

**COPY**

Supreme Court No. 11-0168

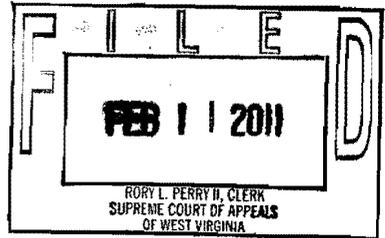
**STATE OF WEST VIRGINIA  
BEFORE THE SUPREME COURT OF APPEALS**

V.P.H., A DISABLED ADULT, )  
BY P.D., HER MOTHER AND )  
GUARDIAN AND CONSERVATOR, )  
AS PETITIONER, )

v. )

MICHAEL J. LEWIS, )  
SECRETARY OF THE DEPARTMENT OF )  
HEALTH AND HUMAN RESOURCES, )  
RESPONDENT. )

CIVIL ACTION No. 09-C-89  
MONROE COUNTY CIRCUIT COURT  
CHIEF JUDGE ROBERT A. IRONS



---

**RESPONSE OF DEPARTMENT OF HEALTH AND HUMAN RESOURCES TO  
PETITION FOR APPEAL**

---

**DARRELL V. McGRAW, JR.  
ATTORNEY GENERAL**

**MICHAEL E. BEVERS  
ASSISTANT ATTORNEY GENERAL  
STATE BAR NO. 9251  
BUREAU FOR MEDICAL SERVICES  
350 CAPITOL STREET, ROOM 251  
CHARLESTON, WEST VIRGINIA 25301  
(304) 558-1448  
Michael.E.Bevers@wv.gov**

**ATTORNEY FOR THE DEPARTMENT OF  
HEALTH AND HUMAN RESOURCES**

**TABLE OF CONTENTS**

TABLE OF AUTHORITIES ..... ii

INTRODUCTION ..... 1

STATEMENT OF THE CASE ..... 2

APPLICABLE LAW ..... 7

    I. Statutory and Regulatory Framework ..... 7

    II. Case Law ..... 11

SUMMARY OF THE ARGUMENT ..... 17

STATEMENT REGARDING ORAL ARGUMENT ..... 18

ARGUMENT ..... 19

    I. Standard of Review ..... 21

    II. The Medicaid Lien is Valid Because *West Virginia Code* § 9-5-11  
Does Not Violate the U.S. Supreme Court’s Holdings in *Arkansas*  
*Department of Health and Human Services v. Ahlborn* ..... 22

    III. The Medicaid Act Prohibits the Department From Further  
Reducing Its Medicaid Lien ..... 28

    IV. The Former Made Whole Rule Does Not Apply ..... 33

CONCLUSION ..... 35

CERTIFICATE OF SERVICE ..... 36

## TABLE OF AUTHORITIES

### CASES:

<i>Aetna Casualty &amp; Surety Co. v. Federal Ins. Co. of New York</i> , 148 W. Va. 160, 133 S.E.2d 770 (1963) .....	22
<i>Anderson v. Wood</i> , 514 S.E.2d 408, 204 W. Va. 558 (1999) .....	11, 13, 14, 33
<i>Andrews ex rel. Andrews v. Haygood</i> , 362 N.C. 599, 603, 669 S.E.2d 310, 313 (2008) .....	25, 26
<i>Arizona Department of Administration v. Cox</i> , 213 P.3d 707 (Ariz. Ct. App. 2009) .....	24
<i>Arkansas Department of Health and Human Services v. Ahlborn</i> , 547 U.S. 268 (2006) .....	1, 9, 11, 14, 19
<i>Connecticut National Bank v. Germain</i> , 503 U.S. 249, 253-54 (1992) .....	34
<i>Espericueta v. Shewry</i> , 79 Cal.Rptr.3d 517, 524-25, 164 Cal.App.4th 615, 625 (Cal. Ct. App. 2008) .....	24
<i>Folio v. Harrison-Clarksburg Health Department</i> , 222 W. Va. 319, 664 S.E.2d 541, (2008) .....	21
<i>Grayam v. Department of Health and Human Resources</i> , 201 W. Va. 444, 498 S.E.2d 12 (1997) .....	11, 12, 13, 18, 33
<i>Hawkins v. U.S. Sports Association, Inc.</i> , 219 W. Va. 275, 633 S.E.2d 31 (2006) .....	21
<i>In re Washington State Department of Social &amp; Health Services</i> , Dec. No. 1561, 1996 WL 157123 (HHS Dept. App. Bd., Feb. 7, 1996) .....	9
<i>In re California Department of Health Services</i> , Dec. No. 1504, 1995 WL 66334 (HHS Dept. App. Bd., Jan. 5, 1995) .....	9
<i>Kelley v. City of Williamson, West Virginia</i> , 221 W. Va. 506, 655 S.E.2d 528 (2007) .....	21

## TABLE OF AUTHORITIES, Cont'd

<i>Kittle v. Icard</i> , 405 S.E.2d 456, 185 W. Va. 126 (1991) .....	11, 12
<i>Mace v. Ford Motor Co.</i> , 221 W. Va. 198, 653 S.E.2d 660 (2007) .....	21
<i>Martin v. Randolph County Board of Education</i> , 195 W. Va. 297, 312, 465 S.E.2d 399, 414 (1995) .....	34
<i>McMillian v. Stroud</i> , 83 Cal.Rptr.3d 261, 270, 166 Cal.App.4th 692, 702 (Cal. Ct. App. 2008) .....	25
<i>Nicholas Loan &amp; Mortgage, Inc. v. W. Va. Coal Co-Op, Inc.</i> , 209 W. Va. 296, 547 S.E.2d 234 (2001) .....	21
<i>Painter v. Peavy</i> , 192 W. Va. 189, 451 S.E.2d 755 (1994) .....	21, 22
<i>Powderidge Unit Owners Association v. Highland Properties, Ltd.</i> , 196 W. Va. 692, 474 S.E.2d 872 (1996) .....	21
<i>Russell v. Agency for Health Care Administration</i> , 23 So.3d 1266, 1267-68 (Fla. Dist Ct. App. 2010) .....	24, 27
<i>San Francisco v. Wendy's International, Inc.</i> 221 W. Va. 734, 656 S.E.2d 485 (2007) .....	21
<i>Smith v. Agency for Health Care Administration</i> , 24 So.3d 590, 591 (Fla. Dist. Ct. App. 2009) .....	24, 26
<i>South Dakota v. Dole</i> , 483 U.S. 203, 206 (1987) .....	8
<i>State ex rel. Smith v. Maynard</i> , 193 W. Va. 1, 8-9, 454 S.E.2d 46, 53-54 (1994) .....	34
<i>Terra Firma Co. v. Morgan</i> , 223 W. Va. 329, 674 S.E.2d 190 (2008) .....	21, 22

**TABLE OF AUTHORITIES, Cont'd**

**STATUTES:**

42 U.S.C. § 1396 .....	7
42 U.S.C. § 1396a .....	8
42 U.S.C. § 1396a(25) .....	12
42 U.S.C. § 1396a(25)(A) .....	8, 28
42 U.S.C. § 1396a(25)(B) .....	8, 28, 29
42 U.S.C. § 1396a(25)(H) .....	8
42 U.S.C. § 1396d(b) .....	7
42 U.S.C. § 1396k(a) .....	15
42 U.S.C. § 1396k(a)(1) .....	8, 29
42 U.S.C. § 1396k(b) .....	9, 30
42 U.S.C. § 1396p(a) .....	9
42 U.S.C. § 1396p(a)(1) .....	9
<i>West Virginia Code</i> § 9-5-11 .....	1, 4, 5, 6, 10, 13, 17, 18, 19, 20, 22, 23, 30, 34, 35
<i>West Virginia Code</i> § 9-5-11(a) .....	10, 12, 23, 29, 33
<i>West Virginia Code</i> § 9-5-11(b) .....	11

**REGULATIONS:**

42 C.F.R. § 433.135 .....	28
42 C.F.R. § 433.139 .....	29
42 C.F.R. § 433.140 .....	29

## INTRODUCTION

This is a Medicaid subrogation case in which the West Virginia Department of Health and Human Resources paid medical expenses attributable to an automobile accident on behalf of the accident victim. The State Medicaid agency seeks reimbursement for the payments it made on behalf of V.P.H. It is undisputed that West Virginia Medicaid paid \$146,556.49 of V.P.H.'s medical bills attributable to the accident and later reduced the Medicaid lien to \$76,741.00.

