shall not be defeated nor rendered ineffective as against the

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persons who have been given such notice, because of failure to give such notice to other persons named. LSA-R.S. 46-446(H).

Any insurer, potentially liable third party, or other person who, having received notice in accordance with the above stated provisions, pays over any monies subject to the privilege created herein to any injured person, or the attorney, heirs, or legal representatives of any injured person, and any injured person, his legal representative, or attorney who receives monies subject to the created privilege shall be liable to the Department, Medicaid managed care organization, or both, for the amount of the privilege not to exceed the amount paid by the insurer, potentially liable third party, or other person. LSA-R.S. 46-446(I).

A person who furnishes services and is participating as a provider in the Medicaid program may not refuse to furnish services to an individual who is entitled to have payment made by Medicaid for the services the person furnishes because of a third party's potential liability for payment of the service. LSA-R.S. 46-446.5(A). In the case of an individual who is entitled to Medicaid with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual or any financially responsible relative or representative for that individual payment of an amount for that service if: (1) the total of the amount of the liability of third parties for that service is at least equal to the amount payable for that service under Medicaid disregarding 42 U.S.C. § 1396(o), and (2) the amount which exceeds the lesser of the amount which may be collected under Medicaid pursuant to 42 U.S.C. § 1396(o) or the amount by which the amount payable for that service under Medicaid disregarding 42 U.S.C. 1396(o) exceeds the total of the amount of the liabilities of third parties for that service. LSA-R.S. 46-446.5(B)(1)-(2).

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Recovery Procedures

When benefits are provided or will be provided to a member under the MaineCare program administered by the department pursuant to the United States Social Security Act, Title XIX, including any prescription drug programs administered under the auspices of MaineCare, referred to collectively in this section as MaineCare, for the medical costs of injury, disease, disability or similar occurrence for which a 3rd party is, or may be, liable, the commissioner may recover from that party the cost of the benefits provided. This right of recovery is separate and independent from any rights or causes of action belonging to a member under the MaineCare program. For MaineCare recipients who participated in the MaineCare managed care program, "cost" means the total value of coverable medical services provided measured by the amount that MaineCare would have paid to providers directly for such services, were it not for the managed care system. The MaineCare program is the payor of last resort and shall provide medical coverage only when there are no other available resources. The Attorney General, or counsel appointed by the Attorney General, may, to enforce this right, institute and prosecute legal proceedings directly against the 3rd party in the appropriate court in the name of the commissioner. 22 M.R.S. § 14.

The Commissioner must also be subrogated, to the extent of any benefits provided under the MaineCare program, to any cause of action or claim that a member has against a third party who is or may be liable for medical costs incurred by or on behalf of the member. *Id*. In order to enforce this right, the AG, or counsel appointed by the AG, may institute and prosecute legal proceedings in the name of the injured person, member, guardian, personal representative, estate or survivor. *Id*. The Commissioner's right to recover the cost of benefits provided constitutes a statutory lien on the proceeds of an award or settlement from a third party if recovery for MaineCare costs was or could have been included in the recipient's claim for damages from the third party to the extent of the recovery for medical expenses. *Id*. The Commissioner is entitled to recover the cost of the benefits actually paid out when the Commissioner has determined that collection will be cost-effective to the extent that there are proceeds available for such recovery after the deduction of reasonable attorney's fees and litigation costs from the gross award or settlement. *Id*.

Assignment of Rights

The receipt of benefits under the MaineCare program constitutes an assignment by the recipient or any legally liable relative to the Department of the right to recover from third parties for the medical cost of injury, disease, disability or similar occurrence for which the recipient receives medical benefits. M.R.S.A. § 14(2-A). The Department's assigned right to recover is limited to the amount of medical benefits received by the recipient and does not operate as a waiver by the recipient of any other right of recovery against a third party that a recipient may have. *Id*. In addition, the recipient is deemed to have appointed the Commissioner as the recipients attorney in fact to perform the specific act of submitting claims, making inquiries, requesting

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information, verifying other previous, current or potential coverage for the recipient or the recipient's spouse or dependents or endorsing over to the Department any and all drafts, checks, money orders or any other negotiable instruments connected with the payment of third party medical claims to third parties, liable parties or potentially liable third parties. *Id*. The appointment includes complete access to medical expenses, records and data, insurance policies and coverage and all other information relating to MaineCare's duty to cost-avoid and seek other coverage or payment response.

Direct Reimbursement to Health Care Provider

When an insured is eligible under the MaineCare program for the medical costs of injury, disease, disability or similar occurrence for which an insurer is liable, and the insured's claim is payable to a health care provider as provided or permitted by the terms of a health insurance policy or pursuant to an assignment of rights by an insured, the insurer shall directly reimburse the health care provider to the extent that the claim is honored. M.R.S.A. § 14(2-B).

Direct Reimbursement to Department

When an insured is eligible under the MaineCare program for the medical costs of injury, disease, disability or similar occurrence for which an insurer is liable, and the claim is not payable to a health care provider under the terms of the insurance policy, the insurer shall directly reimburse the Department for any medical services paid by the Department on behalf of a recipient under the MaineCare program to the extent that those medical services are payable under the terms of the insurance policy. M.R.S.A. § 14(2-C). If the insurer knows or has information upon which to reasonably conclude that the insured is a recipient of MaineCare services, the insurer shall advise the Department in writing as to the existence of the claim prior to any other payment. *Id*.

Written Notice

A recipient under the MaineCare program, or any agent, representative or attorney representing a recipient under the MaineCare program, who makes a claim to recover the medical cost of injury, disease, disability or similar occurrence for which the party received medical benefits under the MaineCare program shall notify the Department in writing prior to settlement negotiations and provide information required by the Department of the existence of the claim. M.R.S.A. § 14(2-D). If the notice is not given and the Department's ability to recover for the benefits paid is compromised, the Department may institute legal proceedings against a recipient, including the agent, representative or attorney of that recipient, who has received a settlement or award from a third party. *Id*. The Department may accept a letter of MaineCare claim protection in lieu of this section.

Notification of Pleading

In an action to recover the medical cost of injury, disease, disability or similar occurrence for which the party received medical benefits under the MaineCare program, the party bringing the action shall notify the Department of that action at least ten days prior to filing the pleadings. M.R.S.A. § 14(2-E). The notification must provide timely opportunity for the Department, at its discretion, to intervene in all actions as an interested party. *Id*. If adequate opportunity to intervene is not given and the Department's ability to recover for benefits paid is compromised, the Department may institute legal proceedings against a recipient, including the agent, representative or attorney of that recipient, who has received a settlement or award from a third party. *Id*. The Department may accept a letter of MaineCare claim protection in lieu of intervention. *Id*. Department records indicating medical benefits paid by the Department on behalf of the recipient are prima facie evidence of the medical expenses incurred by the recipient for the related medical services. *Id*.

Disbursement

Except as otherwise provided, a disbursement of any award, judgment or settlement may not be made to a recipient without the recipient or the recipient's attorney first paying to the Department that amount of the award, judgment or settlement that constitutes reimbursement for medical payments made or obtaining from the Department a release of any obligation owed to it for medical benefits provided to the recipient. M.R.S.A. § 14(2-F). If a dispute arises between the recipient and the Commissioner as to the settlement of any claim that the Commissioner may have, the third party or the recipient's attorney shall withhold from disbursement to the recipient an amount equal to the Commissioner's claim. *Id*. Either party may apply to the Superior Court or the District Court in which an action based upon the recipient's claim could have been commenced for an order to determine a reasonable amount in satisfaction of the statutory lien, consistent with federal law. *Id*.

Definitions

"Estate," unless otherwise required by the United States Social Security Act, 42 United States Code, Section 1396p(b), "estate" does not include an account established under a qualified ABLE program that complies with the requirements of the federal Achieving a Better Life Experience Act of 2014, Public Law 113-295."

"Insurance carrier" includes, but is not limited to, health insurers, group health plans as defined in 29 U.S.C. § 1167(1), service benefit plans and health maintenance organizations, as well as any other entity included in 42 U.S.C. § 1396a(a)(25)(I).

"Liable Party," "potentially liable party," or "third party" includes the trustee or trustees of any mortuary trust established by the recipient or on the recipient's behalf in which there is money remaining after the actual costs of the funeral and burial have been paid in accordance with the terms of the trust and in which there is no provision that the excess be paid to the decedent's estate.

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"Liable party," "potentially liable party" or "third party" may also include the recipient of benefits under the MaineCare program.

"Third party" or "liable party" or "potentially liable party" means any entity, including, but not limited to, any health insurer as included in 42 U.S.C. § 1396a(a)(25)(I) and any other parties that are, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, that may be liable under a contract to provide health, automobile, workers' compensation or other insurance coverage that is or may be liable to pay all or part of the medical cost of injury, disease, disability or similar occurrence of an applicant or recipient of benefits under the MaineCare program.

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Right of Subrogation

If a Maryland Medical Assistance Program recipient has a cause of action against a person, the Department of Health and Mental Hygiene shall be subrogated to that cause of action to the extent of any payments made by the Department on behalf of the program recipient that result from the occurrence that gave rise to the cause of action. MD Code § 15-120.

Notice Requirements

An attorney representing a program recipient in a cause of action to which the Department has a right of subrogation shall notify the Department prior to filing a claim, commencing an action, or negotiating a settlement. MD Code § 15-120(b)(1). The attorney shall notify the Department in advance of the resolution of a cause of action and shall allow the Department three business days from the receipt of the notice to establish its subrogated interest. *Id*. 15-120(b)(2).

Settlement Money

Any program recipient or attorney, guardian, or personal representative of a program recipient who receives money in settlement of or under a judgment or award in a cause of action in which the Department has a subrogation claim shall, after receiving written notice of the subrogation claim, hold that money, for the benefit of the Department, to the extent required for the subrogation claim, after deducting applicable attorney's fees and litigation costs. MD Code § 15- 120(c)(1). A person who, after written notice of a subrogation claim and possible liability, disposes of the money, without the written approval of the Department, is liable to the Department for any amount that, because of the disposition, is not recoverable by the Department. *Id*. § 15-120(c)(2). The Department may compromise or settle and release its subrogation claim if, in its judgment, collection of the claim will cause substantial hardship: (1) to the program recipient; or (2) in a wrongful death action, to the surviving dependents of a deceased program recipient. *Id*. § 15-120(c)(3)(i)-(ii). The Department is not liable for payment of or contribution to any attorney's fees or litigation costs of any program recipient or attorney, guardian, or personal representative of any program recipient. *Id*. § 15-120(c)(4)(i).

Actions

Any action brought under MD Code § 15-120 is not exclusive and is independent of and in addition to any right, remedy, or cause of action available to the State, the Department, any other State agency, or a program recipient or any other individual. MD Code § 15-120(d).

Assignment of Rights

The Department may assign its right of subrogation under §§ 15-120, 15.121.1, and 15-121.2 to a managed care organization. MD Code § 15-121.3. A "managed care organization" means: (1) a certified health maintenance organization that is authorized to receive medical assistance

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prepaid capitation payments; or (2) a corporation that: (i) is a managed care system that is authorized to receive medical assistance prepaid capitation payments; (ii) enrolls only program recipients or individuals or families served under the Maryland Children's Health Program; and (iii) is subject to the requirements of § 15-102.4 of this subtitle. MD Code § 15-101(e).

Subrogation Claims under Insurance §§ 19-505 and 19-506

If a program recipient has a claim for any medical, hospital or disability benefits under §§ 19-505 and 19-506 of the Insurance Article, the Department shall be subrogated to that claim to the extent of any payments made by the Department on behalf of the program recipient that results from the occurrence that gave rise to the claim less: (1) applicable attorney's fees; and (2) any rights for loss of income. MD Code § 15-121.1(a). An attorney representing a program recipient under this subtitle on a claim to which the Department has a right of subrogation shall notify the Department prior to filing the claim. *Id*. § 15-121.1(b)(1).

Any program recipient or attorney, guardian, or personal representative of a program recipient who receives money for a claim to which the Department has a subrogation claim shall, after receiving written notice of the subrogation claim, hold that money, for the benefit of the Department, to the extent required for the subrogation claim, after deducting applicable attorney's fees. *Id*. § 15-121.1(c)(1). A person who, after written notice of a subrogation claim from the Department and possible liability, disposes of the money, without the written approval of the Department, is liable to the Department for any amount that, because of the disposition, is not recoverable by the Department. *Id*. § 15-121.1(c)(2). The Department may compromise or settle and release its subrogation claim if, in its judgment, collection of the claim will cause substantial hardship to the program recipient or in a wrongful death action, the surviving dependent of a deceased program recipient. *Id*. § 15-121.1(c)(3).

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Right of Recovery

The Medicaid program in Massachusetts is known as MassHealth. The Executive Office for Health and Human Services is the single state agency responsible for the administration of MassHealth. Mass. Gen. Laws ch. 118E § 1. A claimant who receives payment from a liable party, workers' compensation insurer or any other third party as a result of a loss must repay to the Executive Office the total of medical assistance benefits provided by the office from monies allocated in the payment, settlement or compromise of claim or action, court award or judgment for medical expenses. Mass. Gen. Laws ch. 118E § 22(b). The failure to specify what portion of the payment, settlement or compromise of action, court award or judgment is payment for medical expenses will result in the presumption that the payment applies first to the medical expenses incurred by the claimant in an amount equal to the medical assistance benefits provided. Mass. Gen. Laws ch. 118E § 22(c). This rule does not violate the Supreme Court's ruling in *Wos* because Massachusetts established a rebuttable presumption of full reimbursement. *Wos v. E.M.A. ex rel. Johnson*, 133 S.Ct. 1391, 1401 (2013). The Court did not go as far as holding that the Massachusetts rule is necessarily compliant with the federal statute which leaves the possibility that this rule may be challenged in the future. *Id*. The Executive Office has the ability to dispute any allocation for medical damages that results in less than a full recovery of medical assistance benefits paid by the office. Mass. Gen. Laws ch. 118E § 22(d). The Executive Office has the ability to have a hearing before a court of competent jurisdiction on the allocation of damages either prior to or after disbursement of payment by the third party. *Id*. If the claimant received medical assistance through a managed care organization, the Executive Office may recover the amount that the managed care organization paid for medical services provided. *Id*. If a claimant is already eligible for financial assistance benefits, the claimant will only have to repay the increase in financial assistance that occurred as a result of the incident. Mass. Gen. Laws ch. 118E § 22(f).

The Executive Office will receive a pro rata share of the money available from the claim if the money available for repayment is insufficient to satisfy the state in full. Mass. Gen. Laws ch. 118E § 22(h). The application for and receipt of benefits that are recoverable from a third party, after notice to the third party, will operate as a lien to secure repayment against monies which may be provided by the third party up to the amount of such recoverable benefits. Mass. Gen. Laws ch. 118E § 22(g). The Executive Office may also perfect their rights to a lien against any monies which may come into possession of the claimant's attorney from the third party by giving notice to that attorney. *Id*.

Notice Requirements

The claimant, or if represented by counsel, the claimant's attorney, must notify the Executive Office in writing within ten days upon engaging in recovery activity which includes, but is not limited to, making an insurance claim or sending a demand later and upon commencement of a civil action or other proceeding to establish the liability of a third party or collection of money

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from insurance or workers' compensation. Mass. Gen. Laws ch. 118E § 22(j). A settlement or judgment between the claimant and a third party will not be final without first providing the executive office with a written notice and a reasonable opportunity to intervene or otherwise perfect their rights to recovery. *Id*.

Right of Subrogation

The Executive Office will be subrogated to the claimant's entire cause of action or right to proceed against a third party and to a claimant's claim for monies to the extent of the medical assistance that was provided by MassHealth. Mass. Gen. Laws ch. 118E § 22(k). The Executive Office also has a separate and independent cause of action to recover from a third party the assistance that was provided to a claimant. *Id*. The Executive Office can commence a civil action or other proceedings to establish the liability of a third party or to collect such monies. *Id*. The Executive Office may also intervene as of right in a civil action commenced by a claimant against a third party. *Id*. A claimant will be subject to grounds for the termination of their benefits if the claimant fails to provide the requisite notice to the Executive Office without good cause. MassHealth. Mass. Gen. Laws ch. 118E § 22(l). A third party must provide information that is requested by the Executive Office regarding the recovery of payments for public assistance benefits unless otherwise specified by any general or special law, rule, or regulation to the contrary. MassHealth. Mass. Gen. Laws ch. 118E § 22(m). The inclusion of attorney's fees and costs has not been discussed by any statute, regulation, or case. Mass. Gen. Laws ch. 118E § 22 and Mass. Gen. Laws ch. 18 § 5G are both applicable to individuals receiving Medicaid and the recovery from a third party, however, courts have generally relied on ch. 118E § 22. *Whelan v. Division of Medical Assistance*, 44 Mass. App. Ct. 663, 665 (1998). The two statutes are the same in design and substantially similar in language. *Id*.

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According to M.C.L.A. § 400.106, a "medically indigent individual" is defined as the following:

- An individual receiving family independence program benefits or an individual receiving supplemental security income under title XVI of the social security act ("title XVI") or state supplementation under title XVI subject to limitations imposed by the Director according to title XIX; and

- An individual who meets all of the following conditions:

  i. The individual has applied in the manner the Department prescribes;

  ii. The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or resources of the patient;

  iii. The individual has an annual income that is below, or subject to limitations imposed by the Director and because of medical expenses falls below, the protected basic maintenance level;

    (1) The protected basic maintenance level for 1-person and 2-person families must not be less than 100% of the payment standards generally used to determine eligibility in the family independence program.

    (2) For families of 3 or more persons, the protected basic maintenance level must not be less than 100% of the payment standard generally used to determine eligibility in the family independence program.

  iv. The individual, if a family independence program related individual and living alone, has liquid or marketable assets of not more than $2,000.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than $3,000.00 in value;

  v. Except as provided in § 106(b), the individual is not an inmate of a public institution except as a patient in a medical institution; and

  vi. The individual meets the eligibility standards for supplemental security income under title XVI or for state supplementation under the act, subject to limitations imposed by the Director of the department according to title XIX; or meets the eligibility standards for family independence program benefits, or meets the eligibility standards for optional eligibility groups under title XIX, subject to

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limitations imposed by the director of the department according to title XIX. M.C.L.A. § 400.106(1)(a)-(b).

Notice Requirements

An individual who meets the above criteria and receives medical assistance under this act or his or her legal counsel shall notify the department and, if the individual is enrolled in the contracted health plan, the contracted health plan if either of the following occurs:

(a) The individual, his or her representative, or his or her legal counsel, or all here, file a complaint in which the department or the contracted health plan may have a right to recover expenses paid under this act.

