No. 04-1506

In the Supreme Court of the United States

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

HEIDI AHLBORN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

PAUL D. CLEMENT
Solicitor General
Counsel of Record

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

PATRICIA A. MILLETT
Assistant to the Solicitor General

WILLIAM KANTER
ANNE MURPHY
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

QUESTION PRESENTED

The federal Medicaid program, 42 U.S.C. 1396 *et seq.*, requires participating States to "take all reasonable measures to ascertain the legal liability of third parties" for medical expenses paid by Medicaid and to "seek reimbursement for such [medical] assistance to the extent of such legal liability." 42 U.S.C. 1396a(a)(25)(A) and (B). To that end, Medicaid beneficiaries must "assign the State any rights * * * to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A). Federal law also prohibits States from imposing any lien "against the property of any individual prior to his death on account of medical assistance paid." 42 U.S.C. 1396p(a)(1). The question presented is:

Whether, when a Medicaid beneficiary receives a lump-sum settlement from a third party who is legally liable for the costs of her medical care, Medicaid's claim to full reimbursement is properly accorded priority in the distribution of the settlement proceeds.

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INTEREST OF THE UNITED STATES

This case concerns the third-party liability provisions of the federal Medicaid Act, which represent a significant source of compensation for that program at both the federal and state levels. In 2004, approximately $1.6 billion in third party liability payments were recovered nationwide. Congress has vested the Secretary of Health and Human Services with broad authority to administer the Medicaid program. 42 U.S.C. 1302. The question presented directly implicates the Secretary's interpretation and implementation of the Medicaid statute.

STATEMENT

1. a. Medicaid, which Congress enacted as Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program under which the federal government provides funding to States to provide medical assistance to indigent individuals. Under the program, the federal government pays between 50% and 83% of the cost of patient care incurred by a State, as determined by a formula keyed to each State's *per capita* income. See 42 U.S.C. 1396d(b). In Arkansas, the federal government generally has paid approximately 74% of each patient's care. States that participate in the Medicaid program must sub-

mit to the Secretary of Health and Human Services (Secretary) a plan for medical assistance that conforms to the requirements of the Medicaid statute. See 42 U.S.C. 1396a (2000 & Supp. II 2002); 42 C.F.R. 430.10. All 50 States participate in the Medicaid program.

Congress has charged the Secretary with administering the federal Medicaid program, including reviewing and approving State plans and operations, and has vested the Secretary with "extremely broad regulatory authority" to implement the requirements of the Medicaid Act. *Wisconsin Dep't of Health & Family Servs.* v. *Blumer*, 534 U.S. 473, 496 n.13 (2002); see 42 U.S.C. 1302. The Secretary exercises his authority through the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration). See 66 Fed. Reg. 35,437 (2001).

b. At times, an individual's need for Medicaid arises from circumstances, such as injuries incurred in an automobile accident, that render third parties liable for the costs of the beneficiary's medical care.[1] Potentially responsible third parties include tortfeasors, insurance companies, employee health benefit plans, and non-custodial parents. See 42 C.F.R. 433.136, 433.138. In order to preserve Medicaid's role as the payer of last resort and to maximize the amount of assistance available for all qualifying individuals, the Medicaid statute requires participating States to "take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and services" provided by Medicaid. 42 U.S.C. 1396a(a)(25)(A). Each State's plan also must specify how it will pursue third-party liability claims. 42 U.S.C. 1396a(a)(25)(A)(ii). That plan must include provisions for the collection, any time a beneficiary's eligibility is established or redetermined, of "sufficient in-

[1] "[E]xperience indicates that due to the severity of motor vehicle accident related injuries, extended medical care is usually required which results in substantial Medicaid program expenditures." 52 Fed. Reg. 5971 (1987).

formation" "to enable the State to pursue claims against such third parties." 42 U.S.C. 1396a(a)(25)(A)(i).

In addition, the State must enact "laws under which * * * the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." 42 U.S.C. 1396a(a)(25)(H). Each State's Medicaid plan also must require, as "a condition of eligibility," that recipients "assign the State any rights * * * to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A); see 42 U.S.C. 1396a(a)(45). States likewise must require Medicaid beneficiaries to "cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." 42 U.S.C. 1396k(a)(1)(C). As an "essential[]" part of such cooperation, States can require beneficiaries to "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 C.F.R. 433.147(b)(4).

Once potential third-party liability for medical care and services is identified, the State must "seek reimbursement for [its] assistance to the extent of such legal liability." 42 U.S.C. 1396a(a)(25)(B). With respect to any money collected by the State following an assignment, the Medicaid statute accords priority to the State's claim for reimbursement by directing the State to "retain[]" "[s]uch part of any amount collected * * * as is necessary to reimburse it for medical assistance payments made." 42 U.S.C. 1396k(b); see 42 C.F.R. 433.154. The State, in turn, must reimburse the federal government for its share of the payments. *Ibid.* Only then will "the remainder of such amount collected" be paid to the beneficiary. *Ibid.*[2] The Secretary has promul-

[2] The Secretary allows for deduction of the costs of obtaining the award, including attorneys' fees, before reimbursement of the Medicaid program. Centers for Medicare & Medicaid Servs., Dep't of Health & Human Servs.,

gated regulations that implement Medicaid's third-party liability provisions. See 42 C.F.R. 433.135 *et seq*.[3]

c. The Medicaid statute separately provides that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 U.S.C. 1396p(a)(1). An exception is made for liens imposed "pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual." 42 U.S.C. 1396p(a)(1)(A).

2. As a participant in the federal Medicaid program, Arkansas provides by law that, "[a]s a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Arkansas Department of Health and 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) (Michie 1991). "The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law." *Id*. § 20-77-307(b). State law further provides that the "assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party." *Id*. § 20-77-307(c).

If a Medicaid beneficiary brings suit against a "third party who may be liable for [her] injury, disease, disability, or death," "any settlement, judgment, or award obtained is subject to the [State's] claim for reimbursement of the benefits provided to the recipient under the medical assistance

State Medicaid Manual § 3907 (last modified Sept. 16, 2004), <www.cms.hhs.gov/manuals/45_smm/ sm_03_3_toc. asp>.

[3] Under Medicare, the government likewise must be reimbursed in full, to the extent of the third party's liability for medical damages, before tort settlement proceeds may be used for other purposes. See 42 U.S.C. 1395y(b)(2)(B)(ii); 42 C.F.R. 411.24(c); see generally *Zinman* v. *Shalala*, 67 F.3d 841, 845 (9th Cir. 1995).

program." Ark. Code Ann. § 20-77-302(a). That same law accords the State's claim for Medicaid reimbursement priority in the distribution of any settlement, judgment, or award, irrespective of whether the recipient alone brought the action or whether the State also participated. *Id.* §§ 20-77-302(b), 20-77-303(b). In addition, Medicaid beneficiaries must notify the State of the institution or settlement of any claims against third parties who are liable for medical expenses. *Id.* § 20-77-304(a) and (b). "No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability" in which the State has an interest can be "satisfied without first giving the [State] notice and a reasonable opportunity to establish its interest." *Id.* § 20-77-305(a).

