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142 S.Ct. 1751
Supreme Court of the United States.

Gianinna GALLARDO, an incapacitated person, BY AND THROUGH her parents and co-guardians Pilar VASSALLO and Walter Gallardo, Petitioner
v.
Simone MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration

No. 20-1263
|
Argued January 10, 2022
|
Decided June 6, 2022

Synopsis
Background: **Medicaid** recipient, who suffered catastrophic injuries resulting in permanent disability when she was struck by vehicle after stepping off her school bus, brought § 1983 action, through her parents, against Secretary of Florida Agency for Health Care Administration (FAHCA), seeking declaration that FAHCA was violating **Medicaid** Act by trying to recover its **Medicaid** expenses, pursuant to Florida's **Medicaid** Third-Party Liability Act, from portions of settlement proceeds in personal injury action against responsible parties that compensated recipient for future, as opposed to past, medical expenses. The United States District Court for the Northern District of Florida, No. 4:16-cv-00116, Mark E. Walker, J., 263 F.Supp.3d 1247, granted recipient summary judgment, and, 2017 WL 3081816, granted in part and denied in part FAHCA's motion to alter or amend judgment. FAHCA appealed. The United States Court of Appeals for the Eleventh Circuit, Branch, Circuit Judge, 963 F.3d 1167, reversed and remanded, and, 977 F.3d 1366, denied rehearing and rehearing en banc. Certiorari was granted.

Holdings: The Supreme Court, Justice Thomas, held that:

[1] **Medicaid** Act's anti-lien provision did not preempt Florida's **Medicaid** Third-Party Liability Act, and

[2] under **Medicaid** Act provision requiring a state to acquire from each **Medicaid** recipient an assignment of any rights of the individual to payment for medical care from any third party, a state may seek reimbursement of its

Gallardo By and Through Vassallo v. Marstiller, 142 S.Ct. 1751 (2022)

213 L.Ed.2d 1, Med & Med GD (CCH) P 307,377, 22 Cal. Daily Op. Serv. 5541...

Medicaid expenses from tort settlement amounts representing payment for medical care, past or future, abrogating *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53.

Affirmed.

Justice Sotomayor filed dissenting opinion, in which Justice Breyer joined.

Procedural Posture(s): Petition for Writ of Certiorari; On Appeal; Request for Declaratory Judgment.

West Headnotes (8)

[1] **Health**Settlements or judgments, recovery from
StatesSocial security and public welfare

Because a **Medicaid** recipient has a property right in the proceeds of any personal injury settlement, the **Medicaid** Act provision prohibiting states from placing liens against a **Medicaid** recipient's property to recover **Medicaid** expenses protects settlements from states' reimbursement efforts absent some statutory exception. Social Security Act §§ 1912, 1917, 42 U.S.C.A. §§ 1396k(a)(1)(A), 1396p(a)(1).

[2] **Health**Settlements or judgments, recovery from

State laws requiring a **Medicaid** recipient's assignment of the right to receive payments from third parties for medical care are expressly authorized as an exception to the **Medicaid** Act provision prohibiting states from placing liens against a **Medicaid** recipient's property to recover **Medicaid** expenses. Social Security Act §§ 1902, 1912, 1917, 42 U.S.C.A. §§ 1396a(a)(25)(H), 1396k(a)(1)(A), 1396p(a)(1).

[3] **Health**Settlements or judgments, recovery from

As an exception to the **Medicaid** Act provision prohibiting states from placing liens against a **Medicaid** recipient's property to recover **Medicaid** expenses, a state may seek reimbursement from the portion of a personal injury settlement designated for the medical care of the recipient. Social Security Act §§ 1902, 1912, 1917, 42 U.S.C.A. §§ 1396a(a)(25)(H), 1396k(a)(1)(A), 1396p(a)(1).

[4] **Health** Preemption
Health Settlements or judgments, recovery from
States Social security and public welfare

Medicaid Act provision prohibiting states from placing liens against a **Medicaid** recipient's property to recover **Medicaid** expenses did not preempt provisions of Florida's **Medicaid** Third-Party Liability Act authorizing Florida Agency for Health Care Administration (FAHCA) to seek reimbursement of its **Medicaid** expenses from portions of tort settlement proceeds that represented all medical expenses, both past and future; **Medicaid** Act required states to acquire from each **Medicaid** recipient an assignment of any rights of the individual to payment for medical care from any third party, such reimbursement requirement was exception to **Medicaid** Act's anti-lien provision, and reimbursement requirement was not limited to payment for past medical care. Social Security Act §§ 1912, 1917, 42 U.S.C.A. §§ 1396k(a)(1)(A), 1396p(a)(1); Fla. Stat. Ann. §§ 409.910(4), 409.910(6)(b), 409.910(6)(c), 409.910(17)(b).

[5] **Health** Settlements or judgments, recovery from

Under the **Medicaid** Act provision requiring a state to acquire from each **Medicaid** recipient an assignment of any rights of the individual to

payment for medical care from any third party, a state may seek reimbursement of its **Medicaid** expenses from tort settlement amounts representing payment for medical care, past or future; abrogating *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53. Social Security Act § 1912, 42 U.S.C.A. § 1396k(a)(1)(A).

[6] **Health**Third Persons, Recovery from

The relevant distinction for purposes of the **Medicaid** Act provision requiring a state to acquire from each **Medicaid** recipient an assignment of any rights of the individual to payment for medical care from any third party is between medical and nonmedical expenses, not between past **Medicaid** expenses a state has paid and future expenses it has not. Social Security Act § 1912, 42 U.S.C.A. § 1396k(a)(1)(A).

[7] **Statutes**Express mention and implied exclusion; expressio unius est exclusio alterius

In construing a statute, a court must give effect to, not nullify, Congress' choice to include limiting language in some provisions but not others.

[8] **Assignments**Nature and extent of rights of assignee in general

Assignments typically cover only those rights possessed by the assignors at the time of the assignments.

***1752** *Syllabus*[*]

Petitioner Gianinna Gallardo suffered catastrophic injuries resulting in permanent disability when a truck struck her as she stepped off her Florida school bus. Florida's **Medicaid** agency paid $862,688.77 to cover Gallardo's initial medical expenses, and the agency continues to pay her medical expenses. Gallardo, through her parents, sued the truck's owner and driver, as well as the Lee County School Board. She sought compensation for past medical expenses,

future medical expenses, lost earnings, and other damages. That litigation resulted in a settlement for $800,000, with $35,367.52 expressly designated as compensation for past medical expenses[1]. The settlement did not specifically allocate any amount for future medical expenses.

The **Medicaid** Act requires participating States to pay for certain needy individuals' medical costs and then to make reasonable efforts to recoup those costs from liable third parties. 42 U.S.C. § 1396k(a)(1)(A). Under Florida's **Medicaid** Third-Party Liability Act, a beneficiary like Gallardo who "accept[s] medical assistance" from **Medicaid** "automatically assigns to the [state] agency any right" to third-party payments for medical care. Fla. Stat. § 409.910(6)(b). Applied to Gallardo's settlement, Florida's statutory framework entitled the State to $300,000—*i.e.*, 37.5% of $800,000, the percentage the statute sets as presumptively representing the portion of the tort recovery that is for "past and future medical expenses," absent clear and convincing rebuttal evidence. §§ 409.910(11)(f)(1), (17)(b).[2] Gallardo challenged the presumptive allocation in an administrative proceeding. She also brought this lawsuit seeking a declaration that Florida was violating the **Medicaid** Act by trying to recover from portions of the settlement compensating for future medical expenses. The Eleventh Circuit concluded that the relevant **Medicaid** Act provisions do not prevent a State from seeking reimbursement from settlement monies allocated for future medical care. 963 F.3d 1167, 1178.

Held: The **Medicaid** Act permits a State to seek reimbursement from settlement payments allocated for future medical care. Pp. 1757 - 1761.

(a) Gallardo argues that the **Medicaid** Act's anti-lien provision—which prohibits States from recovering medical payments from a beneficiary's "property," § 1396p(a)(1)—forecloses recovery from settlement amounts other than those allocated for past medical care paid for by **Medicaid**. But this Court has held that the provision does not apply to state laws "expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a)" of the **Medicaid** Act. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 284, 126 S.Ct. 1752, 164 L.Ed.2d 459. Here, Florida's **Medicaid** Third-Party Liability Act—under which Florida may seek reimbursement from settlement amounts representing "payment for medical care," past or future—"is expressly authorized by the terms of ... [§]1396k(a)" and thus falls squarely within the "exception to the anti-lien provision" that this Court has recognized. *Ibid.*

The plain text of § 1396k(a)(1)(A) decides this case. Nothing in § 1396k(a)(1)(A) limits a beneficiary's assignment to payments for *past* "medical care" already paid for by **Medicaid**. To the contrary, the grant of "any rights ... to payment for medical care" most naturally covers not only rights to payment for past medical expenses, but also rights to payment for future medical expenses. § 1396k(a)(1)(A); see *United States v. Gonzales*, 520 U.S. 1, 5, 117 S.Ct. 1032, 137 L.Ed.2d 132. The relevant distinction is thus "between medical and nonmedical expenses," *Wos v. E. M. A.*, 568 U.S. 627, 641, 133 S.Ct. 1391, 185 L.Ed.2d 471, not between past and future medical expenses.

[1] Shawn Majette note 8/2022: Parties' express allocation for past damages was $35,367.00, less than 12%.
[2] Shawn Majette note 8/2022: Formula from Medicaid plan was 37.5%, more than 3x the parties' express finding.

Statutory context reinforces that § 1396k(a)(1)(A)'s reference to "payment for medical care" is not limited as Gallardo suggests. For example, when the **Medicaid** Act separately requires state plans to comply with § 1396k, it describes that provision as imposing a "mandatory assignment of rights of payment for *medical* support and other *medical* care owed to recipients." § 1396a(a)(45) (emphasis added). Section 1396a(a)(45) thus distinguishes only between medical and nonmedical care, not between past (paid) medical care payments and future (unpaid) medical care payments. If Congress had intended to draw such a distinction, "it easily could have drafted language to that effect." *Mississippi ex rel. Hood v. AU Optronics Corp.*, 571 U.S. 161, 169, 134 S.Ct. 736, 187 L.Ed.2d 654. In fact, Congress did include more limiting language elsewhere in the **Medicaid** Act. Section 1396a(a)(25)(H), which requires States to enact laws granting themselves automatic rights to certain third-party payments, contains precisely the limitation that Gallardo would read into the assignment provision. Thus, if § 1396k(a)(1)(A)'s broad language alone were not dispositive, its contrast with the limiting language in § 1396a(a)(25)(H) would be. Pp. 1757 - 1759.

(b) Gallardo's arguments that § 1396k(a)(1)(A) has a different meaning are unconvincing. Gallardo construes the prefatory clause to § 1396k(a)(1)(A)— which provides that the "purpose" of the assignment provision is to "assis[t] in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan"—to limit the assignment provision to payments that are already "owed" for "past medical care provided under the [state] plan." Brief for Petitioner 30. But the prefatory clause defines to whom the third-party payments are "owed"—"recipients of medical assistance under the State plan." It does not specify the purpose for which those payments must be made, referring to "medical support" and "medical care" payments, consistent with the adjacent language in § 1396k(a)(1)(A).

Gallardo also proposes that the Court read the assignment provision to incorporate the more limited language in § 1396a(a)(25)(H). But the Court must give effect to, not nullify, Congress' choice to include limiting language in some provisions but not others, see *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17. *Ahlborn*, which Gallardo contends eliminated any daylight between § 1396a(a)(25)(H) and § 1396k(a)(1)(A), was clear that these two provisions "ech[o]" or "reinforc[e]" each other insofar as they both involve "recovery of payments for medical care," 547 U.S. at 282, 126 S.Ct. 1752, and not "payment for, for example, lost wages," *id.*, at 280, 126 S.Ct. 1752. *Ahlborn* did not suggest that these provisions must be interpreted in lockstep. Gallardo's idea that one of these two complementary provisions must "prevail" over the other is therefore mistaken. The complementary provisions concern different requirements; they do not conflict just because one is broader than the other.

Gallardo and the United States also argue that § 1396k(a)(1)(A) should be interpreted consistently with §§ 1396a(a)(25)(A) and (B), which require a State to seek reimbursement "to the extent of " a third party's liability "for care and services available under the plan." But the relevant language—"pay[ment] for care and services available under the plan"—could just as readily refer to payment for medical care "available" in the future. Regardless, Congress did not use this language to define the scope of an assignment under § 1396k(a)(1)(A), implying again that the provisions should not be interpreted the same way. This implication is strengthened by the fact that § 1396k(a)(1)(A) was enacted after §§ 1396a(a)(25)(A) and (B), and Congress did not use the existing language in §§ 1396a(a)(25)(A) and (B) to define the scope of the mandatory assignment.

Finally, Gallardo's two policy arguments for her preferred interpretation both fail. First, citing a footnote from *Ahlborn*, she contends that it would be " 'absurd and fundamentally unjust' " for a State to " 'share in damages for which it has provided no compensation.' " 547 U.S. at 288, n. 19, 126 S.Ct. 1752. But the Court's holding there was dictated by the **Medicaid** Act's "text," not by the Court's sense of fairness. *Id.*, at 280, 126 S.Ct. 1752. Second, Gallardo speculates that the Court's reading of § 1396k(a)(1)(A) would authorize a "lifetime assignment" covering not only the rights an individual has while a **Medicaid** beneficiary but also any rights acquired in the future when the individual is no longer a **Medicaid** beneficiary. Not so. The provision is most naturally read as covering those rights "the individual" possesses while on **Medicaid**. And given background legal principles about the scope of assignments, § 1396k(a)(1)(A) cannot be read to cover the sort of "lifetime assignment" Gallardo invokes. Pp. 1759 -1761.[3]

963 F.3d 1167, affirmed.

THOMAS, J., delivered the opinion of the Court, in which ROBERTS, C. J., and ALITO, KAGAN, GORSUCH, KAVANAUGH and BARRETT, JJ., joined. SOTOMAYOR, J., filed dissenting opinion in which, BREYER, J., joined.

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Opinion

Justice THOMAS delivered the opinion of the Court.

Medicaid requires participating States to pay for certain needy individuals' medical costs and then to make reasonable efforts to recoup those costs from liable third parties. Consequently, a State must require **Medicaid** beneficiaries to assign the State "any rights ... to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). That

[3] Shawn Majette note 8/2022: if injured party withdraws from Medicaid after treatment but before settlement will this non-lifetime assignment prevent application of future benefits? If the injured party can create a 1396p trust or complete a 1396p transfer to a third party with the otherwise at risk proceeds and then apply for Medicaid benefits?

assignment permits a State to seek reimbursement from the portion of a beneficiary's private tort settlement that represents "payment for medical care," *ibid.*, despite the **Medicaid** Act's general prohibition against seeking reimbursement from a beneficiary's "property," § 1396p(a)(1). The question presented is whether § 1396k(a)(1)(A) permits a State to seek reimbursement from settlement payments allocated for future medical care. We conclude that it does.

I

A

States participating in **Medicaid** "must comply with [the **Medicaid** Act's] requirements" or risk losing **Medicaid** funding. *Harris v. McRae*, 448 U. S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980); see ***1756** 42 U.S.C. § 1396c. Most relevant here, the **Medicaid** Act requires a State to condition **Medicaid** eligibility on a beneficiary's assignment to the State of "any rights ... to support ... for the purpose of medical care" and to "payment for medical care from any third party." § 1396k(a)(1)(A); see also § 1396a(a)(45) (mandating States' compliance with § 1396k). The State must also enact laws by which it automatically acquires a right to certain third-party payments "for health care items or services furnished" to a beneficiary. § 1396a(a)(25)(H). And the State must use these (and other) tools to "seek reimbursement" from third parties "to the extent of [their] legal liability" for a beneficiary's "care and services available under the plan." §§ 1396a(a)(25)(A)–(B).

[1] [2] [3] The **Medicaid** Act also sets a limit on States' efforts to recover their expenses. The Act's "anti-lien provision" prohibits States from recovering medical payments from a beneficiary's "property." § 1396p(a)(1); see also § 1396a(a)(18) (requiring state **Medicaid** plans to comply with § 1396p). Because a "beneficiary has a property right in the proceeds of [any] settlement," the anti-lien provision protects settlements from States' reimbursement efforts absent some statutory exception. *Wos v. E. M. A.*, 568 U.S. 627, 633, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013). State laws "requir[ing] an assignment of the right ... to receive payments [from third parties] for medical care," as "expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a)," are one such exception. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 284, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). Accordingly, a State may seek reimbursement from the portion of a settlement designated for the "medical care" described in those provisions; otherwise, the anti-lien provision prohibits reimbursement. *Id.*, at 285, 126 S.Ct. 1752.

B

To satisfy its **Medicaid** obligations, Florida has enacted its **Medicaid** Third-Party Liability Act, which directs the State's **Medicaid** agency to "seek reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by **Medicaid**." Fla. Stat. § 409.910(4) (2017).[1] To this end, the statute provides that when a beneficiary "accept[s] medical assistance" from

Medicaid, the beneficiary "automatically assigns to the [state] agency any right" to third-party payments for medical care. § 409.910(6)(b). A lien "for the full amount of medical assistance provided" then "attaches automatically" to any settlements related to an injury "that necessitated that **Medicaid** provide medical assistance." §§ 409.910(6)(c), (6)(c)(1), 409.901(7)(a).

Rather than permit the State to recover from a beneficiary's entire settlement, the statute entitles Florida to half a beneficiary's total recovery, after deducting 25% for attorney's fees and costs (*i.e.*, 37.5% of the total). See § 409.910(11)(f)(1). This amount presumptively represents the portion of the tort recovery that is for "past and future medical expenses." § 409.910(17)(b). Beneficiaries can rebut that presumption by proving with clear and convincing evidence "that the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by [Florida's] formula." *Ibid.*

***1757** C

In 2008, a truck struck then-13-year-old petitioner Gianinna Gallardo after she stepped off her school bus. Gallardo suffered catastrophic injuries and remains in a persistent vegetative state. Florida's **Medicaid** agency paid $862,688.77 to cover her initial medical expenses, after WellCare of Florida, a private insurer, paid $21,499.30. As a condition of receiving **Medicaid** assistance, Gallardo had assigned Florida her right to recover from third parties. Because Gallardo is permanently disabled, **Medicaid** continues to pay her medical expenses.

Gallardo, through her parents, sued the truck's owner and driver, as well as the Lee County School Board, seeking compensation for past medical expenses, future medical expenses, lost earnings, and other damages. Although Gallardo sought over $20 million in damages, the litigation ultimately settled for $800,000—a 4% recovery. The settlement expressly designated $35,367.52 of that amount as compensation for past medical expenses—4% of the $884,188.07 paid by **Medicaid** and WellCare. The settlement also recognized that "some portion of th[e] settlement may represent compensation for future medical expenses," App. 29, but did not specifically allocate any amount for future medical expenses.

Under Florida's statutory formula, the State was presumptively entitled to $300,000 of Gallardo's settlement (37.5% of $800,000). Gallardo, citing the settlement's explicit allocation of only $35,367.52 as compensation for past medical expenses, asked Florida what amount it would accept to satisfy its **Medicaid** lien. When Florida did not respond, Gallardo put $300,000 in escrow and challenged the presumptive allocation in an administrative proceeding. There, Florida defended the presumptive allocation because, in its view, it could seek reimbursement from settlement payments for past *and* future medical expenses, and so was not limited to recovering the portion Gallardo had allocated for past expenses.

While the administrative proceeding was ongoing, Gallardo brought this lawsuit seeking a declaration that Florida was violating the **Medicaid** Act by trying to recover from portions of the settlement compensating for future medical expenses. The U. S. District Court for the Northern District of Florida granted Gallardo summary judgment. See *Gallardo v. Dudek*, 263 F.Supp.3d 1247, 1260 (2017). The Eleventh Circuit reversed, concluding that "the text and

structure of the federal **Medicaid** statutes do not conflict with Florida law" because they "only prohibit a State from asserting a lien against any part of a settlement not 'designated as payments for medical care.' " *Gallardo v. Dudek*, 963 F.3d 1167, 1176 (2020) (quoting *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752). The Eleventh Circuit explained that the relevant **Medicaid** Act provisions "d[o] not in any way prohibit [a State] from seeking reimbursement from settlement monies for medical care allocated to future care." 963 F.3d at 1178 (emphasis deleted). Judge Wilson dissented, contending that the **Medicaid** Act "limit[s] the state to the part of the recovery that represents payment for past medical care." *Id.*, at 1184.

Because the Supreme Court of Florida came to the opposite conclusion of the Eleventh Circuit, see *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53, 56 (2018), we granted certiorari, 594 U. S. ——, 141 S.Ct. 2884, 210 L.Ed.2d 990 (2021).

II

[4] Gallardo argues that the Eleventh Circuit erred by permitting Florida to seek reimbursement for medical expenses ***1758** from settlement amounts representing payment for future medical care. According to Gallardo, the **Medicaid** Act's anti-lien provision in § 1396p forecloses recovery from settlement amounts other than those allocated for past medical care paid for by **Medicaid**. Thus, Gallardo concludes, the anti-lien provision preempts any state law that permits additional recovery.

[5] We disagree. Under § 1396k(a)(1)(A), Florida may seek reimbursement from settlement amounts representing "payment for medical care," past or future. Thus, because Florida's assignment statute "is expressly authorized by the terms of ... [§]1396k(a)," it falls squarely within the "exception to the anti-lien provision" that this Court has recognized. *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752.

A

[6] The plain text of § 1396k(a)(1)(A) decides this case. This provision requires the State to acquire from each **Medicaid** beneficiary an assignment of "any rights ... of the individual ... to support ... for the purpose of medical care ... and to payment for medical care from any third party." § 1396k(a)(1)(A). Nothing in this provision purports to limit a beneficiary's assignment to "payment for" *past* "medical care" already paid for by **Medicaid**. To the contrary, the grant of "*any* rights ... to payment for medical care" most naturally covers not only rights to payment for past medical expenses, but also rights to payment for future medical expenses. *Ibid.* (emphasis added); see *United States v. Gonzales*, 520 U.S. 1, 5, 117 S.Ct. 1032, 137 L.Ed.2d 132 (1997) ("[T]he word 'any' has an expansive meaning"). The relevant distinction is thus "between medical and nonmedical expenses," *Wos*, 568 U.S. at 641, 133 S.Ct. 1391, not between past expenses **Medicaid** has paid and future expenses it has not.

Statutory context reinforces that § 1396k(a)(1)(A)'s reference to "payment for medical care" is not limited as Gallardo suggests. First, when § 1396k(a)(1)(A) limits the kind of "support" (*e.g.*, child support) covered by a beneficiary's assignment, the statute does not single out support allocated for past expenses that a State has already paid. Instead, it requires only that support payments be "specified as support *for the purpose of medical care*" generally. § 1396k(a)(1)(A) (emphasis added). Second, when the **Medicaid** Act separately requires state plans to comply with § 1396k, it describes that provision as imposing a "mandatory assignment of rights of payment for *medical* support and other *medical* care owed to recipients." § 1396a(a)(45) (emphasis added). In short, § 1396k(a)(1)(A) and § 1396a(a)(45) distinguish only between medical and nonmedical care, not between past (paid) medical care payments and future (unpaid) medical care payments. If Congress had intended to draw such a distinction, "it easily could have drafted language to that effect." *Mississippi ex rel. Hood v. AU Optronics Corp.*, 571 U.S. 161, 169, 134 S.Ct. 736, 187 L.Ed.2d 654 (2014).

In fact, Congress did include such limiting language elsewhere in the **Medicaid** Act. Section 1396a(a)(25)(H), which requires States to enact laws granting themselves automatic rights to certain third-party payments, contains precisely the limitation that Gallardo would read into the assignment provision. That provision applies only when "payment has been made under the State plan for medical assistance for health care items or services *furnished* to an individual," and covers only third-party payments "for *such* health care items or services." § 1396a(a)(25)(H) (emphasis added). Thus, if § 1396k(a)(1)(A)'s ***1759** broad language alone were not dispositive, its contrast with the limiting language in § 1396a(a)(25)(H) would be. "Had Congress intended to restrict" § 1396k(a)(1)(A) to past expenses **Medicaid** has paid, it "would have done so expressly as it did in" § 1396a(a)(25)(H). *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983).

In sum, because the plain meaning of § 1396k(a)(1)(A), informed by statutory context, allows Florida to seek reimbursement from settlement amounts representing past or future "payments for medical care," Florida's assignment provision falls within the "exception to the anti-lien provision." *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752.[2]

B

Gallardo nevertheless argues that § 1396k(a)(1)(A) has a different meaning, largely by discounting the text of § 1396k(a)(1)(A) and then relying on other differently worded provisions or on policy arguments, none of which we find convincing.

Insofar as she confronts § 1396k(a)(1)(A) itself, Gallardo largely focuses on its prefatory clause, which provides that the "purpose" of the assignment provision is to "assis[t] in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan." § 1396k(a). Gallardo construes this language to limit the assignment provision to payments that are already "owed" for "*past* medical care provided under the [state] plan." Brief for Petitioner 30.

Gallardo's argument misreads the statutory text. The prefatory clause does not refer to payments "owed" "under the State plan," but rather to "payments owed *to recipients of medical assistance* under the State plan." § 1396k(a)

(emphasis added). In other words, the prefatory language Gallardo invokes defines *to whom* the third-party payments are "owed"—"recipients of medical assistance under the State plan." It does not specify *the purpose* for which those payments must be made. On that score, the prefatory clause refers to "medical support" and "medical care" payments, consistent with the adjacent language in § 1396k(a)(1)(A).

[7] With little support in the text of § 1396k(a)(1)(A), Gallardo proposes that we read the assignment provision to incorporate § 1396a(a)(25)(H)'s more limited language. But as explained above, see *supra*, at 1758 - 1759, we must give effect to, not nullify, Congress' choice to include limiting language in some provisions but not others, see *Russello*, 464 U.S. at 23, 104 S.Ct. 296. Gallardo responds that our decision in *Ahlborn* eliminated any daylight between § 1396a(a)(25)(H) and § 1396k(a)(1)(A), because we said there that these provisions "reiterat[e]," "reinforc[e]," and "ech[o]" each other. 547 U.S. at 276, 280, 281, 126 S.Ct. 1752. But *Ahlborn* was clear that these two provisions "ech[o]" or "reinforc[e]" each other insofar as they both involve "recovery of payments ***1760** for medical care," *id.*, at 282, 126 S.Ct. 1752, and not "payment for, for example, lost wages," *id.*, at 280, 126 S.Ct. 1752. *Ahlborn* did not suggest that we must otherwise interpret these provisions in lockstep.

Conceding the provisions' scope could differ, Gallardo argues that the later enacted § 1396a(a)(25)(H) should "prevai[l]" over the earlier enacted § 1396k(a)(1)(A). Brief for Petitioner 34. But Gallardo does not identify any conflict requiring one of the provisions to prevail. Both provisions require the State to obtain rights—either by assignment or by statute—to certain third-party payments. Because they concern different requirements, they do not conflict just because one is broader in scope than the other. In fact, the provisions complement each other. Section 1396k(a)(1)(A) provides a broad, but not foolproof, contractual right to third-party payments for medical care. See Brief for Respondent 33–34 (explaining circumstances when an assignment under § 1396k(a)(1)(A) might be ineffective). By contrast, § 1396a(a)(25)(H) provides a more targeted statutory right for when the assignment might fail. See Brief for United States as *Amicus Curiae* 28–29 (explaining that, prior to § 1396a(a)(25)(H)'s enactment, insurers were "thwarting [§ 1396k(a)(1)(A)] by refusing to recognize assignments and arguing that their insurance contracts forbade assignments" (internal quotation marks omitted)).[3] Thus, the idea that one of these two complementary provisions must "prevail" over the other is mistaken.

Gallardo and the United States also invoke §§ 1396a(a)(25)(A) and (B), which require States to "take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available under the [**Medicaid**] plan" and to "seek reimbursement ... to the extent of such legal liability." They argue that these provisions are the **Medicaid** Act's "main" or "anchor" third-party liability provisions and limit the State's recovery under any other provision "to the extent of " a third party's payments "for care and services available under the plan," §§ 1396a(a)(25)(A)–(B), which they interpret to include only payments for medical care that **Medicaid** has already covered. Reply Brief 6 (internal quotation marks omitted); see Brief for United States as *Amicus Curiae* 18.

This argument suffers from several problems. To begin, it is far from clear that §§ 1396a(a)(25)(A) and (B) refer only to past expenses the State has already paid. The relevant language—"pay[ment] for care and services available under the plan"—could just as readily refer to payment for medical care "available" in the future. Regardless, even if this language means what Gallardo says it does, Congress did not use this language to define the scope of an

assignment under § 1396k(a)(1)(A), implying again that the ***1761** provisions should not be interpreted the same way. See *supra*, at 1758 - 1759. This implication is strengthened by the fact that § 1396k(a)(1)(A) was enacted after §§ 1396a(a)(25)(A) and (B). It would have been easy for Congress to use the existing language in §§ 1396a(a)(25)(A) and (B) to define the scope of the mandatory assignment. But it did not.[4]

Finally, Gallardo relies on two policy arguments for her preferred interpretation. First, citing a footnote from *Ahlborn*, she contends that it would be " 'absurd and fundamentally unjust' " for a State to " 'share in damages for which it has provided no compensation.' " 547 U.S. at 288, n. 19, 126 S.Ct. 1752 (quoting *Flanigan v. Department of Labor and Industry*, 123 Wash.2d 418, 426, 869 P.2d 14, 17 (1994)). Although *Ahlborn* noted possible unfairness if States were given "absolute priority" to collect from the entirety of a tort settlement, 547 U.S. at 288, 126 S.Ct. 1752, our holding there was dictated by the **Medicaid** Act's "text," not by our sense of fairness, *id.*, at 280, 126 S.Ct. 1752. Had the text of the **Medicaid** Act authorized "absolute priority," *Ahlborn* would have been decided differently.

[8] Second, Gallardo speculates that our reading of § 1396k(a)(1)(A) would authorize a "lifetime assignment" covering not only the rights an individual has while he is a **Medicaid** beneficiary but also any rights he acquires in the future when he is no longer a **Medicaid** beneficiary. Brief for Petitioner 32. Not so. Section 1396k(a)(1)(A) only assigns "any rights ... *of the individual*" (emphasis added), which is most naturally read as covering those rights "the individual" possesses while on **Medicaid**. We must also read § 1396k(a)(1)(A)'s text in light of background legal principles, and it is blackletter law that assignments typically cover "only [those] rights possessed by the assignors at the time of the assignments," *United States v. Central Gulf Lines, Inc.*, 974 F.2d 621, 629 (C.A.5 1992); see also 6A C. J. S., Assignments § 88 (2022), or those rights "expected to arise out of an existing ... relationship," see Restatement (Second) of Contracts § 321(1) (1981); see also 9 A. Corbin, Contracts § 50.1 (2022). Given that legal backdrop, § 1396k(a)(1)(A) cannot cover the sort of "lifetime assignment" Gallardo invokes.[5]

* * *

For these reasons, we affirm the judgment of the Court of Appeals.

It is so ordered.

Justice SOTOMAYOR, with whom Justice BREYER joins, dissenting.

Where a **Medicaid** beneficiary recovers an award or settlement from a tortfeasor for medical expenses, specific provisions of the **Medicaid** Act direct a State to reimburse itself from that recovery for care for which it has paid. These provisions constitute a limited exception to the Act's default rule prohibiting a State from imposing a lien against the beneficiary's property or ***1762** seeking to use any of that property to reimburse itself. Accordingly, a State may claim portions of the beneficiary's tort award or settlement representing payments for the beneficiary's medical care, but not those representing other compensation to the beneficiary (*e.g.*, damages for lost wages or pain and suffering). *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 282–286, 126 S.Ct. 1752, 164 L.Ed.2d 459

(2006). This statutory structure recognizes that it would be " 'fundamentally unjust' " for a state agency to " 'share in damages for which it has provided no compensation.' " Id., at 288 126 S.Ct. 1752.

Today, however, the Court permits exactly that. It holds that States may reimburse themselves for medical care furnished on behalf of a beneficiary not only from the portions of the beneficiary's settlement representing compensation for **Medicaid**-furnished care, but also from settlement funds that compensate the **Medicaid** beneficiary for future medical care for which **Medicaid** has not paid and might never pay. The Court does so by reading one statutory provision in isolation while giving short shrift to the statutory context, the relationships between the provisions at issue, and the framework set forth in precedent. The Court's holding is inconsistent with the structure of the **Medicaid** program and will cause needless unfairness and disruption. I respectfully dissent.

I

Congress conditions a State's receipt of federal **Medicaid** funding, see 42 U.S.C. § 1396d(b), on compliance with federal requirements for the program. The Court today details at length one of these requirements: that a state **Medicaid** plan pursue reimbursement for the State's payments where reimbursement is available from a third party. See *ante*, at 1755 - 1756. It devotes comparatively little attention to another central requirement: that a State not assert claims against the property of **Medicaid** beneficiaries or recipients.

Under the **Medicaid** Act's anti-lien provision, enacted in 1965 as part of the original Act, "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance" provided under the state **Medicaid** plan, whether "paid or to be paid." § 1396p(a)(1); see *Ahlborn*, 547 U.S. at 283–284, 126 S.Ct. 1752. In addition, the Act's anti-recovery provision, also enacted in 1965, provides that "[n]o adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made." § 1396p(b)(1). Together, the anti-lien and anti-recovery provisions establish that acceptance of **Medicaid** does not render a beneficiary indebted to the State or give the State any claim to the beneficiary's property. In other words, **Medicaid** is not a loan. If a **Medicaid** beneficiary's financial circumstances change and a beneficiary gains the ability to pay for his or her own medical expenses, the beneficiary is not obligated to repay the State for past expenses, no matter the magnitude of the change in circumstances. Rather, the ordinary consequence is that the individual simply becomes ineligible for benefits moving forward.[1]

***1763** In *Ahlborn*, this Court held that the **Medicaid** provisions enabling the State to seek reimbursement from third parties liable for a beneficiary's medical care (discussed in detail below) establish a narrow exception to the anti-lien provision. The exception applies where the beneficiary directly sues a tortfeasor for payment of medical costs.[2] As a threshold matter, the Court held that a beneficiary's settlement proceeds qualified as beneficiary "property" protected by the anti-lien provision unless an exception to that provision applied. *Id.*, at 285–286, 126 S.Ct. 1752. The Court further held that **Medicaid's** assignment to the State of rights to reimbursement from third parties "carved

out" an "exception to the anti-lien provision" permitting the State "to recover that portion of a settlement that represents payments for medical care." *Id.*, at 282, 284–285, 126 S.Ct. 1752.

