No. 19-539

IN THE
Supreme Court of the United States

OFFICE OF RECOVERY SERVICES,
Petitioner,

v.

JOHN R. LATHAM,
Respondent.

On Petition for a Writ of Certiorari
to the Utah Supreme Court

BRIEF IN OPPOSITION

PAUL R. SMITH
MICHAEL JUDD
JONES WALDO HOLBROOK &
MCDONOUGH, PC
170 S. Main Street
Suite 1500
Salt Lake City, UT 84101
(801) 375-9801

ISHAN K. BHABHA
Counsel of Record
ADRIENNE LEE BENSON
JENNER & BLOCK LLP
1099 New York Ave., NW
Suite 900
Washington, DC 20001
(202) 639-6000
ibhabha@jenner.com

QUESTION PRESENTED

Whether Utah's state Medicaid agency may recover the past medical expenses it paid for a Medicaid recipient only from the portion of the recipient's settlement with a third-party tortfeasor allocated to cover past medical expenses, or if it may also draw from the portion of the settlement intended to pay future medical expenses, even when the recipient is no longer eligible for Medicaid and his future medical expenses will not be paid for by the State?

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INTRODUCTION

Respondent John R. Latham suffered permanent neurological damage from a misdiagnosed stroke, the consequences of which will impose significant medical costs on him for the remainder of his life. At the time of his stroke, Mr. Latham was eligible for Medicaid, and Medicaid paid for his medical expenses. When suing the tortfeasor hospital, Mr. Latham entered a collection agreement with Utah's Office of Recovery Services ("ORS"). Under that agreement, Mr. Latham would bring suit against the hospital and ORS would be assigned Mr. Latham's right to proceeds for which the third party was legally liable to pay for medical care covered by Medicaid. Mr. Latham and the hospital settled the entire case for a total of $800,000 in liability, unallocated among categories of damages. Following the settlement, Mr. Latham and ORS agreed that Mr. Latham's claim was worth an estimated $7.2 million, including $104,065.32 in estimated past medical costs and approximately $6.4 million in future medical costs. The hospital's liability at settlement thus amounted to only 11% of Mr. Latham's estimated total claim. As a result of the settlement, Mr. Latham is now ineligible for Medicaid and must pay his extensive future medical expenses out of pocket from the settlement funds or through another form of medical coverage.

ORS now seeks to recover the entirety of its past medical expenses with no discount for the fact that Mr. Latham settled for far less than the total value of his claim. Moreover, it seeks to collect this amount from the portion of the settlement that is compensation

for Mr. Latham's past *and future* medical care, even though Medicaid will not cover any of Mr. Latham's future care. In short, Medicaid now expects Mr. Latham to use the settlement funds to cover his future medical expenses, while at the same time ORS is attempting to take those very funds away from Mr. Latham to cover the State's past expenses.

The question presented is whether ORS may recover the State's past medical expenses only from the portion of Mr. Latham's settlement intended for that purpose, or if it may also recover from the portion of the settlement covering his *future* medical expenses. The Utah Supreme Court concluded that ORS may recover past medical expenses only from the portion of Mr. Latham's settlement representing those past medical expenses. That correct decision does not merit this Court's review.

In the decision below, the Utah Supreme Court joined every state court of last resort to consider the issue in the past ten years. This Court has already twice facilitated the emerging convergence among state supreme courts with its guidance in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), and *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013), both of which the Utah Supreme Court relied upon extensively in the decision below. True, a decade ago the Idaho Supreme Court took a different view in a brief, one-paragraph analysis. *See Idaho Dep't of Health & Welfare v. Matey (In re Matey)*, 213 P.3d 389, 393-94 (Idaho 2009). But that decision predated this Court's clarifying opinion in *Wos*, which affirmed a decision holding that "[a]s the

unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses." *E.M.A. ex rel. Plyler v. Cansler*, 674 F.3d 290, 312 (4th Cir. 2012), *aff'd sub nom. Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013). Unsurprisingly, the Idaho Supreme Court's approach has been rejected by every other state supreme court to consider the question. Moreover, although the Center for Medicare and Medicaid Services ("CMS") provided policy guidance to state Medicaid agencies following this Court's 2006 *Ahlborn* decision, it has not yet weighed in on the specific policy question here. It would thus be doubly premature for this Court to intervene while state courts of last resort are independently resolving the issue and before the federal agency tasked with administering the Medicaid statute has expressed a view.