3. After sustaining permanently disabling injuries in a car accident, respondent applied for and received more than $215,000 in medical assistance from the Arkansas Medicaid program. Those benefits have "fully relieved her debt to health care providers." Pet. App. 2; J.A. 11. In applying for benefits, respondent assigned to the State her "right to any settlement, judgment, or award" that she might receive from third parties up "to the full extent of any amount which may be paid by Medicaid" on her behalf. Pet. App. 2.

Respondent subsequently filed a state-court suit against her insurance company and other third parties that she alleged were legally liable for her injuries. Pet. App. 2. She asserted more than $3 million in damages for her medical care, pain and suffering, and lost earning capacity. *Id.* at 2, 17. The State intervened in the suit. J.A. 24. Respondent, however, settled the litigation for $550,000, without any advance notice to the State. Pet. App. 2. The settlement was paid as a lump-sum amount that was not allocated among the various damages claims. *Ibid.* Those sums purported to constitute full and complete settlement of all

claims of any nature, whether past or future, arising out of respondent's injuries. J.A. 4-5; see J.A. 12, 23-24. The State then asserted a lien against the settlement proceeds in the amount of the medical benefits that it had provided to respondent. Pet. App. 2.

4. Respondent filed suit in federal district court against petitioners, the Arkansas Department of Human Services and a number of its officials (collectively "Arkansas"), seeking a declaratory judgment that the Medicaid statute forbids Arkansas from recovering more than the percentage of the settlement that respondent herself attributes to medical expenses. Pet. App. 3. The parties stipulated that respondent would have claimed $3,040,708.12 in total damages had the state court litigation gone to trial. *Id.* at 2. Because the $550,000 settlement was deemed to represent one-sixth of the total recovery she sought from third parties—it actually represents a recovery of just over 18%—respondent contended that Arkansas could only recover 16.5% of its medical damages claim, which amounts to $35,581.47. *Id.* at 3; J.A. 18.

The district court granted summary judgment for Arkansas. Pet. App. 16-31. Considering the statute as a whole and Medicaid's intended role as the "payer of last resort," *id.* at 30 & n.6, and deferring to the Secretary's interpretation of the proper operation of the third-party liability and lien provisions, *id.* at 28, 30, the court concluded that Arkansas was entitled to full reimbursement of its medical expenses, *id.* at 30. In the district court's view, respondent's prior assignment of her right to recover medical damages from liable third parties eliminated her property interest in that money, which made the Medicaid statute's anti-lien provision "drop[] out of the analysis." *Id.* at 26. The district court observed that respondent's contrary approach would promote "manipulation of tort awards by recipients who seek to prevent the public from being reim-

bursed for the funds it has advanced for their medical care," and who thus have "no interest in placing an appropriate value on that component of recovery." *Id.* at 31.

5. The court of appeals reversed. Pet. App. 1-15. The court held that Medicaid's anti-lien provision limits the State to recovering only that portion of the lump-sum settlement that is designated, after the fact, to be compensation for medical care. *Id.* at 10. Finding that Medicaid beneficiaries have a property interest in their "right to a settlement that may be received from a third party," *id.* at 6, the court concluded that the anti-lien provision precluded Arkansas from recovering anything more than the amount respondent had designated as medical damages. *Ibid.* The court rejected the Secretary's view that States must recover more than just a compromised payment for medical costs as "inconsistent with the plain language of the statute." *Id.* at 11. The court noted the Secretary's and the State's concern about the manipulation of settlement amounts, but reasoned that a State could address that problem by suing the third-party tortfeasor directly, *id.* at 13, or by seeking to "recharacterize" settlement amounts ostensibly for other purpose as payments for medical expenses, *id.* at 14. Here, however, the court held that Arkansas's recovery was limited to $35,581.47, while respondent was free to retain $180,063.83 that otherwise would have been used to reimburse Medicaid expenses. *Id.* at 2, 14-15.

SUMMARY OF ARGUMENT

A. Medicaid is the payer of last resort for medical expenses of the indigent. To preserve that status, the Medicaid Act requires participating States and beneficiaries acting in cooperation with them to seek to recover from responsible third parties the full amount of medical assistance rendered. As the Medicaid statute and Arkansas law require, respondent assigned to the State her right to recover medical damages from third parties to the full extent

of those parties' legal liability for Medicaid's expenses. By pressing its entitlement to full payment of its claim for medical damages out of the settlement proceeds, Arkansas seeks merely to vindicate its own assigned right; it does not impermissibly encroach upon any distinct property rights held by the beneficiary.

The fundamental flaw in the court of appeals' holding that States may recover only a portion of a post hoc allocation of settlement proceeds is that it mistakenly equates a *compromised* payment of medical damages with the *full extent* of the paying party's legal liability for medical damages. The text and purposes of the Medicaid Act demand that the beneficiary cooperate with the State in collecting the latter, rather than unilaterally resolving the third parties' liability and attempting to force the State, after the fact, to accept only a fraction of its claim, while keeping the balance for herself. The rule that the Medicaid claim be paid first and in full preserves Medicaid as the payer of last resort, gives full effect to the State's assigned right to medical damages and priority in their compensation, compels beneficiaries to adhere to their voluntarily assumed duty of cooperation with the State, and prevents unjustified inequities in the administration of the Medicaid program.

That rule also accords with common sense. Respondent's suit against the responsible third parties resolved their liability for her medical damages. Because the State's and federal government's claims were not—could not—have been unilaterally compromised by respondent, federal law reasonably treats the settlement amount as encompassing the full amount of the Medicaid claim.

B. The requirement of full payment does not implicate Medicaid's anti-lien provision. That provision protects property that rightfully belongs to the Medicaid beneficiary, not property that federal law requires to be assigned to the State as a condition of the beneficiary's receipt of

Medicaid benefits in the first instance. To the extent that the portion of the settlement proceeds dedicated to compensation of Arkansas' medical damages claim temporarily passed into respondent's hands, she held it in constructive trust for the State. To hold otherwise would invite the arbitrary truncation, if not outright manipulation, of settlement awards to deprive the taxpayers' of their rightful claim to reimbursement for Medicaid benefits. The Secretary of Health and Human Services has reasonably interpreted the Medicaid statute not to require that result, and that interpretation is entitled to deference. The court of appeals, for its part, offered no reason why respondent, who received benefits conditioned upon assigning her full right to payments for medical expenses and cooperating with the State in maximizing that recovery, should obtain a $180,000 windfall based on nothing more than her unilateral compromise of the State's claim to reimbursement, without fair notice to the State and in contravention of her duty of cooperation.

