

Supreme Court Docket No. \_\_\_\_\_

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

**PATSY HARDY, Secretary, West Virginia  
Department of Health and Human Resources,**

**Petitioner/ Intervenor Below**

v.

**Civil Action No. 09-P-47 M  
Circuit Court of Hancock County (J. Mazzone)**

**HOLLY GRESS, as next friend of  
E.B., a minor,**

**Respondent/ Petitioner Below**

**PETITION FOR APPEAL**

2010 NOV 12 PM 10:29  
CIRCUIT COURT  
CLERK  
SHERIFF  
HONORABLE JUDGE

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## TABLE OF CONTENTS

|  |     |
|--|-----|
| TABLE OF CONTENTS.....   | i   |
| TABLE OF AUTHORITIES.....  | iii |
| PETITION FOR APPEAL.....   | 1   |
| KIND OF PROCEEDING AND NATURE OF THE RULING BELOW.....   | 1   |
| PROCEDURAL HISTORY AND STATEMENT OF FACTS.....   | 2   |
| STATUTORY AND REGULATORY FRAMEWORK.....  | 11  |
| The Medicaid Program.....  | 11  |
| West Virginia's Medicaid Subrogation Act.....  | 12  |
| ASSIGNMENT OF ERROR.....   | 13  |
| ARGUMENT.....  | 14  |
| Standard of Review.....  | 14  |
| A. The Circuit Court Committed Error In Granting Plaintiffs' Motion<br>For A Proportional Reduction Of The State's Recovery According<br>To The Ratio Of The Settlement Amount To The "Full Value" Of<br>The Case..... | 14  |
| Preemption.....  | 14  |
| 1. <i>Ahlborn</i> Does Not Invalidate <i>W.Va. Code</i> § 9-5-11 (2009).....   | 17  |
| 2. <i>Ahlborn</i> Does Not Require A Specific Method For Determining<br>The Medical Expense Portion A Medicaid Recipient's Lump<br>Sum Settlement.....   | 23  |
| 3. The Circuit Court's Order Violates The Separation<br>Of Powers Doctrine.....  | 26  |
| a. The Secretary of DHHR Has the Sole Discretion To Waive<br>All Or Part Of a West Virginia Medicaid Recipient's Lien.....   | 26  |
| b. The Secretary Did Not Abuse Her Discretion.....   | 28  |

B. The Circuit Court Committed Error In Ordering Distribution of The Net Settlement Proceeds To A “Special Needs” Trust Before Satisfying DHHR’s Reimbursement For Past Medical Expenses It Paid On Behalf Of E.B.....29

C. The Circuit Court Was Without Jurisdiction When It Applied *Ohio Revised Code* § 2315.18(B(3)) To DHHR's Reimbursement Claim.....32

D. Dr. Yarkony’s Opinion Regarding Future Medical Expenses Was Inadmissible Under Rules 702 and 703, *WVRE*; The Circuit Court Committed Clear Error In Relying On It.....35

CONCLUSION.....37

## TABLE OF AUTHORITIES

### CASES

|   |  |
|---|--|
| <i>Anderson v. Wood</i> ,<br>204 W.Va. 558, 514 S.E.2d 408 (1999).....  | 2, 11, 21, 28  |
| <i>Andrews v. Heygood</i> ,<br>362 N.C. 599, 669 S.E.2d 310 (2008).....   | 17, 21, 26   |
| <i>Arkansas Department of Health and Human Services v. Ahlborn</i> ,<br>547 U.S. 268 (2006).....                          | 1, 3, 7, 11, 12, 13, 14, 17 - 25, 27, 28, 29, 33, 37 |
| <i>Armstrong v. Canster</i> ,<br>2010 WL 2629740 (W.D.N.C.)(June 28, 2010).....   | 2, 17, 21, 24, 26                                    |
| <i>CSX Transp., Inc. v. Easterwood</i> ,<br>507 U.S. 658, 664, 113 S.Ct. 1732, 1737, 123 L.Ed.2d 387 (1993).....          | 15   |
| <i>Cuello v. Valley Farm Workers Clinic, Inc.</i> ,<br>91 Wash. App. 307, 957 P.2d 1258 (1998).....                       | 31   |
| <i>Cricchio v. Pennisi</i> ,<br>90 N.Y.2d 296, 683 N.E.2d 301, 660 N.Y.S.2d 679 (1997).....                               | 31   |
| <i>Cutright v. Metropolitan Life Ins. Co.</i> ,<br>201 W.Va. 50, 491 S.E.2d 308 (1997).....                               | 14   |
| <i>Davis v. Eagle Coal and Dock Company</i> ,<br>220 W.Va. 18, 640 S.E.2d 81 (2006).....                                  | 14, 15, 16   |
| <i>Eastman v. Stanley Works</i> ,<br>180 Ohio App.3d 844, 907 N.E.2d 768 Ohio App.10 District (2009).....                 | 36   |
| <i>Fla. Lime &amp; Avocado Growers, Inc. v. Paul</i> ,<br>373 U.S. 132, 142-43, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963)..... | 17   |
| <i>General Motors Corp. v. Smith</i> ,<br>216 W.Va. 78, 83, 602 S.E.2d 521, 526 (2004).....                               | 15   |
| <i>Grayam v. Department of Health &amp; Human Resources</i> ,<br>201 W.Va. 444, 498 S.E.2d 12 (1997) .....                | 1, 11, 13, 26, 27, 28, 29, 33                        |
| <i>Hartley Marine Corp. v. Mierke</i> ,<br>196 W.Va. 669, 673, 474 S.E.2d 599, 603 (1996).....                            | 15, 16   |

|   |        |
|---|--------|
| <i>Hines v. Davidowitz</i> ,<br>312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941).....   | 17     |
| <i>In the Matter of Valeria Pace Helm</i> ,<br>Civil Action No. 09-C-89, Cir. Ct. of Monroe Co. (9-24-2010).....  | 2      |
| <i>In re: West Virginia Asbestos Litigation</i> ,<br>215 W.Va. 39, 42, 592 S.E.2d 818, 821 (2003).....  | 15, 16 |
| <i>Jordan v. Bero</i> ,<br>158 W.Va. 28, 210 S.E.2d 618 (1974).....   | 36     |
| <i>Hammerschmidt v. Mignona</i> ,<br>115 Ohio App.3d 276, 281-82, 685 N.E.2d 281 (1996).....  | 36     |
| <i>Lankford v. Sherman</i> ,<br>451, F.3d. 496, 510 (8 <sup>th</sup> Cir. 2006).....  | 16     |
| <i>Maryland v. Louisiana</i> ,<br>451 U.S. 725, 746, 101 S.Ct. 2114, 2129, 68 L.Ed.2d 576, 595 (1981).....  | 15     |
| <i>Matey v. Idaho Department of Health &amp; Welfare</i> ,<br>147 Idaho 604, 213 P.3d 389 (2009).....   | 17, 31 |
| <i>McMillian v. Stroud</i> ,<br>166 Cal.Rptr.3d 261, 269-70 (Ct.App.2008).....  | 28, 37 |
| <i>Mooney v. Grazier</i> ,<br>225 W.Va. 358, 693 S.E.2d 333 (2010).....   | 14     |
| <i>Morgan v. Ford Motor Company</i> ,<br>-- S.E.2d --, 2009 WL 17398680 (WV, June 18, 2009).....  | 14     |
| <i>Norwest Bank North Dakota, N.A. v. Doth</i> ,<br>969 F.Supp. 532 (1997).....   | 32     |
| <i>Northwest Cent. Pipeline Corp. v. Kansas Corp. Comm'n</i> ,<br>489 U.S. 493, 509, 109 S.Ct. 1262, 1273, 103 L.Ed.2d 509 (1989).....                    | 16     |
| <i>Pac. Gas &amp; Elec. Co. v. State Energy Res. Conservation &amp; Dev. Comm'n</i> ,<br>461 U.S. 190, 203-04, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983)..... | 16     |
| <i>Price v. Wolford</i> ,<br>D.O., 608 F.3d 698, 706 (2010).....  | 37     |

|  |            |
|--|------------|
| <i>Rapp v. Khan</i> ,<br>07-C-102, Cir. Ct. Nicholas Co. (2009).....   | 13         |
| <i>Robinson v. Bates</i> ,<br>112 Ohio St.3d 171, 857 N.E.2d 1195 (2006).....  | 10, 36     |
| <i>Russell v. Agency for Health Care Administration</i> ,<br>23 So.3d 1266, 1268 (Fla.DCA 2010).....                         | 17, 22, 24 |
| <i>Scharba v. Everett L. Braden, LTD</i> ,<br>2010 WL 1380121 (M.D.Fla.).....  | 17, 22, 24 |
| <i>State Agency for Health Care Administration v. Wilson</i> ,<br>782 So.2d 977, 980 (Fla. 1 <sup>st</sup> DCA 2001).....    | 26         |
| <i>State ex rel. Orlofske v. City of Wheeling</i> ,<br>212 W.Va. 538, 543, 575 S.E.2d 148, 153 (2002).....                   | 15         |
| <i>State v. Peters</i> ,<br>287 Conn. 82, 946 A.2d 1231(2008).....   | 21         |
| <i>Wilt v. Buraker</i> ,<br>191 W.Va. 39, 443 S.E.2d 196 (1993),<br><i>cert. denied</i> , 114 S.Ct. 2137, 511 U.S. 1129..... | 35, 37     |

**CONSTITUTIONAL PROVISIONS**

|  |       |
|--|-------|
| <i>U.S. Const.</i> Art. VI, Cl. 2..... | 14    |
| <i>Ohio Const.</i> Art. 4, § 4.....    | 9, 35 |
| <i>W.Va. Const.</i> , Art. V, § 1..... | 27    |

**STATUTES**

|   |                |
|---|----------------|
| Title XIX of the Social Security Act, 42 U.S.C. § 1396 – 1396v..... | 11             |
| 42 U.S.C. § 1396a(5).....   | 27             |
| 42 U.S.C. § 1396a (a) (25) (A) – (B) (2000).....                    | 11, 19, 20, 25 |
| 42 U.S.C. § 1396k.....  | 12, 19, 29, 30 |
| 42 U.S.C. § 1396p (a) (1).....                                      | 12, 19, 30, 31 |

|  |   |
|--|---|
| <i>A.C.A. § 30-77-307 (1993)(Arkansas)</i> ..... | 21, 22  |
| <i>O.R.C. § 2315.18 (2004)(Ohio)</i> .....       | 9, 13, 32 - 35  |
| <i>W.Va. Code §§ 9-2-3 (1970)</i> .....          | 27  |
| <i>W.Va. Code, 9-2-6 (2005)</i> .....            | 27  |
| <i>W.Va. Code § 9-5-11(2009)</i> .....           | 1, 2, 12, 13, 14, 17, 20 - 23, 25, 27, 28, 30, 33, 36, 37 |
| <i>W.Va. Code § 9-5-11c (1995)</i> .....         | 30  |
| <i>W.Va. Code §44-10-14 (2002)</i> .....         | 4, 33   |
| <i>W.Va. Code § 55-7B-8(a)(2003)</i> .....       | 9   |