In addition, review here is unnecessary because the question presented is not of significant import. ORS's own numbers show the amount of Utah's state Medicaid funding that is actually covered by reimbursements from third-party tortfeasors is minimal. Moreover, particularly given that Utah's statutory scheme gives ORS the right to sign off on any settlement, ORS could have achieved precisely the end it seeks here by requiring the settlement to specify the amount of funds attributable to past versus future medical expenses.

Finally, the decision below was correct. As the Utah Supreme Court explained, its decision is not only mandated by the statutory text but also animated by

the reasoning in *Ahlborn* and *Wos*. Moreover, unlike many former Medicaid recipients who are entitled to third-party coverage of past and future medical care, Mr. Latham is no longer eligible for Medicaid. As such, Medicaid is not obligated to pay his future medical expenses. The range of Medicaid funding and congressional policy concerns asserted by ORS's petition are simply not implicated here. Indeed, if ORS recovered full past medical costs from Mr. Latham's discounted settlement of future medical costs, it would receive a significant windfall at Mr. Latham's expense.

The petition should be denied.

STATEMENT

A. Statutory Background

Medicaid is a cooperative federal-state program that assists States in covering medical treatment for residents who cannot otherwise afford care. *Ahlborn*, 547 U.S. at 275. The Federal Government covers most of the costs a State incurs for this care, "and, in return, the State pays its portion of the costs and complies with certain statutory requirements." *Id.*

Among these requirements, federal law broadly prohibits States from attaching a lien on the "property" of a Medicaid beneficiary "on account of medical assistance paid" to that beneficiary. 42 U.S.C. § 1396p(a)(1). Such property includes proceeds of a tort settlement with a third party. *See Wos*, 568 U.S. at 633. In a narrow exception to this prohibition, the Medicaid statute provides that when a third-party tortfeasor's "legal liability . . . to pay for [Medicaid] care and services" "is found to exist after medical assistance has

been made available on behalf of" a Medicaid beneficiary, "the state or local [Medicaid] agency will seek reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(A)-(B). It is undisputed, and indeed stands to reason, that a state Medicaid agency can only seek reimbursement for medical payments it has already made—that is, a Medicaid recipient's *past* medical expenses. *See* 42 U.S.C. § 1396a(a)(25)(B); Pet. App. 12a-13a.

Pursuant to ORS's federal obligation to collect reimbursement from third-party tortfeasors, Utah law conditions Medicaid coverage on the recipient assigning to ORS the recipient's right to recover past expenses for care that Medicaid "furnished to [the] individual," to the extent of those third parties' "legal liability" to the individual for that care. 42 U.S.C. § 1396a(a)(25)(H); Utah Code § 26-19-401. Utah law also requires the written consent of ORS before a Medicaid recipient may seek to recover Medicaid's past medical expenses from a third party. Utah Code § 26-19-403(1)(a).

B. Factual Background

On March 17, 2014, Mr. Latham began to experience symptoms associated with a stroke, and went to a hospital for treatment. Pet. App. 4a. The hospital failed to conduct a neurological exam that could have diagnosed the stroke; instead, it sent Mr. Latham home with pain and anti-nausea medication. *Id.* His condition worsened throughout the day, and that evening Mr. Latham was brought by ambulance to a second hospital. *Id.* The doctors in the second hospital performed a brain scan that revealed his stroke, and began treatment. *Id.*

By the time the second hospital began Mr. Latham's treatment, he had already suffered extensive and irreversible neurological damage. Among other permanent injuries, Mr. Latham lost approximately 75% of his vision, has permanently decreased hearing, and can no longer perform daily life tasks such as cooking, reading, and writing. Complaint at 3-4, *Latham v. Office of Recovery Servs.*, No. 160904935 (Utah Dist. Ct. 2017) ("Complaint"). In order to function on a daily basis, Mr. Latham requires significant and expensive medical care. *Id.* at 4-5. This care includes physical, occupational, speech, and cognitive therapy; ongoing neurological testing; and 14 to 18 hours of attendant care every day. *Id.*

At the time of his stroke, Mr. Latham was a Medicaid recipient in the State of Utah. The cost of his stroke treatment was therefore covered by Medicaid. Pet. App. 4a.