ARGUMENT

THE MEDICAID STATUTE REQUIRES THAT MEDICAID EXPENSES BE REIMBURSED FIRST AND IN FULL OUT OF A BENEFICIARY'S LUMP-SUM SETTLEMENT, TO THE EXTENT OF THE THIRD PARTY'S LIABILITY FOR SUCH MEDICAL EXPENSES

The problem at hand—which is a common one—arises when a Medicaid beneficiary unilaterally obtains a lump-sum settlement from responsible third parties that resolves their liability for damages, medical and otherwise, without affording the State an opportunity to protect its own interests or providing any objective determination of the actual extent of the defendants' liability for medical damages. That problem can be avoided by the simple expedient of the beneficiary honoring her duty of cooperation and involving the State in the settlement process. In the Secretary's

view, the text and purposes of the Medicaid Act require that, in the event of unilateral action that excludes the State, the Medicaid claim be paid first and in full. Any other approach would run afoul of statutory text and purposes, would reward beneficiaries' circumvention of their statutory duties of assignment and cooperation, and would make the Medicaid program a source of financial windfalls, rather than a payer of last resort.[4]

A. The Text And Purpose Of Medicaid's Third-Party Liability Provisions Require Full Reimbursement

1. Medicaid is the payer of last resort

Medicaid is "the primary federal program for providing medical care to indigents at public expense." *Memorial Hosp.* v. *Maricopa County*, 415 U.S. 250, 262 n.19 (1974). Unlike Medicare, Medicaid does not function as an insur-

[4] Almost every court to decide the question has agreed with the Secretary's position. See *Sullivan* v. *County of Suffolk*, 174 F.3d 282, 286 & n.5 (2d Cir.), cert. denied, 528 U.S. 950 (1999); *Copeland* v. *Toyota Motor Sales U.S.A., Inc.*, 136 F.3d 1249, 1258 (10th Cir. 1998); *Richards* v. *Georgia Dep't of Cmty. Health*, 604 S.E.2d 815 (Ga. 2004); *Houghton* v. *Department of Health*, 57 P.3d 1067, 1069 (Utah 2002), cert. denied, 538 U.S. 945 (2003); *Grey Bear* v. *North DakotaDep't of Human Servs.*, 651 N.W.2d 611, 617-618 (N.D. 2002), cert. denied 539 U.S. 960 (2003); *Wilson* v. *State*, 10 P.3d 1061, 1066 (Wash. 2000), cert. denied, 532 U.S. 1020 (2001); *Calvanese* v. *Calvanese*, 710 N.E.2d 1079, 1081-1082 (N.Y.), cert. denied, 528 U.S. 928 (1999); *S.S.* v. *State*, 972 P.2d 439, 442-443 (Utah 1998); *Roberts* v. *Total Health Care, Inc.*, 709 A.2d 142, 148-149 (Md. Ct. App. 1998); *Grayam* v. *Department of Health & Human Res.*, 498 S.E.2d 12, 20-21 (W. Va. 1997); *In re Kietur*, 752 A.2d 799 (N.J. Super. Ct. App. 2000); *Payne* v. *State*, 486 S.E.2d 469, 471 (N.C. Ct. App. 1997), review denied, 493 S.E.2d 656 (N.C. 1997); cf. *Zinman*, 67 F.3d at 844-845 (same, under Medicare program); but see *Arizona Health Care Cost Containment Sys.* v. *Bentley*, 928 P.2d 653, 656 (Ariz. Ct. App. 1996) (" 'Medical benefits' does not include tort settlement proceeds."), review denied (Dec. 17, 1996). Contra *Martin* v. *City of Rochester*, 642 N.W.2d 1, 13 (Minn. 2002) (anti-lien provision violated where state law assigned a cause of action, rather than a right to payment, and where state property law attached independent property rights to each component of damages), cert. denied, 539 U.S. 957 (2003).

ance plan. It is a needs-based entitlement program for the poor, "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396; see *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36 (1981). "Medicaid is intended to be the payer of last resort" for needy individuals, S. Rep. No. 146, 99th Cong., 1st Sess. 312 (1985). All "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *Ibid.*

It is not uncommon for Medicaid to provide benefits to individuals who have extremely limited resources available to pay for medical care, see 42 U.S.C. 1396a(a)(10), but for whom third parties (such as tortfeasors, insurance companies, or non-custodial parents) may be liable for all or a portion of the medical expenses incurred. S. Rep. No. 744, 90th Cong., 1st Sess. 184 (1967).[5] Medicaid often pays first in circumstances like respondent's unfortunate sudden and serious accident because the applicant lacks the funds at hand to pay for large medical bills. Medicaid steps in on short notice, affording the beneficiary needed medical care, respite from medical debts, and medical security. But Medicaid's status as the payer of last resort can only be preserved in those circumstances if Medicaid's third-party liability provisions are stringently enforced. Accordingly, when those same beneficiaries later recover payments from third parties, the Medicaid Act requires them to reimburse the Medicaid program to the extent of the third parties' liability for medical damages, before retaining funds for themselves. Otherwise, Medicaid becomes a program of short-term financial expedience that enables long-term financial windfalls, rather than a payer of last resort for the truly indigent.

[5] The Secretary has advised that approximately 17% of all Medicaid beneficiaries have some form of third-party coverage for their medical expenses.

2. The text of the third-party liability provisions requires full compensation of Medicaid's claim from settlements

By its plain terms, the Medicaid statute requires States to seek to recover Medicaid payments in full from a third-party settlement, up to the full extent of that third-party's legal liability for medical payments. The Medicaid law directs that, whenever "a legal liability is found to exist," the State "*will* seek reimbursement" for the medical assistance it has provided. 42 U.S.C. 1396a(a)(25)(B) (emphasis added). The only exception to that directive is when the costs of recovery can reasonably be expected to exceed the amount reimbursed. *Ibid.* The State, moreover, must seek reimbursement "to the extent of such legal liability"—no more, but also no less. *Ibid.* The beneficiary's duty to cooperate likewise extends to assisting the State in "pursuing[] any third party who may be liable to pay for care and services" provided under the Medicaid program, to the extent of that liability. 42 U.S.C. 1396k(a)(1)(C).

Medicaid's assignment provision gives effect to that mandate. Section 1396k requires a Medicaid beneficiary, as a condition of receiving benefits, to assign to the State "any rights" the beneficiary has to any "payment for medical care" from "any third party." 42 U.S.C. 1396k(a)(1)(A). Congress thus charged the States with recovering Medicaid payments from any liable third party in whatever form those payments may take, whether an insurance payment, a court judgment, or a lump-sum settlement.