**REGULATIONS**

|   |            |
|---|------------|
| 42 C.F.R. § 430.0 (1988).....   | 11, 16, 26 |
| 42 C.F.R. § 431.10 (e) (1979).....  | 27         |
| 42 C.F.R. Part 433, Subpart D (1980).....   | 11         |
| 42 C.F.R. § 433.140 (1980).....   | 13         |
| 42 C.F.R 447.15(1985).....  | 11         |
| <i>West Virginia Medicaid Policy,</i><br>Chapter 300, §§ 340.1, 320.4 (2004)..... | 8          |
| <i>West Virginia Medicaid Policy,</i><br>Chapter 600, § 620 (2005).....           | 8, 12      |

**RULES**

|  |             |
|--|-------------|
| Rule 702, <i>West Virginia Rules of Evidence</i> ..... | 13, 35 - 37 |
| Rule 703, <i>West Virginia Rules of Evidence</i> ..... | 13, 35 - 37 |

## PETITION FOR APPEAL

### I. KIND OF PROCEEDING AND NATURE OF THE RULING BELOW

This is an appeal by Patsy Hardy, Secretary, West Virginia Department of Health and Human Resources (“DHHR”), Intervenor Below, from a final Order of the Circuit Court of Hancock County, West Virginia (J. Mazzone), entered on July 12, 2010, in an infant summary proceeding under *W.Va. Code* §44-10-14 (2002). The Circuit Court granted Holly Gress’ motion for allocation of the \$3.6 million dollars in settlement proceeds based on the “full value” of the case, ruling that *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) “takes precedence over *W.Va. Code* § 9-5-11 and any other existing case law regarding [the Medicaid reimbursement] issue;” that *Ahlborn* requires a proportionate reduction of the State’s recovery based on the ratio of the settlement to the “full value” of the case among the various damages categories; reduced the DHHR’s Medicaid statutory reimbursement from \$289,075.44 to \$79,040.82; and directed that the net settlement proceeds (in excess of \$1.5 million) be placed in a “special needs” trust for the benefit of E.B. DHHR timely filed a motion to stay the execution of the July 12, 2010 Order pending appeal on July 26, 2010<sup>1</sup>, and now perfects its appeal.

Secretary Hardy requests that her petition be granted and placed on the argument document. Secretary Hardy seeks reversal of the July 12, 2010 Order and remand of the case to the Circuit Court with instructions to pay forthwith the West Virginia Department of Health and Human Resources the amount of \$ 289,075.44, plus interest thereon as provided by law, and provide DHHR such further relief as this Court deems appropriate. The Circuit Court’s Decision is in contravention of the decisions of the West Virginia Supreme Court of Appeals in *Grayam v.*

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<sup>1</sup> The Circuit Court has not ruled on DHHR’s motion to stay the execution of the July 12, 2010 Order.

*Department of Health & Human Resources*, 201 W.Va. 444, 498 S.E.2d 12 (1997) and *Anderson v. Wood*, 204 W.Va. 558, 514 S.E.2d 408 (1999). The question of whether *Ahlborn* preempts *W.Va. Code* § 9-5-11 (2009) has not been decided by the Supreme Court of Appeals of West Virginia. The Hancock County Circuit Court Decision is in conflict with other West Virginia Circuit Court decisions, e.g., see *In the Matter of Valeria Pace Helm*, Civil Action No. 09-C-89, Circuit Court of Monroe County (9-24-2010) (J. Irons), and federal court decisions within the 4<sup>th</sup> Circuit Court of Appeals, e.g., see, *Armstrong v. Canster*, 2010 WL 2629740 (W.D.N.C.) (June 28, 2010).

## II. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On \_\_\_\_\_, Holly Gress gave birth to her son, E.B., at Coshocton County Memorial Hospital in Coshocton, Ohio. His father is Albert \_\_\_\_\_. E.B. was born with severe brain damage, which has required and will continue to require significant medical care. Ms. Gress, on behalf of E.B., applied for and received Medicaid benefits from the Ohio Department of Job and Family Services (“ODJFS”) until February, 2007, when she and E.B. moved to Hancock County, West Virginia. On February 5, 2007, Ms. Gress, on behalf of E.B., applied for and received Medicaid benefits from the West Virginia Department of Health and Human Resources (“DHHR”) – the Medicaid agency in West Virginia. As a condition of receiving benefits, Ms. Gress assigned to DHHR the right to receive any payments from a third party for E.B.’s medical care. See Exh. C, attached to *WV DHHR’s Supplemental Evidence in Support of WV DHHR’s Motion for Summary Judgment*, filed March 12, 2010. See 42 U.S.C. §1396k(a)(1)(A) (As a condition of federal funding, States must require Medicaid recipients to assign such rights); 42 C.F.R. § 433.136 (1980). *Accord*, *W.Va. Code* § 9-5-11 (2009).

West Virginia has a statute that requires Medicaid recipients who receive damages from

third parties to reimburse the West Virginia Department of Health and Human Resources to the extent of the medical expenses it paid on behalf of the recipient. *Id.* In *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752 (2006), the United States Supreme Court limited the reimbursement obligation to that portion of the damages representing medical expenses.

On or about May 16, 2007, Holly Gress, as next friend of E.B., filed a complaint against Coshocton County Memorial Hospital, Gabriel Yandam, M.D., LaFemme Obstetrics and Gynecology, LLC and Janet Burrell, R.N., in the United States District Court for the Southern District of Ohio, Eastern Division, at Columbus. Ms. Gress settled the case against Dr. Yandam and LaFemme and Gynecology, LLC in September, 2009 for \$1 million. She settled the case against the hospital and Nurse Burrell in December 2009 for an additional \$2.6 million. Both settlements constituted the policy limits of the defendants' insurance coverage and were contingent upon court approval. The settlement agreements did not allocate the amount recovered among the various elements of damages suffered. The settlement agreements and releases explicitly state that the settlements are for a full and complete release of all claims of any kind. *See* Agreement attached to 12-21-09 Order. The settlements explicitly contemplated the existence and size of the Medicaid liens and their release played a necessary role in the settlement. *Id.*

As of December 9, 2009 (date of last settlement), DHHR had paid medical expenses for E.B. in the amount of \$557,104.71. DHHR sought reimbursement for its medical payments from the settlement proceeds Gress had obtained on E.B.'s behalf. DHHR agreed to reduce the amount of medical payments it was owed by 40% (\$222,841.88), to reflect its *pro rata* share of attorney's fees incurred by Ms. Gress in her medical malpractice case. DHHR also agreed to deduct an

additional amount (\$45,187.39) as its proportionate share of Gress' legal costs in obtaining the settlements. This reduced DHHR's reimbursement to \$289,075.44 in accordance with W.Va. Code § 9-5-11 (2009). Gress refused.

On September 15, 2009, Gress filed a *Motion for Allocation of Settlement* in the Federal trial Court, which she later withdrew on November 16, 2009.<sup>2</sup>

On October 13, 2009, Gress petitioned the Circuit of Hancock County, West Virginia, pursuant to *W.Va. Code* §44-10-14 (2002), for approval of the first settlement. In her Petition, she asked the Court to pay her attorneys fees and legal expenses from the settlement funds, to pay her a "fair share," to "pay nothing" to Medicaid,<sup>3</sup> and to place the net settlement proceeds in a "special needs" trust for the benefit of E.B. DHHR moved to intervene. DHHR did not agree to set aside its reimbursement, did not agree to a judicial allocation or apportionment and further asserted that a Medicaid recipient's settlement funds first must satisfy the State's reimbursement for past medical expenses paid on behalf of the Medicaid recipient as a result of the third party's tortuous conduct before the remainder may be transferred to a "special needs" trust.

On November 12, 2009, the Circuit Court held a hearing, after which it granted the DHHR's motion to intervene, approved the first settlement, approved payment of attorneys fees and litigation costs out of the settlement proceeds, ordered that the net settlement proceeds (\$368,000) be paid into an escrow bearing account in the name of E.B. until further order of the Court and directed Gress, the DHHR and ODJFS to engage in good faith negotiations to attempt to resolve the disputes between them. *See* Order entered November 24, 2009.

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<sup>2</sup> DHHR had filed motions for *pro hac vice* admission of Mary McQuain, to intervene and to dismiss the motion for allocation of settlement proceeds in the Federal Court which were mooted by Plaintiff's withdrawal of the *Motion For Allocation of Settlement* and *Stipulation of Dismissal* (1-29-2010).

<sup>3</sup> The Ohio Department of Jobs and Family Services also asserted a Medicaid subrogation claim of \$698,225.24 which it agreed to reduce to \$377,041.63 for its *pro rata* share of attorneys fees and costs, notwithstanding that the Ohio subrogation statute does not include a provision for reduction for attorneys fees and costs.

Ms. Gress did not amend her petition after reaching the \$2.6 settlements with the hospital and Nurse Burrell. After hearing, on December 21, 2009, the Circuit Court approved the settlements, approved the payment of attorneys fees and additional litigation costs from the settlement proceeds, allocated \$50,000 to Ms. Gress, \$15,000 to Albert Burke, ordered that the contested amount of the Medicaid reimbursements be placed in an escrow account pending further Order of the Court, directed that the net settlement proceeds be placed in a “special needs” trust for the benefit of E.B., and set a briefing schedule on the Medicaid subrogation issues. *See* Order entered December 21, 2009.

On January 29, 2010, the United States District Court for the Southern District of Ohio dismissed the medical malpractice action without ruling on DHHR's motions.

By letter dated February 26, 2010, the Circuit Court of Hancock County informed the remaining parties (Gress, DHHR and ODJFS) that “the Court will consider evidence relating to the full value of the minor’s claim” and offered the parties “the opportunity to present additional evidence regarding the full value of the minor’s claim.”

