Supreme Court Docket No. 10/537

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

RESPONSE TO PETITION FOR APPEAL

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RESPONSE TO PETITION FOR APPEAL

PRELIMINARY STATEMENT

Respondent respectfully suggests that the Court should decline the West Virginia Department of Health and Human Resources's ("DHHR") invitation to grant the appeal. The appeal presents no new issues. In approving the settlement in this matter, the Circuit Court, in a lengthy, well-reasoned order, followed settled law, specifically the United States Supreme Court's decision in *Arkansas DHS v. Ahlborn,* 547 U.S. 268 (2006). In *Ahlborn,* the United States Supreme Court held that the Medicaid assignment relied on by DHHR gives DHHR no more than the right to recover the portion of a settlement or judgment representing payments for past medical expenses. The rule that has emerged in state litigation after *Ahlborn* is that where there is clear evidence of the total value of a plaintiff's claim, the court applies a ratio (computed based on the actual settlement versus the total value of the claim) to the total reimbursement claim being made by the State. This procedure avoids running afoul of the anti-lien provisions of 42 U.S.C. sections 1396a(a)(18) and 1396p by ordering a Medicaid recipient to reimburse the State out of settlement funds designated for purposes other than medical care, something explicitly barred by the United States Supreme Court in *Ahlborn. Ahlborn,* 547 U.S. at 284-85. As the Circuit Court recognized, the computation mechanism advanced by DHHR is not consistent with this controlling precedent and the governing federal law. The Circuit Court's evidentiary determinations with respect to the total value of the plaintiff's claims are entitled to deference and should be disturbed. Because the Circuit Court applied the controlling precedent, a precedent binding on this Court, the Petition should be denied.

STANDARD OF REVIEW

While the State is correct that a question of law is subject to *de novo* review, DHHR has also challenged factual determinations made by the Circuit Court without articulating the correct standard of review. (Petition at 14.) A circuit court's findings of fact are entitled to deference. *See Stover v. Milam,* 210 W.Va. 336, 557 S.E.2d 390 (2001) (when factual issues submitted to circuit court judge, finding will not be disturbed on appeal "unless the evidence plainly and decidedly preponderates against such finding"), *quoting* Syl. Pt.6, *Daugherty v. Ellis,* 142 W.Va. 340, 97 S.E.2d 33 (1956).

ARGUMENT AND AUTHORITIES

Point I The Petition Should be Denied Because the Circuit Court Correctly Applied Controlling United States Supreme Court Precedent Governing Reimbursement of Medicaid Expenditures.

The Court should deny the Petition. This is not a "preemption" case because federal and state law go hand in hand with respect to Medicaid. As this Court has held, when federal assistance programs are involved, state law must be applied consistently with federal law. The Circuit Court did exactly that in this case by applying controlling United States Supreme Court precedent. That precedent established the procedure used by the Circuit Court here. Given that the Circuit Court followed controlling law, the Circuit Court's decision should not be disturbed.

A. This is not a "Preemption" Situation Because, by Statute, Medicaid is a Cooperative Program Administered by a State in Harmony With Governing Federal Law.

Contrary to DHHR's assertion, this is not a classic "preemption" situation. (Petition at 14-17.) The West Virginia Medicaid program is not a creature of state law

but is a cooperative program with the federal government. As such, federal law is controlling, and this Court has so held – "it is by now axiomatic that the manner in which a state administers a federal assistance program must be consistent with federal law." *Harrison v. Ginsberg,* 169 W.Va. 162, 167, 286 S.E.2d 276, 280 (1982); *see also* W.Va. Code § 9-2-3 (federal assistance program must be run "in accordance with the provisions of this chapter and the conditions imposed by applicable federal laws, rules and regulations"). Both this Court's holdings and section 9-2-3 establish that West Virginia courts and agencies must defer to federal law when addressing the interaction of the state and federal Medicaid statutes.

