Arkansas Department of Health & Human Services v. Ahlborn:

Sea Change or Status Quo for Resolution of Medicaid Liens?

The Medicaid program, a public-assistance system providing medical care for certain disabled and low-income individuals, is exceptionally complicated. The complexity begins with the text of the federal Medicaid law, which the United States Supreme Court has described as "an aggravated assault on the English language, resistant to attempts to understand it." Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981). Another federal judge called on to interpret federal Medicaid law commented: "The Medicaid Act is actually a morass of interconnecting legislation. It contains provisions which are circuitous and, at best, difficult to harmonize." Mertz v. Houston, No. 01-2627, (E. D. Pa. July 31, 2001).

Adding to the complexity, Medicaid is governed by both federal and state law. In every State, the Medicaid program is administered locally, through state Medicaid agencies. (In Oregon, Medicaid is administered through the Oregon Department of Human Services.) Each state is free to enact its own statutes and administrative rules to regulate its Medicaid program, provided those statutes and rules comport with the overarching federal law. 42 USC 1396(a).

Perhaps unsurprisingly, there are a number of areas in which Medicaid agencies of different states apply different, and sometimes contradictory, interpretations of federal law. One such area is the satisfaction of Medicaid liens against personal injury settlements. These materials are intended to provide guidance on how Oregon's Department of Human Services (hereafter, "Oregon DHS" or "DHS") applies the federal law governing Medicaid liens. In particular, the information presented here addresses the way Oregon DHS is applying *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), a landmark U.S. Supreme Court decision dealing with Medicaid liens in personal injury cases.

Background:

The *Ahlborn* decision is a textbook illustration of the "difficult-to-harmonize" provisions of the Medicaid Act. The case addressed an apparent contradiction between 42 USC 1396(a), which requires state Medicaid agencies to seek reimbursement of Medicaid expenditures from liable third parties; and 42 USC 1396(p), which prohibits states from placing liens against Medicaid recipients' property prior to their deaths (this latter provision is commonly known as the "anti-lien provision"). In a unanimous decision, the Supreme Court resolved the apparent conflict, limiting the reach of state Medicaid agencies' liens against personal injury settlements and judgments.

Although the ruling in *Ahlborn* seems relatively straightforward, its application in the states has been far from uniform. In this regard, the case is a textbook illustration of the second source of complexity mentioned above (interstate discrepancies). State Medicaid agencies have interpreted and applied the decision in quite disparate ways and, as a result, confusion abounds regarding the practical impact of the decision for Oregon lawyers settling personal injury cases for Oregon Medicaid recipients.

Although *Ahlborn* has at times been described as a "sea change" for the way Medicaid liens are negotiated and resolved, its practical impact in Oregon has been more nuanced. Oregon DHS personnel (and their advocates at the Oregon Department of Justice) are well aware of the *Ahlborn* ruling, and have addressed it in writing. But the extent to which *Ahlborn* has changed the status quo for negotiating and resolving Medicaid liens in Oregon remains somewhat unclear, because DHS examines every case individually, and resists a formulaic interpretation of the decision. Personal injury attorneys representing Oregon Medicaid recipients should proceed with caution, and avoid making assumptions about how *Ahlborn* will be applied in their cases.

The Facts and Holding of *Ahlborn*:

In order to gain a general understanding of how Oregon DHS is currently applying the *Ahlborn* decision, a review of the case is necessary:

In 1996, Arkansas resident Heidi Ahlborn suffered permanent brain damage resulting from a car accident. Lacking the resources to pay for her medical care, Ahlborn applied for Medicaid through the Arkansas Department of Health and Human Services (hereafter "ADHS"). As a condition of eligibility for Medicaid, Arkansas law required that Ahlborn assign to ADHS her right to any settlement, judgment, or award she might obtain against any third party, up to the full amount of Medicaid benefits she received. ADHS deemed Ahlborn eligible for benefits, and ultimately paid out $215,645.30 on her behalf.

Ahlborn sued the alleged third-party tortfeasors in state court, seeking damages for past and future medical costs; permanent physical injury; past and future pain, suffering, and mental anguish; and past and future loss of earnings. In 2002, her case settled out of court for $550,000.00, a sum representing approximately one-sixth of the total value of her claim. Initially, no allocation was made between the various categories of damages, but the parties later stipulated that only $35,581.47 of the total settlement represented compensation for past medical expenses. ADHS did not participate (nor did it ask to participate) in the settlement negotiations. Instead, acting pursuant to Arkansas statute, ADHS asserted a lien against the settlement proceeds for the full $215,645.30 it had paid on Ahlborn's behalf.

Ahlborn challenged the lien in federal court, relying on the "anti-lien provision" of the Medicaid Act. The anti-lien provision generally bars states from imposing liens against the property of Medicaid recipients prior to death. (See 42 USC 1396p(a)(1), attached as Exhibit 1.) Ahlborn argued that ADHS's lien violated the anti-lien provision to the extent that its satisfaction would force her to turn over settlement funds not allocable to past medical expenses. She maintained that the settlement was her property, and that the forced assignment to ADHS applied *only* to that portion of the settlement allocable to past medical expenses.

ADHS contended that the anti-lien provision did *not* prevent full recovery because, as a condition of Medicaid eligibility, Ahlborn had assigned to the State her right to *any* settlement paid by a third party who was liable for her medical costs. The agency invoked

the third-party liability provisions of the Medicaid Act which, among other things, require states to:

- Ascertain the legal liability of third parties for the injury-related medical expenses of Medicaid recipients;
- Seek reimbursement of Medicaid costs from liable third-parties to the extent of their liability; and
- Enact laws empowering state agencies to recover injury-related medical costs (including forced assignments).

(See 42 USC 1396a(a)(25) and 42 USC 1396k(a), attached as Exhibits 2 and 3.) ADHS's position rested on its assertion that the settlement proceeds remained the property of the third party tortfeasors until the Medicaid program was fully reimbursed for the funds it had expended on Ahlborn's medical care.