(b) The individual, his or her representative, or his or her legal counsel, or all three, seek to settle an action, without filing a complaint, in which the department or the contracted health plan may have a right to recover expenses paid under this act. "Contracted health plan" means a managed care organization with whom the department contracts to provide or arrange for the delivery of comprehensive health services as authorized under this act. *Id*. § 400.106(2)(a).

Failure to Provide Notice

The notice required under subsection (3)(a), along with a copy of the complaint and all documents filed with the complaint, must be provided to the department and, if applicable, the contracted health plan within 30 days after the complaint is filed with the court. The individual, his or her representative, or his or her legal counsel shall certify that notice and a copy of the complaint have been provided to the department and, if applicable, the contracted health plan on the summons and complaint form. This certification must be made in cases with the following case type codes: NF (no-fault automobile insurance), NH (medical malpractice), NI (personal injury, auto negligence), NO (other personal injury), and NP (product liability), and in any other case in which the department or the contracted health plan may have a right to recover expenses paid under this act. The state court administrator shall revise the summons and complaint form to allow certification under this subsection. § 400.106(4).

The notice required under subsection (3)(b) must be provided in writing to the department and, if applicable, the contracted health plan before the action is settled and must include the proposed settlement terms, including the settlement amount, attorney costs, attorney fees, and Medicaid health plan or Medicare subrogation interest amounts, if applicable. . § 400.106(5).

If notice is not given as required by subsections (3) through (5), the department, or the contracted health plan may file a legal action against the individual, his or her representative, or his or her legal counsel, or both all 3, to recover expenses paid under this act. The attorney general or the

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contracted health plan shall recover any cost or attorney fees associated with a recovery under this subsection. § 400.106(6).

An attorney who knowingly fails to timely notify the department or the contracted health plan as required by this section is subject, at the discretion of the department, to a $1,000.00 civil fine for each violation. The civil fine is payable to the department and must be deposited in the general fund. The money deposited in the general fund under this subsection may be used to offset the cost to this state for operating the Medicaid program.

Right of Subrogation

The department is subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of money expended by the department for the care and treatment of the patient. M.C.L.A. § 400.106(1)(b)(ii). The patient or other person acting in the patient's behalf shall execute and shall notify the department of the action or proceeding entered into upon commencement of the action or proceeding. *Id*. An action taken by the State, the department in connection with the right of recovery afforded by this section does not deny the injured, diseased, or disabled individual any part of the recovery beyond the costs expended on the individual's behalf by the department. *Id*. The costs of legal action initiated by the state must be paid by the State. *Id*.

A payment may be withheld under this act for medical assistance for an injury or disability for which the individual is entitled to medical care or reimbursement for the cost of medical care under chapter 31 of the insurance code of 1956, 1956 PA 218, MCL §§ 500.3101 to 500.3179, or under another policy of insurance providing medical or hospital benefits, or both, for the individual unless the individual's entitlement to that medical care of reimbursement is at issue. *Id*. If a payment is made, the department, to enforce its subrogation right, may do either of the following: (a) intervene or join in an action or proceeding brought by the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors, against the third-person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual; or (b) institute and prosecute a legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. *Id*.

The Department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. *Id*. The department, in enforcing its subrogation right, shall not satisfy

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a judgment against a third-person's property that is exempt from levy and sale. *Id*. The injured, diseased, or disabled individual shall notify the department of the action or proceeding entered into upon commencement of the action or proceeding. *Id*. An action taken by the State, or the department in connection with the right of recovery afforded by this section does not deny the injured, diseased, or disabled individual any part of the recovery beyond the costs expended on the individual's behalf by the department. *Id*. The costs of legal action initiated by the state must be paid by the State. *Id*.

Priority against Proceeds of Settlement or Judgment

The department has first priority against the proceeds of the net recovery from the settlement or judgment in an action settled in which notice has been provided. M.C.L.A. § 400.106(8). A contracted health plan has priority immediately after the department in an action settled in which notice has been provided. *Id*. The department and a contracted health plan shall recover the full cost of expenses paid under this act unless the department or the contracted health plan agrees to accept an amount less than the full amount. *Id*. If the individual would recover less against the proceeds of the net recovery than the expenses paid under this act, the department or contracted health plan, and the individual shall share equally in the proceeds of the net recovery. *Id*. The department or a contracted health plan is not required to pay an attorney fee on the net recovery. "Net recovery," as used here, means the total settlement or judgment less the costs and fees incurred by or on behalf of the individual who obtains the settlement or judgment. *Id*.

MINNESOTA

Automatic Lien

Minnesota's State Agency will have a lien for the cost of care upon any and all causes of action or recovery rights under any policy or plan that provides benefits for health care or injury if it provides, pays for, or becomes liable for medical care. Minn. Stat. 256B.042(1).

Notice Requirements

Recipients of medical assistance must notify the Agency of any possible monetary claims against another party that may be liable to pay part or all of the cost of medical care when the Agency has paid or becomes liable for the cost of that care. Minn. Stat. 256B.042(4). The party to the claim must notify the Agency of its potential lien claim when a claim is filed, when an action is commenced, and when a claim is concluded by payment, settlement, judgment, or otherwise. *Id*. Notice must be provided by the injured party or the injured party's legal representative. *Id*. The statute provides that any party involved in the cause of action or claim has a duty to notify the Agency of a potential or actual lien claim. *Id*. However, the Court of Appeals of Minnesota has dismissed that duty stating that only recipients of medical assistance have a duty to notify the Department. *State, Dept. of Human Services v. Mohs*, 496 N.W.2d 817, 820 (Minn. Ct. Appl. 1993). The Agency has one year from the date notice is first received, even if notice is untimely, or one year from the date medical bills are first paid by the Agency, whichever is later, to file its verified lien statement. Minn. Stat. 256B.042(2). The Agency may enforce its lien by following the procedures set forth in sections 514.69, 514.70, and 514.71. Any judgment, award, or settlement of a cause of action must have reasonable costs of collection including attorney fees deducted first. Minn. Stat. 256B.042(5). The Agency must be paid next followed by the medical assistance recipient receiving the remainder. *Id*. The recipient must receive at least one-third of the net recovery after attorney fees and other collection costs. *Id*. The Department of Human Services may commence an action to recover on the lien against any or all of the parties which have either paid or received payments if they have not been notified of the commencement of an action. Minn. Stat. 256B.042(2).

MISSISSIPPI

The State Department of Public Welfare shall assist the Division of Medicaid in the Office of the Governor in identifying cases involving third party liability, including without limitation, third party insurance benefits, health insurance or other health coverage maintained by the recipient or absent parent through intake, initial determinations, and redeterminations of eligibility, and shall promptly transmit such information to the Division of Medicaid or the fiscal agent of the Division of Medicaid. Miss. Code Ann. § 43-13-301.

Assignment of Rights

By accepting Medicaid from the Division of Medicaid in the Office of the Governor, the recipient shall, to the extent of the payment of medical expenses by the Division of Medicaid, be deemed to have made an assignment to the Division of Medicaid of any and all rights and interests in any third party benefits, hospitalization or indemnity contract or any cause of action, past, present or future, against any person, firm or corporation for Medicaid benefits provided to the recipient by the Division of Medicaid for injuries, disease or sickness caused or suffered under circumstances creating a cause of action in favor of the recipient against any such person, firm, or corporation as set out in § 43-13-125. Miss. Code Ann. § 43-13-305(1). The recipient shall be deemed, without the necessity of signing any document, to have appointed the Division of Medicaid as his or her true and lawful attorney-in-fact in his or her name, place and stead in collecting any and all amounts due and owing for medical expenses paid by the Division of Medicaid against such person, firm or corporation. *Id*.

Whenever a provider of medical services or the Division of Medicaid submits claims to an insurer on behalf of a Medicaid recipient for whom an assignment of rights has been received, or whose rights have been assigned by the operation of law, the insurer must respond within sixty days of receipt of a claim by forwarding payment or issuing a notice of denial directly to the submitter of the claim. *Id*. § 43-13-125(2). The failure of the insuring entity to comply with these provisions shall subject the insuring entity to recourse by the Division of Medicaid in accordance with the provision of § 43-13-315 as explained below. *Id*. The Division of Medicaid shall be authorized to endorse any and all, including, but not limited to, multi-payee checks, drafts, money orders or other negotiable instruments representing Medicaid payment recoveries that are received by the Division of Medicaid. *Id*.

Court orders or agreements for medical support shall direct payments to the Division of Medicaid, which shall be authorized to endorse any and all checks, drafts, money orders or other negotiable instruments representing medical support payments which are received. *Id*. 43-13-125(3). Any designated medical support funds received by the State Department of Human Services or through its local county Departments shall be paid over to the Division of Medicaid. *Id*. When medical support for a Medicaid recipient is available through an absent parent or custodial parent, the insuring entity shall direct the medical support payment(s) to the provider of medical services or to the Division of Medicaid. *Id*.

MISSISSIPPI

All providers of medical services participating in the Medicaid program shall, in submitting claims for the payment of services, identify, if known to the provider, the third party or parties who are or may be liable for the injuries, disease, or sickness of the recipient and shall cooperate with the Division of Medicaid in the recoupment of the payments from such third party or parties. Miss. Code. Ann. § 43-13-311. Any provider submitting claims for the payment of medical services by the Division of Medicaid, who, having knowledge of the liability or potential liability of a third party for the injuries, disease, or sickness of the recipient, fails to identify such third party or parties to the Division of Medicaid or who fails to cooperate with the Division of Medicaid in the recoupment of its payments from such third party or parties shall be liable to the Division of Medicaid to the extent of the payments made to the provider for medical assistance or services rendered to a recipient to which the third party or parties is, are, or may be liable. *Id*.

Failure to Honor Subrogation Rights

Any person, firm, or corporation who fails or refuses to honor the subrogation rights of the Division of Medicaid and, specifically, without limitation, hospital insurance and indemnity benefits accruing to a recipient, after advanced written notice and a reasonable opportunity of responding, shall be liable to the division, should suit become necessary by the division and liability be established, for double the amount of Medicaid benefits paid by the Division of Medicaid or double the amount of the insurance policy limits, whichever is the lesser, inclusive of the assessment of a reasonable attorney's fees and all costs of court. Miss. Code Ann. § 43-13-315.

MISSOURI

Right of Recovery

MO HealthNet is the Medicaid program in Missouri. It is the payer of last resort. Mo. Rev. Stat. § 208.001. The MO HealthNet Division can recover payments made on behalf of a participant receiving public assistance from any person, corporation, or institution that is liable, pursuant to a contract or otherwise, to the participant. Mo. Rev. Stat. § 208.215(1). The amount that the Division may recover cannot exceed the payments that the Division made on behalf of the participant. *Id*. In a case where an insurance company should have covered the costs for the participant, the amount the Division can recover is limited to what the entity would have paid as if it had been properly billed. Mo. Rev. Stat. § 208.215(1)(1)(e).

Assignment of Rights

Each individual that participates in MO HealthNet assigns their rights to the Division of any funds that are recovered or expected to be recovered. Mo. Rev. Stat. § 208.215(4). Individuals who participate in the program should also cooperate and help the Division in identifying and providing information to assist the Division in pursuing any third party who may be liable to pay for the care and services that were provided by MO HealthNet. *Id*. A failure to cooperate without good cause may lead to the participant to become ineligible for MO HealthNet benefits. A participant who has notice or knowledge of the Department's right to third party benefits and who receives the benefit or proceeds is required to either pay the full amount owed to the Division within sixty days after receiving the settlement proceeds or to place the full amount owed into a trust account for the benefit of the Division pending judicial or administrative determination of the Division's right to third party benefits. Mo. Rev. Stat. § 208.215(4). A person who acts for or on behalf of an individual who is eligible for MO HealthNet for the purpose of pursuing the participant's claim must notify the Division upon agreeing to assist such person. Mo. Rev. Stat. § 208.215(5). Additionally, the individual must notify the Division of any institution of a proceeding, settlement or the results of the pursuit of the claim. *Id*. The individual must give thirty days' notice before any judgment, award, or settlement that may be satisfied in any action or any claim by the participant to recover damages. *Id*.

Notice Requirements

Every participant, or their attorney, should promptly notify the Division of any recovery from a third party and should immediately reimburse the Division from the proceeds. Mo. Rev. Stat. § 208.215(6). A judgment or settlement may not be satisfied without first giving the Division notice and a reasonable opportunity to file and satisfy the claim or proceed. *Id*. Third party payers will provide the information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal Health Insurance Portability and Accountability Act if requested by MO HealthNet.

MISSOURI

Liens by MO HealthNet

MO HealthNet shall have a lien upon any money to be paid by an insurance company or in satisfaction of a judgment on any claim where the division made medical payments to the recipient. Mo. Rev. Stat. § 208.215(8). The lien is applicable to any money which may come into the possession of any attorney who is handling the claim. In each case, a lien notice should be served by certified mail or registered mail, upon the parties whom the participant has a claim, demand or cause of action. *Id*. The lien should claim the charge and describe the interest the division has in the claim, demand or cause of action. *Id*. The lien attaches to any judgment entered and to any money which may be recovered on account of such claim from and after the time of the service of the notice. *Id*. The court may determine what portion of the recovery should be paid to the Department against the recovery. Mo. Rev. Stat. § 208.215(9). The court may allow the recovery of attorney's fees and costs incurred by the participant incident to the recovery, and whether the Department, as a matter of fairness and equity, should bear its proportionate share of the fees and costs incurred to generate the recovery from which the charge is sought to be satisfied. Mo. Rev. Stat. § 208.215(9)(1). The party who is seeking a reduction of the recovery will have the burden of producing evidence sufficient to support the reduction. Mo. Rev. Stat. § 208.215(10). The MO HealthNet Division shall pay its pro rata share of attorney's fees based on the Division's lien as it compares to the total settlement agreed upon. The acceptance of MO HealthNet benefits will constitute as an assignment to the Division of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care. Mo. Rev. Stat. § 208.215(15).

All MO HealthNet participants should notify the Division within thirty days of any occurrences where an injury is sustained. Mo. Rev. Stat. § 208.215(16). The Director may compromise, settle or waive any claim in whole or in part in the interest of the MO HealthNet program. Mo. Rev. Stat. § 208.215(18). The Division is not required to seek reimbursement from a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. *Id*.

MONTANA

Lien by the Department

The Department of Public Health and Human Services shall administer and supervise public assistance, including medical care payments on behalf of recipients of public assistance. MCA 53-2-201(1)(a). Upon notice by the Department or the recipient to a third party or the third party's insurer, the Department has a lien upon money paid by a third party or the third party's insurer in satisfaction of a judgment or settlement arising from a recipient's claim for damages or compensation for personal injury, disease, illness, or disability to the extent that the Department has paid medical assistance on behalf of the recipient for the same personal injury, disease, illness, or disability and to the extent that the money represents payment for medical expenses. MCA 53-2-612(1). The Department may, in the name of the recipient on whose behalf medical assistance has been paid by the Department, commence and prosecute to final conclusion any action that may be necessary to recover from a third party or the third party's insurer compensation or damages for medical assistance paid by the Department on behalf of the recipient. *Id*. 53-2-612(2).

The lien is subordinate to the lien of an attorney under MCA 37-61-420. Unless specifically provided by law, the recipient's right to recover damages or compensation from a third party or a third party's insurer may not be reduced or denied on the ground that the recipient's costs of medical treatment and medical-related services have been paid by the Department under any public assistance program. MCA 53-2-612(3)(b). From the amount collected by the Department or recipient from legal proceedings or as a result of settlement, reasonable attorney fees and costs must be first deducted and paid. *Id*. 53-2-612(3)(c). Unless the Department and the recipient agreed to a different settlement, the amount previously paid as medical assistance by the Department, less a pro rata share of attorney fees and costs, must be deducted next and paid to the Department, but only to the extent that the amount paid as medical assistance does not exceed the portion of the amount collected that represents payment of medical expenses. *Id*. The remainder, if any, must be paid to the recipient.

In all cases of payment to the Department out of an amount collected from a third party or insurer on a recipient's claim, the amount of the lien must be reduced by a pro rata share of attorney fees and costs as provided in subsection (3)(c), but the Department may not be required to participate in payment of attorney fees and costs unless the recipient's claim results in recovery out of which the Department receives full or partial payment of its lien. MCA 53-2-612(3)(d).

The Department may: (1) impose a lien upon a self-sufficiency trust or upon the assets of a self-sufficiency trust established pursuant to Title 53, chapter 18, part 1, if the Department is required by federal law to recover or collect from the trust or its assets as a condition of receiving federal financial participation for the Medicaid program; and is not precluded from (2) asserting a claim or imposing a lien upon real or personal property prior to transfer of the property to the trust.

MONTANA

MCA 53-2-612(3)(e)(ii)-(iii). If the Department imposes a lien upon property prior to transfer to a self-sufficiency trust, any transfer of the property to the trust is subject to the lien. *Id*.

Notice Requirements

A recipient of medical assistance or the recipient's legal representative shall notify the Department by certified letter within thirty days if the recipient or the recipient's legal representative asserts a claim against a third party or a third party's insurer for damages or compensation for a personal injury, disease, illness, or disability for which the Department paid medical assistance in whole or in part or for which the recipient has applied for medical assistance. MCA 53-2-612(4)(a). The notice must be mailed to the Director of the Department, and a copy must be sent by certified mail to the third party or the third party's insurer. *Id*. The notice must contain the following information: (a) the name and address of the recipient and the recipient's legal representative, if any; (b) the name and address of the third party alleged to be liable to the recipient; (c) the name and address of any known insurer of the third party; and (d) the judicial district and docket number of any action filed. *Id*. 53-2-612(4)(b). A recipient or the recipient's legal representative who has received actual notice that the Department has paid medical assistance is liable to the Department for the amount it is entitled to receive under this section if: (a) the recipient or the recipient's legal representative fails to timely notify the Department or fails to mail a copy of the notice to the third party or the third party's insurer; and (b) a third party or the third party's insurer that did not receive notice from the Department as provided for in subsection (5)(b) pays the recipient or the recipient's legal representative without satisfying any lien of the Department. *Id*. 53-2-612(4)(c)(i)-(ii).