West Virginia courts are also bound by the United States Supreme Court's interpretation of the federal Medicaid statutes. As this Court has stated:

> Article I, Section 1 of the West Virginia Constitution recognizes that the United States Constitution shall be the supreme law of the land. Accordingly, the decisions of the United States Supreme Court interpreting the First Amendment are binding on this Court . . . . .

State by and through McGraw v. Imperial Marketing, 196 W.Va. 346, 359 n. 43, 472 S.E.2d 792, 805 (1996). This is particularly true where, as in section 9-2-3, the legislature has explicitly indicated that West Virginia statutes are to be harmonized with federal law. *See Kessel v. Monongalia County General Hosp. Co.,* 220 W.Va. 602, 617, 648 S.E.2d 366, 381 (2007) (Legislature specifically evidenced intent that state antitrust law be harmonized with comparable federal antitrust law). Accordingly, no "presumption against preemption" applies. Instead, as the Circuit Court determined, federal law, and the United States Supreme Court's decision in *Ahlborn,* govern.

B. The Circuit Court Properly Applied *Ahlborn*, Which Addressed and Decided the Very Issue Presented.

The United States Supreme Court's decision in *Ahlborn* is directly on point and, as the Circuit Court ruled, *Ahlborn* established the proper procedure for awarding a Medicaid reimbursement without violating federal law. The *Ahlborn* court explicitly held that a state may not violate the anti-lien provisions of 42 U.S.C. §§ 1396a(a)(18) and 1396p by requiring a Medicaid recipient to reimburse it out of settlement funds designated for purposes other than medical care. Contrary to DHHR's assertion, the holding in *Ahlborn* is not limited to cases where the parties have stipulated as to the value of the claim. The United States Supreme Court articulated how a reimbursement is to be computed so as to avoid violating the anti-lien laws, and the Circuit Court here correctly followed that procedure.

1. The *Ahlborn* Decision.

In *Ahlborn,* the United States Supreme Court addressed the very issue of Medicaid reimbursement that was presented to the Circuit Court here. In *Ahlborn,* Heidi Ahlborn sustained serious and permanent injuries in a car accident. The Arkansas Department of Health and Human Services (ADHS) paid out $215,645.30 to health care providers on her behalf. *Ahlborn,* 547 U.S. at 272-73. Ahlborn filed suit against third-party tortfeasors for causing her injuries and sought damages for past medical expenses, pain and suffering, loss of future earnings, and future medical care. The parties settled the case for $550,000, but the parties did not allocate the settlement funds between categories of damages. ADHS did not participate or ask to participate in the settlement negotiations.

Ahlborn, 547 U.S. 273-74. ADHS then intervened in the suit, asserting that it had a lien against the settlement proceeds for the full amount it paid for Ahlborn's care. ADHS cited Arkansas law giving ADHS an assignment of any tort recovery. The parties stipulated that Ahlborn's case was reasonably valued at $3,040,708.12 and that the settlement of $550,000 amounted to approximately one-sixth of that sum.

Ahlborn filed a declaratory relief action in the district court, seeking a declaration that ADHS's lien violated federal Medicaid laws because its satisfaction would require depletion of compensation for injuries other than past medical expenses. *Ahlborn,* 547 U.S. at 274. The federal district court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHS her right to any recovery from the third party tortfeasors to the full extent of Medicaid's payments for her benefit. The district court found that ADHS was entitled to a lien of $215,645.30. *Id.* The Eighth Circuit reversed, ruling ADHS was entitled to only that portion of the judgment that represented payment for medical care. The United States Supreme Court affirmed.