The District Court sided with ADHS, holding that it was entitled to a lien in the full amount expended on Ahlborn's behalf ($215,645.30). The Court found no conflict between the federal anti-lien provision and the Arkansas statute giving ADHS the right to recover the full amount of its expenditures, regardless of allocation. The Eighth Circuit reversed this decision, holding that ADHS could only recover from that portion of the settlement allocable to past medical expenses.

The Supreme Court unanimously affirmed the Eight Circuit, holding that the third-party liability provisions of the Medicaid Act cannot and do not trump the anti-lien provision. Addressing the arguments put forth by ADHS, the Court recognized that the anti-lien provision of the Medicaid Act cannot be read in isolation, as such a reading would bar *all* liens (including liens against settlement funds properly allocated to past medical care). The Court acknowledged that under the third-party liability provisions, states are specifically authorized to require "forced" assignments of third-party reimbursements as a condition of eligibility. However, the Court held that those provisions are *exceptions* to the anti-lien provision:

> To the extent that the forced assignment [of settlement proceeds] is expressly authorized by the terms of [the Medicaid Act], it is an exception to the anti-lien provision.... But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception... is limited to payments for medical care. Beyond that, the anti-lien provision applies.

The Court thus limited the reach of the third-party liability provisions of federal Medicaid law.

To ADHS's concern that parties to personal injury disputes might manipulate settlements and allocate away states' interests, the Court responded that the risk of manipulation could be avoided, either "...by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." This part of the opinion, though technically dictum, has in some cases impacted the process of Medicaid lien negotiation and resolution more than the case's central legal holding.

***Ahlborn's* Impact Generally:**

In the immediate aftermath of the decision, the Centers for Medicare and Medicaid Services[1] issued a Memorandum clarifying the third-party recovery rules. The Memorandum (attached as Exhibit 4) advised Regional Medicaid Administrators of the *Ahlborn* ruling, and suggested that it could result in significant changes in the resolution of Medicaid liens. The Memorandum stated:

> Prior to the Supreme Court's decision in *Ahlborn*, CMS had interpreted the Medicaid third party liability provisions to authorize States to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws.

The Memorandum went on to include a list of "State Actions Prohibited Under *Ahlborn*," as well as a list of "State Actions Which Would Mitigate the Adverse Consequences of *Ahlborn*."

[1] Also known as "CMS," The Centers for Medicare and Medicaid Services is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer the Medicaid program. Pronouncements from CMS are generally accorded substantial deference by state Medicaid agencies.

CMS's list of prohibited state actions can be summarized as generally precluding enforcement of state Medicaid laws (including forced assignment laws) to the extent that such laws purport to reach settlement funds *properly* allocated to non-medical damages. The list of suggested mitigating state actions—which is both longer and more specific--includes (but is not limited to) the following:

- Active involvement by state Medicaid agencies in the litigation and settlement process;
- Passage of state laws requiring mandatory joinder of a state when a Medicaid lien is at issue;
- Strengthening of notification and cooperation requirements for attorneys, such that non-compliance (i.e., failure to notify) could render settlements voidable;
- Passage of state tort and/or insurance laws giving priority to payment of medical expenses and/or permitting settlement only with state's consent;
- Use of cost-effectiveness criteria for determining which liability settlements should be pursued for recovery of Medicaid expenses;
- Pursuit of a lesser amount than the full cost of care in order to avoid litigation.

The Memorandum made clear that, in the view of CMS, all of these suggested mitigating actions comport with federal Medicaid law.

As mentioned above, the *Ahlborn* decision has not been uniformly interpreted and applied in every state. Some states have enacted new laws specifically addressing *Ahlborn*, and setting out formal procedures for allocating settlements (see, for example, California Welfare and Institutions Code Section 14124.76). At least one state has enacted a strict statute requiring the written consent of the state Medicaid agency before a claim involving a Medicaid recipient can be commenced or settled. Utah Code Ann. 26-19-7(1)(a). Still other states, including Oklahoma, Idaho, and Oregon, have enacted laws or administrative rules creating a rebuttable presumption that all settlement proceeds are in payment for medical services. 63 Okla St. 5051.1(d); I.C. 56-209b; OAR 461-195-0305.

Oregon's Position Vis-à-Vis *Ahlborn*:

Shortly after *Ahlborn* was decided, representatives of DHS's Personal Injury Liens unit[2] circulated two letters commenting on the decision. (See Letters from Susie Smith and Angela Molthan, attached as Exhibit 5). Although first letter addressed the central holding of the case (i.e., the limitations on personal injury liens required by the anti-lien provision), its focus was the reporting obligation imposed by ORS 416.530. This statute (attached as Exhibit 6) requires Medicaid applicants and recipients, *or their attorneys*, to **immediately** notify Oregon DHS whenever a personal injury claim is made against a potentially liable third party. The second letter focused almost entirely on the reporting obligation.

In addition to shining a light on the statutory reporting obligation, the DHS letters suggested that, in the wake of *Ahlborn,* failure to timely notify DHS would have serious consequences. Specifically, the letters stated that in cases where DHS was not given timely notice of a claim, and was therefore not included in settlement negotiations regarding the claim, it would explore "any and all legal means for challenging any resulting settlement agreement." The letter cited ORS 416.610, 416.580, and 95.230 (attached as Exhibits 7, 8, and 9 respectively) as possible avenues for such challenges.

Clearly, Oregon DHS intends to follow the advice of CMS and participate actively in the litigation and settlement process. Presumably, unless DHS is included in settlement negotiations, it will challenge allocations it deems suspect. However, the extent to which the *Ahlborn* decision has created opportunities for Medicaid lien reduction based on settlement allocation is, at best, ill defined.