While the assignment entitles the State to reimbursement of its medical expenses to the extent of the third person's liability, the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages. See 42 U.S.C. 1396k(b). The State's claim, however, has priority. Only after the State retains the

amount "necessary to reimburse it for medical assistance payments made" will the "remainder" "be paid to such individual." *Ibid.* "Pay[ing] to the agency any support or medical care funds received that are covered by the assignment of rights" is an "essential[]" component of the statutorily mandated duty of cooperation. 42 C.F.R. 433.147(b)(4).

The court of appeals held, however, that because respondent had chosen to settle for roughly 18% of all the damages she had alleged, she could force the State to accept just 16.5% of its claim for medical damages. Pet. App. 3, 15. That is wrong. The settlement constitutes "a payment for medical care from any third party," 42 U.S.C. 1396k(a)(1)(A), in "a[] case where such a legal liability [for medical damages] is found to exist," 42 U.S.C. 1396a(a)(25)(B). Indeed, respondent does not dispute that the settlement constitutes a qualifying third-party liability payment, within the meaning of the Medicaid Act, and that both the underlying lawsuit and the settlement included her claim for the medical damages that Medicaid, in fact, paid. Nor is there any dispute that the settlement exhausts insurance coverage or that respondent executed a release of the tortfeasor's liability. J.A. 4-5, 12, 23-24; Pet. C.A. Br. 10.

The only dispute is how to measure the amount of the State's recovery from the funds respondent received. The Medicaid statute resolves that dispute. The State, and the respondent in cooperation with the State, must seek to recover all Medicaid expenditures to the full "extent of such legal liability," 42 U.S.C. 1396a(a)(25)(B); Ark. Code Ann. § 20-77-302(b) (Michie 1991), and not just to the extent of some arbitrary calculation of compromised liability crafted after the fact by the beneficiary. Where the State is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances, based on its assessment of the existence or extent of the defendant's liability. But that is a judgment

for the State to make, pursuing the objectives of and within the limits imposed by the federal Medicaid program.

Where, however, the beneficiary has breached the duty of cooperation and has unilaterally resolved the third parties' liability, the Medicaid statute requires as a default rule that the settlement be presumed to include full compensation of the State's Medicaid claim. That result ensures that the statutory assignment to the State of "any rights" to any "payment for medical care from any third party" remains, as it must, an assignment to the full extent of legal liability, rather than an assignment merely of the beneficiary's post hoc, unilaterally determined compromise valuation of the claim. 42 U.S.C. 1396a(a)(25)(H) (the State "acquire[s] the *rights* of such individual *to payment* by any other party for such health care items or services" as the State has rendered) (emphases added); cf. *United States* v. *Lorenzetti,* 467 U.S. 167, 173-178 (1984).

That approach also recognizes the reality that respondent, in settling the case, had no unilateral capacity to accept anything less than full compensation for Medicaid's expenditures. Because the litigation resolved all potential sources of third-party liability for her injuries, J.A. 4-5, 12, 23-24, the duty of cooperation precluded respondent from omitting or understating the medical damages claim from her lawsuit and attempting to horde for herself the third-party liability payments. And to the extent respondent claimed medical damages, she sought recovery not in her own right, but pursuant to her statutorily imposed duty of cooperation in the pursuit of payments from third parties, 42 U.S.C. 1396k(a)(1)(C), to the full "extent of [their] legal liability" for medical damages, 42 U.S.C. 1396a(a)(25)(B); Ark. Code Ann. § 20-77-302(b). That is because respondent had no independent legal claim for medical damages unless and until Medicaid was fully compensated, having assigned to the State her right to any payment for medical damages

up to the amount of Medicaid expenditures. 42 U.S.C. 1396k(a)(1)(A) and (b).

Thus, having assigned to the State her right to medical damages, respondent had no legal authority or capacity to compromise unilaterally the State's $215,000 claim. That is particularly true here, where respondent settled the case out from under the State despite (i) repeated notifications of the State's claim, J.A. 23-24; (ii) the State's intervention in the litigation, J.A. 24; and (iii) state law requirements that the State be notified of any settlement negotiations, Ark. Code Ann. § 20-77-304(b), and be afforded a "reasonable opportunity to establish its interest" before the settlement is "satisfied," *id.* § 20-77-305(a). While respondent presumably hoped that she would be able, after the fact, to force the State to accept the same compromise of its claim that she was willing to accept for her own claims, she was wrong. And having forsaken her federal and state statutory duties of candid and forthcoming cooperation—simple duties for which she received in exchange $215,000 dollars worth of taxpayer-funded medical care—respondent, rather than the taxpayers, must bear the financial consequences of her actions. Because Arkansas's claim to compensation was not and could not have been compromised by respondent, federal law entitles Arkansas to full payment of its claim, rather than just 16.5% of it. And the State's claim must be paid first. 42 U.S.C. 1396k(b).

3. The Medicaid statute does not require the State to litigate its own claims directly

The court of appeals reasoned (Pet. App. 13) that Arkansas's ability "to pursue directly the third-party tortfeasor for medical expenses" obviated the unfairness of limiting the State's recovery under the settlement agreement. This case proves otherwise. Arkansas attempted to do exactly what the court of appeals prescribed by intervening in the

state court litigation, asserting its claim to compensation, and requesting notice of all future proceedings. J.A. 24. The case nevertheless was settled, the insurance policy was paid out at its liability cap, J.A. 23, and respondent executed a full release in favor of the tortfeasors, J.A. 24, without notice to or participation by the State, Pet. App. 2.[6]

Beyond that, the assignment provision is just one of a number of "reasonable measures," 42 U.S.C. 1396a(a)(25)(A), that States can take to identify and recoup medical payments from liable third parties. Nothing in the statutory text indicates that independent pursuit of an assigned claim is the sole statutorily permitted mode of recovery. *Wilson* v. *State*, 10 P.3d 1061, 1066 n.3 (Wash. 2000), cert. denied, 532 U.S. 1020 (2001). The States, in fact, have experimented with a variety of approaches to this problem, many of which the Secretary has endorsed, see Health Care Fin. Admin., Dep't of Health & Human Servs., *Third Party Liability in the Medicaid Program: A Guide to Successful State Agency Practices* (Sept. 1990).