The Petitioner, Phyllis D., is V.P.H.'s mother and guardian. Ms. D. ("Petitioner"), asserts that the Medicaid lien is "excessive [on its face] in light of the catastrophic injuries in this case given the inadequate recoveries received for such injuries." Petition for Appeal at p. 15. Chief Judge Robert Irons of the Monroe County Circuit Court disagreed. Judge Irons denied the Petitioner's request to set aside the applicable statute and set aside the Medicaid lien, and entered summary judgment in favor of the Department.

The Department of Health and Human Resources ("Department" or "DHHR") respectfully submits that the principal issue on appeal is whether the Medicaid lien asserted under *West Virginia Code* § 9-5-11 violates the U.S. Supreme Court's holding in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), by attempting to collect more than the portion of the settlement that constitutes reimbursement for past medical payments. The Department submits that the Medicaid lien and *West Virginia Code* § 9-5-11 are valid and asks that the Petition for Appeal be REFUSED.

## STATEMENT OF THE CASE

The Department agrees with the information contained in the “Facts and Procedural History” section of Judge Robert Irons’s Order Granting Summary Judgment in favor of the Department. The Department agrees with most of the information the Petitioner offered in the “Statement of Proceeding and Ruling by the Circuit Court” and “Statement of Facts of the Case” sections of the *Petition for Appeal*, but disagrees with certain representations made by the Petitioner. The Department offers the following summary of the procedural and factual background, attempting to correct the inaccuracies and omissions in the *Petition for Appeal*.

The underlying action arises from a motor vehicle accident that occurred in Monroe County, West Virginia on May 26, 2009. V.P.H. (“Ms. H.”), who was a passenger in one of the vehicles, suffered serious traumatic brain injuries. She is now a disabled adult and protected person who lives in Monroe County, West Virginia, with her mother and stepfather.

Ms. H. incurred medical bills of approximately \$550,000.00 as a result of the accident. West Virginia Medicaid paid \$146,556.49 in medical bills on behalf of Ms. H. The medical providers agreed to accept the Medicaid payments as satisfaction, discharging Ms. H. from further obligation. Having accepted payment from Medicaid, the providers are now prohibited from looking to Ms. H. to pay the difference between the amounts they accepted as satisfaction and the amounts they billed.

Between May 26, 2009, and November 2009, the Petitioner and the insurance carriers negotiated a settlement agreement. On November 12, 2009, the Petitioner filed a verified petition seeking permission to compromise and settle the personal injury claim with the Circuit

Court of Monroe County. *Petition of [P.D.] for Permission to Settle Personal Injury Claim.*

Under the terms of the settlement, State Farm agreed to pay the policy liability coverage of \$100,000.00 and Nationwide Mutual agreed to pay household policy underinsurance coverage of \$200,000.00. State Farm also paid a medical provider \$5,000.00 and Nationwide Mutual paid no fault medical payments coverage of \$1,000.00. Both insurers agreed to waive their liens for medical payments coverages. The settlement proceeds totaled \$301,000.00.

*Report on Disbursements of Settlement Proceeds.*

The Department's Bureau for Medical Services("Bureau"), which is the State Medicaid agency, asserted its subrogation interest of \$146,556.49. After a pro rata reduction for attorney fees and expenses, the Bureau, through its fiscal agents, reduced the Medicaid lien from \$146,556.49 to \$96,238.76. The Bureau further reduced that Medicaid lien amount to \$76,741.00 after discussions with the Petitioner's attorney.

Judge Irons held a hearing on November 16, 2009. He allowed the Department to intervene and gave all parties the opportunity to present their cases. He approved the settlement agreement at the conclusion of the hearing.

From the gross settlement proceeds, \$84,000.00 was paid to the Petitioner's attorney for attorney fees, \$3,920.21 was paid to the Petitioner's attorney for expenses, \$1,997.50 was paid to the Petitioner as reimbursement for medical expenses, \$600.00 was paid for bond costs, and the adjusted Medicaid lien amount of \$76,741.00 was paid to the Monroe County Circuit Clerk as an interpleader deposit. The remaining \$133,741.29, was placed in a special needs trust to be used for the benefit of Valeria H. *Report on Disbursements of Settlement Proceeds.*

After the hearing, the Petitioner filed a *Motion for Summary Judgment to Set Aside Department's Lien*, asking Judge Irons to set aside *West Virginia Code* § 9-5-11 as unenforceable, to nullify the Medicaid lien of \$76,741.00 altogether, to order the Department to negotiate the amount of the lien, to order mediation if negotiations were unsuccessful, or to conduct evidentiary proceedings and allocate the settlement proceeds between medical payments and other damages. The Petitioner requested evidentiary proceedings despite having filed a Motion for Summary Judgment.

The Department also filed a Motion for Summary Judgment, asking Judge Irons to order the Medicaid lien amount of \$76,741.00 be distributed to the Department from the interpleader deposit held by the Circuit Clerk. The Petitioner filed a Response to the Department's Motion for Summary Judgment, asking Judge Irons to set aside *West Virginia Code* § 9-5-11 and instead to apply the former "made-whole rule."

Judge Irons granted the Department's Motion for Summary Judgment by Order entered September 24, 2010. Judge Irons concluded:

The Court finds that W. Va. Code § 9-5-11 provides that the DHHR has a right of subrogation. W.Va. Code § 9-5-11(a) states that "[s]ubmission of an application to the [DHHR] 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." Therefore, the DHHR is entitled to take reasonable measures to ascertain the legal liability of third parties and to seek reimbursement for all third parties where legal liability has been found to exist.

The Petitioner argues that the Court should set aside W. Va. Code § 9-5-11 in favor of equitable rules, such as the made-whole rule as stated in *Kittle*, which limit enforcement of such liens to cases where an injured person is fully compensated for all damages. In *Grayam*, the West Virginia Supreme Court of Appeals held that the DHHR's right to subrogation is no longer subject to the made-whole rule.

The Court believes W. Va. Code § 9-5-11 is enforceable and will not set it aside and apply equitable rules. The Court does not believe the lien is excessive. Ms. Helm assigned her right to recovery of medical expenses paid on her behalf by West Virginia Medicaid in the amount of \$146,556.49. The DHHR reduced the lien twice to a final lien amount of \$76,741.00. The amount of the lien does not exceed the amount of medical expenses for the injury and/or disability of Ms. Helm and the Court believes the DHHR is entitled to this lien amount.

*Order - Granting Intervenor's Motion for Summary Judgment* at pp. 6-7.

The Petitioner did not file a motion to stay the Order granting summary judgment under Rule 62(i) of the *West Virginia Rules of Civil Procedure*. Pursuant to the Order granting summary judgment, the Monroe County Circuit Clerk distributed the interpleader deposit to the Department.

The Department will respond to the inaccuracies in the Petitioner's Statement of Proceedings and Statement of Facts more fully in the following sections, but lists here each of the Petitioner's inaccuracies with the Department's summary responses thereto:

- Petitioner's statement: Because the Department's lien statute requires the lien to reach all damages without allocation for non medical expense damages, the lien is invalid and should be set aside. Petition for Appeal at p. 2. Response: This is a legal conclusion based on a misinterpretation of *West Virginia Code* § 9-5-11 that belongs in the Petitioner's Argument.
- Petitioner's statement: No allocation of damages to medical expenses was ever made by the Department, and none was required by the circuit court because *West Virginia Code* § 9-5-11 expressly forbids such a federally mandated allocation. Petition for Appeal at p. 3. Response: This is a misinterpretation of *West Virginia Code* § 9-5-11 that belongs in the Petitioner's Argument.
- Petitioner's statement: The Order granting summary judgment is erroneous because *West Virginia Code* § 9-5-11 is contrary to federal law, because the lien amount

under federal law must be determined by allocation of damages and not by standard reductions for costs of recovery. Petition for Appeal at p. 3. Response: This is a legal conclusion based on a misinterpretation of *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) that belongs in the Petitioner's Argument.