Oregon law governing Medicaid liens in personal injury cases does not specifically address the *Ahlborn* ruling. The statutory provisions, located at ORS 416.510 through 416.610, are substantially reiterated in the implementing administrative rules, located at OAR 461-195-301 through 461-195-350, and neither source offers formal guidelines or procedures for

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[2] The Personal Injury Liens Unit is a subdivision of Oregon DHS's Office of Payment Accuracy and Recovery, with primary responsibility for negotiating and resolving Medicaid liens in personal injury cases.

proper allocation of settlements. However, the administrative rules, which generally provide greater detail than the statutes, do state DHS's default position with regard to allocation. OAR 461-195-0305(5) states: "There is a rebuttable presumption that the entire proceeds from any judgment, settlement, or compromise, are, unless otherwise identified, in payment for medical services."

Like several other states, Oregon has enacted a presumption that, if not successfully rebutted, will produce the same result as the Arkansas statute at issue in *Ahlborn* (i.e., full recovery of all Medicaid expenditures). Because the rule allows for the *possibility* of other allocations, it does not run afoul of the *Ahlborn* holding. However, the circumstances in which settlement proceeds may be "otherwise identified" (i.e., allocated to damages other than past medical expenses) are nowhere defined.

Recently, this author spoke with a Liens Coordinator at the Personal Injury Liens Unit regarding Oregon DHS's current interpretation and application of the *Ahlborn* decision. The Liens Coordinator confirmed that DHS has no fixed methodology for lien valuation or approval of settlement allocation, and indicated that each case is evaluated individually, taking into account all relevant facts and circumstances. The Lien Coordinator followed up with a letter (attached as Exhibit 10), quoting Assistant Attorney General Gretchen Merrill as saying: "The Supreme Court in Ahlborn did not require any methodology for valuation; rather, that was a specific factual stipulation entered into by the parties, and it is not binding on the State of Oregon, absent any statute or law otherwise."

Although DHS has not implemented any specific methodology for lien valuation, nor provided formal guidance as to what will constitute an acceptable settlement allocation under its interpretation of *Ahlborn*, Oregon law does provide one specific avenue for lien reduction (albeit one only tangentially related to *Ahlborn*). ORS 416.600 and OAR 461-195-320 (attached as Exhibits 11 and 12, respectively) provide that DHS may release or compromise its lien in cases where the plaintiff is likely to have significant future medical expenses as a result of the personal injury. In deciding whether a given plaintiff qualifies for full or partial release of the lien, DHS will consider, among other things:

- The nature and timing of the future medical treatment;
- The anticipated cost of the future medical treatment;
- The amount of the settlement or judgment at issue;
- Whether the recipient has timely complied with the notification requirement imposed by ORS 416.530;
- Whether the recipient has other sources of payment of future medical treatment; and
- The effect of the requested release on the recipient's continued eligibility for public assistance

The statute and rule containing the above criteria predate *Ahlborn*, but representatives of DHS's Personal Injury Liens Unit point to these provisions as examples of the factors DHS will take into account in evaluating settlement allocations.

Practical Application of *Ahlborn* in Oregon:

Although many questions remain regarding *Ahlborn's* impact in Oregon, some things are clear. First and most important, attorneys should be diligent in complying with the reporting obligation of ORS 416.530. In most cases, compliance requires only the completion of a simple form (there are two forms; one for vehicle related injuries, and one for non-vehicle related injuries). The forms are available on the Personal Injury Liens Unit's website, which also contains specific contact information and links to relevant statutes and rules:

http://www.dhs.state.or.us/admin/opar/pil.html

(A hard-copy of the website information, including a copy of each form, is attached as Exhibit 13.)

The main phone number for the Personal Injury Liens Unit is **503-378-4514**.

In addition to the initial notification, personal injury lawyers should keep DHS apprised of proposed settlements and/or other significant developments in the case. The Personal

Injury Liens Unit can and will participate in mediations when appropriate, and is available to negotiate with regard to Medicaid liens at any point during the course of litigation. While it is not clear that allowing full participation by DHS will result in the agency's approval of a favorable allocation of damages (and thus, a reduction in the Medicaid lien), the consequences of failing to allow such participation can be grave.

Personal injury lawyers should bear in mind that DHS is emphasizing the reporting obligation because it intends to prevent parties to personal injury disputes from allocating away its interest. In Oregon, where no formula or methodology exists to guide the process, it is critical to seek a negotiated agreement with DHS regarding the equitable allocation of the settlement. In cases where a negotiated agreement on allocation cannot be reached, it may be necessary to submit the matter to a court for decision, as the *Ahlborn* opinion suggested. Although DHS is generally quite zealous in defending its positions, some factual circumstances (and the proposed allocations that stem from them) might inspire DHS to apply one of CMS's suggested mitigating actions and "[pursue] a lesser amount than the full cost of care in order to avoid litigation." In some cases, including those where negotiation proves difficult or court action appears necessary, it may be prudent to retain, or co-associate with, advisors who have experience dealing with Oregon DHS and expertise navigating the maze that is Medicaid law.

42 USC § 1396 p. 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).

42 USC § 1396a. 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, self-insured plans, 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, 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) 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;

EXHIBIT 2

(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. 1167 (1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), 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;

(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; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, 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, 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 in the State, to—

(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State 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 State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

42 USC § 1396 k. 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

July 3, 2006

TO: All Associate Regional Administrators for Medicaid and State Operations

FROM: Gale Arden /S/
Director

RE: State Options for Recovery Against Liability Settlements In Light of U. S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*

The purpose of this memorandum is to clarify third party recovery rules and options for States in the context of the U. S. Supreme Court's decision in *Arkansas Department of Human Services v. Ahlborn ("Ahlborn")*. The Court ruled against the State in this case, in which the federal government had filed an *amicus* brief, holding that the federal assignment and lien provisions prohibited full recovery of the State's payments for Medicaid if the State's recovery claim exceeded the amount designated as compensation for medical items and services. States must comply with the decision in *Ahlborn*. However, States may be able to mitigate the adverse impact of the case by taking some of the actions discussed in this Memorandum. The Centers for Medicare & Medicaid Services (CMS) strongly encourages States to consider implementing mitigating strategies, and we ask that you share the information in this memorandum with the States in your region.