Mr. Latham sued the first hospital to which he went for treatment for its negligent failure to diagnose and treat his stroke. *Id.* Before he initiated suit, and pursuant to the assignment provision described above, Mr. Latham also entered into a collection agreement with ORS. *Id.* at 5a; Complaint Ex. C. That agreement allowed Mr. Latham to include within his claimed damages the "medical care costs paid by the State of Utah," and it provided that "ORS's recovery shall be the statutory claim, as reduced by the attorney's fee of 33.3% of ORS' recovery." Complaint at 7; *id.* Ex. C. ORS and Mr. Latham agreed that Medicaid had paid an "estimated" $104,065.32 in past medical expenses related to the stroke, and that his future medical

expenses would be approximately $6.4 million. *Id.* at 6; *id.* Ex. C. In addition to this approximately $6.5 million in past and future medical expenses, Mr. Latham also sought approximately $700,000 for other injuries suffered as a result of his stroke, for a total estimated damages claim of around $7.2 million. *Id.* at 6-7.

Mr. Latham and the hospital agreed to settle for $800,000, or 11% of the estimated $7.2 million Mr. Latham could have claimed. Pet. App. 5a. ORS participated in these negotiations and, as required by Utah law, approved the settlement agreement. Pet. 7. The settlement agreement could have, but did not, apportion the $800,000 between past medical costs, future medical costs, pain and suffering, and other categories of alleged damages. The parties placed $69,376.88—their agreed-upon estimated of Mr. Latham's past medical expenses less attorney's fees—in a trust account pending determination of how that amount should be distributed between Mr. Latham and ORS. Complaint at 8.

C. Proceedings Below

On August 9, 2016, Mr. Latham sued for declaratory relief in Utah district court on two issues. *First*, Mr. Latham sought a judicial determination that ORS could collect only from the portion of his settlement attributable to past medical expenses. *Second*, Mr. Latham argued the district court should calculate this by determining the percentage that the settlement amount represented of Mr. Latham's total estimated claim ($800,000 out of $7.2 million, or 11%), and then applying that same percentage to the estimated amount of his past medical expenses. *See* Pet. App. 5a-6a.

In response, ORS first argued that its past medical expenses could in fact be paid from settlement funds intended to cover all of Mr. Latham's medical expenses, both past and future. Pet. App. 6a. ORS then disputed Mr. Latham's proposed calculation of that amount. ORS argued that once future medical expenses were included, total "medical expenses" constituted 90% of Mr. Latham's damages claim against the hospital. According to ORS, this meant it could lay claim to up to 90% of Mr. Latham's $800,000 settlement fund to pay its past medical expenses. *Id.* Thus, ORS asserted a right to full reimbursement of the amount it had paid for Mr. Latham's past medical expenses, notwithstanding that the settlement itself only represented 11% of Mr. Latham's total claim against the hospital.[1]

The district court held that ORS could recover the amounts it spent for Mr. Latham's past medical expenses by drawing upon settlement funds

[1] The only question presented here is the first issue, i.e., whether ORS can recover its past medical expenses only from the portion of Mr. Latham's settlement intended to cover past medical expenses, or if it can also recover from the portion representing future medical expenses, regardless of how the specific dollar amounts of those two separate categories are calculated. Even so, ORS spends a significant portion of its petition detailing its arguments below about how to numerically calculate the precise amounts (the second issue). That question is simply not presented here. The Utah Supreme Court agreed with Mr. Latham that ORS could only collect from the portion of the settlement attributable to past medical expenses, and then remanded the case for the district court to decide in the first instance what portion of the $800,000 settlement was actually attributable to past medical expenses. Pet. App. 20a.

representing liability for both his past and future medical expenses. The district court reasoned that this Court's opinion in *Ahlborn* did not expressly limit the term "medical expenses" to "past medical expenses," and it "decline[d] to impose a qualification not found in *Ahlborn*." Pet. App. 30a. In doing so, the district court relied upon a pre-*Wos* decision of the Idaho Supreme Court and upon a Florida lower court decision that has subsequently been reversed by the Florida Supreme Court on this very point. *Id.* at 31a. The district court also relied upon a Utah case predating *Ahlborn* by almost two decades that discussed the Utah legislature's intent for "public funds [to] have priority" over "medical recipients' need to be compensated for their injuries." *Id.* at 31a-32a. (quoting *Camp v. ORS*, 779 P.2d 242 (Utah Ct. App. 1989)). The district court also agreed with ORS on the means of actually calculating how much of the settlement constituted past and future medical expenses, and awarded ORS $69,376.88, a full recovery of its estimated past medical expenses reduced by attorney's fees. *Id.* at 32a.