- Petitioner's statement: The Supreme Court cannot rewrite *West Virginia Code* § 9-5-11 to make it comply with federal law as announced after the Court's controlling interpretation in *Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997). That is a legislative function. Petition for Appeal at p. 3. Response: The Department is not asking the Court to rewrite the statute. The Department is asking the Court to apply the statute as written.
- Petitioner's statement: There is no dispute that Ms. H.'s damages are catastrophic and her general damages greatly exceed the amounts of her monetary recoveries. Petition for Appeal at p. 5. Response: No evidence of the amount of general damages was presented at the hearing. It is undisputed that Ms. H.'s injuries were serious, but it is also undisputed that Medicaid paid almost all of her medical bills. Ms. H. did not allege and prove the amount of her general damages in the proceedings below, so the Department does not have sufficient information or knowledge to agree that her general damages exceed the amounts of her monetary recoveries.
- Petitioner's statement: The Department sought its usual full reimbursement after reduction for attorney fees and expenses, using a longstanding internal incentive formula applied to catastrophic cases. Petition for Appeal at p. 6. Response: As noted above, the Department paid \$146,556.49 of Ms. H.'s medical bills attributable to the accident and reduced its Medicaid lien to \$76,741.00. The Petitioner's description of the adjusted Medicaid lien as "full reimbursement" is misleading.

- Petitioner's statement: At the hearing and steadfastly thereafter, the Department contended that it had a duty to seek a full and first dollar reimbursement on *any* settlement proceeds realized, whether for Medicaid payments or general damages. Petition for Appeal at p. 6. Response: This mischaracterizes the Department's position. The Department has never sought more than a portion the medical expenses it paid on Ms. H.'s behalf.

## APPLICABLE LAW

### I. STATUTORY AND REGULATORY FRAMEWORK

The Medicaid program provides joint federal and state funding for medical care for individuals who cannot afford to pay their own medical costs. The program was launched in 1965 with the enactment of Title XIX of the Social Security Act, 42 U.S.C. § 1396. Medicaid is administered by the Secretary of Health and Human Services, who exercises her authority through the Centers for Medicare and Medicaid Services, or CMS. States are not required to participate in Medicaid, but all of them do. Medicaid is a cooperative program; the Federal Government pays between fifty percent (50%) and eighty-three percent (83%) of the costs a state incurs for patient care. The exact percentage of the federal contribution is calculated using a formula keyed to each state's per capita income. *See* 42 U.S.C. § 1396d(b). In West Virginia, not including temporary stimulus funding through the American Recovery and Reinvestment Act of 2009, the Federal Government pays approximately seventy-four percent (74%) of the Medicaid costs.

Because Congress provides funding for the Medicaid program, it possesses the constitutional authority under the Spending Clause and the Necessary and Proper Clause to

attach conditions on the states' receipt of federal funds in order to "further broad policy objectives." *South Dakota v. Dole*, 483 U.S. 203, 206 (1987) (quoting *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) (Burger, C.J.)). In return for federal funding, a state pays its portion of the costs and complies with certain statutory requirements. See 42 U.S.C. § 1396a. A state's noncompliance with these statutory requirements would jeopardize federal funding.

Title XIX of the Social Security Act includes many of the conditions Congress has attached on the receipt of federal funds. One such requirement is that the state Medicaid agency take all reasonable measures to determine the legal liability of third parties to pay for care and services available under the plan. 42 U.S.C. § 1396a(a)(25)(A). In any case where such a third party's legal liability is found to exist after the individual has received medical assistance and where the amount of reimbursement the state can reasonably expect to recover exceeds the costs of such recovery, the state must seek reimbursement for such assistance to the extent of legal liability. 42 U.S.C. § 1396a(a)(25)(B). To the extent that Medicaid has paid for medical assistance when a third party has a legal liability to pay for such assistance, the state must have in effect laws under which, to the extent that Medicaid has paid for medical items or services, the state is considered to have acquired the rights of such individual to payment by any other party for such medical items or services. 42 U.S.C. § 1396a(a)(25)(H).

A state's Medicaid plan must require an individual to assign the state that individual's rights to support and to payment for medical care from any third party as a condition of eligibility for Medicaid. 42 U.S.C. § 1396k(a)(1). The state shall retain proceeds collected under such an assignment "as is necessary to reimburse it for medical assistance payments

made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.” 42 U.S.C. § 1396k(b). If Medicaid funds are recovered, the state retains its expended amount and returns the federal share to the federal government. *Id.* A state may compromise the state’s share of Medicaid funding in the settlement of a Medicaid claim, but it may *not* compromise the federal share of funds unless it can show such recovery was not cost-effective. See *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 290 (2006), citing *In re Washington State Department of Social & Health Services*, Dec. No. 1561, 1996 WL 157123 (HHS Dept. App. Bd., Feb. 7, 1996), and *In re California Department of Health Services*, Dec. No. 1504, 1995 WL 66334 (HHS Dept. App. Bd., Jan. 5, 1995) (the HHS Departmental Appeals Boards held that Washington and California could not compromise the federal share of Medicaid funds).

A state may not impose liens against the property of any individual prior to the individual’s death on account of medical assistance paid or to be paid on the individual’s behalf. 42 U.S.C. § 1396p(a)(1). As discussed more fully below, the United States Supreme Court found that the anti-lien prohibition in 42 U.S.C. § 1396p(a) encumbers proceeds designated as payments for medical care and precludes attachment or encumbrance of the remainder of the settlement. *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 284-86 (2006). A state’s Medicaid lien recovery against a recipient’s personal injury settlement or award is limited to the portion of the settlement proceeds or verdict that represents past medical expenses. *Id.*

West Virginia met its obligation to seek reimbursement for its Medicaid expenses by enacting *West Virginia Code* § 9-5-11. An application to the Department for Medicaid benefits is an assignment of the right of the applicant or the applicant's legal representative to recovery from personal insurance or liable third parties, to the extent of the cost of medical services paid for by Medicaid. The Department therefore has a right of subrogation against the recovery a Medicaid recipient receives from third party tortfeasors. The statute provides:

Submission of an application to [DHHR] 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. This assignment of rights does not extend to Medicare benefits.

....

The department shall be legally assigned the rights of the recipient against the person so liable, but only to the extent of the reasonable value of the medical assistance paid and attributable to the sickness, injury, disease or disability for which the recipient has received damages.

....

The claim of [DHHR] assigned by such recipient shall not exceed the amount of medical expenses for the injury, disease, disability or death of the recipient paid by [DHHR] on behalf of the recipient. The right of subrogation created in this section includes all portions of the cause of action, by either settlement, compromise, judgment or award, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to the subrogation. Any settlement, compromise, judgment or award that excludes or limits the cost of medical services or care shall not preclude [DHHR] from enforcing its rights under this section.

*West Virginia Code* § 9-5-11(a).

The statute provides that the Department's subrogation interest is reduced by a pro rata share of attorney fees:

Irrespective of whether the case be terminated by judgment or by settlement without trial, from the amount required to be paid to [DHHR] 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 [DHHR] shall bear the pro rata portion of such attorney fees . . . . No judgment, award of or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease or disability, in which [DHHR] has interest, shall be satisfied without first giving [DHHR] notice and reasonable opportunity to establish its interest . . . . In the event of less than full recovery the recipient and [DHHR] shall agree as to the amount to be paid to [DHHR] for its claim. If there is no recovery, [DHHR] shall under no circumstances be liable for any costs or attorney's fees expended in the matter . . . . In the event that a controversy arises concerning the subrogation claims by [DHHR], an attorney shall interplead, pursuant to rule twenty-two of the rules of civil procedure, the portion of the recipient's settlement that will satisfy [DHHR] exclusive of attorney's fees and costs regardless of any contractual arrangement between the client and the attorney.