Ms. Gress argued that the “true value” of the case was \$25,373,937.20, which includes \$1,255,329.95 for past medical expenses, \$19,118,608 for future medical expenses, and \$5,000,000 for non-economic loss, and that the \$3.6 million dollar settlement thus represents a recovery of 14.19% of the claim’s value. Therefore, according to Gress, DHHR is only entitled to 14.19% of its reimbursement, or \$79,053.16. To prove past medical expenses, Gress offered into evidence the Medicaid lien letters from ODJFS (\$698,225.24) and the DHHR (\$557,104.71). To prove future medical expenses and E.B’s pain and suffering, Gress offered the discovery deposition of Gary Yarkony, M.D.<sup>4</sup>, dated October 2, 2009, and a “life care plan”

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<sup>4</sup> Dr. Yarkony is Board Certified in Physical Medicine and Rehabilitation and practices medicine in Illinois. *Dep. at 100.*

prepared by Dr. Yarkony on June 11, 2008<sup>5</sup>, from the underlying tort action, and the testimony at the November 12, 2009 and December 21, 2009 proceedings of the *guardian ad litem* and Gress.

The life care plan provides for 24 hours per day in-home nursing services at the RN or LPN level of care (dep. at 32 -33), various items of durable medical equipment and supplies, a handicapped-accessible home and vehicle and a cell phone. Dr. Yarkony opined that E.B. has a life expectancy of 50 years “if he gets everything in my plan plus all treatment of any complications that arise.” *Dep. at 102*. He testified that his “gross calculation” of future medical expenses, “to a reasonable medical probability,” is “\$19,118,608 – 19,191,768.” *Dep. at 102 – 104*. This range includes housing and upgrades to a house (\$82,000 - \$99,500) along with a handicapped-equipped van (\$8840 - \$ 9050) and cell phone. The bases of his opinion was his review of E.B.’s medical records from his birth to 2007 (*dep. at 17*), his examination of E.B. on March 11, 2008 while E.B. was a patient in the Pittsburgh Children’s Hospital (*dep. at 22*), a visit (on the same day) with E.B.’s mother and father in E.B.’s home in Chester, West Virginia (*dep. at 22 -23*), and the billed rates for medical equipment, supplies and services he had obtained from various providers by calling them on the telephone (*dep. at 33 -36*). There are no documents from the providers verifying these expenses. The highest medical expense item listed in the life care plan is for in-home nursing services (\$306,000/yr), which Dr. Yarkony admitted is based on the billed rate in Chicago (\$35/hr), rather than the rate charged E.B. by Maxim Healthcare, Inc. (\$14.50/hr)<sup>6</sup> in West Virginia. *See Dep. at 36*.

Dr. Yarkony’s “gross calculation” of future medical expenses gives no consideration to the fact that all of E.B.’s medical expenses to date have been paid by Medicaid (ODJFS and DHHR) at a discounted rate and that Gress and the *guardian ad litem* anticipate that the bulk of

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<sup>5</sup> See Yarkony dep. at 96.

<sup>6</sup> See Exh. A to DHHR’s Supplemental Evidence in Support of DHHR’s Motion for Summary Judgment (E.B.’s WV Medicaid Claims History).

E.B.'s medical expenses in the future will likewise be paid by Medicaid (DHHR). *See* TR 11-12-09 at 23, 24, 28; TR 12-21-09 at 49-54 (GAL admitting these facts). *See also*, TR 11-12-09 at 15 - 17 (Gress admitting these facts).

Gress presented no evidence from an economic expert. There was no evidence regarding to lost wages and future medical expenses were not reduced to present value.

Gress had testified that Medicaid currently provides for 16 hours a day nursing care for E.B. in their home and that she cares for him 8 hours a day. TR 11-12-09 at 17. She provided no medical bills, no evidence of any out-of-pocket medical expenses to date and no evidence that medical expenses were paid from any source other than Medicaid. She provided no evidence of the economic value of her medical services to E.B. Gress further testified that she anticipates that Medicaid will continue to pay for E.B.'s future medical care. TR 11-12-09 at 15 – 17.

The *guardian ad litem* opined that E.B.'s pain and suffering should be valued at between "\$5 million and \$10 million dollars," that nothing should be paid to reimburse Medicaid, that \$50,000 should be paid to Holly Gress and \$15,000 to Albert Burke for their damages, and the net settlement proceeds should be placed into a "special needs" trust for the benefit of E.B. The DHHR objected to the *guardian ad litem's* competency to give medical, economic and legal opinions under Rules 702 and 703 of the *West Virginia Rules of Evidence*.

DHHR argued that *Ahlborn* neither compels the use of a "full value" method nor renders West Virginia's statutory method invalid. DHHR asserted that the applicable method is derived from W.Va. Code § 9-5-11 (2009). By applying that method, DHHR is entitled to recover \$289,075.82. To prove medical expenses paid on behalf of E.B., DHHR produced the affidavit of Patricia Miller, Director of the Medicaid Management Information System ("MMIS"), Operations and Information Technology ("IT") Support, with a Medicaid claims history for E.B.

from February 2007 to December 9, 2009, showing that the West Virginia Medicaid Program has paid for a wide range of services on behalf of E.B., including, but not limited to, private duty nursing (currently 16 hours/day), durable medical equipment, medical supplies, pharmacy services, physician services, psychological services, physical therapy, rehabilitation services, laboratory services, hospital services, ambulance services, etc. *See* Exh. A to *WV DHHR's Supplemental Evidence in Support of WV DHHR's Motion for Summary Judgment*, filed March 12, 2010.<sup>7</sup> All of the categories of medical services and items listed in the life care plan appear to be covered in E.B.'s Medicaid claims history. *Id.* The claims history shows both, the billed rate (\$1,857,417.71) and the amount actually paid by DHHR (\$565,973.92) for all medical items and services provided to E.B. during this period. *Id.* It also reveals that, since 2007, Maxim Healthcare, Inc. has provided in-home skilled nursing services to E.B. and that its billed rate and paid rate are the same – i.e., \$14.50/hr – and not the \$35/hr rate listed in the life care plan. *Id.* Thus, the record indicates that the only supplemental medical expenses may be 8 hours a day nursing services at \$14.50/hr. The proposed upgrades to the house and the provision of a vehicle are not covered by Medicaid.

DHHR also produced the affidavit of Rick Levoch, Health Care Management Systems, DHHR's tort recovery contractor, with attached exhibits showing that from February 2007 to December 9, 2009 (the date of settlement), DHHR was billed \$1,855,008.11 for medical expenses related to E.B.'s birth-related injury and that DHHR paid \$557,104.71 to providers. Because Medicaid is the payer of last resort, the provider cannot bill the Medicaid recipient for any amount in excess of the Medicaid rate. *See* 42 CFR 447.15. *Accord, West Virginia Medicaid Policy*, Chapter 300, §§ 340.1, 320.4; Chapter 600, § 620. Also, Medicaid members are not liable

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<sup>7</sup> The claims history includes non-accident related services such as immunizations, well-child care visits, etc., as well as services paid in connection with his injury which is the subject of the settlements.

for any third party-related co-insurance amounts, deductible amounts or HMO-related co-pays and deductibles. *Id.*

In addition, DHHR submitted copies of Form DFA-RR-1, "Rights and Responsibilities," signed by Holly Gress on February 5, 2007, July 25, 2007, October 4, 2007 March 20, 2008, September 15, 2008, and November 2, 2009. This form is part of the application and re-application for Medicaid and includes an agreement to "give back to the State any and all money that is received by anyone listed on this application from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has or will make payment..." to cooperate with DHHR in pursuing any resource available to meet the medical expenses of any Medicaid recipient" and "to assign to DHHR benefits available to any Medicaid recipient from any third-party source as a result of injury, accident, or illness... an amount up to, but not exceeding, the amount of Medicaid liability." *Id.*, Exh. C, p.3 (emphasis added).

DHHR pointed out that West Virginia and Ohio have statutes that place caps on noneconomic damages in a medical malpractice case. *See W.Va. Code* § 55-7B-8(a)(2003) (\$250,000). Ohio's statute caps noneconomic damages at \$250,000 or three times the economic damages up to \$350,000. *See O.R.C.* § 2315.18 (2004). There is an exception in Ohio to the cap for "permanent and substantial deformity, loss of use of a limb, or loss of a bodily organ. *See O.R.C.* § 2325.18(B)(1); however, the exception does not apply in E.B.'s case because *O.R.C.* § 2325.18(E)(1) provides that "... Division B of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages" and *O.R.C.* § 2315.18(F)(1) provides that "[a] court of common pleas has no jurisdiction to enter judgment on an award for non-economic loss in excess of the limits set forth in this section".<sup>8</sup>

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<sup>88</sup> In Ohio, a court of common pleas has jurisdiction over probate matters, such as an infant summary proceeding for approval of a tort settlement. *See Ohio Const.* Art. 4, § 4.

The ODJFS provided an affidavit and exhibit showing Medicaid rates in Ohio for various services and argued that the “full value” of the case using the Medicaid rate for everything but the phone, van and home would be \$4,875,013.59. If one third (8 hours a day) nursing care is paid at the \$35/hr life care plan billed rate, ODJFS estimated the “full value” of the case to be \$8,631,272.40. ODJFS pointed out that, under Ohio law, both the original medical bill and the amount actually paid to a provider are admissible to prove the reasonable value of medical expenses. *See Robinson v. Bates*, 112 Ohio St.3d 171, 857 N.E.2d 1195 (2006).

On July 12, 2010, the Circuit Court entered its Order granting judgment to Ms. Gress. The Circuit Court, found that the “full value” of the case was \$25,373,937.95. The Court found that \$1,255,329.95 constituted past medical expenses based on the amount actually paid by ODJFS (\$698,225.94) and DHHR (\$557,104.71) on E.B.’s behalf. The Circuit Court found that \$19,118,608 constituted future medical expenses based on the Yarkony deposition and life care plan. The Circuit Court found that E.B.’s pain and suffering was \$5 million. In making this finding, the Circuit Court stated that “pursuant to Ohio Revised Code § 2315.18(B)(3), the Court is free to add its own value, without limitation, as the fact finder in this instance, for E.B.’s non-economic losses...” The Circuit Court then found that the portion of the settlement attributed to DHHR's payment of medical expenses represented 14 % of the "full value" of the case or \$79,040.82. The Circuit Court specifically held that DHHR was not entitled to satisfy its reimbursement from the portion of the settlement it attributed to future medical expenses. The Circuit Court directed that the net settlement proceeds be placed in a “special needs” trust for the benefit of E.B.

The July 12, 2010 Order was received by DHHR on July 16, 2010. DHHR filed a motion to stay the execution of the Order on July 26, 2010 pending appeal. DHHR now perfects its

appeal.