Background:

On May 1, 2006 the United States Supreme Court, in a unanimous decision, held that the federal Medicaid statute only permits a State to recover its payments for medical assistance from the portion of a liability settlement attributable to medical items and services. The Court further held that if the State attempted to recover from more than the portion of a settlement that the parties allocated to medical items and services, it was in violation of the federal anti-lien statute. The federal government had filed an *amicus* brief in this case on behalf of the State of Arkansas.

The case concerned a Medicaid recipient who subsequently received a tort liability settlement of $550,000. The settlement was not apportioned between medical services, loss of earnings or pain and suffering claims. Arkansas asserted a lien in the amount of $215,645 against the entire settlement amount. Ahlborn argued that Arkansas could recover only that portion of the settlement proceeds that Ahlborn determined was payment for medical expenses, as opposed to the much larger payment for lost wages or pain and suffering. Ahlborn based her argument on the federal anti-lien provision that prohibits imposition of a lien against the property of any individual on account of medical assistance paid or to be paid on his or her behalf under a State

plan. Arkansas contended that the anti-lien provision did not prevent full recovery because, as a condition of Medicaid eligibility, Ahlborn had assigned to the State her right to any settlement, judgment or award paid by a third party liable for her medical costs resulting from the accident. The State argued that those settlement proceeds remained the property of the third party tortfeasor until the Medicaid program was fully reimbursed for the funds it expended on respondent's medical care. During the course of this litigation, in order to pave the way for summary judgment, Arkansas and Ahlborn entered into a stipulation which indicated that if Ahlborn's view of the case was correct, the amount of her settlement allocated to medical expenses would be only $35,581 or approximately 16% of its total recovery claim.

The Supreme Court held that the federal assignment provision, Section 1912(a)(1)(A) of the Social Security Act (the "Act"), provides only a limited assignment from the Medicaid recipient to the State for payment for medical items and services from a liable third party. Likewise, the Supreme Court held that the statutory provisions authorizing States to recover prohibit the States from seeking anything greater than the limit of the tortfeasor's legal liability. See Section 1902(a)(25)(H) of the Act. The Court found that the limited assignment to the State prohibited full recovery, under Section 1902(a)(25)(H), of the State's payments for medical assistance if the State's recovery claim exceeded the amount attributed to compensation for medical items and services. Finally, to the extent the Arkansas State statute provided for filing a lien for full recovery of medical assistance payments, the Court found it conflicted with the Medicaid laws anti-lien provision, Section 1917(a)(1) of the Act, which prohibits the State from imposing liens against any individual prior to his death on account of medical assistance paid on his/her behalf.

What this means for Medicaid third party liability recovery programs:

Prior to the Supreme Court's decision in *Ahlborn*, CMS had interpreted the Medicaid third party liability provisions to authorize States to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws.

However, the Supreme Court also strongly noted that the States should become involved in the underlying tort litigation in order to influence the amount that is allocated in a settlement to medical items and services. Thus, the Supreme Court determined that a State's recovery rights could be protected, and the adverse consequences of the decision mitigated, by vigorous action on the part of a State to increase the amount of a settlement allocated to medical items and services. Absent such involvement, the Supreme Court found little sympathy in the State's argument that they should be able to recover from the total settlement.

While the federal government is reviewing its legislative options, it is imperative that States comply with the decision in *Ahlborn*. To assist States in determining how to proceed under the federal Medicaid third party liability recovery rules post-*Ahlborn* we provide the following:

State Actions Prohibited Under *Ahlborn:*

- The Court interpreted current federal Medicaid law to preclude the State from enforcing laws which broaden the assigned rights of a Medicaid recipient. States may only require

assignment of the right to payment from a third party for healthcare (or medical) items and services.

- The Court interpreted current federal Medicaid law to preclude the State from enforcing laws which broaden the recovery rights, *vis a vis* Medicaid beneficiaries, of the State Medicaid agency. A State may only recover from the amount of a third party payment to a Medicaid recipient that is allocated to healthcare (medical) items and services. **However, note that State tort or insurance liability provisions are a matter of State law and could be utilized to mitigate the adverse affects of the decision.** For example, a State can enact laws which provide for a specific allocation amongst damage, i.e., pain and suffering, lost wages, and medical claims. The State may also require that cases can only be compromised with the consent of the State.

- A State's lien laws may only operate to recover from that portion of a settlement that is allocated to healthcare items or services, even if it means that Medicaid must forego full recovery of its claim. According to *Ahlborn,* federal Medicaid anti-lien law precludes the State from passing lien laws which broaden the recovery rights of the State Medicaid agency. Note however, that the State may pass other laws which give it a priority right of recovery in tort actions.

State Actions Which Would Mitigate the Adverse Consequences of *Ahlborn*:

- In order to protect the Medicaid program's interest in the allocation of settlement monies to medical items and services it is extremely important for States to be involved in the litigation and settlement process.

- States may pass laws which require mandatory joinder of a State when a Medicaid lien is at issue. The States may also want to strengthen their laws regarding the duty of attorneys to notify and cooperate to include provisions which could render voidable any settlement of which the State was not notified and given an opportunity to present its recovery claim for medical assistance paid. These actions are consistent with the federal Medicaid laws.

- As part of its governance of tort and insurance law, the State may enact laws which define tort rights of action, judicial procedures and settlement standards in State courts. For example, a State could enact laws which give priority to the repayment of medical expenses, only permit compromising a claim with the State's consent, or any other laws which ensure that the State will have an opportunity to fully recover its expenditures.

- The States may use the cost effectiveness criteria set forth in Section 1902(a)(25)(B) of the Act in determining which liability case settlements they should pursue for recovery of Medicaid claims. For example, where a Medicaid recipient decides not to pursue a claim, depending on the amount of the claim, the State Medicaid agency may determine that it is not cost-effective to pursue its direct right of recovery against the potentially liable party. States that choose this option should use the State plan process to adopt a threshold or other guidelines for determining whether to seek reimbursement. These actions are consistent with the federal Medicaid law.