*West Virginia Code* § 9-5-11(b).

## II. CASE LAW

The controlling cases in West Virginia are *Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997), and *Anderson v. Wood*, 514 S.E.2d 408, 204 W. Va. 558 (1999). The controlling United States Supreme Court case is *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006).

*Kittle v. Icard*, 405 S.E.2d 456, 185 W. Va. 126 (1991), which previously controlled, noted that in order to receive federal funds, the state Medicaid agency must comply with the requirements of the Medicaid Act that state plans for medical assistance must provide that the administering agency will “take all reasonable measures to ascertain the legal liability of third parties to pay for care and service (available under the plan)” and will seek reimbursement from all third parties where legal liability has been found to exist. *Kittle v. Icard*, 185

W. Va. 126, 129, 405 S.E.2d 456, 459 (1991), *overruled on other grounds by Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997).

The issue in *Kittle v. Icard* was whether the Department of Human Services, DHHR's predecessor, was entitled to be fully reimbursed for medical expenses where such expenses were collected from a third party. Evidence showed that a settlement did not fully compensate a minor for his injuries and that further setoffs would reduce any money needed to be saved for future medical expenses. The trial court applied the "made-whole rule" to deny the Department of Human Services full reimbursement for medical expenses it paid on behalf of the minor from the amount the minor eventually received from the settlement. The Supreme Court of Appeals held that reimbursements of state agencies through subrogation was recognized by 42 U.S.C. § 1396a(a)(25) (1982 Ed.) and by *West Virginia Code* § 9-5-11(a) (1990). The Court held that generally, subrogation gives a payor the right to collect what it has paid from party who caused damage, but subrogation is an equitable remedy and is subject to equitable principles. Justice Brotherton, writing for the Court, affirmed the trial court's application of the made-whole rule, finding it to be a valid equitable principle that was applicable in subrogation cases. *Kittle v. Icard*, 405 S.E.2d 456, 185 W. Va. 126 (1991).

The West Virginia Legislature modified *West Virginia Code* § 9-5-11 in 1993 and again in 1995. In 1997, the Supreme Court discussed *Kittle v. Icard* and analyzed the effect of the subsequent amendments to *West Virginia Code* § 9-5-11. *Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997). In *Grayam v. Department of Health and Human Resources*, the issue was whether the made-whole rule precluded the Department from fully enforcing a subrogation interest considering the 1993

and 1995 amendments to the *West Virginia Code*. Chief Justice Workman, writing for the Court, noted that the made-whole rule had been interpreted to mean that in the absence of statutory law or valid contractual obligations to contrary, an insured must be fully compensated for injuries (made whole) before the subrogation rights of an insurance carrier arise. In the 1993 and 1995 amendments to *West Virginia Code* § 9-5-11, the Legislature rendered the made-whole rule inapplicable by unambiguously modifying the usual and ordinary meaning of subrogation as it is used in that statute. The Court held that *West Virginia Code* § 9-5-11 clearly expresses the Legislature's intent to abolish the former made-whole rule and grant the Department a priority right in receiving reimbursement from legally liable third parties. *Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997). *Grayam* abolished the made-whole rule.

The Supreme Court later confirmed the holding that the 1993 and 1995 amendments to *West Virginia Code* § 9-5-11 rendered the made-whole rule inapplicable to the DHHR's right to subrogation. *Anderson v. Wood*, 204 W. Va. 558, 562, 514 S.E.2d 408, 412 (1999) ("This Court found [in *Grayam*] that the statute nullified the made-whole rule and allowed the Department to recover all payments expended for medical assistance paid on behalf of its recipient"). In *Anderson v. Wood*, the primary issue was whether *West Virginia Code* § 9-5-11 required the Department to pay a pro rata share of costs and attorney fees when a Medicaid recipient recovers from a tortfeasor. The statute required the Department to pay a pro rata share of attorney fees, but it did not specify that the Department must pay costs. The Court held that the Department is liable for its pro rata share of the costs and attorney fees incurred by the recipient in recovering his or her medical expenses. Justice Davis, writing for

the Court, concluded, “[f]undamental fairness requires that DHHR assume its pro rata share of the litigation costs incurred when obtaining reimbursement for medical payments expended on behalf of a recipient.” *Anderson v. Wood*, 204 W. Va. 558, 565, 514 S.E.2d 408, 415 (1999).

In *Arkansas Department of Health and Human Services v. Ahlborn*, the issue was whether a State Medicaid program’s right of recovery against a Medicaid recipient’s personal injury settlement or award is restricted to only that portion of the proceeds specifically allocated to past medical expenses. The United States Supreme Court held that a state may assert and collect its Medicaid liens, but it may not assert or collect payment of those liens from non-medical settlement awards. *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) [hereinafter *Ahlborn*]. *Ahlborn* reinforces the priority given to Medicaid liens.

Heidi Ahlborn, a college student, was injured and permanently disabled in a motor vehicle accident in 1996. She applied and qualified for Medicaid benefits in Arkansas. According to Arkansas law, as a condition of Medicaid eligibility, she was required to assign “any settlement, judgment, or award which may be obtained against any third party” to the Arkansas Department of Human Services (“ADHS”), the state Medicaid agency, “to the full extent of any amount which may be paid by Medicaid” for her benefit. By the time Ms. Ahlborn settled her third party tort claim, Medicaid had paid \$215,645.30 for her care. The net amount of Ms. Ahlborn’s settlement was \$550,000.00. The parties stipulated that \$35,581.47 represented settlement of her claim for past medical expenses, but ADHS then attempted to assert a Medicaid lien of \$215,645.30. The Court found that federal Medicaid law, which requires that a Medicaid recipient assign to the state any right to payment from a

third party who is liable for the recipient's medical expenses, does not entitle the state to full reimbursement from personal injury settlements or awards if a lesser amount has been designated as compensation for medical care.

The Court's analysis of federal Medicaid law focused on the plain meaning of "payment for medical care" in 42 U.S.C. §1396k(a). The Court interpreted that language to mandate a Medicaid recipient's assignment of only the rights to "payment for medical care" from a third party as a condition of Medicaid eligibility, and not any other payments from the third party, such as compensation for lost wages, pain and suffering, or other damages. Justice Stevens delivered the opinion for a unanimous Court:

Medicaid recipients must, as a condition of eligibility, "assign the [s]tate any rights . . . to *payment for medical care* from any third party," 42 U.S.C. §1396k(a)(1)(A) (emphasis added), not their rights to payment for, for example, lost wages . . . .

First, ADHS points to § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability*" (emphasis added) and suggests that this means the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, "such legal liability" refers to "the legal liability of third parties . . . to *pay for care and services available under the plan.*" § 1396a(a)(25)(A) (emphasis added). 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.

Second, ADHS argues that the language of § 1396a(a)(25)(H) favors its view that it can demand full reimbursement of its costs from Ahlborn's settlement . . . . But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services.*" § 1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses – not lost wages, not pain and suffering, not an inheritance.

Finally, ADHS points to the provision requiring that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from “any amount collected by the State under an assignment” before “the remainder of such amount collected” is remitted to the recipient. § 1396k(b). In ADHS’ view, this shows that the state must be paid in full from any settlement . . . . The “amount recovered . . . under an assignment” is not, as ADHS assumes, the entire settlement; as explained above, under the federal statute the State’s assigned rights extend only to recovery of payments for medical care. Accordingly, what § 1396k(b) requires is 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* at 280-82 (footnotes and internal citations omitted).