### III. STATUTORY AND REGULATORY FRAMEWORK

#### A. The Medicaid Program

The Medical services, equipment and supplies rendered for E.B.'s injuries were paid in full through the taxpayer funded program known as Medicaid. *See* 42 C.F.R. 447.15 (1985) (Acceptance of State Payment as payment in full). Medicaid is a cooperative program that provides federal and state medical care funding for certain individuals who are unable to afford their own medical costs. *See* Title XIX of the Social Security Act, 42 U.S.C. § 1396 – 1396v; 42 C.F.R. § 430.0 (1988). Participating states are required by federal law to “take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available under the plan” and to “seek reimbursement for [medical] assistance [made available on behalf of a recipient] to the extent of such legal liability.” 42 U.S.C. § 1396a(a)(25)(A) – (B) (2000). State laws control the administration of the program, including the method by which a state may seek reimbursement for prior Medicaid assistance. *See* 42 C.F.R. § 430.0 (“... Within broad federal rules, each State decides eligible groups, types and range of services, *and administrative and operating procedures...*”)(emphasis added); *Arkansas Dep’t of Health & Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). *Accord*, *Grayam v. Department of Health & Human Resources*, 201 W.Va. 444, 498 S.E.2d 12 (1997) and *Anderson v. Wood*, 204 W.Va. 558, 514 S.E.2d 408 (1999). To maintain the viability of the Medicaid system, federal law requires states to enact legislation to secure Medicaid’s reimbursement from recipients’ settlements with, or judgments or awards against, liable third parties. 42 U.S.C. §1396a(a)(25); 42 C.F.R. Part 433, Subpart D (1980). Federal law requires that “any amount collected by the State ... shall be retained by the State as is necessary to reimburse it for medical

assistance payments made on behalf of an individual....” 42 U.S.C. § 1396k(b). To accomplish this, federal law mandates that participating states require Medicaid recipients to effect a comprehensive assignment of their rights as to claims against third parties in order to qualify for Medicaid benefits. 42 U.S.C. § 1396k.

While Medicaid laws are organized to effect full Medicaid lien recovery, they are not intended to allow the pursuit of a living Medicaid recipient’s property to satisfy a pending lien. 42 U.S.C. § 1396p(a)(1) (the “anti-lien” statute). The assignment and reimbursement provisions of the Medicaid Act, 42 U.S.C. §§ 1396a(a)(25) and 1396k(a) are exceptions to this general anti-lien rule. *Ahlborn* at 284 - 85.

#### **B. West Virginia’s Medicaid Subrogation Act**

In keeping with federal law, West Virginia’s Medicaid Policy expressly states that West Virginia Medicaid is “the payer of last resort.” See Chapter 600 Reimbursement Methodologies, §620 (2005), [www.wvdhhr.org/bms/Manuals](http://www.wvdhhr.org/bms/Manuals). West Virginia’s subrogation statute, *W.Va. Code* § 9-5-11(a) (2009), provides that “[s]ubmission of an application to the Department of Health and Human Resources for medical assistance is, as a matter of law, an assignment of the right of the applicant or legal representative thereof to recovery from personal insurance or other sources, including, but not limited to, liable third parties, to the extent of the cost of medical services paid for by the Medicaid program.” In accordance with the federal anti-lien statute, West Virginia’s Act incorporates equitable provisions that restrict the amount DHHR may obtain from a recipient’s recovery against a third party. *Id.* West Virginia’s Act limits the recovery (whether by judgment, verdict or settlement<sup>9</sup>) to “the extent of medical expenses paid” by DHHR on behalf of the recipient, reduced by DHHR’s *pro rata* share of attorneys fees incurred by or on

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<sup>9</sup> In a jury case, the *W.Va. Code* §9-5-11 provides that the amount of the medical expenses paid by DHHR on behalf of the recipient “shall not be disclosed to the jury.”

behalf of the Medicaid recipient at the fee contracted by the recipient or his legal guardian and by DHHR's proportionate share of the recipient's legal costs. *Id.* The Secretary of the DHHR has discretion to further reduce DHHR's reimbursement.<sup>10</sup> *Id.* However, that discretion is limited in that the State may not waive the Federal share of the recovery.<sup>11</sup> See 42 C.F.R. § 433.140 (1980).

### III. ASSIGNMENT OF ERROR

- A. **The Circuit Court Committed Error In Granting Plaintiff's Motion For A Proportional Reduction Of The State's Recovery According To The Ratio Of The Settlement Amount To The "Full Value" Of The Case.**
  1. **The Circuit Court Committed Error In Finding that *Ahlborn* Preempts *W.Va. Code* § 9-5-11 (2009) and *Grayam v. Department of Health and Human Resources*, 201 W.Va. 444, 498 S.E.2d 12 (1997).**
  2. **The Circuit Committed Error In Finding That *Ahlborn* Requires Judicial Determination and A Specific Method For Determining The Portion Of A Medicaid Recipient's Lump Sum Settlements Attributed To Past Medical Expenses.**
  3. **The Circuit Court's Order Violates The Separation Of Powers Doctrine.**
- B. **The Circuit Court Committed Error In Ordering Distribution of The Net Settlement Proceeds To A "Special Needs" Trust Before Satisfying DHHR's Reimbursement For Past Medical Expenses It Paid On Behalf Of E.B.**
- C. **The Circuit Court Was Without Jurisdiction When It Applied *Ohio Revised Code* § 2315.18(b)(3) (2004) to DHHR's Subrogation Claim.**
- D. **Dr. Yarkony's Opinion Regarding Future Medical Expenses Was Inadmissible Under Rules 702 and 703, WVRE; The Circuit Court Committed Clear Error In Relying On It.**

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<sup>10</sup> When the settlement proceeds is less than the amount of medical expenses paid, DHHR limits its reimbursement to 1/3 of the settlement proceeds. *E.g., see Rapp v. Khan*, 07-C-102, Cir. Ct. Nicholas Co. (2009).

<sup>11</sup> The Federal Medical Assistance Percentage ("FMAP") for West Virginia is currently 83.05%.

## IV. ARGUMENT

### Standard Of Review

The Circuit Court decision granting summary judgment to Holly Gress is subject to *de novo* review in this Court. In addition, issues concerning preemption, separation of powers doctrine, interpretation of a statute, rule or regulation, legal standards, and choice of law, are purely legal issues subject to *de novo* review. *Morgan v. Ford Motor Company*, -- S.E.2d --, 2009 WL 17398680 (WV, June 18, 2009); *Davis v. Eagle Coal and Dock Company*, 220 W.Va. 18, 640 S.E.2d 81 (2006) (preemption); *Mooney v. Grazier*, 225 W.Va. 358, 693 S.E.2d 333 (2010).

#### **A. The Circuit Court Committed Error In Granting Plaintiff's Motion For A Proportional Reduction Of The State's Recovery According To The Ratio Of The Settlement Amount To The "Full Value" Of The Case.**

##### **Preemption**

The Circuit Court held that *W.Va. Code* § 9-5-11 (2009) was preempted by *Arkansas Department of Human Services v. Ahlborn*, 547 U.S. 268 (2006). See Order at 14.

The authority of federal law to preempt state law is found in the United States Constitution in what is known as the Supremacy Clause which provides:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

*U.S. Const.* Art. VI, Cl. 2.

The Supreme Court of Appeals of West Virginia has held that "[t]he Supremacy Clause of the United States Constitution, Article VI, Clause 2, invalidates state laws that interfere with or are contrary to federal law." Syllabus Point 1, *Cutright v. Metropolitan Life Ins. Co.*, 201

W.Va. 50, 491 S.E.2d 308 (1997). However, “[West Virginia] law has a general bias against preemption.” *Davis v. Eagle Coal and dock Co.*, 220 W.Va. 18, 23, 640 S.E.2d 81, 86 (2006), quoting, *General Motors Corp. v. Smith*, 216 W.Va. 78, 83, 602 S.E.2d 521, 526 (2004). “[B]oth this Court and the U.S. Supreme Court have explained that federal preemption of state court authority is generally the exception, and not the rule.” *Davis, supra*, quoting, *In re: West Virginia Asbestos Litigation*, 215 W.Va. 39, 42, 592 S.E.2d 818, 821 (2003). “Given the importance of federalism in our constitutional structure ... we entertain a strong presumption that federal statutes do not preempt state laws; particularly those laws directed at subjects-like health and safety-‘traditionally governed’ by the states.” *Davis, supra*, quoting, *Law v. General Motors Corp.*, 114 F.3d 908, 909-910 (9<sup>th</sup> Cir.1997), quoting *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 664, 113 S.Ct. 1732, 1737, 123 L.Ed.2d 387 (1993). Therefore, “preemption is disfavored in the absence of convincing evidence warranting its application.” *Davis, supra*, quoting, *Hartley Marine Corp. v. Mierke*, 196 W.Va. 669, 673, 474 S.E.2d 599, 603 (1996). Said another way, “pre-emption will not lie unless it is ‘the clear and manifest purpose of Congress.’ ” *Davis, supra*, quoting, *Law*, 114 F.3d at 910, quoting *Easterwood, id.* For these reasons, “[c]onsideration under the Supremacy Clause starts with the basic assumption that Congress did not intend to displace state law.” *Davis, supra*, quoting, *State ex rel. Orlofske v. City of Wheeling*, 212 W.Va. 538, 543, 575 S.E.2d 148, 153 (2002), quoting *Maryland v. Louisiana*, 451 U.S. 725, 746, 101 S.Ct. 2114, 2129, 68 L.Ed.2d 576, 595 (1981).

The West Virginia Supreme Court of Appeals has previously recognized that “[i]n any preemption analysis, the focus of the inquiry is on congressional intent.” *Davis, supra*, quoting, *Hartley Marine Corp.*, 196 W.Va. at 674, 474 S.E.2d at 604 (citations omitted). We have also explained that “[p]reemption may either be explicit, *i.e.*, set forth in the federal statute, or

implied.” *Davis, supra*, quoting, *In re: West Virginia Asbestos Litigation*, 215 W.Va. at 43, 592 S.E.2d at 822. Implied preemption may take two forms:

[I]n the absence of explicit statutory language signaling an intent to pre-empt, we infer such intent where Congress has legislated comprehensively to occupy an entire field of regulation, leaving no room for the states to supplement federal law, or where the state law at issue conflicts with federal law, either because it is impossible to comply with both or because the state law stands as an obstacle to the accomplishment and execution of congressional objectives[.]