Moreover, participation in private litigation has some advantages over independent litigation by the State. While the assignment of rights to the State provides a legal basis for bringing suit, the State comes to the case armed only with its proof of damages, but no independent proof of liability. The State is largely, if not entirely, dependent upon the beneficiary for that evidence, and the State could reasonably conclude that a beneficiary will be most effective in establishing liability when the beneficiary's own separate claims for relief are also on the line. In addition, consolidating the State's and beneficiary's claims in a single suit avoids duplicative and potentially inconsistent judgments

[6] The State did not sign a release, J.A. 24, and it is not apparent that a beneficiary could release the State's claim, at least if the third party knew or should have known of the State's claim.

and allows the States to devote Medicaid resources to medical care rather than litigation.[7]

B. Full Recovery Of The State's Medical Expenses From A Settlement Is Consistent With Medicaid's Anti-Lien Provision

The Medicaid statute prohibits States from imposing any lien "against the property of any individual prior to his death on account of medical assistance paid." 42 U.S.C. 1396p(a)(1). Central to the court of appeals' analysis was its assumption (Pet. App. 6-14) that Arkansas's effort to recover anything more than the percentage of the settlement unilaterally allocated to medical damages by respon-

[7] Courts occasionally conduct post-settlement hearings to allocate settlements between taxable and non-taxable income categories, see *Commissioner* v. *Schleier*, 515 U.S. 323, 334, 336 (1995). See, *e.g.*, *Delaney* v. *Commissioner*, 99 F.3d 20 (1st Cir. 1996); *Dotson* v. *United States*, 87 F.3d 682 (5th Cir. 1996). Such post hoc hearings are not a sufficient remedy in this instance, however. Unlike taxpayers, the Medicaid beneficiary has actually assigned the right to payment for medical damages to the State and has a statutory duty of full cooperation in litigation, including in the settlement proceedings. Secret settlements that effectively extinguish or impair the State's claim are not the type of "good-faith" settlements that are amenable to reliable post hoc review in court. *Dotson*, 87 F.3d at 687. By that point, the incentives of the beneficiary (who has already evidenced disloyalty to the State's claim) would be to use her control over the relevant evidence of liability to play up her own contributory negligence and to allocate claims artificially to other damage categories, in order "to benefit at the expense of the government." *Ibid.*

If the States are involved up front in the settlement, by contrast, the beneficiary's inherent interest in maximizing the recovery will be better aligned with the State's, and the State will have more information on which to assess for itself the full extent of the third party's liability for medical damages. Furthermore, the tax cases ask the more objective and tangible question of whether damages were paid "on account of personal physical injuries or physical sickness," rather than economic or contractual injuries. 26 U.S.C. 104(a)(2). Here, the hearing would have to answer how unproven personal injury claims might have been subdivided into different manifestations of that injury, as discounted by proof difficulties and myriad other, subjective and individualized considerations that prompt plaintiffs to forgo trials.

dent would violate that anti-lien provision. That assumption is wrong for four reasons.

1. The lien does not attach to the beneficiary's property

Arkansas's lien does not implicate Medicaid's anti-lien provision because it does not attach "against the property" of the Medicaid beneficiary. 42 U.S.C. 1396p(a)(1). Arkansas's claim attaches only to a "payment for medical care from a[] third party," which the beneficiary had previously assigned to the State. 42 U.S.C. 1396k(a)(1)(A). That "payment for medical care" is, at its origin, the property of the paying third party, and thereafter the property of the State. The sole operative effect of Arkansas's lien provision is to ensure that, to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached. See Ark. Code Ann. § 20-77-307(c) (assignment gives rise to an automatic "statutory lien" on "any settlement" "received by the recipient *from a third party*") (emphasis added).[8]

Indeed, the Arkansas Supreme Court has held that, under Arkansas's Medicaid assignment and lien provisions, "the funds recipients received were not their 'property,'" because "the settlement funds from the third party have already been 'dedicated' to the Medicaid fund." *Arkansas Dep't of Human Servs.* v. *Estate of Ferrel*, 984 S.W.2d 807, 810 (1999). Accordingly, as that decision makes clear, a lien attaches to the property of a liable third party upon its payment to a Medicaid beneficiary. *Id.* at 811. The payment from the third party does not become property of the bene-

[8] A property owner can impose a lien on its own property when, as here, equity requires it "to prevent a failure of justice." *Gould* v. *Day*, 94 U.S. 405, 413 (1876).

ficiary subject to the anti-lien provision, if at all, until after the State's Medicaid claim is paid in full.[9]

2. Respondent has no federally recognized property right

Whatever the state-law label, the question of whether a beneficiary's interest in a settlement amount attributable to the State's medical damages claim constitutes "property" within the meaning of Medicaid's anti-lien provision is a question of federal law. In *United States* v. *Craft*, 535 U.S. 274 (2002), this Court held that, in construing a federal statutory lien provision, "state law labels are irrelevant to the federal question of which bundles of rights constitute property" subject to the law. *Id.* at 279; see *id.* at 288; see also *Drye* v. *United States*, 528 U.S. 49, 58 (1999) ("The question whether a state-law right constitutes 'property' or 'rights to property' [under a federal statute] is a matter of federal law.") (citation omitted); cf. *Dames & Moore* v. *Regan*, 453 U.S. 654, 674 n.6 (1981).

Under the Medicaid Act, the beneficiary has no sufficient rights in the amount of the settlement available to pay the State's medical damages claim that would give rise to a federally protected property interest under the anti-lien provision. To the contrary, respondent assigned away "any rights" she had in any "payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A). Arkansas did permit respondent to litigate the medical damages claim along with her own separate damages claims in her state court tort suit.[10] But federal and state law required respondent

[9] See 42 U.S.C. 1396k(b); *Ferrel*, 984 S.W.2d at 811 (Arkansas's "ability to recover Medicaid payments from insurance settlements * * * is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs"); see generally *Wilson*, 10 P.3d at 1065 n.2; *Houghton*, 57 P.3d at 1069; *Cricchio* v. *Pennisi*, 683 N.E.2d 301, 305 (N.Y. 1997).

[10] See Ark. Code Ann. § 20-77-302; *Richards*, 604 S.E.2d at 819 (because "an assignor can sue with the consent of the assignee[,] * * * recipients have the

to conduct that litigation consonant with her legal obligation "to assist the State in pursuing[] any third party" recovery for medical damages first, 42 U.S.C. 1396k(a)(1)(C), and to the full "extent of such legal liability," 42 U.S.C. 1396a(a)(25)(B); see 42 U.S.C. 1396k(b). That authority did not include secretly and unilaterally compromising Arkansas's claim, in contravention of both state law and the federal mandate of good-faith cooperation. In these circumstances, respondent similarly lacked a cognizable interest in the settlement money once she had it, because state law had already attached a lien to the funds paid by the third party to the extent necessary for Medicaid compensation. Respondent thus "was on notice of the contingent nature" of her possession of such funds. *Dames & Moore*, 453 U.S. at 673. Accordingly, with respect to third-party payments to resolve claims for medical damages, respondent possessed none of the rights of control, dominion, or exclusion that are the hallmarks of "property." See *Craft*, 535 U.S. at 283; *Drye*, 528 U.S. at 61.