Importantly, the *Ahlborn* Court rejected the State's claim that it could seek reimbursement more broadly from the remainder of the settlement funds. It held that "the anti-lien provision applies" to bar a State's assertion of a lien beyond the portion of a settlement representing payments for medical care. *Id.*, at 285, 126 S.Ct. 1752; accord, *Wos v. E. M. A.*, 568 U.S. 627, 636, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013). As relevant to the case before it, the *Ahlborn* Court concluded that the State could not recover from portions of a settlement representing compensation "for damages distinct from medical costs—like pain and suffering, lost wages, and loss of future earnings." 547 U.S. at 272, 126 S.Ct. 1752. The Court noted that it would be "unfair to the recipient" and " 'absurd' " for the State to " 'share in damages for which it has provided no compensation.' " *Id.*, at 288, and n. 19, 126 S.Ct. 1752.

II

The Court summarizes Florida's **Medicaid** Third-Party Liability Act and the facts of petitioner Gianinna Gallardo's case. See *ante*, at 1756 - 1758. The question presented is whether the exception to the anti-lien provision recognized in *Ahlborn* extends to permit Florida to claim the share of Gallardo's settlement allocated for her future medical expenses as compensation for the State's expenditures for her past medical expenses.

Before answering that question, a note is in order about what is not in dispute. Consider a hypothetical example in which Florida has spent $1,000 on a beneficiary's medical care, after which the beneficiary secures a $1,500 tort settlement, $200 of which is allocated for those already-incurred medical expenses, $500 of which is allocated for future medical care, and the remainder of which ($800) compensates for nonmedical expenses. The parties agree, as they must, that Florida cannot recover anticipated expenses for services it has not furnished, but may pursue reimbursement only for expenses it has paid (*i.e.*, Florida can recover no more than $1,000). The parties further agree that Florida can recover these expenses from the portion of the beneficiary's settlement allocated for ***1764** these expenses (*i.e.*, the $200), and that Florida can challenge the allocation of the settlement if it contends that too low a portion was designated for past medical expenses. The parties also do not dispute that Florida cannot recover from the $800 representing nonmedical expenses. The only dispute is whether Florida also may recover its past medical costs from the distinct portion of the beneficiary's settlement representing future medical expenses (*i.e.*, the $500)—expenses it has not paid and might never pay. Under a proper reading of the applicable statutory provisions in context, Florida may not do so.

As *Ahlborn* explains, Florida's ability to seek reimbursement from Gallardo's settlement hinges on establishing that an exception to the anti-lien and anti-recovery provisions applies. Several provisions, enacted over a span of decades, set forth the exception relevant here. The first, §§ 1396a(a)(25)(A) and (B) (collectively, the third-party liability provision), was enacted three years after the **Medicaid** Act and the anti-lien and anti-recovery provisions. The third-party liability provision authorizes a State only to recover for "medical assistance" that "*has been made* available on

behalf of the individual," and only "*after* medical assistance has been made available." § 1396a(a)(25)(B) (emphasis added). And it authorizes recovery only "to the extent of," *ibid.*, "the legal liability of third parties ... to pay for care and services available under the plan," § 1396a(a)(25)(A). In this context, the provision's reference to care "available under the plan" can only be understood to refer to care that is available by virtue of having been paid under the plan, not care that theoretically may or may not be made available in the future. Put differently, as a textual matter, this provision extends only to a third party's liability to pay for services actually furnished by a state plan.

Congress subsequently enacted two legal tools for a State to use when seeking reimbursement, consistent with the third-party liability provision, for services paid.

The first of these tools is the assignment provision, § 1396k(a)(1)(A), enacted in 1977 and made mandatory in 1984. In that provision, to "assis[t] in the collection of ... payments for medical care," § 1396k(a), Congress required each state **Medicaid** plan to condition eligibility on assignment of "any rights" of the beneficiary "to payment for medical care from any third party," § 1396k(a)(1)(A). Florida rests its argument on the understanding that this language confers upon it a right to recover payments designated for medical care regardless of whether those payments compensate for medical care for which Florida actually has paid.

Several textual signals foreclose Florida's interpretation of the assignment provision. For one, the provision, by its terms, does not stand alone. Instead, Congress enacted it "[f]or the purpose of assisting in [a State's] collection of " payments for medical care owed to beneficiaries. § 1396k(a). It would be anomalous, then, to read the provision to reach beyond the third-party liability provision it "assist[s]" in implementing. *Ibid.*; see *Guam v. United States*, 593 U. S. ——, ——, 141 S.Ct. 1608, 1613–1614, 209 L.Ed.2d 691 (2021) (similarly interpreting a statutory provision in light of an earlier "anchor provision"). Supporting that understanding, Congress later amended the statute containing the assignment provision to require beneficiaries "to cooperate with the State in identifying ... any third party who may be liable to pay for care and services available under the plan." § 1396k(a)(1)(C) (the cooperation provision). The cooperation provision echoes the third-party liability provision's focus on care "available under the plan." *Ibid.* It would be bizarre for ***1765** Congress to mandate a more far-reaching assignment of a beneficiary's right to payment for all medical support, paid or unpaid, but limit the beneficiary's duty to cooperate only to services paid. Finally, another provision of the Act directs each State to pass laws requiring insurers to "accept ... the assignment to the State of any right of an individual or other entity to payment ... for an item or service for which payment has been made under the State plan." § 1396a(a)(25)(I)(ii). In this insurer acceptance provision, Congress described the assignment provision's mandate as specific to third-party payments for services the State plan has funded. Taken together, these textual indicators establish that the assignment provision reaches only a third party's liability for services made available by **Medicaid**, not liability for services for which **Medicaid** has not paid and may never pay.

The second tool Congress enacted to implement the third-party liability provision is the acquisition provision, § 1396a(a)(25)(H). A 1990 General Accounting Office report found that some health insurers were "thwart[ing]" the assignment provision by "refusing to pay [States] for any of several reasons," including by declining to recognize **Medicaid** assignments or by insisting that such assignments conflicted with their insurance contracts. **Medicaid**: Legislation Needed to Improve Collections From Private Insurers 5 (GAO/HRD–91–25, Nov.). Congress addressed this in 1993 by directing each State to enact laws under which the State automatically acquires a beneficiary's rights

to third-party payments specifically "for health care items or services furnished" to the beneficiary, without the need for separate assignments. § 1396a(a)(25)(H). The text of this acquisition provision, too, clearly restricts a State's acquisition to the portion of a third-party payment pertaining to "health care items or services" for which "payment has been made under the State plan" and does not extend to third-party payments for services the plan has not furnished. *Ibid.*; see *ante,* at 1758 - 1759.

This Court's task is to interpret these provisions " 'as a symmetrical and coherent regulatory scheme' " while " 'fit[ting] ... all parts into an harmonious whole.' " *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133, 120 S.Ct. 1291, 146 L.Ed.2d 121 (2000). Doing so here leads to only one "symmetrical and coherent" conclusion: that the assignment and acquisition provisions work in tandem to effectuate the third-party liability provision. As explained by the United States as *amicus curiae* in support of Gallardo, Congress "added the belt" (the acquisition provision) "because it feared that the suspenders" (the assignment provision) "were not doing their job." Brief for United States as *Amicus Curiae* 29. The two provisions take different paths toward the same goal, and each reinforces the other. All of the provisions enable a State to reimburse itself for expenses it has paid, not for expenses it may or may not incur in the future. None of the provisions authorize a State to seek such reimbursement from the portions of a beneficiary's tort settlement representing payments for care for which the State has not paid.

This interpretation is also consistent with the structure of the **Medicaid** program as a whole, under which a State's recovery from a beneficiary's compensation in tort is permissible under a narrow exception to the general, asset-protective rule established by the anti-lien and anti-recovery provisions. *Ahlborn* further explained that the third-party liability provision and acquisition provision both "reinforce[d] the limitation implicit in the assignment provision." 547 U.S. at 280, 126 S.Ct. 1752. In particular, the ***1766** Court described the acquisition provision's requirement (that a State enact laws under which it acquires a beneficiary's rights to third-party payments for "health care items or services furnished to an individual" "under the State plan," § 1396a(a)(25)(H)) as "reiterat[ing]" and "echo[ing]" the assignment provision's requirement (that a state plan condition eligibility on a beneficiary's assignment of rights to payment). *Id.*, at 276, 281, 126 S.Ct. 1752. *Ahlborn*'s repeated recognition of the relationships between these three provisions cannot be squared with Florida's primary argument, which would sever the provisions and read the assignment provision to eclipse the limitations of the other two.

Moreover, **Medicaid** is an insurance statute, and *Ahlborn*'s discussion of the unfairness that would ensue from a State's " 'shar[ing] in damages for which it has provided no compensation,' " *id.*, at 288, n. 19, 126 S.Ct. 1752, tracks background principles of insurance law. Under those principles, recovery by an insurer against a third party "is generally limited to the same elements as those for which [the insurer] has made payment," absent contractual terms to the contrary. 16 S. Plitt, D. Maldonado, J. Rogers, & J. Plitt, Couch on Insurance § 226:36 (3d ed. 2021); see Brief for United States as *Amicus Curiae* 21–22. This, too, supports a cohesive reading of these provisions as allowing States to recover their past expenses only from sources that compensate for the care and services state plans actually have furnished.[3]

An additional absurdity would flow from an overbroad reading of the assignment provision decoupled from its companions. Florida maintains that the assignment provision's reference to "any rights ... to payment for medical care from any third party," § 1396k(a)(1)(A), permits recovery from settlement funds compensating for all medical

expenses, past or future. If this provision were interpreted in isolation to sweep so broadly, however, its text would place no temporal limitation on the rights assigned to the State. For example, if **Medicaid** were to fund an individual's medical care as a teenager, the State would be entitled to recover the costs of that care from any unrelated future tort settlement for medical expenses, regardless of whether the individual remained on **Medicaid** or the state plan furnished any services related to those future injuries. Such a nonsensical "lifetime assignment," Brief for Petitioner 32, would constitute an "unfair" erosion of the anti-lien provision, *Ahlborn*, 547 U.S. at 288, 126 S.Ct. 1752, contravening Congress' careful design. In contrast, a harmonious reading of the statute, consistent with *Ahlborn*, limits the funds from which a State may recover to those awarded for expenses paid and therefore presents no such concern.

III

Despite the foregoing, the Court reads the assignment provision standing alone to establish, unlike all the other provisions of the Act at issue, a substantially broader right to recover from payments for all medical care, whether paid by the State or ***1767** not. The Court commits several errors on the path to its holding, which departs from the statutory scheme as understood in *Ahlborn* and forces the Court to adopt an implausible workaround in order to mitigate the absurd consequence, discussed above, of its acontextual reading.

A

The Court's analysis starts off backward. The Court states first that the Act requires a State to condition **Medicaid** eligibility on assignment of rights, and only then notes that the anti-lien provision "also" limits States' recovery efforts. *Ante*, at 1755 - 1756. In fact, the anti-lien and anti-recovery provisions establish a general rule, and the subsequently enacted third-party liability provision and its companions create a limited exception. That exception, in turn, should not be construed "to the farthest reach of [its] linguistic possibilit[y] if that result would contravene the statutory design." *Maracich v. Spears*, 570 U.S. 48, 60, 133 S.Ct. 2191, 186 L.Ed.2d 275 (2013). The Court's misframing, however, causes it to displace the background principle of the anti-lien and anti-recovery provisions by relying on language in the assignment provision that is vague at best.

The Court places great weight on the assignment provision's use of the word "any" in its reference to "rights ... to payment for medical care." § 1396k(a)(1)(A); see *ante*, at 1758. The Court presumes that " '[t]he word "any" has an expansive meaning.' " *Ibid.* But whether the word "any" indicates an intent to sweep broadly "necessarily depends on the statutory context." *National Assn. of Mfrs.* v. *Department of Defense*, 583 U. S. ——, ——, 138 S.Ct. 617, 629, 199 L.Ed.2d 501 (2018). Here, as explained, statutory context establishes that the word "does not bear the heavy weight the [Court] puts upon it." *Ibid.* To the extent the Court suggests the word "any" supersedes all other contrary contextual indications, it ignores precedent. See, *e.g.*, *United States v. Alvarez-Sanchez*, 511 U.S. 350, 356–358,

114 S.Ct. 1599, 128 L.Ed.2d 319 (1994) (relying on context to interpret " 'any law-enforcement officer or law-enforcement agency' " as limited to those making arrests under federal law).

The Court also repeatedly relies on the fact that the acquisition provision and third-party liability provision use specific language to limit the pool from which a State may recover to funds that compensate for expenses **Medicaid** has paid, whereas the assignment provision uses different language. See *ante*, at 1758 - 1759, 1759 - 1760, 1760 - 1761. The Court invokes the presumption that " '[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.' " *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983). This is unpersuasive. Putting aside the many contextual clues that support Gallardo's reading of the assignment provision, see *supra*, at 1764 - 1765, the presumption the Court cites is " 'strongest' in those instances in which the relevant statutory provisions were 'considered simultaneously when the language raising the implication was inserted.' " *Gómez-Pérez* v. *Potter*, 553 U.S. 474, 486, 128 S.Ct. 1931, 170 L.Ed.2d 887 (2008). It has less force where, as here, different Congresses enacted the provisions at issue over the course of multiple decades. The presumption is especially unhelpful in this case because it cuts both ways: Since 1965, the anti-lien provision has specified that a State may not impose a lien against a beneficiary's property "on account of medical assistance paid *or to be paid* on his behalf." § 1396p(a)(1) (emphasis added). ***1768** Accepting the Court's logic, Congress should have required an assignment that unambiguously reached payments for both furnished and unfurnished care using this existing "paid or to be paid" language, but it failed to do so in the assignment provision. See *ante*, at 1760 - 1761.

Meanwhile, the Court fails to give due regard to the clear textual limitations imposed by the Act as a whole. For instance, as to the assignment provision's mirror image in the insurer acceptance provision, see *supra*, at 1764 - 1765, the Court reasons that the latter's "narrower focus on health insurers, who typically pay only once medical services are rendered, explains its application to a narrower category of third-party payments," *ante*, at 1760, n. 3. This is beside the point. In the assignment provision, Congress required beneficiaries to assign certain rights to the State; in the insurer acceptance provision, it required insurers to accept that assignment. It makes no sense that Congress would require insurers to accept only a sliver of the mandatory assignment, regardless of how insurers typically pay.

Ultimately, "[s]tatutory construction ... is a holistic endeavor." *United Sav. Assn. of Tex. v. Timbers of Inwood Forest Associates, Ltd.*, 484 U.S. 365, 371, 108 S.Ct. 626, 98 L.Ed.2d 740 (1988). Yet rather than reading the assignment provision in a manner "compatible with the rest of the law," *ibid.*, the Court disconnects it from much of the Act. The Court does not hold that the third-party liability provision extends as far as its reading of the assignment provision. See *ante*, at 1760 - 1761; see also *supra*, at 1763 - 1764. The Court also agrees that the acquisition provision is "more limited," meaning that the scope of that provision, too, "differ[s]" from that of the assignment provision. *Ante*, at 1759 - 1760. To justify these anomalies, the Court asserts that Congress, in enacting the acquisition provision, saw fit to "provid[e] a more targeted statutory right for when the assignment might fail." *Ibid.* The Court offers little explanation, however, for why Congress might have narrowed such a necessary backstop in this way. The statutory hodgepodge the Court perceives contrasts sharply with the reasonable scheme Congress actually crafted.

B

The Court's reasoning also contradicts precedent. The Court distinguishes *Ahlborn* because that case did not squarely hold that the relevant provisions "must" be interpreted in "lockstep," and it reduces *Ahlborn*'s concern about fairness to a disfavored "policy argumen[t]" that must yield to text. *Ante,* at 1759 -1760, 1760 - 1761. But *Ahlborn*'s analysis reflected the Court's view of the text and context of the Act as a cohesive whole. It is not only "our sense of fairness," *ante,* at 1761, but Congress' sense of fairness, as codified in the Act's anti-lien and anti-recovery provisions and recognized in *Ahlborn*, that demonstrates the Court's error.

The Court itself appears to recognize that its textual analysis leads to unfair and absurd results, leading it to suggest an unpersuasive workaround. The Court responds to the lifetime-assignment quandary, see *supra,* at 1766 - 1767, by reasoning that the assignment provision's use of the phrase " 'any rights ... *of the individual*' " is "most naturally read" to impose a temporal limitation to rights possessed while on **Medicaid**, *ante,* at 1760 - 1761. Neither party even suggests this reading of the statute.[4] That is because it is anything but natural, especially under the interpretive ***1769** approach the Court uses today. An "individual" continues to be an "individual" for the duration of his or her life, whether on or off **Medicaid**. Were there any ambiguity, the word " 'any,' " we are told, " 'has an expansive meaning' " that would counsel against the Court's implicit limitation. *Ante,* at 1758. Perhaps sensing that its claim to natural meaning lacks force, the Court, at last, acknowledges "background legal principles" that militate against allowing a lifetime assignment. *Ante,* at 1761. While background principles indisputably are relevant, the Court errs by discarding the more relevant background rule of insurance law that Congress embraced in the Act, see *supra,* at 1766, which could have avoided the Court's dilemma altogether.[5]

Over the long term, the Court's alteration of the balance Congress struck between preserving **Medicaid's** status as payer of last resort and protecting **Medicaid** beneficiaries' property might frustrate both aims. As a State's right of recovery from any damages payout expands, a **Medicaid** beneficiary's share shrinks, reducing the beneficiary's incentive to pursue a tort action in the first place. See Brief for American Justice Association et al. as *Amici Curiae* 16–20. Under the provisions of the Act at issue here, States may sue tortfeasors directly, but as Florida itself explains, it is "more cost-effective" for beneficiaries to sue. Tr. of Oral Arg. 65. By diminishing beneficiaries' interests in doing so, the Court's expansion of States' assignment rights could perversely cause States to recover fewer overall expenses, all while unsettling expectations in the States that have relied on a contrary reading of federal law.[6]

In the end, the Court's atomizing interpretation has little to commend it, particularly when contrasted with the consistent, administrable scheme Congress crafted. The Court's reading also undercuts Congress' choice to allow **Medicaid** beneficiaries to place their excess recovery funds in Special Needs Trusts, protecting their ability to pay for important expenses **Medicaid** will not cover. See n. 1, *supra*. Congress may wish to intercede to address any disruption that ensues from today's decision, but under a proper reading of the Act, such intervention would have been unnecessary.

* * *

"[T]he meaning of a statute is to be looked for, not in any single section, but in all the parts together and in their relation to the end in view." *Panama Refining Co. v. Ryan*, 293 U.S. 388, 439, 55 S.Ct. 241, 79 L.Ed. 446 (1935) (Cardozo, J., dissenting). Because the Court disserves this cardinal rule today, I respectfully dissent.

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Footnotes

* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

1 For the sake of simplicity, we refer to the State, its **Medicaid** agency, or simply **Medicaid** interchangeably.

2 According to the dissent, our conclusion conflicts with the "background principl[e] of insurance law" that an insurer's third-party recovery is limited " 'to the same elements as those for which [the insurer] has made payment.' " *Post*, at 1766 (opinion of SOTOMAYOR, J.) (quoting 16 S. Plitt, D. Maldonado, J. Rogers, & J. Plitt, Couch on Insurance § 226:36 (3d ed. 2021)). But even assuming this principle is relevant as the dissent supposes, the dissent concedes that it gives way if a "contractual ter[m]"—an assignment provision, for example—permits a broader recovery. *Post*, at 1766; see also, *e.g.*, 16 Couch on Insurance § 222:63 (citing examples). Here, § 1396k(a)(1)(A) mandates an assignment provision that does just that.

3 The United States makes a similar argument when it relies on § 1396a(a)(25)(I)(ii), under which States must enact laws requiring health insurers to "accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan." We disagree that this provision "suggests that Congress understood the assignment of rights under Section 1396k to be limited to third-party payments for services covered by **Medicaid**." Brief for United States as *Amicus Curiae* 19. Like § 1396a(a)(25)(H), this provision targets specific attempts by health insurers to avoid making payments to state **Medicaid** programs. Its narrower focus on health insurers, who typically pay only once medical services are rendered, explains its application to a narrower category of third-party payments, and says little to nothing about the meaning of § 1396k(a)(1)(A)'s broader scope.

4 That Congress required States' compliance with § 1396k(a)(1)(A) via a separate paragraph—§ 1396a(a)(45)—rather than subordinating it under § 1396a(a)(25), supports our conclusion that they need not be interpreted in lockstep.

5 Florida also suggested at argument that § 1396k(a)(1)(A) includes a germaneness requirement such that the assignment extends only to payments for medical care germane—*i.e.*, related—to an injury or illness for which **Medicaid** covered treatment. See Tr. of Oral Arg. 69. However, we have no adversary briefing on this issue and no cause to resolve it. It is undisputed that the settlement from which Florida seeks recovery is germane to the injury for which Florida paid out **Medicaid** funds, and Florida law requires as much. See Fla. Stat. § 409.910(6)(c).

1 Petitioner Gianinna Gallardo has continued to receive **Medicaid** benefits, despite the proceeds from her tort settlement, because those proceeds were transferred into a congressionally authorized Special Needs Trust, a narrow exception to **Medicaid's** asset limits. See Reply Brief 22, n. 6. Such a trust exists to pay expenses not covered by **Medicaid**, which may include, for example, certain home nursing care or a home ramp for a wheelchair. Upon a beneficiary's death, all trust assets are transferred to the State until the State is fully reimbursed for all medical assistance it has furnished. See § 1396p(d)(4)(A); Brief for American Justice Association et al. as *Amici Curiae* 4–7.

2 The *Ahlborn* Court "assume[d]" without deciding "that a State can fulfill its obligations under the federal third-party liability provisions by ... placing a lien on ... the settlement that a **Medicaid** recipient procures on her own." *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 280, n. 9, 126 S.Ct. 1752, 164 L.Ed.2d 459

(2006); see also *id.*, at 281, 126 S.Ct. 1752 ("assuming" that one of these provisions, § 1396k(b), "applies in cases where the State does not actively participate in the litigation").

3 Much as an insurer might modify this default rule under contract, Congress could do so by statute. The parties agree that Congress did so as to Medicare, which, in the parties' view, permits a broader scope of recovery for services (both furnished and to be furnished) from a third party's liability in tort. See Brief for Respondent 41; Reply Brief 8–9. The difference, if any, between the two programs reflects **Medicaid's** focus on the needy, as well as the fact that individuals may lose and regain **Medicaid** eligibility over time based on changes in their circumstances, whereas most Medicare enrollees are seniors entitled to coverage for the rest of their lives.

4 In its briefing, Florida responded to the lifetime-assignment concern by stating only that its own law did not go so far. Brief for Respondent 45. Confronted anew with the concern at argument, Florida proposed an implicit "germaneness requirement," see Tr. of Oral Arg. 68–70, which the Court does not embrace, see *ante*, at 1761, n. 5.

5 The Court does not dispute the background principle that an insurer's third-party recovery is limited to the elements for which the insurer has made payment. See *supra*, at 1766. The Court responds, however, that Congress clearly displaced this principle in the assignment provision. See *ante*, at 1759, n. 2. That, of course, is the entire question. For the reasons explained, the Court's reading of the assignment provision is erroneous.

6 The vast majority of lower courts (including Florida's Supreme Court) read these provisions much as I do. See, *e.g.*, *Latham v. Office of Recovery Servs.*, 2019 UT 51, 448 P.3d 1241; *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53 (Fla. 2018); *In re E. B.*, 229 W.Va. 435, 729 S.E.2d 270 (2012); *Doe v. Vermont Office of Health Access*, 2012 VT 15A, 191 Vt. 517, 54 A.3d 474; Pet. for Cert. 18–19 (collecting additional cases).

300 Va. 458
Supreme Court of Virginia.

Amir FARAH
v.
Commonwealth of Virginia, DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Record No. 201413
|
FEBRUARY 17, 2022

Synopsis

Background: After settlement of motorist's personal-injury action against oncoming motorist, the Circuit Court, Fairfax County, Brett A. Kassabian, J., held apportionment hearing and determined portion of settlement subject to **Medicaid** lien. Motorist appealed.

Holdings: The Supreme Court, Stephen R. McCullough, J., held that:

[1] in determining portion of settlement subject to **Medicaid** lien, court is not required to employ any particular mathematical formula;

[2] the decision as to portion of plaintiff's settlement subject to **Medicaid** lien should be based on the amount **Medicaid** has actually paid, not on amounts of medical expenses billed but not paid; and

[3] evidence was sufficient to support trial court's allocation of approximately 23 percent of motorist's $375,000 personal-injury settlement to **Medicaid** lien.

Affirmed.

Procedural Posture(s): On Appeal; Other.

West Headnotes (12)

[1] **Health**Settlements or judgments, recovery from

Pursuant to state's apportionment statute, in determining portion of settlement subject to **Medicaid** lien, court is not required to employ any particular mathematical formula. Va. Code Ann. § 8.01-66.9.

[2] **Health**Settlements or judgments, recovery from

In the absence of advance agreement by Commonwealth to an allocation of a plaintiff's settlement proceeds that constitutes compensation for medical care, for determination of value of Commonwealth's **Medicaid** lien pursuant to apportionment statute, it is necessary to submit the matter to a court for decision. Va. Code Ann. § 8.01-66.9.

[3] **Health**Settlements or judgments, recovery from

A hearing is not always required for determination of portion of plaintiff's settlement subject to **Medicaid** lien pursuant to apportionment statute. Va. Code Ann. § 8.01-66.9.

[4] **Health**Settlements or judgments, recovery from

In determining portion of settlement subject to **Medicaid** lien pursuant to apportionment statute, courts must, where appropriate, reduce the **Medicaid** lien to a value that reflects that portion of a settlement that represents payments for medical care. Va. Code Ann. § 8.01-66.9.

[5] **Health**Settlements or judgments, recovery from

In determining portion of settlement subject to **Medicaid** lien pursuant to apportionment statute, courts must examine the totality of a plaintiff's damages, such as lost wages, and damages for pain and suffering, disfigurement, deformity, humiliation, and embarrassment, and make a reasonable allocation for what portion of the verdict, judgment or settlement is attributable to medical expenses paid for by **Medicaid**. Va. Code Ann. § 8.01-66.9.

[6] **Health**Settlements or judgments, recovery from

The decision as to portion of plaintiff's settlement subject to **Medicaid** lien, pursuant to apportionment statute, should be based on the amount **Medicaid** has actually paid, not on amounts of medical expenses billed but not paid. Va. Code Ann. § 8.01-66.9.

[7] **Appeal and Error**Province of, and deference to, lower court in general

Supreme Court accords great deference to trial court's factual findings.

[8] **Appeal and Error**Substitution of Reviewing Court's Discretion or Judgment

Appellate court is not permitted to substitute its own judgment for that of finder of fact, even if appellate court might have reached different conclusion.

[9] **Health**Settlements or judgments, recovery from

Evidence was sufficient to support allocation, following hearing to court, of approximately 23 percent of motorist's $375,000 personal-injury

settlement to **Medicaid** lien, pursuant to apportionment statute, after motorist was gravely injured in collision with oncoming driver, even though motorist had over $62,000 in unreimbursed medical bills and attorney testified that case was worth $4 million; trial court heard extensive evidence concerning motorist's injuries, and complaint had sought only $3 million rather than $4 million. Va. Code Ann. § 8.01-66.9.

[10] **Appeal and Error**🔑Inadequate Award; Additur

Damages🔑Questions for Jury

Although the Supreme Court has the authority to reverse verdicts or judgments that are inadequate as a matter of law, the exercise of this power is limited by the admonitory principle that, ordinarily, it is within the province of the jury to determine the amount of damages.

[11] **Health**🔑Settlements or judgments, recovery from

In order to determine what portion of a plaintiff's settlement can properly be attributed to a **Medicaid** program's payments for medical care, pursuant to apportionment statute, a court must examine the plaintiff's total damages in order to make that allocation; however, court need not go beyond a determination of the amount of the state's **Medicaid** lien or specify from the bench, or in an order, a breakdown for each specific type of damages. Va. Code Ann. § 8.01-66.9.

[12] **Appeal and Error**🔑Apportionment and contribution

On appellate review of trial court's allocation of damages to **Medicaid** lien under apportionment statute, trial court, acting as factfinder, benefits from comparable deference as compared to appellate review of jury verdict. Va. Code Ann. § 8.01-66.9.

****423** FROM THE CIRCUIT COURT OF FAIRFAX COUNTY, Brett A. Kassabian, Judge

Attorneys and Law Firms

Jeremy Flachs on briefs, Alexandria, for appellant.

Michelle S. Kallen, Acting Solicitor General (Mark R. Herring, Attorney General; Samuel Towell, Deputy Attorney General; Brittany M. Jones, Deputy Solicitor General; Rodolfo R. Remigio, Senior Assistant Attorney General; Laurel S. Huerkamp, Assistant Attorney General; Laura H. Cahill, Assistant Attorney general, on brief), for appellee.

Amicus Curiae: Virginia Trial Lawyers Association (John E. Davidson; Davidson & Kitzmann, Charlottesville, on brief), in support of appellant.
PRESENT: Goodwyn, C.J., Mims, Powell, Kelsey, McCullough, and Chafin, JJ., and Koontz, S.J.

Opinion

OPINION BY JUSTICE STEPHEN R. McCULLOUGH

***461** Amir Farah suffered catastrophic injuries in a car accident. The Commonwealth's **Medicaid** program paid for a portion of his extensive subsequent medical care. This entitles the Commonwealth to a lien on the proceeds of a verdict or settlement of claims arising out of the accident, but only on that portion of the recovery ***462** that represents his **Medicaid**-funded care. Farah sued the driver who caused the accident and the case settled. The Circuit Court of Fairfax County then conducted a hearing to determine what portion of the settlement is subject to the **Medicaid** lien. Disappointed with the result the circuit court reached, Farah appeals. For the reasons noted below, we conclude that Virginia's apportionment statute does not conflict with precedent from the United States Supreme Court, and, further, that the factual findings of the circuit court must be sustained under the applicable deferential standard of review. Accordingly, we will affirm the judgment below.

BACKGROUND

Farah, who worked as a cab driver, was gravely injured in a head-on crash. The driver who caused the collision was in the wrong lane of travel. Farah received **Medicaid** benefits following the crash. Farah sued the driver of the vehicle that struck him. His complaint sought $3 million in compensatory damages and $350,000 in punitive damages. The parties ultimately settled the dispute for $375,000 (the policy limits of insurance coverage plus a $25,000 personal contribution from the driver).

****424** The Virginia Department of Medical Assistance Services ("DMAS") asserted a lien in the amount of $96,481.40 against the settlement proceeds for medical services provided to Farah. App. 189, Joint Stipulations § B,1.[1] The parties were unable to agree on the amount of a reduction for the **Medicaid** lien. Farah filed a motion to apportion his settlement under Code § 8.01-66.9. He requested a hearing to apportion the **Medicaid** lien, and the court granted him one over the Commonwealth's objection. Prior to the hearing, Farah and DMAS agreed to certain stipulations of fact.

The stipulations detail the extensive injuries Farah suffered in the accident, including fractures of the skull, face, leg, and foot bones, as well as knocked out front teeth. He underwent over 20 surgeries and was in the intensive care unit ("ICU") for over a month, followed by a period of rehabilitation. While in the ICU, Farah's jaw was wired shut and he was fed through a feeding tube in his stomach. He sustained cosmetic disfigurement from the ***463** injuries to his nose and his knocked out front teeth, which have not been corrected, and he has scars from his surgery on his legs and neck. The stipulations provide that "[t]he retail price of Mr. Farah's claimed medical expenses from the 6/17/2018 crash total[s] $591,483.71." Farah still owes over $62,000 in medical bills not reimbursed by DMAS.

At the apportionment hearing, Farah testified about the injuries he incurred, as well as the suffering he endured during his recovery and that he continues to endure, both psychological and physical. He can no longer work or care for himself. He is able to move around with the aid of a cane, but his strength and mobility are severely limited. An orthopedic surgeon testified about Farah's permanent injuries to his face, mouth, neck, teeth, left arm, left hand, hips, knees, ankles and feet.

The stipulations and evidence from the hearing also address Farah's lost earnings. He was almost 35 years old at the time of the accident. He has not worked since the accident. Farah earned approximately $27,000 per year as a cab driver and his expected work-life at the time of the crash totaled approximately 32.25 years. At the hearing, a rehabilitation counselor opined that the nature of Farah's injuries, and his background as an immigrant with limited education, likely precluded Farah from ever working again in any capacity. Farah estimated his lost wages over the course of his lifetime at $832,000.

Brien Roche, an experienced personal injury attorney, offered testimony at the hearing concerning his assessment of the value of Farah's case. He testified that a conservative valuation of Farah's case is $4 million. He based his assessment on a review of the file, including medical reports, reports concerning Farah's lost earnings, his inability to gain employment, and other documentation.

Following the hearing, the circuit court explained that it was unpersuaded by Farah's argument that certain cases from the United States Supreme Court compelled the use of a specific formula. The court acknowledged "the nature of this horrific accident and the substantial and permanent injuries sustained by this Plaintiff who by all accounts was innocent of any wrongdoing which contributed to this accident." The court reviewed in detail Farah's injuries, his pain and suffering, and his inability to work. The circuit court apportioned the $375,000 settlement as follows:

***464** $ 85,500 to DMAS for its reduced lien;

$ 100,000 to Farah's counsel for attorney's fees;

$ 15,807 to Farah's counsel for costs advanced;

$ 173,693 to Farah.

Under the circuit court's ruling, the **Medicaid** lien represents approximately 23 percent of the settlement.

Farah appeals from this decision.

****425** ANALYSIS

Medicaid is a federal-state program that provides medical assistance to residents of participating states who cannot afford medical care. *See* 42 U.S.C. § 1396a(a). Federal law requires States to include a provision in their **Medicaid** plans for recouping from liable third parties funds spent on behalf of **Medicaid** recipients. 42 U.S.C. § 1396a(a)(25)(A). States must take all reasonable measures to find third parties that are liable for the coverage of a **Medicaid** recipient's medical costs. *Id.* States must also include a provision that requires **Medicaid** participants to sign over their rights to seek and collect payment for medical care from a liable third party to the State. 42 U.S.C. § 1396a(a)(25)(H). States are required to seek reimbursement from the third party if legal liability is found, unless the cost of pursuing the reimbursement outweighs the amount of reimbursement. 42 U.S.C. § 1396a(a)(25)(B); *see also* 42 U.S.C. § 1396p(a).