A third party or the third party's insurer has been given notice if: (a) the Department mails, by certified mail, to the third party or the third party's insurer: (1) a statement of the medical assistance paid or that may be paid by the Department on behalf of the recipient, and (2) a claim for reimbursement; (b) the recipient or the recipient's legal representative mails, by certified mail, to the third party or the third party's insurer: (1) a copy of the notice required by subsection (4)(a), or (2) a statement stating that the recipient has applied for or has received medical assistance from the Department in connection with the same claim; or (c) the recipient or the recipient's legal representative has commenced an action against the third party or the third party's insurer for damages or compensation for personal injury, disease, illness, or disability for which the Department has paid or may pay medical assistance, in whole or in part, and the Department files in the court in which the action is pending a notice of lien stating that a lien is claimed for medical assistance on any money paid in satisfaction of any judgment or in settlement of the action and that: (1) medical assistance in a stated amount has been paid by the Department on behalf of the recipient; or (2) medical assistance may be paid on behalf of the recipient. MCA 53-2-612(5)(b). If a third party or the third party's insurer that has received notice of the Department's lien as set forth in subsection (5)(b) makes payment in whole or in part of the recipient's claim without first satisfying the lien of the Department, the third party or

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the third party's insurer is liable to the Department for the amount the Department is entitled to receive under this section. *Id*. 53-2-612(5)(a).

Definitions

"Legal representative" means an attorney having or exercising authority on behalf of a recipient with respect to a claim or action to recover damages or compensation from a third party or a third party's insurer.

"Recipient" means a person on whose behalf the Department has paid or may pay medical assistance for the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability. If the context allows, the term includes a recipient's legal representative.

"Third party" means an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the Department and includes but is not limited to insurers, health service organizations, and parties liable or who may be liable in tort. MCA 53-2-612(6)(a)-(c).

NEBRASKA

Right of Subrogation

An application for medical assistance shall give a right of subrogation to the Department of Health and Human Services or its assigns. Neb. Rev. St. § 68-716. Subject to §§ 68-921 to 68-925, subrogation shall include every claim or right which the applicant may have against a third party when such right or claim involves money for medical care. *Id*. The third party shall be liable to make payments directly to the Department or its assigns as soon as he or she is notified in writing of the valid claim for subrogation under this section. *Id*.

An application for county general assistance or for county health services shall give a right of subrogation to the county furnishing such aid. Neb. Rev. St. § 68-150. Subject to sections 68-921 to 68-925, subrogation shall include every claim or right which the applicant may have against a third party when such claim or right involves money for medical care. *Id*. The third party shall be liable to make payments directly to the county as soon as he or she is notified in writing of the valid claim for subrogation under this section. *Id*.

Assignment of Rights

The application for medical assistance shall constitute an automatic assignment of the rights specified in this section to the Department or its assigns effective from the date of eligibility for such assistance. Neb. Rev. St. § 68-916. The assignment shall include the rights of the applicant or recipient and also the rights of any other member of the assistance group for whom the applicant or recipient can legally make an assignment. *Id*.

Pursuant to section 68-916 and subject to sections 68-921 to 68-925, the applicant or recipient shall assign to the Department or its assigns any rights to medical care support available to him or her to other members of the assistance group under an order of a court or administrative agency and any rights to pursue or receive payments from any third party liable to pay for the cost of medical care and services arising out of injury, disease, or disability of the applicant or recipient or other members of the assistance group which otherwise would be covered by medical assistance. *Id*. Medicare benefits shall not be assigned pursuant to this section. *Id*. Rights assigned to the Department or its assigns under this section may be directly reimbursable to the Department or its assigns by liable third parties, as provided by rule or regulation of the Department, when prior notification of the assignment has been made to the liable third party. *Id*.

Failure to Cooperate

Refusal by the applicant or recipient specified in section 68-916 to cooperate in obtaining reimbursement for medical care or services provided to him or herself or any other member of the assistance group renders the applicant or recipient ineligible for assistance. Neb. Rev. St. § 68-917. Ineligibility shall continue for so long as such person refuses to cooperate. *Id*.

NEBRASKA

Waiver of Cooperation

Cooperation may be waived by the Department upon a determination of the reasonable likelihood of physical or emotional harm to the applicant, recipient, or other member of the assistance group if the applicant or recipient were to cooperate. *Id*. Eligibility shall continue for any individual who cannot legally assign his or her own rights and who would have been eligible for assistance but for the refusal by another person, legally able to assign such individual's rights, to cooperate as required by this section. *Id*.

NEVADA

Right of Subrogation

When a recipient of Medicaid or a recipient of insurance provided pursuant to the Children's Health Insurance Program incurs an illness or injury for which medical services are payable by the Department and which is incurred under circumstances creating a legal liability in some person other than the recipient or a division of the Department to pay all or part of the costs of such medical services, the Department is subrogated to the right of the recipient to the extent of all such medical costs and may join or intervene in any action by the recipient or any successors in interest to enforce such legal liability. N.R.S. 422.293(1).

If a recipient or any successors in interest fail or refuse to commence an action to enforce the legal liability, the Department may commence an independent action, after notice to the recipient or successors in interest, to recover all medical costs to which it is entitled. *Id*. 422.293(2). In any such action by the Department, the recipient or successors in interest may be joined as third party defendants. *Id*.

Automatic Lien

In any case where the Department is subrogated to the rights of the recipient or any successors in interest as provided above in section 1, the Department has a lien upon the proceeds of any recovery from the persons liable, whether the proceeds of the recovery are by way of judgment, settlement or otherwise. *Id*. 422.293(3). Such a lien must be satisfied in full, unless reduced pursuant to subsection 4, at such time as:

> (a) The proceeds of any recovery or settlement are distributed to or on behalf of the recipient, the successors in interest or the attorney of the recipient; and
>
> (b) A dismissal by any court of any action brought to enforce the legal liability established by subsection 1. *Id*. 422.293(3)(a)-(b).

If the Department receives notice pursuant to NRS 422.293001, the Director or a representative designated by the Director may, in consideration of the legal services provided by an attorney to procure a recovery for the recipient, reduce the lien on the proceeds of any recovery. *Id*. 422.293(4).

The attorney of a recipient shall not condition the amount of attorney's fees or impose additional attorney's fees based on whether a reduction of the lien is authorized by the Director or a designated representative pursuant to subsection 4. *Id*. 422.293(5).

Notice Requirements

A recipient, upon assertion of a claim against a third party to which the Department is subrogated pursuant to NRS 422.293, or the attorney of the recipient, upon agreeing to represent the

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recipient, shall provide notice to the Department and must include, without limitation, the following:

(a) The name of the recipient;

(b) The social security number of the recipient;

(c) The date of birth of the recipient;

(d) The name of the attorney of the recipient, if applicable;

(e) The name of any person against whom the recipient is making a claim, if known;

(f) The name of any insurer of any person against whom the recipient is making a claim if known;

(g) The date of the incident giving rise to the claim; and

(h) A short statement identifying the nature of the recipient's claim or the terms of any settlement, judgment or award. *Id*. 422.293001(2)(a)-(h).

Any statute of limitations applicable to any claim or action by the Department is tolled until such time as the Department receives the notice required. *Id*. 422.293001(3). The term "claim," as used above, means a right to payment, whether or not the right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured or unsecured. *Id*. 422.293001(4).

Upon receiving the notice, the Department shall, within thirty days, provide written notice to the recipient or the attorney of the recipient and to the third party. *Id*. 422.293003. The written notice must include, without limitation, the name of the recipient and the amount of the Department's lien. *Id*. No lien created pursuant to NRS 422.293 is enforceable unless written notice is first given to the person against whom the lien is asserted or the attorney of the person against whom the lien is asserted. *Id*.

Failure to Comply

Except as otherwise provided in subsection 2, any person who fails to comply with the provisions of NRS 422.293 and 422.293001 is liable to the Department for: (a) the total amount of the Department's lien created pursuant to NRS 422.293, and (b) any attorney's fees and litigation expenses incurred by the Department in enforcing the Department's rights pursuant to NRS 422.293 and 422.293001. N.R.S. 422.293005(1)(a)-(b). A person other than the recipient

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is not liable to the Department if the court determines that the failure to provide notice was caused by excusable neglect. *Id*. 422.293005(2).

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Assignment of Rights

Any person who is a recipient of financial assistance, medical assistance, old age assistance, aid to the needy blind, Medicaid for employed adults with disabilities, or aid to the permanently and totally disabled shall, by his acceptance of such assistance, be deemed to have assigned any claim or right of action against any person or party to the Commissioner of Health and Human Services, to the extent that such assistance is furnished. N.H. Rev. Stat. § 167:14-a(I).

Whenever a recipient of financial assistance, medical assistance, old age assistance, aid to the needy blind, Medicaid for employed adults with disabilities, or aid to the permanently and totally disabled shall have a legally cognizable claim against any person or party for expenses or support and the Department of Health and Human Services has already furnished assistance to such recipient, the amount of assistance furnished may be recovered in an action brought in the name of the state from such person or party against whom the recipient has a legally cognizable claim for expenses or support. *Id*. § 167:14(a)(II).

Settlement or Award from a Liable Third Person

The State Medical Assistance Program is the payer of last resort and shall provide medical coverage only when there are no other available resources. *Id*. § 167:14-a(III). Whenever a recipient of medical assistance shall receive or receives a settlement or an award from a liable third person or party, such recipient shall repay the amount of medical assistance furnished by the State to the extent that the amount of the recovery makes repayment possible. *Id*. If a recipient of medical assistance receives a settlement or an award from a third party, the settlement or award is subject to disbursement as follows:

> The Commissioner may recover the full amount of medical assistance furnished by the State from the portion of any settlement or judgment reasonably attributable to medical expenses. *Id*. § 167:14-a(III-a). The Commissioner may waive or reduce the amount due the State for good cause upon written request from a recipient or recipient's attorney. The acceptance of any waiver or the payment of any reduced amount due shall create a rebuttable presumption that the apportionment was equitable in any action brought pursuant to paragraph IV.
>
> A disbursement of any award, judgment, or settlement shall not be made to a recipient without the recipient or the recipient's attorney, first providing at least thirty days written notice of any scheduled trial, alternative dispute resolution hearing, or settlement to the Commissioner that the recipient has a claim which could result in a recovery from a third party or obtaining from the Commissioner a written release of any obligation owed to the State for medical assistance provided to the recipient. *Id*. § 167:14-a(IV). The Commissioner shall notify the recipient or the recipient's attorney of the amount of the Commissioner's claim within twenty-one days of the notice. *Id*. If a dispute arises

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between the recipient and the Commissioner as to the settlement of any claim that arises under this section, the third party or the recipient's attorney shall withhold from disbursement to the recipient or to any legal instrument created for the benefit of the recipient, an amount equal to the Commissioner's claim. *Id*. Either party may apply to the superior court or the district court in which an action based upon the recipient's claim could have been commenced for an order to determine an equitable apportionment between the Commissioner and the recipient of the amount withheld. *Id*.

The court shall have broad discretion to apportion the amount withheld as justice may require. *Id*. An order of apportionment has the effect of a judgment. The obligation of a third party under this section to withhold all or part of a disbursement is conditional upon the receipt by the third party of written notice from the Commissioner, the recipient, or the recipient's attorney that the Commissioner is asserting a claim. *Id*.

Recovery upon Death

All property, real or personal, in a revocable trust is subject to recovery by the Department for recovery for any medical assistance provided the decedent. *Id*. § 167:14-a(V). Upon the death of the grantor, the Department shall provide the trustee with a statement containing the amount of medical assistance which was provided to the decedent.

For purposes of recovering the costs of medical assistance, the estate of a recipient shall include all property, real or personal, which at the time of a recipient's death was held by the recipient in joint tenancy with rights of survivorship, or life estate for all such title or interest established on or after July 1, 2005. *Id*. § 167:14-a(VI)(a). Recovery shall be limited to the value of the recipient's ownership interest and in no case shall such amount exceed the total amount of medical assistance provided to the deceased recipient, nor shall recovery extend to any interest in property, real or personal, for which a non-recipient owner paid fair market value at the time said ownership interest was acquired. *Id*.

No sooner than forty-five days from the death of the recipient, the Department shall provide the other joint owner or owners notice of the Department's claim. *Id*. 167:14-a(VI)(b). Written notice shall include a description of all categories of individuals exempt from recovery by reason of familial status as allowed under 42 U.S.C. § 1396p(b)(2) and RSA 167:16-a, IV, as well as the availability and method of requesting a hardship waiver. *Id*. Within thirty days of the receipt of notification of the Department's claim, the joint owner or owners shall acknowledge receipt of the Department's claim and, provided that there shall not be undue hardship imposed upon the surviving joint owner or owners, either tender an amount equal to the deceased recipient's interest in the identified property and/or financial instrument to the state of New Hampshire toward the deceased's medical assistance bill, but such amount shall not exceed the total amount of medical assistance provided to the deceased recipient or enter into a binding agreement to make such payment as soon as is practicable. *Id*. If the joint owner or owners refuse to

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acknowledge receipt of the Department's claim or to tender payment or fail to fulfill the agreement to pay without good cause, the Commissioner may bring an action in superior court or probate court, as the case may be, to compel such payment. *Id*.

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Duty of the Commissioner

The Commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the state of New Jersey the maximum federal participation that is available with respect to a program of medical assistance, including the following:

> To take all reasonable measures to ascertain the legal or equitable liability of third parties to pay for care and services arising out of injury, disease, or disability; where it is known that a third party has a liability, to treat such liability as a resource of the individual on whose behalf the care and services are made available for purposes of determining eligibility; and in any case where such liability is found to exist after medical assistance has been made available on behalf of the individual, to seek reimbursement for such assistance to the extent of such liability. N.J.S.A. 30:4D-7(k).

Enforcement Action

The Commissioner may request the Attorney General to enforce any rights against any third party, institute legal proceedings against any third party, or intervene in any pending proceeding against a third party initiated by a recipient, his guardian, executor, administrator or other appropriate representative, either in the Commissioner's own name, as subrogee of the rights of the recipient, or to enforce the Commissioner's rights as assignee of the recipient. N.J.S.A. 30:4D-7.1(a). If such a legal proceeding is instituted by the AG, written notice shall be given to the recipient or his guardian, executor, administrator or other appropriate representative, who shall then have the right to intervene in the proceeding. *Id*. Any recovery by the recipient in excess of the outstanding claim of the division shall be treated as a resource of said individual for purposes of determining eligibility for assistance. *Id*.

Written Notice

When a recipient, his guardian, executor, administrator or other appropriate representative brings an action for damages against a third party, written notice shall be given to the Director of the Division of Medical Assistance and Health Services. N.J.S.A. 30:4D-7.1(b). In addition, every recipient or his legal representative shall promptly notify the Division of any recovery from a third party and shall immediately reimburse the Division in full from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party subject to a pro rata deduction for counsel fees, costs, or other expenses incurred by the recipient or the recipient's attorney; provided, however, that the Director may make application to a court of competent jurisdiction for an award of counsel fees and costs incurred in the pursuit of a claim. *Id*.

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Any settlement, judgment, dismissal, exchange of releases, or action affecting the disposition of a recipient's independent action against a third party shall not serve to bar a claim or cause of action brought by the AG on behalf of the Commissioner against that third party. *Id*.

In addition, every recipient, as a condition of eligibility for medical assistance, is deemed to have assigned to the Commissioner any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party. N.J.S.A. 30:4D-7.1(c).

Definitions

"Applicant" means any person who has made application for purposes of becoming a "qualified applicant". N.J.S.A. 30:4D-3(a).

"Commissioner" means the Commissioner of Human Services. N.J.S.A. 30:4D-3(b).

"Recipient" means any qualified applicant receiving benefits under the Medical Assistance and Health Services Act. N.J.S.A. 30:4D-3(j).

"Third party" means any person, institution, corporation, insurance company, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. § 1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under P.L. 1968, c. 413. N.J.S.A. 30:4D-3(m).

NEW MEXICO

Sections 21-2-1 through 27-2-34 of N.M.S.A., 1978, are in reference to the Public Assistance Act.

Enforcement Action

The Income Support Division of the Human Services Department shall make reasonable efforts to ascertain any legal liability of third parties who are or may be liable for pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance. N.M.S.A. 1978, § 27-2-23(A).

Right of Subrogation

When the Department makes medical assistance payments on behalf of a recipient, the Department is subrogated to any right of the recipient against a third party for recovery of medical expenses to the extent that the Department has made payment. *Id*. § 27-2-23(B). "Subrogation" to which State Health and Social Services Department is entitled under statute providing that Department is subrogated to any right of recipient of medical assistance against third party for recovery of medical expenses is a right of recovery subject to equitable principles. *White v. Sutherland*, 92 N.M. 187 (1978).

Health insurers, including self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers or other parties, that are, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business with New Mexico, shall:

> (1) provide, with respect to individuals who are eligible for or are provided medical assistance under the Medicaid program, upon the request of the state, information to determine during what period the individual, the individual's spouse or the individual's dependents may be, or may have been, covered by a health insurer and the nature of the coverage provided by the health insurer, including the name, address and identifying number of the plan;
>
> (2) accept New Mexico's right of recovery and the assignment to New Mexico of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the Medicaid program;
>
> (3) respond to any inquiry by New Mexico regarding a claim for payment for any health care item that is submitted no later than three years after the date of the provision of such health care item or service; and

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(4) agree not to deny a claim submitted by New Mexico solely on the basis of the date of submission of the claim by the provider, the type of the claim form or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

(a) the claim is submitted by New Mexico within the three-year period beginning on the date on which the item or service was furnished; and

(b) any action by New Mexico to enforce its rights with respect to such claim is commenced within six years of New Mexico's submission of such claim. *Id.* § 27- 2-23(c)(1)-(4).

Assistance

Assistance granted under this act shall not be transferable or assignable, at law or in equity, and none of the money paid or payable under this act shall be subject to execution, levy, attachment, garnishment or other legal process, or to the operation or any bankruptcy or insolvency law. N.M.S.A. 1978, § 27-2-21.

Assignment of Rights

An application for public assistance by any person constitutes an assignment by operation of law of any support rights the person is entitled to during the time the person's household receives public assistance, whether the support rights are owed to the applicant or to any family member for whom the applicant is applying for or receiving assistance. N.M.S.A. 1978, § 27-2-28(F).

By operation of law, an assignment to the Department of any and all rights of an applicant for or receipt of medical assistance under the Medicaid program in New Mexico or supplemental security income through the social security administration:

(1) is deemed to be made of:

(a) any payment for medical care from any person, firm or corporation, including an insurance carrier, and

(b) any recovery for personal injury, whether by judgment or contract for compromise or settlement;

(2) shall be effective to the extent of the amount of medical assistance actually paid by the Department under the Medicaid program; and

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(3) shall be effective as to the rights of any other individuals who are eligible for medical assistance and whose rights can legally be assigned by the applicant or recipient. *Id*. § 27- 2-28(G).

