MEDICARE AND MEDICAID LIENS: SUBROGATION AND REIMBURSEMENT
AN OVERVIEW

By
Paul J. Gitnik, J.D., LL.M.

The Medicare and Medicaid programs were created as amendments to Title XIX of the Social Security Act,¹ which was originally signed into law by President Franklin D. Roosevelt in 1935. President Lyndon B. Johnson, on July 30, 1965, signed the Medicare and Medicaid programs into law during a signing ceremony in Independence, Missouri. Former President Harry S. Truman attended the ceremony and was the first member enrolled into the Medicare program. It was President Johnson who actually enrolled Truman and distributed to him the first ever Medicare card.

The Medicare part of the amendment was created, in large part, to provide hospital and health insurance for older individuals. The Medicaid aspect of the amendment was designed primarily to temporarily provide certain low-income individuals and families health care services.²

The Centers for Medicare and Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), oversees Medicare; however, private insurance companies have been given the responsibility of administering the program. In other words, private insurance companies have the responsibility of receiving claims, processing payments, making payments, enrolling health professionals, etc. Medicaid, on the other hand, is partially funded at the federal level, but is also partially funded by individual states. Administration, however, is entirely at the state level, though guided by federal statute.

A Word of Caution Before Proceeding

Construing the provisions of Title XIX in 42 United States Code section 1396a is not for the faint of heart. For all of the good the Medicare and Medicaid acts have bestowed on Americans, the Social Security amendments that breathed life into the programs are a quagmire of legalese. The language of the statutes is circuitous and so complex that readers searching for answers to their questions are often left having forgotten what they were looking for in the first place.

This Lethe-like quality of the statute is only complicated by the amount of effort it takes to use the cross references in the statutes. The reader is directed to read a subsection of the statute, which, in turn, directs the reader to read yet another subsection. It may take four or

² If you have difficulty remembering which program caters to which population, just remember that Medicare, which has an “r” in its spelling, has many individuals who have reached the age of 65 and have retired from their jobs.
five cross references before the reader finally finds what he or she originally set out to find. The Sisyphean effort it takes to maneuver through the statute led former Supreme Court Justice Powell to write: “The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction ... makes the Act ‘almost unintelligible to the uninitiated.’”

Judge Watt, a district judge in New York, described the Medicaid statute as “an aggravated assault on the English language, resistant to attempts to understand it. The statute is complicated and murky, not only difficult to administer and to interpret but a poor example to those who would like to use plain and simple expressions.” While the import of the statutory language that created Medicare and Medicaid cannot be overstated, this treatise will intentionally avoid citing to the Social Security statute to avoid any further complication of a relatively complex subject matter.

Despite these less-than-ringing endorsements of the Medicare and Medicaid statutes, our treatise, which will soon be available, attempts to give a broad overview of some of the most important facets of the statutes as they pertain to Medicare and Medicaid subrogation, reimbursement, and lien issues. While the subject matter of our treatise and this session goes beyond Medicare/Medicaid Subrogation/Reimbursement 101, the material is presented in a straightforward, hopefully easy-to-understand format and only cites to statutes and case law when necessary, and then only when the statutes or cases are integral to understanding the described concept. While our presentation gives only a quick overview of the Medicaid statutes in each state, our treatise provides detailed analysis of each state’s laws and the full text of the statute so the reader can “go to the source” if more clarification is needed.

For anyone unfamiliar with some of the legal jargon or Medicare/Medicaid vernacular, check the “Some Common Terminology” section at the end of this primer for some definitions of terms frequently used.

**Medicare vs. Medicaid: Briefly**

While the two programs bear similar names, what each actually accomplishes is quite different.

**Medicare**

Medicare is a federal health insurance program. Medical bills are paid from trust funds, into which those who are covered by Medicare have previously paid through payroll deductions. Generally speaking, Medicare is the same everywhere in the United States and is run by the CMS, an agency of the federal government. Medicare is governed by a federal statute that identifies with specificity who is and who is not eligible for the health insurance program.

Medicare, according to CMS, is a health insurance program for:

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people age 65 or older,
people under age 65 with certain disabilities, and
people of all ages with end-stage renal disease (permanent kidney failure requiring
dialysis or a kidney transplant).

Perhaps the most significant change to the Medicare plan since its inception more than
four decades ago was a December 8, 2003 amendment to the plan, which provided prescription
drug coverage for Medicare participants. The legislative change is called the “Medicare
Modernization Act,” but is more commonly known as the “MMA.”\(^5\) The implications of the
MMA will be discussed in greater detail later in this document.