Another provision, 42 U.S.C. § 1396p(a)(1), known as the "anti-lien" provision, limits a State's ability to recover the full value of their lien in certain circumstances. This statute specifies that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." *Id.*

The third-party liability requirements can operate in tension with the anti-lien strictures when a **Medicaid** recipient receives a tort recovery that is insufficient to both cover **Medicaid's** expenditures and to fully compensate the recipient for his or her other damages. In a pair of cases, the United States Supreme Court addressed the tension between these statutory commands. In *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), the State claimed that it was entitled to "more ***465** than just that portion of a judgment or settlement that represents payment for medical expenses," i.e., that it was entitled to recover the entirety of its lien. *Id.* at 278, 126 S.Ct. 1752. The plaintiff was a young woman who suffered debilitating injuries in a car crash. *Id.* at 268, 126 S.Ct. 1752. The parties stipulated that the case was reasonably valued at approximately three million dollars. *Id.* at 274, 126 S.Ct. 1752. The case settled for $550,000. The State had expended approximately $215,000 and it sought "to recover the entirety of the costs it paid on the **Medicaid** recipient's behalf." *Id.* at 278, 126 S.Ct. 1752. The Supreme Court rejected that argument, concluding that the anti-lien provision limits the State to a recovery of "that portion of a settlement that represents payments for medical care." *Id.* at 282, 126 S.Ct. 1752. The State could not satisfy its lien by encumbering the plaintiff's other recovered damages, such as lost wages or pain and suffering. In *Ahlborn*, given the stipulated reasonable value of the case, the proportional amount the State could recover was approximately $35,000. *Id.* at 288, 126 S.Ct. 1752.

Later, in *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013), the Court examined whether a state could employ a lien allocation method that automatically attributed up to one-third of every judgment or settlement to its **Medicaid** lien. *Id.* at 630, 133 S.Ct. 1391. The Court concluded that picking an arbitrary number, such as one third, was not a reasonable method of allocation. *Id.* at 636, 133 S.Ct. 1391. The Court offered further guidance, noting that "[w]hen the State and the beneficiary are unable to agree on an allocation," the parties can "submit the matter to a court for decision." *Id.* at 638, 133 S.Ct. 1391. The Court observed that "States have considerable latitude to design administrative and judicial procedures to ensure a prompt and fair allocation of damages." *Id.* at 641, 133 S.Ct. 1391.

Virginia's apportionment statute is found in Code § 8.01-66.9. It provides in relevant part:

> The court in which a suit by an injured person or his personal representative has been filed against the person, firm or corporation alleged to have caused such injuries or in which such suit may properly be filed, may, upon motion or petition by the injured person, his personal representative or his attorney, and after written notice is given to all those holding liens attaching to the recovery, reduce the amount of the ****426** liens and apportion the recovery, whether by verdict or negotiated ***466** settlement, between the plaintiff, the plaintiff's attorney, and the Commonwealth or such Department or institution as the equities of the case may appear, provided that the injured person, his personal representative or attorney has made a good faith effort to negotiate a compromise pursuant to § 2.2-514. The court shall set forth the basis for any such reduction in a written order.[2]

I. Virginia's apportionment statute does not conflict with precedent from the United States Supreme Court.

A. Supreme Court precedent does not require any particular formula.

[1] Farah contends that case law from the United States Supreme Court requires a State to employ the following formula:

*[Total Settlement ÷ Full Value of Claim] x **Medicaid** Lien Amount].* Ap. Br. at 18.

We discern nothing in either *Wos* or *Ahlborn* that compels the use of such a formula. The Court itself expressly acknowledged that the decision in *Ahlborn* did not prescribe any particular method for apportionment of the **Medicaid** lien. *Wos*, 568 U.S. at 634, 133 S.Ct. 1391 ("A question the Court had no occasion to resolve in *Ahlborn* is how to determine what portion of a settlement represents payment for medical care."). The Supreme Court made it clear that "States have considerable latitude" to develop their own procedures for allocating funds. *Id.* at 641, 133 S.Ct. 1391; *see also* *id.* at 643, 133 S.Ct. 1391 (noting that the States have "ample means available to allocate **Medicaid** beneficiaries' tort recoveries in an efficient manner that complies with federal law").[3]

***467** B. The proportional amount of the State's **Medicaid** lien can be determined by stipulations or by the presentation of evidence.

[2] [3] It may be possible to determine the value of the Commonwealth's **Medicaid** lien by a stipulation of the portion of the settlement that constitutes compensation for medical care. To avoid a challenge by the State on the basis that such a stipulation shortchanges the State, a plaintiff may find it wise to obtain "the State's advance agreement to an allocation." *Ahlborn*, 547 U.S. at 288, 126 S.Ct. 1752.[4] In the absence of such an agreement, it will be necessary to "submit[ ] the matter to a court for decision." *Id.* A hearing will not always be required. When the trial court has presided over a trial of the case, for example, a hearing will ordinarily not be required. Parties also may be able to reach stipulations that obviate the need for an evidentiary hearing.

[4] [5] Code § 8.01-66.9 broadly allows a trial court to reduce a **Medicaid** lien "as the equities of the case may appear." Although United States Supreme Court precedent does not compel the use of a particular formula, precedent from that Court does cabin a court's discretion under Code § 8.01-66.9. Courts are not free to simply choose a number that seems fair. Following *Ahlborn* and *Wos*, courts must, where appropriate, reduce the **Medicaid** lien to a value that reflects "that portion of a settlement that represents payments for medical care." *Ahlborn*, 547 U.S. at 282, 126 S.Ct. 1752. The Supreme Court has construed the anti-lien provision to foreclose the State from claiming more than its proportional share of a verdict, judgment or settlement. *Id.* at 282, 284, 126 S.Ct. 1752 ****427** (anti-lien provision "precludes attachment or encumbrance of the remainder of the settlement"). Code § 8.01-66.9 empowers trial courts to examine the potentially wide range of variables specific to each case in determining whether to reduce the **Medicaid** lien at all, and if so, by how much. Therefore, following *Ahlborn* and *Wos*, courts must examine the totality of a plaintiff's damages, such as lost wages, and damages for pain and suffering, disfigurement, deformity, humiliation, and embarrassment, ***468** and make a reasonable allocation for what portion of the verdict, judgment or settlement is attributable to medical expenses paid for by **Medicaid**.

C. The **Medicaid** lien is based on amounts paid by the State's **Medicaid** program, not total medical expenses.

The parties disagree about whether a court tasked with apportioning a **Medicaid** lien should consider the entirety of the medical expenses or merely the portion of a **Medicaid** lien that the State has actually paid. Farah contends that the court should only look to the amount actually paid by the **Medicaid** program, whereas the Commonwealth argues that the court should consider total amounts billed (but not necessarily paid) by medical care providers. We agree with Farah.

[6] First, we note that the Supreme Court's decisions in *Ahlborn* and *Wos* did not specifically address the issue of "[w]hether a **Medicaid** lien may be enforced against the portion of a tort settlement that represents medical expenses that are billed but not paid because medical providers have accepted discounted payments in full satisfaction of their bills." *See*

Southwest Fiduciary, Inc., v. Ariz. Health Care Cost Containment Sys. Admin., 226 Ariz. 404, 249 P.3d 1104, 1107 (Ariz. Ct. App. 2011). We conclude that the allocation decision should be based on the amount **Medicaid** has actually paid, not on amounts of medical expenses billed but not paid. We base this conclusion on the statutory text and the logic of Supreme Court precedent. First, under the **Medicaid** anti-lien provision, "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance *paid or to be paid* on his behalf under the State plan." 42 U.S.C. § 1396p(a)(1) (emphasis added). This provision contemplates a lien for medical assistance paid, not an artificial "list price" billed by a medical provider that was never, in fact, paid. Furthermore, when a benefit recipient makes an assignment to the State, 42 U.S.C. § 1396k(b) provides that "any amount collected by the State under [such] an assignment ... shall be retained by the State ... to reimburse it for [**Medicaid**] *payments made* on behalf of" the recipient, and "the remainder of such amount collected shall be ***469** paid" to the recipient. (Emphasis added). Again, the text of the statute contemplates a lien for amounts actually paid. Another part of this statute provides that,

> *to 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 is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

42 U.S.C. § 1396a(a)(25)(H) (emphasis added). "[S]uch health care items or services" is most naturally and reasonably read as referring to those "health care items or services" for which "payment has been made under the State plan." *Id.* Finally, the Virginia statute, Code § 8.01-66.9 provides a lien for "the total amount paid" – not abstract amounts billed but never actually paid. Therefore, we conclude that the relevant amount for purposes of allocating the **Medicaid** lien is the amount the State **Medicaid** program actually paid, not medical expenses billed by the provider but never paid by the State's **Medicaid** program.

Second, the thrust of the decisions in *Ahlborn* and *Wos* was to ensure the State could recoup a proportional share of the sums it expended on indigent medical care, but no more. The Supreme Court stated in *Ahlborn* that "the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to *payments* for medical care." 547 U.S. at 284-85, 126 S.Ct. 1752 (emphasis added). The Supreme Court's decision in *Ahlborn* to limit the lien exception to that portion of a settlement allocated to medical *payments* supports our conclusion in these cases that the **Medicaid** lien does not extend beyond those amounts that are actually paid.

****428** II. The circuit court's factual findings were not plainly wrong or without evidence to support them.

[7] [8] [9] With these principles in mind, we now turn to the question of whether the circuit court's judgment should be sustained. The familiar standard of review guides our examination of the record. We accord "[g]reat deference" to a trial court's factual findings. *Jones v. Eley*, 256 Va. 198, 201, 501 S.E.2d 405 (1998). "[A]n appellate court is not permitted to substitute its own judgment for that of the finder of ***470** fact, even if the appellate court might have reached a different conclusion." *Commonwealth v. Presley*, 256 Va. 465, 466, 507 S.E.2d 72 (1998). We will not set aside the factual findings of a trial court unless they are "plainly wrong or without evidence to support [them.]" Code § 8.01-680. *See, e.g.*, *Grayson v. Westwood Buildings L.P.*, 300 Va. 25, 58, 859 S.E.2d 651 (2021).

Allocating damages is no easy task, a fact the Supreme Court acknowledged. *Wos*, 568 U.S. at 640, 133 S.Ct. 1391 (absent stipulation, a fair settlement allocation "may be difficult to determine"). Tort cases come in a wide range of guises, from a relatively simple "fender bender" to cases that are extremely complex, factually and legally. Parties commonly disagree over the extent of a plaintiff's pain and suffering, lost wages, the extent to which injuries are permanent, and so on.

In the present case, the circuit court heard extensive evidence concerning Farah's injuries. The record is clear that the court carefully considered this evidence. The court acknowledged the extensive nature of the plaintiff's medical bills, his pain and suffering, and his inability to work. As the finder of fact, the circuit court was entitled to discredit evidence that it found unpersuasive. For example, Mr. Roche testified that the full value of the case was $4 million, but the ad damnum of the complaint asked for $3 million.

[10] [11] [12] The circuit court did order a reduction of the State's lien. Following the reduction, the **Medicaid** lien constitutes approximately 23 percent of the settlement. Although we have the authority to reverse verdicts or judgments that are inadequate as a matter of law, *see, e.g.*, *Bowers v. Sprouse*, 254 Va. 428, 492 S.E.2d 637 (1997),

> [t]he exercise of this power ... is limited by the admonitory principle that, ordinarily, it is within the province of the jury to determine the amount of damages. In a personal injury case, where there is no legal measure of damages for physical pain and suffering, and the jury has arrived at a verdict based upon competent evidence and controlled by proper instructions, in an impartially conducted trial, it has always been held that their verdict is inviolate and cannot be disturbed by the court.

***471** *Davenport v. Aldrich*, 207 Va. 271, 273-74, 148 S.E.2d 768 (1966). Here, the circuit court, acting as factfinder, benefits from comparable deference in making its factual findings to allocate damages under Code § 8.01-66.9. *See Commonwealth, Dep't of Med. Assistance Servs. v. Huynh*, 262 Va. 165, 172, 546 S.E.2d 677 (2001) (apportionment of medical and nonmedical damages is a matter of "sound judicial discretion"). The deferential standard leads us to affirm the circuit court's judgment.[5]

CONCLUSION

The judgment of the circuit court will be affirmed.

Affirmed.

All Citations

300 Va. 458, 868 S.E.2d 422

Footnotes

1 The Commonwealth did not claim that its lien extended to future medical payments. Therefore, *Gallardo v. Marstiller*, No. 20-1263, which deals with this question and which is currently pending before the United States Supreme Court, has no bearing on the present case.

2 The General Assembly has repeatedly considered amendments to this statute, but it has not enacted any of the proposed changes. *See* S.B. 159, Va. Gen. Assem. (Reg. Sess. 2018); S.B. 155, Va. Gen. Assem. (Reg. Sess. 2010).

3 Other courts agree. *See Latham v. Office of Recovery Servs.*, 448 P.3d 1241, 1248 (Utah 2019) ("The *Ahlborn* Court did not endorse any such formula."); *In re E.B.*, 229 W.Va. 435, 729 S.E.2d 270, 296 (2012) ("There can be no question that the *Ahlborn* formula is not the only method of allocation to be followed. There is nothing in the *Ahlborn* decision that compels the use of the formula applied in that case.").

4 The Supreme Court has recognized the possibility "that **Medicaid** beneficiaries and tortfeasors might collaborate to allocate an artificially low portion of a settlement to medical expenses," *Wos.*, 568 U.S. at 634, 133 S.Ct. 1391, to manipulate the settlement in order to "allocate away the State's interest." *Ahlborn*, 547 U.S. at 288, 126 S.Ct. 1752.

5 In its ruling from the bench and in its final order, the circuit court did not specifically provide a breakdown of each discrete category of damages, such as pain and suffering or lost wages. In order to determine what portion of a plaintiff's settlement can properly be attributed to a **Medicaid** program's payments for medical care, a court must examine the plaintiff's total damages in order to make that allocation. We perceive nothing in the law of Virginia or in federal law, however, that requires a circuit court to go beyond a determination of the amount of the State's **Medicaid** lien and to specify from the bench, or in an order, a breakdown for each specific type of damages. The United States Supreme Court has not imposed such a requirement. The text of Code § 8.01-66.9 does not require it either. Although such specificity might be helpful, the court here provided figures for persons or entities that needed to be paid a portion of the settlement, such as DMAS and plaintiff's counsel. Nothing more was required.

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2022 WL 2783933 (Fla.Div.Admin.Hrgs.)

Division of Administrative Hearings

State of Florida

LILLIAN HENDERSON AND NICKY RAINES, ON BEHALF OF AND AS PARENTS AND NATURAL GUARDIANS OF J.R., A MINOR, Petitioners

v.

AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent

Case No. 22-0704MTR

July 11, 2022

Final Order

***1** An administrative hearing was held in this case on May 10, 2022, by Zoom conferencing, before James H. Peterson III, Administrative Law Judge with the Division of Administrative Hearings (DOAH).

Appearances

For Petitioners:

Jason Dean Lazarus, Esquire
Special Needs Law Firm
2420 South Lakemont Avenue, Suite 160
Orlando, Florida 32814

For Respondent:

Alexander R. Boler, Esquire
2073 Summit Lake Drive, Suite 300
Tallahassee, Florida 32317

Statement of the Issue

The issue to be determined is the amount payable to the Agency for Health Care Administration (AHCA or Respondent) towards satisfaction of its $73,245.59 Medicaid lien asserted against personal injury settlement proceeds received by J.R., a minor, by and through his parents and natural guardians, Lillian Henderson and Nicky Raines (Petitioners).

Preliminary Statement

On March 3, 2022, Petitioners filed a petition entitled "Petition to Determine Medicaid's Lien Amount to Satisfy Claim Against Personal Injury Recovery by the Agency for Health Care Administration" (Petition) pursuant to section 409.910(17)(b), Florida Statutes (2022).[1] Thereafter, the final hearing was scheduled and held on May 10, 2022.

At the final hearing, Petitioners presented the testimony of two witnesses, Mark A. Avera, Esquire, and Donald M. Hinkle, Esquire, each of whom was accepted as an expert in valuation of damages in personal injury cases. Petitioners' Exhibits P-1 through P-5 were received into evidence. The parties' Joint Motion for Protective Order to maintain the confidentiality of Exhibits P-4 and P-5 was granted, and those exhibits were placed in an envelope marked confidential and are not available for viewing on DOAH's public website. Other than cross-examination of Petitioners' witnesses, AHCA did not present testimony and did not submit any exhibits.

The proceedings were recorded and a transcript was ordered. The parties were given 10 days from the filing of the transcript within which to file proposed final orders. The one-volume Transcript of the proceedings was filed on June 13, 2022. Thereafter, the parties timely filed their respective Proposed Final Orders, both of which were considered in rendering this Final Order.

FIndings of Fact[2]

1. On October 23, 2019, Lillian Henderson, J.R.'s mother, was admitted to North Florida Regional Medical Center in Gainesville, Florida, at more than 40 weeks pregnant for an induction of labor. After more than 24 hours in labor, the defendant doctor attempted to deliver J.R. by forcep extraction. Using forceps, the defendant doctor pulled on J.R.'s skull three times, which failed to deliver J.R.

***2** 2. After the failed forceps delivery, J.R. was delivered via a cesarean section. At birth, nurses noted that J.R. presented with a weak cry and poor tone and color. J.R. was transferred from the normal newborn nursery to the neonatal intensive care unit (NICU) due to indications of a skull fracture and seizures. J.R. was noted to have a left parietal depression, indicative of a depressed skull fracture.

3. On October 25, 2019, J.R. was transported from the NICU at North Florida Regional Medical Center to Shands Hospital where he was diagnosed with a skull fracture and underwent pediatric neurosurgical intervention.

4. As a result of the alleged negligence of the defendants, J.R. suffered a depressed skull fracture, seizures, and other physically-disabling conditions.

5. In November of 2020, J.R.'s parents brought a medical malpractice personal injury action to recover damages related to the alleged malpractice. This action was brought against several defendants. Thereafter, a Neurological Injury Compensation Association petition to determine eligibility for benefits was filed in April of 2021.

6. In December of 2021, after the suit was filed, Petitioners agreed to settle J.R.'s medical malpractice claim.

7. AHCA was properly notified of J.R.'s lawsuit against the defendants and indicated it had paid benefits related to the injuries from the incident in the amount of $73,245.59. AHCA has asserted a lien for the full amount it paid, $73,245.59, against J.R.'s settlement proceeds.

8. AHCA, through its Medicaid program, provided $73,245.59 in payment for J.R.'s medical care related to his injuries. This $73,245.59 represents J.R.'s entire claim for past medical expenses.

9. No portion of the $73,245.59 paid through the Medicaid program on behalf of J.R. represents expenditures for future medical expenses, and Medicaid did not make payments in advance for medical care.

10. Given the amount of the settlement, applying the statutory reduction formula set forth in section 409.910(11)(f) to this particular settlement would result in no reduction of the $73,245.49 Medicaid lien.

11. Petitioners have deposited the full Medicaid lien amount of $73,245.49 in an interest-bearing account for the benefit of AHCA pending an administrative determination of AHCA's rights, and this constitutes “final agency action” for purposes of chapter 120, Florida Statutes, pursuant to section 409.910(17).

12. At the final hearing, Mark A. Avera, Esquire, who represented Petitioners in the underlying medical malpractice action, and Donald M. Hinkle, Esquire, were both accepted, without objection, as experts in the valuation of damages suffered by injured parties. Both Mr. Avera and Mr. Hinkle are members of several trial attorney associations and stay abreast of jury verdicts relative to birth injuries, and ascertain the value of damages suffered by injured parties as a routine part of their practices.

13. According to both Mr. Avera and Mr. Hinkle, J.R.'s damages have a value $1,500,000.

***3** 14. AHCA did not call any witnesses, present any evidence as to the value of Petitioners' claim, or propose a differing valuation of the damages. Based upon the unrebutted evidence presented by Petitioners' experts, it is found that a reasonable value of Petitioners' claim is $1,500,000.

15. Although the evidence convincingly demonstrated that the value of Petitioners' damages claim is $1,500,000, the evidence as to what portion of that claim represents past and future medical expenses was less than clear. Rather than giving a particular figure for economic damages, Mr. Avera indicated that non-economic damages were 75 to 80 percent of Petitioners' claim. Mr. Hinkle indicated that non-economic damages were in the range of 80 to 90 percent of the claim.

16. Without stating the dollar amount of Petitioners' settlement,[3] both Mr. Avera and Mr. Hinkle testified that Petitioners' settlement represents only a 16.67 percent recovery of Petitioners' damages.

17. Neither Mr. Avera nor Mr. Hinkle included past medical expenses in valuing Petitioners' claim. If Medicaid's past payment of $73,245.59 is added to 25 percent of the settlement estimated by Mr. Avera to represent the high end of economic damages, the result, after reducing the amount to 16.67 percent of the value of Petitioners' claim, is more than sufficient to pay AHCA's Medicaid lien in full, as follows: [(25% x $1,500,000) + 73,245.49] x 16.67% = $74,722.52.

18. Further, a life care plan detailing the costs of J.R.'s medical expenses because of his injuries was never prepared. According to Mr. Avera, the life plan portion is 20 to 30 percent of the value of Petitioners' claim, for a range of $300,000 to $450,000.

19. Even without adding past medical expenses, 16.67 percent of Mr. Avera's estimated $300,000 to $450,000 range for future medical expenses results in $50,010 to $75,015 of economic damages attributable to future medical expenses. If past medical expenses paid by Medicaid are added, the range for future plus past medical expenses becomes $373,245.49 to $523,245.49, which, when multiplied by 16.67 percent, results in a range of proportional sums from $62,220.02 to $87,225.02 in settlement proceeds available to satisfy AHCA's Medicaid lien.

20. In sum, the evidence, as outlined in the Findings of Fact, above, does not support reduction of AHCA's Medicaid lien.

Conclusions of Law

21. DOAH has jurisdiction over the subject matter and parties in this case pursuant to sections 120.569, 120.57(1), and 409.910(17).

22. AHCA is the agency authorized to administer Florida's Medicaid program. *See* § 409.902, Fla. Stat.

23. The Medicaid program "provide[s] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). Though participation is optional, once a state elects to participate in the Medicaid program, it must comply with federal requirements governing the same. *Id.*

***4** 24. As a condition for receipt of federal Medicaid funds, states are required to seek reimbursement for medical expenses incurred on behalf of Medicaid recipients who later recover from legally-liable third parties. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 276 (2006).

25. Consistent with this federal requirement, the Florida Legislature has enacted section 409.910, which authorizes and requires the State to be reimbursed for Medicaid funds paid for a recipient's medical care when that recipient later receives a personal injury judgment or settlement from a third party. *Smith v. Ag. for Health Care Admin.*, 24 So. 3d 590 (Fla. 5th DCA 2009). The statute creates an automatic lien on any such judgment or settlement for the medical assistance provided by Medicaid. *See* § 409.910(6)(c), Fla. Stat.

26. The amount to be recovered for Medicaid medical expenses from a judgment, award, or settlement from a third party is determined by the formula in section 409.910(11)(f). *Ag. for Health Care Admin. v. Riley*, 119 So. 3d 514, 515 n.3 (Fla. 2d DCA 2013).

27. Application of the formula in section 409.910(11)(f) to Petitioners' settlement proceeds in this case requires payment to AHCA of its full $73,245.49 Medicaid lien.

28. Respondent correctly asserts that it is not automatically bound by any allocation of damages set forth in a settlement between a Medicaid recipient and a third party that may be contrary to the formulaic amount, citing section 409.910(13). *See also* § 409.910(6)(c) 7., Fla. Stat. ("No release or satisfaction of any ... settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the agency joins in the release or satisfaction or executes a release of the lien."). Rather, in cases such as this, where Respondent has not participated in or approved the settlement, the administrative procedure created by section 409.910(17)(b) is the means for determining whether a lesser portion of a total recovery should be allocated as reimbursement for medical expenses in lieu of the amount calculated by application of the formula in section 409.910(11)(f).

29. Section 409.910(17)(b) provides:

> (b) If federal law limits the agency to reimbursement from the recovered medical expense damages, a recipient, or his or her legal representative, may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. In order to successfully challenge the amount designated as recovered medical expenses, the recipient must prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f). Alternatively, the recipient must prove by clear and convincing evidence that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

***5** 30. Petitioners proved that the settlement proceeds represent only 16.67 percent of Petitioners' claim, which is valued at $1,500,000.

31. While, in the past, Medicaid recipients have successfully argued that the percentage reduction (in this case 16.67 percent) should be applied only to Medicaid's lien for *past* medical expenses, the recent United States Supreme Court's decision in *Gallardo v. Marstiller*, 596 U.S. _, 2022 U.S. LEXIS 2683, 2022 WL 1914096 (June 6, 2022), made it clear that Medicaid's lien extends to the amount of a claim attributed to past and *future* medical expenses.

32. In this case, evidence that AHCA's Medicaid lien should be reduced was less than clear and convincing. Rather than showing that the proportional sum of the value of Petitioners' claim to pay past and future medical expenses was less than AHCA's full Medicaid lien of $73,245.49, the evidence showed a range of $62,220.02 to $87,225.02 from settlement proceeds available to pay the lien. The top of that range is more than sufficient to pay the full lien and the evidence was otherwise insufficient to demonstrate that the lien should be reduced.

33. Therefore, it is concluded that Respondent is not entitled to less than the full amount of $73,245.49 in satisfaction of AHCA's Medicaid lien.

Order

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby Ordered and Determined that the Agency for Health Care Administration is entitled to recover 100 percent of its lien, and is hereby awarded the full amount of $73,245.49 from Petitioners.

Done and Ordered this 11th day of July, 2022, in Tallahassee, Leon County, Florida.

JAMES H. PETERSON, III
Administrative Law Judge
Division of Administrative Hearings
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060

Filed with the Clerk of the Division of Administrative Hearings this 11th day of July, 2022.

Notice of Right to Judicial Review

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing one copy of a Notice of Administrative Appeal with the agency clerk of the Division of Administrative Hearings and a second copy, accompanied by filing fees prescribed by law, with the District Court of Appeal, First District, or with the District Court of Appeal in the appellate district where the party resides. The Notice of Administrative Appeal must be filed within 30 days of rendition of the order to be reviewed.

Footnotes

[1] Unless otherwise noted, all statutory references to section 409.910 and other statutes are to current versions, which have not substantively changed since 2021 when Petitioners' medical malpractice case settled.

[2] Findings of Fact 1 through 11 are derived from the parties' Statement of Admitted and Stipulated Facts in their Joint Pre-Hearing Stipulation.

[3] While the amount was not revealed for confidentiality purposes, the settlement amount can be readily determined by applying the recovery percentage to the value of the claim.

2022 WL 2783933 (Fla.Div.Admin.Hrgs.)

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2022 WL 2707875 (Fla.Div.Admin.Hrgs.)

Division of Administrative Hearings

State of Florida

TYLER DAGENHART, Petitioner
v.
AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent

Case No. 22-0835MTR

July 6, 2022

Final Order

***1** Pursuant to notice, a formal administrative hearing was conducted via Zoom on May 23, 2022, before Administrative Law Judge Garnett W. Chisenhall of the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner:

Mark N. Tipton, Esquire
Daniel L. Hightower, P.A.
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Ocala, Florida 34470

For Respondent:

Alexander R. Boler, Esquire
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Tallahassee, Florida 32317

Statement Of The Issue

The issue to be determined is the amount Respondent, Agency for Health Care Administration ("AHCA"), is to be reimbursed for medical expenses paid on behalf of Tyler Dagenhart ("Petitioner" or "Mr. Dagenhart"), pursuant to section 409.910, Florida Statutes (2021).[1]

Preliminary Statement

If a Medicaid recipient receives an injury settlement from a third party, then section 409.910 mandates that those settlement proceeds shall be used to reimburse the Medicaid program for medical expenses paid on the Medicaid recipient's behalf. This

mandate is facilitated by a statutory lien in AHCA's favor on the settlement proceeds, and federal law mandates that Medicaid's lien applies to past and future medical expenses that the Medicaid recipient *actually recovered through the settlement*. When a Medicaid recipient's settlement proceeds are less than the recipient's total damages (which may consist of multiple components, such as past medical expenses, future medical expenses, economic damages, and noneconomic damages), a question can arise as to how much of the medical expenses were actually recovered by the Medicaid recipient and thus subject to the Medicaid lien. Section 409.910(11)(f) sets forth a formula to determine the amount Medicaid shall recover from the settlement proceeds, and section 409.910(17)(b) provides that a Medicaid recipient can request a formal administrative hearing to demonstrate, by clear and convincing evidence, that the past and future medical expenses *actually recovered through the settlement* were less than the amount calculated via section 409.910(11)(f).

On May 26, 2021, Mr. Dagenhart filed a "Petition to Determine the Amount Payable to [AHCA] and Wellcare in Satisfaction of Medicaid Lien" to challenge Medicaid liens filed by AHCA and Wellcare Health Plans, Inc. ("Wellcare"), against settlement proceeds recovered by Mr. Dagenhart via a workers' compensation claim. Mr. Dagenhart valued his total damages as being well in excess of $2,500,000.00. After accounting for attorney's fees and costs, Mr. Dagenhart asserted that his net recovery was $183,951.77, or approximately 7.3 percent of the full value of his damages. Accordingly, Mr. Dagenhart asserted that AHCA was only entitled to recover 7.3 percent of the medical expenses it paid on his behalf, i.e., $8,143.16.

***2** The parties filed a Joint Pre-hearing Stipulation in which they identified stipulated facts for which no further proof would be necessary. Those stipulated facts have been accepted and considered in the preparation of this Final Order.

The final hearing was held as scheduled on May 23, 2022. During the final hearing, Petitioner presented no live testimony. The undersigned accepted Petitioner's Exhibits 1 through 15 into evidence. In the process of doing so, the undersigned noted AHCA's hearsay objections to Petitioner's Exhibits 13 and 14.

AHCA offered no witnesses and did not move any exhibits into evidence.

The one-volume Transcript from the final hearing was filed on June 6, 2022.

Proposed Final Orders were timely filed on June 16, 2022, and both Proposed Final Orders were considered during the preparation of this Final Order.

Findings Of Fact

The following findings are based on exhibits accepted into evidence, admitted facts set forth in the Pre-hearing Stipulation, and matters subject to official recognition.

Facts Pertaining to Petitioner's Injuries, the Settlement, and the Medicaid Lien

1. On November 28, 2018, Mr. Dagenhart was catastrophically injured when he slipped and fell approximately 30 feet from the roof of an airplane hangar. Mr. Dagenhart was transported from the accident scene by ambulance to Ocala Regional Medical Center ("ORMC"). He remained at ORMC until he was discharged on approximately February 13, 2019.

2. Mr. Dagenhart had the following injuries: (a) severely comminuted and angulated distal tibial and fibular fractures in both ankles; (b) a severe complex burst type compression fracture in the lumbar spine with traumatic grade 1 anterolisthesis and extensive hematoma from T12 through the sacral canal; (c) spinal stenosis; and (d) a left wrist fracture.

3. Mr. Dagenhart underwent multiple surgeries and extensive rehabilitation. Nevertheless, he still relies on a wheelchair for mobility.

4. Mr. Dagenhart's charges from ORMC total $1,448,817.80. He incurred additional medical expenses for multiple surgeries, and he also suffered lost wages.

5. Because Mr. Dagenhart was in the course and scope of his employment at the time of the November 28, 2018, accident, he filed a workers' compensation claim.

6. The Employer/Carrier ("the E/C") denied that Mr. Dagenhart was entitled to workers' compensation benefits. In doing so, the E/C asserted that he tested positive for marijuana metabolites while in the hospital.[2] Mr. Dagenhart also refused to submit to a drug/alcohol test as requested by the E/C.[3]

7. Because of the substantial uncertainty associated with pursuing a claim for workers' compensation benefits, Mr. Dagenhart elected to accept $250,000, inclusive of attorney's fees and costs, as payment for past and future medical and indemnity benefits.

8. Non-compensatory damages, such as pain and suffering, are unavailable under Florida's Workers' Compensation Act.

***3** 9. Mr. Dagenhart's net recovery was $183,951.77 because he paid attorney's fees of $62,500 and costs of $3,548.23.

10. AHCA and WellCare paid $98,238.31 and $13,311.87, respectively, for Mr. Dagenhart's past medical expenses. AHCA and Wellcare, through their respective collection contractors, have asserted liens totaling $111,550.18.

11. Pursuant to the formula set forth in section 409.910(11)(f), AHCA and WellCare would be entitled to half of Mr. Dagenhart's net recovery after deducting the taxable costs and 25 percent for attorney's fees. Because Mr. Dagenhart's net recovery after deducting attorney's fees and costs was $183,951.77, the maximum lien allowable under the statutory formula would be $91,975.88 ($183,951.77 x .5 = $91,975.88).

12. Mr. Dagenhart has deposited $91,975.88 into an interest-bearing account pending an administrative determination regarding the amount of AHCA's Medicaid lien.

Valuation of Mr. Dagenhart's Damages

13. Lynne Shigo has been practicing workers' compensation law in Florida since January of 1994. She estimates that workers' compensation accounts for 90 to 95 percent of her current practice. In the course of representing her clients, she must evaluate the full value of particular claims.[4]

14. Ms. Shigo offered the following testimony regarding the value of Mr. Dagenhart's workers' compensation claim:
Q: And can you tell us if Mr. Dagenhart's entitlement to workers' compensation benefits had not been in dispute, what would be the full value of his case, if you have an opinion?

A: The full value I believe would be approximately about 2.5 million. When you look at the present value of [permanent total disability] that was supplied to me, that was $804,418.96. So also look at the - how much the carrier would approximately pay, which is between 50 and 60 percent of that. Then I looked at the outstanding medical bills which were about 1.5 million. And then at the time of the settlement, he was in a wheelchair and not walking, so I conservatively estimated the medical at 600,000,

which really is conservative based upon the fact that his life expectancy was 42.6 years. That would give medical benefits [of] approximately $14,084 and some odd cents a year.

Q: The 600,000, if I understand correctly, would be a future medical projection?