The *Ahlborn* Court held that a state’s Medicaid lien recovery is limited to the portion of a verdict or settlement representing amounts recovered by a plaintiff for medical expenses. The *Ahlborn* Court rejected the state’s argument 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.” *Ahlborn* at 272. The Court reasoned that the federal statutory provisions regarding the forced assignment of third-party benefits “require an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care” and that the “anti-lien provision [of federal law] precludes attachment or encumbrance of the remainder of the settlement.” *Ahlborn* at 282, 284. The Court thus rejected the “rule of absolute priority” (*Ahlborn* at 288) embodied in the Arkansas Medicaid lien provision and held that “Federal Medicaid law does not authorize [the state] to assert a lien on *Ahlborn*’s settlement in an amount exceeding \$35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so.” *Ahlborn* at 292.

The *Ahlborn* decision has had little impact in West Virginia. *Ahlborn* reinforces the priority given to Medicaid in settlements. West Virginia has made no changes to its third party liability statutes, rules, or policies in response to *Ahlborn*. *Ahlborn* dealt with Arkansas statutes that conflicted with 42 U.S.C. § 1396p(a)(1), the Title XIX anti-lien provision, because they entitled the State to full reimbursement from personal injury settlements or awards even if a lesser amount had been designated as compensation for medical care. The West Virginia statutes comply with 42 U.S.C. § 1396p(a)(1). Contrary to the Petitioner's assertions, *West Virginia Code* § 9-5-11 specifies that DHHR's right of recovery against a recipient's personal injury settlement or award is restricted to only that portion of the proceeds specifically allocated to past medical expenses. *Grayam v. Department of Health and Human Resources* and *Anderson v. Wood* are still valid in terms of West Virginia Medicaid having a priority in any settlement. *See Ahlborn* at 282.

### **SUMMARY OF THE ARGUMENT**

It is undisputed that Medicaid paid medical bills totaling \$146,556.49 on behalf of Ms. H. The issue before Judge Irons was the equitable distribution of the settlement proceeds. Judge Irons was correct in distributing the adjusted Medicaid lien of \$76,741.00 to the Department. The Petitioner's assertion that the Supreme Court should now set aside *West Virginia Code* § 9-5-11, set aside the Medicaid lien, or remand the case for evidentiary hearings to further reduce the Medicaid lien amount because of the seriousness of Ms. H.'s injuries lacks merit.

The 1993 and 1995 amendments to *West Virginia Code* § 9-5-11 and the holdings in *Grayam v. Department of Health and Human Resources* and *Anderson v. Wood* abolished West Virginia's former made-whole rule. The Department has a statutory right to subrogation from a judgment or settlement, whether or not a Medicaid recipient was made whole by a judgment or settlement. Just as the Supreme Court concluded in *Grayam* that it must "follow the legislative mandates set forth in the statute," the Court should again follow the legislative mandates set forth in *West Virginia Code* § 9-5-11 and recognize the Department's priority right to its subrogation interest.

#### **STATEMENT REGARDING ORAL ARGUMENT**

The Department hopes this Response answers all questions the Court may have, but would welcome the opportunity to present oral argument before the Court to provide any additional information or answer any questions that might help the Court in deciding the issues presented on appeal. The Revised Rules of Appellate Procedure, which were promulgated on October 19, 2010:

shall be applicable to all certified questions and appeals arising from rulings, orders or judgments entered on or after December 1, 2010, and to original jurisdiction proceedings in the Supreme Court of Appeals filed on or after December 1, 2010. In cases arising from orders entered prior to the effective date, the Court may on its own motion direct the parties to comply with the revised rules in whole or in part by entering an appropriate order.

Rule 1(d), Revised Rules of Appellate Procedure.

The Petition for Appeal in the case at bar arises from an order entered before the effective date of the Revised Rules of Appellate Procedure. The Court has not yet granted the Petition for Appeal, and the Department asks the Court to *refuse* the Petition for Appeal.

If the Court were to grant the Petition for Appeal, the Department would suggest that the Petition for Appeal and Department's Response provide enough information that the Court could consider those documents as if they were Petitioner's Brief and Respondent's Brief under the unified briefing process in the Revised Rules of Appellate Procedure. The Department believes the issue of whether the Medicaid lien asserted pursuant to *West Virginia Code* § 9-5-11 violates the U.S. Supreme Court's holding in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) is an issue of first impression, but is a narrow issue of statutory interpretation. The Department believes this appeal would be appropriate for consideration by the Court under Rule 19 of the Revised Rules of Appellate Procedure and for disposition by Memorandum Decision under Rule 21 of the Revised Rules of Appellate Procedure.

### ARGUMENT

The primary issue before the Court is whether the Medicaid lien under *West Virginia Code* § 9-5-11 violates the U.S. Supreme Court's holding in *Ahlborn*, by attempting to collect more than the portion of the settlement that constitutes reimbursement for past medical payments. The Department submits that Judge Irons was correct in finding the Medicaid lien was valid and in distributing the interpleader funds to Medicaid. Medicaid never attempted to collect more than the portion of the settlement that constitutes reimbursement for past medical payments. It instead recovered approximately one-half of what it paid to Ms. H.'s medical providers.

The Petitioner assigns the following error, “[i]n a catastrophic injury case, the Circuit Court of Monroe County erred in granting summary judgment to the West Virginia Department of Health and Human Services, upholding its Medicaid lien created by *West Virginia Code* § 9-5-11, on findings that the Medicaid lien, which attaches to recoveries for non medical damages, does not violate the federal Medicaid anti-lien statute as reviewed in [*Ahlborn*], and that the Department’s lien is not excessive, and that the Department fairly negotiated over its lien by making reductions relating to the costs of recovery for compensation, all without full evidentiary proceedings.” Petition for Appeal at p. 7. The Department will attempt to respond to each part of the assignment of error in the order set out in the Petition for Appeal.

Judge Irons correctly followed the applicable statutes and controlling case law. He correctly found that 1) the Medicaid lien asserted pursuant to *West Virginia Code* § 9-5-11 is valid and fully comports with the U.S. Supreme Court’s holding in *Ahlborn*, because the Department did not attempt to collect more than the portion of the settlement that constitutes reimbursement for past medical payments, 2) the adjusted Medicaid lien was not excessive because the Department limited the recovery it sought to approximately half of what it had paid for Ms. H.’s medical care, and 3) the Department negotiated fairly, reduced the Medicaid lien from \$146,556.49 to \$96,238.76, and further reduced the Medicaid lien to \$76,741.00 after discussions with Ms. H.’s attorney. On appeal, the Petitioner asks this Court to set aside *West Virginia Code* § 9-5-11, to set aside the Medicaid lien, or to remand the case to the Monroe County Circuit Court so it can conduct evidentiary proceedings and allocate the

settlement proceeds between medical payments and other damages. The Court should deny all of these requests.

## I. STANDARD OF REVIEW

The Supreme Court of Appeals reviews a circuit court's entry of summary judgment under a de novo standard. *Terra Firma Co. v. Morgan*, 223 W. Va. 329, 674 S.E.2d 190 (2008); Syllabus Point 1, *Painter v. Peavy*, 192 W. Va. 189, 451 S.E.2d 755 (1994); *Folio v. Harrison-Clarksburg Health Department*, 222 W. Va. 319, 664 S.E.2d 541, (2008); *San Francisco v. Wendy's International, Inc.* 221 W. Va. 734, 656 S.E.2d 485 (2007); *Kelley v. City of Williamson, West Virginia*, 221 W. Va. 506, 655 S.E.2d 528 (2007); *Mace v. Ford Motor Co.*, 221 W. Va. 198, 653 S.E.2d 660 (2007); *Hawkins v. U.S. Sports Association, Inc.*, 219 W. Va. 275, 633 S.E.2d 31 (2006). Where the issue on an appeal from the circuit court is clearly a question of law or involving an interpretation of a statute, the Supreme Court of Appeals applies a de novo standard of review. Rule 56, *Rules of Civil Procedure*; *Nicholas Loan & Mortgage, Inc. v. W. Va. Coal Co-Op, Inc.*, 209 W. Va. 296, 547 S.E.2d 234 (2001). The Supreme Court of Appeals reviews de novo a circuit court's entry of summary judgment, and applies the same standard that the circuit courts employ in examining summary judgment motions. *Id.* The Supreme Court of Appeals reviews circuit court's grant of summary judgment de novo, and applies the same standard as the circuit court, reviewing all facts and reasonable inferences in the light most favorable to nonmoving party. Rule 56, *Rules of Civil Procedure*; *Powderidge Unit Owners Association v. Highland Properties, Ltd.*, 196 W. Va. 692, 474 S.E.2d 872 (1996).