**Medicaid**

Medicaid is a federal–state program and is governed by state and local governments
within federal guidelines. These state and local statutes vary from state to state, and,
consequently, who does and who does not qualify for Medicaid varies between states. Even in
each individual state, people can move in and out of eligibility depending on their financial
status from month to month.

Whereas Medicare is a federal health insurance program, Medicaid is an assistance
program through which medical bills are paid from federal, state, and local tax funds. Medicaid
serves low-income people of every age. Patients usually pay no part of costs for covered
medical expenses, although, a small copayment is sometimes required. Within guidelines
established by federal statutes, regulations, and policies, each state:

- establishes its own eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for services; and
- administers its own program.\(^6\)

States are required to include certain types of individuals or eligibility groups under their
Medicaid plans, and other individuals or eligibility groups may be included under each state’s
plan.

(Dec. 8, 2003).

\(^6\) U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Medicaid Program,
A More Detailed Look at Medicaid Eligibility

The following is a list of groups under which each individual or group who is eligible for Medicaid is categorized: categorically needy, medically needy, or special groups.

“Categorically needy” is defined by CMS as:

- Families who meet states’ Aid to Families with Dependent Children (AFDC) eligibility requirements in effect on July 16, 1996.
  Pregnant women and children under age 6 whose family income is at or below 133% of the federal poverty level.
- Children ages 6 to 19 with family income up to 100% of the federal poverty level.
  Caretakers (relatives or legal guardians who take care of children under age 18 (or 19 if still in high school)).
- Supplemental Security Income (SSI) recipients (or, in certain states, aged, blind, and disabled people who meet requirements that are more restrictive than those of the SSI program).
- Individuals and couples who are living in medical institutions and who have monthly income up to 300% of the SSI income standard (federal benefit rate).

“Medically needy” is defined by CMS as those who “have too much money (and in some cases resources like savings) to be eligible as categorically needy. If a state has a medically needy program, it must include pregnant women through a 60-day postpartum period, children under age 18, certain newborns for one year, and certain protected blind persons.”

States may additionally choose to provide Medicaid to:

Children under age 21, 20, 19, or under age 19 who are full-time students. If a state does not want to cover all of these children, it can limit eligibility to reasonable groups of these children.

  Caretaker relatives (relatives or legal guardians who live with and take care of children).
  Aged persons (age 65 and older).
  Blind persons (blindness is determined using the SSI program standards or state standards).
  Disabled persons (disability is determined using the SSI program standards or state standards).

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Persons who would be eligible if not enrolled in a health maintenance organization.

The final category is “special groups.”

Medicaid pays Medicare premiums, deductibles, and coinsurance for Qualified Medicare Beneficiaries (QMB)—individuals whose income is at or below 100% of the federal poverty level, and whose resources are at or below twice the standard allowed under SSI. Additionally, Medicare beneficiaries with income greater than 100% but less than 135% of the federal poverty level are eligible.10

Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals have income below 200% of the federal poverty level and resources that are no more than twice the standard allowed under SSI.11

States may also improve access to employment, training, and placement of people with disabilities who want to work through expanded Medicaid eligibility. Eligibility can be extended to working disabled people between ages 16 and 65 who have income and resources greater than that allowed under the SSI program. States can extend eligibility even more to include working individuals who become ineligible for the group described above because their medical conditions improve. States may require such individuals to share in the cost of their medical care.12

There are two eligibility groups related to specific medical conditions that states may include under their Medicaid plans. One is a time-limited eligibility group for women who have breast or cervical cancer; the other is for people with tuberculosis (TB) who are uninsured. Women with breast or cervical cancer receive all plan services; TB patients receive only services related to the treatment of TB.13

A More Detailed Look at Medicare Coverage

The Medicare program is divided into several sections, the major parts being Part A, which is hospital insurance; Part B, which is medical insurance; and Part D, which is prescription drug coverage. Part A (hospital insurance) helps “cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care.”14

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11 Id.
12 Id.
13 Id.
Part B (medical insurance) helps cover some “other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.” For the most part, Medicare Part B helps cover doctors’ services and outpatient care. Finally, Part D, which started in January 2006, provides insurance coverage for prescription drugs. The plan pays for both brand name and generic drugs.

**Who Pays for the Programs**

**Medicare**

The majority of individuals do not pay a monthly premium for Part A (hospital insurance) because they or a spouse have already paid into the program through payroll taxes when they worked. Part B (medical insurance) and Part D (prescription drug coverage), however, are different in the respect that most individuals do pay a monthly premium for the insurance.