A: Yes.[5]

Q: Okay. And then as you're aware, the settlement amount, the amount that Mr. Dagenhart received, was a total of $250,000; is that correct?

A: Yes.

Q: Can you tell us under the workers' compensation act if an accident is occasioned primarily by the intoxication of the employee, what impact does that have on their eligibility for workers' compensation benefits?

A: Huge. Basically the settlement of 250 was a wonderful settlement based upon the fact that he denied taking the drug test. Right there that's a presumption that he was under the influence at the time of the accident which was the reason that he was injured.

***4** Q: Okay. And so his refusal to take the drug test would be - would raise a presumption that he - that this accident was occasioned by intoxication?

* * *

A: Yes.

Q: And if, in fact, he is found to have refused to submit to the drug test and that presumption arose, would that disqualify him from any workers' compensation benefits?

A: Yes. That's why the 250,000 settlement was a wonderful settlement because he could have [gotten] zip, meaning zero.

* * *

Q: Very good. And in terms of your testimony and opinions regarding the full value of

Mr. Dagenhart's case, are those opinions you can state within a reasonable degree of legal certainty?

* * *

A: The - based upon the evidence that I looked at, there's a - the presumption that the intoxication defense would hold with the judge, there would not be clear and convincing evidence to show that the accident would have happened without the alcohol defense. In other words, the intoxication defense is the reason that he was injured, because he was impaired.

Findings Regarding the Testimony Presented at the Final Hearing

15. The undersigned finds that the testimony from Ms. Shigo was compelling and persuasive with regard to the full value of Mr. Dagenhart's claim, his past and future medical expenses, and the present value of his permanent total disability.

16. Ms. Shigo did not provide any testimony that a pro-rata reduction would accurately or correctly determine the portion of Mr. Dagenhart's settlement that accounts for past and future medical expenses. Therefore, Petitioner failed to prove, by clear and convincing evidence, that a lesser portion of his settlement should be allocated as past and future medical expenses than the amount determined via the statutory formula in section 409.910(11)(f).

Conclusions Of Law

17. DOAH has jurisdiction over the subject matter and the parties in this case pursuant to sections 120.569, 120.57(1), and 409.910(17), Florida Statutes.

18. AHCA is the agency authorized to administer Florida's Medicaid program. § 409.902, Fla. Stat.

19. The Medicaid program "provide[s] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980).

20. "The Medicaid program is a cooperative one. The Federal Government pays between 50 percent and 83 percent of the costs a state incurs for patient care. In return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program." *Est. of Hernandez v. Ag. for Health Care Admin.*, 190 So. 3d 139, 141-42 (Fla. 3rd DCA 2016) (internal citations omitted).

21. Though participation is optional, once a state elects to participate in the Medicaid program, it must comply with federal requirements. *Harris*, 448 U.S. at 301.

***5** 22. One condition for receipt of federal Medicaid funds requires states to seek reimbursement for medical expenses incurred on behalf of Medicaid recipients who later recover funds from legally liable third parties. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 276 (2006); *see also Est. of Hernandez*, 190 So. 3d at 142 (noting that one such requirement is that "each participating state implement a third-party liability provision, which requires the state to seek reimbursement for Medicaid expenditures from third parties who are liable for medical treatment provided to a Medicaid recipient.").

23. Consistent with this federal requirement, the Florida Legislature enacted section 409.910, designated as the "Medicaid Third-Party Liability Act," which authorizes and requires the state to be reimbursed for Medicaid funds paid for a recipient's medical care when that recipient later receives a personal injury judgment, award, or settlement from a third party. *Smith v. Ag. for Health Care Admin.*, 24 So. 3d 590 (Fla. 5th DCA 2009); *see also Davis v. Roberts*, 130 So. 3d 264, 266 (Fla. 5th DCA 2013)(stating that in order "[t]o comply with federal directives the Florida legislature enacted section 409.910, Florida Statutes, which authorizes the State to recover from a personal injury settlement money that the State paid for the plaintiff's medical care prior to recovery.").

24. Section 409.910(1) sets forth the Florida Legislature's clear intent that Medicaid be repaid in full for medical care furnished to Medicaid recipients by providing that:

> It is the intent of the Legislature that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien, and subrogation are abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

25. In addition, the Florida Legislature has authorized AHCA to recover the monies paid from any third party, the recipient, the provider of the recipient's medical services, and any person who received the third-party benefits. § 409.910(7), Fla. Stat. AHCA's effort to recover the full amount paid for medical assistance is facilitated by section 409.910(6)(a), which provides that AHCA:

***6** [I]s automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the agency from any and all third-party benefits. Equities of a recipient, his or her legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recovery by the agency as to its subrogation rights granted under this paragraph.

See also § 409.910(6)(b) 2., Fla. Stat. (providing that AHCA "is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. Equities of a recipient, the recipient's legal representative, his or her creditors, or health care providers shall not defeat or reduce recovery by the agency as to the assignment granted under this paragraph.").

26. AHCA's efforts are also facilitated by the fact that AHCA has "an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness by which a third party is or may be liable, upon the collateral, as defined in s. 409.901." § 409.910(6)(c), Fla. Stat.

27. The amount to be recovered by AHCA from a judgment, award, or settlement from a third party is determined by the formula in section 409.910(11)(f). *Ag. for Health Care Admin. v. Riley*, 119 So. 3d 514, 515 n.3 (Fla. 2d DCA 2013).

28. Section 409.910(11)(f) provides:

Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

1. After attorney's fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.

2. The remaining amount of the recovery shall be paid to the recipient.

3. For purposes of calculating the agency's recovery of medical assistance benefits paid, the fee for services of an attorney retained by the recipient or his or her legal representative shall be calculated at 25 percent of the judgment, award, or settlement.

29. Applying the formula in section 409.910(11)(f) to Mr. Dagenhart's $250,000 settlement results in AHCA being owed $91,975.88.

30. As noted above, section 409.910(6) prohibits the Medicaid lien from being reduced because of equitable considerations. However, when AHCA has not participated in or approved a settlement, the administrative procedure created by section 409.910(17)(b) serves as a means for determining whether a lesser portion of a total recovery should be allocated as reimbursement for medical expenses in lieu of the amount calculated by application of the formula in section 409.910(11)(f).

***7** 31. Section 409.910(17)(b) provides, in pertinent part, that:

> A recipient may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a) .... In order to successfully challenge the amount payable to the agency, the recipient must prove, by clear and convincing evidence,[6] that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses[7] than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f) or that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

32. Therefore, the formula in section 409.910(11)(f) provides an initial determination of AHCA's recovery for medical expenses paid on a Medicaid recipient's behalf, and section 409.910(17)(b) sets forth an administrative procedure for adversarial testing of that recovery. *See Harrell v. State*, 143 So. 3d 478, 480 (Fla. 1st DCA 2014)(stating that petitioner "should be afforded an opportunity to seek the reduction of a Medicaid lien amount established by the statutory default allocation by demonstrating, with evidence, that the lien amount exceeds the amount recovered for medical expenses.").

33. In the instant case, the parties agree that Petitioner recovered 10 percent of the full value of his case. The parties also agree that the statutory formula in section 409.910(11)(f) would result in AHCA recovering $91,975.88.

34. Mr. Dagenhart made the following argument in his Proposed Final Order:
The only two categories of benefits that go into calculating the full value of a workers' compensation settlement according to Ms. Shigo's testimony are medical and indemnity benefits. Carving out $804,000.00, the approximate value of the Petitioner's potential indemnity benefits, from the $2,500,000.00 full value of the Petitioner's workers' compensation case, as testified to by Ms. Shigo, reveals that approximately 68% of the full value of the Petitioner's case, or approximately $1,700,000.00, was attributable to past and future medical care. Applying this percentage to approximate how much of the gross settlement is attributable to the medical care reveals that approximately $170,000.00 of the settlement is fairly allocated to past and future medical care. ($250,000.00 gross settlement * 68% = $170,000.00). Thus, [Mr. Dagenhart]'s settlement represents approximately 10% of the full value of his past and future medical care. ($170,000.00/$1,700,000.00).

The statutory (11)(f) formula would result in AHCA recovering $91,975.88. This represents a recovery of approximately 82.4% of the total amount expended by Medicaid, whereas the Petitioner only recovered 10% of the full value of his case.

* * *

***8** Contrary to the mandate in Wos, the (11)(f) formula does not achieve a fair allocation where AHCA would recover over 82% of the amount expended on medical care, and the Petitioner recovered only 10% of the value of his case. I find that AHCA's proper lien recovery should be in the same proportion as [[Petitioner]'s net recovery to the full value of his settlement. Thus, AHCA is entitled to recover $9,823.83, 10% of the amount paid by AHCA.

35. In short, Mr. Dagenhart argues that the statutory formula in section 409.910(11)(f) does not achieve a fair allocation when it would result in AHCA recovering over 82 percent of the amount it spent on Petitioner's medical care while Petitioner's settlement only represents 10 percent of the full value of his workers' compensation claim. Therefore, Petitioner utilizes the "pro rata method" to argue that AHCA's recovery should be limited to 10 percent, i.e., $9,823.83, of the $98,238.31 AHCA spent on Petitioner's past medical care. *See generally Willoughby v. Ag. for Health Care Admin.*, 212 So. 3d 516, 522 (Fla. 2d DCA 2017)(noting that Appellant argued for a pro rata allocation "because the settlement represents but only some forty percent of the total value of the case, Mr. Willoughby urges that AHCA can recover only about 40 percent of the expenses it incurred.").

36. Mr. Dagenhart's argument regarding what portion of his settlement represents past and future medical expenses is limited to a computational argument set forth in his Proposed Final Order. That argument is unsupported by any expert testimony opining that this computational argument is a reasonable method by which to determine what portion of Mr. Dagenhart's settlement amounts to a recovery of past and future medical expenses.[8]

37. As a result, the outcome of the instant case is controlled by *Gray v. Agency for Health Care Administration*, 288 So. 3d 95 (Fla. 1st DCA 2019).

38. In *Gray*, an ALJ ruled that AHCA was entitled to recover the full amount of its Medicaid lien. The *Gray* appellant argued, in part, that the ALJ erred by failing to use a pro rata formula to calculate AHCA's portion of the recovery. In rejecting that argument, the Court ruled as follows:
Gray argued that the $10,000 recovery represented 0.349% of the value of his $2.8 million verdict, so AHCA's lien should be limited to 0.349% of the total amount Medicaid expended in medical benefits ($65,615.054), which would equate to $229.49. AHCA argued that, under the statutory formula, it was entitled to $3,750 from Gray's recovery and that Gray failed to prove that AHCA should be entitled to a lesser amount. Gray conceded that no case law or other statute authorized the ALJ to apply a pro rata formula instead of the formula provided in the statute.

The ALJ found that Gray failed to show by clear and convincing evidence that AHCA was entitled to less than the presumptive amount under the statute - $3,750. The ALJ found no evidence in the record to show that "the $10,000 recovery does not include at least $3,750 that could be attributed to [[Gray's] medical costs. Neither does the evidence indicate that the $3,750 amount includes payments for expenses other than [Gray's] medical care and services." The ALJ ruled that AHCA was entitled to $3,750 from the $10,000 recovery.

* * *

***9** Even though he failed to produce evidence or present testimony to meet his burden to show that the lien amount should be reduced, Gray maintains that the ALJ should have used a pro rata formula to calculate AHCA's share of the tort recovery. Gray acknowledges that nothing in the statute authorizes the ALJ to use a pro rata formula to calculate the lien amount. Rather, *in situations such as this case, when the plaintiff fails to produce evidence or present testimony showing that the lien amount*

should be reduced, the plain language of section 409.910(11)(f) requires the ALJ to apply the statutory formula. The ALJ did exactly that here and did not err in calculating the lien amount.

Gray, 288 So. 3d 95. (emphasis added)

39. Like the appellant in *Gray*, Mr. Dagenhart failed to carry his burden of demonstrating that AHCA's Medicaid lien should be reduced. There is no competent, substantial evidence on which the undersigned could base a finding that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses than the amount calculated by AHCA pursuant to the formula set forth in section 409.910(11)(f). *See* § 409.910(17)(b).

40. Moreover, even if Mr. Dagenhart had presented evidence sufficient to justify utilizing the pro rata method, the formula in section 409.910(11)(f) would still control. The United States Supreme Court recently ruled that a Medicaid lien attaches to past and future medical expenses. *See* *Gallardo v. Marstiller*, 2022 WL 1914096 at *5 (U.S. 2022)(stating that "[t]he relevant distinction is thus "between medical and nonmedical expenses, not between past expenses Medicaid has paid and future expenses it has not.").

41. Mr. Dagenhart's past medical expenses include $1,448.817.80 in outstanding medical bills, $98,238.31 in medical bills paid by AHCA, and $13,311.87 in medical bills paid by Wellcare. Thus, Mr. Dagenhart's total past medical expenses are $1,560,367.98. With Ms. Shigo estimating Mr. Dagenhart's future medical expenses to be $600,000, then his past and future medical expenses total $2,160,367.98. Because 10 percent of that total results in a recovery far in excess of AHCA's lien (i.e., $216,036.80), the lien must be paid via the statutory formula in section 409.910(11)(f).

42. In sum, Mr. Dagenhart failed to prove by clear and convincing evidence that a lesser portion of his settlement should be allocated as past and future medical expenses than the amount determined via the statutory formula in section 409.910(11)(f).

Order

Based on the foregoing Findings of Fact and Conclusions of Law, it is Ordered that the Agency for Health Care Administration is entitled to $91,975.88 in satisfaction of its Medicaid lien.

Done And Ordered this 6th day of July, 2022, in Tallahassee, Leon County, Florida.

G. W. CHISENHALL
Administrative Law Judge
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060

***10** Filed with the Clerk of the Division of Administrative Hearings this 6th day of July, 2022.

Notice Of Right To Judicial Review

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk

of the district court of appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.

Footnotes

[1] Unless indicated otherwise, all statutory references will be to the 2019 version of the Florida Statutes because Petitioner's exhibits indicate his workers' compensation case settled in 2019. *See* *Suarez v. Port Charlotte HMA*, 171 So. 3d 740, 742 (Fla. 2d DCA 2015).

[2] Section 440.09(3), Florida Statutes (2019), provides that "[c] ompensation is not payable if the injury was occasioned primarily by the intoxication of the employee; by the influence of any drugs, barbiturates, or other stimulants not prescribed by a physician; or by the willful intention of the employee to injure or kill himself, herself, or another."

[3] Section 440.101(2), Florida Statutes (2019), provides that "a drug-free workplace program must require the employer to notify all employees that it is a condition of employment for an employee to refrain from reporting to work or working with the presence of drugs or alcohol in his or her body and, if an injured employee refuses to submit to a test for drugs or alcohol, the employee forfeits eligibility for medical and indemnity benefits."

[4] Counsel for Petitioner took Ms. Shigo's deposition in lieu of live testimony and offered her as an expert in the field of workers' compensation. Counsel for AHCA did not raise an objection. The undersigned accepts Ms. Shigo as an expert in workers' compensation.

[5] Ms. Shigo testified that the future medical expenses would consist of additional surgeries, pain management, physical therapy, and perhaps occupational therapy.

[6] *See* *Gallardo by & through Vassallo v. Dudek*, 963 F.3d 1167, 1182 (11th. Cir. 2020)(finding no conflict between the clear and convincing evidence standard and federal law).

[7] The United States Supreme Court recently determined in *Gallardo v. Marstiller*, 2022 WL 1914096 (U.S. 2022), that the Medicaid lien attaches to past and future medical expenses.

[8] Mr. Dagenhart's argument differs from those of other petitioners who have predominantly relied on expert testimony to justify a pro rata reduction in AHCA's Medicaid lien. The detailed opinion in *Eady v. State*, 279 So. 3d 1249 (Fla. 1st DCA 2019), describes how petitioners typically argue for a pro rata reduction. The *Eady* petitioner called two attorneys as witnesses, and both were accepted as experts in the valuation of damages. *Id.* at 1251. The first expert witness conservatively estimated the value of the petitioner's damages as being at least $15,000,000. *Id.* at 1252. That witness then testified that the petitioner's $1,000,000 settlement represented approximately 6.66 percent of his total estimated damages.
"Applying that same percentage difference to the $177,747.91 in past medical expenses claimed by AHCA, [the first witness] testified that $11,838 *would be a reasonable allocation of the confidential settlement agreement for past medical expenses*.
In other words, the $11,838 represented a pro rata share of the million dollar settlement." *Id.* (emphasis added) The second expert witness agreed that $15,000,000 was a conservative estimate of the petitioner's total damages. *Id.* at 1253. The second expert witness also agreed that the petitioner's $1,000,000 settlement represented a 6.66 percent recovery of his total damages.

"[The second expert] also agreed that if [the petitioner] recovered only 6.66% of the full value of his case, that same percentage should be allocated to past medical expenses recoverable by AHCA. Furthermore, he added that applying that ratio was not only reasonable, but was common practice in the legal proceedings with which he historically had been associated. Again, [the second expert witness] approved of the notion that applying a pro rata formula to the settlement amount would result in $11,838 allocated to past medical expenses." *Id.* Mr. Dagenhart did not provide expert testimony of a similar nature.

2022 WL 2707875 (Fla.Div.Admin.Hrgs.)

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2022 WL 2783929 (Fla.Div.Admin.Hrgs.)

Division of Administrative Hearings

State of Florida

LILLIAN HENDERSON and NICKY RAINES, on behalf of and as parents and natural guardians of J.R., a minor, Petitioner
v.
AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent

Case No.: 22-0704MTR

June 23, 2022

RESPONDENT'S PROPOSED FINAL ORDER

***1** Pursuant to notice, a final hearing was held in this case on May 10, 2022, by Zoom video-teleconference, before James H. Peterson, III, a designated Administrative Law Judge of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner:

Jason D. Lazarus
2420 South Lakemont Avenue
Suite 160
Orlando, FL 32814

For Respondent:

Alexander R. Boler
2073 Summit Lake Drive
Suite 330
Tallahassee, Florida 32317

STATEMENT OF THE ISSUE

The issue to be determined is whether AHCA's Medicaid lien of $73,245.59 shall be paid in full from the settlement recovery for Petitioner, under section 409.910(11)(f), Florida Statutes, or some lesser amount under section 409.910(17)(b).

PRELIMINARY STATEMENT

All citations to statutes are to the Florida Statutes (2021), unless otherwise indicated.

Petitioner LILLIAN HENDERSON and NICKY RAINES, on behalf of and as parents and natural guardians of J.R., a minor will be referred to as "Petitioner," while the minor J.R. "Will be referred to as "J.R." Respondent AGENCY FOR HEALTH CARE ADMINISTRATION will be referred to as "Respondent" or "AHCA."

BACKGROUND

On March 3, 2022, Petitioner filed a Petition under section 409.910(17)(b) with DOAH. Before the final hearing, Petitioner and AHCA filed a Joint Stipulation in which they agreed upon several facts. The undersigned will rely on those stipulated facts in addition to any facts proven by clear and convincing evidence.

At the final hearing, Petitioner presented two witnesses and submitted into evidence 5 exhibits (labeled 1-5), which were accepted into evidence, although exhibits 3-5 were noted to be hearsay, subject to the administrative hearsay rule. AHCA noticed one exhibit (labeled A), but explained that it was duplicative of stipulated facts, and did not submit it.

Unless proven otherwise, AHCA must be reimbursed in accordance with the statutory formula in section 409.910(11)(f), which limits AHCA's recovery to the lesser of (1) its full lien, or (2) one-half of the settlement remaining after attorney fees (calculated at 25%) and taxable costs are subtracted. Here, it is not disputed that the statutory formula results in the AHCA recovering its $73,245.59 Medicaid lien in full.

Under section 409.910(17)(b) Petitioner may try to prove that the portion of the gross settlement amount which should be allocated to medical expenses is less than the $73,245.59 due under the statute. This statutory process complies with the United States Supreme Court decision in *Wos v. E.M.A.*, 133 S. Ct. 1391 (2013), under which Medicaid recipients must be able to contest the amount designated as recovered medical expense damages payable to AHCA following the formula specified in 409.910(11)(f), which is the default allocation. If the recipient wishes to challenge the default allocation, Florida law provides the recipient a right to petition DOAH to determine whether AHCA should receive a lesser amount of the recipient's recovery to satisfy the statutory lien.

***2** Here, AHCA argued that Petitioner failed to prove with clear and convincing evidence that AHCA should recover less than $73,245.59. Petitioner did not prove that his pro-rata method would result in a correct determination of past and future medical expenses recovered in the settlement. Further, even using Petitioner's pro-rata method, Petitioner's recovery in the settlement for past and future medical expenses was unproven.

APPLICABLE PORTIONS OF LAW

Section 409.910(17), Florida Statutes (2021), provides DOAH with subject matter jurisdiction and governs this case:
(b) If federal law limits the agency to reimbursement from the recovered medical expense damages, a recipient, or his or her legal representative, may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. In order to successfully challenge the amount designated as recovered medical expenses, the recipient must prove, by clear and convincing evidence, that the portion of the total recovery

which should be allocated as past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f). Alternatively, the recipient must prove by clear and convincing evidence that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

(c) The agency's provider processing system reports are admissible as prima facie evidence in substantiating the agency's claim.

(d) Venue for all administrative proceedings pursuant to this subsection lies in Leon County, at the discretion of the agency. Venue for all appellate proceedings arising from the administrative proceeding outlined in this subsection lies at the First District Court of Appeal in Leon County, at the discretion of the agency.

(e) Each party shall bear its own attorney fees and costs for any administrative proceeding conducted pursuant to paragraphs (b)-(e).

Section 409.910(11)(f) provides:

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows: 1. After attorney's fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.

***3** Thus, AHCA will recover $73,245.59, calculated under section 409.910(11)(f), unless Petitioner proves that the past and future medical expense portion of the settlement is less than that amount. *Gallardo v. Marstiller*, 596 U.S. ___, 2022 U.S. LEXIS 2683, 2022 WL 1914096 (June 6, 2022); *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006).

FINDINGS OF FACT

Based on the Joint Pre-Hearing Stipulation,[1] the testimony, and the documentary evidence presented, the undersigned finds:
1. On October 23, 2019, LILLIAN HENDERSON, J.R.'S mother, was admitted to North Florida Regional Medical Center in Gainesville, FL at more than forty weeks pregnant for an induction of labor. After more than 24 hours in labor, the defendant doctor attempted to deliver J.R. by forcep extraction. Using forceps, the defendant doctor pulled on J.R.'s skull three times which failed to deliver J.R. After the failed forcep delivery, J.R. was delivered via a cesarean section. At birth, nurses noted that J.R. presented with a weak cry and poor tone and color. J.R. was transferred from the normal newborn nursery to the NICU due to indications of a skull fracture and seizures. J.R. was noted to have a left parietal depression indicative of a depressed skull fracture.

2. On October 25th, J.R. was transported from the NICU at North Florida Regional Medical Center to Shands Hospital where he was diagnosed with a skull fracture and underwent pediatric neurosurgical intervention.

3. As a result of the alleged negligence of the defendants, J.R. suffered a depressed skull fracture, seizures and other physically disabling conditions.

4. In November of 2020, J.R.'s parents, brought a medical malpractice personal injury action to recover damages related to the alleged malpractice. This action was brought against several defendants. Thereafter, a NICA petition to determine eligibility for benefits was filed in April of 2021.

5. In December of 2021, after suit was filed, Petitioners agreed to settle J.R.'s medical malpractice claim.

6. AHCA was properly notified of J.R.'s lawsuit against the defendants and indicated it had paid benefits related to the injuries from the incident in the amount of $73,245.59. AHCA has asserted a lien for the full amount it paid, $73,245.59, against J.R.'s settlement proceeds.

7. Applying the statutory reduction formula to this particular settlement would result in no reduction of the lien given the amount of the settlement.

8. AHCA, through its Medicaid program, provided $73,245.59 in payment for J.R.'s medical care related to his injuries. This $73,245.59 represents J.R.'s entire claim for past medical expenses.

9. Mark Avera is an attorney in Gainesville. He was admitted to the Florida Bar in 1989, and the North Carolina Bar in 2021. He is a graduate of the University of Florida. Mr. Avera's practice is in civil litigation, practicing in the areas of personal injury and wrongful death. He has handled large tort cases, tobacco cases, and medical malpractice cases, amongst others. (Testimony of Mr. Avera.)

***4** 10. Mr. Avera explained that medical malpractice litigation is difficult; not many lawyers handle it. The task is to ask jurors to find that the physician did not meet the standard of care. Experts are a big piece of the litigation, and can be a significant expense. (Testimony of Mr. Avera.)

11. Mr. Avera represented J.R. and his parents in their medical malpractice case. (Testimony of Mr. Avera.)

12. Mr. Avera's testimony regarding the injury to J.R. was consistent with the stipulated facts.

13. A lawsuit was filed against the liable third parties, but first a notice of intent was provided following Florida's pre-suit requirements. While an expert OBGYN opined that the physician did not depart from the standard of care, DOAH determined that J.R. was not NICA eligible, opening the physician to potential liability. There was a dispute over liability and over damages. (Testimony of Mr. Avera.)

14. J.R. seemed to make a good recovery, but amongst other things, he is still on seizure medication to this day. He is behind on some “milestones,” while normal on others. (Testimony of Mr. Avera.)

15. J.R.'s economic damages include past medical expenses, future medical expenses (which could be determined with a life care plan), and loss of earning capacity (which would be difficult to establish given that J.R. is recovering). At one point Mr. Avera explained 75-80% of J.R.'s full damages are non-economic, and at another point he explained that 20-30% of J.R.'s full damages would be economic. (The undersigned will address this slight incongruence below.) The vast majority of J.R.'s economic damages would be for the damages reflected in the life care plan. Mr. Avera was not comfortable with determining a loss of capacity to earn for J.R. (Testimony of Mr. Avera.)

16. J.R.'s non-economic damages would be the bulk of his damages. (Testimony of Mr. Avera.)

17. Mr. Avera asserted that J.R.'s damages have a value in the neighborhood of $1,500,000. While this is the value Mr. Avera gave to all damages, it is also the value he testified to as a conservative value non-economic damages. He would not hesitate to ask a jury for more than $1.5 million. (Testimony of Mr. Avera.)

18. Litigation was difficult and encompassed liability issues, and drove up costs. Ultimately, a settlement was reached for. (Testimony of Mr. Avera.)

19. It is simple math that the settlement amount is approximately 16.67% of the $1.5 million full value of J.R.'s damages.

20. Mr. Avera testified to the operation of the pro-rata method, and explained what would happen if it was used. He did not testify that it would be correct or appropriate in J.R.'s case.

21. Don Hinkle is a trial lawyer. He graduated from Florida State in 1980 and has been practicing in mostly personal injury, wrongful death, and medical malpractice law for 42 years. He is board certified in civil trial and professional liability. He has tried dozens of cases. (Testimony of Mr. Hinkle.)

***5** 22. Mr. Hinkle reviewed the civil complaint against liable third parties, the answers to the same, J.R.'s medical records, the NICA report, various additional records, the petition in this matter, and talked to Mr. Avera about J.R.'s injury. He does not have personal knowledge of J.R.'s injury or damages. (Testimony of Mr. Hinkle.)

23. Mr. Hinkle thought Mr. Avera's $1.5 million valuation would be reasonable and appropriate, but the value could perhaps be more or less. (Testimony of Mr. Hinkle.)

24. He did not break down the damages between economic and non-economic, but stated that most of the damages would be non-economic. (Testimony of Mr. Hinkle.)

25. He did not do jury verdict research. (Testimony of Mr. Hinkle.)

26. Like Mr. Avera, Mr. Hinkle described the pro-rata method, and what would result in J.R.'s case if the pro-rata method was used. He did not testify that it would be correct or appropriate.

27. The expenses that petitioners incurred in their litigation against the liable parties was $4599.34. (Testimony of Mr. Avera.)

CONCLUSIONS OF LAW

AHCA and the Statutory Formula

AHCA is responsible for administering Florida's Medicaid program. § 409.902. Both Florida and federal law require it to seek full reimbursement for the amount it has paid in Medicaid expenditures, when the resources of a liable third party become available. § 409.910(4), Fla. Stat.; 42 U.S.C. § 1396a(a)(25)(B). To accomplish this, Florida and federal law also establish that AHCA is automatically assigned any rights Petitioner has to third party benefits. § 409.910(6), Fla. Stat.; 42 U.S.C. § 1396k(a)(1)(A). The Florida Legislature laid out its intent:

[I]t is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid.

§ 409.910(1).

In any event, when a judgment or settlement determines the liability of the third party, AHCA may recover its lien only from the portion of the settlement that represents "payment for medical care." 42 U.S.C. § 1396k(a)(1)(A); *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 280 (2006). If the verdict or judgement does not allocate a portion to medical care, section 409.910(11)(f) establishes a formula to determine the portion that represents payment for medical care, and section 409.910(17)(b) entitles recipients to initiate an administrative proceeding to rebut the formula-based allocation.

Challenges to the Statutory Formula

Section 409.910(17)(b) provides a mechanism to challenge the amount of the Medicaid lien payable to AHCA.

In 2018, the Florida Supreme Court interpreted federal law to limit AHCA's lien to the past only medical expense portion of a recipient's settlement. *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53 (Fla. 2018). However, the U.S. Supreme Court recently interpreted the same federal law to allow AHCA's lien against the past and future medical expense portion of a recipient's settlement. *Gallardo v. Marstiller*, 596 U.S. ___, 2022 U.S. LEXIS 2683, 2022 WL 1914096 (June 6, 2022). While a state supreme court interpretation of its own state law is final, the U.S. Supreme Court's interpretation of federal law supersedes a state supreme court's interpretation of federal law.

*The (17)(b) Challenge and **No Requirement for the Pro-Rata Formula***

***6** Section 409.910(17)(b) provides:

> .... In order to successfully challenge the amount payable to the agency, the recipient must prove, by clear and convincing evidence, that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses than the amount calculated by the agency pursuant to the formula set forth in paragraph(11)(f) ....[4]

The phrase "should be allocated" presupposes no particular method of allocation. Instead, it leaves to the Petitioner to prove not only what amount should be allocated, but also how that amount should be determined.

The Florida District Courts of Appeal have repeatedly explained that the pro-rata method— such as that embraced by the Petitioner here—is neither required nor without its own problems:

[T]he [U.S. Supreme Court] in *Ahlborn*[, 547 U.S. 268] simply accepted the stipulation, and in no way adopted the [pro-rata] formula as a required or sanctioned method to determine the medical expense portion of an overall settlement amount.

Moreover, the formula used by the *Ahlborn* parties is problematic in that it assumes the Medicaid lien amount to be the only medical expense included by the plaintiff as part of his or her overall damage claim, which is not a reasonable assumption.

[4] **R. Shawn Majette August 28, 2022 Editorial Footnote**

Smith v. Agency for Health Care Admin., 24 So. 3d 590, 591 (Fla. 5th DCA 2009).

[The Medicaid recipient] urged the ALJ to employ a pro rata allocation to calculate the amount of the [liable third party] settlement allocable to past medical expenses .... Indeed, because the settlement represents but only some forty percent of the total value of the case, [the recipient] urges that AHCA can only recover about forty percent of the expenses it incurred. We do not condemn this approach ... [b]ut we also acknowledge that the U.S. Supreme Court has not explicitly endorsed this method.

Willoughby v. Agency for Health Care Admin., 212 So.3d 516, 522 (Fla. 2d DCA 2017).

Citing *Smith* and *Willoughby*, the Administrative Law Judge Kilbride explained: "Those decisions correctly point out that the proportionality formula suggested by Petitioner in this case is not the required or accepted method, nor is it a method that is necessarily correct." *Savain v. Agency for Health Care Admin.*, Case No. 17-5946MTR, FO at 13 (Fla. DOAH Feb. 26, 2018).

Florida courts have rejected the assumption that a pro-rata method is the way to calculate past medical expenses in order challenge the full amount of a Medicaid lien.

Clear and Convincing Evidence

The clear and convincing evidence standard of section 409.910(17)(b) is required in this proceeding. Previously, a federal injunction barred AHCA from requiring a clear and convincing standard to rebut its statutory formula. *Gallardo v. Dudek*, Case No.: 4:16cv116-MW/CAS, 2017 WL 3081816 (U.S. N.D. Fla. July 18, 2017). While the injunction was not directly binding on DOAH, AHCA would stipulate to the preponderance of the evidence standard (found in section 120.57(1)(j), Fla. Stat.) for the administrative hearings, and the Administrative Law Judges would apply it. *See, e.g., Alcala v. Agency for Health Care Admin.*, Case No. 20-0605MTR, FO at 4 (Fla. DOAH Aug. 18, 2020). The Eleventh Circuit Court of Appeal reversed the District Court, *Gallardo v. Dudek*, 963 F.3d 1167 (U.S. 11th Cir. 2020), and subsequently the District Court vacated its injunction on AHCA, *Gallardo v. Senior*, Case No.: 4:16cv116-MW/CAS, ECF No. 85 (U.S. N.D. Fla. Nov. 4, 2020). Without the federal injunction, stipulation between the parties, or any holding binding on the undersigned that the state statute is pre-empted by federal law, the text of the state statute controls in this case.[2] Petitioner's contention that the Florida Supreme Court (or any other court) has not spoken on the standard of evidence issue fails to realize that all judges are bound to interpret the law, including the undersigned, not just the appellate courts.

***7** Clear and convincing evidence is a standard used in American jurisprudence and is a greater than preponderance of the evidence. It has been defined in Florida:

> We ... hold that clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

Therefore, the burden is on the Petitioner to prove, with clear and convincing evidence, what portion of the gross settlement should be allocated as recovery for past and future medical expenses. It will follow from the evidence and the statutory scheme

whether AHCA's lien, payable under the statute in full at $73,245.59, exceeds that amount and should thus be limited to the amount of the recovery for past and future medical expenses.