The court of appeals nevertheless found (Pet. App. 6) a property interest because Arkansas's lien arises "*after* Ahlborn receive[d] her settlement from the tortfeasor." The Arkansas Supreme Court has ruled otherwise as a matter of state law, holding that the legal effect of the lien precedes the beneficiary's receipt of funds, prevents her from obtaining a property interest in the funds, and even permits an independent action by the State against the tortfeasor. *Ferrel*, 984 S.W.2d at 810-811. Obviously, if the State's rights under the lien provision arose only after the litigation was concluded and a settlement paid, "[t]he lien itself" would *not* "allow[] [Arkansas] to pursue the third

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power to pursue claims against tortfeasors for all injuries, including medical expenses").

party." *Id.* at 811. That construction of state law by the State's highest court is "authoritative."[11]

Furthermore, quite aside from the operation of state law, the federal Medicaid statute required respondent to assign "any rights" to "payment[s] for medical care" to the State, and to cooperate fully in getting those funds into the State's hands. 42 U.S.C. 1396k(a)(1)(A) and (C). One "essential" aspect of cooperation is "[p]ay[ing] to the agency any support or medical care funds received that are covered by the assignment of rights." 42 C.F.R. 433.147(b)(4). Accordingly, when respondent received funds encompassed by the assignment provision, federal law imposed a constructive trust or equitable lien on those funds that obligated her to pass them through to the State.[12]

In addition, the Medicaid anti-lien provision expressly permits a lien to be imposed, pursuant to a court order, "on account of benefits incorrectly paid on behalf of such individual." 42 U.S.C. 1396p(a)(1)(A). Respondent's backdoor settlement of the medical damages claim and retention for herself of settlement funds attributable to medical care resulted in obstruction and attrition, rather than effectuation, of the right assigned to the State and violated her duty of cooperation. The district court's order upholding Arkansas's lien properly enforced the statutory conditions

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[11] See *National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 125 S. Ct. 2688, 2701 (2005); *O'Brien* v. *Skinner*, 414 U.S. 524, 531 (1974).

[12] See *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204, 213 (2002); *Harris Trust & Sav. Bank* v. *Salomon Smith Barney Inc.*, 530 U.S. 238, 250-251 (2000); George T. Bogert, *Trusts* § 77, at 287 (6th ed. 1987) (constructive trust may be imposed where the "trustee's sole duty is to transfer the title and possession [of trust property] to the beneficiary"); see generally George T. Bogert, *Trusts and Trustees* §§ 471, 484 (2d ed. rev. 1978 & Supp. 2004); *id.* § 471, at 6 ("[T]he defendant has been under an equitable duty to give the complainant the benefit of the property ever since the defendant began to hold unjustly.").

for her receipt of benefits, and thereby prevented those benefits from having been "incorrectly paid," *ibid.*[13]

The court of appeals further reasoned (Pet. App. 13) that Medicaid beneficiaries are not required to assign their rights "to the extent of the third party's liability," but only "to third-party payments for medical care." That is true, but beside the point here. There is no dispute that the settlement qualified as a "third-party payment[] for medical care." *Ibid.*[14] The only question is how much of the undifferentiated settlement payment is attributable to medical care. The court of appeals presumed that the settlement embodied only a percentage (16.5%) of Arkansas's claim for medical damages, and on that basis held that the State's effort to collect any more than that designated percentage was an impermissible attempt to impose a lien on respondent's property interest in payment of her other, non-assigned claims. See *id.* at 6, 12, 13.

But the court of appeals' starting presumption was wrong. Respondent had no legal authority to compromise Arkansas's claim, and any attempt to do so unilaterally and without affording the State a "reasonable opportunity to establish its interest" before the settlement was "satisfied" violated both state law, Ark. Code Ann. §§ 20-77-302, 20-77-

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[13] See C.A. App. 20; cf. *Rose* v. *Rose*, 481 U.S. 619, 634 (1987) (permitting contempt proceedings to recover veterans' benefits, despite anti-lien provision, where the claim "would further, not undermine," congressional purpose).

[14] When cases go to trial and a court or jury assigns a specific dollar value to the defendants' liability for medical damages, the Secretary ordinarily accepts that finding as controlling, even if the amount proves to be less than the medical expenses incurred by Medicaid. Cf. Centers for Medicare & Medicaid Servs., *Medicare Intermediary Manual*, Pt. 3, Ch. V, § 3418.7 (Dec. 1994). That might occur when, for example, the beneficiary's own negligence diminished the defendant's liability for medical damages. But different considerations might obtain if the State had not participated and the beneficiary had failed to present evidence of the full extent of the payment by Medicaid for medical expenses.

305, and her federal-law duty of cooperation, 42 U.S.C. 1396k(a)(1)(C), 42 C.F.R. 433.147(b)(4). And even if state law had authorized respondent to compromise Arkansas's share of the Medicaid reimbursement, respondent had no power to compromise the *federal government's* claim to approximately 74% of the recovery. Quite the opposite, the Secretary, through the Departmental Appeals Board (Board), has twice issued published decisions holding that state law may not authorize compromise of the federal government's share while allocating funds to the beneficiary's other damages claims. See *In re Washington State Dep't of Social & Health Servs.*, Dec. No. 1561 (HHS Feb. 7, 1996), Pet. App. 45-67; *In re California Dep't of Health Servs.*, Dec. No. 1504 (HHS Jan. 5, 1995), Pet. App. 68-86. For that reason, federal law treats the Medicaid claim as uncompromised and due in full from a settlement.[15]

The court of appeals' conclusion that respondent's after-the-fact and self-interested proposed allocation of only 6.5% of the settlement (16.5% of the Medicaid claim) to medical damages should be controlling also makes no practical sense. The court offered no basis, in state or federal law, for concluding that a lump-sum settlement could be apportioned in a legally binding manner without any adjudication of the issue and without notice and opportunity for the State meaningfully to participate. See *Zinman* v. *Shalala*, 67 F.3d 841, 846 (9th Cir. 1995) ("Apportionment * * * would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages.").

[15] While the States, in settlement proceedings in which they participate, are "free to allow recipients to retain the state's share of the recovery," they may not permit the beneficiary to retain payments from a settlement before the federal government's share of the medical damages is recovered. *Washington*, *supra*, Pet. App. 63; *California*, *supra*, Pet. App. 85; Health Care Fin. Admin., Dep't of Health & Human Servs., *Dallas Regional Medical Services Letter No. 88-23* (June 1, 1998), Pet. App. 90-91.

Moreover, generally speaking, proof of past medical damages is easier than many other elements of a tort recovery, such as respondent's claims for prospective economic loss or pain and suffering. The medical costs incurred are specific, identified, and carefully documented in medical records; they do not entail speculation; they are easily reduced to concrete dollar measurements; and they are not readily susceptible to self-interested inflation or manipulation. Indeed, it is usually the ready verifiability of the medical claims that lays the groundwork for assertion of the inherently speculative pain and suffering and prospective economic harms. In any event, any doubt about the amount of medical damages included in the settlement must be resolved against the respondent, who crafted the agreement in secret and deliberately excluded the State in contravention of state and federal law, and who has better access to the facts needed to establish actual liability. Cf. *Schaffer* v. *Weast*, No. 04-698 (Nov. 14, 2005), slip op. 10.