On a direct appeal from the trial court, the Utah Supreme Court reversed, joining "the majority of courts that have held that states may collect from only the portion of a [Medicaid] recipient's settlement award representing past medical expenses." Pet. App. 10a. It explained that "[t]he *Ahlborn* decision helps resolve this issue" by "interpret[ing] section 1396a(a)(25)(H) as limiting the scope of an assignment of rights," specifically by *not* sanctioning an assignment of a recipient's rights to damages for purposes other than those specifically spelled out in the statute. *Id.* at 14a.

The Utah Supreme Court reasoned that, given the plain text of the Medicaid Act's assignment-of-rights provisions, *Ahlborn* recognized a statutory "ceiling [that] limits [ORS's] lien to the portion of a settlement representing past medical expenses." *Id.* at 14a-15a.

The Utah Supreme Court further explained that under the particular facts of this case, "ORS is not attempting to collect future medical expenses that Medicaid may or may not pay on behalf of Latham," and thus "under the Supreme Court's logic in *Ahlborn*, that is precisely why ORS may not place a lien on any of Latham's settlement allocable to future medical expenses." *Id.* at 17a. It also reasoned that the provision of the Medicaid Act defining the scope of assignment of recovery rights, 42 U.S.C. § 1396a(a)(25)(H), limits a separate provision directing that a Medicaid recipient receive the "remainder" of amount collected under assignment of a recipient's rights once the State has been reimbursed, 42 U.S.C. § 1396k(b). *Id.* at 16a. The Utah Supreme Court then remanded "for a determination of the portion of Latham's settlement that is fairly allocable to past medical expenses." *Id.* at 21a-22a.

ARGUMENT

ORS insists that a State may recover the entirety of its *past* medical expenses from a Medicaid beneficiary by laying claim to the portion of a beneficiary's settlement intended to cover *future* medical expenses not yet incurred. No state court of last resort has accepted this argument for the past decade, as it is clearly contrary to statutory text, congressional purpose, and this Court's common-sense reasoning in

Ahlborn and *Wos*. State courts are coalescing by themselves on the appropriate result, as the Utah Supreme Court did in the decision below. This Court's intervention is unnecessary.

In *Ahlborn*, this Court rejected an argument that a state Medicaid agency may "recover the entirety of the costs it paid on [a] Medicaid recipient's behalf" by claiming "more than just the portion of a judgment or settlement that represents payment for medical expenses." *Ahlborn*, 547 U.S. at 278. This Court held that the plain text of the Medicaid statute limits the agency's recovery to "the third party tortfeasor's particular liability . . . 'for such health care items or services'" that "'the State plan for medical assistance for health care items or services furnished to'" the beneficiary. *Id.* at 281 (quoting 42 U.S.C. § 1396a(a)(25)(H)). In *Wos*, this Court provided further guidance that, again, rejected the argument that a State can maximize its recovery of past medical expenses from a Medicaid beneficiary without regard for what portion of the beneficiary's settlement actually represents such expenses. *See Wos*, 568 U.S. at 636. *Wos* affirmed a lower court decision that explained that "*Ahlborn* is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care already received." *E.M.A. ex rel. Plyler*, 674 F.3d at 307.

Particularly in light of the guidance this Court has already provided in *Ahlborn* and *Wos*, the petition for certiorari should be denied, for three reasons.

First, ORS's claim of a conflict among state supreme

courts is overblown. The one state supreme court decision it cites as conflicting with the decision below barely addressed the question presented and, more critically, pre-dated this Court's decision in *Wos*. No state court of last resort or federal appeals court has ruled contrary to the Utah Supreme Court since *Wos* was decided, a fact that strongly suggests further percolation will eradicate any conflict that exists. In addition, the CMS has yet to issue guidance on this issue—as it did post-*Wos*—and such guidance might well by itself eliminate any disagreement.

Second, the question presented is of minimal financial importance to state Medicaid agencies, and in any event can be solved as a matter of contract. Indeed, Utah law requires ORS to consent to an individual suing for past medical expenses that were covered by Medicaid. ORS participated in the settlement negotiations after entering into a collection agreement with Mr. Latham, and it had the opportunity to avoid this dispute simply by insisting upon a negotiated allocation of settlement funds.