All Medical Expense Damages

In *Smith v. Agency for Health Care Admin.*, 24 So. 3d 590 (Fla. 5th DCA 2009), then-Judge Alan Lawson writing for the Fifth District Court of Appeal explained that evidence of the Medicaid lien amount only is insufficient. It is not proof of all of the medical expense damages. *Id.* at 591-92. Rather, evidence of all medical expenses must be presented, as AHCA may recover from the entirety of the medical expense portion—not just the portion that represents its own lien. *Id.* The *Smith* court contrasts the AHCA portion of the recovery with the medical expense portion of the recovery, which may be greater. AHCA is limited under federal law to this greater medical expense portion of the recovery. To illustrate the point, the *Smith* court analyzes a hypothetical in which the medical expense damages were $600,000, the Medicaid lien was only about $122,000, and the recovery was made at a one-third rate ($2,225,000 / $7,000,000). *Id.* at 591, n.1. The District Court then concluded that using the pro-rata formula, $200,000 is the medical expense portion of the recovery (this is one-third multiplied by the $600,000 medical expense damages). *Id.* AHCA's $122,000 lien could then be paid in full out of this $200,000 recovered for medical expenses. *Id.*

Further, section 409.910(17)(b), under which Petitioner brought the Petition grants the undersigned power to find "the portion of the total recovery which should be allocated as past and future medical expenses," and to limit AHCA to that amount. The statute does not authorize a reduction of the Medicaid lien to some smaller portion of the total recovery. It authorizes a reduction to the past and future medical expense portion. The undersigned cannot ignore the statute's directive.[3]

***8** As Administrative Law Judge Schwartz explained: "The full amount of all past medical expenses must then be considered, not just the past medical expenses representing the amount of AHCA's lien." *Garcia v. Agency for Health Care Admin.*, Case No. 19-2013MTR, FO at 10 (Fla. DOAH Aug. 27, 2019) (parenthetical comment omitted). *See also Fallon v. Agency for Health Care Admin.*, Case No. 19-1923MTR, FO (Fla. DOAH July 26, 2019)(concluding that past medical expenses of $592,554.18 from another provider must be included in calculating total past medical expenses even though this amount was reduced through negotiation); *Osmond v. Agency for Health Care Admin.*, Case No. 16-3408MTR (Fla. DOAH Sept. 8, 2016)(full amount of medical expenses is the amount to be applied in calculating that portion of the settlement which is available for reimbursement of AHCA's Medicaid lien); *Ramella v. Agency for Health Care Admin.*, Case No. 17-5454MTR, FO at 17 (Fla. DOAH Feb. 15, 2018)(no reduction for other liens).

Future Medical Expenses

In *Gallardo v. Marstiller*, 596 U.S. ___, 2022 U.S. LEXIS 2683, 2022 WL 1914096 (June 6, 2022), the U.S. Supreme Court clarified its *Ahlborn* and *Wos* decisions by holding that federal law does not limit a state Medicaid program's lien to the past medical expense portion of a settlement. Because Medicaid is required to be assigned "any" payments for "medical care," the Court reasoned that includes past and future medical care. *Id.* The assignment provision of 42 U.S.C § 1396k(a)(1) is an exception to the anti-lien provision of § 1396p(a)(1). *Id.* Therefore, while the anti-lien provision means that AHCA may not lien the portion of a settlement that represents non-economic damages or lost wages, for example, it may lien any portion that represents any medical care, past or future. *Id.*

Section 409.910(17)(b), Florida Statutes, further requires a petitioner to prove what was recovered for past and future medical expenses, to limit AHCA's lien.[5]

[5] **R. Shawn Majette August 28, 2022 Editorial Footnote**

ANALYSIS

Petitioner did not put on evidence that the pro-rata method would be appropriate or correct to determine what was recovered for J.R.'s past and future medical expenses. Therefore, the undersigned cannot use this method, and cannot limit AHCA's lien.

Assuming use of the pro-rata method, it must be applied to the past and future medical expense portion of the settlement. Petitioner did not put on evidence of the future medical expense portion of the settlement, but did put on evidence showing that there would be such a portion. Therefore, the undersigned cannot find what was recovered for past and future medical expense damages, and cannot limit AHCA's lien.[6]

Assuming use of the pro-rata method, and assuming that the entirety of the economic damages for J.R. were past and future medical expense damages (which Mr. Avera's testimony supports as he effectively wrote off J.R. having loss of earning capacity damages), then it is for the undersigned to calculate what portion of the total damages is past and future medical expenses.

***9** Mr. Avera testified that 75% to 80% of the damages were non-economic, meaning that 25% to 20% were economic damages. He also testified that 20% to 30% were economic damages. Using the 30% figure would be in AHCA's favor, but any other percentage is counter to Mr. Avera's 30% estimate. Because Mr. Avera is petitioner's own expert, the undersigned will use this 30% figure.

Further both witnesses' evaluation of J.R.'s damages at $1.5 million was for everything other than the past medical expense damages (the Medicaid lien amount) of $73,245.59. That means that J.R.'s total damages would be $1,573,245.59, not just $1.5 million. Thirty percent of 14 J.R.'s total damages is then $471,973.68. This figure represents J.R.'s claim for past and future medical expense damages.

Applying the pro-rata method, J.R.'s recovered 15.89% of his total $1,573,245.59 claim.[4] Multiplying this by his past and future medical expense damages results in $75,000 being recovered for past and future medical expenses.

Because this $75,000 is in excess of AHCA's lien amount of $73,245.59, AHCA's lien cannot be reduced.

DISPOSITION

WHEREFORE, based on the foregoing findings of fact and conclusions of law, it is hereby DETERMINED that:
1. Petitioner failed to prove by clear and convincing evidence that a lesser portion of the total recovery should be allocated as past and future medical expenses than the amount calculated by AHCA under the formula set forth in paragraph (11)(f); and

2. AHCA's lien against the Petioner's settlement amount remains payable in the amount of $ $73,245.59. § 409.910(11)(f).

DONE AND ORDERED this ___ day of _____, 2022 in Tallahassee, Leon County, Florida.

James H. Peterson, III
Administrative Law Judge
Division of Administrative Hearings

[6] **R. Shawn Majette August 28, 2022 Editorial Footnote**

The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060

Filed with the Clerk of the Division of Administrative Hearings this ___ day of _____, 2022.

* * *

WHEREFORE, Respondent requests entry of the above detailed final order.

Respectfully submitted on this the 23rd day of June 2022.

Alexander R. Boler
2073 Summit Lake Drive, Suite 330
Tallahassee, Florida 32317
Counsel for the Agency for Health Care Admin.

Footnotes

1 Findings 1 through 8 are taken from the Joint Pre-Hearing Stipulation.

2 An Administrative Law Judge may not exceed the authority granted under statute. *Florida Elections Commission v. Davis*, 44 So. 3d 1211 (Fla. 1st DCA 2010). "The Division of Administrative Hearings is no exception to the rule that '[a]dministrative agencies are creatures of statute and have only such powers as statutes confer.'" *Id.* at 1215 (quoting *Fiat Motors of N. Am. v. Calvin*, 356 So. 2d 908, 909 (Fla 1st DCA 1978), and in turn citing *State ex rel. Greenb[e]rg v. Florida State Bd. of Dentistry*, 297 So. 2d 628, 634 (Fla. 1st DCA 1974)).

3 An Administrative Law Judge may not exceed the authority granted under statute. *Florida Elections Commission v. Davis*, 44 So. 3d 1211 (Fla. 1st DCA 2010). "The Division of Administrative Hearings is no exception to the rule that '[a]dministrative agencies are creatures of statute and have only such powers as statutes confer.'" Id. at 1215 (quoting *Fiat Motors of N. Am. v. Calvin*, 356 So. 2d 908, 909 (Fla 1st DCA 1978), and in turn citing *State ex rel. Greenb[e]rg v. Florida State Bd. of Dentistry*, 297 So. 2d 628, 634 (Fla. 1st DCA 1974)).

4 While his recovery is approximately 16.67% of the $1.5 million, as testified by the witnesses, using the greater $1.573 million figure his recovery is only 15.89%.

2022 WL 2783929 (Fla.Div.Admin.Hrgs.)

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Catherine Ann TOMLIN, a/k/a Kathy Tomlin, a/k/a Cathy Ann Tomlin, s/k/a Katherine Ann Tomlin
v.
COMMONWEALTH of Virginia

Record No. 0561-21-3

Court of Appeals of Virginia.

MARCH 15, 2022

Kieran Bartley, Assistant Public Defender, for appellant.

Rosemary V. Bourne, Senior Assistant Attorney General (Mark R. Herring,[1] Attorney General, on brief), for appellee.

Present: Judges Huff, Athey and Friedman

OPINION BY JUDGE CLIFFORD L. ATHEY, JR.

[74 Va.App. 398]

Catherine Ann Tomlin ("Tomlin") was convicted in the Circuit Court of Augusta County ("trial court") of financially exploiting an incapacitated adult and of abusing or neglecting an incapacitated adult. On appeal, Tomlin makes three arguments: (1) there was insufficient evidence to prove that the victim was "mentally incapacitated" with respect to the financial exploitation conviction; (2) there was insufficient evidence to prove that the victim suffered a "serious bodily injury or disease" with respect to the abuse or neglect conviction; and (3) the trial court improperly admitted hearsay during the trial. For the following reasons, we affirm the abuse or neglect conviction and reverse the financial exploitation conviction.

I. BACKGROUND

"[T]he evidence and all reasonable inferences flowing from that evidence [are viewed] in the light most favorable to the Commonwealth." *Pooler v. Commonwealth* , 71 Va. App. 214, 218, 834 S.E.2d 530 (2019) (quoting *Williams v. Commonwealth* , 49 Va. App. 439, 442, 642 S.E.2d 295 (2007) (*en banc*)).

Viewed in that light, the evidence reflects that Tomlin, who was in her fifties, and her mother, B.T., who was in her eighties, utilized B.T.'s Social Security

benefits and Tomlin's income from her job at Walmart to pay for partially subsidized housing and other living expenses. The furniture in their apartment consisted of a high-backed chair, a futon, and a

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television. Tomlin slept on the futon, and B.T. slept in the chair. Although B.T. could go to the bathroom without assistance and wore Depends, she sometimes needed Tomlin's help to change them. B.T. also relied on Tomlin for food and transportation, and the daughter gave her mother sponge baths to address issues relating to personal hygiene. They had a joint bank account, but Tomlin established a separate account in 2019 so she could receive her pay from Walmart sooner.

Michelle Shank ("Shank") from the Shenandoah Valley Department of Social Services ("Department") interacted with the Tomlins from January to April of 2020. During the first three visits in January of that year, B.T. smelled strongly of urine and was offered services, including assistance in securing a hospital bed, a Medicaid application, and in-home rehabilitative and general services. Tomlin and her mother rejected those services. Believing B.T. was mentally competent, Shank closed her investigation on January 20, 2020. Tomlin was referred to the Department again in February as a result of B.T.'s immobility and swollen legs. Shank visited with the Tomlins three or four more times in March of 2020 and secured two mattresses for them. Shank offered the same services as she had in January, but Tomlin refused all assistance, claiming that she was maintaining her mother's hygiene through

[869 S.E.2d 902]

sponge baths and by changing her Depends regularly.

On April 22, 2020, B.T. fell. Two days later, a pest control worker encountered Tomlin and B.T. in the apartment and called 911 to report that an elderly woman was lying on the floor, covered in bed bugs, and requiring medical attention. Firefighter Andrew Tanner ("Tanner") responded to the call in a county ambulance.

At trial, Tanner testified that he and his coworker entered the apartment to find Tomlin standing in the kitchen doorway and B.T. lying on the living room floor "on her left side[,] covered in feces and urine, [with] what looked to be bed bugs crawling on her." Tanner also noted that her clothing and Depends were "well over saturated" with urine and that feces

[74 Va.App. 400]

were all over B.T., her clothes, and the floor. Tomlin admitted that B.T. had been on the floor since her fall two days before and when asked why she had not cleaned B.T. up, she replied that she "did not have time." B.T. was placed on a stretcher and taken to the hospital, complaining of hip pain.

When she arrived at the emergency room, Physician's Assistant Tyler Prewitt ("Prewitt") examined her. At trial, Prewitt was qualified as an expert in "diagnosing wounds ... [and] bed sores ... in an emergency department." He found her condition as follows: "a very uncommonly large amount of feces" and urine on her body and so many bed bugs that some fell to the floor. He testified that she was covered in "a noteworthy amount of stool and urine ... essentially from head to toe." Prewitt later clarified that B.T. had feces at least "from toe to neck."

Prewitt further testified that although B.T. had no "acute injuries," her condition included bed bug bites and bed sores (ulcers). She had "moderate" bed sores below the buttocks, one five and a half centimeters by one and a half or two centimeters and another three centimeters by one centimeter. Prewitt testified that some parts of these bed sores had passed the dermis and approached the fascia, indicating an increased risk of infection. Prewitt doubted that these sores were infected at that time but testified that additional sores on a lower part of her legs might have been. He believed the bed sores had been developing for at least one week.

Prewitt also testified that B.T.'s risk of death from infection was serious if left untreated, but he admitted the ulcers would not have killed her directly and that she was not at risk of imminent death. He also testified that the risk of infection from a bed sore was significant. In addition, the ubiquitous urine and the fecal matter covering close to fifty percent of her body had greatly increased her risk of infection during the time she lay on the floor. B.T.'s "indifference to the amount of stool and dishevelment" and her bed sores concerned Prewitt because it indicated a "level of confusion." B.T. was aware of what was happening around her, but not the day of the week

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or who was President. Prewitt had her admitted to the hospital for further diagnosis and treatment. After being discharged, B.T. died in hospice care in June of 2020. There was no testimony directly bearing on B.T.'s mental capacity from the time she was admitted to the hospital to the time of her death approximately two months later.

Shortly after B.T. entered the hospital, Tomlin was evicted from their apartment. She lived in a motel for eighty dollars per day and used B.T.'s Social Security money to pay for the room and other necessities. B.T. did not

consent to this use of her money. While under cross-examination, Shank was asked why she did not inquire about Tomlin's use of B.T.'s money during the first days of B.T.'s hospital stay in April. Shank responded that she was focused on B.T.'s medical condition because her "prognosis was poor." Asked to clarify, Shank said the hospital told her that B.T.'s prognosis was poor. Tomlin's counsel objected to Shank's response as hearsay, but the trial court ruled that he could not object to an answer to his own question.

Tomlin moved to strike the Commonwealth's evidence on both charges, and her motion was denied. The trial court subsequently convicted Tomlin of misdemeanor financial exploitation of a mentally incapacitated adult and felony abuse or neglect of an

[869 S.E.2d 903]

incapacitated adult. The trial court reasoned that a person lacks the mental capacity to consent to have her "only assets" used "for somebody else's benefit when [the person does not] have the ability to recognize [she has] sores that could lead ... to [her] death." The trial court also concluded that the bed sores qualified as "serious bodily injuries" because they "could lead to death," had a significant impact on B.T.'s health, and were unlikely to be properly attended to by Tomlin had B.T. been released.

II. STANDARD OF REVIEW

"[W]e interpret the Code *de novo*. " *Hutton v. Commonwealth* , 66 Va. App. 714, 719, 791 S.E.2d 750 (2016) (citations omitted). In a sufficiency case, although we "review *de novo* the trial court's application of defined legal standards

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to the particular facts of the case," *Trent v. Commonwealth* , 35 Va. App. 248, 250, 544 S.E.2d 379 (2001) (citation omitted), we defer to the trial court's factual findings unless they are "plainly wrong or without evidence to support [them]," *Pijor v. Commonwealth* , 294 Va. 502, 512, 808 S.E.2d 408 (2017) (quoting Code § 8.01-680). The trier of fact is required "to resolve conflicts in the testimony, to weigh the evidence, and to draw reasonable inferences from basic facts to ultimate facts." *Brown v. Commonwealth* , 68 Va. App. 44, 55, 802 S.E.2d 190 (2017) (quoting *Jackson v. Virginia* , 443 U.S. 307, 319, 99 S.Ct. 2781, 2789, 61 L.Ed.2d 560 (1979)). There was sufficient evidence if "*any* rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt." *Dietz v. Commonwealth* , 294 Va. 123, 132, 804 S.E.2d 309 (2017) (quoting *Bowman v. Commonwealth* , 290 Va. 492, 496-97, 777 S.E.2d 851 (2015)). Just because another trier of fact "might have

reached a different conclusion" about what the evidence showed does not mean that this "[C]ourt [can] say that the evidence does or does not establish [the defendant's] guilt beyond a reasonable doubt." *Commonwealth v. Perkins* , 295 Va. 323, 327, 812 S.E.2d 212 (2018) (first alteration in original) (quoting *Cobb v. Commonwealth* , 152 Va. 941, 953, 146 S.E. 270 (1929)).

III. ANALYSIS

A. Financial Exploitation of a Mentally Incapacitated Adult

Tomlin argues the evidence was insufficient to convict her of financially exploiting an incapacitated person in violation of Code § 18.2-178.1. Specifically, she argues that the trial court had insufficient evidence to find beyond a reasonable doubt that B.T. suffered from "mental incapacity" as defined by Code § 18.2-178.1(D). At its core, Tomlin's argument is that evidence establishing B.T.'s mental incapacity with respect to her healthcare decisions cannot justify the trier of fact's conclusion that her mental incapacity extended to financial matters. We agree.

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Pursuant to Code § 18.2-178.1(A), a person is guilty of larceny if she uses another person's mental incapacity to "take, obtain, or convert money or other thing of value belonging to that other person with the intent to permanently deprive him thereof." Subsection (D) defines "mental incapacity" as "that condition of a person existing at the time of the offense ... that prevents him from understanding the nature or consequences of the transaction or disposition of money or other thing of value involved in such offense." The mental incapacity must exist "at the time of the offense." *White v. Commonwealth* , 68 Va. App. 241, 249, 807 S.E.2d 242 (2017).

"[P]roof of general mental incapacity or retardation or an IQ range or mental age" cannot prove that "a victim is prevented or unable to understand the nature and consequences of a sexual act ...." *Adkins v. Commonwealth* , 20 Va. App. 332, 346, 457 S.E.2d 382 (1995). In *Adkins* , the Commonwealth had to provide evidence probative of the victim's inability "to comprehend or appreciate either the distinguishing characteristics or physical qualities of the sexual act or the future natural behavioral or societal results or effects which may flow from the sexual act." *Id.* Hence, *Adkins* stands for the proposition that, where a criminal statute expressly requires that the mental incapacity of a victim of the crime extend to a specific subject matter, proof of the victim's general mental incapacity cannot justify the trier of fact in concluding that the victim's mental incapacity extends to the required subject

[869 S.E.2d 904]

matter.[2] *Id.* ; *White v. Commonwealth* , 23 Va. App. 593, 597, 478 S.E.2d 713 (1996) ; *see Sanford v. Commonwealth* , 54 Va. App. 357, 363-65, 678 S.E.2d 842 (2009) (relying on an expert's testimony that the victim lacked the ability to understand social interactions and the victim's mother's testimony that the victim had not been told about the nature of the sexual act);

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Clark v. Arizona , 548 U.S. 735, 745, 126 S.Ct. 2709, 2717-18, 165 L.Ed.2d 842 (2006) (recounting that a defendant's insane delusions made him believe police officers were aliens but did not prevent him from understanding that bullets can be used to kill animate beings).

If proof of a crime victim's general mental incapacity by itself cannot justify the trier of fact in concluding that the incapacity extends to a particular subject matter, then proof of mental incapacity with respect to a particular subject matter cannot, by itself, justify the trier of fact in concluding that the victim's mental incapacity extends to another, unrelated subject matter. This principle applies to lay testimony as well as expert testimony which does not expressly draw a connection between the victim's general or partial mental incapacity and their mental incapacity with respect to the particular subject matter specified in the relevant statute.[3]

Therefore, evidence that B.T. was mentally incapacitated with respect to healthcare decisions could not, by itself, justify the trial court in finding beyond a reasonable doubt that she was also mentally incapacitated with respect to financial matters. The record contains no evidence that specifically addresses B.T.'s mental capacity in financial matters. The trial court based its decision about her inability to understand financial matters on evidence of her inability to understand her healthcare needs: "I don't think that [an] incapacitated person can give consent to use their only assets for somebody else's benefit when they don't have the ability to recognize they have sores that could lead ... to their death." Furthermore, Prewitt's testimony regarding B.T.'s "level of confusion," if taken by the trial court as evidence of general mental incapacity, falls squarely under the *Adkins* rule. Therefore, the trial court erred in finding there was sufficient

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evidence to convict Tomlin of financial exploitation of an incapacitated adult.[1]

B. Abuse or Neglect of an Incapacitated Adult

Tomlin also argues that the evidence adduced at trial, even in the light most favorable to the Commonwealth, was insufficient to convict her of abuse or neglect of an incapacitated adult that caused serious bodily injury. Code § 18.2-369(A) makes it "unlawful for any responsible person to abuse or neglect any incapacitated adult." Subsection B provides that abuse or neglect that "results in serious bodily injury or disease to the incapacitated adult" is a "Class 4 felony." Subsection C defines "abuse," "neglect," "responsible person," "incapacitated adult," and "serious bodily injury or disease." Tomlin does not challenge the trial court's finding that she was a responsible person or the finding that her failure to properly care for B.T. amounted to neglect and caused B.T.'s physical condition. She challenges only the trial court's determination that B.T. suffered a "serious bodily injury or disease," arguing that B.T.'s condition when admitted to the hospital was not sufficiently serious. We disagree.

"Serious bodily injury or disease" includes but is not "limited to (i) disfigurement, (ii) a fracture, (iii) a severe burn or laceration, (iv) mutilation, (v) maiming, or (vi) life-threatening internal injuries or conditions, whether or not caused by trauma." Code § 18.2-369(C). Tomlin argues that an injury, disease, or condition must imminently threaten near-certain death to be sufficiently serious and that

[869 S.E.2d 905]

an injury, disease, or condition cannot be sufficiently serious if the victim is expected to recover with proper treatment. Tomlin's sufficiency challenge requires us to interpret "serious bodily injury or disease" *de novo* and then determine whether the trial court was plainly wrong in deciding that the evidence showed that B.T.'s condition was a serious bodily injury or disease within the meaning of the statute.

Our Supreme Court applied Code § 18.2-369(C) in *Correll v. Commonwealth* , 269 Va. 3, 607 S.E.2d 119 (2005). In *Correll* , emergency personnel transported an elderly woman to the

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hospital for treatment. *Id.* at 8, 607 S.E.2d 119. She was severely dehydrated and undernourished and had been so for at least several weeks. *Id.* at 8-9, 607

[1] **R. Shawn Majette August 28, 2022 Editorial Footnote**

S.E.2d 119. She also suffered from "stage 3 and early stage 4 decubiti," or bed sores. *Id.* at 8, 607 S.E.2d 119. The doctor testified the bed sores must have taken more than two days to develop, a nurse testified she believed they had developed over a month or longer, and another nurse testified that they must have taken weeks to develop. *Id.* at 9, 607 S.E.2d 119. The elderly woman also had a condition in which "bacteria [were] present in the blood," and the doctor testified this showed "that the [bed sores] had not been treated properly." *Id.* Twenty-two days after being discharged to a nursing home, she was readmitted with pneumonia and died shortly thereafter. *Id.* at 10, 607 S.E.2d 119. A forensic pathologist testified that she was "extremely emaciated" and had been in "a state of chronic starvation." *Id.* The doctor testified that her conditions "imposed a significant threat to her life or health." *Id.* at 14, 607 S.E.2d 119.

We have held that the ordinary meaning of "serious bodily injury" is central to interpreting Code § 18.2-369(C). *Brewster v. Commonwealth* , 23 Va. App. 354, 357-58, 477 S.E.2d 288 (1996) (holding that the statute was not unconstitutionally vague because "serious bodily injury" is both reasonably understandable and is a part of Virginia's legal vocabulary). "Because the Code of Virginia is one body of law, other Code sections using the same phraseology may be consulted in determining the meaning of a statute." *Newton v. Commonwealth* , 21 Va. App. 86, 90, 462 S.E.2d 117 (1995) (quoting *Branch v. Commonwealth* , 14 Va. App. 836, 839, 419 S.E.2d 422 (1992)). In *Nolen v. Commonwealth* , 53 Va. App. 593, 673 S.E.2d 920 (2009), we discussed the ordinary meaning of "serious" and "bodily injury" in the context of Code § 16.1-253.2, which prohibits violating a protective order and provides for increased penalties when the violation causes serious bodily injury.[4] According to *Nolen* , "[b]odily injury comprehends

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... *any bodily hurt* whatsoever." *Id.* at 598, 673 S.E.2d 920 (quoting *Bryant v. Commonwealth* , 189 Va. 310, 316, 53 S.E.2d 54 (1949)). Such bodily hurt is "serious" if it is "grave in ... appearance" or "requir[es] considerable care." *Id.* (first alteration in original) (quoting *Webster's Third New International Dictionary* 2073 (1981)). "Serious" bodily hurts are those which are "not trifling[, but instead are] grave [and] giv[e] rise to apprehension[, or are] attended with danger." *Id.* at 599, 673 S.E.2d 920 (quoting *Commonwealth ex rel. Lamb v. Hill* , 196 Va. 18, 23, 82 S.E.2d 473 (1954)).

Tomlin's counsel argued on brief and at oral argument that an injury, disease, or condition needs to threaten imminent death in order to be sufficiently serious and that a condition not expected to lead to death if properly treated is not sufficiently serious to fall within the meaning of the statute. That is a

very narrow approach to "serious bodily injury or disease." We reject it for several reasons.

First, the statute lists several categories of injuries that are not necessarily life-threatening but are nevertheless serious. Disfigurements, bone fractures, and even mutilations

[869 S.E.2d 906]

and maimings are not invariably, imminently life-threatening, yet they are included in the non-exhaustive list of specific categories of serious bodily injuries or diseases in Code § 18.2-369(C). In fact, many bone fractures are expected to fully heal with proper treatment. Severe lacerations sometimes leave nothing more than a scar after appropriate treatment and time to heal.

Second, an injury, disease, or condition can be life-threatening yet not cause certain and impending death. It is true that a small paper cut is not a serious bodily injury even

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though, if untreated, there is a remote chance it could become infected and the infection could lead to death. Conversely, terminal cancer is life-threatening even though there is a marginal chance that an experimental drug could save the patient. It is a matter of degree. The higher the risk of death, the more the injury, disease, or condition can be said to actually threaten the injured person's life. For an injury, disease, or condition to be life-threatening, it must present a real, appreciable risk of death, but need not create a likelihood of imminent, near-certain death.

In light of the foregoing, we conclude that the trial court did not err when it decided that B.T. suffered from a "life-threatening ... condition," and therefore a serious bodily injury or disease as defined in the statute. Prewitt testified that he was not sure if B.T.'s bed sores were infected but there was a significant risk of infection if not properly treated and that an infection might very well kill B.T. In particular, he indicated that parts of these bed sores had passed the dermis and approached the fascia, indicating an increased risk of infection. Although he doubted the bed sores immediately below her buttocks were infected, he testified that the sores on a lower part of her legs might have already been infected. Prewitt felt it important to have her admitted to the hospital for treatment as a result of her condition.

The risk of infection (and ultimately, of death) was a result of her neglected condition, which included being covered by bed bugs, urine, and feces. In this case, although Tomlin assured the case worker that she would change her

mother's Depends and give her regular sponge baths, Tomlin failed to do so because she "didn't have time." As a result of this neglect, the likelihood of infection and eventual death was at its highest during the two days she lay on the floor covered in bed bugs and her own waste.

The evidence was therefore sufficient for the trial court to conclude that B.T.'s bed sores presented a risk of death significant enough to make them a "life-threatening ... condition." Although Tomlin argues the bed sores were treatable,

[74 Va.App. 409]

B.T. lay in her own filth for two days without any treatment or cleaning. Her condition was life-threatening because of the combination of bed sores, leg sores, and the increased risk of infection created by the ubiquitous bed bugs, feces, and urine covering her body. *See Correll* , 269 Va. at 6-11, 14, 607 S.E.2d 119 (holding that bed sores combined with other medical problems and risk factors, including infection, can be a "life-threatening ... condition"). Therefore, the trial court had sufficient evidence to convict Tomlin of violating Code § 18.2-369(C).

C. Hearsay

On appeal, evidentiary rulings are reviewed for abuse of discretion. *Jones v. Commonwealth* , 71 Va. App. 70, 85, 833 S.E.2d 918 (2019) (citing *Blankenship v. Commonwealth* , 69 Va. App. 692, 697, 823 S.E.2d 1 (2019)). A court has abused its discretion if its decision was affected by an error of law or was one with which no reasonable jurist could agree. *Grattan v. Commonwealth* , 278 Va. 602, 620, 685 S.E.2d 634 (2009) (citing *Porter v. Commonwealth* , 276 Va. 203, 661 S.E.2d 415 (2008)); *Jones* , 71 Va. App. at 86, 833 S.E.2d 918 (citing *Lawlor v. Commonwealth* , 285 Va. 187, 212-13, 738 S.E.2d 847 (2013)).

While cross-examining Shank, Tomlin's attorney asked Shank a question that elicited hearsay from Shank. Tomlin's attorney promptly objected, was overruled, and noted his objection to the ruling on the record. The trial court held that Shank's answer was hearsay but was admissible because Tomlin's attorney elicited it. On appeal, Tomlin argues that inadmissible hearsay is not rendered admissible merely because a witness presented

[869 S.E.2d 907]

it in response to the objecting party's question. In response, the Commonwealth argues that the statement was not hearsay because it was admissible to prove "why Shank did not speak to B.T. after she was in the

hospital" or in the alternative, as the court ruled, that Tomlin's attorney invited the hearsay.

[74 Va.App. 410]

Assuming without deciding the trial court's decision was error, the error was harmless. The admission of evidence contrary to Virginia's evidence law is harmless if the appellate court "can[ ] say, with fair assurance, ... that the judgment was not substantially swayed by the error." *Commonwealth v. Swann* , 290 Va. 194, 201, 776 S.E.2d 265 (2015) (quoting *Anderson v. Commonwealth* , 282 Va. 457, 467, 717 S.E.2d 623 (2011)). At oral argument, Tomlin's counsel conceded that if this Court adopted a less stringent definition of "serious bodily injury" than the one he advocated, the error was likely harmless. He believed the statement was necessary to convict Tomlin under his definition of serious bodily injury as life-threatening injury, but he admitted that the statement was likely not necessary to convict Tomlin under a broader definition. As discussed *supra* , we rejected Tomlin's stringent definition in favor of a broader definition.

After a mature consideration of the entire record, we conclude that Shank's statement did not "substantially sway" the trial court. The Commonwealth did not mention Shank's response in closing arguments and the trial court did not mention it during its ruling, but instead relied expressly on Prewitt's testimony. As explained above in detail, there was ample evidence from which to conclude that B.T. had suffered a serious bodily injury: the size and depth of the bed sores, the risk of infection leading to death, the ubiquitous feces and urine increasing that risk of infection, and the bed bug bites. Shank's statement was less than a cherry on top. Therefore, we hold that any error was harmless.

IV. CONCLUSION

First, the trial court lacked sufficient evidence to conclude that B.T. was mentally incapacitated with respect to financial matters. Second, it had sufficient evidence to conclude that B.T. had suffered "serious bodily injuries." Third, even if the trial court improperly admitted hearsay during Shank's testimony, the error was harmless. Accordingly, we reverse and dismiss with respect to the conviction for financial exploitation

[74 Va.App. 411]

of a mentally incapacitated adult[2], but we affirm the conviction for abuse or neglect of an incapacitated adult.

Affirmed in part, reversed and dismissed in part.

Notes:

[1] Jason S. Miyares succeeded Mark R. Herring as Attorney General on January 15, 2022.

[2] There is an exception not relevant here: evidence of severe intoxication can demonstrate that mental incapacity extends to a particular subject matter. *See Molina v. Commonwealth* , 272 Va. 666, 674, 636 S.E.2d 470 (2006).

[3] Prewitt was not qualified at trial as an expert in diagnosis or treatment of mental illness. Even if he had been so qualified, he offered testimony only on her general mental capacity and her mental capacity with respect to healthcare decisions. He did not testify to any conclusions he formed regarding her mental capacity with respect to financial matters.[3]

[4] At the time *Nolen* was decided, Code § 16.1-283(E), which provides for termination of parental rights, defined "serious bodily injury" as "bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ or mental faculty." *Nolen* , 53 Va. App. at 597, 673 S.E.2d 920 (quoting Code § 16.1-283(E)). The *Nolen* Court rejected that definition because, "[b]y its terms, it applies only to Code § 16.1-283(E)." *Id.* We reject it here for the same reason.

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[2] **R. Shawn Majette August 28, 2022 Editorial Footnote**
[3] **R. Shawn Majette August 28, 2022 Editorial Footnote**

Virginia Undue Influence Cases > 7-31-21 &< 8-1-2022

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Discussion of elements necessary to support claim for undue influence.

☛ Warning!

§ 64.2-454.1. Will contest; presumption of undue influence.

In any case contesting the validity of a decedent's will where a presumption of undue influence arises, the finder of fact shall presume that undue influence was exerted over the decedent unless, based on all the evidence introduced at trial, the finder of fact finds that the decedent did intend it to be his will.[1]

2022 WL 1406545 (Va.Cir.Ct.) (Trial Order)
Circuit Court of Virginia.
Augusta County

Re: Robert Joseph CLEMENTS and Linda McNeil Clements,
v.
Heather Clements FOX.

No. CL19002288-00.
May 3, 2022.

Order

Nicholas A. Hurston, Hurston Law Offices, PLLC, P.O. Box 246, Stanton, VA 24402, info@hurstonlaw.com, Counsel for Plaintiffs.

John B. Simpson, MartinWren, P.C., 400 Locust Avenue, Suite 1, Charlottesville, VA 22902, simpson@martinwrenlaw.com, Counsel for Defendant.
Paul A. Dryer, Judge.

***1** Dear Counsel:

Before the Court is Defendant, Heather Clements Fox's, (hereinafter “Fox”) Demurrer to Plaintiffs, Robert Joseph Clements and Linda McNeil Clements's, (hereinafter “Plaintiffs”) Amended Complaint requesting recission of a deed of gift conveying to Fox a remainder interest in three separate tracts of real estate in Augusta County which collectively form the Clements

[1] See *Friendly Ice Cream Corp. v. Beckner,* 268 Va. 23, 31 (2004), cited below.

family farm (hereinafter "the farm"). The Court previously granted Defendant's Demurrer to the original Complaint on March 3, 2021, and granted Plaintiffs leave to amend.