- As part of its State plan, the State may determine that it is more cost-effective to pursue a

lesser amount than the full cost of care in order to avoid litigation. Cost-effectiveness must be determined on a case by case basis. For example, the State could reduce the amount of its claim which becomes the amount of reimbursement that the State can reasonably expect to recover. However, in order to do so, a State must amend its State plan to include cost effectiveness criteria such as the following:

a. Factual and legal issues of liability as may exist between the Medicaid recipient and the liable party; and

b. Total funds, e.g., policy limits, available for settlement; and

c. An estimate of the cost to the Medicaid program of pursuing its claim.

See the attached copy of general cost effectiveness criteria and Washington's State plan concerning third party liability and cost-effectiveness.

- The Medicaid statute does not require the State to repay the federal government its full federal share, i.e., the total amount the federal government expended, where the State has determined that it is not cost-effective to attempt to recover the full cost of care from a recipient's settlement. What the Medicaid statute does require is that the federal share of the State's actual recovery amount be repaid to the federal government. Such an action is not considered a compromise of the federal share for purposes of third party liability recovery. These actions are consistent with the federal Medicaid laws and the federal share would be based on the amount that is actually recovered by Medicaid.

Attachments (2)
Fact Sheet—June 2000
Washington SPA 99-07

EXHIBIT 4

May 18, 2006

Re: Personal Iniurv Liens

Dear N

In regard to the recent Supreme Court decision on Arkansas Department of Health and Human Services v. Ahlborn, we wish to inform you of the impact upon the Oregon Department of Humans Services lien.

In *Arkansas Department of Health and Human Services v. Ahlborn, 547 U.S.* _____, (May 1, 2006) the U.S. Supreme Court held that federal Medicaid law did not authorize the State of Arkansas to assert a lien on settlement proceeds in an amount exceeding the portion of the settlement that represents recovery for medical expenses. As a result, DHS continues to have a lien under ORS 416.540 for the amount of public assistance provided to the client, but that lien is limited to the portion of any settlement or judgment or compromise that represents recovery for medical expenses.

The Court indicated that the states' concerns about possible manipulation of settlement allocations by plaintiffs to reduce the states' recovery can be avoided if the state either agrees in advance to an allocation, or, if necessary, by submitting the matter to a court for a decision. Accordingly, from this point forward, DHS intends to be involved in all settlement negotiations to protect its interests. In addition, DHS has the authority to intervene in an action pursuant to ORCP 33 and will do so if necessary to protect its interests.

Current law requires the recipient or the recipient's attorney to immediately notify DHS when an applicant or recipient makes a claim for payment from an insurer, or begins any action to enforce a claim against a potentially liable third party. ORS 416.530. This notification requirement was not affected by *Ahlborn* and continues as a mandatory reporting obligation for attorneys. If DHS is not given timely notice of a claim and is therefore not included in any settlement negotiations regarding the claim, DHS will be looking at any and all legal means for challenging any resulting settlement agreement, including actions under ORS 416.610 and ORS 95.230 (to the extent a settlement is structured to transfer proceeds to the client in a way that defeats any or all of DHS' lien). DHS is also evaluating its option with respect to an attorney who fails to comply with these mandatory reporting requirements.

EXHIBIT 5

Please immediately provide DHS with notice of any and all claims of your client's against potentially liable third parties as well as notice of any settlement negotiations regarding your client's claims against any potentially liable third party.

If you need further assistance concerning this matter, please contact me at 503-378-2737.

Sincerely,

Susie Smith, Coordinator
Personal Injury Liens

cc Gretchen Merrill, Department of Justice

dss

Department of Human Services
Office of Payment Accuracy and Recovery
Personal Injury Liens
PO Box 14512
Salem, OR 97309-0416
Voice: (503) 378-4514
Fax: (503) 378-2577

Re: Statutory requirement to report injury claims/settlements for Medicaid recipients

Since the *Alhborn* decision, the state has seen a significant reduction in the number of attorney notification letters. I would like to thank those who are currently in compliance and working with the staff of the Personal Injury Liens Unit. This is sent to remind you of attorneys' statutory reporting requirement and to provide you with our current contact information.

Current law (ORS 416.530) requires an individual receiving Medicaid or that individual's attorney to immediately notify the Oregon Department of Human Services (DHS) when they make claim for payment from an insurer, or when they begin any action to enforce a claim against a potentially liable third party. This notification requirement was not affected by *Ahlborn* and continues as a mandatory reporting obligation for attorneys. If DHS is not given timely notice of a claim and is therefore not included in any settlement negotiations regarding the claim, DHS will look at any and all legal means for challenging any resulting settlement agreement. This could include actions under ORS 416.610, 416.580 and ORS 95.230 (to the extent a settlement is structured to transfer proceeds to the client in a way that defeats any and all of a DHS initiated lien). DHS also will evaluate its options with respect to an attorney who fails to comply with these mandatory requirements.

When you represent a Medicaid individual for a third party personal injury you are required to notify the Personal Injury Liens Unit at 503-378-4514 prior to any judgment, settlement or compromise. Our Web site at http://www.dhs.state.or.us/admin/opar/pil.html provides additional contact phone numbers as well as useful resources. Please contact our office if you have any questions.

Please note that DHS liens are separate from any lien that might be filed by an attorney who represents an Oregon Health Plan (OHP) contracted managed care plan. DHS is represented solely by the Department of Justice.

Sincerely,

Angela Molthan, Manager

CC: Gretchen Merrill, Senior Assistant Attorney General, Oregon Department of Justice

"Assisting People to Become Independent, Healthy and Safe"
An Equal Opportunity Employer

HSB 1014 (4/00)

EXHIBIT 5

Oregon Revised Statutes

ORS 416.530 Notice of claim to department, authority or prepaid managed care health services organization. (1) 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 prepaid managed care health services 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. The notification shall include the name and address of each person or public body, agency or commission against whom claim is made or action is brought. If claim is made or action is brought against a corporation, the address given in such notification shall be that of its principal place of business. If the applicant or recipient is a minor, the parents, legal guardian or foster parents of the minor shall give the notification required by this section.