Third, the decision below is correct. ORS may pursue reimbursement for past medical expenses against third parties directly or, in a narrow exception to the Medicaid Act's anti-lien provision, by the assignment of rights of a Medicaid recipient pursuing the recipient's own lawsuit. Utah Code §§ 26-19-401, -403; 42 U.S.C. § 1396a(a)(25)(H). When ORS seeks recovery of past medical expenses via an assignment of rights, it enjoys the "rights of [the] individual to payment . . . for [Medicaid] services" "to the extent of [the third party's] legal liability" for those services. 42

U.S.C. § 1396a(a)(25)(H); *id.* § 1396a(a)(25)(A)-(B). But ORS may not lay claim to the Medicaid recipient's other property, including other portions of the settlement proceeds. 42 U.S.C. § 1396p; *Ahlborn*, 547 U.S. at 278; *Wos*, 568 U.S. at 633. Thus, ORS may recover past medical expenses from the portion of a settlement allocated to pay a third party's liability for the individual's past medical expenses. ORS cannot reimburse itself from settlement funds allocated to other purposes, including funds allocated to Mr. Latham to pay his extensive future medical expenses. This common-sense approach is, in the words of the Florida Supreme Court, "compelled by *Ahlborn* and *Wos*," and by "the plain language of the Medicaid Act." *Giraldo v. Agency of Health Care Admin.*, 248 So. 3d 53, 56 (Fla. 2018).

I. This Court's Intervention Is Unnecessary And, At A Minimum, Premature.

In petitioning for this Court's review, ORS claims the lower courts are deeply divided and in need of more guidance. That is not correct. This Court has twice given direction to lower courts and, as a result, those courts are steadily converging on the position adopted by the Utah Supreme Court. Moreover, to the extent that any conflict persists, CMS, the expert agency that administers the Medicaid program, can and should first be given the opportunity to provide guidance that will most likely eradicate any disagreement in the lower courts and, at a minimum, provide this Court with valuable substantive information on the question presented.

A. Post-*Wos*, courts are in uniform agreement on the question presented, and any conflict is likely to resolve with further percolation.

ORS argues that state supreme courts are split 3-to-1 on the question presented, but the Idaho Supreme Court's barely-reasoned decision from which all subsequent state supreme courts have diverged provides no basis for this Court to grant certiorari. In *In re Matey*, a minor suffered traumatic brain injuries as a result of a car accident, and his post-accident care was paid for by Medicaid. 213 P.3d at 390. The minor's parents settled for one-sixteenth of their estimated claim with their insurance company which, as a condition of settlement, required court approval and allocation of the funds to a special needs trust. *Id.* at 391. The trial court established the trust after allocating to the state Medicaid agency $4,817.88, which represented one-sixteenth of the agency's past medical expenditures, less attorney's fees. *Id.* On appeal, the Idaho Supreme Court rejected the agency's argument that, under the Idaho law, it should have been reimbursed for the full amount it spent on the minor's medical care. *Id.* at 392-93. However, in a single paragraph, the court also concluded that because *Ahlborn* used the term "medical expenses" without making a "distinction between damages for past medical care and those for future medical care," the State could "be reimbursed out of a Medicaid recipient's award for future medical expenses." *Id.* at 394. *In re Matey* was the first post-*Ahlborn* opinion of a state supreme court to consider the question

presented in ORS's petition. In the decade since, every state court of last resort has gone the other way, including in the decision below. *See Giraldo*, 248 So. 3d at 56; *In re E.B.*, 729 S.E.2d 270, 298 (W. Va. 2012).

The first such decision was issued by the West Virginia Supreme Court in 2012. *In re E.B.* arose from a medical malpractice settlement on behalf of an infant injured at birth whose care was subsequently covered by Medicaid. 729 S.E.2d at 276. In a detailed, 54-page opinion, the West Virginia Supreme Court closely examined this Court's reasoning in *Ahlborn* and concluded that decision "is properly understood to prohibit recovery by the State of more than the amount of settlement proceeds representing payment for medical care already received." *Id.* at 289. In reaching its holding, the West Virginia Supreme Court also relied extensively upon *E.M.A. ex rel. Plyler*, which this Court affirmed in *Wos*. *See id.* at 290 (quoting *E.M.A. ex rel. Plyler*'s holding that "federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses").