An applicant or recipient must cooperate fully with the Department in its efforts to secure the assignment and to execute and deliver any instruments and papers deemed necessary to complete the assignment by the Department. *Id*.

NEW YORK

Assignment of Rights

A recipient of medical care must assign to the State and Social Services District any rights against any third party for support and payment of medical care. N.Y. Comp. Codes R. & Regs. tit. 18 § 360-7.4(a)(4). The State will seek reimbursement from a liable third party only if the expected amount of reimbursement is more than the costs of making the recovery. N.Y. Comp. Codes R. & Regs. tit. 18 § 360-7.4(a)(5).

Right of Subrogation

The State will be subrogated to any rights the recipient may have to medical support or third party reimbursement when the state provides medical assistance to a recipient. N.Y. Comp. Codes R. & Regs. tit. 18 § 360-7.4(a)(6). If the District finds that the third party has paid or will pay within a reasonable time, then the District will only pay the amount by which the allowable medical assistance claim exceeds the third party liability. N.Y. Comp. Codes R. & Regs. tit. 18 § 360-7.4(b). However, if the payment will not be made within a reasonable time, the District can file a lien covering the costs of such assistance. *Id*. An individual who is an applicant or recipient of medical assistance must cooperate with the State or District in helping to identify any third party who may be liable to pay for the care. N.Y. Comp. Codes R. & Regs. tit. 18 § 360- 7.4(a)(3). A recipient must provide information to the State to assist in pursuing a third party. *Id*. The recipient may refuse to cooperate in the pursuit of a third party only for good cause. *Id*.

The lien cannot exceed the total of amount of the assistance provided by the State. N.Y. Soc. Serv. Law § 104-b(1) (McKinney). The State should be notified of any commencement by a recipient against a third party where the State has provided medical assistance. *Id*. The third party must notify the District by certified or registered mail at least ten days prior to the date they intend to make payment on a personal injury claim upon which the State has filed a lien. N.Y. Soc. Serv. Law § 104-b(5)(a) (McKinney). The State will have five days to amend their lien to include any additional payments that have been made since the last amended lien was filed. N.Y. Soc. Serv. Law § 104-b(5)(b) (McKinney). The failure to give notice will result in the third party being liable for the same amount it would have been had the State been given timely notice and amended its lien. N.Y. Soc. Serv. Law § 104-b(5)(c) (McKinney). Attorney fees are not deducted from the State's lien because there is no basis to require the State to pay a proportionate share of attorneys' fees. *Rahl v. Hayes 73 Corp*., 99 A.D.2d 529, 530 (N.Y. App. Div. 1984).

NORTH CAROLINA 

Assignment of Rights

By accepting medical assistance under the Medical Assistance Program, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled. N.C.G.S.A. § 108A-59(a). It is the responsibility of the county attorney of the county from which the medical assistance benefits are received or an attorney retained by that county and/or the State to enforce the right of assignment. *Id*. The responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources. *Id*. 108A-59(b). In all actions brought pursuant to subsection (a) to obtain reimbursement for payments for medical services, liability shall be determined on the basis of the same laws and standards, including bases for liability and applicable defenses, as would be applicable if the action were brought by the individual on whose behalf the medical services were rendered. *Id*. 108A-59(c).

Subrogation Rights

To the extent of payments under the Medical Assistance Program, the State shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. N.C.G.S.A. § 108A-57(a). Under this section, to the extent of Medical Assistance payments made to a Medicaid recipient, the State or county providing the payments is "subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of assistance," means those common law, statutory or contractual causes of action whereby the sick or injured Medicaid recipient or another person legally responsible to pay the cost of his medical care can recover damages from another person for the cost of treating his sickness or injury. 52 Op.Atty.Gen. 52, Brannon, Dec. 7, 1982. These "rights of recovery" include, but are not necessarily limited to, causes of action arising in tort or under workers compensation. *Id*.

A personal injury or wrongful death claim brought by a medical assistance beneficiary against a third party shall include a claim for all medical assistance payments for health care items or services furnished to the medical assistance beneficiary as a result of the injury. Id. Said claim is referred to as the "Medicaid claim." N.C.G.S.A. § 108A-57(a). Any personal injury or wrongful death claim brought by a medical assistance beneficiary against a third party that does not state the Medicaid claim shall be deemed to include the Medicaid claim. *Id*.

If the amount of the Medicaid claim does not exceed one-third of the medical assistance beneficiary's gross recovery, it is presumed that the gross recovery includes compensation for the full amount of the Medicaid claim. *Id*. § 108A-57(a1). If the amount of the Medicaid claim exceeds one-third of the medical assistance beneficiary's gross recovery, it is presumed that one- third of the gross recovery represents compensation for the Medicaid claim. *Id*. A medical assistance beneficiary may dispute these presumptions by applying to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then

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to a court of competent jurisdiction, for a determination of the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim. *Id*. This application must be filed with the court and served on the Department pursuant to the Rules of Civil Procedure no later than thirty days after the date that the settlement agreement is executed by all parties and, if required, approved by the court, or in cases in which judgment has been entered, no later than thirty days after the date of entry of judgment. *Id*. The court shall hold an evidentiary hearing no sooner than thirty days after the date the action was filed. *Id*. All of the following must apply to the court's determination:

> (1) The medical assistance beneficiary has the burden of proving by clear and convincing evidence that the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim is less than the portion presumed under subsection (a1).
>
> (2) The presumption arising under subsection (a1) is not rebutted solely by the fact that the medical assistance beneficiary was not able to recover the full amount of all claims.
>
> (3) If the beneficiary meets its burden of rebutting the presumption arising under subsection (a1), then the court shall determine the portion of the recovery that represents compensation for the Medicaid claim and shall order the beneficiary to pay the amount so determined to the Department in accordance with subsection (a5) as outlined below. In making this determination, the court may consider any factors that it deems just and reasonable.
>
> (4) If the beneficiary fails to rebut the presumption arising under subsection (a1), then the court shall order the beneficiary to pay the amount presumed pursuant to subsection (a1) to the Department in accordance with subsection (a5). N.C.G.S.A. § 108A-57(a2)(1)-(4).

Notwithstanding the presumption arising pursuant to subsection (a1) of this section, the medical assistance beneficiary and the Department may reach an agreement on the portion of the recovery that represents compensation for the Medicaid claim. *Id*. § 108A-57(a3). If such an agreement is reached after an application has been filed pursuant to subsection (a2) as outlined above, a stipulation of dismissal of the application signed by both parties shall be filed with the court. *Id*.

Within thirty days of receipt of the proceeds of a settlement or judgment related to a Medicaid claim, the medical assistance beneficiary or any attorney retained by the beneficiary must notify the Department of the receipt of the proceeds. *Id*. § 108A-57(a4). The medical assistance beneficiary or any attorney retained by the beneficiary shall, out of the proceeds obtained by or on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third

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party by reason of injury or death, distribute to the Department the amount due pursuant to this section as follows:

(1) If, upon the expiration of the time for filing an application under subsection (a2), no application has been filed, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within thirty days of the beneficiary's receipt of the proceeds, in the absence of an agreement pursuant to subsection (a3).

(2) If an application has been filed pursuant to subsection (a2) and no agreement has been reached pursuant to subsection (a3), then the Department shall be paid as follows:

a. If the beneficiary rebuts the presumption arising under subsection (a1), then the amount determined by the court pursuant to subsection (a2), as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within thirty days of the entry of the court's order.

b. If the beneficiary fails to rebut the presumption arising under subsection (a1), then the amount presumed pursuant to subsection (a1), as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within thirty days of the entry of the court's order.

(3) If an agreement has been reached pursuant to subsection (a3), then the agreed amount, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the Department within thirty days of the execution of the agreement by the medical assistance beneficiary and the Department. N.C.G.S.A. § 108A-57(a5)(1)-(3).

Penalties

It is a Class 1 misdemeanor for any person seeking or having obtained assistance under the Medical Assistance Program for himself or another to willfully fail to disclose to the county Department of Social Services or its attorney and to the Department the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise. *Id*. § 108A-57(b).

As required to ensure compliance with § 108A-57, the Department may apply to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction for enforcement of this section. *Id*. § 108A-57(d).

NORTH CAROLINA

Definitions

All references to a "subsection" are subsections within N.C.G.S.A. § 108A-57.

"Department" means the Department of Health and Human Services.

NORTH DAKOTA

Assignment of Rights

Each applicant or recipient of benefits under Chapter 50-24.1, titled Medical Assistance for Needy Persons, must be deemed to have assigned, to the Department, any right of recovery the applicant of recipient may have for medical costs incurred under this chapter not exceeding the amount of funds expended by the Department for the care and treatment of the applicant or recipient. NDCC § 50-24.1-02.1(1).

The Department shall seek recovery of reimbursement from a third party up to the full amount of medical assistance paid. NDCC § 50-24.1-30(1). A medical assistance recipient must inform the Department of any rights the recipient has to third party benefits and shall inform the Department of the name and address of any individual, entity, or program that is or may be liable to provide third party benefits. *Id*. § 50-24.1-30(2). A release or satisfaction of a cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement is not valid or effectual as against a claim under this chapter unless the Department joins in the release or satisfaction or executes a release of its claim. *Id*. § 50-24.1-30(3). The Department shall recover the full amount of all medical assistance provided on behalf of a recipient to the full extent of third party benefits received by the recipient or the Department for medical expenses. *Id*. § 50-24.1- 30(4). The Department shall recover the third party benefits directly from any third party or from the recipient or legal representative, if the recipient or legal representative has received third party benefits, up to the amount of medical assistance provided to the recipient. *Id*. An applicant for or recipient of medical assistance shall cooperate in the recovery of third party benefits. *Id*. § 50- 24.1-30(4).

Right of Recovery

The Department shall seek recovery of reimbursement from a third party up to the full amount of medical assistance paid. NDCC § 50-24.1-30(2). A medical assistance recipient must inform the Department of any rights the recipient has to third party benefits and shall inform the Department of the name and address of any individual, entity, or program that is or may be liable to provide third party benefits. *Id*. § 50-24.1-30(3). A release or satisfaction of a cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement is not valid or effectual as against a claim under this chapter unless the Department joins in the release or satisfaction or executes a release of its claim. *Id*. § 50-24.1-30(4).

The Department shall recover the full amount of all medical assistance provided on behalf of a recipient to the full extent of third party benefits received by the recipient or the Department for medical expenses. *Id*. § 50-24.1-30(5). The Department shall recover the third party benefits directly from any third party or from the recipient or legal representative, if the recipient or legal representative has received third party benefits, up to the amount of medical assistance provided

NORTH DAKOTA

to the recipient. *Id*. An applicant for or recipient of medical assistance shall cooperate in the recovery of third party benefits. *Id*. § 50-24.1-30(6).

Enforcement Actions

To enforce its rights to third party benefits, the Department may institute, intervene in, or join any legal or administrative proceeding in its own name.

Written Notice

If either the recipient or the Department brings an action against a third party, the recipient or the Department must provide to the other within thirty days after commencing the action written notice by personal delivery or registered mail of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If either the Department or the recipient brings an action, the other may become a party to or may consolidate an action brought independently with the other. A judgment, award, or settlement of a claim in an action by a recipient to recover damages for injuries or other third party benefits in which the Department has an interest may not be satisfied or released without first giving the Department notice and a reasonable opportunity to file and satisfy its claim or proceed with any action as otherwise permitted by law. NDCC § 50-24.1-30(6)(a)-(b).

A recipient who has notice or who has actual knowledge of the Department's rights to third party benefits who receives any third party benefit or proceeds for a covered illness or injury is either required to pay the Department within sixty days after receipt of settlement proceeds the full amount of the third party benefits up to the total medical assistance provided or to place a sum equal to the full amount of the total medical assistance provided in a trust account pending judicial or administrative determination of the Department's right to the third party benefits. *Id*. § 50-24.1-30(8).

The Department is not required to seek reimbursement from, or may reduce or compromise a claim against, a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost-effectiveness is determined based on the following: (a) actual and legal issues of liability as may exist between the recipient and the liable party; (b) total funds available for settlement; and (c) an estimate of the cost to the Department of pursuing its claim. *Id*. § 50-24.1-30(9).

Statute of Limitations

The statute of limitations does not run against claims of the state of North Dakota for repayment of medical assistance provided under this chapter. NDCC § 50-24.1-08.

NORTH DAKOTA

Definitions

"Department" means the Department of Human Services. NDCC § 50-24.1-00.1.

"Third party" means an individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance under §§ 50-24.1-30 and 50-24.1-02.1. NDCC § 50-24.1-00.1.

OHIO

Assignment of Rights

A medical assistance recipient's enrollment in a medical assistance program gives an automatic right of recovery to the Department of Medicaid against the liability of a third party for the cost of medical assistance paid on behalf of the recipient. Ohio Rev. Code § 5160.37(A). Any action or claim brought by a medical assistance recipient against a third party that results in any payment, settlement or compromise is subject to the recovery right of the Department of Medicaid. *Id*. An exception to that rule is if a medical assistance recipient receives medical assistance through a Medicaid managed care organization, then the Department's claim shall not exceed the amount of medical assistance paid by the Department on behalf of the recipient. *Id*. The Department will not be precluded from enforcing its rights under section 5160.37 when a payment, settlement, compromise, judgment, or award excludes the cost of medical assistance paid for by the Department. *Id*.

Written Notice

The medical assistance recipient and the recipient's attorney shall cooperate with the Department by providing a written notice of an activity or a filing of a legal recovery action against a third party. Ohio Rev. Code § 5160.37(C). The notice must come within thirty days after the initiation of any of the preceding activities. *Id*.

A settlement, compromise, judgment, or award that a medical assistance recipient receives shall not be made final if the Department has a right of recovery. Ohio Rev. Code § 5160.37(E). If notice is not given by the recipient or the recipient's attorney then both individuals are liable to reimburse the Department for the recovery received to the extent of medical assistance payments made by the Department. *Id*.

Attorney's Fees

Attorneys' fees cannot exceed one-third of the total judgment, award, or settlement. Ohio Rev. Code § 5160.37(G)(2). Attorney fees, costs and other expenses that are incurred by the medical assistance recipient in securing the judgment, award, or settlement will first be deducted from the total judgment, award, or settlement. *Id*. After the deduction is made, there shall be a rebuttable presumption that the Department shall receive no less than one-half of the remaining amount, or the actual amount of medical assistance paid, whichever is less. *Id*.

Enforcement Action

The Department has a right to intervene or join any action brought by the medical assistance recipient against any third party who may be liable for the cost of medical assistance paid. Ohio Rev. Code § 5160.37(H)(1). The Department may also institute and pursue legal proceedings against any third party who may be liable for the cost of medical assistance paid, or initiate legal proceedings in conjunction with any injured medical assistance recipient or the recipient's

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attorney or representative. Ohio Rev. Code § 5160.37(H)(2)(3). The medical assistance recipient shall not assess attorney fees, costs, or other expenses against the Department when the Department enforces its right of recovery. Ohio Rev. Code § 5160.37(I).

A recipient of medical assistance may rebut the Department's recovery by successfully showing clear and convincing evidence that a different allocation is warranted. Ohio Rev. Code § 5160.37(L)(2). The recipient may also file an administrative appeal with the Medicaid Director. Ohio Rev. Code § 5160.37(M)(1). A decision made by the Medicaid Director is final and binding on the Department. *Id*.

OKLAHOMA

On and after July 1, 1993, the Oklahoma Health Care Authority shall be the state entity designated by law to assume the responsibilities for the preparation and development for converting the present delivery of the Oklahoma Medicaid Program to a managed care system. 63 Okl. St. § 5009.

The payment of medical expenses by the Authority for or on behalf of or the receipt of medical assistance by a person who has been injured or who has suffered a disease as a result of the negligence or act of another person creates a debt to the Authority, subject to recovery by legal action pursuant to this section. 63 Okl. St. § 5051.1(A)(1). The payment of medical expenses by the Authority for or on behalf of a person who has been injured or who has suffered a disease, and either has a claim or may have a claim against an insurer, to the extent recoverable, creates a debt to the Authority whether or not such person asserts or maintains a claim against an insurer. *Id*. § 5051.1(A)(2).

Assignment of Rights

Whenever the Authority pays for medical services or renders medical services, for or on behalf of a person who has been injured or suffered an illness or disease, the right of the provider of the services to reimbursement shall be automatically assigned to the Authority, upon notice to the insurer or other party obligated as a matter of law or agreement to reimburse the provider on behalf of the patient. 63 Okl. St. § 5051.2(A). Upon the assignment, the Authority, for purposes of the claim for reimbursement, becomes a provider of medical services. *Id*. § 5051.2(B). The assignment of the right to reimbursement shall be applied and considered valid against any employer or insurer under the Workers' Compensation Act. *Id*. § 5051.2(C).

Each insurer, upon receiving a claim from the Authority, shall accept the State's right to recovery, to process and, if appropriate, pay the claim to the same extent that the plan would have been liable if it had been billed at the point of sale or by the original provider of services. *Id*. § 5051.2(D). Insurer shall not deny the Authority claims on the basis of the date of submission, the format of the claim, or for failure to present proper documentation of coverage at the point of sale. *Id*. Insurer shall make appropriate payments to the Authority as long as the claim is submitted for consideration within three years from the date the service was furnished. *Id*. § 5051.2(E). Any action by the Authority to enforce the payment of the claim shall be commenced within six years of the submission of the claim by the Authority. *Id*. § 5051.2(E).

Notice to Recipients

The Authority must provide notice to all recipients of medical assistance at the time of application for such assistance of their obligation to report any claim or action, and any judgment, settlement or compromise arising from the claim or action, for injury or illness for which the Authority makes payments for medical assistance. *Id*. § 5051.1(B).

OKLAHOMA

The recipient of medical assistance from the Authority for an injury or disease who asserts a claim or maintains an action against another on account of the injury or disease, or the recipient's legal representative, must notify the Authority of the claim or action and of any judgment, settlement or compromise arising from the claim or action prior to the final judgment, settlement or compromise. *Id*. § 5051.1(C).

Rights of the Authority

If the injured or diseased person asserts or maintains a claim against another person or tortfeasor on account of the injury or disease, the Authority shall:

(1) Have a lien upon payment of the medical assistance to the extent of the amount so paid upon that part going or belonging to the injured or diseased person of any recovery or sum had or collected or to be collected by the injured or diseased person up to the amount of the damages for the total medical expenses, or by the heirs, personal representatives or next of kin in case of the death of the person, whether by judgment or by settlement or compromise. The lien shall:

> (a) be inferior only to a lien or claim of the attorney or attorneys handling the claim on behalf of the injured or diseased person, the heirs or personal representative;
>
> (b) not be applied or considered valid against any temporary or permanent disability award of the claimant due under the Workers' Compensation Act;
>
> (c) be applied and considered valid as against any insurer adjudged responsible for medical expenses under the Workers' Compensation Act; and
>
> (d) be applied and considered valid as to the entire settlement, after the claim of the attorney or attorneys for fees and costs, unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence.