*Davis, supra*, quoting, *Hartley Marine Corp.*, 196 W.Va. at 674, 474 S.E.2d at 604, quoting *Northwest Cent. Pipeline Corp. v. Kansas Corp. Comm’n*, 489 U.S. 493, 509, 109 S.Ct. 1262, 1273, 103 L.Ed.2d 509 (1989).

The Medicaid Act expressly gives States great leeway in defining the scope of their Medicaid Programs. Specifically, 42 C.F.R. §430.0 provides that

...The [Medicaid] program is jointly financed by the Federal and State governments and administered by States. *Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures....* (emphasis added).

Therefore, because Congress has clearly expressed its intent *not* to preempt all state law or to occupy the entire field, field preemption does not exist in this case. *Id.* According to the clear provision of 42 C.F.R. §430.0, only State laws that are in actual conflict with the federal rules, are superceded by the federal rules. *Id. See also, Lankford v. Sherman*, 451, F.3d. 496, 510 (8<sup>th</sup> Cir. 2006)(Where Congress has not expressly preempted or entirely displaced state regulation in a specific field, as with the Medicaid Act, “state law is preempted to the extent that it actually conflicts with federal law,” citing, *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 203-04, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983).

An actual conflict arises where compliance with both state and federal law is a “physical impossibility,” or where the state law “ ‘stands as an obstacle to the accomplishment and

execution of the full purposes and objectives of Congress.’ ” *Id.*, quoting *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963) and *Hines v. Davidowitz*, 312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941).

**1. *Ahlborn* Does Not Invalidate W.Va. Code § 9-5-11 (2009).**

In the present case, the Circuit Court of Hancock County, held that *W.Va. Code § 9-5-11* (2009) was in conflict with the *Ahlborn* decision because "W.Va. Code § 9-5-11 (2009) seems to give a priority right to WV DHHR for full reimbursement of any monies it expended on behalf of a recipient without regard to whether the monies received by the recipient, either by settlement or judgment, were meant to compensate the recipient for past medical costs, or some other loss, such as lost wages, pain and suffering...etc." See July 12, 2009 Order at 13 - 14.

However, the central focus of *Ahlborn* was not whether a state could assert its priority right against and seek reimbursement from a Medicaid recipient's entire settlement but, rather, was Arkansas' stipulation concerning the portion of the settlement attributable to medical expenses. See *Armstrong v. Canster*, 2010 WL 2629740 (W.D.N.C.)(June 28, 2010)(quoting *Ahlborn*, 547 U.S. at 279-80, 126 S.Ct 1752); *Andrews v. Heygood*, 362 N.C. 599, 669 S.E.2d 310 (2008)(same); *Scharba v. Everett L. Braden, LTD*, 2010 WL 1380121 (M.D.Fla.)(same); *Russell v. Agency for Health Care Administration*, 23 So.3d 1266, 1268 (Fla.DCA 2010)(same); *Matey v. Idaho Department of Health & Welfare*, 147 Idaho 604, 213 P.3d 389 (2009)("The *Ahlborn* decision did not affect a state's ability to assert its priority to recovery of damages attributable to medical expenses from all categories of medical expenses, including, future medical expenses). *Ahlborn* controls when there has been a prior determination by a jury (or trial judge in a case tried without a jury) or stipulation as to the medical expense portion of a

plaintiff's settlement. *Id.* In those cases, the State may not receive reimbursement in excess of the portion so designated. *Id.*

In the present case, there was no such prior determination or stipulation. *W.Va. Code* § 9-5-11 (2009) provides a method for determining DHHR's reimbursement in the absence of judicial allocation that is consistent with federal law. DHHR is only seeking reimbursement out of the medical expenses portion of the settlements.

In *Ahlborn*, the Supreme Court was asked to determine whether the Arkansas Department of Health and Human Resources ("ADHS") could claim a statutory lien on a settlement for more than the portion that by stipulation represented the recovery of medical expenses. *Ahlborn*, 547 U.S. at 279- 80, 126 S.Ct. 1752. The Medicaid recipient in *Ahlborn* challenged the statute because it permitted reimbursement to ADHS for settlement proceeds recovered for damages other than medical expenses. *Id.* at 274, 126 S.Ct. 1752.

The Supreme Court, in *Ahlborn*, considered whether the Arkansas Medicaid statute, under which the state asserted an unqualified "right to recover the entirety of the costs it had paid on the Medicaid recipient's behalf," violated the third-party liability provisions of the federal Medicaid law. *Id.* at 278, 126 S.Ct. 1752. Central to *Ahlborn*'s reasoning was the state's stipulation concerning the portion of the settlement attributable to medical expenses. *Id.* The Medicaid recipient and the state stipulated that the entire tort claim was reasonably valued at \$3,040,708.12, although the case had been settled for a total of \$550,000. (The deduction was due to the Medicaid recipient's comparative negligence in the automobile accident which caused her injuries.) Furthermore, the state "stipulated that only \$35,581.47 of that [settlement] sum represent[ed] compensation for medical expenses," although it asserted a lien for \$215,645.30. *Id.* at 280, 126 S.Ct. 1752.

Thus, ADHS agreed that the portion of the settlement attributable to medical expenses was roughly equivalent to one-sixth of the lien amount. To reach this figure, the parties utilized a formula under which the portion of the settlement attributable to medical expenses was roughly based on the ratio of the amount recovered in the settlement to the amount of the stipulated “full value” of the case.

The Supreme Court rejected ADHS’ claim that it was entitled to obtain satisfaction of its lien “out of [settlement] proceeds meant to compensate the recipient for damages distinct from medical costs—like pain and suffering, lost wages, and loss of future earnings.” *Id.* at 272, 126 S.Ct. 1752. The Court reasoned that the federal statutory provisions regarding the forced assignment of third-party benefits, 42 U.S.C. §§ 1396a(a)(25) and 1396k(a) are exceptions to the federal anti-lien provision, authorizing the State “to demand as a condition of Medicaid eligibility that the recipient ‘assign’ in advance any payments that may constitute reimbursement for medical costs,” *Id.* These provisions “*require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care,” *Id.* at 282, and that the “anti-lien provision” of federal law “ [§1396p(a)] precludes attachment or encumbrance of the remainder of the settlement.” *Id.* at 284. The Court held that the federal Medicaid law did not authorize the ADHS “to assert a lien on Ahlborn’s settlement in an amount exceeding \$35,581 [the stipulated portion of the settlement constituting payments for medical care], and the federal anti-lien provision affirmatively prohibit[ed] it from doing so,” *Id.* at 292.

The *Ahlborn* decision did not affect a state’s ability to assert its priority to recovery of damages attributable to medical expenses. Indeed, the United States Supreme Court stated that “the State be paid first out of any damages representing payments for medical care *before* the

recipient can recover *any* of her own costs for medical care.” *Ahlborn*, 547 U.S. at 282, 126 S.Ct. at 1761, 164 L.Ed.2d at 472 (emphasis added).

In the present case, there was no stipulation as to the “full value” of the case, no stipulation as to the portion of the settlement attributed to medical expenses, no evidence of any medical expenses paid by sources other than Medicaid, no evidence of lost wages, insufficient evidence of future economic damages<sup>12</sup>, and a statutory cap on non-economic damages<sup>13</sup> and comparative negligence was not a factor to be considered. The past medical expenses paid by Medicaid on E.B.'s behalf were undisputed. DHHR is only asserting its lien for past medical expenses paid against the portions of the settlement that represent damages for medical care.

Furthermore, *W.Va. Code* § 9-5-11 (2009) is consistent with federal law. Under 42 U.S.C. § 1396a, funding from the federal Medicaid program is conditioned on the adoption of a state plan that conforms to specific federal requirements. Participating states are required to “take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available under the plan,” and to “seek reimbursement for assistance to the extent of such legal liability.” 42 U.S.C. § 1396a(a)(25)(A) – (B). West Virginia has complied by enacting the State Plan For Medical Assistance, which includes an assignment and subrogation statute, *W.Va. Code* §9-5-11 (2009). Implementation of a Medicaid recipient’s assignment is governed by *W.Va. Code* § 9-5-11(2009) which provides:

...When an action or claim is brought by a medical assistance recipient or by someone on his or her behalf against a third party who may be liable for the injury... of a medical assistance recipient, any settlement, judgment or award obtained is subject to the claim of the Department of Health and Human Resources for reimbursement of an amount sufficient to reimbursement the department the full amount of benefits paid on behalf of the recipient under the medical assistance program for the injury... of the medical assistance recipient. The claim of the Department .... assigned by such recipient shall not exceed the

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<sup>12</sup> See discussion in Part IV, Subpart D, *infra*.

<sup>13</sup> See discussion in Part IV, Subpart D, *infra*.

amount of the medical expenses for the injury... of the recipient paid by the department on behalf of the recipient... The secretary may compromise, settle and execute a release of any such claim, in whole or in part.... The trial judge shall, upon the entry of judgment of the verdict, direct that an amount equal to the amount of medical assistance given be withheld and paid over to the Department of Health and Human Resources. Irrespective of whether the case be terminated by judgment or by settlement without trial, from the amount required to be paid to the Department ... there shall be deducted the attorney fees attributable to such amount in accordance with and in proportion to the fee arrangement made between the recipient and his or her attorney of record so that the department shall bear the pro rata portion of such attorney fees. Nothing in this section shall preclude any person who has received medical assistance from settling any cause of action which he or she may have against another person and delivering to the Department of Health and Human Resources, from the proceeds of such settlement, the sums received by him or her from the department or paid by the department for his or her medical assistance...

Accordingly, in the absence of judicial allocation, West Virginia has determined that the State may only recover the amount of the medical expenses paid by DHHR reduced by DHHR's *pro rata* share of attorneys fees and proportionate share of the legal costs<sup>14</sup> incurred by the Medicaid recipient in obtaining the settlement and that the Secretary of the Department, in her discretion, may further compromise the claim "in whole or in part." For example, when the settlement amount is less than the amount paid by DHHR, the Secretary authorizes DHHR to limit its recovery to one third of the gross amount obtained. These equitable provisions<sup>15</sup> are absent in the Arkansas statute at issue in *Ahlborn*. See *A.C.A.* § 30-77-307 (1993). In West Virginia, the net amount (after the statutory mandated deduction and any discretionary deduction) essentially defines the portion of the settlement that represents "payment for medical expenses" in cases, such as this matter, involving a lump sum settlement. See *Armstrong*, 2010 WL 2629740 at \*4, citing *Andrews*, 362 N.C. at 604, 669 S.E.2d 310 (similarly construing North

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<sup>14</sup> In *Anderson v. Wood*, 514 S.E.2d 408 (1999), the Court held that this provision requires DHHR to pay its *pro rata* share of attorneys fees and costs.