Last year, the Florida Supreme Court adopted the same view. In *Giraldo*, a Medicaid recipient was severely injured in an all-terrain vehicle accident and later died. *Giraldo*, 248 So. 3d at 54-55. The Florida intermediate appeals court had relied on *In re Matey* to conclude that that the State could collect its past medical expenses "from the sums that [the beneficiary] recover[ed] for both past and future medical expenses," a holding that was then rejected by a different Florida appeals court. *See Giraldo v. Agency for Health Care*

Admin., 208 So. 3d 244 (Fla. 1st DCA 2016), *disagreed with by Willoughby v. Agency for Health Care Admin.*, 212 So. 3d 516 (Fla. 2d DCA 2017). The Florida Supreme Court took the *Giraldo* case expressly to resolve this conflict. It began by closely analyzing the statutory language of 42 U.S.C. § 1396a(a)(25)(H), which provides, "*[t]o the extent that payment has been made under the State plan for medical assistance for health care items* or services *furnished* to an individual," the State acquires the rights of a Medicaid beneficiary to payment "by any other party *for such health care items*." *Giraldo*, 248 So. 3d at 56 (quoting 42 U.S.C. § 1396a(a)(25)(H) (emphasis in opinion)). The Florida Supreme Court "s[aw] no reasonable way to read this language as giving states a right to assignment of that portion of a tort recovery from which the injured party will be expected to pay his or her anticipated medical expenses in the future, without aid from the government." *Id.* The court explained that its reading "appears to be compelled by *Ahlborn* and *Wos*," but even if not, it is compelled by "the plain language of the Medicaid Act." *Id.*

In the decision below, the Utah Supreme Court has now joined Florida and West Virginia in rejecting *In re Matey's* holding. Thus, over the past ten years, and all the more so in the seven years since *Wos*, no state court of last resort has agreed with ORS's position. An overwhelming consensus is forming to the contrary. Indeed, the only federal decisions adopting ORS's position are two 2011 district court opinions that predated *Wos* as well as *Giraldo* and *E.B.*, and that relied heavily on *In re Matey*. *See I.P. ex rel. Cardenas*

v. Henneberry, 795 F. Supp. 2d 1189, 1197 (D. Colo. 2011); *Special Needs Trust for K.C.S. v. Folkemer*, No. 08:10-cv-1077, 2011 WL 1231319 (D. Md. Mar. 28, 2011). Thus, there is every reason to believe that with further percolation the Idaho Supreme Court will reconsider its decision in light of the binding precedent of *Wos* and persuasive authority from every state supreme court to consider the issue since *In re Matey*.

In short, what ORS attempts to characterize as a "split" is, in truth, a consistent pattern of state courts moving away from the outdated single paragraph in *In re Matey*, and relying upon statutory text and this Court's decisions in *Ahlborn* and *Wos* to correctly reject ORS's position on the merits. This Court's intervention is not required at this time.

B. Any dispute on the question presented could, and should, first be addressed by the Center for Medicare and Medicaid Services.

This Court's intervention would also be premature for a second, independent reason: CMS, the federal agency tasked with administering the Medicaid statute at issue here, has offered no view on the matter. ORS admits as much in its petition. Pet. 14.

This Court has often abstained from statutory interpretation in favor of the agency charged with administering the statute, an approach "which seeks to produce better informed and uniform legal rulings by allowing courts to take advantage of an agency's specialized knowledge, expertise, and central position within a regulatory regime." *Pharm. Research & Mfrs.*

of Am. v. Walsh, 538 U.S. 644, 646 (2003). This is particularly appropriate under the Medicaid statute, for which "Congress conferred on the Secretary [of Health and Human Services] exceptionally broad authority to prescribe standards for applying certain sections of the Act." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981); *see also Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1395 (2015) ("When the agency has made a determination with respect to . . . the validity of a State's procedures for implementing its Medicaid plan, that determination should be accorded the appropriate deference."). "[W]here the [Medicaid] law and the Secretary are silent on a specific question, it is up to the States—sometimes informally advised by [CMS]—to make sense of it all in running their programs." *Wos*, 568 U.S. at 648 (Roberts, C.J., dissenting).