The court reviewed federal Medicaid law and concluded that ADHS's recovery for benefits paid could not exceed the portion of the settlement representing payments for medical care. The court held that a Medicaid lien is limited to judgment or settlement proceeds from "that portion of a settlement that represents payments for medical care." *Ahlborn,* 547 U.S. at 282. In reaching this conclusion the Supreme Court cited the text of the federal Medicaid third-party liability provision, which provides that Medicaid recipients must, as a condition of eligibility, "assign the State any rights ... to payment for medical care from any third party," 42 U.S.C. § 1396k(a)(1)(A). The *Ahlborn* court also

cited the anti-lien prohibition contained in 42 U.S.C. § 1396p(a), holding that while Medicaid may attach (in many cases) a lien to settlement proceeds attributable to past medical costs, this statute "precludes attachment or encumbrance of the remainder of the settlement." *Ahlborn,* 547 U.S. at 284. In determining the portion of Ahlborn's settlement attributable to medical expenses, the Court approved application of a ratio (based on the value of the claim versus the settlement amount) to ADHS's reimbursement claim, stating: "Here, the tortfeasor has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant 'liability' extends no further than that amount." *Ahlborn,* 547 U.S. at 280-81. *Ahlborn* explicitly approved the apportionment formula used by the Circuit Court in this case.

2. <u>*Ahlborn* is not Limited to Cases Where the Parties Have Stipulated to the Value of the Plaintiff's Claim.</u>

DHHR incorrectly asserts that *Ahlborn* only applies to cases where there has been a determination of damages on the merits or a stipulation as to allocation of damages. (Petition at 17-23.) Nothing in *Ahlborn* limits the application of its central principle – that any reimbursement must comply with the anti-lien laws and be limited to the portion of damages attributable to past medical expenses. In particular, DHHR's assertion that in cases where there is no stipulation, the state can recover "from a Medicaid recipient's entire settlement" is clearly wrong. In addressing the stipulation made by the parties in *Ahlborn,* the United States Supreme Court found that "the effect of the stipulation is the same as if a trial judge had found that Ahlborn's damages amounted to $3,040,708.12 (of

which $215,645.30 were for medical expenses), but because of her contributory negligence, she could only recover one-sixth of those damages." *Ahlborn,* 547 U.S. at 280 n.10. The court went on to make it plain that in cases where a settlement had been reached but no allocation had been made, the same principles must be applied. "Even in the absence of such a postsettlement agreement, ... the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Ahlborn,* 547 U.S. at 288. Nothing in *Ahlborn* limits its application as suggested by DHHR. Indeed, the *Ahlborn* court recommended that in cases where no allocation has been made, the very procedures used by the Circuit Court here should be used.

3. The Circuit Court Correctly Applied the *Ahlborn* Decision and not the Allocation Scheme in Section 9-5-11.

DHHR is also wrong in claiming that the provisions of West Virginia Code section 9-5-11 establish a reimbursement scheme consistent with *Ahlborn.* (Petition at 20-23.) As the United States Supreme Court noted in *Ahlborn,* the federal Medicaid program includes a requirement "that the state agency in charge of Medicaid ... 'take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available under the plan'." *Ahlborn,* 547 U.S. at 275, *citing* 42 U.S.C. § 1396a(a)(25)(A). The federal Medicaid statutes further obligate participating states to enact so-called "assignment laws" to provide for such reimbursement. *Ahlborn,* 547 U.S. at 276-77, *citing* 42 U.S.C. §§ 1396a(a)(25)(H), 1396k(a). In enacting section 9-5-11, the

Legislature fulfilled this requirement. Among other things, this section provides that DHHR's recovery is limited to "the reasonable value of the medical assistance paid and attributable to the sickness, injury, disease or disability for which the recipient has received damages." In addition, section 9-5-11(b) deducts a portion of any recovery for attorney's fees expended in seeking the recovery. W. Va. Code § 9-5-11(b). DHHR contends that these provisions" comport with the *Ahlborn* decision. DHHR also notes that it has the authority to compromise any claim. (Petition at 21.)