BACKGROUND

Plaintiffs' Amended Complaint alleges that on May 8, 2019, Plaintiffs executed a deed of gift (hereinafter "the Deed") conveying to Fox a remainder interest in the Clements family farm. Plaintiffs retained a life estate. Prior to the execution of the Deed, Plaintiffs held the farm in the Robert Joseph Clements Living Trust (hereinafter "the Trust"). In late 2018, Fox discovered that while the farm was in the trust, it would not pass to her automatically upon Robert's death. Fox became angry when she discovered this fact.¶ 10. As such, Fox and her husband subsequently began pressuring Plaintiffs to change their estate plans. The Amended Complaint alleges that this pressure consisted of "yelling at and calling her parents cheats and liars; cutting off visits and communications for months; and refusing to help around the Farm as they had previously." Amended Complaint at ¶ 11. Further, the Amended Complaint alleges, as Fox's pressure to dissolve the trust mounted, Robert's health deteriorated which caused him to suffer weakness of mind. Robert felt that the only way to repair the relationship with Fox and ensure continuity of care for Linda was to give in to Fox's demands to dissolve the trust and convey her a remainder interest in the farm. The Amended Complaint notes that: "At all times relevant hereto, [Fox] maintained a confidential and fiduciary relationship with the Plaintiffs being a joint owner of the Farm bank account from which she managed mortgage and bill payments for the Farm." ¶ 16.

The Amended Complaint includes five causes of actions as grounds for its requested relief of recission. Counts I, III, IV, and V request recission based on a theory that the Deed should be treated as a contract and that there was either a breach of said contract or that Fox's inequitable conduct would require the recission of the contract. Count II alleges Fox's **undue influence** on Plaintiffs caused them to execute the Deed against their free agency.

ANALYSIS

The purpose of a demurrer is to test whether a complaint states a sufficient basis to establish a cause of action for which relief can be granted. *Grossmann v. Saunders*, 237 Va. 113, 119 (1989). For the purposes of a demurrer, the moving party admits all of the material, well-pleaded facts in the pleadings, including those expressly alleged, those that can fairly be viewed as impliedly alleged and all reasonable inferences arising from the facts alleged. *Rosillo v. Winters*, 235 Va. 268, 270 (1988). "A demurrer tests the legal sufficiency of facts alleged in pleadings, not the strength of proof." *Glazebrook v. Bd. of Supervisors*, 266 Va. 550, 554 (2003). In short, if Plaintiffs could obtain judgment simply by proving what they alleged, the demurrer will fail. Nevertheless, "[t]o survive a challenge by demurrer a pleading must be made with sufficient definiteness to enable the court to find the existence of a legal basis for its judgment." *Moore v. Jefferson Hosp., Inc.*, 208 Va. 438, 440 (1967) (internal quotations omitted).

Count I: Recission for Failure of Consideration.

***2** Plaintiffs seek recission of the Deed for failure of consideration. The Virginia Supreme Court has stated that a "gift has been defined as a contract *without* a consideration." *Ott v. L & J Holdings, LLC*, 275 Va. 182, 188 (2008). Indeed, "by definition, a deedofgiftrequires no consideration." *Hill v. Brooks*, 253 Va. 168, 178 (1997). Consideration represents "the price bargained for and paid for a promise." *Smith v. Mountjoy*, 280 Va. 46, 53 (2010) (citation omitted). It may come in "a benefit to the party promising or a detriment to the party to whom the promise is made." *GSHH-Richmond, Inc. v. Imperial Assocs.*, 253 Va. 98, 101 (citation omitted); *see also Sfreddo v. Sfreddo*, 59 Va. App. 471, 485-86 (2012).

In this case, the Deed is clear and unambiguous that it is a deed of gift. Further, the Deed recites Virginia Code Section 58.1-811(D), which is the code section exempting the imposition of a grantor's tax on certain real estate transactions. The use of the language for 'love and affection' is merely a legal fiction to represent that there is no valuable consideration given for the gift. *Utsch v. Utsch*, 266 Va. 124, 130 (2003) (use of language "for love and affection" supported conclusion that conveyance was gift). As the Deed is clear and unambiguous, Plaintiffs cannot introduce parole evidence to explain the definitions or meanings that they apply to the words in the Deed or to their intentions when they executed the Deed. *Id.* Therefore, the Court sustains the Demurrer to Count I.

Count II-Coercion/Duress:

In Count II, Plaintiffs do not explicitly state that they seek rescission of the Deed based on undue influence, but all of their allegations implicitly allege undue influence "[t]o set aside a deed or contract on the basis of undue influence requires a showing that the free agency of the contracting party has been destroyed." *Friendly Ice Cream Corp. v. Beckner,* 268 Va. 23, 31 (2004) (citations omitted). "Because undue influence is a species of fraud, the person seeking to set aside the contract must prove undue influence by clear and convincing evidence." *Id.* "While 'undue influence' is not actual fraud in that it does not involve misrepresentation, it is a species of fraud." *Id.* "To set aside a deed or contract on the basis of undue influence requires a showing that the free agency of the contracting party has been destroyed." *Id.*

Undue influence may be proven in two ways. First, "[i]f the party seeking rescission of the deed or contract produces clear and convincing evidence of great weakness of mind *and* grossly inadequate consideration or suspicious circumstances, he has established a prima facie case of undue influence and, absent sufficient rebuttal evidence, is entitled to rescission of the document." *Id.* at 32. (emphasis added). That test requires that the party seeking rescission prove great weakness of mind before considering the adequacy of consideration or any suspicious circumstances.[2]

[2] **R. Shawn Majette August 28, 2022 Editorial Footnote**

In this case, the Amended Complaint alleges that Robert experienced declining health and resulted in him experiencing great weakness of mind. ¶ 12. Also, Plaintiffs alleges that "Robert suffered great weakness of body and mind due to the effects of multiple strokes, one of which occurred shortly before execution of the deed." ¶ 30. Plaintiffs also allege that the Fox's influence was sufficient to destroy Robert's free agency. The Amended Complaint lacks any allegations that Linda suffered weakness of mind or that Fox influenced Linda in such a way as to destroy her free agency. The Amended Complaint merely states that "Linda was aware of and also felt [Fox's] pressure to coerce Robert into dissolving the Trust and convey the Farm to her." *Id.* at ¶ 20. Plaintiffs alleged gross inadequacy of consideration and that the circumstances of the conveyance were suspicious "because [Fox] knew the Farm was unencumbered by a mortgage loan and of great value when she knowingly offered a worthless promise to the Plaintiffs to compel them to give her the Farm earlier than she would have received it from the Trust." *Id.* at ¶ 32-33.

***3** Plaintiffs' Amended Compliant fails to allege sufficient facts to assert a claim of **undue influence** under the first method outlined above. First, there is no allegation that Linda suffered from weakness of mind, which is the first fact that must be alleged to state a claim for **undue influence** under the first method. Second, although the Amended Complaint does allege Robert's weakness of mind, the allegation of grossly inadequate consideration is not applicable to a deed of gift. *Henderson v. Henderson*, 255 Va. 122, 127 (1998) ("there is no issue of adequacy of consideration in this case, since the property was conveyed by deed of gift"). Finally, the Amended Complaint fails to allege facts setting forth suspicious circumstances. Plaintiffs state in a conclusory manner that the conveyance occurred under suspicious circumstances but do not articulate facts that would support their conclusions. For example, there are no allegations that the Plaintiffs significantly altered their estate plan as a result of the conveyance. Nor does the Amended Complaint allege the circumstances of who prepared the Deed and under what circumstances the Plaintiffs signed the Deed. *See Gelber v. Glock*, 293 Va. 497, 527 (2017) (plaintiff while hospitalized signed a deed of gift that altered her estate plan, without the benefit of any legal or financial counsel). Therefore, the Plaintiffs have failed to state a claim for **undue influence** due to weakness of mind and grossly inadequate consideration or suspicious circumstances.

The second method of proving undue influence arises from a situation "[w]here one person stands in a relation of special confidence towards another, so as to acquire a habitual influence over him, he cannot accept from such person a personal benefit without exposing himself to the risk, in a degree proportioned to the nature of their connection, of having it set aside as unduly obtained." *Fishburne v. Ferguson*, 84 Va. 87, 112-13 (1887); *accord Friendly Ice Cream Corp.*, 268 Va. at 32. The Court in *Friendly Ice Cream Corp.* approved the previously articulated parameters of a "confidential relationship," noting that it is:

> **not confined to any specific association of the parties; it is one wherein a party is bound to act for the benefit of another and can take no advantage to himself. It appears when the circumstances make it certain the parties do not deal on equal terms, but, on the one side, there is an overmastering influence, or, on the other, weakness, dependence, or trust, justifiably reposed; in both an unfair advantage is possible.**

> **Trust alone, however, is not sufficient. We trust most men with whom we deal. There must be something reciprocal in the relationship before the rule can be invoked. Before liability can be fastened upon one there must have been something in the course of dealings for which he was in part responsible that induced another to lean upon him, and from which it can be inferred that the ordinary right to contract had been surrendered. If this were not true a reputation for fair dealing would be a liability and an unsavory one an asset.**

***Id.* at 34 (quoting *Hancock v. Anderson*, 160 Va. 225, 240-41 (1933)).[3]**

The Virginia Supreme Court has addressed different circumstances where a confidential relationship exists. "We have also held that a confidential relationship exists between a parent and child when accompanied by an attorney-client or principal-agent relationship, or between family members when the family member provides financial advice or handles the finances of another family member." *Id. See Nicholson v. Shockey*, 192 Va. 271, 278 (1951) (business relationship between mother and son existed over period of years); *Jackson v. Seymour*, 193 Va. 735, 737-38 (brother managed and rented sister's land); *Ayers v. Shaffer*, 286 Va. 212, 228 (2013) (confidential relationship may also arise between co-owners of joint bank accounts).[4]

In this case, Plaintiffs do allege that Fox maintained a confidential and fiduciary relationship with the Plaintiffs by "being a joint owner of the Farm bank account from which she managed mortgage and bill payments for the Farm." Amended Complaint at ¶ 16. In paragraph seventeen, Plaintiffs allege that "in exchange for her confidential fiduciary services, the Plaintiffs allowed [Fox] to utilize Farm deductions for her appraisal business." However, the *Ayers* case is instructive on when a joint bank account between parties may create a confidential relationship necessary to establish an **undue influence** claim.

***4** In *Ayers*, the plaintiff alleged a confidential relationship with the defendants because the plaintiff and defendants were joint owners of bank accounts for which plaintiff provided all the assets. *Id.* at 227. The plaintiff alleged that the defendants breach their duties as agents on the joint bank accounts. The Virginia Supreme Court stated that:

> Virginia Code § 6.2-619(A) provides that "[p]arties to a joint account in a financial institution occupy the relation of principal and agent as to each other, with each standing as a principal in regard to his ownership interest in the joint account and as agent in regard to the ownership interest of the other party." In *Parfitt* we explained that where, as in this case, a joint account is established between two parties under which all the assets are contributed by one party, the second party becomes "an agent with regard to the entire account. By statute, a confidential relationship was established creating a fiduciary duty [and] a presumption that the self-dealing transactions were unduly obtained." *[Parfitt v. Parfitt*, 277 Va. 333, 342 (2009)]. Under such circumstances, it need not be alleged or proven that the defendant procured the creation

[3] **R. Shawn Majette August 28, 2022 Editorial Footnote**
[4] **R. Shawn Majette August 28, 2022 Editorial Footnote**

> of the joint account by **undue influence**. Rather, the existence of the account itself imposes a fiduciary duty on the defendant and with regard to a subsequent transaction creates the presumption of **undue influence** which shifts to the defendant the burden of proving the bona fides of the transaction. *Id.*

Ayers, 286 Va. at 227-28. The Court concluded that since the complaint in *Ayers* sufficiently pled the existence of a joint bank account in which the plaintiff contributed all the assets, and that the defendants undertook transactions from those accounts for their benefit the plaintiff had pled a confidential relationship sufficient to survive demurrer. *Id.*

In this case, Plaintiffs' Amended Complaint alleges only that Fox was a joint owner of the farm bank account from which she managed mortgage and bill payments for the farm. The Amended Complaint does not specify, whether Plaintiffs contributed all the assets to the joint account or if Fox contributed her assets to the account. Further, in *Ayers* the defendants' self-dealing involved the joint accounts at issue whereas in this case, Fox's alleged self-dealing relates to the Deed. The mere existence of the joint farm account does not establish the confidential relationship necessary for Plaintiffs **undue influence** claim, when that joint account had nothing to do with the transaction Plaintiffs seek to rescind. Finally, the Amended Complaint's allegation that Plaintiffs allowed Fox to utilize farm deductions for her appraisal business does not establish a confidential relationship. Again, Plaintiffs use the necessary legal terms "confidential fiduciary relationship" but do not provide the facts that would support the stated legal theory. For these reasons the Court will sustain the Demurrer to Count II.[1]

Count III-Mutual Mistake

***5** "A contract may be reformed or rescinded in equity on the ground of mutual mistake. The mistake must be common to both parties." *Langonan v. Alumni Assoc. of the Univ. of Va.*, 247 Va. 491, (1994) (internal citations omitted). A mutual mistake occurs when "there has been a meeting of minds - their agreement actually entered into, but the contract, deed, settlement, or other instruments, in its written form, does not express what was really intended by the parties thereto; in such cases the instrument may be made to conform to the agreement or transaction entered into according to the intention of the parties." *Dickenson Cnty. Bank v. Royal Exch. Assurance*, 157 Va. 94, 103 (1931). To prevail on a claim of a mutual mistake, a party must present proof that is "clear, convincing, satisfactory, and such as to leave no reasonable doubt on the mind that the writing does not correctly embody the intention of the parties." *Id.* at 104. Whereas a unilateral mistake is "where there is mistake on the part of one party and misrepresentation and fraud perpetrated by the other ...." *Shevel's, Inc.-Chesterfield v. Se. Assocs., Inc.*, 228 Va. 175, 183 (1984) (quoting *Larchmont Properties v. Cooperman*, 195 Va. 784, 792 (1954)).

The Court has ruled that the Deed is clear and unambiguous as to whether the Deed was in fact a deed of gift, thus barring parole evidence on that issue. However, there are exceptions to the Parole Evidence Rule including instances of mutual mistake. *Gibbs v. Price*, 207 Va. 448, 449-50 (1966) ("[e]quity should give effect to the true intent of the parties, despite a contrary intent

reflected by a writing the parties mistakenly believed to monument their bargain"). Despite the exception to the Parole Evidence Rule that may be applicable to a claim of mutual mistake, in this case, Plaintiffs' Amended Complaint does not allege a mutual mistake, but instead alleges a unilateral mistake by Plaintiffs. The Amended Complaint does not allege that Fox misrepresented a fact or perpetrated a fraud on Plaintiffs. Paragraph nine of the Amended Complaint only alleges that the parties expressed a mutual intention that Fox would take over the farm and provide daily assistance for Linda after Robert passed away. However, for the reasons set forth under Count IV below, Plaintiffs have failed to allege Fox misrepresented a material existing fact sufficient to allege a recission of the Deed based on a unilateral mistake. Therefore, the Court sustains the Demurrer to Count III.

Count IV Recission for Misrepresentation:

Under Virginia law a party alleging fraud must prove by clear and convincing evidence (1) a false representation, (2) of a material fact, (3) made intentionally and knowingly, (4) with intent to mislead, (5) reliance by the party misled, and (6) resulting damage to him. *Thompson v. Bacon,* 245 Va. 107, 111 (1993). "Because fraud must involve a misrepresentation of a present or a pre-existing fact, fraud ordinarily cannot be predicated on unfulfilled promises or statements regarding future events." *Supervalu, Inc. v. Johnson,* 276 Va. 356, 367 (2008). Further, "if a defendant makes a promise that, when made, he has no intention of performing, that promise is considered a misrepresentation of present fact and may form the basis for a claim of actual fraud." *Id.* at 368; *see also* *Station #2, LLCv. Lynch,* 280 Va. 166,172 (2010). Finally, fraud claims have a heightened pleading standard, "[w]here fraud is relied on, the [pleading] must show specifically in what the fraud consists, so that the defendant may have the opportunity of shaping his defense accordingly, and since [fraud] must be clearly proved it must be distinctly stated." *Mortarino v. Consultant Eng'g Servs., Inc.,* 251 Va. 289, 295 (1996) (citations omitted).

In this case, Plaintiffs fail to specifically allege Fox's false representation. For example, paragraph nine alleges that during the years preceding the execution of the deed, the parties "discussed their mutual intention that Fox would take over the farm and provide daily assistance for Linda after Robert passed away." Paragraph nine of the Complaint does not allege a misrepresentation of present or pre-existing fact but is a statement regarding future events. Further, paragraph 36 of the Amended Complaint only alleges the Plaintiffs' understanding of Fox's future obligations to them but does not state any material misrepresentation of present or pre-existing fact by Fox. Paragraph 43 of the Amended Complaint states "[Fox's] representations prior to conveyance of the farm persuaded the Plaintiffs to believe that she understood their intention that she provide them love and affection, as well as daily assistance for them on the farm." Again, Plaintiffs fail to allege a specific misrepresentation of material fact by Fox. Reviewing the Amended Complaint in the most generous light to Plaintiffs at best suggests that Fox made representations about future events. Finally, Plaintiffs fail to allege in any manner that Fox's alleged promises were made with no intention of fulfilling them in the future. *Supervalu, Inc.,* 276 Va. at 368. Therefore, the Court sustains the Demurrer as to Count IV.

Count V Unjust Enrichment.

***6** To state a cause of action for unjust enrichment, Plaintiffs had to allege that: (1) they conferred a benefit on Fox; (2) Fox knew of the benefit and should reasonably have expected to repay Plaintiffs; and (3) Fox accepted or retained the benefit without paying for its value. *Schmidt v. Household Fin. Corp., II*, 276 Va. 108, 116 (2008) (citations omitted). Plaintiffs' Amended Complaint fails to allege facts to support a claim of unjust enrichment. Plaintiffs did confer a benefit on Fox by gifting her the real estate. However, Plaintiffs did not allege that Fox should have reasonably expected to repay the Plaintiffs for the conveyance, as the conveyance was a gift. A gift does not require the recipient to repay the donor. Therefore, the Court sustains the Demurrer to Count V.

CONCLUSION

For the foregoing reasons the Court sustains Fox's Demurrer to all counts with prejudice. Plaintiffs did not request leave to amend in their opposition to the Demurrer. Further, the Court previously sustained a Demurrer filed by Fox and granted Plaintiffs leave to amend. While leave to amend should be liberally granted, the Court is not required to grant leave to amend when it is apparent that such an amendment would accomplish nothing more than to provide opportunity for re-argument of issues already decided. *Hechler Chevrolet, Inc. v. Gen. Motors Corp.*, 230 Va. 396, 403-04 (1985).

The Court directs Mr. Simpson to prepare and circulate for endorsement an appropriate order that specifically incorporates the Court's opinion by reference. The Order should be tendered to the Court within twenty-one days of the date of this letter opinion.

Sincerely,

<<signature>>

Paul A. Dryer

Circuit Court Judge

cc: R. Steve Landes, Clerk of Court

Footnotes

[1] Fox also argued that Count II of the Amended Complaint should be dismissed as barred by the statute of limitations. Fox raises this issue in her Demurrer. "While **'[t]he** standards of review for a defensive plea in bar and a demurrer are substantially similar, '[a] plea in bar presents a distinct issue of fact which, if proven, creates a bar to the plaintiff's right of recovery. The moving party has the burden of proof on that issue.'" *Hilton v. Martin*, 275 Va. 176, 179-80 (2008) (quoting *Sullivan v. Jones*, 42 Va. App. 794, 802, (2004)). *See also Station #2, LLC v. Lynch*, 280 Va.

166, 175, (2010). In adjudicating a demurrer, the Court is bound by the facts alleged in the complaint and all reasonable inferences drawn from the alleges facts. In adjudicating a plea in bar, the burden is on the proponent of the plea in bar to present evidence to prove the distinct issue that will bar a plaintiff's right to recovery. Fox's use of the Demurrer is the improper pleading to assert that the statute of limitations bars Plaintiffs' claim for **undue influence**.

Discussion of undue influence claim elements, capacity, equity maxim (that is done which was intended to be done), and importance of draftsman testimony.[5]

108 Va. Cir. 560A

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.
Circuit Court of Virginia,
Culpeper County.

John A. COX, Trustee
v.
Caroline LOWE, et al.

CL-19-940
|
October 3, 2021

Attorneys and Law Firms

T. Huntley Thorpe, Esq. (via email)

Ryan Huttar, Esq. (via email)

Antonio Benedi, Esq. (via email)

Opinion

Dale B. Durrer, Judge

***1** Dear Counsel:
The court's opinion on the Commissioner's Report is below. Thank you for your arguments and presentations. They were well-organized and easy to follow.

The court has reviewed the transcript, written and oral arguments of counsel, the exhibits introduced and the Commissioner's Report in reaching its decision.

I. Contested Issue

The contested issue in this case is the effectiveness of the deed of gift/quitclaim deed executed by Ms. Anne Cox on or about March 28, 2019

[5] **R. Shawn Majette August 28, 2022 Editorial Footnote**. Mr. Hook obviously spent a good amount of time in at least one deposition after the death of his client. Could he, cognizant of likely litigation in the future, provide for Mrs. Cox to have deposited fees to be paid for his time if called as a fact witness, to be chargeable to estate or to be held in trust until the final disposition of the estate? Could he have strengthened the defense of the deed and other documents by engaging an expert witness (LCSW, psychologist, etc.) to have met with the client during the execution and then to have secured a report of capacity?

II. Facts, Reasonable Inferences and Conclusions of Law

On or about January 10, 2006, Anne Cox (Anne) created a revocable living trust (TRUST) for her two children, John Cox (John) and Caroline Lowe (Caroline). The trust had several amendments with the most recent occurring in January 2018.

The trust named Anne and her deceased husband Walter Cox (Walter) as original co-trustees. John served as a successor trustee in the event that Walter and Anne could not execute the duties of the Trust.

The Trust contained several assets, including, without limitation, parcels of real property in Culpeper County. The disputed ten (10) acre parcel of real property is located at 17477 Fleetwood Lane, Jeffersonton, Virginia.

On or about March 4, 2019, John executed a document resigning Anne and Walter as trustees. John relied, *inter alia*, on Dr. Leroy Gravette's (Gravette) medical evaluation of Anne. At that time, Gravette found Anne overwhelmed by her husband's needs and her numerous medications. Gravette specifically found that these numerous medications contributed to Anne's confusion. Gravette had provided medical care and advice to Anne and her family for approximately thirty (30) years.

John relied on Gravette's letters and his authority under the Trust and executed a document resigning John and Anne as trustees on or about March 4, 2019. Consistent with the Trust's requirements, John accepted the position of Substitute Trustee of the Trust. John recorded a copy of this acceptance in the Circuit Court on or about April 2, 2019.

During this 2019 timeframe Anne had been residing in a rehabilitation facility. Anne scheduled a March 26, 2019 meeting with Gravette to discuss and challenge his findings in his February 20, 2019 letter. Gravette conducted a series of cognitive tests and consulted with Anne's neurologist Dr. George Stergis (Stergis). Gravette then reversed his previous opinion concerning Anne's inability to manage her affairs.

On or about March 28, 2019, Anne met with Scott C. Hook, Esq. in Warrenton, Virginia. Anne expressed her wish to execute a deed of gift to her daughter and son in law concerning the ten (10) acre parcel of land previously referenced. Hook followed Anne's instructions and prepared the deed of gift. In the deed, Hook referred to Anne in the deed as the trustee of the Trust. Hook also indicated that he met privately with Anne to ensure that she wanted the deed drafted. Hook testified that he found Anne coherent and that they could communicate without issue. The notice of Anne's removal was not recorded in the Culpeper County Circuit Court Clerk's Office until on or about April 2, 2019. Hook's actions in drafting the deed represented the correct legal status of the land records in early April 2019 in the Culpeper County Circuit Court.

***2** One disputed issue is whether John's actions successfully removed Anne as the trustee from the Trust. The Trust states that if either Anne or Walter could not act on their own behalf, the co-Trustee (John) could resign their trusteeship. The same section of the Trust specifically gives the

co-trustee this authority regardless of any judicial finding of incompetency. Thus, it is a reasonable inference that John's actions are consistent with Gravette's findings at the time of resignation. Further, Anne had delivered to Caroline a birthday card expressing her desire to gift the cabin and real property to Caroline.

John also tried to provide notice to Anne. The testimony is conflicting concerning Anne's notice of her removal. However, the language of the Trust (Section 9.2, et seq) does not require that she receive actual notice because the removal is based on impairment. There are no indirect or direct provisions in 6.2 or 9.2 that require notice when removal is based on impairment. The Virginia Code also indicates that the real estate passes to John upon his assumption of the trustee role, regardless of Anne's knowledge of any land transfer. Va. Code Ann. 64.2-760 (LEXIS 2021).

When Anne executed the deed of gift and quitclaim, she could successfully navigate and manage her affairs. At that time Gravette had reversed his earlier opinion and Hook observed her in a one-on-one environment. Further, John had assumed his role as successor trustee consistent with 64.2-760. Anne further directed that upon her death she intended Caroline to receive a portion of her real property. Anne further named no other child in the Trust that would receive real property.

On or about March 28, 2019 Anne was no longer the trustee of the Trust and Section 1.2 of the Trust indicates the steps necessary to amend or revoke the Trust. The Trust contains no indirect or direct provision concerning the steps necessary for Anne to remove assets. Further, by March 28, 2019 Anne had regained her ability to manage her own affairs.

A. **The March 28, 2019 deed is effective because Anne could manage her own affairs and when she executed the deed of gift she intended that it remove the property from the trust and transfer the same to her daughter**.

A trial court should sustain a commissioner's findings unless they are not supported by the evidence. Hill v. Hill, 227 Va. 569, 576-77 (1984); Venable v. McNutt, 154 Va. 597 (1930); Tidewater Railway Co. v. Cowan, 106 Va. 817 (1907).

Under Virginia law, in considering the language of a trust agreement, the intent of the grantor controls. Harbour v. SunTrust Bank, Inc., 278 Va. 514, 519-20 (2009); Huaman v. Aquino, 272 Va. 170, 174 (2006); Clark v. Strother, 238 Va. 533, 539–40 (1989). Further, “Equity regards that as done which ought to have been done.” Wood v. Martin, 299 Va. 238-249-51 (2020); Federal Rsrv. Bank of Richmond v. Peters, 139 Va. 45, 57 (1924). Similarly, equity mandates that as done which by agreement is agreed to be done and is proper to fully effectuate intentions of parties concerned. Pleasants v. Pleasants, 221 Va. 1017 (1981).

To set aside a deed or contract on the basis of **undue influence** requires a showing that the free agency of the contracting party has been destroyed. Friendly Ice Cream Corp. v. Beckner, 268 Va. 23, 31-33 (2004). **Undue influence** is a species of fraud and the person seeking to set aside the contract must prove **undue influence** by clear and convincing evidence. Redford v. Booker, 166 Va. 561, 574 (1936).

In this case, the court accepts adopts and incorporates the Commissioner's Report in its entirety. Specifically, Hook's testimony resolves any doubt concerning whether anyone subjected Anne to **undue influence**. Hook's testimony further buttresses this conclusion. Hook specifically testified that Anne "seemed fully aware and wishing to sign this document." (Transcript, p. 85). The lack of **undue influence** is further buttressed by the birthday card entered into evidence.

***3** It is true that Anne no longer remained as a Trustee on or about March 28, 2019. However, on or about that date, Gravette had certified her to manage her own affairs. Hook's testimony supports this conclusion and Anne had no reason to believe that when she executed this deed it would not be effectively carried out. The grantor of the Trust, consistent with 1.2 retained the authority to remove property from the Trust. Specifically. 1.2 does not apply to the Grantor's powers to remove or reallocate Trust assets. Anne could withdraw the property at her discretion.

The court holds that Anne intended to convey the property to Caroline and that she possessed the requisite capacity to do so. Based on the foregoing, the court dismisses the complaint, title to the property is quited in Caroline Lowe and they be allowed to recover their reasonable costs in the case.

Mr. Huttar shall prepare an Order incorporating this opinion and the entire Commissioiner's Report.

With best wishes,

Sincerely,

Dale B. Durrer

Judge

All Citations

Not Reported in S.E. Rptr., 108 Va. Cir. 560A, 2021 WL 8314631

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Discussion of Undue Influence and breach of Virginia Uniform Power of Attorney Act, whether punitive damages may be granted.

2021 WL 3741397 (Va.Cir.Ct.) (Trial Order)
Circuit Court of Virginia,
Nineteenth Judicial Circuit.
Fairfax County

Achilles PAPADATOS,
v.
Jasvir KAUR.

No. CL 2019-15656.
August 24, 2021.

Trial Order

Richard E. Gardiner, Judge.
***1** Joseph W. Stuart

Joseph W. Stuart, PLC

10427 North Street, Suite 200

Fairfax, VA 22030

Christopher T. Craig

Cook, Craig & Francuzenko, PLLC

3050 Chain Bridge Road, Suite 200

Fairfax, VA 22030

Dear Mr. Stuart and Mr. Craig:

This matter is before the court on the motion of Petitioner, filed July 23, 2021, to reconsider the court's denial of punitive damages.

BACKGROUND

Petitioner brought a five count petition against Jasvir Kaur for **Undue Influence** (Count I), Fraud (Count II), Breach of Fiduciary Duty (Count III), Conversion (Count IV), and Unjust Enrichment (Count V) as a result of powers of attorney given to Kaur by Petitioner's parents, Evangelos and Bonnie Papadatos, on December 8, 2017. In Count I, Petitioner asserted that a fiduciary

relationship existed between Evangelos and Kaur "as a result of the power of attorney ...." *Petition*, ¶ 49. Counts II-V restated and incorporated by reference that assertion.

In each count, Petitioner sought "compensatory damages in the amount of $173,000, plus costs and pre-judgment interest and post-judgment interest";[1] in Counts I-IV, Petitioner also sought "punitive damages in the amount of $340,000 ..." The court thus construes the counts as alternative theories pursuant to Sup. Ct. Rule 1:4(k) and the identical language in Code § 8.01-281(A),[2] which was adopted "to grant a party asserting any claim or defense the right to join alternative claims or defenses, that is, to present alternative statements of the facts or alternative legal theories." *Powers v. Cherin*, 249 Va. 33, 37 (1995).

On June 21, 2021, Petitioner filed a *Trial Brief* in which he further articulated his arguments. Of importance for this motion, Petitioner argued that the breach of fiduciary duties arose from Kaur's violation of the powers of attorney and sought recovery pursuant to Uniform Power of Attorney Act (Code § 64.2-1600, *et seq.*) ("the Act") -- in particular, Code § 64.2-1615,[3] -- to wit, that Kaur should "restore to Achilles, as successor in interest to his parents, the value of the Evangelos' and Bonnie's funds principal's (sic) to what it would have been had the violation not occurred." *Petitioner's Trial Brief* at 6.

Petitioner's Trial Brief also contended that the court should award damages for the breach of fiduciary duties in the amount of $183,868.19. With regard to each of the other four common law claims -- Fraud, **Undue Influence**, Conversion, and Unjust Enrichment -- Petitioner also sought recovery of $183,868.19 on each claim.

***2** At trial, the court found that Kaur breached her fiduciary duties to Evangelos and Bonnie Papadatos in violation of the Act and ordered that Kaur restore to Achilles, as successor in interest to his parents, the sum of $140,519.19 based upon Kaur's violation of the powers of attorney. The award was on Count III, the claim pursuant to Code § 64.2-1615. The court denied Petitioner's request for punitive damages, but, pursuant to Code § 64.2-1614(E),[4] awarded attorney fees as justice and equity so required.

Petitioner now asks the court to reconsider its denial of punitive damages.

ANALYSIS

Common Law Punitive Damages

In his motion for reconsideration, Petitioner appears to seek common law punitive damages or, alternatively, to seek punitive damages pursuant to the Act, in particular, Code § 64.2-1619 ("Unless displaced by a provision of this chapter, the principles of law and equity supplement this chapter") and Code § 64.2-1621 ("The remedies under this chapter are not exclusive and do not abrogate any right or remedy, including a court-supervised accounting, under the laws of the Commonwealth other than this chapter.").

To recover common law punitive damages, Petitioner must have succeeded on one of his common law claims, i.e., Counts I, II, IV, or V. The court, however, awarded restoration of $140,519.19 (and attorney fees) to Achilles pursuant to the Act (Count III). Accordingly, because "the trial court must assure that a verdict, while fully and fairly compensating a plaintiff for loss, does not include duplicative damages," *Wilkins v. Peninsula Motor Cars,* 266 Va. 558, 561 (2003), the court cannot also award $140,519.19 for each of the other four alternative common law claims. It follows that the court also cannot award punitive damages with respect to Counts I-II and IV-V.

Punitive Damages Under The Act

Having ordered recovery on the breach of fiduciary duties pursuant to Code § 64.2-1615 (Count III), the court may only award an additional monetary recovery (*i.e.*, punitive damages) pursuant to the terms of the Act.

Petitioner argues that, "[u]nder § 64.2-1619, the principles of law and equity supplement this chapter" and that Code § 64.2-1619:

> authorizes courts to "employ both statutory principles from the Uniform Power of Attorney Act (Act), Code § 64.2-1600 et *seq.*, and common law principles." *Davis v. Davis,* 298 Va. 157, 168, 835 S.E.2d 888, ___ (2019).

Motion for Reconsideration at 2.

With respect to the first argument, Petitioner has omitted the first part of Code § 64.2-1619 ("Unless displaced by a provision of this chapter [Chapter 16],"). In full, Code § 64.2-1619 states: "Unless displaced by a provision of this chapter, the principles of law and equity supplement this chapter [Chapter 16]." Accordingly, the court must determine whether any provision of Chapter 16 (which is the Act) "displaces" the right to punitive damages for an intentional tort under the common law of Virginia where a respondent has acted willfully and wantonly.[5]

***3 In the court's view, Code § 64.2-1615 displaces the common law right to punitive damages in that it makes the agent liable "for the amount required to:**

> **1. Restore the value of the principal's property to what it would have been had the violation not occurred; and**
>
> **2. Reimburse the principal or the principal's successors in interest for the attorney fees and costs paid on the agent's behalf."[6]**

Had the General Assembly intended to allow punitive damages, it could have expressly authorized them. Instead, it authorized, for an agent's violation of the Act, only restoration of the lost value of the principal's property and attorney fees and costs.[6]

[6] **R. Shawn Majette August 28, 2022 Editorial Footnote**

Turning to Petitioner's reliance on *Davis v. Davis*, 298 Va. 157 (2019), the Court did not hold, as argued by Petitioner, that "Code § 64.2-1619 authorizes courts to 'employ both statutory principles from the Uniform Power of Attorney Act (Act), Code § 64.2-1600 et *seq.*, and common law principles.' " In fact, in the sentence partially quoted by Petitioner, the Court did not mention Code § 64.2-1619. And Petitioner's purported quotation omitted key introductory language. What the Court actually stated was the following:

> In interpreting a power of attorney document, we employ both statutory principles from the Uniform Power of Attorney Act (Act), Code § 64.2-1600 et *seq.*, and common law principles. Code § 64.2-1619 (recognizing that "the principles of law and equity" supplement the Act).