<sup>15</sup> A *pro rata* reduction is not required by federal Medicaid law, but rather is a policy matter that the Legislature is free to address. *State v. Peters*, 287 Conn. 82, 98, FN 21, 946 A.2d 1231, 1241, FN 21(2008)(noting that 34 states have statutes that govern attorneys fees in the context of state recovery of Medicaid funds and finding it "significant that those courts have not found that the federal Medicaid statutes require such a reduction").

Carolina's statute).<sup>16</sup> *Accord, Russell v. Agency for Health Care Administration*, 23 So.3d 1266 (Fla.2d DCA 2010); *Scharba v. Everett L. Braden, Ltd.*, 2010 WL 1380121 (M.D.Fla. Mar. 31, 2010)(similarly construing Florida's statute.)<sup>17</sup> By preventing the State from obtaining more than this portion of a Medicaid recipient's settlement, regardless of whether the State in fact provided more assistance, the West Virginia statute avoids the conflict at issue in *Ahlborn*. The Arkansas reimbursement statute, as applied in *Ahlborn*,<sup>18</sup> violated the federal anti-lien provision because the State sought to impose a lien beyond the portion of the settlement allocated to medical care. *Ahlborn*, 547, U.S. at 284, 126 S.Ct. 1752.

The Supreme Court in *Ahlborn* was also critical of the Arkansas statutory scheme because there was an absence of a limit on the state's recovery. 547 U.S. at 278, 126 S.Ct. 1752. Under such a scheme, if the State had provided substantial assistance to a Medicaid recipient, beyond the amount the individual obtained in a third-party settlement, ADHS could require the entire settlement and leave the Medicaid recipient with nothing. *Id.* That is not the case in West Virginia. W.Va. Code § 9-5-11 (2009) prevents a Medicaid recipient from incurring such a hardship in the West Virginia system because the State never receives "full reimbursement." The statutory reduction for attorneys' fees and costs typically reduce the States recovery by more than 40%. In E.B.'s case, DHHR's recovery under the statutory formula is less than 52% of the amount paid by DHHR on E.B.'s behalf, leaving close to \$1 million dollars to fund E.B.'s "special needs" trust. A "special needs" trust is intended to supplement Medicaid. Accordingly,

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<sup>16</sup> In the absence of judicial allocation, North Carolina's statute provides that "Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with ... a third party ... distribute to the Department the amount of assistance paid by the Department... but the amount shall not exceed one-third of the gross amount obtained or recovered.

<sup>17</sup> Where the parties to a settlement have not agreed to an allocation, Florida's statutory fifty-percent rule governs. In those cases, the State recovers the lesser amount of the past medical assistance provided to the recipient or one-half of the recipient's total settlement. *See Russell* at 1267- 69 (affirming that *Ahlborn* did not apply, and upholding Florida's fifty-percent allocation statute as a permissible framework under federal Medicaid law).

<sup>18</sup> *A.C.A.* §20-55-307 (1993) has not been amended. The reporter notes only show that it is "limited on preemption grounds."

there is no concern of “excessive depletion of a plaintiff’s recovery to satisfy the State’s reimbursement lien.” *Id.* The statutory reduction for DHHR’s *pro rata* share of the recipient’s attorneys’ fees and expenses and, further reduction if the Secretary deems it is warranted within the scope of her authority, is a fair balance, “providing a reasonable method for determining the State’s medical reimbursements, which it is required to seek in accordance with federal Medicaid law,” while also protecting the recipient’s interests. *Id.*

Thus, *W.Va. Code* § 9-5-11 (2009) is consistent with federal law as interpreted in *Ahlborn* and it was error for the Circuit Court to hold otherwise.

## **2. *Ahlborn* Does Not Require A Specific Method For Determining The Medical Expense Portion Of A Medicaid Recipient’s Lump Sum Settlement.**

The Circuit Court cited *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268, 288, 126 S.Ct. 1752, 1765, 164 L.Ed.2d 459, 476 (2006), in support of granting Ms. Gress’ motion for judicial apportionment of medical expenses from the settlement based on the “full value” of the case:

Importantly, while discussing ADHS’ argument that reimbursement of the full Medicaid lien is needed to avoid the risk of settlement manipulation, the Supreme Court suggested that such a risk can be avoided by the State’s advance agreement to an allocation, or if necessary, by submitting the matter to a court for decision. *See Ahlborn, supra*, at 288 (Emphasis added).

*See* July 12, 2010 Order at 12.

However, the Supreme Court went on to say that “some courts have adopted special rules and procedures for allocating tort settlements” under certain circumstances, but ultimately “express[ed] no view on the matter” and le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.” *Id.* at 288 n. 18, 126 S.Ct. at 1765 n.18, 164 L.Ed.2d at 476 n.18. Thus, *Ahlborn* does not mandate a judicial determination or a specific method for calculating the portion of the settlement from which the State may be

reimbursed for prior medical expenses. Instead, the Supreme Court left to the States the decision on the measures to employ in the operation of their Medicaid Programs. *Id. Accord, Armstrong v. Canster*, 2010 WL 2629740 (W.D.N.C.)(June 28, 2010), *Andrews v. Haygood*, 362 N.C. 599, 603, 669 S.E.2d 310, 313 (2008); *Russell v. Agency for Health Care Administration*, 23 So.3d 1266 (Fla.2d DCA 2010); *Scharba v. Everett L. Braden, Ltd.*, 2010 WL 1380121 (M.D.Fla. Mar. 31, 2010).

Also, it is illogical to assume that simply because a plaintiff settled for a fraction of the supposed "true value" of his claim that this fractional reduction applies uniformly across the various heads of damage. For example, a plaintiff's past medical expenses can more easily be proven to a jury than can a plaintiff's non-economic damages and future damages. Therefore, a plaintiff faces less uncertainty regarding recovery of medical expenses and thus will be less willing during settlement negotiations to reduce his request for past medical expenses than for other, more uncertain heads of damage. Another example: where (as here) the settlement expressly contemplated the existence and size of the Medicaid lien and preserved the Department's right to recover its amount via the "hold harmless" agreement, it can be inferred that the lien's satisfaction played a necessary role in the settlement. Another example: In West Virginia, as a result of the statutory cap on non-economic damages in medical malpractice cases, the ratio of non-economic damages progressively diminishes as the settlement amount increases (e.g., \$250,000 cap constitutes 25% of \$1 million settlement; 12.5% of a \$ 2 million settlement; 8.33% of a \$3 million settlement; 6.25% of a \$4 million settlement).

W.Va. Code § 9-5-11 (2009) is an alternative statutory procedure that DHHR asserts comports with *Ahlborn*, 547 U.S. at 18, 126 S.Ct. at 1765 n.18. Our state law defines "the portion of the settlement that is attributable to medical expenses" as the amount of the medical expenses

paid by DHHR on behalf of the Medicaid recipient reduced by DHHR's *pro rata* share of the Medicaid recipient's attorney's fees and legal costs incurred by the recipient in obtaining the settlement or a lesser amount in the discretion of the Secretary of the Department of Health and Human Resources, limiting the DHHR's reimbursement to the portion so designated. *See* W.Va. Code § 9-5-11. *See also, Ahlborn*, 547 U.S. at 282, 126 S.Ct. at 1762. This limitation on the DHHR's recovery comports with *Ahlborn* by providing a reasonable method for determining the State's Medicaid reimbursements, which it is required to seek in accordance with federal Medicaid law. *See* 42 U.S.C. §§ 1396a(a)(25)(A) - (B) (2000).

This statutory scheme protects recipients' interests while promoting efficiency in Medicaid reimbursement cases throughout West Virginia. It is noted that the West Virginia Legislature amended *W.Va. Code* § 9-5-11, in 2009, without making any substantive changes to the method for determining the DHHR's Medicaid reimbursement. The West Virginia Legislature may have considered such factors as the federal participating share of the funding of the West Virginia Medicaid Program (currently, 83.05%)<sup>19</sup> and whether allocation hearings would substantially curtail the State's federally mandated recovery under the West Virginia statute; the logistical problems associated with a theory (like the theory advanced in this case) that requires a judicial ascertainment of the platonic "true value" of a plaintiff's claims<sup>20</sup>; whether mini trials replete with competing damages experts and witnesses testifying as to issues like humiliation, pain and suffering, and loss of enjoyment of life would undermine the economy of settlement; the strain on resources to send State employees across the State of West Virginia to participate in evidentiary allocation hearings each time a Medicaid recipient recovers from a third party; that case by case determination of the medical portion of settlements could lead to

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<sup>19</sup> The State can not waive the federal share.

<sup>20</sup> This is especially problematic where, as here, the Court ruling on the subrogation issue is not the court that tried the underlying tort action.

variable results and increased litigation due to inconsistency in outcomes. Certainly, these and other public policy considerations are the province of our Legislature and not the Court. *Accord, Grayam v. Department of Health and Human Resources*, 201 W.Va. 444, 498 S.E.2d 12 (1997).

In *Grayam*, this Court recognized that with respect to DHHR's subrogation interest under the Medicaid statutory scheme, the Legislature must be accorded deference in the decisions it makes for the citizens of this State. 201 W.Va. at 454, 498 S.E.2d at 22 ("the Court must follow the legislative mandate"). *See also, Andrews ex rel. Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310, 314 (N.C. 2008); *State Agency for Health Care Administration v. Wilson*, 782 So.2d 977, 980 (Fla. 1<sup>st</sup> DCA 2001)(the court cautioned the judiciary against curtailing the State's federally mandated recovery under the Florida statute).