3. The anti-lien provision protects, but does not independently define, property rights

At bottom, Arkansas's demand that its claim be compensated in full from the settlement funds is not an attempt to encroach on respondent's property, but an effort to protect its own property interest in the face of respondent's calculated evasion of her legal obligations. The court of appeals' reliance on Medicaid's anti-lien provision under those circumstances was misplaced. The protections of the anti-lien provision are triggered only after a property right has been recognized by federal law. The anti-lien provision says nothing about the predicate question of whether a property right exists and, in particular, about where the State's property interests stop and the beneficiary's property interests begin in an undifferentiated lump-sum settlement of third-party liability claims.

That question is answered by Medicaid's third-party liability provisions, which (i) unequivocally assign all rights to third-party payments for medical care to the States, to the full extent of Medicaid payments, (ii) mandate candid and forthcoming cooperation by Medicaid beneficiaries in collecting those payments, and (iii) grant the Medicaid claim a priority in the distribution of any third-party payments recovered as a result of that assignment and cooperative litigation process. In the absence of a determination in which the State participates—or of any other specific evidence satisfactory to the State and considered reliable by the Secretary that limits the third parties' liability for medical damages—federal law accorded Arkansas a priority right to full compensation of its Medicaid claim out of the third parties' payment of damages. Nothing in respondent's unilateral settlement process could have diminished the State's right or enhanced respondent's claim to those funds. The anti-lien provision takes property rights as it finds them. It does not transform, through unilateral settlement, the State's rights under Medicaid's third-party liability provisions into federally protected property rights of the beneficiary.

C. The Secretary's Harmonization of Medicaid's Provisions Merits Deference

1. The court of appeals' construction of the intersecting obligations imposed by the Medicaid statute's third-party liability and anti-lien provisions puts Medicaid at war with itself, by reading the anti-lien provision as protecting what the assignment and cooperation requirements forbid. By contrast, the Secretary's established interpretation of the anti-lien and third-party liability provisions as respecting the property lines drawn by the third-party liability provisions harmonizes those provisions, and does so in a manner that gives full effect to Congress's purpose that Medicaid serve as the payer of last resort. That approach is consis-

tent with the "cardinal rule that a statute is to be read as a whole," *King* v. *St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991), and with the Court's obligation "to make sense rather than nonsense" out of the statutory scheme, *West Va. Univ. Hosps., Inc.* v. *Casey*, 499 U.S. 83, 101 (1991). That reading also accords with this Court's specific recognition that anti-lien provisions within the Social Security Act should not be read to forbid what the substantive provisions of the law expressly permit. See *Washington State Dep't of Social & Health Servs.* v. *Guardianship Estate of Keffeler*, 537 U.S. 371, 383-385 & n.7 (2003) (Social Security Act's anti-lien provision does not prohibit payments that the representative payee provisions authorize).

The Secretary's interpretation and implementation of the third-party liability provisions in the context of lump-sum settlement agreements, moreover, merits deference because of "the interstitial nature of the legal question, the related expertise of the Agency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the Agency has given the question over a long period of time." *Barnhart* v. *Walton*, 535 U.S. 212, 222 (2002); see *Auer* v. *Robbins*, 519 U.S. 452 (1997).

The court of appeals withheld deference because it viewed (Pet. App. 11) the Secretary's interpretation as inconsistent with the plain language of the anti-lien provision. But if the statutory text says anything unambiguously, see *Gray Panthers*, 453 U.S. at 43 (noting that the Social Security Act's "Byzantine construction * * * makes the Act almost unintelligible to the uninitiated") (internal quotation marks & citation omitted), it says that the State must recover the full extent of third party liability for medical damages, not its privately and unilaterally compromised value, and that the beneficiary must cooperate in, rather than undermine, that endeavor. The court of appeals' read-

ing of the anti-lien provision would fatally undermine the specific and targeted full-recovery and assignment provisions. Reading the anti-lien provision as inapplicable to recoveries of medical damages, by contrast, would allow that provision to continue to play an important role in other contexts, such as preventing claims against a beneficiary's inheritance. Beyond that, nothing in the text of the Medicaid Act speaks directly to how the third-party liability and anti-lien provisions are to be implemented in the context of settlement awards, and such silence normally creates, rather than resolves, ambiguity. *Barnhart*, 535 U.S. at 218. How to implement those provisions when the State is confronted with a lump-sum settlement, and how the States' recoupment obligations and the beneficiaries' duty of cooperation are defined present the very type of "complex and highly technical regulatory [matters]" that the Secretary has been "granted exceptionally broad authority" to address. *Blumer*, 534 U.S. at 497 (citations omitted). In this case, the Secretary's interpretation is embodied not only in informal agency guidance, see Pet. App. 87-89; J.A. 31-33, 37-38, but also in formal adjudications by the Board, see 45 C.F.R. 16.1 to 16.23 & App. A; 42 C.F.R. 430.42(b).

In *California*, *supra*, and *Washington*, *supra*, the Board interpreted the Medicaid Act's third-party liability provisions to require that Medicaid be reimbursed in full from a settlement award before those funds could be allocated to other purposes, such as compensating the beneficiary for pain and suffering or other damages. In *California*, the Board found invalid a state law that, much like the mathematical formula that the court of appeals endorsed here, automatically set aside a percentage of settlement proceeds for the beneficiaries' own use, without respect to whether Medicaid had been fully reimbursed or to the actual extent of the third party's liability. Pet. App. 68-86.

The Board explained that the fundamental premise of the third-party liability provisions is that, "where a third party has caused the need for medical care[] and is liable for its payment, the Act looks to that third party to reimburse the public." *Id.* at 80-81. The Board also concluded that the assignment and cooperation provisions give Medicaid "superior status to the recipient in relation to the tortfeasor to recover [medical] costs," and allow the Secretary "to characterize recoveries from third parties first as payments for medical care." *Id.* at 81. Similarly, in *Washington*, *supra*, the Board concluded that discretionary, case-by-case reductions in Medicaid collections to ensure payment of other damages to the beneficiary are impermissible because, "where there is a third party that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care." *Id.* at 50, 54.

As the Board recognized (*California*, *supra*, Pet. App. 75, 78), the State's claim must be paid first not because the State may claim damages beyond the extent of the third party's liability for medical damages, but because federal law affords the State's claim a payment priority in the distribution of settlement funds. See 42 U.S.C. 1396k(b); 42 C.F.R. 433.154; see *Washington*, *supra*, Pet. App. 54 (the Secretary "has not taken the position that a recipient assigns or loses his/her right to seek compensation for injuries beyond the cost of medical care," but has only required States "to assert a collection priority").