**Medicaid**

States may pay health care providers directly on a fee-for-service basis, or states may pay for Medicaid services through prepayment arrangements. The states do not pay the insured any funds directly; rather, the state pays the insurance companies for any services they provide for the insured.

States have broad discretion to determine the type of payment methods. According to CMS, “[Healthcare] [p]roviders participating in Medicaid must accept Medicaid payment rates as payment in full.” For example, should a Medicaid insured patient need a procedure that on average around the country costs $1,500, but Medicaid is only willing to pay $1,250 for the procedure, the participating physician or health provider must accept the $1,250 as payment in full.

As stated above, states may impose deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. There are certain beneficiaries, however, who, according to federal statute, must not be charged. “The following Medicaid beneficiaries ... must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services.”

**A Primer on Subrogation and Reimbursement**

**Subrogation**

Black’s Law Dictionary defines “subrogation” as: “The substitution of one party for another whose debt the party pays, entitling the paying party to rights, remedies, or securities

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15 Id.
17 Id.
that would otherwise belong to the debtor....”

Some legal scholars have said that subrogation is the right of one party to “stand in the shoes” of another party for legal purposes.

With this basic definition of subrogation in mind, *Black’s Law Dictionary*’s third definition of “subrogation” is perhaps even more germane to the explanation of Medicare and Medicaid subrogation. Subrogation, according to the dictionary, is “[t]he principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.”

For Medicare and Medicaid purposes, subrogation matters arise any time an individual who is enrolled in Medicare or Medicaid is injured by a third party, and Medicare or Medicaid pays the medical bills that resulted from the injury. What will oftentimes happen is that the injured (enrolled) party will sue the third party who injured him or her, and a court will determine that the injured party should recover money damages (or the parties will decide out-of-court on a settlement, i.e., an amount of money that both parties agree is owed). Often, part of the money damages the court will award the injured party is to pay for medical bills.

The Medicare and Medicaid statutes allow the federal or state government (the federal government for Medicare subrogation, and a state government for Medicaid subrogation) that paid money to the injured party be able to get its money back. It was the third party, after all, who injured the enrolled individual and not the government. The federal or state government then “subrogates” the claim of the injured party and places a lien on any recovery amount for medical expenses that a court may award the injured party. Legally speaking, a lien is “[a] legal right or interest that a creditor has in another’s property, lasting usually until a debt or duty that it secures is satisfied.” In plain terms, however, a lien is simply a legal entitlement to money or property that someone else has or may eventually have.

The effect of the lien placed on any judgment that the injured party may receive is that, should the injured party be awarded money for medical expenses, the government, and not the injured individual (who has already been compensated for his medical expenses from Medicare or Medicaid) gets the money.

**Reimbursement**

Reimbursement is a similar principle to subrogation, and the only real difference for Medicare and Medicaid purposes is the timing of when the state or federal government has a right to be paid back the money it paid for medical bills. *Black’s Law Dictionary* defines
reimbursement as, “Repayment.” While the Medicare or Medicaid insured certainly should “repay” the applicable government agency, reimbursement in the legal sense is more closely related to the second definition of reimbursement, which is, “Indemnification.”

Indemnify means, “To reimburse (another) for a loss suffered because of a third party’s or one’s own act or default.” This may seem like a circular definition, but really to define “reimbursement” as “indemnification” makes good legal sense because of the connotation that is tied to the word “indemnify.” To indemnify someone in the legal sense means that you are legally obligated to pay them any money that they needed to pay to a third party because of you.

Just as above, when an individual who is enrolled in Medicare or Medicaid is injured by a third party, and the enrolled individual is paid by Medicare or Medicaid for medical expenses, the government may be reimbursed for the money it paid. The difference between subrogation and reimbursement, however, is that whereas with subrogation the government is entitled to its money before a court even awards any damages, reimbursement arises after the court awards damages (or the parties settle) and after the injured party has been paid by the third party.

At this point, the injured party has been compensated for his medical bills two times: once when Medicare or Medicaid has paid for the medical bills, and then once when the court says the injured party is owed money to cover his medical bills. While the injured party certainly deserves to recover the costs of medical bills, the law, and specifically the Medicare and Medicaid statutes prevent the injured party from recovering twice for the same injury. The government therefore files a lien against the money the injured party received to be reimbursed for the money it paid to or on behalf of the injured party.