(2) May take any other legal action necessary to recover the amount so paid or to be paid to the injured or diseased person or to the heirs, personal representative or next of kin in case of the death of the person; and

(3) Shall have the right to file a written notice of its lien in any action commenced by the injured or diseased person. 63 Okl. St. § 5051.1(D)(1)-(3).

In order to secure and enforce the right of recovery or reimbursement on behalf of the injured or diseased person, the Authority may initiate and prosecute any action or proceeding against any other person or tortfeasor who may be liable to the injured or diseased person, if the injured or diseased person has not initiated any legal proceedings against the other person or tortfeasor. *Id*. § 5051.1(E). Any person or insurer that has been notified by the authority of a claim of lien authorized by this section and who, directly or indirectly, pays to the recipient any money as a

OKLAHOMA

settlement or compromise of the recipient's claim arising out of the injury shall be liable to the Authority for the money value of the medical assistance rendered by the Authority in an amount not in excess of the amount to which the recipient was entitled to recover from the tortfeasor or insurer because of the injury. *Id*. § 5051.1(F).

Notice to the Authority

A Medicaid recipient must notify the Authority prior to a compromise or settlement against a third party in which the Authority has provided or has become obligated to provide medical assistance. *Id*. § 5051.1(H).

Definitions

"Insurer" means any insurance company that administers accident and health policies or plans or that administers any other type of insurance policy containing medical provisions, and any nonprofit hospital service and indemnity and medical service and indemnity corporation, actually engaged in business in Oklahoma, regardless of where the insurance contract is written, or plan is administered or where such corporation is incorporated.

"Medical expenses" includes the cost of hospital, medical, surgical and dental services, care and treatment, rehabilitation, and prostheses and medical appliances, and nursing and funeral services.

"Person" includes, in addition to an individual, the guardian of an individual, and the administrator or executor of the estate of an individual, and a corporation. *Id*. § 5051.1(I)(1)-(3).

OREGON

Notice Requirements

If any applicant or recipient makes a claim or, without making a claim, begins an action to enforce such claim, the applicant or recipient, or the attorney for the applicant or the recipient, shall immediately notify the Department of Human Services or the Oregon Health Authority and the recipient's coordinated care organization, if the recipient is receiving services from the organization. If an applicant or recipient, or the attorney for the applicant or the recipient, has given notice that the applicant or recipient has made a claim, it shall not be necessary for the applicant or recipient, or the attorney for the applicant or the recipient, to give notice that the applicant or recipient has begun an action to enforce such claim. O.R.S. § 416.530(1).

The notification requirement shall be provided to the following:

> (a) The Oregon Health Authority by applicants for or recipients of assistance provided by the Authority; and
>
> (b) The Department of Human Services for assistance provided by the Department. *Id*. 416.530(2)(a)-(b).

Failure to Notify

The Department, the Authority or the recipient's coordinated care organization, if the recipient is receiving services from the organization, shall have a cause of action against any recipient who fails to give the notification required by section 416.530 for amounts received by the recipient pursuant to a judgment, settlement or compromise to the extent that the Department, the Authority or the coordinated care organization could have had a lien against such amounts had such notice been given. O.R.S. § 416.610.

Automatic Lien

Except as provided below, the Department and the Authority shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise for all assistance received by such recipient from the date of the injury of the recipient to the date of satisfaction of such judgment or payment under such settlement or compromise. O.R.S. § 416.540(1).

The lien does not attach to the amount of any judgment, settlement or compromise to the extent of attorney's fees, costs and expenses incurred by a recipient in securing such judgment, settlement or compromise and to the extent of medical, surgical and hospital expenses incurred by the recipient on account of the personal injuries for which the recipient had a claim. *Id*. § 416.540(2).

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The Authority may assign the lien referenced in paragraph one to a prepaid managed care health services organization or a coordinated care organization for medical costs incurred by a recipient: (a) during a period for which the Authority paid a capitation or enrollment fee or a payment using a global payment methodology; and (b) on account of the personal injury for which the recipient had a claim. *Id*. at § 416.540(3)(a)-(b). A prepaid managed care health services organization or a coordinated care organization to which the Authority has assigned a lien shall notify the Authority no later than ten days after filing notice of a lien. *Id*. at § 416.540(4). If the Authority and a prepaid managed care health services organization or a coordinated care organization both have filed a lien, the Authority's lien shall be satisfied first. *Id*. at § 416.540(6).

Lien Perfection

Upon receiving notice pursuant to section 416.530, the Department or the Authority must perfect its lien by:

> (a) Filing a notice of lien, substantially in the form prescribed in section 416.550, with the recording officer of the county in which the person against whom the claim is made or action is brought resides. If the claim or action is against a corporation, the notice of lien shall be filed with the recording officer of the county within the state in which such corporation has its principal place of business. If the claim or action is against a public body, agency or commission, the notice of lien shall be filed with the recording officer of the county in which the public body, agency or commission has its main offices; and
>
> (b) Prior to the date of satisfaction of the judgment or payment under the settlement or compromise, send a certified copy of the notice of lien by registered mail or by certified mail with return receipt to each person or public body, Agency or commission against whom the claim is made or action is brought by the recipient. O.R.S. § 416.550(1)(a)-(b).

Upon filing the notice of lien by the Department or the Authority, the recording officer shall enter the name of the injured person, the approximate date of the injury and the name of the Department or the Authority as lienor in the lien docket provided for in section 87.575 and shall make an index thereto in the names of the injured persons and the Department or the Authority. *Id*. 416.550(2).

Notice after Judgment or Settlement

Immediately after a judgment has been rendered in favor of a recipient or a settlement or compromise has been agreed upon, the person or public body, agency or commission bound by such judgment, settlement or compromise shall notify the Department or the Authority. After

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such notification, the Department or the Authority shall send a statement of the amount of its lien to such person or public body, agency or commission by registered mail or by certified mail with return receipt. O.R.S. § 416.570.

Payment in Satisfaction of Lien

After a notice of lien is filed in the manner provided in O.R.S. § 416.550(2), any person or public body, agency or commission who makes any payment to the injured recipient, the heirs, personal representatives or assigns of the recipient, or their attorneys, under a judgment, settlement, or compromise, without previously having paid to the Department or the Authority the amount of its lien, shall be liable to the State of Oregon, for the use and benefit of the Department or the Authority for a period of 180 days after the date of such payment to the extent that the lien attached. O.R.S. § 416.580(1).

Any amount paid to the Department or the Authority in satisfaction of its lien shall be distributed by the Department or the Authority to the United States Government and the Public Welfare Account, as their interests may appear. *Id*. § 416.580(2).

If the recipient is a minor, no payments to the Department or the Authority in satisfaction of its lien and, except to the extent of the fees, costs and expenses specified in section 416.540(2), no payments to the recipient under a judgment, settlement or compromise shall be made until a hearing has taken place and the court has issued its order under section 416.590. *Id*. § 416.580(3).

Denying Assistance

If any applicant or recipient has a claim for damages for personal injuries, the existence of such claim or any action to enforce such claim shall not be grounds for denying or discontinuing assistance to such applicant or recipient. O.R.S. § 416.520.

Penalties

Any person who makes, renders, signs or verifies any false or fraudulent statement, or supplies any false or fraudulent information with intent to evade any lawful requirement of the Department or the Authority is guilty of a misdemeanor. O.R.S. § 416.990.

Definitions

"Assistance" means monies paid by the Department to persons directly and monies paid by the Authority or by a prepaid managed care health services organization or a coordinated care organization for services provided under contract pursuant to O.R.S. 414.651 to others for the benefit of such persons. O.R.S. § 416.510(4).

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"Claim" means a claim of a recipient of assistance for damages for personal injuries against any person or public body, agency or commission other than the State Accident Insurance Fund Corporation or Workers' Compensation Board. *Id*. § 416.510(6).

"Settlement" means a settlement between a recipient and any person or public body, agency or commission against whom the recipient has a claim. *Id*. § 416.510(12).

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Right of Subrogation

Each publicly funded health care program that furnishes or pays for health care service to a recipient having private health care coverage shall be entitled to be subrogated to the rights that such person has against the insurer of such coverage to the extent of the health care services rendered. Such action may be brought within five years from the date that service was rendered such person. 62 P.S. § 1409(a)(3).

When health care services are provided to a person under this section who at the time the service is provided has any other contractual or legal entitlement to such services, the Secretary of the Department shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. *Id*. at § 1409(a)(4). The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, health service plan, or fraternal society owing such entitlement in the appropriate court in the name of the Secretary of the Department. *Id*.

Third Party Recovery

When benefits are provided or will be provided to a beneficiary because of an injury for which another person is liable, or for which an insurer is liable in accordance with the provisions of any policy of insurance issued pursuant to Pennsylvania insurance laws and related statutes the Department shall have the right to recover from such person or insurer the reasonable value of benefits so provided. 62 PS § 1409(b)(1). The Attorney General or his designee may, at the request of the Department, to enforce such right, institute and prosecute legal proceedings against the third person or insurer who may be liable for the injury in an appropriate court, either in the name of the Department or in the name of the injured person, his guardian, personal representative, estate or survivors. *Id*.

The Department may do either of the following: (i) compromise or settle and release any such claims; or (ii) waive any such claim, in whole or in part, or if the Department determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased. *Id*. § 1409(b)(2)(i)-(ii).

If either the beneficiary or the Department brings an action or claim against a third party or insurer, the beneficiary or the Department shall, within thirty days of filing the action, give to the other written notice by personal service or by certified or registered mail of the action or claim. Any third party or insurer that has received information indicating that the beneficiary received benefits under the medical assistance program shall give written notice to the

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Department by personal service or by certified or registered mail of the action or claim. Proof of notices shall be filed in the action or claim. *Id*. § 1409(b)(5).

No action taken on behalf of the Department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, personal representative, estate, dependents or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder. *Id*. § 1409(b)(3).

Notice Requirements

Where an action is brought by the Department pursuant to this section, it shall be commenced within seven years of the date the cause of action arises. However, if a beneficiary has commenced an action to recover damages for an injury for which benefits are provided or will be provided and if the Department was not provided with adequate notice under this section or section 1409.1, the Department may commence an action under this section within the later of seven years of the date the cause of action arises or two years from the date the Department discovers the settlement or judgment. *Id*. § 1409(b)(4)(i)-(ii). If an action or claim is brought by the Department pursuant to subsection (b)(1) of 1409, written notice to the beneficiary given pursuant to this section shall advise him of his right to intervene in the proceeding and his right to recover the reasonable value of the benefits provided. *Id*. § 1409(b)(6).

If either the beneficiary or the Department brings an action or claim against such third party or insurer, the beneficiary or the Department shall within thirty days of filing the action give to the other written notice by personal service or by certified or registered mail of the action or claim. Any third party or insurer that has received information indicating that the beneficiary received benefits under the medical assistance program shall give written notice to the Department by personal service or by certified or registered mail of the action or claim. Proof of the notices shall be filed in the action or claim. *Id*. § 1409(b)(5).

If a beneficiary files an action or claim that does not seek recovery of expenses for which benefits under the medical assistance program are provided, the beneficiary shall include in the notice to the Department a statement that the action or claim does not seek recovery of the expenses. *Id*. § 1409(b)(5)(i). If a parent files an action or claim that does not seek recovery of a minor's medical expenses paid by the medical assistance program, the parent shall include in the notice to the Department a statement that the action or claim does not seek the recovery of the expenses. *Id*. § 1409(b)(5)(ii). If a beneficiary files an action or claim that seeks recovery of expenses for which benefits under the medical assistance program are provided and later elects not to seek recovery of the expenses, the beneficiary shall provide reasonable notice to the Department by personal service or by certified or registered mail. *Id*. § 1409(b)(5)(iii). Notice

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shall be reasonable if it allows the Department sufficient time to petition to intervene in the action and prosecute its claim. *Id*.

Notice of any settlement shall be provided to the Department by the beneficiary and any third party or insurer within thirty days of the settlement. *Id*. § 1409(b)(5)(iv). Where judicial approval of the settlement is required, reasonable notice of the settlement shall be provided to the Department before a judicial hearing for approval of the settlement. *Id*. Notice is reasonable if it allows the Department sufficient time to intervene in the action and prosecute its claim. *Id*. If an action or claim is brought by the Department or beneficiary, the other may, at any time before trial on the facts, become a party to or shall consolidate his action or claim with the other if brought independently. *Id*. § 1409(b)(5)(vi). The beneficiary may include as part of his claim the amount of benefits that have been or will be provided by the medical assistance program. *Id*.

Notice shall be adequate if all of the following notices have been provided to the Department, if required:

> (A) Notice of suit under clause (5)(i) from either the beneficiary or any third party or insurer.
>
> (B) Notice of any election from the beneficiary under clause (5)(iii).
>
> (C) Notice of settlement under clause (5)(iv) from either the beneficiary or any third party or insurer.
>
> (D) Notice of any allocation proceeding under section 1409.1(b)(3). *Id*. § 1409(b)(4)(ii)(A)-(D).

Furthermore, the following sections shall apply to third party liability under section 1409:

> (A) The death of the beneficiary does not abate any right of action established by this section.
>
> (B) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the Department's claims for reimbursement of the benefits provided to the beneficiary under the medical assistance program.
>
> (C) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the Department's

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claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the services to the beneficiary.

(D) Where benefits are provided or will be provided for a minor's care, any statute of limitation or repose applicable to an action or claim in which the minor's medical expenses may be sought shall be tolled until the minor reaches the age of majority. The period of minority shall not be deemed a portion of the time period within which the action must be commenced. The term "minor," as used in this clause, means any individual who has not yet attained the age of 18. *Id*. § 1409(b)(4)(iii)(A)-(D).

Consequences of a Judgment, Award or Settlement

In the event of judgment, award or settlement in a suit or claim against such third party or insurer:

(i) If the action or claim is prosecuted by the beneficiary alone, the court or Agency shall first order paid from any judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of such expenses and attorney's fees the court or Agency shall, on the application of the Department, allow as a first lien against the amount of such judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(ii) If the action or claim is prosecuted both by the beneficiary and the Department, the court or Agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of such expenses and attorney's fees, the court or Agency shall apply out of the balance of the judgment or award an amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(iii) With respect to claims against third parties for the cost of medical assistance services delivered through a managed care organization contract, the Department shall recover the actual payment to the hospital or other medical provider for the service. If no specific payment is identified by the managed care organization for the service, the Department shall recover its fee schedule amount for the service. *Id*. § 1409(b)(7)(i)-(iii).

Automatic Lien

Except as provided under section 1409.1, upon application of the Department, the court or Agency shall allow a lien against any third party payment or trust fund resulting from a

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judgment, award or settlement in the amount of any expenditures in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the medical assistance program, when such benefits were provided or became payable subsequent to the date of the judgment, award or settlement. *Id*. § 1409(b)(8).

When the Department has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the medical assistance program, the Department shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the Department shall be entitled to a writ of execution against such beneficiary to the extent of the Department's lien, with interest and other accruing costs as in the cost of other executions. *Id*. § 1409(b)(10).

Unless otherwise directed by the Department, no payment or distribution shall be made to a claimant or a claimant's designee of the proceeds of any action, claim or settlement where the Department has an interest without first satisfying or assuring satisfaction of the interest of the Commonwealth. Any person who, after receiving notice of the Department's interest, knowingly fails to comply with the obligations established under this clause shall be liable to the Department, and the Department may sue to recover from the person. *Id*. § 1409(b)(9).

The entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the Department's claim for reimbursement of the benefits provided any lien filed pursuant thereto, but in no event shall the Department's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury. *Id*. § 1409(b)(11).

In the event that the beneficiary, his guardian, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by the act shall be given to the Secretary (or his designee) in Harrisburg except in cases where the Secretary specifies that notice shall be given to the Attorney General. The beneficiary's obligations under this subsection shall be met by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, personal representative, estate or survivors, if no attorney is retained. *Id*. § 1409(b)(12).

Definitions

"Beneficiary" means any person who has received benefits or will be provided benefits because of an injury for which another person may be liable. It includes such beneficiary's guardian, conservator, or other personal representative, his estate or survivors. *Id*. § 1409(b)(13).

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"Insurer" includes any insurer as defined in "The Insurance Department Act of one thousand nine hundred and twenty-one," including any insurer authorized under the Laws of this Commonwealth to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement of coverage pursuant to the "Pennsylvania No-fault Motor Vehicle Insurance Act." *Id*.

RHODE ISLAND

Assignment of Rights and Right of Subrogation

An applicant or recipient of medical assistance provided by the Executive Office of Health and Human Services is deemed to have made an assignment and given a right of subrogation to the Executive Office of any and all rights and interests that such person may have to payment for any medical support and to any payment from any third party that has legal liability to pay for care and services available and provided to the applicant or recipient. 40 R.I. Gen. Laws § 40-6- 9(b) (2016). A subrogor requesting the court to asses a pro rata share of recovery costs to the subrogee bears the burden of showing that the assessment of a pro rata share is equitable and that the recovery costs are justified. *U.S. Inv. & Dev. Corp. v. Rhode Island Dep't of Human Servs.*, 606 A.2d 1314, 1318 (R.I. 1992).

Insurers must determine whether the Executive Office has provided medical assistance to the claimant or payee. R.I. Gen. Laws § 27-57.1-1(b). If the Executive Office has not provided medical assistance then the insurer may make the payment to the claimant in accordance with the contract of the insurance. *Id*. The insurer must withhold a payment from the claimant and pay the Executive Office in the amount of medical assistance provided by the Executive Office. R.I. Gen. Laws § 27-57.1-1(c). The remaining balance may be paid to the recipient. *Id*. The Executive Office must provide a written notice to the claimant and the claimant's attorney which states the amount being withheld to reimburse the State, the reason for repayment, and an opportunity to request a hearing as provided for in R.I. Gen. Laws § 27-57.1-1(e). *Id*. Any claimant that is aggrieved by any action taken under R.I. Gen. Laws § 27-57.1-1 may within thirty days of the mailing of notice to the claimant request a hearing from the Executive Office. R.I. Gen. Laws § 27-57.1-1(e).

Notice

The Executive Office must notify the recipient in any case where the Executive Office intercepts an insurance payment. R.I. Gen. Laws § 27-57.1-2.