(2) The notification required by subsection (1) of this section shall be provided to:

(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. [Formerly 411.556; 2001 c.600 §2; 2009 c.595 §347]

EXHIBIT 6

Oregon Revised Statutes

ORS 416.610 Action against recipient who fails to provide notice of claim. The Oregon Health Authority or the recipient's prepaid managed care health services 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 ORS 416.530 for amounts received by the recipient pursuant to a judgment, settlement or compromise to the extent that the department or the authority or the prepaid managed care health services organization could have had a lien against such amounts had such notice been given. [Formerly 411.572; 2001 c.600 §3; 2009 c.595 §355]

Oregon Revised Statutes

ORS 416.580 Payment in satisfaction of lien. (1) After a notice of lien is filed in the manner provided in ORS 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 of Human Services or the Oregon Health 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 for the amount of such payment to the extent that the lien attached thereto under ORS 416.540.

(2) 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.

(3) 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 ORS 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 ORS 416.590. [Formerly 411.566; 1969 c.45 §3; 2001 c.600 §8; 2009 c.595 §352]

EXHIBIT 8

Oregon Revised Statutes

ORS 95.230 Transfers fraudulent as to present and future creditors. (1) A transfer made or obligation incurred by a debtor is fraudulent as to a creditor, whether the creditor's claim arose before or after the transfer was made or the obligation was incurred, if the debtor made the transfer or incurred the obligation:

(a) With actual intent to hinder, delay, or defraud any creditor of the debtor; or

(b) Without receiving a reasonably equivalent value in exchange for the transfer or obligation, and the debtor:

(A) Was engaged or was about to engage in a business or a transaction for which the remaining assets of the debtor were unreasonably small in relation to the business or transaction; or

(B) Intended to incur, or believed or reasonably should have believed that the debtor would incur, debts beyond the debtor's ability to pay as they become due.

(2) In determining actual intent under subsection (1)(a) of this section, consideration may be given, among other factors, to whether:

(a) The transfer or obligation was to an insider;

(b) The debtor had retained possession or control of the property transferred after the transfer;

(c) The transfer or obligation was disclosed or concealed;

(d) Before the transfer was made or obligation was incurred, the debtor was sued or threatened with suit;

(e) The transfer was of substantially all the debtor's assets;

(f) The debtor had absconded;

(g) The debtor had removed or concealed assets;

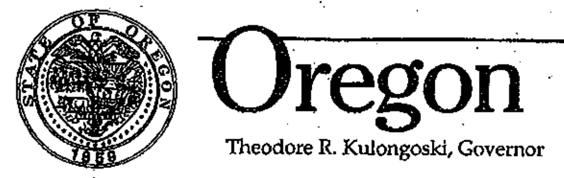
(h) The value of the consideration received by the debtor was reasonably equivalent to the value of the asset transferred or the amount of the obligation incurred;

(i) The debtor was insolvent or became insolvent shortly after the transfer was made or the obligation was incurred;

(j) The transfer had occurred shortly before or shortly after a substantial debt was incurred; and

(k) The debtor had transferred the essential assets of the business to a lienor who had transferred the assets to an insider of the debtor. [1985 c.664 §4]

EXHIBIT 9



Department of Human Services
Office of Payment Accuracy and Recovery
Personal Injury Liens
PO Box 14512
Salem, OR 97309-0416
Voice: (503) 378-4514
Fax: (503) 378-2577

March 31, 2010

Michael Edgel
Attorney at Law
Fitzwater Meyer LLP
6400 SE Lake Rd Ste 440
Portland, OR 97222

Re: Ahlborn decision

Dear Mr. Edgel,

Thank you for taking the time to discuss the Department of Human Services, Personal Injury Liens Unit's (PIL) response to the Supreme Court's decision on the Ahlborn case. As we discussed yesterday, PIL does not use any formula for determining the amount of money that will be accepted in a settlement.

I do not have a letter from our Assistant Attorney General, Gretchen Merrill however in an email she sent to one of my co worker's regarding this issue she wrote:

"The Supreme Court in Ahlborn did not require any methodology for valuation; rather, that was a specific factual stipulation entered into by the parties, and it is not binding on the State of Oregon, absent any statute or law otherwise."

I hope this is helpful. Please call me if I can be of further assistance.

Sincerely;

Mary Beth Pike
Personal Injury Liens Coordinator
503 378 2919

Form-SPD 8655

EXHIBIT 10

Oregon Revised Statutes

ORS 416.600 Release of portion of lien in certain cases. When the Department of Human Services or the Oregon Health Authority determines that a recipient will incur additional medical, surgical or hospital expenses or that additional assistance will have to be given to the recipient after the date of satisfaction of judgment or payment under a settlement or compromise, the department or the authority may release any portion of its lien to the extent of such anticipated expenses and assistance. [Formerly 411.570; 2001 c.600 §10; 2009 c.595 §354]

OREGON ADMINISTRATIVE RULE 461-195-0320 - Release of Lien for Future Medicals

(1) To qualify for consideration of a full or partial release of the State's share of the Department's lien (including the amount of an assigned lien) pursuant to ORS 416.600, the recipient must demonstrate, through documentation satisfactory to the Department, that:

(a) As a result of the personal injury for which the recipient has a claim, the recipient has a medical condition which will require future medical treatment;

(b) The nature of future medical treatment;

(c) The date on which the future medical treatment can reasonably be expected to occur;

(d) The anticipated cost of the future medical treatment;

(e) The amount of the settlement, compromise, or judgment awarded the recipient;

(f) Timely compliance by the recipient with the notification requirements; and

(g) Any other documentation requested by the Department.