Other than the attorney's fees provision, however, nothing in section 9-5-11 limits the total amount DHHR may recover from a settlement. While DHHR references language limiting its rights to the amount of medical expenses paid by DHHR, nothing in section 9-5-11 includes the limitation called for in *Ahlborn* – that is, nothing limits DHHR's recovery to the portion of a settlement or judgment attributable to medical expenses. It is this lack of any limitation that is inconsistent with *Ahlborn.*

Ahlborn directly addresses and determines the question presented by this case. The West Virginia statute is similar to the one at issue in *Ahlborn* and the factual situations are analogous. Justice Stevens' explanation of how the Arkansas statute works is equally applicable to section 9-5-11:

> When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs-like pain and suffering, lost wages, and loss of future earnings.

Ahlborn, 547 U.S. at 272. The West Virginia statute purports to give DHHR the same right of recover (with the exception of a pro rata share of attorney's fees). *Ahlborn* stands for the proposition that such a scheme runs afoul of the federal anti-lien laws:

- The *Ahlborn* court emphasized that, regardless of how an allocation is made, "the exception carved out by [the anti-lien provisions laid out in 42 U.S.C. §§ 1396a(a)(18) and 1396p] is limited to payments [by the third party to the plaintiff-beneficiary] for medical care. Beyond that, the anti-lien provision applies." *Ahlborn,* 547 U.S. at 284-85.
- The *Ahlborn* court repeatedly emphasized this point as to "whether [a state agency] can lay claim to more than the portion of [settling plaintiff's] settlement that represents medical expenses." *Id.* at 280.
- The court also stated that "under the federal statute the State's assigned rights extend only to recovery of payments for medical care." *Id.* at 282.
- Likewise, "assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions." *Id.* at 286 n. 16.

In sum, *Ahlborn* broadly prohibits a state from claiming reimbursement out of funds not earmarked solely for medical expenses under any circumstances. When the terms of a settlement are unclear as to the portion designated for medical expenses, *Ahlborn* requires states to fashion a method to make those determinations and protect their right to reimbursement, such as by agreement or by submitting the matter to a court for adjudication. The indispensible step of any analysis is determining what portion of a

settlement is attributable to medical expenses. Simply applying section 9-5-11, as DHHR asks, could allow exactly the result that is explicitly barred by *Ahlborn* – that the state receives monies not attributable to medical expenses. Section 9-5-11 makes *no* distinction with respect to the type of damages recovered by a plaintiff, only the upper limit of the state's recovery. Applying that scheme, without the allocation called for in *Ahlborn,* would clearly violate the anti-lien provisions of the federal Medicaid statutes. As the Circuit Court held, *Ahlborn* requires that any claim for Medicaid reimbursement comply with the following language:

> Federal Medicaid law does not authorize [the state agency] to assert a lien on [a beneficiary's] settlement in an amount exceeding [the pro rata portion designated as reimbursement for medical payments made], and the federal anti-lien provision affirmatively prohibits it from doing so. [The State's] third-party liability provisions are unenforceable insofar as they compel a different conclusion.

Ahlborn, 547 U.S. at 292.

4. The Allocation Mechanism Used by the Circuit Court was Approved in *Ahlborn* and has Been Applied in Other States.

The allocation mechanism the Circuit Court applied has also been explicitly approved by the United States Supreme Court. In *Ahlborn,* the parties applied a ratio of the settlement amount to the total value of the claim, multiplying the reimbursement request by that ratio. One very direct indication of the Supreme Court's approval of the approach followed by the parties in *Ahlborn* is the court's unequivocal conclusion that ADHS was entitled to no more than $35,581 – the amount resulting from such a computation. *Ahlborn,* 547 U.S. at 292. By applying this procedure, the Circuit Court properly followed the guidance of the United States Supreme Court.