The Supreme Court of Appeals has often stated, “[a] motion for summary judgment should be granted only when it is clear that there is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law.” *Terra Firma Co. v. Morgan*, 223 W. Va. 329, 674 S.E.2d 190 (2008) (quoting Syllabus Point 3, *Aetna Casualty & Surety Co. v. Federal Ins. Co. of New York*, 148 W. Va. 160, 133 S.E.2d 770 (1963)). “[T]he party opposing summary judgment must satisfy the burden of proof by offering more than a mere ‘scintilla of evidence,’ and must produce evidence sufficient for a reasonable jury to find in a nonmoving party’s favor.” *Painter v. Peavy*, 192 W. Va. at 192-93, 451 S.E.2d at 758-59 (1994).

II. THE MEDICAID LIEN IS VALID BECAUSE WEST VIRGINIA CODE § 9-5-11 DOES NOT VIOLATE THE U.S. SUPREME COURT’S HOLDINGS IN ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES V. AHLBORN.

The Petitioner attempts to create a preemption issue by asserting that *West Virginia Code* § 9-5-11 violates federal Medicaid law and that the *Ahlborn* Court’s holdings render *West Virginia Code* § 9-5-11 unenforceable. Petition for Appeal at pp. 2, 3, 10, 13, 16, 17. The Petitioner also asserts that federal law requires allocation between medical and non-medical damages and state law forbids allocation between medical and non-medical damages. Petition for Appeal at pp. 3, 11, 14, 16, 17. These assertions lack support, and the Court should reject them.

As discussed above, *Ahlborn* dealt with Arkansas statutes that violated the Medicaid Act anti-lien provisions because they entitled the State to full reimbursement from personal injury settlements or awards even if a lesser amount had been designated as compensation for

medical care. *West Virginia Code* § 9-5-11 specifies that the Department's right of recovery against a personal injury settlement or award is restricted to only that portion of the proceeds allocated to past medical expenses. *West Virginia Code* § 9-5-11(a) (2009). This is entirely consistent with the *Ahlborn* decision.

Contrary to the Petitioner's repeated assertions, *West Virginia Code* § 9-5-11 does not prohibit allocation between medical and non-medical damages. The statute provides, "[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.*" It further provides, "The department shall be legally assigned the rights of the recipient against the person so liable, *but only to the extent of the reasonable value of the medical assistance paid and attributable to the sickness, injury, disease or disability for which the recipient has received damages.*" Moreover, it provides, "The claim of the Department of Health and Human Resources assigned by such recipient *shall not exceed the amount of medical expenses for the injury, disease, disability or death of the recipient paid by the department on behalf of the recipient.* *West Virginia Code* § 9-5-11(a) (2009) (emphasis added). Contrary to the Petitioner's representations, the statute expressly provides for allocation between medical and non-medical damages.

This Court should deny the Petitioner's request to set aside the Medicaid lien as contrary to federal law. The Petitioner's assertion that a "first and full dollar reimbursement" lien is unenforceable under *Ahlborn* (Petition for Appeal at pp. 12, 13, 15) rests on a

misreading of *Ahlborn*. The *Ahlborn* Court specifically held, “what [42 U.S.C.] § 1396k(b) requires is 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* at 281. The Petitioner’s assertion that *Ahlborn* stands for the proposition that the Medicaid lien is contrary to federal law lacks merit.

This Court has not addressed the *Ahlborn* decision. The West Virginia Legislature amended *West Virginia Code* § 9-5-11 in 2009 to include language not relevant for the instant purposes, but those amendments did not alter or change any language in the statute regarding the priority right of the Department to recover monies paid for medical benefits from monies paid from liable third parties.

Other states have addressed the *Ahlborn* decision. They have found that *Ahlborn* contemplates the allocation of damages, but does not require the allocation of damages. *Russell v. Agency for Health Care Administration*, 23 So.3d 1266, 1267-68 (Fla. Dist Ct. App. 2010) (The contention that since the value of the case was \$30 million and the \$3 million settlement constituted a recovery of only one-tenth of the actual damages suffered by the Medicaid recipient, the state was entitled to recover only one-tenth of its Medicaid lien “is based on an untenable reading of *Ahlborn*”); *Arizona Department of Administration v. Cox*, 213 P.3d 707 (Ariz. Ct. App. 2009) (Trial court erred in applying an apportionment formula to determine the state’s recovery); *Smith v. Agency for Health Care Administration*, 24 So.3d 590, 591 (Fla. Dist. Ct. App. 2009) (The argument that *Ahlborn* mandates “a percentage reduction in a Medicaid lien in the same ratio as the settlement bears to actual damages” rests on a “misreading of *Ahlborn*.”); *Espericueta v. Shewry*, 79

Cal.Rptr.3d 517, 524-25, 164 Cal.App.4th 615, 625 (Cal. Ct. App. 2008) (*Ahlborn* does not require a Medicaid lien “be reduced by the same percentage that [a] settlement bears to the overall value of [a] case.” *Ahlborn* imposes no formula for reducing Medicaid liens); *McMillian v. Stroud*, 83 Cal.Rptr.3d 261, 270, 166 Cal.App.4th 692, 702 (Cal. Ct. App. 2008) (*Ahlborn* “neither considers nor mandates” the use of any formula based on a lien reduction by the same percentage that a settlement bears to the overall value of a case).

The *Ahlborn* Court’s holding was limited by the parties’ stipulations and does *not* require a specific method for determining the portion of a settlement that represents the recovery of medical expenses. *Andrews ex rel. Andrews v. Haygood*, 362 N.C. 599, 603, 669 S.E.2d 310, 313 (2008). The *Ahlborn* Court recognized that “some States 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.” *Ahlborn* at 288 n. 18. *Ahlborn* thus does *not* mandate a judicial determination of the portion of a settlement from which the State may be reimbursed for prior medical expenditures. Instead, the *Ahlborn* Court left to the States the decision on the measures to employ in the operation of their Medicaid programs. *Id.*

Central to the *Ahlborn* Court’s reasoning was the state’s stipulation concerning the portion of the settlement attributable to medical expenses. Based on that stipulation, the Court reached its conclusion that the state’s lien claim exceeded “that portion of a settlement that represent[ed] payments for medical care.” *Ahlborn* at 282. Contrary to the Petitioner’s suggestion, the *Ahlborn* decision does not establish as a rule of law the formula used by the

State of Arkansas to determine the portion of the settlement attributable to medical expenses. That formula was only part of the facts presented to the Court. *See Smith v. Agency for Health Care Admin.*, 24 So.3d 590, 591 (Fla. 5th DCA 2009) (“[T]he [C]ourt in *Ahlborn* simply accepted the stipulation, and in no way adopted the formula as a required or sanctioned method to determine the medical expense portion of an overall settlement amount”); *see also Andrews ex rel. Andrews v. Haygood*, 362 N.C. 599, 603, 669 S.E.2d 310, 313 (2008) (“The *Ahlborn* holding, limited by the parties’ stipulations, did not require a specific method for determining the portion of a settlement that represents the recovery of medical expenses”).