(2) In considering a request for a full or partial release of a lien pursuant to ORS 416.600, the Department may take into account:

(a) Whether the recipient has provided the documentation required by section (1) of this rule;

(b) Whether the future medical treatment is likely to occur in the near future. The Department will evaluate this factor in light of the nature and certainty of the type of medical treatment anticipated;

(c) Whether the amount of the settlement, compromise, or judgment is sufficient to pay the future medicals and all or part of the Department's lien;

(d) Whether the recipient has or is likely to have another source for payment of the future medical expenses;

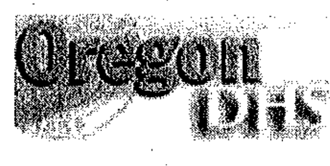
(e) The effect, if any, of the requested release on the continuing eligibility for future medical or public assistance of the recipient;

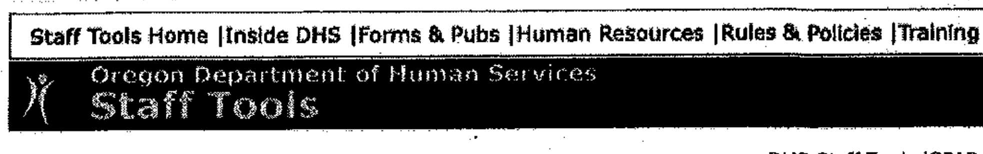
(f) Any other factor deemed relevant by the Department, including information received from a prepaid managed health care services organization;

(g) In the event the recipient is a minor, the provisions of OAR 461-195-0350 may apply.

(3) In no case will the Department consider a request for a partial or full lien release pursuant to ORS 416.600 unless the recipient and the liable third party have entered into a final, binding settlement or compromise agreement or the recipient has received a final judgment. In every case, the lien amount that represents the federal share of Title XIX or Title XXI payments must be repaid to the federal government and shall not be subject to partial or full lien release.

Stat. Auth.: ORS 416.510 - 416.600
Stats. Implemented: ORS 25.020, 25.080, 409.020 & 411.060
Hist.: AFS 14-1995, f. 6-30-95, cert. ef. 7-1-95; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06





Office of Payment Accuracy and Recovery

Personal Injury Lien (PIL)

The Personal Injury Liens Unit files liens on settlements for recovery of money owed to the state by a liable third party, when a client has been involved in a vehicle or a personal injury accident.

Medicaid recipients are required to pursue all resources. If a client is injured in a vehicle or personal injury accident and Medicaid has paid medical bills related to that injury, the client must file a claim against the liable third party. If an injury occurred before they applied for Medicaid, the client is still required to report to their caseworker any claims or potential claims at their time of application. Caseworkers may assist clients with completing the DHS0451 (Vehicle) or DHS0451NV (Non-Vehicle) form to report the accident or injury to PIL.

PIL is responsible for investigating potential recovery claims once they have been reported to the Department. By doing this, the state complies with federal Medicaid regulations and also recovers funds that reimburse Oregon Medicaid programs.

Attorneys are required to immediately notify the Department when they become aware that their client is a Medicaid recipient. They must notify PIL prior to any judgment, settlement or compromise. [ORS 416.530]

For more information about PIL, visit our FAQs page.

Contact information

- **General inquiries:**
  Phone: 503-378-4514
  Toll-free: 1-800-377-3841
  Fax: 503-378-2577
  Email: pinjury@dhs.state.or.us

  Mailing address:
  DHS-PIL
  PO Box 14512
  Salem, Or 97309-5024

- **Staff contacts for specific client/public inquiries:**
  The following is a list, sorted by client last name, which identifies person responsible for handling inquiries regarding a specific client:

EXHIBIT 13

A - F:
Susie Smith (503-378-2737)

G - H and L - Q:
Susan Fredinburg (503-378-4957)

I - K and R - Z:
Mary Beth Pike (503-378-2919)

Back to top

Assault Restitutions

- Janice Curoso
  503 378-2724

Additional Contact Information

- Angi Molthan — *Manager*
  503 378-8097
- Carolyn Thiebes — *Policy Analyst*
  503-378-3507

Resources

- SPD Worker Guide - Personal Injury Claim Procedure
- PIL Training (PPT)
- Related Links Procedure
- DHS Family Services Manual - Personal Injury Liens
- OAR 461-145-0400 - Personal Injury Settlement

Forms

- Vehicle Related Personal Injury form-AE0451 (PDF)
- Non-Vehicle Related Personal Injury form-AE0451NV (PDF)

Administrative Rules

- Chapter 410 (DMAP rules)
- Chapter 411 (Service rules)
- Chapter 461 (Eligibility rules)
- Other DHS administrative rules
- Other State agency administrative rules

Back to top

FAQs

What form does a client use to report a vehicle or personal injury accident?
Vehicle accidents are reported on the DHS451 and personal injury accidents are reported on the 415NV. Once completed, the client sends this form directly to PIL.

Why does the client have to fill out the DHS451 or DHS415NV form?
Clients are required to report all potential resources as a condition of Medicaid eligibility.

What will happen if I don't fill out the DHS451 form?

If a client refuses to cooperate it could affect their eligibility.

Why does a client have to fill out the DHS451 if their car insurance is paying their medical bills?
It is a Federal requirement that the state pursue recoveries from third party payers. In addition, there may be services provided that Medicaid would pay for that the car insurance does not cover.

Why does a client have to report an injury that occurred before they were on Medicaid?
If the claim/suit is still open and the client is being treated for accident related injuries, Medicaid can file a lien for any services that we pay for that are related to the injury.

The client reported an accident to their caseworker, but the client has not returned the DHS451 form. Can the form be submitted without the clients signature?
PIL does not require a signed form. If the client has reported an accident or personal injury a caseworker may fill out the 451 with as much information as possible. PIL will research the incident.

Are attorneys from other states required to notify PIL prior to settling a claim if an Oregon Medicaid client has an accident or injury in another state?
Yes. The rules that govern Oregon Medicaid clients apply to our clients even if the accident happens in another state.

If a client is enrolled in DMAP contracted managed care plan does their attorney also represent DHS?
No. DHS liens are separate from any lien that may be filed by an attorney. DHS is solely represented by the Department of Justice.

Back to top

If you have questions or comments about this site send email to DHS-Web (groupwise) or dhs-web@state.or.us

DHS Oregon Department of Human Services

Vehicle Related Personal Injury

Send original to Personal Injury Liens. Make copy for case record.