That decision is consistent with other cases decided in the wake of *Ahlborn.* In *Bolanos v. Superior Court*, 169 Cal.App.4th 744, 87 Cal.Rptr.3d 174 (2008), the California Court explained that "*Ahlborn* has three aspects to it. First, the state is entitled only to that portion of the settlement that compensates for past medical expenses. (Footnote omitted.) Second, this means that the state is not automatically entitled to the entire settlement, even if the claim for reimbursement exceeds the settlement ... [¶] ... [¶] Third, we come now to the aspect of *Ahlborn* that addresses how to allocate medical and nonmedical damages in an otherwise unallocated settlement." It concluded that "settlement that does not distinguish between past medical expenses and other damages must be allocated between these two classes of recoveries. Without such an allocation, the principle set forth in *Ahlborn*, that the state cannot recover for anything other than past medical expenses, cannot be carried into effect." *Bolanos*, concluded as follows: "We agree that *Ahlborn* itself does not require the application of the precise formula used in that case, although we do not think this approach, which has the Supreme Court's approval, should be abandoned lightly. We do not agree, however, that *Ahlborn* did not 'consider' the formula--its decision in the case was based on the results of the formula--nor do we agree that *Ahlborn* is of no consequence when it comes to a settlement that has not been allocated between past medical expenses and other damages." *Bolanos,* 169 Cal.App.4th at 761. In a later case the California court explained that, "the trial court was required to distinguish past medical benefits in the settlement from other categories of damage using a rational approach that takes into consideration the trial court's various findings, including its findings concerning the total value of plaintiff's damages and the

reasonableness of the settlement amount in light of those total damages." *Lima v. Vouis*, 174 Cal.App.4th 242, 260, 94 Cal.Rptr.3d 183, 196 (Cal. App. 2009).[1]

Petitioner's reliance on Florida cases is misplaced. (Petition at 24.) In awarding full reimbursement, the court in *Russell v. Agency for Health Care Admin.*, 2010 WL 21167 (Fla. App. 2010), noted that *Ahlborn* limited Medicaid's right to reimbursement – otherwise limited to 50% by statute. *Russell,* 2010 WL 21167 at * 1. The *Russell* court, however, said that *because* the appellant in *Russell* "failed to establish any basis for concluding that the lien asserted by AHCA extends to a portion of the settlement 'meant to compensate the recipient for damages distinct from medical costs...,' Florida's statutory allocation rule must prevail," even though this appears at odds with the federal anti-lien provisions. *Id.* at *3 (citations omitted). Of course in *this case*, the only evidence of the value of the claim is the evidence petitioner offered in the Circuit Court.

Reaching this conclusion – that *in the absence* of the plaintiff's establishing the percentage of settlement to which the lien amount applied, the state statute applied – *Russell* incorrectly relies, as Petitioner does, on *Andrews ex rel. Andrews v. Haygood*, 669 S.E.2d 310, 313 (N.C. 2008). (Petition at 23-24.) In *Andrews* the North Carolina Court applied that state's statute, limiting reimbursement to no more than one third of total settlement, without mentioning whether the claimant had demonstrated some other

[1] *But see In re Matey*, 147 Idaho 604, 213 P.3d 389 (2009), in which the Idaho court decided that past medical reimbursement could be satisfied out of future medical damages. *In re Matey* however conflicts with *Ahlborn's* holding that the statute's anti-lien provisions prevent satisfaction of the lien from any part of the recovery other than that for medical expenses. Future costs reflect opinions of many expenses other than those actually covered by Medicaid.

method. West Virginia's statute, of course, contains no such limitation. In any event, the holding in *Armstrong* flies in the face of *Ahlborn*'s holding that the anti-lien provisions of 42 U.S.C. §§ 1396a(a) "require that [the reimbursement claim be] limited to payments for medical care. Beyond that, the anti-lien provision applies." *Ahlborn,* 547 U.S. at 285. A court is simply *prohibited* from applying the claimed reimbursement right to any portion of settlement amounts other than that properly allocated to past medical expenses. *Russell* seems to say that where there is no evidence of how to allocate, the court may be guided by state statute. To the extent *Andrews* holds that the state formula automatically controls, this is simply incorrect.