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Assignment of Rights

An applicant or recipient, only to the extent of the amount of the medical assistance paid by Medicaid, is considered to have assigned his right to recover an amount paid by Medicaid from a third party or private insurer to the South Carolina Department of Health and Human Services. This assignment shall not include rights to Medicare benefits. The applicant or recipient must cooperate fully with the Department in its efforts to enforce its assignment rights. The receipt of medical assistance by an applicant or recipient shall create a rebuttable presumption that the applicant or recipient received information regarding the requirements for and the consequences of assigning his right to recover from a third party or private insurer either from the Department, or in the case of an applicant or recipient qualified by the Social Security Administration under Section 1634 of the Social Security Act, from the Social Security Administration. Code 1976 § 43-7-420(A).

An applicant and recipient's determination of, and continued eligibility for, medical assistance under Medicaid are contingent on his cooperation with the Department in its efforts to enforce its assignment rights. Cooperation includes, but is not limited to, reimbursing the Department from proceeds or payments received by the applicant or recipient from a third party or private insurer. *Id*. § 43-7-420(B). An applicant or recipient is considered to have authorized all persons, including insurance companies and providers of medical care, to release to the Department information needed to enforce the assignment rights of the Department. *Id*. § 43-7-420(C).

Subrogation Rights

The Department automatically is subrogated, only to the extent of the amount of medical assistance paid by Medicaid, to the rights an applicant or recipient has to recover an amount paid by Medicaid from a third party or private insurer. The applicant or recipient shall cooperate fully with the Department and shall do nothing after medical assistance is provided to prejudice the subrogation rights of the Department. *Id*. § 43-7-430(A).

An applicant and recipient's determination of, and continued eligibility for, medical assistance under Medicaid are contingent on his cooperation with the Department in its efforts to enforce its subrogation rights. Cooperation includes, but is not limited to, reimbursing the Department from proceeds or payments received by the recipient from a third party or private insurer. *Id*. § 43-7- 430(B). An applicant is considered to have authorized all persons, including insurance companies and providers of medical care, to release to the Department information needed to enforce the subrogation rights of the Department. *Id*. § 43-7-430(C).

Enforcing the Department's Rights

In order to enforce its assignment or subrogation rights, the Department may do the following:

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(1) Intervene or join in an action or proceeding brought by the applicant or recipient against a third party, or private insurer, in state or federal court;

(2) Commence and prosecute legal proceedings against a third party or private insurer who may be liable to an applicant or recipient in state or federal court, either alone or in conjunction with the applicant or recipient, his guardian, personal representative of his estate, dependent, or survivor;

(3) Commence and prosecute a legal proceeding against a third party or private insurer who may be liable to an applicant, or his guardian, personal representative of his estate, dependent, or survivor;

(4) Commence and prosecute a legal proceeding against an applicant or recipient;

(5) Settle and compromise an amount due to the Department under its assignment and subrogation rights. A representative or attorney retained by an applicant or recipient shall not be considered liable to the Department for improper settlement, compromise, or disbursement of funds unless he has written notice of the Department's assignment and subrogation rights prior to disbursement of funds; or

(6) Reduce an amount due to the Department by twenty-five percent if the applicant or recipient has retained an attorney to pursue the applicant's or recipient's claim against a third party or private insurer, that amount to represent the Department's share of attorney fees paid by the applicant or recipient. Additionally, the Department may share in other costs of litigation by reducing the amount due to it by a percentage of those costs, the percentage calculated by dividing the amount due to the Department by the total settlement received from the third party or private insurer. A representative or attorney retained by an applicant or recipient shall not be considered liable to the Department for improper settlement, compromise, or disbursement of funds unless he has written notice by certified mail of the Department's assignment and subrogation of rights prior to disbursement of funds. *Id*. § 43-7-440(A)(1)-(7).

All providers or practitioners who participate in the Medicaid program must cooperate with the Department in the identification of all third parties whom they have reason to believe may be liable to pay all or part of the medical costs of the injury, disease, or disability of an applicant or recipient. *Id*. § 43-7-440(B).

An assignment or subrogation right of the Department is superior to any right of reimbursement, subrogation, or indemnity of a third party or recipient. A representative or attorney retained by an applicant or recipient shall not be considered liable to the Department for improper settlement, compromise, or disbursement of funds unless he has written notice of the Department's assignment and subrogation rights prior to disbursement of funds. Where a third

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party has a legal liability to make a payment for medical assistance to or on behalf of a person, the State is considered to have acquired the rights of the person to payment by another party for the health care items or services, to the extent that payment was made under a State Plan for medical Assistance Pursuant to Title XIX of the Social Security Act for a health care item or service furnished to the person. *Id*. § 43-7-440(D).

Definitions

"Applicant" means an individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. *Id*. § 43-7-410(A)

"Person" means a natural person, company, association, partnership, corporation, or other legal entity. *Id*. § 43-7-410(D)

"Practitioner" means a physician or other health care professional licensed under state law to practice his profession. *Id*. § 43-7-410(E)

"Recipient" means an individual determined to be eligible for a health service described in the State Medical Assistance Plan in accord with Title XIX of the Social Security Act-Medical Assistance, also known as Medicaid. *Id*. § 43-7-410(H)

"Third party" means an individual, entity, or program that is or may be liable by contract, agreement, or statute, to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient. *Id*. § 43-7-410(I)

SOUTH DAKOTA

Assignment of Rights and Right of Subrogation

An application for or acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation by operation of law of any rights to medical support, insurance proceeds, or both, that the applicant or recipient may have for the applicant's or recipient's person, spouse, or child. This assignment and subrogation includes all claims or actions for damages, either general or special. An application for or acceptance of medical assistance from the Department shall be deemed by an applicant or recipient and any insurance provider, including self-insurance, as a release of information authorizing the release of insurance coverage information to the Department regardless of the policyholder. Any rights or amounts so assigned or subrogated shall be applied against the cost of medical care paid under this chapter, less all reasonable expenses, including attorney's fees incurred by the applicant or recipient to collect such support or proceeds. Any insurance provider or attorney who, after notice, fails to recognize or accept an assignment or subrogation established by operation of law by this section is liable to the Department for the full amount of medical assistance paid to or on behalf of the applicant or recipient by the Department for the accident, injury, or illness for which collection is claimed or made. SDCL § 28-6-7.1.

Under this statutory authority is Administrative Rule 67:16:26:08, requiring reimbursement from third-party collections. "If the department has made payments in behalf of a recipient, providers and recipients must reimburse the department when a payment is received from a third-party liability source. The total reimbursement must be either the amount of the third-party payment for services paid by the department or the amount paid by the department, whichever is less. If a recipient employs an attorney to establish a third-party liability source and the attorney collects from that source, the department may participate in the payment of the attorney's fees and expenses by reducing the amount of the reimbursement due the department."

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To the extent permitted by federal law, the Department of Health may require or permit that responsible parties of a recipient of medical assistance supplement or reimburse for any benefits rendered to the recipient. T.C.A. § 71-5-115.

Subrogation Rights

Medical assistance paid to, or on behalf of, any recipient cannot be recovered from a beneficiary unless such assistance has been incorrectly paid, or, unless the recipient or beneficiary recovers or is entitled to recover from a third party reimbursement for all or part of the costs of care or treatment for the injury or illness for which the medical assistance is paid. T.C.A. § 71-5-117 (a). To the extent of payments of medical assistance, the Department shall be subrogated to all rights of recovery, for the cost of care or treatment for the injury or illness for which medical assistance is provided, contractual or otherwise, of the recipients against any person. *Id*.

Medicaid payments to the provider of the medical services shall not be withdrawn or reduced to recover funds obtained by the recipient from third parties for medical services rendered by the provider if these funds were obtained without the knowledge or direct assistance of the provider of medical assistance. When the Department asserts its right to subrogation, the Department shall notify the recipients in language understandable to all recipients, of recipient's rights of recovery against third parties and that recipient should seek the advice of an attorney regarding those rights of recovery to which recipient may be entitled. *Id*.

If, while receiving assistance, the recipient becomes possessed of any resource or income in excess of the amount stated in the application, it shall be the duty of the recipient immediately to notify the agency designated to determine eligibility of the receipt or possession of such resource or income. When it is found that any person has failed to notify the agency that such person is or was possessed of any resource or income in excess of the amount allowed or when it is found that, within five years prior to the date of recipient's application, a recipient made an assignment or transfer of property for the purpose of rendering the recipient eligible for assistance, any amount of assistance paid in excess of the amount to which the recipient was entitled shall constitute benefits incorrectly paid. Any benefits incorrectly paid shall be recoverable from the recipient, while living, as a debt due to the Department and, upon the recipient's death, as a claim classified with taxes having preference under the laws of Tennessee. *Id*.

Assignment of Rights

Upon accepting medical assistance, the recipient shall be deemed to have made an assignment to the state of the right of third party insurance benefits to which the recipient may be entitled. Failure of the recipient to reimburse the State for medical assistance received from any third party insurance benefits received as a result of the illness or injury from which the medical assistance was paid may be grounds for removing the recipient from future participation in the

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benefits available; provided, that any removal from participation shall be after appropriate advance notice to the recipient and that the provider of service shall not be prevented from receiving payment from the Department for medical assistance services previously furnished the recipient, and that nothing in this section requires an insurer to pay benefits to the Department that have already been paid to the recipient. T.C.A. § 71-5-117(b).

Who is a "third party?"

The Commissioner of Finance and Administration, the Director of the Bureau of TennCare or individual managed care organizations under contract with the State are authorized to require certain information identifying persons covered by third parties for medical services. Third parties for medical services shall include, but not be limited to, health and liability insurers, administrators of ERISA plans, employee welfare benefit plans, workers' compensation plans, CHAMPUS and Medicare. All third parties must, upon request from the Commissioner, the Director or managed care organization, provide for a computerized data match of their respective files to identify all persons covered by both the third party and by the state's TennCare program for medical services. No third party shall be liable to a policyholder for proper release of this information to the Commissioner, the Director or managed care organization. The information shall be provided pursuant to a written request from the Commissioner, the Director or managed care organization, with each third party establishing confidentiality requirements. *Id*. § 71-5-117(c).

To the extent necessary to reimburse the Department for expenditures for its costs for services provided for any child eligible for medical services under Title XIX of the federal Social Security Act, compiled in 42 U.S.C. § 1396 et seq., the Department shall have a right of action against, and shall be permitted to garnish the wages, salary, or other employment income of, any person who: (A) is required by a court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under Title XIX of the federal Social Security Act; (B) has received payment from a third party for the costs of such services provided to such child; and (C) has not used such payments from the third party to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services. *Id*. § 71-5-117(d)(1)(A)-(C).

Department's Right of Action

The Department's right of action under this section shall be authorized as part of the contractual functions of the individual managed care organization or organizations that incurred the medical expenses on behalf of a TennCare recipient where the TennCare program deems appropriate. The Bureau of TennCare shall maintain an easily accessible and clearly identified Internet web page, updated at least bi-annually, that identifies that individual managed care organization or organizations having authorization to pursue the Department's right of action under this section and such Internet web page, at the minimum, shall provide the appropriate manner, method and

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form for contacting the managed care organization or organizations. The form made accessible through such Internet web page shall be consistent with the requirements of subsection (f). *Id*. § 71-5-117(e).

Notice

Before the entry of the judgment or settlement in a personal injury case, the plaintiff's attorney shall notify and contact in writing by facsimile or certified mail return receipt requested any entity acting pursuant to and identified in accordance with subsection (e), in order to determine if the state or managed care organization(s) have a subrogation interest. Notice by the plaintiff's attorney, at the minimum, shall provide the following information: the full name of the plaintiff's client; the client's date of birth; the client's social security number, if known; the client's TennCare or managed care organization identification number; and the date the client's claim arose. Notice by the plaintiff's attorney shall be consistent with the foregoing in order to be considered valid. *Id*. § 71-5-117(f).

Subrogation Interest

Within sixty days of receipt of the notice, the entities having a subrogation interest must respond to the plaintiff's attorney in writing via facsimile or certified mail return requested with either the amount of the subrogation interest or advise the plaintiff's attorney that additional time is necessary in order to determine the amount of the subrogation interest, but in no event shall a response containing the amount of the subrogation interest exceed one hundred twenty days. *Id*. § 71-5-117(f). If the plaintiff's attorney received a timely response, but the amount of the subrogation interest remains in disagreement, then the trial judge may hold a hearing in accordance with subsection (i). After trial and at the time of the entry of the judgment or settlement in a case in which the state or an entity acting pursuant to subsection (e) has a subrogation interest, it is the responsibility of the trial judge to calculate the amount of the subrogation interest and incorporate the court's findings concerning the subrogation interest in the final judgment or settlement. The gross amount of the subrogation interest shall be based upon the findings of the jury concerning medical expenses and evidence introduced after the trial about the total sum of monies paid by the state or any entity acting pursuant to subsection (e) for medical expenses for injuries arising from the incident that is the basis of the action. The gross amount of the subrogation interest shall be reduced by one or more of the following factors, as applicable:

> (1) To the extent that the plaintiff is partially at fault in the incident giving rise to the litigation, the subrogation interest is reduced by the percentage of fault assessed against the plaintiff;

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(2) To the extent that the finder of fact allocated fault to a person who was immune from suit, the subrogation interest is reduced by the percentage of fault assessed against the immune person;

(3) To the extent that the finder of fact allocates fault to a governmental entity that has its liability limited under state law and the fault of the entity, when multiplied by the total dollar value of the damages against the entity, the subrogation interest is reduced proportionately by a percentage derived by dividing the uncollectable portion of the judgment against the governmental entity by the total damages awarded; or

(4) To the extent that the finder of fact allocated fault to a person that the plaintiff did not sue, the subrogation interest is reduced by the percentage of fault assessed against the nonparty. *Id*. § 71-5-117(f).

The court should, in addition, reduce the subrogation interest pro rata by the amount of reasonable attorneys' fees and litigation costs incurred by the plaintiff in obtaining the recovery. *Id*. § 71-5-117(g).

The amount determined after performance of the calculations in subsections (f) and (g) is the net subrogation interest. If the plaintiff or plaintiff's attorney collects the judgment, each has the obligation to promptly remit the net subrogation interest, and attorneys' fees and costs to any counsel employed by the Department or its assignee, as required by the final judgment. If the plaintiff and plaintiff's attorney collect only a portion of the final judgment, each has the obligation to promptly remit a pro rata share of the net subrogation interest, and attorneys' fees and costs to any counsel employed by the Department or its assignee, as required by the final judgment. If the plaintiff and plaintiff's attorney later collect additional monies against the judgment, there is a continuing obligation on both of them to remit a pro rata share of the monies collected as required by the final judgment. *Id*. § 71-5-117(h).

If the case between the plaintiff and defendant is settled before trial but after a lawsuit is filed and the parties and the state or its assignee are unable to reach an agreement on the amount of the subrogation interest, the trial judge shall hold a hearing to determine the gross and net subrogation interests, taking into account the criteria listed in subsections (f) and (g) and the likelihood of collecting any judgment against parties determined to be at fault. Any aggrieved party may appeal the court's decision. *Id*. § 71-5-117(i).

TEXAS

Assignment of Rights

The filing of an application for or receipt of medical assistance constitutes an assignment of the applicant or recipient's right of recovery from: (1) personal insurance; (2) other sources; or (3) another person for personal injury caused by the other person's negligence or wrong. V.T.C.A., Human Resources Code § 32.033(a).

Notice Requirements

A person who applies for or receives medical assistance must inform the Commission, at the time of application or at any time during eligibility and receipt of services, of any unsettled tort claim which may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. A recipient shall inform the Commission of an injury requiring medical attention that is caused by the act or failure to act or some other person. An applicant or a recipient shall inform the Commission as required by this subsection within sixty days of the date the person learns of his or her insurance coverage, tort claim, or potential cause of action. An applicant or recipient who knowingly and intentionally fails to disclose the information required by this subsection commits a Class C misdemeanor. *Id*. § 32.033(b).

If a person has a claim for damages for personal injury, it does not constitute grounds for denying or discontinuing assistance under the Medical Assistance Program. *Id*. § 32.033(c).

A separate and distinct cause of action in favor of the State is created, and the Commission may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under this section need not be ancillary to or dependent upon any other action. *Id*. § 32.033(d). The Commission's right of recovery is limited to the amount of the cost of medical care services paid by the Commission. *Id*. § 32.033(e). Other subrogation rights granted under this section are limited to the cost of the services provided. *Id*.

The Commission may designate an agent to collect funds that the Commission has a right to recover from third parties under this section. *Id*. § 32.033(g). The Commission shall use any funds collected to pay costs of administering the medical assistance program. *Id*. The Executive Commissioner may adopt rules for the enforcement of the Commission's right of recovery. *Id*. § 32.033(h).

Waiver of Recovery

The Executive Commissioner may waive the Commission's right of recovery in whole or in part when the Executive Commissioner finds that enforcement would tend to defeat the purpose of public assistance. *Id*. § 32.033(f).

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The purpose of the Medical Assistance Program is to enable the State to provide medical assistance on behalf of needy individuals and to enable the State to obtain all benefits for those persons authorized under the Social Security Act or any other federal act. *Id*. § 32.001.

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Assignment of Rights

To the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third party otherwise payable to or on behalf of a recipient are assigned by operation of law to the Department if the Department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient. U.C.A. 1953 § 26-19-201.

The assignment authorizes the Department to submit its claim to the third party and authorizes payment of benefits directly to the Department, and the assignment is effective for all medical assistance. *Id*. § 26-19-201(1)(b). The Department may recover the assigned benefits or payments in accordance with section 26-19-401 and as otherwise provided by law. *Id*. § 26-19-201(2).

The assignment of benefits includes medical support and third party payments ordered, decreed, or adjudged by any court of this State or any other state or territory of the United States. That assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment. *Id*. § 26-19-201(3). When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the Department are a reimbursement to the Department. *Id*. § 26-19-201(4).

Right of Recovery

Under U.C.A. § 26-19-401, et seq., (1) (a) When the department provides or becomes obligated to provide medical assistance to a recipient that a third party is obligated to pay for, the department may recover the medical assistance directly from that third party. (b) Any claim arising under Subsection (1)(a) or Section 26-19-201 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by that third party. This lien has priority over all other claims to the proceeds, except claims for attorney fees and costs authorized under Subsection 26-19-403(2)(c)(ii).

(2) (a) The department shall mail or deliver written notice of its claim or lien to the third party at its principal place of business or last-known address.(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury;

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.