**Funds to Which the Government Is Entitled**

**Medicaid**

Medicaid is entitled only to those funds received from a third party that were earmarked for medical costs. The Supreme Court of the United States held in 2006 in a case captioned *Arkansas Department of Health and Human Services, et al., v. Ahlborn* that the federal Medicaid statute does not allow states to place liens on any funds not demarcated as medical reimbursement costs. Prior to the decision, state courts were split as to whether Medicaid could place a lien on all of the money damages recovered from a liable third party or only those funds allocated for medical expenses.

The facts of the *Ahlborn* case are as follows:

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23 Id.
24 Id.
25 Id.
In 1996 Heidi Ahlborn who was then a 19-year-old college student and aspiring teacher, was severely and permanently injured in a car accident. As a result of the accident, she was left brain damaged and incapable of pursuing her chosen career.

Because of the severity of her injuries, Ahlborn had insufficient funds to pay for her medical treatment. She applied for and received Medicaid benefits from the Arkansas Department of Health Service (ADHS), which determined that Ahlborn was eligible for Medicaid benefits, and subsequently paid health care providers $215,645.30 on behalf of the state’s Medicaid plan.

In 1997 Ahlborn filed a personal injury action in Arkansas state court to recover for her injuries and other damages arising from the motor vehicle accident, including her permanent physical injuries, past and future pain and suffering, mental anguish, future medical costs, and past and future lost earnings.

In February of 1998, ADHS intervened in Ahlborn’s lawsuit and placed a lien on any proceeds she might recover from the responsible third party. Four years later, the case was settled between the parties out of court for a total of $550,000. The problematic issue of the case arose because the parties did not stipulate how they arrived at the $550,000 figure. In other words, the parties did not say what portion of the settlement was for, e.g., pain and suffering, medical expenses, lost earnings, etc. As a result, ADHS asserted a lien against the settlement proceeds in the amount of $215,645.30—the total cost of payments made by ADHS on behalf of Ahlborn.

In September of 2002, Ahlborn filed an action in the United States District Court seeking a judgment by the court that the lien violated the federal Medicaid laws because payment of the $215,645.30 would take money away from the settlement that was not intended to compensate her for medical expenses. The parties and the court calculated that the portion of Ahlborn’s settlement that constituted reimbursement for medical payments was $35,581.47—far below the amount of the Medicaid lien placed on her settlement.

The District Court agreed with the ADHS and awarded it the full amount of the lien. Ahlborn appealed the decision to the United States Court of Appeals for the 8th Circuit, which reversed the lower courts decision, and awarded ADHS only the pro rata share27 of the settlement. Unhappy with the decision, the ADHS appealed to the Supreme Court of the United States, which unanimously affirmed the 8th Circuit’s decision, thereby setting the precedent that only those judgment or settlement funds intended for medical costs are subject to state Medicaid liens.

While there are no stronger judicial precedents than those created by the Supreme Court of the United States, each individual Medicaid subrogation or reimbursement case has its

27 In other words, just the amount of the settlement that was designated for medical costs: in this case, the $35,581.47.
own identity. It is not at all unlikely that a state court could distinguish the facts of a case so as not to apply the holding in the Ahlborn case.

**Medicare**

The Supreme Court of the United States’ decision in Ahlborn likely does not apply to Medicare subrogation settlement cases. Whenever a third party may be liable for injuries incurred by an individual enrolled in Medicare, Medicare’s payments are made on the condition that it will be reimbursed from any recovery from the third party. The statute states:

Any payment under this title [42 U.S.C.A. §§ 1395 et seq.] with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title [42 U.S.C.A. §§ 1395 et seq.] when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.\(^\text{28}\)

In other words, CMS’s payments for medical services are conditional, and CMS retains the right of reimbursement, which is not limited to the amount of a third party’s payments made in settlement for medical expenses.

In 1995 in a case captioned Zinman v. Shalala,\(^\text{29}\) a class action law suit was brought against CMS, in which it was argued that the government should only be entitled to the pro rata amount the injured party recovered from the third party for medical expenses. The court in Zinman proffered the following example to illustrate the issue:

Assume an accident victim receives a $50,000 settlement. This is the limit of the third-party tortfeasor’s liability policy. The victim alleged damages of $80,000 in medical expenses (of which Medicare paid $50,000); $20,000 in property damage; $40,000 in lost wages; and $60,000 in pain and suffering. The total claim for damages is $200,000.