In *Lugo v. Beth Israel Med. Center*, 13 Misc.3d 681, 819 N.Y.S.2d 892 [N.Y. Sup. 2006]) the New York trial court decided that *Ahlborn* required it to hold a hearing – as the Circuit Court did– to determine the full value of the claim and allocate settlement. There, the $3.5 million settlement was unallocated and the court afforded the parties discovery to determine the "true value" of the case and how the settlement should be allocated. That procedure was approved in *Homan v. County of Cattaraugus Dept. of Social Services*, 24 Misc.3d 1243(A), 2009 WL 2751070 (N.Y. Sup. 2009). The Circuit Court's decision is therefore consistent with the majority of courts that have interpreted and applied *Ahlborn.*

Point II The Petition Should be Denied Because the Circuit Court Otherwise Properly Applied the Law in Reaching its Decision.

The Court should also deny the Petition because the Circuit Court properly applied the law in making the allocation. With respect to non-economic damages, DHHR is

incorrect in claiming that the Circuit Court erred by applying Ohio law. (Petition at 32-35.) Petitioner bizarrely claims the Circuit Court was "without jurisdiction" to apply Ohio law. (Petitioner at 32-33.) Presumably, this is in a reality a claim that the Circuit Court's choice-of-law analysis was flawed. As the Circuit Court noted, the underlying action was filed in a federal court in the Southern District of Ohio, and Ohio law provided the rules of decision – that is, Ohio law was the basis for determining what portion of any judgment or settlement was compensation for medical expenses. *See Miles v. Raymond Corp.*, 612 F. Supp. 2d 913 (N.D. Ohio 2009) (district court sitting in diversity jurisdiction applies forum state's choice-of-law rules). The case was to be tried in Ohio federal court under Ohio law. DHHR cites no authority for the proposition that West Virginia substantive law regarding liability and damages applies here.

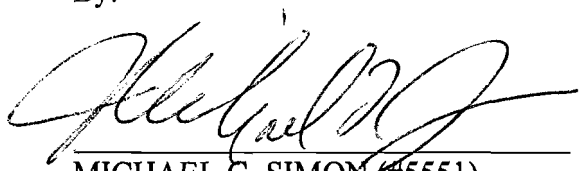
DHHR is also mistaken in challenging the expert testimony relied on by the Circuit Court. (Petition at 36-37.) The Circuit Court received uncontested evidence of the settlement, the actual amount of the claim and the amount of the Medicaid expenditure. DHHR could have attempted to offer its own evidence but did not. DHHR had an opportunity to challenge the expert testimony relied on by the Circuit, but did not do so. In this case, as is borne out by the opinions of Dr. Yarkony contained in his report and deposition, Evan is permanently disabled to the point that he will need constant and complete care for the rest of his life – 50 years of age. He is unable to care for himself at all and never will become able. Given that the Circuit Court's findings on these issues are entitled to deference, the Petition should be denied.

CONCLUSION

Based on the foregoing, Respondent asks this Court to deny the Petition for Appeal in its entirety.

Respectfully submitted,

By:



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IN THE CIRCUIT COURT OF HANCOCK COUNTY, WEST VIRGINIA

IN RE: E.B., a minor	:	CIVIL ACTION NO. 09-P-47M

CERTIFICATE OF SERVICE

I, Michael G. Simon, Counsel for Plaintiff E.B., a Minor, hereby certify that I have served a true and correct copy of the foregoing Response to Petition for Appeal by regular United States First Class Mail and facsimile on this 10th day of December, 2010.

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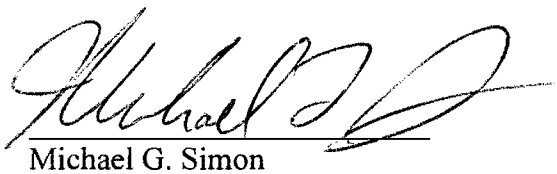

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