☐ **Branch** ☐ **PIL**	Program	Branch	Case Number	Worker ID
	Case Name			File
	Injured Person's Prime Number		Worker's Phone Number	

1. Name and address of injured person:

2. Date of injury/accident

3. Were you employed at time of accident?

4. Location/address where injury/accident occurred (include city and state)

5. Did you receive Wage Loss Benefits?
☐ Yes ☐ No
If yes, amount? $ ______________

5a. Did you have automobile medical insurance at the time of the accident?
☐ Yes ☐ No

6. Have you filed a personal injury claim?
☐ Yes ☐ No

6a. Has the claim been settled or resolved?
☐ Yes: $__________ ☐ No
Date: ______________

7. Were your medical expenses covered by an insurance company?
☐ Yes: Claim # ______________
Ins. Co. ______________
☐ No

7a. Are your medical expenses still covered by this insurance company?
☐ Yes ☐ No

8. Your attorney's name

8a. Attorney's address/city/state

8b. Attorney's phone

9. Were you? ☐ **Driver** ☐ **Passenger** ☐ **Pedestrian** ☐ **Bicyclist**

10. Driver's	Vehicle #1: Injured Person's Vehicle		Vehicle #2: Other Vehicle	
Name				
Address				
City/State/Zip		Phone #		Phone #
Drivers Insurance Co.		Policy #		Policy #
Claim #				
Adjuster's Name		Phone #		Phone #

11. Owner (if other than driver)				
Name				
Address				
City/State/Zip		Phone #		Phone #
Insurance Company		Policy #		Policy #
Claim #				
Adjuster's Name		Phone #		Phone #

State Office Use Only	Expense Avoid. Status		Date 451 rcvd	Injury/Accident		Source	Coverage	Lien File	
	Code	Date		Code	Date			Date	Status

12. Describe the accident:

13. Diagram (Optional)

- Show the car you were in as Number 1: 1
- Show the other car as Number 2: 2
- Show path by: →
- Show pedestrian/bicyclist by: ○
- Show railroad tracks by: ++++++++

N W E S

(name of street, road or route)

(name of street, road or route)

(name of street, road or route)

14. List your injuries:

15. List any one else in your vehicle and their injuries.

16. Did the police investigate the accident? ☐ Yes ☐ No	16a. If yes, by whom? ☐ City Police ☐ State Police ☐ County Sheriff
17. Was a citation issued? ☐ Yes ☐ No	17a. If yes, to Whom?

I understand the questions on this form. I have a copy of my Rights and Responsibilities. I understand my rights and what I must do. I know I must give true and complete information. I understand there are penalties for giving wrong or incomplete information. My answers are true and complete to the best of my knowledge. I agree to give the Department of Human Services (DHS) proof of the statements I have made. I will let DHS contact other people and agencies to get proof I do not have.

Client's Signature	Date	Client's Phone Number

Purpose of Form:

- To file a lien on any claim for damages resulting from the accident/injury.
- If you need help, contact your case worker.

Return to: Personal Injury Liens
PO Box 14512
Salem Oregon 97309

Under Oregon Law you must report all personal injury claims to us.

The Department of Human Services (DHS) will not discriminate against anyone. This means DHS will help all who qualify. DHS will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons.

DHS
Oregon Department of Human Services

Non-Vehicle Related Personal Injury

Send original to Personal Injury Liens. Make copy for case record.				
☐ Branch ☐ PIL	Program	Branch	Case Number	Worker ID
	Case Name			File
	Injured Person's Prime Number		Worker Phone Number	

1. Name and Address of injured person:

2. Date of injury/accident

3. Were you employed at time of accident?

4. Location/address where injury/accident occurred (include city and state)

5. State what happened and injuries received: (Additional space on back of form)

6. Did you receive Wage Loss Benefits: ☐ Yes ☐ No
If yes, amount: $ ____________
Workers Compensation?
Claim#: ____________

7. Have you filed a claim for damages? ☐ Yes ☐ No
Has the claim been settled or resolved?
☐ Yes: $ ________ ☐ No
Date: ____________

8. Were your medical expenses covered by an insurance company?
☐ Yes: Policy # ____________
Ins. Co. ____________
☐ No
Are your medical expenses still covered by this insurance company?
☐ Yes ☐ No

LIABILITY

9. Your attorney's name	Attorney's address/city/state	Attorney's phone #

10. **IF INJURY OR ACCIDENT IS THROUGH JOB**				11. **IF INJURY OR ACCIDENT IS NOT THROUGH JOB**			
	Name of Employer				Name of Person/Organization Causing Injury		
	Address				Address		
	City	State	Zip		City	State	Zip
	Phone #				Phone #		

INSURANCE

12. **INSURANCE COMPANY HANDLING CLAIM**					
	Name			Policy Number	Claim Number
	Address			Adjuster's Name	Phone #
	City	State	Zip	Policy Holder Name	

I declare that the information I have given on this form is correct and complete to the best of my knowledge. I understand that to knowingly give false information or to withhold information may result in a fine, imprisonment, or both. If I am unable to provide verification for any of the information on this form, I will authorize the Department of Human Services (DHS) to contact persons or agencies to obtain verification.

Client's Signature	Date	Client's Phone #

State Office Use Only	Expense Avoid. Status		Date 451 rcvd	Injury/Accident		Source	Coverage	Lien File	
	Code	Date		Code	Date			Date	Status

Purpose of Form:

- To determine if alternative resources are available to meet medical and/or maintenance expenses incurred due to the accident/injury.

- To file a lien on any claim for damages resulting from the accident/injury.

- If you need help, contact your case worker.

Shaded Areas:

- To be completed by Department of Human Services staff.

Under Oregon Law you must report all personal injury claims to us.

The Department of Human Services (DHS) will not discriminate against anyone. This means DHS will help all who qualify. DHS will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons.

Return to: Personal Injury Liens
PO Box 14512
Salem Oregon 97309