The case at bar is distinguishable from *Ahlborn*. In the case at bar, there is no stipulation or similar basis for determining an allocation of the settlement proceeds. In *Ahlborn*, the parties entered into stipulations that governed the allocation of the Medicaid recipient's settlement proceeds. *Ahlborn* at 274. They also stipulated to the amount that the underlying claim had been worth, with the understanding that the settlement agreement at issue had accounted for only one-sixth of the value of the claim. *Id.* Consequently, the *Ahlborn* Court was presented with a neatly packaged legal question that did not require significant inquiry about how a settlement amount should be allocated in circumstances where the differing amounts claimed by the parties are subject to serious dispute. The *Ahlborn* Court specifically noted that it was *not* deciding whether a state could adopt special rules or procedures for allocating tort settlement proceeds for the purpose of preventing Medicaid recipients from seeking to manipulate their damage allocations in order to prevent the state from asserting a claim for reimbursement. *Ahlborn* at 288 n. 18.

Here, the Petitioner seeks to manipulate the settlement and eliminate the Medicaid lien completely or reduce it to a small fraction of the amount paid by Medicaid. This effectively advances the position that *little or none* of the settlement represents medical costs paid by Medicaid. The settlement agreement here contains no allocation of the amount recovered among the various elements of damages suffered by the recipient. Nor have the parties to the settlement or the Department otherwise agreed to such an allocation. The Petitioner elected to offer no evidence of the value of the claim either before or during the settlement hearing. The only evidence of record showing the value of the claim is the settlement amount. The record contains no evidence of the proper allocation of damages. The record contains no evidence of lost wages. The record contains no evidence of pain and suffering.

In recognizing the significance of the lack of an allocation in a settlement agreement, the Florida District Court of Appeal recently found that an allocation in the settlement agreement entered without the agreement of the state would not be dispositive. As the *Ahlborn* Court acknowledged, “the risk that parties to a tort suit will allocate away the State’s interest” (*Ahlborn* at 288) may justify the use of “special rules and procedures” (*Ahlborn* at 288 n. 18) or may require submission of “the matter to a court for decision” (*Ahlborn* at 288). But the Florida District Court of Appeal found that such a judicial determination is *not necessary* where the parties to a settlement agreement have not agreed on an allocation. “*Ahlborn* . . . does *not* mandate a judicial determination of the portion of a settlement from which the State may be reimbursed for prior medical expenditures.” *Russell v. Agency for Health Care Administration*, 23 So.3d 1266, 1269 (Fla. Dist Ct. App. 2010) (emphasis added).

*Ahlborn* contemplates the allocation of damages, but does not require the allocation of damages. The parties to the settlement agreement at issue here have not agreed on an allocation of damages. The Petitioner offered no evidence of the value of the claim or the proper allocation of damages before or at the hearing. The Petitioner has offered no evidence that the Medicaid lien asserted by the Department extends to a portion of the settlement “meant to compensate the recipient for damages distinct from medical costs.” *Ahlborn* at 272.

III. THE MEDICAID ACT PROHIBITS THE DEPARTMENT FROM FURTHER REDUCING ITS MEDICAID LIEN.

The Petitioner asks the Court to set aside the Medicaid lien altogether, as she has asked the Department and Judge Irons to do. In the alternative, she asks the Court to remand the case and order the parties to negotiate over an allocation of damages, order mediation, and order the circuit court to conduct evidentiary proceedings to allocate damages. Petition for Appeal at pp. 1, 4, 17, 18. The Court should deny these requests.

The Department is required to comply with the requirements of the Medicaid Act. The Department is required to take all reasonable measures to ascertain the legal liability of third parties to reimburse Medicaid for the costs of medical care and services for which Medicaid has paid. If such legal liability exists after Medicaid has paid for medical services, the Department must seek reimbursement for such assistance to the extent of such legal liability. 42 U.S.C. § 1396a(a)(25)(A)-(B) 42 U.S.C. § 1396a(a)(25)(A) (1994) (1994 ed. and Supp. II 1996). *See also* 42 C.F.R. §§ 433.135. One such requirement is that state plans for medical assistance must provide that the administering agency will “take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and service available

under the plan,” , and to seek reimbursement from all third parties where legal liability has been found to exist. 42 U.S.C. § 1396a(a)(25)(B). A state’s noncompliance with the Medicaid Act jeopardizes continued federal funding and recovery of money from third party liability is a necessary cost containment measure.

The *West Virginia Code* provides that the Department has a right of subrogation to the extent of the cost of medical expenses paid by Medicaid after a reduction of its subrogation interest by a pro rata share of attorney fees and costs. The applicable statute provides, in pertinent part, “[s]ubmission of an application to the Department of Health and Human Resources for medical assistances 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.” *West Virginia Code* § 9-5-11(a) (emphasis added).

Ms. H. assigned her right to recovery of medical expenses paid on her behalf by West Virginia Medicaid. As discussed above, Medicaid paid medical bills attributable to the auto accident totaling \$146,556.49, reduced the Medicaid lien from \$146,556.49 to \$96,238.76, and further reduced the Medicaid lien amount to \$76,741.00. But the Department does not have the authority to waive its lien altogether or accept only a small percentage of the adjusted Medicaid lien as satisfaction of its lien.

Federal regulations prohibit the Department from compromising the federal share of Medicaid payments. *See* 42 C.F.R. §§ 433.139 and 433.140. The Medicaid Act requires an individual to assign the State the individual’s rights to payment for medical care from any third party as a condition of eligibility for Medicaid. 42 U.S.C. § 1396k(a)(1). The State must

retain proceeds collected under such an assignment “as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.” 42 U.S.C. § 1396k(b). If the Department were to attempt to negotiate away the federal share of Medicaid payments made on Ms. H.’s behalf, continued federal funding for West Virginia Medicaid would be jeopardized.

The Court should deny the Petitioner’s request for the Court to order the Department to negotiate the amount of the Medicaid lien. The Petitioner’s allegation that the Department has refused to negotiate, insisting that it has “a duty to seek a full and first dollar reimbursement on any settlement proceeds realized, whether for Medicaid payments or general damages” (Petition for Appeal at p. 6) is incorrect. The Department has never demanded full reimbursement of the \$146,556.49 it paid. Medicaid paid medical bills attributable to the auto accident totaling \$146,556.49, but reduced the Medicaid lien to \$76,741.00. *West Virginia Code* § 9-5-11 gives the Department the authority to compromise or settle the State’s share of a Medicaid lien, which the Department has done, but contains no requirement that the Department negotiate.

The Department never agreed to the Petitioner’s demand that the Medicaid lien be waived entirely or reduced to a small fraction of its value, but that does not mean the Department has refused to negotiate. The Department reduced the Medicaid lien from \$146,556.49 to \$76,741.00 to bear its pro rata portion of attorney fees and expenses. It agreed to accept \$76,741.00 in satisfaction of its lien. The Petitioner counter offered that the

Medicaid lien should be entirely waived or substantially reduced. The Department does not have authority to waive its lien altogether or to accept only a small percentage of the lien as satisfaction. The Department cannot negotiate away the federal share of the Medicaid lien and risk losing continued federal funding for the Medicaid program. The Department has negotiated to the full extent of its authority. The Petitioner's assertion that the Department should be ordered to further negotiate away its lien lacks merit.

The Court should also deny the Petitioner's request for the Court to order mediation if negotiations are unsuccessful. If the adjusted Medicaid subrogation interest were more than the settlement amount, the Department would have more discretion in negotiating an agreement over an equitable allocation of the settlement proceeds between the Medicaid recipient and the Department. But here, the settlement amount greatly exceeds the adjusted Medicaid subrogation interest. The Department has limited negotiating authority since the Federal statutes and regulations require that the Department seek reimbursement for Medicaid payments to the extent of the legal liability of third parties. Again, the Department's failure to do so would jeopardize continued federal funding for the Medicaid program. The Petitioner's assertion that the Court should order mediation if negotiations are unsuccessful lacks merit.