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(3) The department may commence an action on its claim or lien in its own name, but that claim or lien is not enforceable as to a third party unless:

(a) the third party receives written notice of the department's claim or lien before it settles with the recipient; or

(b) the department has evidence that the third party had knowledge that the department provided or was obligated to provide medical assistance.

(4) The department may:

(a) waive a claim or lien against a third party in whole or in part; or

(b) compromise, settle, or release a claim or lien.

(5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.

(6) The department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

Further, the department may recover medical assistance incorrectly provided, whether due to administrative or factual error or fraud, from the recipient or the recipient's recovery estate, and pursuant to a judgment, impose a lien against real property of the recipient. U.C.A. § 26-19- 406 (1-2).

Notice Requirements to the Department

A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the Department has provided or has become obligated to provide medical assistance, without the Department's written consent. *Id*. § 26-19-403(1)(a).

Consent may be obtained if:

(i) a recipient who files a claim, or commences an action against a third party notifies the Department in accordance with Subsection (1)(d) within ten days of the recipient making the claim or commencing an action; or

(ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the Department in accordance with Subsection (1)(d) of the recipient's claim (A) within thirty days after being retained by the recipient for that purpose or (B) within thirty days from the date the attorney either knew or should

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have known that the recipient received medical assistance from the Department. *Id*. § 26-9- 403(1)(b).

Subsection (1)(d) provides that the notice of claim must include the following information:

(i) the name of the recipient;

(ii) the recipient's social security number;

(iii) the recipient's date of birth;

(iv) the name of the recipient's attorney, if applicable;

(v) the name or names of individuals or entities against whom the recipient is making the claim, if known;

(vi) the name of the third party's insurance carrier, if known;

(vii) the date of the incident giving rise to the claim; and

(viii) a short statement identifying the nature of the recipient's claim. *Id*. § 26-19-403(1)(d)(i)-(viii).

Service of the notice of the claim to the Department must be made by certified mail, personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the Director of the Office of Recovery Services. *Id*. § 26-19-403(1)(c). Within thirty days of receipt of the notice of the claim, the Department must acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and must notify the recipient or the recipient's attorney in writing of the following:

(i) if the Department has a claim or lien pursuant to Section 26-19-401 or has become obligated to provide medical assistance; and

(ii) whether the Department is denying or granting written consent in accordance with Subsection (1)(a). *Id*. § 26-19-403(2)(a).

Notice Requirements to the Recipient

Within thirty days after commencing an action under Subsection 26-19-402(1)(a), the Department shall give the recipient, his guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:

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(i) personal service or certified mail to the last known address of the person receiving notice; or

(ii) if no last-known address is available, by publishing a notice:

(A) once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides; and

(B) in accordance with Section 45-1-101 for three weeks. *Id*. § 26-19-402(1)(a).

Proof of service must be filed in the action. *Id*. § 26-19-402(b). The recipient may intervene in the Department's action at any time before trial. *Id*. § 26-16-402(c). The notice required must name the court in which the action is commenced and advise the recipient of:

(a) the right to intervene in the proceeding;

(b) the right to obtain a private attorney; and

(c) the Department's right to recover medical assistance directly from the third party. *Id*. § 26-16-402(2).

Collection Agreement between the Department and the Recipient

The Department shall provide the recipient's attorney with the opportunity to enter into a collection agreement with the Department, with the recipient's consent, unless:

(i) the Department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the Department before the date the Department received notice of the recipient's claim, and the agreement is documented in the Department's record; or

(ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:

(A) failing to comply with the notice provisions of this section;

(B) failing or refusing to enter into a collection agreement;

(C) failing to comply with the terms of a collection agreement with the Department; or

(D) failing to disburse funds owed to the state in accordance with this section.

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The collection agreement must be:

(A) consistent with this section and the attorney's obligation to represent the recipient and represent the State's claim; and

(B) state the terms under which the interests of the Department may be represented in an action commenced by the recipient. *Id*. § 26-19-403(2)(c)(i).

If the recipient's attorney enters into a collection agreement with the Department, or includes the Department's claim in the recipient's claim or action pursuant to Subsection (4), the Department must pay attorney fees at the rate of 33.3% of the Department's total recovery and must pay a proportionate share of the litigation expenses directly related to the action. *Id*. § 26-19- 403(2)(c)(ii). However, the Department is not required to enter into a collection agreement with the recipient's attorney for collection of personal injury protection under Subsection 31A-22- 302(2). *Id*. § 26-19-403(2)(d).

If the Department receives notice pursuant to Subsection (1), and notifies the recipient and the recipient's attorney that the Department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against the third party if the recipient excludes from the claim: (i) any medical expenses paid by the Department; or (ii) any medical costs for which the Department is obligated to provide medical assistance. *Id*. § 26-19-403(3)(a). When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the Department's claim for expenses under Subsection (3)(a)(i) or (ii). *Id*. § 26-19-403(3)(b).

If the Department receives notice pursuant to Subsection (1), and does not respond within thirty days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

(a) may proceed with the recipient's claim or action against the third party;

(b) may include the state's claim in the recipient's claim or action; and

(c) may negotiate, compromise, settle, or waive the Department's claim without the Department's consent. *Id*. § 26-19-403(4).

Right to Intervene and Non-compliance

Under U.C.A. § 26-19-404, (1) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.

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(2)(a) If the recipient proceeds without complying with the provisions of Section 26-19-403, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action. (b) The department:

(i) may recover in full from the recipient, or any party to which the proceeds were made payable, all medical assistance that the department has provided; and

(ii) retains its right to commence an independent action against the third party, subject to Subsection 26-19-401(3).

(3) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-201 and 26-19-401 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.

(4)(a) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-201 and 26-19-401 collected directly by the recipient's attorney shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account. (b) The date by which the funds shall be remitted to the department may be modified based on agreement between the department and the recipient's attorney. (c) The department's consent to another date for remittance may not be unreasonably withheld. (d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(5) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:

(a) the amount of the department's claim or lien pursuant to Subsection (1);

(b) a penalty equal to 10% of the amount of the department's claim; and

(c) attorney fees and litigation expenses related to recovering the department's claim.

Definitions

"Care facility" means:

(a) a nursing facility;

(b) an intermediate care facility for an individual with an intellectual disability; or

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(c) any other medical institution. *Id*. § 26-19-102(2).

"Claim" means:

(a) a request or demand for payment; or

(b) a cause of action for money or damages arising under any law. *Id*. § 26-19-102(3).

"Recipient" means:

(a) an individual who has applied for or received medical assistance from the State;

(b) the guardian, conservator, or other personal representative of an individual under Subsection (10)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of an individual under Subsection (11)(a) if the individual is deceased. *Id*. § 26-19-102(11).

"Third party" includes the following:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by Department rule; and

(b) a spouse or parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order. *Id*. § 26-19-102(15).

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Subrogation Rights

To the extent that payment for covered expenses has been made under the Medicaid program or through any State Agency administering health benefits or a health benefit plan for which Medicaid is a source of funding for health care items or services furnished to an individual, in any cases where a third party has a legal liability to make payments, the State is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. An insurer shall accept the Agency of Human Services right to recovery and the assignment to the Agency of any right of a person to payment from the third party for medical services for which the agency has made payment under this chapter. 33 V.S.A. § 1907.

Automatic Lien

The Agency shall have a lien against a third party, to the extent of the amount paid by the Agency for medical expenses, on any recovery for that claim, whether by judgment, compromise, mediation, or settlement, whenever (1) the Agency pays medical expenses for or on behalf of a recipient who has been injured or has an illness or disease as a result of negligence; and (2) the recipient asserts a claim against a third party for damages resulting from the injury, illness, or disease. *Id*. § 1910(a).

The Agency shall have a lien against the insurer, to the extent of the amount paid by the Agency for past medical expenses, on any recovery from the insurer, whenever the agency pays medical expenses or renders medical services on behalf of a recipient who has been injured or has an injury, illness, or disease and the recipient asserts a claim against an insurer as a result of the injury, illness, or disease. *Id*. § 1910(b)(1).

Written Notice

A recipient who has applied for or has received medical assistance under this subchapter and the recipient's attorney, if any, shall cooperate with the Agency by informing the Agency in writing within a reasonable period of time after learning that the Agency has paid medical expenses for the recipient. The recipient's attorney shall take reasonable steps to discover the existence of the Agency's medical assistance. *Id*. § 1910(c). Any written notice provided to the Agency pursuant to subsection (c) must disclose the identity and address of any third party and his, her, or its insurer against whom the recipient has a right of recovery, and the name of the court in which the legal recovery action, if any, was brought. *Id*. § 1910(d).

A recipient or an attorney on behalf of a recipient shall allocate the full amount paid by the Agency for past medical expenses to or for any recovery obtained by whatever means. A recipient or an attorney on behalf of a recipient must pay to the Agency, within thirty days after receipt of settlement proceeds or recovery of a judgment, the full amount of the medical expenses owed to the Agency. If full payment of the required sum is not made to the Agency,

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within the thirty-day period, the recipient or his or her attorney shall place a sum equal to the full amount of the medical expenses paid in an escrow account pending an agreement, mediation, or judicial determination of the Agency's right to the amount. *Id*. § 1910(e)(1)-(2). The Agency's lien for its medical expenditures relating to the recipient's injury, illness, or disease shall be given priority over all other claims on the total amount recovered. *Id*. § 1910(e)(3).

In making the determination whether to pursue, reduce, or compromise a claim, the Agency may in its discretion consider the factual, evidentiary, and legal issues of liability between the recipient and any liable third party and the total amount available to satisfy the recipient's claim. Where the amount of reimbursement the Agency can reasonably expect to recover exceeds the costs of such recovery, the Agency shall not be required to seek reimbursement from or may reduce or compromise a claim against any liable third party, the insurer, or both. Whether or not the Agency exercises its discretion shall not be subject to any claim of abuse of discretion. *Id*. § 1910 (e)(4).

Automatic Lien

A lien created will not be effective unless (1) notice of the lien is filed in the office of the clerk of the town in which the agency is located and contains the name and address of the recipient, acknowledgement of the recipient's application for or receipt of medical assistance, and the name of the person alleged to be liable; and (2) the agency mails a notice of the lien with a statement of the date it was filed to the person alleged to be liable. *Id*. § 1910(f)(1)-(2).

The Agency must send a copy of the notice of the lien required by subsection (f) to the following persons, if the appropriate names and addresses can be determined:

(1) the recipient for whom the Department has paid medical expenses;

(2) any insurance carrier that may be ultimately liable; and

(3) any attorney for the recipient. *Id*. § 1910(g)(1)-(3).

Within forty-five days after the filing of the notice of the lien, the Agency shall send an itemized statement of the medical expenses paid by the Agency for which the Agency seeks to perfect a lien to the persons listed above in subsection (g). The notice provisions contained in this subsection may be waived by agreement of the parties. *Id*. § 1910(h). The Agency may, on behalf of a recipient, file a civil action in the Superior Court in Washington County against a liable third party, the third party's insurer, or both, to recover up to the full amount of medical expenses it has incurred on behalf of the recipient. *Id*. § 1910(i). The Agency may initiate this action only if: (1) the recipient has not initiated legal proceedings against the third party within one year after the occurrence of the injury, illness, or disease resulting, at least in part, from the actions or omissions, including negligence, of the third party; and (2) the time remaining under

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the statute of limitations for the action is six months or less. *Id*. The Attorney General shall be responsible for initiating actions on behalf of the Agency. *Id*.

Whenever the Agency recovers under the lien and that recovery is the result of an action initiated by a recipient, the attorney for the recipient may withhold the Agency's pro rata share of reasonably necessary attorney's fees, costs, and expenses incurred in asserting the claim. If the Agency waives its right to reimbursement, it shall not be liable for any fees, costs, and expenses incurred by the recipient or attorney. *Id*. § 1910(k). In cases where the court has determined the amount of recovery allocated for past medical expenses, the Agency's lien shall be limited to that amount. *Id*. § 1910(l).

Definitions

"Agency" means the Agency of Human Services. *Id*. § 1900(1).

"Department" means the Department of Vermont Health Access. *Id*. § 1900(3).

"Recipient" means any person or group of persons who receive Medicaid. *Id*. § 1900(7).

"Third party" means a person having an obligation to pay all or any portion of the medical expenses incurred by a recipient at the time the medical service was provided. The obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid. Third parties include:

(A) Medicare;

(B) health insurance, including health and accident but not that portion specifically designated for "income protection" which has been considered in determining recipient eligibility to participate in the Medicaid program;

(C) medical coverage provided in conjunction with other benefit or compensation programs, including military and veteran programs or workers' compensation;

(D) liability for medical expenses as agreed to or ordered in negligence suits, support settlements, or trust funds; and

(E) managed care organizations, pharmacy benefit managers, self-insured plans, and other entities that are, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service. *Id*. § 1900(9).

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Automatic Lien

Whenever any person sustains personal injuries and receives treatment in any hospital, public or private, or nursing home, or receives medical attention or treatment from any physician, or receives nursing services or care from any registered nurse in the Commonwealth of Virginia, or receives pharmaceutical goods or any type of medical or rehabilitative device, apparatus, or treatment which is paid for pursuant to the Virginia Medical Assistance Program, the State/Local Hospitalization Program and other programs of the Department of Medical Assistance Services, the Maternal and Child Health Program, or the Children's Specialty Services Program, or provided at or paid for by any hospital or rehabilitation center operated by the Commonwealth, the Department for Aging and Rehabilitative Services or any public institution of higher education, the Commonwealth shall have a lien for the total amount paid pursuant to such program, and the Commonwealth or such Department or institution shall have a lien for the total amount due for the services, equipment or devices provided at or paid for by such hospital or center operated by the Commonwealth or such Department or institution, or any portion thereof compromised pursuant to the authority granted under § 2.2-514, on the claim of such injured person or of his personal representative against the person, firm, or corporation who is alleged to have caused such injuries. VA Code Ann. § 8.01-66.9.

The Commonwealth or such Department or institution shall have a lien on the claim of the injured person or his personal representative for any funds which may be due to him from insurance moneys received for such medical services under the injured party's own insurance coverage or through an uninsured or underinsured motorist insurance coverage endorsement. The lien granted to the Commonwealth for the total amounts paid pursuant to the Virginia Medical Assistance Program, the State/Local Hospitalization Program and other programs of the Department of Medical Assistance Services, the Maternal and Child Health Program, or the Children's Specialty Services Program shall have priority over the lien for the amounts due for services, equipment or devices provided at a hospital or center operated by the Commonwealth. The Commonwealth's or such Department's or institution's lien shall be inferior to any lien for payment of reasonable attorney's fees and costs, but shall be superior to all other liens. Expenses for reasonable legal fees and costs shall be deducted from the total amount recovered. The amount of the lien may be compromised pursuant to § 2.2-514. *Id.*

The court in which a suit by an injured person or his personal representative has been filed against the person, firm or corporation alleged to have caused such injuries or in which such suit may properly be filed, may, upon motion or petition by the injured person, his personal representative or his attorney, and after written notice is given to all those holding liens attaching to the recovery, reduce the amount of the liens and apportion the recovery, and the Commonwealth or such Department or institution as the equities of the case may appear, provided that the injured person, his personal representative or attorney has made a good faith

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effort to negotiate a compromise pursuant to § 2.2-514. The court must set forth the basis for any such reduction in a written order. *Id*.

Written Notice of Lien

The lien provided for in § 8.01-66.9 shall not become effective unless and until a written notice of lien setting forth the name of the Commonwealth or the institution, hospital, nursing home, physician, nurse, or physical therapist, or emergency medical services agency that provided emergency medical services or emergency medical services vehicle transportation and the name of the injured person has been served upon or given to the person, firm, or corporation whose negligence is alleged to have caused such injuries, or the attorney for the injured party, or to the injured party. *Id*. at § 8.01-66.5(A). Such written notice of lien shall not be required if the attorney for the injured party knew that medical services were either provided or paid for by the Commonwealth. *Id*.

In any action for personal injuries or wrongful death against a nursing home or its agents, if the Department of Medical Assistance Services has paid for any health care services provided to the injured party or decedent relating to the action, the injured party or personal representative shall, within sixty days of filing a lawsuit or twenty-one days of determining that the Department of Medical Assistance Services has paid for such health care services, whichever is later, give written notice to the Department of Medical Assistance Services that the lawsuit has been filed. The Department of Medical Assistance Services shall provide a written response, stating the amount of the lien as of the date of their response, within sixty days of receiving a request for that information from the injured party or personal representative. *Id*. § 8.01-66.5(B).

Subrogation Rights

Any municipal corporation or any person, firm or corporation who may pay the charges for which a lien is provided in § 8.01-66.2 shall be subrogated to such lien. *Id*. § 8.01-66.4.

Lien against Person whose Negligence caused Injury

Whenever any person sustains personal injuries caused by the alleged negligence of another and receives treatment in any hospital, public or private, or nursing home, or receives medical attention or treatment from any physician, or receives nursing service or care from any registered nurse, or receives physical therapy treatment from any registered physical therapist in the Commonwealth, or receives medicine from a pharmacy, or receives any emergency medical services and transportation provided by an emergency medical services vehicle, such hospital, nursing home, physician, nurse, physical therapist, pharmacy or emergency medical services provider or agency shall each have a lien for the amount of a just and reasonable charge for the service rendered, but not exceeding $2,500 in the case of a hospital or nursing home, $750 for each physician, nurse, physical therapist, or pharmacy, and $200 for each emergency medical

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provider or agency on the claim of such injured person or of his personal representative against the person, firm, or corporation whose negligence is alleged to have cause such injuries. *Id*. § 8.01-66.2.

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Assignment of Rights

To the extent that payment for covered expenses has been made under medical assistance for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the State is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. West's RCWA 74.09.185. Recovery pursuant to the subrogation rights, assignments, or enforcement of the lien granted to the Authority by this section shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, except as provided in RCW 41.05A.060 and 41.05A.070. *Id*. The doctrine of equitable subrogation shall not apply to defeat, reduce, or prorate recovery by the authority as to its assignment, lien, or subrogation rights. *Id*.

The provisions of this chapter, Chapter 74.09, Medical Care, shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: provided, however, that the Director may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the Authority shall thereby be subrogated to the recipient's rights against the recovery had from any tortfeasor or the tortfeasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the Authority. *Id*. 74.09.180. To secure reimbursement for assistance provided under this chapter, the Authority may pursue its remedies under RCW 41.05A.070. *Id*.

The rights and remedies provided to the Authority in this section to secure reimbursement for assistance, including the Authority's lien and subrogation rights, may be delegated to a managed health care system by contract entered into pursuant to RCW 74.09.522. *Id*. A managed health care system may enforce all rights and remedies delegated to it by the Authority to secure and recover assistance provided under a managed health care system consistent with its agreement with the Authority. *Id*.