CMS is entirely capable of providing such advice regarding the scope of the exception to Medicaid's anti-lien provision at issue here; indeed, it issued informal guidance on this provision following *Ahlborn*. *See* Memorandum from Gale Arden, Director of CMS's Center for Medicaid and State Operations Disabled and Elderly Health Programs Group (DEHPG) to all Associate Regional Administrators for Medicaid and State Operations, re: State Options for Recovery Against Liability Settlements in Light of U.S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn* (July 3, 2006). But CMS has yet to provide guidance on the question presented, perhaps because of the growing consensus in state courts of last resort discussed above. Regardless, to the extent any

conflict persists, CMS will be able to weigh in with regulation or informal guidance informed by its detailed understanding of Medicaid's complex operations.

For this Court to intervene now, before CMS has seen fit to express its view, would "ha[ve] the unfortunate consequence of denying flexibility to . . . the Secretary of Health and Human Services [] in resolving a policy question." *Wos*, 568 U.S. at 647 (Roberts, C.J., dissenting).

II. The Question Presented Has A Minimal Financial Impact On State Medicaid Agencies And Can, In Any Event, Be Resolved Via Contract.

As ORS admits, over the past decade the Utah state Medicaid agency has recovered only $32 million under third-party liability provisions, or an average of $3.2 million per year. This might appear to be sizable until it is put in context of Utah's annual Medicaid expenditures, which in FY 2017 totaled almost $2.7 *billion* for just one year. Utah Dep't of Health, *Utah Annual Report of Medicaid and Chip, State Fiscal Year 2017* 6 (2018), https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport_2017.pdf. Even if this Court were to grant the petition, a holding in favor of ORS on these facts would impact so few cases that its actual effect on Utah's Medicaid budget would be nearly negligible.

Moreover, review of the Utah Supreme Court's decision is particularly unnecessary here given that Utah's statutory scheme already allows ORS itself to

achieve precisely the outcome it desires. Writing for a unanimous court in *Ahlborn*, Justice Stevens specifically addressed a concern raised by proponents of full reimbursement: that "in cases where the parties . . . settle without judicial oversight or input from the State," the settlement could be manipulated to "allocate away the State's interest." *Ahlborn*, 547 U.S. at 287-88. This "can be avoided," the Court explained, "either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court." *Id.* at 288.

That is precisely what the particular Utah statutory scheme provides for, and is the process ORS followed here in entering the collection agreement and participating in settlement negotiations. In Utah, a Medicaid recipient may not "settle . . . a claim against a third party for recovery of medical costs . . . for which the department has provided or has become obligated to provide medical assistance, without [ORS's] written consent." Utah Code § 26-19-403(1)(a). To facilitate ORS's recovery of such costs, Utah law provides for a Medicaid recipient and ORS to enter into a collection agreement, which allows the recipient to include "medical expenses paid by the department" in their suit and requires the recipient's attorney to "represent the state's claim." *Id.* § 26-19-403(2)(c)(i), (3)(a)(i). If a recipient fails to notify ORS of the suit and seek consent as required by the Utah Code, ORS "is not bound by any . . . settlement or compromise rendered or made on the claim or in the action." Utah Code § 26-19-404(2)(a).

Mr. Latham and ORS entered such a collection

agreement here. ORS participated in the settlement discussions, and it had the opportunity to negotiate a stipulated allocation of the portion of the settlement from which it could recover its past medical expenses. There is no need for this Court to step in and guarantee ORS a full recovery when it is already empowered to protect its interests by participating in and enjoying a right to approve any third-party settlement.

III. The Decision Below Is Correct.

The Utah Supreme Court's holding is compelled by the plain text of the Medicaid statute, this Court's decisions in *Ahlborn* and *Wos*, and the incongruity of ORS's position as demonstrated by specific facts of Mr. Latham's case.