2. The Secretary's interpretation not only reasonably interprets the statutory text, but also furthers the purpose of the third-party liability provisions, which is "to make Medicaid the payor of last resort where there is a liable third party." *California*, *supra*, Pet. App. 76. "There are limited resources to spend on welfare," *Gray Panthers*, 453

U.S. at 48, and the Secretary's interpretation promotes overall fairness in the provision of the available benefits. Requiring that Medicaid be reimbursed first ensures that tortfeasors, who have "caused the need for medical care and [are] liable for its payment," cannot force the public to cover the victim's medical costs. *Washington*, *supra*, Pet. App. 54. In addition, the Secretary's position equalizes the positions of tort victims who receive third-party payments before and after medical assistance is received. Accepting the private parties' compromise evaluation of medical assistance claims whenever the third-party payment is made after the State has provided care would "create an anomalous situation" in which Medicaid applicants could be disqualified for eligibility because of funds obtained through prior personal injury settlements, "but Medicaid recipients could shield such funds from recoupment by the Department after having received significant public assistance." *Calvanese* v. *Calvanese*, 710 N.E.2d 1079, 1082 (N.Y.), cert. denied, 528 U.S. 928 (1999).

Finally, the Secretary's position takes account of the fact that respondent received substantial medical benefits at public expense, and the government provided those benefits only because of the beneficiary's inability to pay and "on the condition that it would be reimbursed" from any payments by a third party liable for her medical care. *California*, *supra*, Pet. App. 81. Allowing the full "extent of [a third party's] legal liability" for medical damages, 42 U.S.C. 1396a(a)(25)(B), to be carved up between Medicaid reimbursement and the beneficiary would leave the taxpayers picking up more of the beneficiary's tab for medical expenses, while the beneficiary diverted available compensation from the third party to herself. "If Medicaid had not paid [the beneficiaries'] medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settle-

ments." *California*, *supra*, Pet. App. 85. Such an approach also would promote "manipulation of tort awards by recipients," who could "prevent the public from being reimbursed" for the cost of their medical care by the manner in which they allocate their settlements. *Id.* at 81; see *Richards* v. *Georgia Dep't of Cmty. Health*, 604 S.E.2d 815, 818 (Ga. 2004) (refusing to read the statute to "allow a Medicaid recipient to negotiate a tort settlement structured in such a way so as to reflect no, or minimal, compensation for medical expenses, * * * [which] would be blatantly unfair to th[e] taxpayers, and is contrary to the intent of the federal statutes"). Permitting a Medicaid beneficiary to insist, after benefits already have been received, that settlement payments are not compensation for medical bills, when, as a practical matter, those same funds would have to be used to pay outstanding medical bills if Medicaid had not stepped in, would render the beneficiary's acceptance of the assignment and cooperation obligations an empty gesture.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

PAUL D. CLEMENT
Solicitor General
PETER D. KEISLER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
PATRICIA A. MILLETT
Assistant to the Solicitor General
WILLIAM KANTER
ANNE MURPHY
Attorneys

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APPENDIX

1. 42 U.S.C. 1396a provides in pertinent part:

State plans for medical assistance

(a) Contents

A State plan for medical assistance must–

* * * * *

(25) provide–

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including–

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing

and information retrieval systems required under section 1396b(r) of this title;

(B) that 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 State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan 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 of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)], a service

benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State; and

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

* * * * *

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

* * * * *

2. 42 U.S.C. 1396k provides:

Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards

shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

3. 42 U.S.C.A. 1396p(a) provides in pertinent part:

> **Liens, adjustments and recoveries, and transfers of assets**
>
> **(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan**
>
> (1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—
>
> (A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or
>
> (B) in the case of the real property of an individual—
>
> (i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and
>
> (ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,
>
> except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

* * * * *

4. 42 C.F.R. 433.136 provides in pertinent part:

Definitions.

For the purposes of this subpart–

* * * * *

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

* * * * *

5. 42 C.F.R. 433.138 provides:

Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) *Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.* (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her

relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) *Obtaining other information.* Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) *Exchange of data.* Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under § 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in § 435.4 of this chapter and from the SSA wage and earnings files data as specified in § 435.948(a)(2) of this chapter, the agency must—

(i) Use the information that identifies Medicaid recipients that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of recipients and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes

information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under § 435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies those Medicaid recipients that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining—

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid recipients and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) *Diagnosis and trauma code edits.* (1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) *Data exchanges and trauma code edits: Frequency.* Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in § 435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) *Follow-up procedures for identifying legally liable third party resources.* Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(1) *SWICA, SSA wage and earnings files, and title IV-A data exchanges.* With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section—

(i) Except as specified in § 435.952(d) of this chapter, within 45 days, the agency must followup (if

appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) *Health insurance information and workers' compensation data exchanges.* With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section—

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) *State motor vehicle accident report file data exchanges.* With respect to information obtained under paragraph (d)(4)(ii) of this section—

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party

liability payment procedures specified in § 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) *Diagnosis and trauma code edits.* With respect to the paid claims identified under paragraph (e) of this section—

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the time frames for incorporation of the information.

(h) *Obtaining other information and data exchanges: Safeguarding information.* (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in Part 431, Subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify—

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) *Reimbursement.* The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) *Reports.* The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under para-

graph (l) of this section, it is not required to provide the reports required in this paragraph.

(k) *Integration with the State mechanized claims processing and information retrieval system. Basic requirement—Development of an action plan.* (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under Subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to—

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in § 433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in § 433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in § 433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in § 433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(l) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that

changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

6. 42 C.F.R. 433.145 provides:

Assignment of rights to benefits—State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or recipient is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902(l)(1)(A) of the Act (poverty level preg-

nant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under §§ 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid.

7. 42 C.F.R. 433.147 provides in pertinent part:

> **Cooperation in establishing paternity and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be to pay.**

(a) *Scope of requirement.* The agency must require the individual who assigns his or her rights to cooperate in–

(1) Establishing paternity of a child born out of wedlock and obtaining medical support and payments for himself or herself and any other person for whom

the individual can legally assign rights, except that individuals described in section 1902(l)(1)(A) of the Act (poverty level pregnant women) are exempt from these requirements involving paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(2) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan.

(b) *Essentials of cooperation.* As part of a cooperation, the agency may require an individual to—

(1) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(2) Appear as a witness at a court or other proceeding;

(3) Provide information, or attest to lack of information, under penalty of perjury;

(4) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(5) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments, and in identifying and providing information to assist the State in pursuing any liable third party.

* * * * *

8. 42 C.F.R. § 433.154 provides:

Distribution of collections.

The agency must distribute collections as follows–

(a) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(b) To the Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with § 433.153.

(c) To the recipient, any remaining amount. This amount must be treated as income or resources under Part 435 or Part 436 of this subchapter, as appropriate.