In this hypothetical case, is [CMS] entitled to recover its entire $50,000 outlay (minus its portion of attorney fees and costs), or must it apportion its recovery, reducing it in proportion to the plaintiff’s partial recovery of her total damages claim? The victim in the hypothetical example recovered only 25% of her claim. According to the [plaintiffs] … [CMS] should recover no more than 25% of its $50,000 outlay ($12,500).\(^\text{30}\)

The plaintiffs in the case argued that the court should apply the same principles of subrogation and reimbursement that apply to Medicaid third-party settlement claims to Medicare third-party settlement claims. They argued that CMS should only get a pro rata share


\(^{29}\) 67 F.3d 841 (9th Cir. 1995).

\(^{30}\) Id. at 843.
of the $50,000 that the hypothetical person received, and not, as CMS argued, the full $50,000 that Medicare spent, which would leave the individual—in the hypothetical anyway—with no recovery at all.

The court in Zinman disagreed with the plaintiffs and held that under the Medicare Secondary Payer legislation (MSP legislation) enacted by Congress in 1980, CMS can recover all of the money it spent for the medical care of a Medicare member. In other words, when an injured party settles his or her claim with the third party, the government can put a lien on any and all funds recovered from a third party—regardless of why they were recovered—to recoup the money it paid for the member’s health care expenses.

The Zinman court ruled that CMS has an “independent right of recovery against any entity that is responsible for payment of or that has received payment for Medicare-related items or services, including the beneficiary herself.” The result of the court’s decision was to confirm CMS’s stance that Medicare can be fully reimbursed even if the injured party does not receive a full recovery from the responsible third party.

The rationale behind the decision in Zinman was likely based, at least in part, on the reality that an injured party could settle a claim with a third party, and then allocate the vast majority of the settlement amount for lost wages or pain and suffering. The injured party could then allocate a nominal amount or no recovery at all for medical expenses, thereby limiting the amount of money that CMS could recover. As the court stated, “Apportionment of Medicare’s recovery in tort cases would either require a factfinding [sic] process to determine actual damages or would place Medicare at the mercy of a victim’s or personal injury attorney’s estimate of damages.” Either scenario for CMS would be both costly and arduous.

While CMS can recover its full dollar amount expended in settlement cases, CMS will respect allocations of liability amounts to non-medical losses (pain and suffering, lost wages, etc.) when the allocation is based on a court order and on the merits of the case. If a court specifically delineates dollar awards for individual reasons, then CMS will respect those determinations and only attempt to recover against the amount specified for medical costs.

A relatively recent amendment affecting CMS’s Medicare lien is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act). The Act created an unbeatable subrogation interest for CMS on third-party recoveries by adding several amendments to the Medicare statute. The combination of the new provision gives CMS a nearly irrefutable right to recovery.

32 Of course, the recovery must have resulted from the actual injury and not, for example, for a contract claim against the third party, or some other transaction or occurrence.
33 Zinman 67 F.3d at 845.
34 Id. at 846.
35 Also known as the “Senior Citizens Prescription Drug Plan.”
In a subsection titled “Subrogation Rights,” the statute states that, “The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.” The “Subrogation Rights” subsection gives CMS the right to be subrogated to the rights of any Medicare recipient against any third party who may have injured the Medicare insured.

In a subsection titled, “Action by The United States,” the statute reads:

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. **The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity.** In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

This provision, coupled with the “Subrogation Rights” section gives CMS the ability to seek reimbursement against nearly any person or entity that might be responsible to reimburse CMS for medical expenses it paid out on behalf of the Medicare recipient. The real teeth of the statute, however, is the “double recovery” clause that allows CMS to not only recover the amount it paid on the recipient’s behalf, but also to double the amount of recovery from any party or entity that should have reimbursed CMS but failed to do so. Needless to say, it does not behoove any liable third party to challenge the subrogation rights of CMS, lest the third party need to pay double what it might have owed.

**Some Common Terminology in Medicare and Medicaid Subrogation/Reimbursement**

**Agent/Agency:** “One who is authorized to act for or in place of another; a representative.”

For the purposes of Medicare and Medicaid liens, the insurance companies that pay for the medical services provided to the Medicare and Medicaid members are agents of CMS and the state agencies.

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departments that administer Medicaid, respectively. Because they are agents, they have the legal right to act on Medicare and Medicaid’s behalf by placing liens on third-party recoveries.

**Damages:** “Money claimed by, or ordered to be paid to, a person as compensation for loss or injury.” The dictionary gives the following example of how the term is frequently used: “[T]he plaintiff seeks $8,000 in damages from the defendant.”