First, a state Medicaid agency is only required to collect its past expenses "where a third party has a *legal liability* to make payment for such assistance," 42 U.S.C. § 1396a(a)(25)(H) (emphasis added), and must "seek reimbursement for such assistance to the extent of such *legal liability*," 42 U.S.C. § 1396a(a)(25)(A)-(B) (emphasis added). ORS implies, incorrectly, that it has no choice but to seek reimbursement to the full extent of its pre-settlement estimate of $104,065.32 that it agreed upon with Mr. Latham. Pet. 3-4. But the plain meaning of "legal liability" in the Medicaid statute requires ORS to recover only the amount of past medical expenses for which the third party is actually legally liable, i.e., under the settlement agreement, not the amount the agency and a plaintiff come up with on their own. "Legal liability" was fixed at settlement, when the defendant hospital assumed liability of $800,000 total. In this case, the allocation of that

$800,000 in liability among Mr. Latham's various damages categories has not yet been made. Thus, the amount of the hospital's "legal liability" for ORS's past medical expenses has not been determined, and allowing ORS to assert a presumption that its "[e]stimated" pre-settlement costs must determine its post-settlement recovery assumes the conclusion. Complaint Ex. C. It also poses the same risk of arbitrarily encumbering a beneficiary's property that this Court rejected in *Wos*. *See* 568 U.S. at 636-37.

Further, the Medicaid statute permits ORS to acquire "the rights of [the] individual to payment by any other party for such health care items or services" that were "furnished to [the] individual" by Medicaid. 42 U.S.C. § 1396a(a)(25)(H). ORS can therefore recover only to the extent of Mr. Latham's own right to recover for past medical expenses paid by Medicaid. By definition, if ORS recoups past medical expenses beyond the amount of past medical expenses to which Mr. Latham is entitled—as it would do by taking funds from funds designated for future medical expenses—it would exceed its assignment authority under the Medicaid statute. As this Court explained in *Ahlborn*, such an assignment is a permissible "exception to the anti-lien provision" only if the "assignment is expressly authorized by the terms of 42 U.S.C. § 1396a(a)(25) and 1396k(a)." 547 U.S. at 284.

Second, ORS argues that the decision below renders 42 U.S.C. § 1396k(b) a "nullity." Pet. 18. But this "rest[s] on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed any third-party

recovery earmarked for medical expenses"—an assumption was expressly debunked by this Court in *Ahlborn*. *Ahlborn*, 547 U.S. at 282 n.11. As this Court explained in rejecting an argument ORS repeats here, "the recipient often will have paid medical expenses out of her own pocket." *Id.* Thus, a "remainder" could readily exist under § 1396k(b) even if the State agency is limited to compensation for its past medical expenses from the portion of a settlement intended to cover past medical expenses.

Third, even to the extent the text and this Court's decisions in *Ahlborn* and *Wos* suggest any ambiguity, the facts of Mr. Latham's case demonstrate that ORS's position is untenable. There is no dispute that Mr. Latham is no longer a Medicaid recipient and, as a result, that Utah's state Medicaid agency is not obligated to cover his future medical costs. This circumstance was material to the Utah Supreme Court, which explained that "ORS is not attempting to collect future medical expenses that Medicaid may or may not pay on behalf of Latham," and thus "under the Supreme Court's logic in *Ahlborn*, that is precisely why ORS may not place a lien on any of Latham's settlement allocable to future medical expenses." Pet. App. 17a.

When Medicaid has no responsibility for a former recipient's future medical costs, there is no basis for it to reimburse itself out of funds designated to cover those costs. Indeed, ORS's approach would be particularly perverse in Mr. Latham's personal situation. With one hand, Utah's state Medicaid agency has taken away coverage of Mr. Latham's future

medical expenses because he is deemed capable of paying those costs with his settlement funds, most of which, as ORS admits, are intended cover future expenses. But with the other hand, ORS would simultaneously reach into those very funds to fully compensate the State for its past expenses. Further, under these specific facts, ORS would have the State receive all the benefits of Mr. Latham's work to settle the case under circumstances where he was statutorily required to assign his rights to ORS, but without ORS bearing any of the discount that accompanied the settlement.

The absurdity of the mismatch between the category of damages ORS seeks to recover and the categories it seeks to draw from is clear from the facts of this case. The Utah Supreme Court's holding, in line with all other state supreme court decisions over the past decade, was correct as a matter of statutory text and common sense.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

PAUL R. SMITH
MICHAEL JUDD
JONES WALDO HOLBROOK & MCDONOUGH, PC
170 S. Main Street
Suite 1500
Salt Lake City, UT 84101
(801) 375-9801

ISHAN K. BHABHA
Counsel of Record
ADRIENNE LEE BENSON
JENNER & BLOCK LLP
1099 New York Ave., NW
Suite 900
Washington, DC 20001
(202) 639-6000
ibhabha@jenner.com