### **3. The Circuit Court's Order Violates The Separation Of Powers Doctrine.**

#### **a. The Secretary of DHHR Has the Sole Discretion To Waive All Or Part Of a West Virginia Medicaid Recipient's Lien.**

As noted above, *Ahlborn* does not mandate a judicial determination of the portion of the settlement from which the State may be reimbursed for prior medical expenses or a specific method of determining the medical expense portion of a Medicaid recipient's lump sum settlement. Instead, the Supreme Court left to the States the decision on the measures to employ in the operation of their Medicaid Programs. *Id. Accord, Armstrong v. Canster*, 2010 WL 2629740 (W.D.N.C.)(June 28, 2010), *Andrews v. Haygood*, 362 N.C. 599, 603, 669 S.E.2d 310, 313 (2008). *See also*, 42 C.F.R. § 430.0 (1988).<sup>21</sup> The West Virginia Legislature enacted *W.Va. Code* § 9-5-11 (2009), which provides a means of calculating the State's portion of a lump sum settlement in the absence of judicial allocation of medical costs. That statute is consistent with

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<sup>21</sup> Likewise, it is the province of the Ohio Legislature to determine the nature and extent of the Ohio Medicaid Agency's subrogation interests.

federal law. *W.Va. Code* §9-5-11 (2009) expressly provides that “[t]he secretary may compromise, settle and execute a release of any such claim in whole or in part.” The West Virginia Supreme Court of Appeals, in *Grayam*, construed this provision to mean that “the [Secretary of the West Virginia Department of Health and Human Resources] has *sole* discretion to ‘compromise, settle and execute a release of any ... claim...’” 201 W.Va. 444, 453, 498 S.E.2d 12, 21 (1997) (emphasis added).

The Circuit Court of Hancock County lacks authority to fashion a common law rule that conflicts with *W.Va. Code* § 9-5-11(2009), the State Medicaid Plan and that is unnecessary to achieve the purposes of the Medicaid Act. *Id. See also*, 42 U.S.C. § 1396a(5)(requiring states participating in Medicaid to designate a single state agency to administer and supervise the administration of the State Plan); 42 C.F.R. § 431.10(e) (1979)(providing that the single state Medicaid agency so designated “must not delegate, to other than its own officials, authority to (1) exercise discretion in the administration or supervision of the state plan or (2) Issue policies, rules and regulations on program matters”); *W.Va. Code* §§ 9-2-3(1970) (State agrees, as a condition of federal funding, to comply with all applicable federal laws, terms and conditions); 9-2-3 (1970) (DHHR is charged with responsibility and authority to administer the public welfare program); 9-2-6 (2005)(powers of Secretary of Health).

Thus, when the Circuit Court of Hancock County disregarded *W.Va. Code* § 9-5-11 (2009), determined the DHHR’s reimbursement based upon the “full value” of the case, and reduced the DHHR’s reimbursement below the amount DHHR was entitled to under *W.Va. Code* § 9-5-11 (2009), it violated the Separation of Powers Doctrine – i.e., by exercising *executive* discretion in the administration of the Medicaid Program. *Id*; *W.Va. Const.* Art. V, § 1.

The Circuit Court also violated the doctrine of *state decisis* by failing to follow the West Virginia Supreme Court's decisions in *Grayam* and *Anderson v. Woods*.

**b. The Secretary Did Not Abuse Her Discretion.**

The Plaintiffs had the burden of proving that the Secretary abused her discretion in refusing to waive or reduce the DHHR's Medicaid reimbursement below the statutory-mandated reduction. *See McMillian v. Stroud*, 166 Cal.Rptr.3d 261, 269-70 (Ct.App.2008)(analogizing the health care agency to a creditor and concluding that the debtor-benefit recipient bears the burden of proof on the affirmative defense that the amount demanded exceeds what is permitted by law). *W.Va. Code* § 9-5-11(a) (2009) provides that "Submission of an application to the Department of Health and Human Resources for medical assistance is, as a matter of law, an assignment of the right of the applicant or legal representative thereof to recovery from personal insurance or other sources, including, but not limited to, liable third parties, to the extent of the cost of medical services paid for by the Medicaid program" and that DHHR has a priority right to reimbursement for medical expenses it paid on behalf of the Medical recipient. Thus, a lien on the settlement proceeds is created by operation of law. *Id.* The recipient has the burden of proving that the amount of the lien is not owed. *Id.*

For the reasons stated above, *W.Va. Code* § 9-5-11 (2009) is not preempted by *Ahlborn*. This Court definitively determined, in *Grayam*, that equitable principles, such as the "Made Whole" Rule do not apply to DHHR's right to subrogation under *W.Va. Code* § 9-5-11 (1995) and that "the Court must follow the legislative mandate." The theory advanced by the plaintiffs is just another version of the "Made Whole" rule. The provisions of the 1995 version of the statute which were construed in *Grayam* were carried over into the 2009 version without substantive changes. It is undisputed that, as of December 9, 2009, DHHR had paid \$557,104.71

on E.B.'s behalf for medical assistance. Thus, as a matter of law, Ms. Gress assigned E.B.'s right to recovery of medical expenses paid on his behalf by DHHR in the amount of \$557,104.71. See *W.Va. Code* § 9-5-11(a) (2009). In compliance with *W.Va. Code* § 9-5-11(b), DHHR reduced the amount of its reimbursement by its *pro rata* share of the plaintiffs' attorneys fees and legal costs in obtaining the settlements to \$289,075.44. The amount of DHHR's reimbursement is less than 52% of the medical expenses paid by DHHR on E.B.'s behalf. Thus, it does not exceed the amount of the past medical expenses paid for the injury. Moreover, it leaves a substantial amount for placement in a "special needs" or supplemental [to Medicaid] trust for the benefit of E.B, which, with proper investment, will grow over time. The plaintiffs' projected cost of future medical expenses is without sufficient foundation, is not to a reasonable degree of certainty, and is not reduced to present value.<sup>22</sup> The record indicates that the only items listed in the life care plan that may not be covered by Medicaid are the projected costs for upgrades to the home, obtaining a handicap-accessible van, and 8 hours/day in-home nursing services. Accordingly, it cannot be said that the Secretary abused her discretion or committed "clear error" in refusing to waive DHHR's reimbursement or reduce it beyond the amount required by *W.Va. Code* § 9-5-11 (2009).

**B. The Circuit Court Committed Error In Ordering Distribution of The Net Settlement Proceeds To A "Special Needs" Trust Before Satisfying DHHR's Reimbursement For Past Medical Expenses It Paid On Behalf Of E.B.**

The DHHR has a priority right of subrogation for medical services paid to recipients of Medicaid when recovery is made from other sources, including, but not limited to, tort liability settlements with third parties. *W.Va. Code* § 9-5-11 (2009); *Grayam supra*, at Syl.Pt.2. *Accord, Ahlborn*, 547 U.S. at 282, 126 S.Ct. at 1761, 164 L.Ed.2d at 472 (42 U.S.C. § 1396k requires

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<sup>22</sup> See discussion in Part D, *infra*.

that “the State be paid first out of any damages representing payments for medical care *before* the recipient can recover *any* of her own costs for medical care.” (emphasis added).

Pursuant to 42 USC § 1396k, when reimbursement is sought from responsible third parties through the assignment provisions, States are to first "retain" that portion "of any amount collected ... as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed ... and the remainder of such amount collected shall be paid to such individual (42 USC § 1396k[b] [emphasis added]). This provision indicates that the government has priority in recouping funds from third parties who are liable for a Medicaid recipient's medical expenses, and that only the remainder of those funds becomes available to the Medicaid recipient for placement in a trust or other uses.

This recoupment hierarchy follows necessarily from the assignment and subrogation scheme. As the Medicaid recipient's assignee [*see*, 42 USC § 1396k; *W.Va. Code* § 9-5-11(a) (2009)], DHHR obtains all of the rights that the recipient has as against the third party to recover for medical expenses, including the ability to immediately pursue those claims against the third party. Because the injured Medicaid recipient has assigned his recovery rights to DHHR, and DHHR is subrogated to the rights of the beneficiary (*W.Va. Code* § 9-5-11 (2009); *Grayam, supra*), the settlement proceeds are resources of the third party tortfeasor that are owed to DHHR. Accordingly, the lien on the settlement proceeds attaches to the property of the third party, and thus does not violate the statutory prohibition against imposing a lien against a beneficiary's property until after his or her death [*see*, 42 U.S.C. § 1396p; *W.Va. Code* § 9-5-11c (1995)]. The Circuit Court's ruling fails to appreciate this critical distinction between the assets of a responsible third party and assets belonging to the Medicaid recipient.

In *Ahlborn*, a number of damages categories were put off limits to state Medicaid reimbursement claims on the grounds that they were the “property” of the Medicaid recipient and, thereby shielded by 42 U.S.C. § 1396p, the anti-lien provision of the federal Medicaid law. *See Ahlborn*, 547 U.S. at 283, 126 S.Ct. at 1762, 164 L.Ed.2d at 473. Thus, a state may not seek reimbursement from damages awarded for lost earnings, lost household services, non-economic injury and the like, because, according to the Supreme Court, those damage categories are the property of the Medicaid recipient. However, the Supreme Court specifically stated that damages received for “medical care” did not constitute property subject to the anti-lien provisions. *Id.* at 284, 126 S.Ct. at 1763, 164 L.Ed.2d at 473. The Court made no distinction between damages for past medical care and those for future medical care. Nothing in 42 U.S.C. §1396p indicates that the State may not seek recovery of its payments from a Medicaid recipient’s total award of damages for medical care, whether for past, present or future care. *See In The Matter of the Person of Jess C. Matey v. Idaho Department of Health and Welfare*, 147 Idaho 604, 213 P.3d 389 (2009).

In *Cuello v. Valley Farm Workers Clinic, Inc.*, 91 Wash. App. 307, 957 P.2d 1258 (1998), the issue before the Washington Supreme Court of Appeals was whether a Medicaid recipient may place his entire tort settlement recovery into a “special needs” trust prior to satisfying his Medicaid lien. The Court reviewed the legislative history of 42 U.S.C. § 1396p(d)(4)(a) and determined that its purpose was solely to encourage families to make long term financial arrangements without concern for future Medicaid eligibility. *Cuello* at 310, *citing Cricchio v. Pennisi*, 90 N.Y.2d 296, 304, 683 N.E.2d 301, 660 N.Y.S.2d 679 (1997). The Court concluded that a Medicaid recipient’s settlement funds first must satisfy the State’s

reimbursement for past medical expenses paid on behalf of the Medicaid recipient as a result of the third party's tortious conduct and the remainder may then be transferred to a trust. *Id.*

In *Norwest Bank North Dakota, N.A. v. Doth*, 969 F.Supp. 532 (1997), the question, “[m]ay a recipient of Medicaid funds avoid a statutory and contractual obligation to reimburse Medicaid by placing into trust proceeds from a personal injury action,” was squarely presented to the United States District Court in Minnesota. The District Court answered “no.”

In affirming the decision, the Eighth Circuit Court of Appeals held:

The [Special Needs Trust (“SNT”)] amendments do not postpone the State’s right to enforce its vested and existing Medicaid lien... Thus, a State may require a Medicaid lien imposed on the proceeds of a personal injury award or settlement be satisfied before the remaining funds are placed in a SNT.