298 Va. at 168.

Thus, employment of the statutory principles from the Act and common law principles is for the purpose of interpreting a power of attorney document. Code § 64.2-1619 was material only because it allowed the use of "the principles of law and equity" in interpreting a power of attorney document. Because in the case at bar, there is no issue of the interpretation of the power of attorney document, the lesson of *Davis* is inapposite.

Petitioner also relies on Code § 64.2-1621, which states:

> The *remedies* under this chapter are not exclusive and do not abrogate any right or *remedy*, including a court-supervised accounting, under the laws of the Commonwealth other than this chapter. (Emphasis added).

At the time Code § 64.2-1621 was enacted -- in 2010 -- a remedy was "the means employed to enforce a right or redress an injury ...." *Colonna Shipyard v. Bland*, 150 Va. 349, 355 (1928). Thus, damages -- which are the measure of injury -- are not a remedy.[7] As a result, while Code § 64.2-1621 does not abrogate any other means employed to enforce a right or redress an injury, it does not affect the availability *vel non* of damages and thus does not permit financial compensation other than what is otherwise expressly provided for in the Act. As discussed above, for an agent's violation of the Act, the Act authorizes only restoration of the lost value of the principal's property and attorney fees and costs; punitive damages are not authorized.

***4** As Petitioner's recovery was pursuant to the Act and punitive damages are not authorized by the Act, Petitioner's motion for reconsideration is DENIED.

An appropriate order will enter.

Sincerely yours,

<<signature>>

Richard E. Gardiner

Judge

ORDER

THIS MATTER came before the court on the motion of Petitioner, filed July 23, 2021, to reconsider the court's denial of punitive damages.

IT APPEARING to the court, for the reasons stated in the court's letter opinion of today's date, that Petitioner's motion to reconsider the court's denial of punitive damages should be denied, it is hereby

ORDERED that Petitioner's motion to reconsider the court's denial of punitive damages is DENIED.

ENTERED this 24th day of August, 2021.

<<signature>>

Richard E. Gardiner

Judge

ENDORSEMENT OF THIS ORDER BY COUNSEL OF RECORD FOR THE PARTIES IS WAIVED IN THE DISCRETION OF THE COURT PURSUANT TO RULE 1:13 OF THE SUPREME COURT OF VIRGINIA

Copy to:

Joseph W. Stuart

Counsel for Petitioner

Christopher T. Craig

Counsel for Respondent

Footnotes

[1] At the trial on June 23, 2021, the court granted Petitioner's motion to increase the *ad damnum* to $183,868.19.

2 "A party asserting ... a claim ... may plead alternative ... theories of recovery against alternative parties, provided that such claims, defenses, or demands for relief so joined arise out of the same transaction or occurrence."

3 "An agent that violates this chapter is liable to the principal or the principal's successors in interest for the amount required to:
1. Restore the value of the principal's property to what it would have been had the violation not occurred; and
2. Reimburse the principal or the principal's successors in interest for the attorney fees and costs paid on the agent's behalf."

4 "In a judicial proceeding under this chapter, if the court finds that the agent breached his fiduciary duty in violation of the provisions of this chapter, the court, as justice and equity may require, may award costs and expenses, including reasonable attorney fees, to any person who petitions the court for relief under subdivisions A 1 through 8, to be paid by the agent found in violation...."

5 "When a plaintiff pleads and proves an intentional tort under the common law of Virginia, the trier of fact may award punitive damages." *Shaw v. Titan Corporation*, 255 Va. 535, 545 (1998). In *Shaw*, Titan argued that Shaw "was not entitled to recover punitive damages because neither the Virginia Human Rights Act nor any other Virginia statute specifically authorized the recovery of such damages at the time Shaw was discharged and filed this action." *Id.* The Court found "no merit in this argument because the cause of action for wrongful termination of employment asserted by Shaw derives solely from the common law." *Id.* Like the Virginia Human Rights Act, the Act here does not expressly authorize the recovery of punitive damages.

6 The court notes that, for a recovery pursuant to common law remedies such as **undue influence**, conversion, or unjust enrichment, there would be no right to attorney fees, and that, for fraud, the court, **"in the exercise of his discretion, may** award attorney's fees to a defrauded party." *Prospect Development Company v. Bershader*, 258 Va. **75,** 92 (1999) (emphasis added). Thus, the General Assembly could have concluded that allowing for punitive damages, as well as attorney fees, was excessive so it only allowed recovery of attorney fees.

7 The distinction between a remedy and damages is well articulated in *Kozar v. Chesapeake & O. Ry. Co.*, 449 F.2d 1238 (6th Cir. 1971):
But it is a mistake to characterize the right to recover punitive damages at common law a "common law remedy". There is an important distinction between a "remedy" which *Bouvier's Law Dictionary* defines as "the means employed to enforce a right or redress an injury", and "damages" which are defined as "[t]he indemnity recoverable by a person who has sustained an injury *** and the term includes not only compensatory, but also exemplary or punitive or vindictive * * * damages." Damages are simply a measure of injury, and to say that at common law there was "punitive damages as a right of action" or there was available "the common law remedy action of punitive damages" or a "punitive damages remedy" is a misuse of the legal terminology.
449 F.2d at 1240.

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Virginia Power Of Attorney Cases After 7 31 3021 & Before 8 1 22

Table of Contents

Discussion of Interlocutory Appeal Changes, Standing to assert undue influence claim rests with estate personal representative, not agents or heirs

870 S.E.2d 210

Rachel Hurley KITTRELL, as Member of Hurley, LLC, et al., Appellants,
v.
Susan H. FOWLER, et al., Appellees.

Record No. 201419

Supreme Court of Virginia.

March 24, 2022

In this interlocutory appeal, Appellants challenge the circuit court's decision overruling their demurrer and allowing Appellees to proceed with their claims. Upon consideration of the record, briefs, and argument of counsel, the Court is of opinion that the decision of the circuit court should be reversed.

I. Background

Walter Hurley, Sr. and his wife, Margaret, had two daughters, Susan H. Fowler and Lisa H. Foster (collectively, the "Appellees"), and one son, Walter Hurley, Jr. Before Walter, Sr.'s death, Walter, Sr., Margaret, and Walter, Jr. each owned approximately one-third of Hurley, LLC. When Walter, Sr. died on April 28, 2006, his interest in Hurley, LLC passed to Walter, Jr., his tangible personal property passed to Margaret, and the remainder of his property passed to the Walter Boyd Hurley Revocable Trust (the "Walter Sr. Trust"). Walter, Jr. served as trustee of the Walter Sr. Trust, and as such, he was to distribute assets to provide for Margaret during her lifetime and distribute any remaining trust assets to his siblings after Margaret's death.

On May 15, 2006, Margaret signed a document entitled "Sales Verification" transferring her interest in Hurley, LLC to Walter, Jr. in exchange for a promissory note in the amount of $950,000 (the "Hurley Transaction").[1]

In July 2007, Margaret created her own revocable trust, the Margaret H. Hurley Living Trust ("Margaret's Living Trust"), which provided that upon Margaret's death, any residual trust property should be distributed equally between her children. However, Margaret's Living Trust specifically

indicated that Walter, Jr. should not receive a share of the trust after Margaret's death.

In September 2008, Margaret signed a document entitled "First Amendment to the Margaret H. Hurley Living Trust." In the amended trust agreement, Margaret specifically stated that she "intentionally, and with full knowledge, chose[ ] not to provide for [her] child WALTER B. HURLEY, JR., or his issue" as he received "Five Hundred Thousand Dollars ($500,000.00) in disclaimed assets and the Fair Market Value ("FMV") of the campsite properties." Thus, Appellees were to receive the living trust properties in two equal shares.

[870 S.E.2d 212]

On March 8, 2013, Walter, Jr. closed Margaret's checking account titled "Margaret H. Hurley Living Trust" at the Colonial Bank of Gloucester and opened a new account bearing the same title. On April 1, 2013, a check for $999,999.00 was written on the new account and was made payable to "Margaret's Future Trust." Appellees contend this check was repayment for the promissory note given in exchange for Margaret's 2006 sale of her one-third interest in Hurley, LLC to Walter, Jr.

On April 15, 2013, Margaret purportedly signed a document entitled "Second Amendment to the Margaret Hurley Living Trust," which provided that if Margaret resigned as the trustee of her living trust, Walter Jr. would become the substitute trustee. On the same date, Margaret purportedly signed another document entitled "Margaret's Future Trust," creating an irrevocable trust for the benefit of Walter, Jr.’s children, of which Walter, Jr. was named the trustee.

On April 19, 2013, Walter, Jr. made two deposits into the new checking account: one for $1,000,000.00 and one for $36,000.00. On April 22, 2013, Margaret resigned as trustee of Margaret's Living Trust.

On April 16, 2014, Margaret died, and her living trust became irrevocable. Per the terms of the trust, William Farinholt became the trustee and personal representative of Margaret's estate. Appellees became suspicious of Walter, Jr.’s handling of Margaret's assets. In early 2017, Farinholt confronted Walter, Jr. on Appellees’ behalf. On May 16, 2017, Walter, Jr. died by suicide. Walter, Jr.’s will directed that the assets of his estate passed to the Nanba-wan Sai Trust for the benefit of his children.

On February 28, 2018, Appellees filed a complaint against Margaret's Future Trust, the Estate of Walter, Jr., and the Nanba-wan Sai Trust, seeking an accounting of each party's assets, restitution, and the imposition of a

constructive trust on the assets of the trusts based on Walter, Jr.'s alleged fraudulent conduct, unjust enrichment, and breach of fiduciary duty as trustee of Walter, Sr.'s and Margaret's estates. The defendants filed a demurrer and plea in bar. The demurrer specifically alleged that Appellees failed to name the trustees of the trusts or the executors of Walter, Jr.'s estate as defendants, failed to attach the pertinent trust documents, and failed to state a cause of action.

Appellees filed a motion to join the proper parties and attached a First Amended Complaint. The parties submitted an agreed order to the circuit court granting Appellees' motion to join parties and setting a briefing schedule for responsive pleadings. The defendants filed a demurrer and plea in bar to Appellees' First Amended Complaint. Following a hearing, the circuit court overruled both the demurrer and plea in bar and the case was set for trial.

On April 29, 2019, Appellees filed a motion for leave to file a Second Amended Complaint, which proposed to add claims relating to the Hurley Transaction and join the relevant members of Hurley, LLC as defendants. Specifically, the Second Amended Complaint requested that the circuit court declare the Hurley Transaction void and award Appellees an "amount of damages that is equivalent to the value of Margaret's interest in Hurley, LLC as of the date of Margaret's death." The defendants opposed Appellees' motion, contending that the Appellees lacked standing to assert Counts 5, 6, 7, 8, and 9 of the Second Amended Complaint (the "Hurley Claims").[2] The circuit court granted Appellees' motion for leave to amend, specifically stating that the "new issues raised are, in fact, intertwined with the existing issues. Standing, as well as any other issues, can be argued upon proper motions."

The defendants filed a demurrer and plea in bar, contending, among other things, that Appellees lack standing to assert the Hurley

[870 S.E.2d 213]

Claims because neither Appellee was the personal representative of Margaret's estate.[1] The circuit court heard arguments on the demurrer,[3] after which it ruled that "because [Walter, Jr.] basically, allegedly formed [the trust] documents making himself in a representative capacity, I'll overrule the demurrer and allow the claim to go forward."

The defendants at that time, Rachel H. Kittrell, Sarah G. Hurley, and Walter Hurley, III as members of Hurley, LLC, and William and Rachel Edwards as

[1] **R. Shawn Majette August 28, 2022 Editorial Footnote**

trustees of Margaret's Future Trust and Executors of Walter, Jr.'s estate, and Rachel Edwards as trustee of the Nanba-wan Sai Trust (collectively, the "Appellants"), sought an interlocutory appeal of the circuit court's ruling as to standing pursuant to Code § 8.01-670.1. Although the circuit court consented, Appellees withheld their consent.

In January 2020, Appellants filed a "Verified Petition for Writs of Prohibition and Mandamus" in this Court. On September 8, 2020, this Court dismissed Appellants' petition. On July 1, 2020, the General Assembly's amendment to Code § 8.01-670.1 went into effect. The amendment removed the requirement that all parties consent to an interlocutory appeal. *See* 2020 Acts ch. 907. On October 1, 2020, Appellants once again sought interlocutory review of the circuit court's decision as to Appellees' standing. The circuit court certified Appellants' interlocutory appeal to this Court.[2]

II. Analysis

In this interlocutory appeal, Appellants contend that the circuit court "improperly conferred standing on [Appellees] to pursue claims to challenge and unwind the arms-length sale by their mother, Margaret, of her minority interest in Hurley, LLC in 2006." We agree with Appellants.

This issue presents a question of law that we review de novo on appeal. *See Platt v. Griffith* , 299 Va. 690, 692, 858 S.E.2d 413 (2021). "To establish standing, it is essential for a litigant to 'show an immediate, pecuniary, and substantial interest in the litigation, and not a remote or indirect interest.' " *Id.* (quoting *Westlake Prop., Inc. v. Westlake Pointe Prop. Owners Ass'n* , 273 Va. 107, 120, 639 S.E.2d 257 (2007)). "Virginia law establishes that '[t]he personal representative, not a beneficiary of the estate, is the proper party to litigate on behalf of the estate and that is true even when the personal representative is also a possible beneficiary of the estate.' " *Id.* (quoting *Reineck v. Lemen* , 292 Va. 710, 722, 792 S.E.2d 269 (2016)); *see also* Code § 1-234.

Appellees maintain that Margaret's Living Trust, a revocable trust created in 2007, would have received title to Margaret's minority share in Hurley, LLC upon her death in 2014 but for the sale of her interest to Walter, Jr. in 2006. Appellees further theorize that because they were the ultimate remainder beneficiaries of Margaret's Living Trust, they would have received Margaret's minority interest in Hurley, LLC upon her death. Therefore, they seek to unwind the 2006 Hurley Transaction between Margaret and Walter,

[2] **R. Shawn Majette August 28, 2022 Editorial Footnote**

Jr. based upon Walter, Jr.'s alleged undue influence over Margaret and his breach of fiduciary duty.

Notably, the 2006 Hurley Transaction occurred approximately one year before the creation of Margaret's Living Trust, disposing of Margaret's minority interest in Hurley, LLC well before the creation of her revocable trust. Consequently, Margaret's minority interest was never to be a trust asset. As remainder beneficiaries of Margaret's Living Trust, Appellees are legal strangers to the 2006 Hurley Transaction because they never obtained an interest in Margaret's minority interest.

Assuming arguendo that a claim exists for the rescission of the 2006 Hurley Transaction, the claim belongs to Margaret's estate as it would have belonged to Margaret during her lifetime. Upon her death in 2014, any viable claim relating to the sale of her minority interest in Hurley, LLC passed to her estate and may only be pursued by the estate's personal representative. *See Platt* , 299 Va. at 693, 858 S.E.2d 413 ; *see also* Code §§ 8.01-25, 64.2-519, and 64.2-520. Because

[870 S.E.2d 214]

neither Appellee is the personal representative of Margaret's estate, they lack standing to bring such a claim. [3]

For the reasons stated, we reverse the circuit court's decision on these issues, dismiss Appellees' claims relating to the 2006 Hurley Transaction, and remand to the circuit court for further proceedings consistent with this order.

This order shall be published in the Virginia Reports and certified to the Circuit Court of Middlesex County.

Notes:

[1] A $950,000 check dated May 15, 2006, and payable to "Margaret H. Hurley" from Hurley, LLC appears in the record. However, the check does not appear to have been negotiated.

[2] In Counts 5-9, Appellees sought the imposition of a constructive trust on the assets of Hurley, LLC for Appellees' benefit; requested an accounting of Hurley, LLC's assets; requested that Hurley, LLC be required to make restitution to Appellees in the form of all assets they should have received from Margaret at the time of her death, plus interest from that date; and

[3] **R. Shawn Majette August 28, 2022 Editorial Footnote**

sought to unwind the 2006 Hurley Transaction and Margaret's Future Trust because they were both products of Walter, Jr.'s undue influence and breach of fiduciary duty. Appellees only seek relief to the extent the claims apply to the 2006 Hurley Transaction.

[3] The defendants' plea in bar to the Appellees' Second Amended Complaint remains pending in the circuit court. The arguments contained therein are not at issue in this interlocutory appeal.

CATHERINE NICOLE CHITTUM
v.
COMMONWEALTH OF VIRGINIA

No. 0783-20-3

Court of Appeals of Virginia

January 25, 2022

FROM THE CIRCUIT COURT OF ROANOKE COUNTY James R. Swanson, Judge

Robert E. Dean (Rob Dean Law, on brief), for appellant.

Virginia B. Theisen, Senior Assistant Attorney General (Mark R. Herring, [1] Attorney General, on brief), for appellee.

Present: Judges Humphreys, AtLee and Raphael Argued at Lexington, Virginia

MEMORANDUM OPINION [*]

RICHARD Y. ATLEE, JR., JUDGE

Following a bench trial, the circuit court convicted appellant Catherine Nicole Chittum of grand larceny after she transferred $163, 600 belonging to her mother, held in a joint checking account, to herself. On appeal, Chittum argues that she lacked the necessary intent to commit grand larceny because (1) she had joint ownership in the account and her mother had granted her power of attorney, and (2) she made the transfer with her mother's consent and at her behest. Accordingly, she argues, the evidence is insufficient to support her conviction. For the following reasons, we disagree and affirm.

1

I. Background

"On appeal of criminal convictions, we view the facts in the light most favorable to the Commonwealth, and [we] draw all reasonable inferences from those facts." *Payne v. Commonwealth*, 65 Va.App. 194, 198 (2015).

Chittum is the adult daughter, and youngest of four children, of Henry Lee Roadcap, Sr. ("Henry") and Anita Loretta Roadcap ("Anita"). On March 22, 2017, Anita executed a general durable power of attorney, naming her husband and Chittum, "either of whom may serve alone," as her agent. Because Henry's health was failing, he wanted Anita to move in with

Chittum and her family because Anita "needed a little help." Anita moved in with Chittum and her family in March 2017.

Henry passed away on June 1, 2017. The following week, Anita went with Chittum to a Member One Federal Credit Union branch and added Chittum as a joint account holder of an account that was previously in the names of Henry and Anita (the "Member One account").[2]Henry had two insurance policies that paid out after he died: a $200, 246.58 death benefit from Genworth Financial and $2, 616.36 from Settler's Life Insurance Company. Anita was the sole beneficiary of these policies. These funds were deposited into the Member One account. Using that money, Chittum paid off several of Anita's outstanding debts. She also wrote checks for health care expenses, utilities, and other bills. On July 10, 2017, Chittum wrote a check, naming herself as payee, for $163, 600. The memo line on the check said "gift." On September 22, 2017, following a family dispute, Anita revoked the existing power of attorney and executed a new durable power of attorney, naming her son, Paul Roadcap, as her agent.

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A grand jury charged Chittum with grand larceny. At trial, Anita testified that she did not authorize Chittum to transfer the $163, 600. She emphasized that these insurance payouts, along with Social Security checks, were "all [she] had to live on." Anita testified that Henry told her that she could give Chittum $10, 000 to assist on a down payment for a larger house. Anita said that she offered to give that money to Chittum, "and [Chittum] said she did not want it," believing she should receive more.

Chittum testified that she had deposited "$100 maybe" of her own money into the Member One account and that the vast majority of the account's funds came from insurance proceeds. She said that her mother told her "innumerable times" that she wanted Chittum to take money to pay down bills and that Henry had wanted Chittum to be able to purchase a bigger home. Chittum disclaimed any knowledge of the offer of $10, 000 described by Anita.

In a detailed letter opinion, the circuit court found "little dispute as to most of the pertinent facts" and found Chittum guilty of grand larceny. Chittum received a sentence of five years in prison with all but nine months suspended.

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II. Analysis

Chittum advances, on brief, [3] two primary arguments: (1) that she could not be guilty of grand larceny because Anita had given her power of attorney and added her as a joint account holder in the Member One account, and (2) that the $163, 600 was a gift from Anita.[4]

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Larceny, a common law crime, is "the wrongful or fraudulent taking of another's property without his permission and with the intent to permanently deprive the owner of that property." *Brown v. Commonwealth*, 54 Va.App. 107, 119 (2009) (quoting *Britt v. Commonwealth*, 276 Va. 569, 574 (2008)). Grand larceny, as defined in the current version of Code § 18.2-95, includes "simple larceny not from the person of another of goods and chattels of the value of $1, 000 or more." Code § 18.2-95.[5]

"When reviewing the sufficiency of the evidence, '[t]he judgment of the trial court is presumed correct and will not be disturbed unless it is "plainly wrong or without evidence to support it."'" *Smith v. Commonwealth*, 296 Va. 450, 460 (2018) (alteration in original) (quoting *Commonwealth v. Perkins*, 295 Va. 323, 327 (2018)). The reasonableness of a defendant's alternative hypothesis of innocence is determined by the factfinder. *See Gerald v. Commonwealth*, 295 Va. 469, 482 n.8 (2018) ("[T]he factfinder determines which reasonable inferences should be drawn from the evidence, and whether to reject as unreasonable the hypotheses of innocence advanced by a defendant." (alteration in original) (quoting *Moseley v. Commonwealth*, 293 Va. 455, 464 (2017))). The "reasonable hypothesis" principle does not set out a different standard for assessing criminal agency, but rather it is "simply another way of stating that the Commonwealth has the burden of proof beyond a reasonable doubt." *Moseley*, 293 Va. at 464 (quoting *Commonwealth v. Hudson*, 265 Va. 505, 513 (2003)).

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A. *Claim of Right*

Chittum's first argument - that by virtue of her being a joint account holder and having power of attorney, she had a claim of right to the transferred money - fails for several reasons. Virginia law is clear that being named as an owner in a joint account does not provide license to drain funds belonging to or contributed by another account holder. "A joint account belongs, during the lifetimes of all parties, to the parties *in proportion to the net contributions by each* to the sums on deposit . . . unless . . . there is clear and convincing evidence of a different intent." Code § 6.2-606(A) (emphasis added). It is undisputed that most of the money in the Member One account came from insurance and Social Security payments made to Anita and that

Chittum had contributed at most around $100 of the over $200, 000 that was once in the account. No clear and convincing evidence exists to suggest there was a "different intent"; thus, Code § 6.2-606(A) states that the ownership of the funds in the Member One account should be allocated "in proportion to the net contributions" of Anita and Chittum. Accordingly, the $163, 600 was Anita's property that Chittum had no right to transfer to herself solely by virtue of being a joint account holder. [4]

Chittum argues that Anita's execution of the general power of attorney evinces "clear and convincing evidence of a different intent" under the statute. Yet Chittum's role as Anita's agent with power of attorney did not authorize her to transfer Anita's money against Anita's wishes and contrary to her best interest. Under Code § 64.2-1612, someone who has accepted power of attorney shall, among other duties: "[a]ct in accordance with the principal's reasonable expectations to the extent actually known by the agent and, otherwise, in the principal's best interest;" "[a]ct in good faith;" "[a]ct only within the scope of authority granted in the power of attorney;" and "[a]ct loyally for the principal's benefit." Code § 64.2-1612(A), (B)(1). The circuit court, reviewing the evidence, noted that Chittum had an obligation to preserve the assets

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of her mother; those assets were essential to "Anita's long term financial security," because they were "all she had to live on for the rest of her life." By transferring the funds to herself, Chittum acted contrary to, and outside the scope of, her duties owed to Anita acting as her agent pursuant to the power of attorney.

B. *Gift*

Chittum's alternative theory of innocence is, contrary to her mother's testimony before the circuit court, that Anita had given Chittum the $163, 600 as a gift.

"The fact finder, who has the opportunity to see and hear the witnesses, has the *sole* responsibility to determine their credibility, the weight to be given their testimony, and the inferences to be drawn from proven facts." *Commonwealth v. McNeal*, 282 Va. 16, 22 (2011) (quoting *Commonwealth v. Taylor*, 256 Va. 514, 518 (1998)). "In its role of judging witness credibility, the fact finder is entitled to disbelieve the self-serving testimony of the accused and to conclude that the accused is lying to conceal his guilt."

[4] **R. Shawn Majette August 28, 2022 Editorial Footnote**

Flanagan v. Commonwealth, 58 Va.App. 681, 702 (2011) (quoting *Marable v. Commonwealth*, 27 Va.App. 505, 509-10 (1998)).

Here, the circuit court, as factfinder, considered the evidence presented at trial, and concluded that it did not support a finding that Anita intended to give $163, 600 of her money to Chittum. It expressly found Anita to be a "credible and persuasive" witness, and, in so doing, rejected Chittum's theories of innocence. It credited Anita's testimony that she did not authorize this "gift" because that money was "all [she] had to live on." It also concluded that the transfer of this money "was not consistent with either Anita's reasonable expectations or her best interests." These findings are supported by the evidence, and the conclusions drawn from them are not plainly wrong; accordingly, the circuit court did not err in finding the evidence sufficient to support Chittum's grand larceny conviction.

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III. Conclusion

No legal authority supports Chittum's assertion that her having power of attorney, or being a joint account holder, authorized her to transfer $163, 600 of her mother's money to herself in this instance. The circuit court did not err in crediting Anita's testimony that the transfer was not a gift, but rather was contrary to her best interests and wishes. Accordingly, we affirm Chittum's conviction for grand larceny.

Affirmed.

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Notes:

[*] Pursuant to Code § 17.1-413, this opinion is not designated for publication.

[1] Jason S. Miyares succeeded Mark R. Herring as Attorney General on January 15, 2022.

[2] In her testimony, Anita described this visit to the bank, stating that she could not read the paperwork at the bank and that Chittum told her they were "just bank papers" when Anita asked what she was signing. She stated she signed because she trusted Chittum.

[3] At oral argument, Chittum's counsel presented a number of arguments that were neither made before the circuit court, nor argued on brief. Much of

these centered on language in the Member One membership application. For example, he relied on terms governing ownership of funds upon a joint account holder's death, failing to acknowledge that the referenced language is wholly irrelevant here, given that Chittum wrote herself the $163, 600 check while Anita, the joint account holder, was alive.

Furthermore, Chittum's counsel argued that the Member One membership application, by referencing the terms of the "Membership Account Agreement," incorporated that agreement into the record here by reference. He claimed that the language in the account agreement authorized Chittum's actions. Yet the account agreement was not offered into evidence or otherwise included in the trial record or provided to this Court. *See Nelson v. Middlesex Dep't of Soc. Servs.*, 69 Va.App. 496, 502 (2018) ("[U]nder basic principles of appellate review, we may not go beyond the record developed in the trial court." (quoting *Boyd v. Cty. of Henrico*, 42 Va.App. 495, 505 n.4 (2004) (*en banc*))).

In addition to relying on "evidence" not in the record, Chittum's counsel failed to either make these arguments before the circuit court, or assign error encompassing this argument on appeal. As such, this argument is waived. Rule 5A:18 ("No ruling of the trial court . . . will be considered as a basis for reversal unless an objection was stated with reasonable certainty at the time of the ruling, except for good cause shown or to enable this Court to attain the ends of justice. "); Rule 5A:20 ("Only assignments of error listed in the brief will be noticed by this Court.").

[4] At oral argument, appellant's counsel repeatedly insisted, in response to the Court's questioning, that the Member One Account Agreement was included in the record. He told the Court that the agreement stated: "joint owners agree with each other, and with us, that all sums now paid in or hereafter paid in by one or all account owners, including all dividends thereon, are and will be owned by all account owners jointly and equally, regardless of their net contributions." When asked where the Court could find this language, he provided a reference that did not contain it. Even when he returned to make his rebuttal, having had time to search the joint appendix for a correct page reference, he failed to disclose that this language, and the document he ostensibly was quoting from, was not in the record. It took even more probing until he finally relented and admitted that it was, in fact, not in the record, or otherwise made available to the Court.

Moreover, when asked repeatedly where he previously made and preserved certain arguments, appellant's counsel either evaded the question or provided seemingly random (or at best, irrelevant) references to his brief, which, upon careful review, contain nothing resembling his arguments before the Court.

[5] There is no dispute that the amount here exceeds the threshold for grand larceny under any version of Code § 18.2-95. The current $1, 000 threshold went into effect in July 2020. 2020 Va. Acts ch. 401. At the time Chittum took the money belonging to her mother, the threshold amount was $200. 2018 Va. Acts ch. 764 (raising threshold from $200 to $500 effective July 1, 2018).

Discussion of agent's duty to permit inspection and report, equitable accounting per Va. Code 8.01-31.

300 Va. 289
863 S.E.2d 847

SUSAN E. PHILLIPS
v.
JOHN MARK ROHRBAUGH, JR., IN HIS INDIVIDUAL CAPACITY AND IN HIS CAPACITY AS CO-EXECUTOR OF THE ESTATE OF JOHN MARK ROHRBAUGH, SR., ET AL.

No. 200840

Supreme Court of Virginia

October 21, 2021

FROM THE CIRCUIT COURT OF MADISON COUNTY Lon E. Farris, Judge Designate

OPINION

D. ARTHUR KELSEY, JUSTICE

John Mark Rohrbaugh Sr. died in 2016. Two years later, his daughter filed claims seeking both an equitable and a statutory accounting from her brother in his former capacity as an agent managing their father's financial affairs pursuant to a power of attorney and in his present capacity as co-executor of their father's estate. She also filed a claim against the other co-executor of her father's estate, seeking an equitable accounting. The circuit court granted demurrers as to all claims and dismissed the action because, under the facts pleaded, neither theory of accounting applies to this case. We agree and affirm.

I.

"Because this appeal arises from the grant of a demurrer, we accept as true all factual allegations expressly pleaded in the complaint and interpret those allegations in the light most favorable to the plaintiff." *Tingler v. Graystone Homes, Inc.*, 298 Va. 63, 72-73 (2019) (citation omitted). "To

survive a challenge by demurrer," factual allegations must be made with "sufficient definiteness to enable the court to find the existence of a legal basis for its judgment." *Squire v. Virginia Hous. Dev. Auth.*, 287 Va. 507, 514 (2014) (citation omitted).

1

In 2004, John Mark Rohrbaugh Sr. executed a durable power of attorney ("POA") naming his son, John Mark Rohrbaugh Jr., as his agent.[1] In relevant part, the POA provided:

> Pursuant to the provisions of section 11-9.6 of the Code of Virginia of 1950, as amended, it is my intention that, except as specifically provided for herein, my agent shall **never** be required to make disclosure or inspection of my affairs, or their actions as my agent, either under this instrument or otherwise, to any third party. I authorize my agent to refuse any request for disclosure or inspection, and they have the sole discretion to determine the scope, if any, of disclosure or inspection they may wish to permit. I authorize my agent as an expense of the agency to resist any proceeding to compel such disclosure or inspection. . . . Without limitation of the foregoing sentences in this paragraph, I specifically intend that my agent shall never be required to make disclosure of their actions or permit inspection of my affairs under this instrument, pursuant to section 11-9.1, section 11-9.6, section 37.1-134.22 of the Code of Virginia of 1950, as amended, or any other statute. [5]

J.A. at 158-59 (emphasis in original).[2]

The POA granted authority to the agent to make gifts to Rohrbaugh Sr.'s descendants or spouses of his descendants, including a descendant who is serving as his agent, "only if (a) [Rohrbaugh Sr.] ha[d] not excluded and disinherited such donee as a beneficiary of my estate in my will as it is written at the time of such gift(s), or (b) any gift to such donee shall be approved by at least one adult beneficiary under my will." *Id.* at 156. Rohrbaugh Jr. also had a joint money market account with Rohrbaugh Sr. that Rohrbaugh Jr. used to facilitate Rohrbaugh Sr.'s care. Rohrbaugh Jr. never contributed to the account and claimed no interest in it.

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[5] **R. Shawn Majette August 28, 2022 Editorial Footnote** – A good form that incorporates *any* other statute (and could be improved by specifically including Va. Code 8.01-31).

In 2006, a full-time caregiver began living with Rohrbaugh Sr., and in early 2009, Rohrbaugh Jr. began assisting with the management of his father's finances because he "was diminished in capacity and not capable of managing his finances on his own." *Id.* at 135-36. Rohrbaugh Jr. acted as his father's agent until his father's death in January 2016. Rohrbaugh Sr. was survived by Susan E. Phillips, his daughter, and his son. Rohrbaugh Sr.'s will named Phillips and Rohrbaugh Jr. as beneficiaries and named Rohrbaugh Jr. and John J. Davies III as co-executors of his estate.

In September 2017, Phillips sent a letter to counsel for the co-executors of Rohrbaugh Sr.'s Estate, requesting information about transactions that Rohrbaugh Jr. had made under the POA, including gift transfers to Rohrbaugh Sr.'s descendants, his descendants' spouses, or any entity in which a descendant or descendant's spouse held an interest. Phillips alleged that Rohrbaugh Jr. had engaged in suspicious or self-dealing activity in his capacity as Rohrbaugh Sr.'s agent, and her 2017 letter listed numerous transactions for which she was seeking additional information. The letter concluded that Phillips's requests should be taken "at face value" as simply seeking "the facts necessary to understand these various related transactions and not as an assertion that any improper actions were taken by Rohrbaugh Jr. in any capacity." *Id.* at 173.

After Rohrbaugh Jr. provided Phillips with some of the information that she had sought, Phillips deemed his responses to be unsatisfactory. In December 2018, Phillips sent counsel for the co-executors a demand letter to protect all her interests in Rohrbaugh Sr.'s Estate. Phillips also sent Rohrbaugh Jr. a letter in 2019 requesting information "about various unexplained and questionable transactions" in the joint money market account between the years of 2010 and 2015. *Id.* at 141. These transactions included (1) compensation payments to Rohrbaugh Jr. and his wife; (2) payments to credit card companies, various other companies, Rohrbaugh Sr.'s

family members, and non-family members; and (3) transactions related to Rohrbaugh Sr.'s real properties that were used by Rohrbaugh Jr. Phillips alleges that Rohrbaugh Jr. has not satisfied her request for clarification and information regarding the joint-account transactions.