Finally, the Court should deny the Petitioner's request for the Court to order evidentiary proceedings to allocate the settlement proceeds between medical payments and other damages. Ms. H. should not have filed a summary judgment motion if the damages were a genuine issue of fact that was unresolved. The time to prove damages was either before or at the settlement hearing. The record before Judge Irons was sufficient to allow him

to apply the law to the facts of the case. The only reason for conducting additional evidentiary proceedings would be to apply the made-whole rule, which is no longer the law.

Medicaid paid almost all of Ms. H.'s past medical expenses attributable to the accident at no cost to her. The record contains no evidence that the Petitioner and Ms. H. have incurred any unreimbursed out-of-pocket medical expenses. The Petitioner established a special needs trust for Ms. H.'s benefit with the net settlement proceeds of \$133,741.29 so Ms. H. will continue to receive Medicaid benefits without being required to spend down the \$133,741.29. Medicaid will be paying Ms. H.'s medical expenses for the rest of her life at no cost to her.

The Petitioner did not offer evidence of the value of the claim or the proper allocation of damages before or at the settlement hearing. The parties to the settlement have not agreed on an allocation of damages. The Petitioner has not shown that the Department's adjusted Medicaid lien extends to a portion of the settlement meant to compensate Ms. H. for damages distinct from medical costs.

It is undisputed that Ms. H. was injured and permanently disabled in a motor vehicle accident. Ms. H. agreed to settle her third party tort claim for a total amount of \$301,000.00. *See Report on Disbursements of Settlement Proceeds.* Settling her case for \$301,000.00 was an acknowledgment that her damages were \$301,000.0. The relevant extent of her damages extends no further than that amount.

Allowing the Petitioner to reach back and allocate the settlement proceeds to non-economic damages such as "pain and suffering" to defeat the Medicaid lien would defeat the purpose of the Medicaid Program. Medicaid is the payer of last resort for medical expenses of the indigent. To preserve that status, the Medicaid Act requires participating

States and a Medicaid recipient to seek to recover from responsible third parties the full amount of medical assistance rendered.

Ms. H. applied and qualified for West Virginia Medicaid benefits. Submission of an application for Medicaid 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.” *West Virginia Code* § 9-5-11(a).

Ms. H. assigned to the State her right to recover medical damages from third parties to the full extent of those parties’ legal liability for Medicaid’s expenses. By seeking its right to recovery, the Department seeks only to protect its own assigned right and continued federal funding. It does not impermissibly encroach upon any of Ms. H.’s distinct property rights.

#### IV. THE FORMER MADE-WHOLE RULE DOES NOT APPLY.

The Petitioner asks this Court to revive and apply the made-whole rule. Petition for Appeal at pp. 1, 4, 15, 16, 17. The Court should deny the Petitioner’s request. The Department has a statutory right to subrogation from a judgment or settlement, whether or not an injured plaintiff is made whole by a judgment or settlement.

In *Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997), the Supreme Court conclusively determined that the 1993 and 1995 amendments to *West Virginia Code* § 9-5-11 rendered the “made-whole” rule inapplicable to the Department’s right to subrogation. This holding was confirmed in *Anderson v. Wood*, 204 W. Va. 558, 562, 514 S.E.2d 408, 412 (1999) (“This Court found [in *Grayam*] that the statute

nullified the made-whole rule and allowed DHHR to recover all payments expended for medical assistance paid on behalf of its recipient”). In *Grayam*, the Supreme Court expressed empathy for the plaintiffs, but held that it *must* follow the legislative mandates of *West Virginia Code* § 9-5-11 (1995). “Although it is unfortunate that there are inadequate insurance proceeds to fully compensate Appellees for the losses they suffered in these cases, this Court must follow the legislative mandates set forth in the statute and reverse the lower courts’ decisions applying the made-whole rule to the facts of these cases.” *Grayam*, 201 W. Va. 444, 454, 498 S.E.2d 12, 22. “[I]f another person is legally liable to pay for medical assistance provided by [DHHR], the Department possesses a *priority right* to recover full reimbursement from any settlement, compromise, judgment, or award obtained from such other person or from the recipient of such assistance if he or she has been reimbursed by the other person.” Syllabus Point 2, *Grayam* (emphasis added).

There are two presumptions that cannot be ignored. First, the Legislature is presumed to have known and understood the laws it enacted. *State ex rel. Smith v. Maynard*, 193 W. Va. 1, 8-9, 454 S.E.2d 46, 53-54 (1994). Second, “‘courts must presume that a legislature says in a statute what it means and means in a statute what it says there.’” *Martin v. Randolph County Board of Education*, 195 W. Va. 297, 312, 465 S.E.2d 399, 414 (1995), quoting *Connecticut National Bank v. Germain*, 503 U.S. 249, 253-54 (1992).

The statute is clear. The holdings in *Grayam v. Department of Health and Human Resources* and *Anderson v. Wood* are clear. The former made-whole rule is inapplicable. In *Grayam*, this Court correctly concluded it was required to “follow the legislative mandates set forth in the statute.” The Court should not revive and apply the former made-whole rule.

## CONCLUSION

Judge Irons did what he was supposed to do. He recognized the Department's priority right to recover medical expenses Medicaid paid on behalf of Ms. H. that were attributable to the underlying accident. He acknowledged that Medicaid paid \$146,556.49 for Ms. H.'s medical treatment and ultimately reduced its subrogation interest to \$76,741.00. He considered the applicable statutes and case law and honored the Medicaid lien. The Medicaid lien does *not* violate the *Ahlborn* Court's holding by attempting to collect more than the portion of the settlement that constitutes reimbursement for past medical payments. *West Virginia Code* § 9-5-11 and the Medicaid lien are valid.

For the foregoing reasons, the Department asks that the Petition for Appeal be REFUSED.

Respectfully submitted,

West Virginia Department of  
Health and Human Resources,

By Counsel

DARRELL V. McGRAW, JR.  
ATTORNEY GENERAL



Michael E. Bevers, State Bar No. 9251  
Assistant Attorney General  
State Bar No. 9251  
350 Capitol Street, Room 251  
Charleston, West Virginia 25301  
(304) 558-1448  
Michael.E.Bevers@wv.gov

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

**STATE OF WEST VIRGINIA  
BEFORE THE SUPREME COURT OF APPEALS**

V.P.H., A DISABLED ADULT, )  
BY P.D., HER MOTHER AND )  
GUARDIAN AND CONSERVATOR, )  
AS PETITIONER, )

V. )

MICHAEL J. LEWIS, )  
SECRETARY OF THE DEPARTMENT OF )  
HEALTH AND HUMAN RESOURCES, )  
RESPONDENT. )

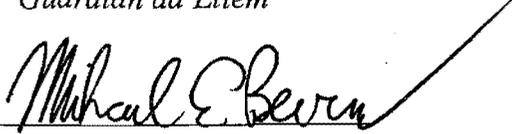
CIVIL ACTION No. 09-C-89  
MONROE COUNTY CIRCUIT COURT  
CHIEF JUDGE ROBERT A. IRONS

**CERTIFICATE OF SERVICE**

I, Michael E. Bevers, Assistant Attorney General, Attorney for the Bureau for Medical Services, hereby certify that this office has filed the original and ten (10) copies of the foregoing *Response of Department of Health and Human Resources to Petition for Appeal* with the Clerk of the Supreme Court of Appeals of West Virginia, on this, the eleventh day of February, 2011, either by hand delivery or by first-class mail, properly addressed and postage prepaid. True and correct copies have been served upon all parties of record by depositing same in the United States Mail, properly addressed and first-class postage prepaid, as follows:

Larry L. Rowe, Esq.  
4200A Malden Drive  
Malden, West Virginia 25306  
*Counsel for the Petitioner*

Geoffrey S. Wilcher, Esq.  
1985 Sweet Springs Valley  
Gap Mills, West Virginia 24941-9844  
*Guardian ad Litem*

  
Michael E. Bevers  
Assistant Attorney General