*Norwest Bank v. Doth*, 159 F.3d 328, 333 (8<sup>th</sup> Cir. 1998)(emphasis added).

Thus, the DHHR was entitled to have its reimbursement of \$289,075.44 satisfied from the portion of the settlement proceeds allocated to medical expenses prior to placement of the remaining settlement proceeds in the Special Needs Trust.

**C. The Circuit Court Was Without Jurisdiction When It Applied *Ohio Revised Code* § 2315.18(B)(3) To DHHR’s Medicaid Reimbursement Claim.**

The Circuit Court ruled that "Ohio state law applies to E.B.'s calculation of damages" and that “The Court is satisfied that, pursuant to *Ohio Revised Statute* §2315.18(b)(3), the Court is free to add its own value, without limitation, as the fact finder in this instance, for E.B.’s non-economic loss.” The Circuit Court found that E.B.’s non-economic damages were \$5,000,000. This was clear error.

The Circuit Court was without jurisdiction when it applied Ohio Revised Statute § 2315.18(b)(3)(2004) to DHHR's claim for reimbursement of medical expenses it paid on behalf of E.B. We were in a West Virginia Court (Circuit Court of Hancock County), in a West

Virginia statutory proceeding for approval of an infant settlement under West Virginia law [W.Va. Code §44-10-14 (2002)]. The matter between Plaintiffs and DHHR involved a question of West Virginia law (the nature and extent of DHHR's subrogation interest), which is contractual in nature, between the State of West Virginia and a West Virginia resident. Thus, the Doctrine of *lex loci contractus* ("law of the place where the contract occurs applies") applies to the choice of law question. Moreover, Federal and State Law provide that West Virginia law controls the administration of the West Virginia Medicaid Program. *Ahlborn, supra*; 42 C.F.R. § 430.0. *Accord, Grayam, supra*. *W.Va. Code* § 9-5-11 (2009) provides the method for determining DHHR's reimbursement from the settlement proceeds in the absence of a judicial determination by the court in the tort action, which the Circuit Court is required to follow. *Grayam, supra*.

Moreover, the plain language of *Ohio Revised Code* §2315.18 (2004) reveals that Section (b)(3) does not apply to this case. Section 2315.18 provides, in pertinent part, as follows:

...

(B) In a tort action to recover damages for injury or loss to person or property, all of the following apply:

(1) There shall not be any limitation on the amount of compensatory damages that represents the economic loss of the person who is awarded the damages in the tort action.

(2) Except as otherwise provided in division (B)(3) of this section, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a tort action under this section to recover damages for injury or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the economic loss, as determined by the trier of fact, of the plaintiff in that tort action to a maximum of three hundred fifty thousand dollars for each plaintiff in that tort action or a maximum of five hundred thousand dollars for each occurrence that is the basis of that tort action.

(3) There shall not be any limitation on the amount of compensatory damages that

represents damages for noneconomic loss that is recoverable in a tort action to recover damages for injury or loss to person or property if the noneconomic losses of the plaintiff are for either of the following:

(a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life-sustaining activities.

...

(E)(1) After the trier of fact in a tort action to recover damages for injury or loss to person or property complies with division (D) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (D)(2) of this section, and, subject to division (F)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for noneconomic loss. Except as provided in division (B)(3) of this section, in no event shall a judgment for compensatory damages for noneconomic loss exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in division (B)(2) of this section. *Division (B) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.*

(2) Prior to the trial in the tort action described in division (D) of this section, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (B)(2) of this section.

*(F)(1) A court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for noneconomic loss in excess of the limits set forth in this section.*

...

Clearly, *Ohio Revised Statute* §2315.18(b)(3) only applies to trial courts in Ohio which hear the personal injury action. *See* §2315.18(E)(1). The Circuit Court of Hancock County was not "the trier of fact in a tort action to recover damages for injury or loss to person or property." Moreover, subsection (F)(1) specifically provides that "[a] court of common pleas has no jurisdiction to enter judgment for noneconomic loss in excess of the limits set forth in this section." In Ohio, the Court of Common Pleas (like the circuit court in West Virginia) is the

court that has jurisdiction over probate matters and infant summary proceedings. *See Ohio Const. Art. IV, § 4.* If E.B. was an Ohio resident and the infant summary proceeding was held in the Ohio Common Pleas Court, his non-economic damages would be capped at \$350,000. *Id.*

Thus, the finding of \$5,000,000 in non-economic losses is clearly erroneous.

**D. Dr. Yarkony's Opinion Regarding Future Medical Expenses Was Inadmissible Under Rules 702 and 703, WVRE; The Circuit Court Committed Clear Error In Relying On It.**

The Circuit Court found that the value of E.B.'s future medical expenses is \$19,118,608. *See Order at 18.* The Court's findings were based, to a large extent, upon the discovery deposition of Dr. Yarkony and the life care plan prepared by him in March 2008. However, Dr. Yarkony's opinion regarding future medical expenses is inadmissible under Rules 702 and 703 of the *West Virginia Rules of Evidence* as a matter of law. *Wilt v. Buraker*, 191 W.Va. 39, 443 S.E2d 196 (1993), *cert. denied*, 114 S.Ct. 2137, 511 U.S. 1129.

Rule 702 provides that

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise.

Rule 703 provides that

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of the type reasonably relied on by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

Dr. Yarkony deposition was taken for discovery purposes and did not address his qualifications, if any, to testify as an economic expert. He testified that his estimation of future damages was only a "gross calculation" to a "reasonable probability." West Virginia and Ohio

law require that future medical expenses be proven by a “reasonable degree of certainty.” *See* Syl. Pt. 7, *Jordan v. Bero*, 158 W.Va. 28, 210 S.E.2d 618 (1974); *Hammerschmidt v. Mignona*, 115 Ohio App.3d 276, 281-82, 685 N.E.2d 281 (1996); *Eastman v. Stanley Works*, 180 Ohio App.3d 844, 907 N.E.2d 768 Ohio App.10 District (2009). Moreover, Dr. Yarkony’s estimation of future medical expenses was not reduced to present value, as required by West Virginia and Ohio law. *Id.* In addition, there was a lack of foundation for his opinion. *See Jordan v. Bero* at 637 (“The general rule on proof of medical services is that the proper measure of damages which may be incurred in the future, is not just simply the expenses or liability incurred or that which may be incurred in the future, but rather, *the reasonable value* of medical services made necessary because of the injury proximately resulting from the defendant’s negligence”)(emphasis added). Dr. Yarkony’s “gross calculation” was based on alleged billed rates of providers. The actual medical bills and rates from the providers were not put into evidence by plaintiffs. The highest item of medical expense in the life care plan is for in-home nursing services by Maxim Healthcare, Inc.; however, the rate listed in the life care plan (\$35/hr) was proven wrong by DHHR. DHHR showed that Maxim's rate was actually much lower (\$14.50/hr). Also, Dr. Yarkony's opinion did not take into account the fact that all of E.B.'s medical expenses to date have been paid by Medicaid and that it is anticipated that the bulk of his future medical expenses will likewise be paid by Medicaid. The Medicaid paid rate is evidence of the reasonable value of the medical services rendered to E.B. and which will be rendered to E.B. *See W.Va. Code* § 9-5-11 (2009) (value of medical assistance defined as “medical expenses paid”). Under Ohio law, the trier of fact, in determining the reasonable value of damages for past, present and future medical care may consider the rate paid as well as the rate billed. *See Robinson v. Bates*, 112 Ohio St.3d 171, 857 N.E.2d 1195 (2006). Thus, it was

clear error for the Circuit Court to rely on Dr. Yarkony's opinion.. *Rules 702 and 703, WVRE; Wilt v. Buraker, supra.*

Because the Circuit Court's findings that E.B.'s future medical expenses are \$19,118,608, and that plaintiffs' non-economic damages are \$5,000,000, are plainly wrong, the Court's conclusion that the "full value" of the case is \$25,373,937.95 is also clearly erroneous. Accordingly, the Circuit Court's finding regarding that the portion of the settlement constituting past medical expenses is clearly erroneous because it lacks foundation.

In jurisdictions that allow judicial determination of the portion of the settlement that constitutes the medical expense portion of a Medicaid recipient's lump sum tort settlement, the settling parties have the burden of proving that the portion of the settlement attributed to past medical expenses is no more than the amount they allege. *See, e.g., Price v. Wolford*, D.O., 608 F.3d 698, 706 (2010). *See also, McMillian v. Stroud*, 166 Cal.Rptr.3d 261, 269-70 (Ct.App.2008).

In the present case, Plaintiffs failed their burden of production. Accordingly, DHHR is entitled to its reimbursement of \$289,075.44. *Id.*

## **V. CONCLUSION AND RELIEF PRAYED FOR**

The Circuit Court committed reversible error in granting Holly Gress' motion for allocation of settlement proceeds based upon the "full value" of the case and reducing DHHR's Medicaid Reimbursement below the amount authorized by *W.Va. Code § 9-5-11 (2009)*. *Ahlborn* neither compels a specific method for determining the medical expense portion of a Medicaid recipient's lump sum tort settlement nor invalidates *W.Va. Code § 9-5-11 (2009)*. DHHR is entitled to reimbursement of \$289,075.44 for medical expenses it paid on behalf of E.B. Secretary Hardy prays that this Court accepts her Petition for Appeal, place this case on the

Argument Docket and, after oral argument, enter an Order reversing the July 12, 2010 Order of the Circuit Court of Hancock County and remanding with instructions to pay forthwith to the West Virginia Department of Health and Human Resources the amount of \$ 289,075.44, plus interest thereon from date of deposit in the escrow account, and provide to DHHR such further relief as this Court deems appropriate.

**PATSY HARDY, Secretary, West Virginia  
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Supreme Court Docket No. \_\_\_\_\_

**IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA**

**PATSY HARDY, Secretary, West Virginia  
Department of Health and Human Resources,**

**Petitioner/ Intervenor Below**

v.

**Civil Action No. 09-P-47 M  
Circuit Court of Hancock County (J. Mazzone)**

**HOLLY GRESS, as next friend of  
E.B., a minor,**

**Respondent/ Petitioner Below**

**CERTIFICATE OF SERVICE**

I, Mary McQuain, Assistant Attorney General, counsel for the West Virginia Department of Health and Human Resource, Bureau for Medical Services, hereby certify that I have served a true and accurate copy of the foregoing "**Petition For Appeal**" by regular United States mail, first-class postage prepaid, this 7<sup>th</sup> day of November, 2010, to:

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