**Enrolled/Insured:** These refer to the individuals who have signed up for either Medicare or Medicaid benefits and who, for subrogation/reimbursement purposes, have been injured by a third party.

**Lien:** “A legal right or interest that a creditor has in another’s property, lasting usually until a debt or duty that it secures is satisfied.” In plain terms, a lien is simply a legal right to money or property that someone else has or may eventually have.

**Negligence:** “The failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation ...” Simply put, negligence is the failure to do something that should have been done or done more carefully, which resulted in injury to another party. If, for example, David was very tired, but he decided to drive his car home from the airport anyway, and while he was driving he fell asleep, causing his car to run over Percy’s mailbox, then David was likely negligent. David had a duty to everyone on the road and everyone who lived near the road to drive carefully so as not to harm them or their property. David breached that duty when he drove his car while he was very tired. Because he drove while he was very tired and fell asleep at the wheel, he caused his car to run over Percy’s mailbox, which will cost money to replace. A reasonably prudent person in David’s situation would have foreseen that he might fall asleep at the wheel and would have called someone to pick him up from the airport.

**Office:** Many Medicaid statutes refer to the Medicaid office or the office of the government department that administers Medicaid simply as the “office.”

**Perfect (a lien):** Pronounced with the emphasis on the second syllable (per-fect’), “To take all legal steps needed to complete, secure, or record (a claim, right, or interest) ...” Often for Medicare and Medicaid liens, the lien is perfected as soon as the proper paperwork is filed with the appropriate Medicare or Medicaid office, and there are no further steps needed to create the legal entitlement in the money recovered from a third party.

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39 Id.
40 Id.
41 Id.
43 Id.
**Precedent:** “A decided case that furnishes a basis for determining later cases involving similar facts or issues.”

The Supreme Court of the United States is the highest court in the United States. The concept of precedent means that if a higher court rules on an issue, then all courts below that court need to (or at least should) make the same ruling when that issue comes before the lower court. Sometimes if a lower court does not agree with a higher court’s decision, the lower court will attempt to “distinguish,” or show how the facts and issues of the case before it differ from the case upon which the higher court ruled. By distinguishing the cases, the lower can avoid apply the higher court’s precedent and make a different ruling.

**Pro Rata:** “Proportionately; according to an exact rate, measure, or interest.”

**Recovery:** “The obtainment of a right to something (especially damages) by a judgment or decree.... An amount awarded in or collected from a judgment or decree.” In Medicare and Medicaid cases, the amount of money that Medicare or Medicaid is able to get back from the third party would be the amount they recovered.

**Reimbursement:** “1. Repayment. 2. Indemnification.”

**Setoff:** “1. A defendant’s counterdemand against the plaintiff, arising out of a transaction independent of the plaintiff’s claim.... 2. A debtor’s right to reduce the amount of a debt by any sum the creditor owes the debtor; the counterbalancing sum owed by the creditor....”

**Subrogation:** “The substitution of one party for another whose debt the party pays, entitling the paying party to rights, remedies, or securities that would otherwise belong to the debtor....” The right of one party to “stand in the shoes” of another party for legal purposes.

**Third party:** A party other than the two parties involved in the primary transaction. For Medicare and Medicaid purposes, the injured party and either the Medicare or Medicaid office are the two parties between which money is being paid for medical expenses. A third party is the person that has caused the injury and the person from whom Medicare or Medicaid will claim they have a right to recover money.

**Tort:** “A civil wrong, other than breach of contract, for which a remedy may be obtained, usually in the form of damages ....” In simple terms, a tort is a wrong or harm that one person does to another person (or his or her property). For example, if Tammy shoves Peter in the back and Peter falls and breaks his arm, he can sue Tammy for the tort of battery, and a court could make Tammy pay for Peter’s medical expenses, his pain and suffering, lost wages, etc.

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44 Id.
45 Id.
46 Id.
47 Id.
48 Id.
49 Id.
51 Id.
Remember that there are civil suits and there are criminal prosecutions. The difference between the two is that for civil actions, like tort actions, Peter can only recover money from Tammy, he cannot make her go to jail or otherwise take away her freedom.  

**Tortfeasor:** This might be the single most intimidating legalese word around, but all that it means is “One who commits a tort.”

**Vendor:** Medicaid statutes often refer to the insurance companies with whom Medicaid contracts to provide health care services to its population as “vendors.”

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51 If he did want Tammy to go to jail, then Peter would need to file charges with the police.