Subrogation Rights

To secure reimbursement of any assistance paid under RCW 74.09, as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the Department shall be subrogated to the recipient's rights against a tortfeasor or the tortfeasor's insurer, or both. West's RCWA 43.20B.060(1).

Automatic Lien

The Department shall have a lien upon any recovery by or on behalf of the recipient from such tortfeasor or the tortfeasor's insurer, or both to the extent of the value of the assistance paid, provided that such lien shall not be effective against recoveries subject to wrongful death when they are surviving dependents of the deceased. *Id*. 43.20B.060(2). The lien shall become effective upon filing with the county auditor in the county where the assistance was authorized

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or where any action is brought against the tortfeasor or insurer. *Id*. The lien may also be filed in any other county or served upon the recipient in the same manner as a civil summons if, in the Department's discretion, such alternate filing or service is necessary to secure the Department's interest. *Id*. The additional lien shall be effective upon filing or service. *Id*.

The lien of the Department shall be upon any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled (a) against the tortfeasor or insurer of the tortfeasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance is paid or provided by the Department. *Id*. 43.20B.060(3). No settlement made by and between the recipient and tortfeasor and/or insurer shall discharge or otherwise compromise the lien created in RCW 43.20B.060 without the express written consent of the Secretary. *Id*. 43.20B.050(1). Discretion to compromise such liens rests solely with the Secretary or the Secretary's designee. *Id*. No settlement or judgment shall be entered purporting to compromise the lien created by RCW 43.20B.060 without the express consent of the Secretary or the Secretary's designee. *Id*. 43.20B.050(2).

If recovery is made by the Department under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the Department shall bear its proportionate share of attorneys' fees and costs. *Id*. 43.20B.060(4). The determination of the proportionate share to be borne by the Department must be based upon: (i) the fees and costs approved by the court in which the action was initiated; or (ii) the written agreement between the attorney and client which establishes fees and costs when fees and costs are not addressed by the court. *Id*. 43.20B.060(4)(a). When fees and costs have been approved by a court, after notice to the Department, the Department shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share. *Id*. 43.20B.060(4)(b). When fees and costs have not been addressed by the court, the Department shall receive at the time of settlement a copy of the written agreement between the attorney and client which establishes fees and costs and may request and examine documentation of fees and costs associated with the case. *Id*. 43.20B.060(4)(c). The Department may bring an action in superior court to void a settlement if it believes the attorneys' calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature. *Id*.

The rights and remedies provided to the Department in this section to secure reimbursement for assistance, including the Department's lien and subrogation rights, may be delegated to a managed health care system by contract entered into pursuant to RCW 74.09.522. *Id*. 43.20B.060(5). A managed health care system may enforce all rights and remedies delegated to it by the Department to secure and recover assistance provided under a managed health care system consistent with its agreement with the Department. *Id*.

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Attorney's Duties

An attorney representing a person who, as a result of injuries or illness sustained through the negligence or wrong of another, has received, is receiving, or has applied to receive assistance under chapter 74.09, shall:

> (a) Notify the Department at the time of filing any claim against a third party, commencing an action at law, negotiating a settlement, or accepting a settlement offer from the tortfeasor or the tortfeasor's insurer, or both; and
>
> (b) Give the Department thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or recipient to recover damages for such injuries or illness. West's RCWA 43.20B.070(1)(a)-(b).

The proceeds from any recovery made pursuant to any action or claim described in RCW 43.20B.060 that is necessary to fully satisfy the Department's lien against recovery shall be placed in a trust account or in the registry of the court until the Department's lien is satisfied. *Id*. 43.20B.070(2).

Definitions

"Authority" means the Washington State Health Care Authority. *Id*. 74.09.010(1).

"Director" means the Director of the Washington State Health Care Authority. *Id*. 74.09.010(9).

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Assignment of Rights

Submission of an application to the Department of Health and Human Services for medical assistance is, as a matter of law, an assignment of the right of the applicant or his or her legal representative to recover from third parties past medical expenses paid for by the Medicaid program. W. Va. Code, § 9-5-11(b). At the time an application for medical assistance is made, the Department shall include a statement along with the application that explains that the applicant has assigned all of his or her rights as provided in this section and the legal implications of making this assignment. *Id*. The assignment of rights does not extend to Medicare benefits. *Id*. The recipient or his or her legal representative is not prevented from maintaining an action for injuries or damages sustained by the recipient against any third party and from including, as part of the compensatory damages sought to be recovered, the amounts of his or her past medical expenses. *Id*.

The Department shall be legally subrogated to the rights of the recipient against the third party. *Id*. § 9-5-11(b)(5). The Department shall have a priority right to be paid first out of any payments made to the recipient for past medical expenses before the recipient can recover any of his or her own costs for medical care. Id. § 9-5-11(b)(6). A recipient is considered to have authorized all third parties to release to the Department information needed by the Department to secure or enforce its rights as assignee under this chapter. *Id*. § 9-5-11(b)(7).

Notice Requirements to the Department

A recipient's legal representative shall provide notice to the Department within sixty days of asserting a claim against a third party. *Id*. § 9-5-11(c)(1). If the claim is asserted in a formal civil action, the recipient's legal representative shall notify the Department within sixty days of service of the complaint and summons upon the third party by causing a copy of the summons and a copy of the complaint to be served on the Department as though it were named a party defendant. *Id*.

If a recipient has no legal representative and the third party knows or reasonably should know that a recipient has no representation, then the third party shall provide notice to the Department within sixty days of receipt of a claim or within thirty days of receipt of information or documentation reflecting the recipient is receiving Medicaid benefits, whichever is later in time. *Id*. § 9-5-11(c)(2). In any civil action implicated by this section, the Department may file a notice of appearance and shall thereafter have the right to file and receive pleadings, intervene and take other action permitted by law. *Id*. § 9-5-11(c)(3). The Department shall provide the recipient and the third party, if the recipient is without legal representation, notice of the amount of the purported subrogation lien within thirty days of receipt of notice of the claim. *Id*. § 9-5-11(c)(4). The Department shall provide related supplements in a timely manner, but no later than fifteen days after receipt of a request for same. *Id*.

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Notice of Settlement Requirement

A recipient or his or her representative must notify the Department of a settlement with a third party and retain in escrow an amount equal to the amount of the subrogation lien asserted by the Department. *Id*. § 9-5-11(d)(1). The notification shall include the amount of the settlement being allocated for past medical expenses paid for by the Medicaid program. *Id*. Within thirty days of the receipt of any such notice, the Department must notify the recipient of its consent or rejection of the proposed allocation. *Id*. If the Department consents, the recipient or his or her legal representation shall issue payment out of the settlement proceeds in a manner directed by the Secretary or his or her designee within thirty days of consent to the proposed allocation. *Id*.

If the total amount of the settlement is less than the Department's subrogation lien, then the settling parties shall obtain the Department's consent to the settlement before finalizing the settlement. *Id*. § 9-5-11(d)(2). The Department must advise the parties within thirty days and provide a detailed itemization of all past medical expenses paid by the Department on behalf of the recipient for which the Department seeks reimbursement out of the settlement proceeds. *Id*. If the Department rejects the proposed allocation, the Department shall seek a judicial determination within thirty days and provide a detailed itemization of all past medical expenses paid by the Department on behalf of the recipient for which the Department seeks reimbursement out of the settlement proceeds. *Id*. § 9-5-11(d)(3). If judicial determination becomes necessary, the trial court is required to hold an evidentiary hearing. *Id*. § 9-5-11(d)(3)(A). The recipient and Department shall be provided ample notice of the same and be given just opportunity to present the necessary evidence, including fact witness and expert witness testimony, to establish the amount to which the Department is entitled to be reimbursed pursuant to this section. *Id*. The Department shall have the burden of proving by a preponderance of the evidence that the allocation agreed to by the parties was improper. *Id*. § 9-5-11(d)(5). For purposes of appeal, the trial court's decision should be set forth in a detailed order containing the requisite findings of fact and conclusions of law to support its rulings. *Id*.

Any settlement by a recipient with one or more third parties which would otherwise fully resolve the recipient's claim for an amount collectively not to exceed $20,000 shall be exempt from the provisions of this section. *Id*. § 9-5-11(d)(4). Nothing herein prevents a recipient from seeking judicial intervention to resolve any dispute as to allocation prior to effectuating a settlement with a third party. *Id*.

Department's Failure to Respond to Notice of Settlement

If the Department fails to appropriately respond to a notification of settlement, the amount to which the Department is entitled to be paid from the settlement shall be limited to the amount of the settlement the recipient has allocated toward past medical expenses. *Id*. § 9-5-11(e).

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Recipient's Failure to Notify the Department of Settlement

A legal representative acting on behalf of a recipient or third party that fails to comply with the provisions of this section is liable to the Department for all reimbursement amounts the Department would otherwise have been entitled to collect pursuant to this section but for the failure to comply. *Id*. at § 9-5-11(f). Under no circumstances may a pro se recipient be penalized for failing to comply with the provisions of this section. *Id*.

Attorneys' Fees

Irrespective of whether an action or claim is terminated by judgment or settlement without trial, from the amount required to be paid to the Department, there shall be deducted the reasonable costs and attorneys' fees attributable to the amount in accordance with and in proportion to the fee arrangement made between the recipient and his or her attorney of record so that the Department shall bear the pro-rata share of the reasonable costs and attorneys' fees. *Id*. § 9-5-11(h). If there is no recovery, the Department shall, under no circumstances, be liable for any costs or attorneys' fees expended in the matter. *Id*.

Notice of Action or Claim by the Department

If either the medical assistance recipient or the Department brings an action or claim against a third person, the recipient, his attorney or such Department shall, within thirty days of filing the action, give to the other written notice of the action or claim by certified mail. W. Va. Code, § 9- 5-11a. This notice must contain the name of the third person and the court in which the action is brought. *Id*. If the Department institutes said action, the notice shall advise the recipient of their right to bring such action in their own name, in which they may include as a part of their claim the sums claimed by such Department. *Id*. Proof of such notice shall be filed in said action subject to the notice and intent procedure as outlined in section eleven of this article. *Id*. If an action is brought by either the recipient or the Department, the other may, at any time before trial, become a part to the action, or shall consolidate his action or claim with the other if brought independently. *Id*.

Definitions

"Department" means the West Virginia Department of Health and Human Resources, or its contracted designee;

"Recipient" means a person who applies for and receives assistance under the Medicaid Program; and

"Third party" means an individual or entity that is alleged to be liable to pay all or part of the costs of a recipient's medical treatment and medical-related services for personal injury, disease, illness or disability, as well as any entity including, but not limited to, a business organization,

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health service organization, insurer, or public or private agency acting by or on behalf of the allegedly liable third party. *Id*. § 9-5-11(a).

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Subrogation Rights

The Department of Health Services shall be subrogated to the rights of a recipient when an injury occurs that creates a claim or cause of action, whether in tort or contract, against a third party. Wis. Stat. § 49.89(2). The Department may make a claim or maintain an action or intervene in a claim or action by the recipient against the third party. *Id*. An individual who applies for medical assistance assigns to the state Department the right to make a claim to recover an indemnity from a third party, including an insurer, if the assistance is provided as a result of the occurrence of an injury that results in a possible recovery of an indemnity from the third party. Wis. Stat. § 49.89(3). The participant, or their attorney, must provide notice to the Department following: (1) the filing of the action asserting the claim; (2) intervention in the action asserting the claim; (3) consolidation of the action asserting the claim; and (4) an award or settlement of all or part of the claim. Wis. Stat. § 49.89(3m)(c). The reasonable costs of collection including attorney fees should be deducted first from a recovery. Wis. Stat. § 49.89(5).

A health maintenance organization or other prepaid health care plan has the powers of the Department to recover costs which the organization or plan incurs in treating an individual if all of the following are present: (a) the costs resulting from an occurrence of an injury or sickness of an individual who is a recipient of medical assistance; (b) the occurrence of the injury or sickness creates a claim or cause of action on the part of the recipient or the estate of the recipient; and (c) the medical costs are incurred during a period for which the Department pays a capitation or enrollment fee for the recipient. Wis. Stat. § 49.89(9).

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Assignment of Rights

Upon signing an application for medical assistance, an applicant assigns to the Department any right to medical support or payment for medical expenses from any other person on his behalf or on behalf of any relative for whom application is made. W.S.1977 § 42-4-106(b). The assignment is effective upon a determination of eligibility. *Id*. Application for medical assistance shall contain an explanation of the assignment. *Id*.

Third Party Recovery

If a person who is or becomes an applicant or recipient for medical assistance receives an injury under circumstances creating a legal liability in some third party, the applicant or recipient shall not be deprived of any medical assistance for which he is entitled under this chapter. W.S.1977 § 42-4-201(a). He may also pursue his remedy at law against the third party. *Id*. If the applicant or recipient recovers from the third party in any manner, including judgment, compromise, settlement or release, the Department is entitled to be reimbursed for all payments made, or to be made, on behalf of the applicant or recipient under this chapter. *Id*.

The Department must be served by certified mail, return receipt requested, with a copy of the complaint within seven days of its filing in any suit initiated pursuant to subsection (a) of this section. *Id*. § 42-4-201(b). Any attorney who knowingly fails to serve the complaint on the Department shall be reported to the State Board of Professional Responsibility for the Wyoming State Bar. *Id*. The Department shall be notified in writing by certified mail return receipt requested of any judgment, compromise, settlement or release entered into by any person who has been an applicant for or recipient of medical assistance under this chapter after the date of injury. *Id*. If there is a settlement, compromise or release entered into by the parties, the Attorney General representing the Director shall be made a party in all negotiations for settlement, compromise or release. *Id*. The Department, for purposes of facilitating compromise and settlement, may in a proper case authorize acceptance by the State of less than the State's claim for reimbursement under this section for all current and future assistance under this chapter. *Id*. Any reimbursement right created pursuant to this article must remain in effect until the State is paid the amount authorized under this section. *Id*. In addition, the person paying the settlement remains liable to the State's reimbursement right unless the State, through the Attorney General, signs the release prior to payment of an agreed settlement. *Id*.

Automatic Lien

When the Department provides, pays for or becomes liable for medical care, it shall have a lien for the cost of the medical assistance provided upon any and all causes of action which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the injuries which necessitated the medical care. *Id*. § 42-4-202(a). The Department may perfect and enforce its lien by following the procedures set forth in W.S. 29-1-312 and 29-1-

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313, and its verified lien statement shall be filed with the appropriate clerk in the county of financial responsibility. *Id*. § 42-4-202(b). The verified lien statement must contain the following:

(i) The name and address of the person to whom medical care was furnished;

(ii) The date of injury;

(iii) The name and address of the vendor or vendors furnishing medical care;

(iv) The dates of the service;

(v) The amount claimed to be due for the care;

(vi) To the best of the Department's knowledge, the names and addresses of all persons, firms or corporations claimed to be liable for damages arising from injuries. *Id*.

Notice Requirements

The Department must be given notice of monetary claims against a person, firm or corporation that may be liable to pay part or all of the cost of medical care when the Department has paid or becomes liable for the cost of that care. Notice shall be given as follows:

(i) Applicants for medical assistance must notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance must notify the Department of any possible claims when those claims arose. A recipient's noncooperation in providing information to the Department to assist in pursuing liable third parties shall result in denial or termination of eligibility per federal law;

(ii) An enrolled Medicaid provider shall notify the Department when the person has reason to believe that a third party may be liable for payment of the cost of medical care. If the person providing medical care services fails to notify the Department when a third party is liable for payment of the cost of medical care and the Department, because of lack of notice from the provider, does not receive reimbursement for the cost of medical care, the Department may adjust the value of those claims from future payments to that provider;

(iii) An attorney representing an applicant for or a recipient of medical assistance in a claim upon which the Department may have a reimbursement right shall notify the Department of its potential claim for reimbursement before filing a claim, commencing an action, or negotiating a settlement. Any attorney who fails to notify the Department of any settlement or fails to ensure the state is reimbursed, to the extent of its reimbursement right, from the proceeds of any settlement or judgment shall be reported

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to the State Board of Professional Responsibility for the Wyoming State Bar. If the attorney knowingly failed to report and insure reimbursement to the State, the Department shall have a claim for relief against the attorney for the amount of the reimbursement right under this chapter;

(iv) Insurers shall not disburse any settlement payment for a personal injury claim made to a recipient of medical assistance under this act until seven working days after the Department has received written notice from the insurer of the proposed settlement or judgment and failed to provide a written objection to the insurer. Failure to provide notice under this paragraph shall commence the tolling of any applicable statute of limitations.

Settlement

No settlement made by and between the applicant or recipient and the tortfeasor or insurer shall discharge the right to reimbursement created pursuant to this article, against any money due or owing by such tortfeasor or insurer to the applicant or recipient or release the tortfeasor or insurer from liability by reason of the right to reimbursement unless the settlement also provides for the payment and discharge of the right to reimbursement and the Attorney General has signed a written release as provided by W.S. § 42-4-201(b). W.S.1977 § 42-4-203.

Subrogation Rights

The Department shall be subrogated to any right of recovery or indemnification arising from an accident or occurrence resulting in expenditures by the Department, which an applicant or recipient of medical assistance or any legally liable party has against an insurer, health insurer, self-insured plan, group health plan, service benefit plan, managed care organization, pharmacy benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for health care items or services, including but not limited to hospitalization, pharmaceutical services, physician services, nursing services and other medical services, not to exceed the amount expended by the Department for the care and treatment of the applicant or recipient. W.S.1977 § 42-4-204(a). An applicant or recipient or legally liable party, by the act of applying for, or recipient receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the Department. *Id*. The Department must inform an applicant of the assignments at the time of application. *Id*.

Furthermore, any entitlements from a contractual agreement with an applicant or recipient or legally liable party, a state or federal program or a claim or action against any responsible third party for medical services, not to exceed the amount expended by the Department, shall be so assigned. *Id*. The entitlements shall be directly reimbursable to the Department by third party payers. *Id*. The Department may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services

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to an applicant or recipient, in order to assist the provider in obtaining payment for the services. *Id*. A provider that has received an assignment from the Department shall notify the insurer of the assignment upon rendering of services to the applicant or recipient. *Id*. Failure to notify the insurer shall render the provider ineligible for payment from the Department. *Id*. Once the insurer has been billed or notified, the provider may not request payment through the Medicaid program until a payment, denial or other explanation of benefits, not including mistakes in billing, is received from the insurer. *Id*. The provider shall notify the Department of any request by the applicant or recipient or his legally liable party or representative for billing information. *Id*.

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