Phillips filed a complaint in January 2018 against Rohrbaugh Jr. in his individual capacity and against Rohrbaugh Jr. and Davies in their capacities as co-executors of the Rohrbaugh Sr. Estate. After the circuit court granted demurrers, Phillips filed an amended complaint in December 2019. The amended complaint asserted two counts. The first count requested a

statutory accounting under Code § 64.2-1614(A) from Rohrbaugh Jr. concerning his actions pursuant to his father's POA. The second count requested an equitable accounting from both co-executors under Code § 8.01-31. The amended complaint sought the repayment of funds due to the Estate if the circuit court later discovered that Rohrbaugh Jr. had inappropriately taken funds from Rohrbaugh Sr. or otherwise violated his fiduciary duties.

No allegation in the amended complaint, however, specifically asserted that Rohrbaugh Jr. or Davies had breached any fiduciary duties.[3] Instead, the amended complaint alleged only that Rohrbaugh Jr. had conducted several "suspect transactions," including among other things failing to collect a debt he owed to his father, making unsecured loans, and purchasing real property for more than its fair market value. J.A. at 136. The amended complaint named the Rohrbaugh Sr. Estate as "an interested party because of the Co-Executors' refusal and/or inability to investigate the matters raised in this Complaint" and because the relief sought by Phillips would benefit the Estate. *Id.* at 133. Because Phillips alleged that the suit would benefit

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the Estate, she also requested reimbursement of her expenses, including attorney fees, under the common-fund doctrine.

Rohrbaugh Jr. and Davies again filed demurrers to the amended complaint. As to both counts, Rohrbaugh Jr. and Davies argued that Rohrbaugh Sr.'s POA specifically forbade his agent from making disclosures to anyone under specific disclosure statutes "or any other statute," *id.* at 158-59. Rohrbaugh Sr. had a right to make that determination, Rohrbaugh Jr. and Davies contended, because the Virginia Power of Attorney Act expressly recognizes it. In response, Phillips argued that the Act authorized a judicial proceeding to obtain these disclosures despite the principal's expressed intent to the contrary.

The circuit court agreed with Rohrbaugh Jr. and Davies, holding that Phillips had no statutory right to obtain an accounting from her brother concerning his management of their father's affairs under the POA. The court also found no legal basis for Phillips's claim against Rohrbaugh Jr. and Davies in their capacities as co-executors of Rohrbaugh Sr.'s Estate. For these reasons, the circuit court granted both demurrers and dismissed the amended complaint with prejudice.

II.

On appeal, Phillips asserts eight assignments of error that cluster around two main arguments. First, Phillips argues that she has asserted a viable claim for an equitable accounting under Code § 8.01-31. Second, she contends that the circuit court misconstrued the Virginia Power of Attorney Act and that properly understood, the Act granted her a statutory right to an accounting. We disagree with both of these arguments.[4]

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A.

1.

We begin with an analysis of Phillips's equitable accounting claim. "The action of account-render was one of the most ancient actions known to the common law." 3 John Norton Pomeroy, A Treatise on Equity Jurisprudence § 1420, at 2193 (2d ed. 1899). "The common-law action of account, or account-render," was used to "adjust and settle mutual accounts where there was some privity or mutual confidence existing between the parties, and its object was to recover the balance ascertained to be due." Martin P. Burks, Common Law and Statutory Pleading and Practice § 101, at 210 (T. Munford Boyd ed., 4th ed. 1952); *see also* 4 John B. Minor, Institutes of Common and Statute Law 1216-17 (1879).

The common-law accounting action, however, fell into disuse as chancery courts began entertaining "bills for account," William Minor Lile, Notes of Lectures on Equity Jurisprudence 264, 271 (1921), that covered a wider range of fiduciary relationships and offered a greater range of remedies. The General Assembly codified this shift from common law to equity when it abolished the statute providing for an "action for account" in 1954, *see* 1954 Acts ch. 593, at 765, and replaced it with the "accounting in equity" action in 1956, *see* 1956 Acts ch. 160, at 163. *See also* T. Munford Boyd, *Virginia Procedural Legislation of 1954*, 40 Va.L.Rev. 1097, 1099-1100 (1954); Burks, *supra*, § 101, at 38 & n.7 (1961 Supp.). Incorporating equitable principles, the statute establishes "a two-stage process": "First, the account is to be stated; this is the determination of who owes what. Second, the account is to be settled; this is the payment by the debtor of the money found to be owing." Bryson, *supra* note 4, § 12.03[2][c], at 12-13.

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Historically, the first stage was initiated by an "interlocutory order," and the second stage ended with a "final order." *Id.*

An equitable accounting should not be misunderstood as merely a judicially managed discovery proceeding in anticipation of a possible lawsuit.[5] It is best understood as a means to enforce an implied duty of disclosure and reckoning arising out of an equitable relationship. "Traditionally, an accounting in equity could be had against any agent, trustee, guardian, committee, partner and many others, fiduciaries or not, because the relationship is 'equitable.'" Kent Sinclair, Virginia Remedies § 44-1, at 44-1 to -2 (5th ed. 2016). Unless excused by the principal, an agent has "a duty to keep, and *render to his principal*, an account of money or other things which he has received or paid out on behalf of the principal." *Bain v. Pulley*, 201 Va. 398, 402 (1959) (emphasis added) (citation omitted). "It is upon the principle of trust mainly, that equity takes jurisdiction at the instance of the principal to compel his agent to account." *Huff v. Thrash*, 75 Va. 546, 548 (1881). Thus, the very nature of an equitable accounting action presupposes that the party seeking the accounting has an equitable right to demand an account and a corresponding right to settle a disputed account in the courts. "Every bill for an account," as Dean Langdell succinctly said, "must be founded upon an obligation to render an account." C.C. Langdell, *A Brief Survey of Equity Jurisdiction*, 2 Harv. L. Rev. 241, 242 (1889); *see also* Lile, *supra*, 271-72.

In the context of a principal-agent relationship, therefore, an equitable accounting claim necessarily arises out of a discrete *cause of action* - the agent's breach of his fiduciary duty to

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provide the required disclosures to his principal.[6] *See* John Adams Jr. et al., The Doctrine of Equity 475-76 (4th Am. ed. 1859); Dan B. Dobbs & Caprice L. Roberts, Law of Remedies § 4.3(5), at 416 (3d ed. 2018). For purposes of asserting a successful equitable accounting claim, it is unnecessary (but permissible) for a principal to go further and allege that stage one of the proceeding would provide evidence of other fiduciary breaches warranting a stage-two award of damages, an order of equitable rescission and restitution, or similar compensatory remedies. *See* Dobbs & Roberts, *supra*, § 4.3(5), at 417-18.

2.

In this case, Phillips and Rohrbaugh Jr. were never in a principal-agent relationship with each other. In his capacity as his father's agent, Rohrbaugh Jr. owed no fiduciary duty to account to his sister concerning his management of their father's financial affairs. She thus has no cause of

[6] **R. Shawn Majette August 28, 2022 Editorial Footnote**

action in her personal capacity for an equitable accounting against her brother. Apparently realizing this, Phillips claims that she has a right to file an equitable accounting claim against him *on behalf of* their deceased father. We do not agree.

An equitable accounting claim survives the death of the principal, and thus, a claim on behalf of a decedent's estate for equitable accounting may be asserted against inter vivos fiduciaries of the decedent. *See* Code § 8.01-25; *Campbell v. Harmon*, 271 Va. 590, 597-98 (2006). As a general rule, the personal representative of an estate has exclusive standing to sue on behalf of an estate. *See Platt v. Griffith*, 299 Va. 690, 692 (2021); *Reineck v. Lemen*, 292 Va. 710, 722 (2016); *Burns v. Equitable Assocs.*, 220 Va. 1020, 1028 (1980); *see also* Code § 1-234 (defining "personal representative"). Phillips nevertheless contends that she fits within a narrow exception to the general rule that enables certain beneficiaries to serve as ad hoc representatives of an estate under special circumstances. *See generally* John Mitford et al., Mitford's and

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Tyler's Pleadings and Practice in Equity 251-52 (1890); Joseph Story, Commentaries on Equity Pleadings § 514, at 394-95 (2d ed. 1840). Affirming the circuit court, we find that the general rule - not the exception - applies to this case.

Although we have recognized that "there is no fixed and rigid rule by which to determine what constitutes such special circumstances," *Jeffries v. Antonsanti*, 142 Va. 218, 227 (1925), the exception may apply if the allegations in the complaint, "so far as they are well pleaded," *Beaty v. Downing*, 96 Va. 451, 454-55 (1898), at least approximate the typical scenarios. These scenarios include a showing of "fraud" or the "refusal to sue," *Bane v. Adair*, 116 Va. 587, 595 (1914), as well as "the insolvency of the personal representative, collusion between him and the debtor, the fact that the debtor was . . . a trustee holding property for, or an agent of, the decedent." *Saunders v. Bank of Mecklenburg*, 113 Va. 656, 659-60 (1912) (citation omitted).[6]"A [complaint] which fails to charge these or other special circumstances which will take the case out of the general rule is bad on demurrer." *Id.*; *cf.* George Cooper, A Treatise of Pleading on the Equity Side of the High Court of Chancery 176 (1813) (observing that the typical recitation of special circumstances omits "mere negligence" of the personal representative as a special circumstance).

Here, Phillips does not accuse her brother of fraud or claim that Davies has turned a collusive blind-eye to any wrongdoing. Nor has she alleged any factually supportable cause of action that the Estate could assert against her

brother. At best, the complaint speaks of "suspicious transactions," *see* J.A. at 137, in which Phillips claims that Rohrbaugh Jr. engaged. Phillips identifies various "questionable transactions," Appellant's Br. at 34, but does not allege

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that he violated any fiduciary duties by participating in these transactions. Several of these specific "suspicious" circumstances associated with his handling of their father's finances involve actions that the POA arguably does not forbid and, in some cases, appears to authorize. *Compare* J.A. at 137-42 (questioning gifts in the amended complaint) *with* J.A. at 156 (authorizing certain gifts in the POA "for any purpose or for no purpose, without limitation as to the amount of such gifts"). In the end, Phillips's argument appears to be no more than an assertion that the "insufficiency of the information," Appellant's Br. at 35, provided by her brother - when considered along with his status as agent, co-executor, and debtor - warrants her reliance on the special-circumstances doctrine.

We hold that the allegations in Phillips's complaint, "so far as they are well pleaded," *Beaty*, 96 Va. at 454-55, do not demonstrate that the circuit court erred by refusing to permit Phillips to serve as a de facto representative of the Rohrbaugh Estate for the purposes of seeking an equitable accounting from Rohrbaugh Jr., either in his capacity as his father's inter vivos agent or as co-executor of the Estate. We similarly see no special circumstances pleaded in Phillips's complaint that warrant an accounting claim against Davies in his capacity as co-executor. We thus affirm the circuit court's grant of the demurrers challenging Phillips's equitable accounting claims asserted on behalf of the Rohrbaugh Estate.

3.

Phillips also claims that as a beneficiary of her father's estate she has a right to assert equitable accounting claims against her brother and Davies in their capacities as co-executors. We agree that she has standing to assert such claims but disagree that she has a right to demand their adjudication in a collateral action that is ancillary to the probate proceeding. [7]

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"Equitable relief is *discretionary* and hence - even if a party makes a valid showing of the required elements for any given form of relief - there is no assured right to exercise of the court's discretion in his or her favor." *See generally* Sinclair, *supra*, § 42-1[A], at 42-4 (emphasis in original). If a court

[7] **R. Shawn Majette August 28, 2022 Editorial Footnote**

of law has "concurrent jurisdiction" over a dispute, for example, the disputant seeking equitable remedies generally must show that legal remedies are either unavailable or inadequate - thereby establishing the "prerequisite to the exercise of equitable jurisdiction." *See Oglesby Co. v. Ould Co.*, 117 Va. 546, 554-55 (1915) (citation omitted). "The test of the chancellor's jurisdiction was, from the beginning, as the test of equity jurisdiction has remained substantially to this day, *the absence of a plain and adequate remedy at law*." Lile, *supra*, at 4 (emphasis in original). This limiting principle explains why Code § 8.01-31 provides that an equitable accounting "may be had" rather than "shall be had" in Virginia courts.

In Virginia, the equitable accounting remedy, as applied to personal representatives of probate estates, has been codified in a comprehensive series of statutes. A probate court appoints an executor of a will, *see* Code §§ 64.2-500 to -508, and the executor remains under the court's supervision and control throughout the administration of the probate estate. Under Code §§ 64.2-1300(A) and -1304, a personal representative must account for estate property in an initial inventory of assets and thereafter make periodic accounts to a "commissioner of accounts" shortly after a will is presented to a probate court.[7] "The commissioner of accounts shall state, settle, and report to the circuit court an account of the transactions of a fiduciary, as provided by law." Code § 64.2-1312. "Any interested person," under Code § 64.2-1209,

> may, before the commissioner of accounts, insist upon or object to anything which could be insisted upon or objected to by such interested person if the commissioner of accounts were acting under an order of a circuit court for the settlement of a fiduciary's accounts made in a suit to which such interested person was a party.

The commissioner has the power to issue witness subpoenas and compel document production, *see* Code § 64.2-1203, for purposes of conducting "a hearing on either an inventory or an account," 2 Frank O. Brown, Jr., Virginia Practice Series: Probate Handbook § 2:11, at 67 (2020-2021 ed.). If any interested party files an exception to the commissioner's report to the probate court, the court may conduct its own hearing and, if requested, empanel a jury to resolve disputed facts. *See* Code § 64.2-1212(B). In addition, Code § 64.2-1213 allows for suits to surcharge or falsify a report even after it has been confirmed by the circuit court.

After surveying these statutes, the Judicial Council of Virginia has explained the quasi-judicial role served by commissioners of accounts as follows:

> The precedent can be traced to the origins of the office of commissioner of accounts. The present office of commissioner of accounts evolved from the established office of commissioner in chancery. . . . Thus, most circuit courts generally treat the commissioner of accounts as having the same general authority as a commissioner in chancery, in addition to the statutory duties and responsibilities of the commissioner of accounts.

The Standing Comm. on the Comm'rs of Accts. of the Jud. Council of Va., Manual for Commissioners of Accounts 293-94 (6th ed. 2019) (footnotes omitted). Based upon these background principles, the Judicial Council concluded that "the circuit court may refer any matter it deems appropriate to the commissioner of accounts pursuant to its general referral powers to commissioners in chancery." *Id.* We agree with this view.

Our cases recognize that "[t]he Commonwealth established the office of the Commissioner of Accounts 'to afford a prompt, certain, efficient, and inexpensive method' for

the settlement of fiduciaries' accounts and the distribution of estates." *Gray v. Binder*, 294 Va. 268, 276 (2017) (citation omitted).[8] The position "evolved from the Commissioner in Chancery, and is 'one of the most important known in the administration of justice.'" *Henderson v. Cook*, 297 Va. 699, 712 (2019) (citation omitted). For good reason, we have recurred to the statutory scheme to emphasize

> how minute, how careful, and how sufficient is the provision made by our statute law for the settlement of the accounts of fiduciaries. It is full, ample, and complete. It guards and protects every interest as amply as could be done by a formal suit in chancery. By the death of the decedent the probate court acquires jurisdiction. It appoints the administrator and commits the estate to his control, and *at every step of his administration the law provides proper machinery by which the fiduciary can be compelled to collect and distribute the funds committed to his care, and to settle his accounts showing the manner in which his trust has been executed.*

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Carter's Adm'r v. Skillman, 108 Va. 204, 213 (1908) (emphasis added).

In the present case, the circuit court was keenly aware of this procedure. *See* J.A. at 451 (confirming that "not allowing her to have an accounting out of this suit doesn't prevent her from filing her complaints with the accounting in the estate itself with the commissioner"). Convinced that its ruling would not prejudice Phillips's ability to take her dispute to the proper forum, the circuit court dismissed the equitable accounting claims. The chancellor did not abuse his discretion in doing so. Both co-executors of Rohrbaugh Sr.'s Estate remained under the supervisory power of the probate court and under the specific oversight of the court's commissioner of accounts. None of the allegations in Phillips's complaint present factual issues that could not be competently adjudicated during probate with the assistance of the commissioner of accounts and, if desired, an advisory jury.

In short, while a chancellor could allow an equitable accounting suit to go forward as a collateral proceeding, the circumstances in this case fall far short of compelling the chancellor to

do so. We thus affirm the circuit court's dismissal of the equitable accounting claims against Rohrbaugh Jr. and Davies in their capacities as co-executors of Rohrbaugh Sr.'s Estate.

B.

Phillips also argues that the Virginia Power of Attorney Act, Code § 64.2-1614(A),[9] grants her a right to file a statutory accounting claim even if she would not otherwise have standing to do so under equitable principles. In one respect, she is quite right. Subsection A of Code § 64.2-1614 grants standing to several categories of claimants, including a principal's relatives, to "petition a court to construe a power of attorney or review the agent's conduct, and grant appropriate relief." If we were to stop reading there, we might presume (as Phillips does) that she has an indefeasible right to an accounting. Four other provisions of the Virginia Power of Attorney Act, however, make clear that such an assumption would be mistaken.

1.

"A cardinal rule of statutory construction is that a statute be construed from its four corners and not by singling out a particular word or phrase." *Commonwealth Nat. Res., Inc. v. Commonwealth*, 219 Va. 529, 536 (1978); *see also Virginia Elec. & Power Co. v. Citizens for Safe Power*, 222 Va. 866,

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869 (1981). Our duty is to interpret "the entire statute - i.e., the entirety of a single legislative enactment as it appears in the Acts of Assembly as a whole - to place its terms in context" and to "interpret the several parts of a statute as a consistent and harmonious whole so as to effectuate the legislative goal." *Eberhardt v. Fairfax Cnty. Emps.' Ret. Sys. Bd. of Trs.*, 283 Va. 190, 194-95 (2012) (citation omitted).

2.

Guided by these principles, we begin with Code § 64.2-1612(H). It was adapted from section 114(h) of a "Uniform Power of Attorney Act" proposed by the National Conference of

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Commissioners on Uniform State Laws. *See generally* Andrew H. Hook & Lisa V. Johnson, *The Virginia Uniform Power of Attorney Act*, 44 U. Rich. L. Rev. 107 (2009). Section 114(h) "codifies the agent's common law duty to account to a principal." Unif. Power of Att'y Act § 114 cmt. (2006). In relevant part, Code § 64.2-1612(H) does the same thing while emphasizing two important qualifications:

> Except as otherwise provided in the power of attorney, an agent shall disclose receipts, disbursements, or transactions conducted on behalf of the principal if requested by the principal, a guardian, a conservator, another fiduciary acting for the principal, or, upon the death of the principal, by the personal representative or successor in interest of the principal's estate.

The first qualification states that the statutory duty to make accounting disclosures is owed to a very short list of individuals: the principal and any fiduciaries acting on his behalf or on behalf of his estate. The list does not categorically include any of the principal's relatives. The second qualification ("[e]xcept as otherwise provided in the power of attorney") recognizes the principal's power to forbid his agent from making accounting disclosures to anyone but the principal. Together, these aspects of subsection H "are consistent with the premise that a principal with capacity should control to whom the details of financial transactions are disclosed." Unif. Power of Att'y Act § 114 cmt.

Making the same point, Code § 64.2-1614(D) states: "Upon motion by the principal, the court shall dismiss a petition filed under this section [Code § 64.2-1614], unless the court finds that the principal lacks capacity to revoke the agent's authority or the power of attorney." This provision gives a

principal (if alive and mentally competent) the right to unilaterally terminate an accounting action initiated by his relatives or any other parties with standing to assert an accounting action under subsection A. The court "shall" enforce the principal's decision even if

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the power of attorney does not expressly forbid the principal's relatives from seeking a statutory accounting. [10]

The Virginia Power of Attorney Act also includes a provision not found in the Uniform Power of Attorney Act that addresses accounting actions when the principal is believed to be incapacitated or deceased, Code § 64.2-1612(I) provides, in relevant part:

> Except as otherwise provided in the power of attorney, an agent shall, on reasonable request made by a person listed in subdivisions A 3 through A 9 of § 64.2-1614 who has a good faith belief that the principal suffers an incapacity or, if deceased, suffered incapacity at the time the agent acted, disclose to such person the extent to which he has chosen to act and the actions taken on behalf of the principal within the five years prior to either (i) the date of the request or (ii) the date of the death of the principal, if the principal is deceased at the time such request is made, and shall permit reasonable inspection of records pertaining to such actions by such person. In all cases where the principal is deceased at the time such request is made, such request shall be made within one year after the date of the death of the principal.

This provision expands the list of persons who may have standing to seek an accounting from the agent. That expanded list includes relatives of the principal. Code § 64.2-1614(A)(4). Subsection I, however, includes three limitations. First, those with standing to seek an accounting can obtain one only if they allege "a good faith belief that the principal suffers an incapacity or, if deceased, suffered incapacity at the time the agent acted." *Id.* Second, like subsection H, subsection I includes a proviso ("[e]xcept as otherwise provided in the power of attorney") which gives the principal the power to forbid account-rendering disclosures to anyone but himself. Lastly, in cases in which the accounting is requested after the principal has died, the request must be made within one year of his death.

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Phillips's argument must also contend with yet another provision of the Virginia Power of Attorney Act. Code § 64.2-1614(B)(1) provides:

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> Whether or not supplemental relief is sought in the proceeding, where an agent has violated duties of disclosure imposed by § 64.2-1612, any person to whom such duties are owing may, for the purpose of obtaining information pertinent to the need or propriety of (i) instituting a proceeding under Chapter 20 (§ 64.2-2000 et seq.); (ii) terminating, suspending, or limiting the authority of the agent; or (iii) bringing a proceeding to hold the agent, or a transferee from such agent, liable for breach of duty or to recover particular assets or the value of such assets of a principal or deceased principal, petition a circuit court for discovery from the agent of information and records pertaining to actions taken pursuant to a power of attorney.

This provision, like the others, has carefully drawn boundaries. The proceeding can only be initiated by a "person to whom such [disclosure] duties are owing," which would necessarily exclude anyone barred by the power of attorney from receiving such disclosures. Even those entitled to disclosures, moreover, must allege that the "purpose" of obtaining the agent's disclosures is to determine the "need or propriety" of litigation against the agent. *See* Code § 64.2-1614(B)(1).

3.

The underlying theme of all of these provisions is that courts should respect the personal financial privacy of competent principals while at the same time providing opportunities for others to initiate account-rendering litigation on behalf of incompetent or deceased principals. The Prefatory Note of the Uniform Power of Attorney Act emphasizes this priority: "While the Act contains safeguards for the protection of an incapacitated principal, the Act is *primarily* a set of default rules that preserve a principal's freedom to choose both the extent of an agent's authority and the principles to govern the agent's conduct." Unif. Power of Att'y Act prefatory note (emphasis added).

In this case, the principal's intentions were not understated. Rohrbaugh Sr.'s POA declares: "[I]t is my intention that, except as specifically provided for herein, my agent shall

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never be required to make disclosure or inspection of my affairs, or their actions as my agent, either under this instrument or otherwise, to any third party." J.A. at 158 (emphasis in original). "I specifically intend," he repeated, "that my agent[s] shall never be required to make disclosure of their actions or permit inspection of my affairs under this instrument, pursuant to section 11-9.1, section 11-9.6 [now § 64.2-1612(I)], section 37.1-134.22 [now § 64.2-1614(B)] of the Code of Virginia of 1950, as amended, *or any other statute*." *Id.* at 158-59 (emphasis added). There can be no doubt, therefore, that Rohrbaugh Sr. intended that his son should not be required by any "third party" or "any . . . statute," *id.*, to make account-rendering disclosures to Phillips. It logically follows that Phillips cannot employ the statutory accounting procedure in Code § 64.2-1614(A) to force Rohrbaugh Jr. to make the very disclosures that his father - exercising his rights later recodified in Code § 64.2-1612(H) & (I) - expressly forbade his son from being forced to make.

Subsection A of Code § 64.2-1614, lifted from § 116(a) of the Uniform Power of Attorney Act, provides a list of "persons who have standing" to seek an accounting if the claimant has a right to one. *See* Unif. Power of Att'y Act § 116 cmt. But it was not meant to grant a right to an accounting when other provisions of the same Act expressly forbid it. If it were meant to do so, as Phillips's contends, subsection A of Code § 64.2-1614 would render subsection B(1) superfluous and negate a competent principal's expressed intent to prevent his or her private financial affairs from being disclosed at the mere request of a host of individuals whose only basis for making the claim is that they have "standing" to do so.

We acknowledge Phillips's concern for the need for such information to be disclosed when there is a good reason to believe the principal is incapacitated and possibly being taken advantage of. But the remedy for that scenario was crafted into subsection B(1) of Code § 64.2-1614,

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and that issue-specific remedy does not apply when a principal makes clear in the power of attorney (as Rohrbaugh Sr. did in his) that he does not want this protection and says so at a time when he was fully competent to make that decision. [11]

The General Assembly made a similar point in subsection I of Code § 64.2-1612. When a competent principal does not expressly reject such disclosures in his power of attorney and later becomes incapacitated or dies, subsection I authorizes relatives and others listed in Code § 64.2-1614(A)(3)

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to (A)(9) to obtain a statutory accounting under subsection A of Code § 64.2-1614. This provision does not support Phillips's claim, however, because Rohrbaugh Sr.'s POA rejects this remedy, and even if it had not done so, Phillips did not make her request within the applicable one-year period. *See* Code § 64.2-1612(I).

In short, it would never be necessary to meet the requirements of Code § 64.2-1614(B)(1) or Code § 64.2-1612(I) if subsection A provided wholly unrestricted access to an even better judicial remedy. Equally anomalous, under Phillips's interpretation, it would never matter that a principal declared his intent to keep his financial affairs private - a prerogative protected by Code §§ 64.2-1612(H), -1612(I), Code § 64.2-1614(B)(1), and Code § 64.2-1614(D). It would be also inconsequential that, even when no such declaration was made, the individual seeking to obtain the accounting disclosures failed to make her request within the prescribed time frame required by Code § 64.2-1612(H). For these reasons, Code § 64.2-1614(A) cannot bear the interpretive weight Phillips places upon it.[8]

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III.

In sum, the circuit court did not err when it dismissed on demurrer Phillips's equitable and statutory accounting claims. The equitable accounting claims should have been asserted, if at all, in the probate proceeding, and the statutory accounting claim was barred by Rohrbaugh Sr.'s expressly declared intent to prohibit it in his POA.

Affirmed.

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Notes:

[1] The POA also named German P. Culver Jr. as Rohrbaugh Sr.'s agent and John J. Davies III as a successor agent in the event that Rohrbaugh Jr. or Culver were not able or willing to serve. Both Culver and Davies, however, never exercised any authority under the POA and resigned as agents in December 2008, leaving Rohrbaugh Jr. as the sole agent.

[2] The statutes mentioned in this provision have been replaced by the Virginia Power of Attorney Act. *See* 2010 Acts ch. 632, at 1130-32; 2012 Acts ch. 614, at 1271-73. Former Code § 11-9.6 correlates to current Code § 64.2-

1612(I), and former Code § 37.1-134.22 correlates to current Code § 64.2-1614(B).

[3] This was not an oversight. Throughout the trial court proceeding and while on appeal, Phillips has asserted that under her theory of recovery no such allegations were necessary. *See* J.A. at 362, 411, 413, 456; *see also* Oral Argument Audio at 13:44 to 13:49.

[4] Phillips also argues that her accounting claims, had they been successful, would have entitled her to an award of attorney fees under the common-fund doctrine. *See generally duPont v. Shackelford*, 235 Va. 588, 594-95; W. Hamilton Bryson, Bryson on Virginia Civil Procedure § 14.04, at 14-15 (5th ed. 2017). The circuit court, she contends, erred in not granting this relief. Given our holdings in this case, we need not address this argument.

[5] Though subject to various limitations, such a discovery proceeding existed in another form in historical chancery practice, *see French v. Stange Mining Co.*, 133 Va. 602, 614-18 (1922) (discussing the "bill of discovery"), but its utility has been greatly diminished by modern discovery rules of procedure, *see* Bryson, *supra* note 4, § 9.06[1][a], at 9-61 to -62; Burks, *supra*, § 257, at 459-60.

[6] The ellipses in the quote from *Saunders*, 113 Va. at 660, omits the phrase "a partner of the decedent" because we rejected that "dictum" in *Conrad's Adm'r v. Fuller*, 98 Va. 16, 19 (1900).

[7] Under certain circumstances not applicable here, a will can waive a personal representative's duty to file accountings with the commissioner of accounts. *See* Code § 64.2-1302.

[8] Focusing our decision on the "best and narrowest grounds," *Logan v. Commonwealth*, 299 Va. 741, 748 n.4 (2021) (citation omitted), we leave several issues undecided - including Rohrbaugh Jr.'s argument that only claimants with a viable cause of action asserting a breach of fiduciary duty or statutory violation may seek judicial review of an agent's conduct under Code § 64.2-1614(A) and Phillips's counterargument that Code § 64.2-1614(A) authorizes judicial review even in the absence of an assertion of a freestanding cause of action. We are also aware that in between those two competing views is the possibility that allegations of egregious circumstances, even if technically insufficient to constitute a viable cause of action, could warrant review under Code § 64.2-1614(A) regardless of what the power of attorney might otherwise provide. In this case, however, we need not and thus do not resolve these hypothetical questions.

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Stoots v. Marion Life Saving Crew, Inc. (2021)

Discussion of advance medical directive and absolute immunity of Virginia Good Samaritan statute 8.01-255(A)(5).

REBECCA ANN STOOTS, ADMINISTRATOR OF THE ESTATE OF CALVIN HARMON STOOTS
v.
MARION LIFE SAVING CREW, INC., ET AL.

Record No. 201202

Supreme Court of Virginia

December 22, 2021

FROM THE CIRCUIT COURT OF SMYTH COUNTY William Alexander, II, Judge Designate.

PRESENT: All the Justices.

OPINION

CLEO E. POWELL, JUSTICE.

Rebecca Ann Stoots ("Stoots") appeals the decision of Circuit Court of Smyth County ruling that Marion Life Saving Crew, Inc. ("MLSC") and its paramedics were entitled to statutory immunity pursuant to Code § 8.01-255(A)(5).

I. BACKGROUND

MLSC is a nonprofit entity qualified under § 501(c)(3) of the Internal Revenue Code, 26 U.S.C. § 501(c)(3), whose primary purpose is to provide organized lifesaving and first aid services for Smyth County, Virginia. On February 12, 2013, the Smyth County Board of Supervisors adopted resolutions recognizing MLSC as an integral part of the official safety system of the county and as a designated emergency response agency. MLSC provided this service through its single salaried employee and volunteer crew members. Although MLSC engages in billing for its services to insurance and individuals, it does not engage in any collection activities for those unable to pay.

Additionally, MLSC had a "Membership Incentive Program"[1] ("MIP") whereby volunteers were eligible to receive payment, commensurate with the volunteer's level of

experience, for each shift beyond the first three worked each month. The volunteers who chose to participate in the program filled out a timesheet at the end of each month and designated which shifts were paid and which shifts were volunteer. The payments were considered taxable income and MLSC issued IRS Form 1099s to the crew members reflecting the payments they received.

On February 9, 2014, forty-three-year-old Calvin Harmon Stoots ("Calvin") began having difficulty breathing at his home in Smyth County. He subsequently became unresponsive and, shortly thereafter his sister, Stoots, arrived. Noting Calvin's difficulty breathing, Stoots believed he was suffering from ketoacidosis associated with his diabetes and called 911 to seek emergency assistance. Two paramedics from MLSC, James Thompson ("Thompson") and Zachary Powell ("Powell"), responded. Upon arrival, they determined that Calvin was still breathing with a normal resting heart rate.

Stoots asked Powell and Thompson to take Calvin to the hospital and render care. She provided them with a Virginia Advance Directive for Health Care (the "Advance Directive"), which named Stoots as Calvin's medical agent and gave her the authority to request treatment on his behalf. Thompson looked briefly at the Advance Directive and saw that it was signed on the front and back pages. Thompson noted that the second page of the Advance Directive stated, "no extraordinary methods," and concluded that Calvin was "DNR, "[2] meaning that he did not want to be resuscitated by medical professionals. Thompson later acknowledged that he did not have time to fully read the Advance Directive. Thompson then handed the Advance Directive to Stoots and said, "We got to go."

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Contrary to Thompson's interpretation of the Advance Directive, the second page does not say "no extraordinary methods" anywhere. Rather, the second page states, in relevant part:

> 1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover.

[Of the options provided, Calvin selected:]

> I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis, or antibiotics. I understand I will receive treatment to relieve pain and make me comfortable.

> 2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain I will never recover this awareness or ability even with medical treatment:

[Of the options provided, Calvin selected:]

> I want treatment for a period of time in the hope of some improvement in my condition. I suggest 2 days as the period of time after which such treatment should be stopped if my condition has not improved.

Stoots told Powell and Thompson that Calvin was not "DNR" and that, as his medical agent, she wanted him to be treated. Powell and Thompson then loaded Calvin into the ambulance and connected him to oxygen. Stoots rode in the front of the ambulance. They drove to the hospital in a non-emergency fashion (i.e., without lights and sirens and stopping to adhere to all traffic signals along their route). They also stopped to pick up Larry Chatham ("Chatham"), an Advanced EMT. This was done because Chatham could provide Advanced Life Support Services.

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Calvin died in the ambulance on the way to the hospital.[3] Upon arrival at the hospital, the emergency room staff were informed that no attempt to resuscitate Calvin was made because he had a Do Not Resuscitate Order. MLSC subsequently generated a "Billing Report" and billed Calvin's insurance for its services. Calvin's insurance paid an undisclosed amount to MLSC.

In 2016, Stoots brought a wrongful death action against Powell, Thompson, Chatham (collectively, the "Paramedics") and MLSC, alleging that their "reckless, wanton, negligent and grossly negligent conduct . . . was the direct and proximate cause of the premature death of [Calvin]."[4] In response, the Paramedics and MLSC filed a plea in bar asserting statutory immunity under Code § 8.01-225, as well as sovereign and charitable immunity.[5] The stipulated facts established that Powell designated his February 9, 2014 shift as a volunteer shift. Additionally, in February 2014, he worked a total of five shifts and received $150 from the MIP. Thompson did not participate in the MIP, as he never worked more than three shifts per month. Chatham worked eight shifts in February 2014 and received $500 from the MIP. Chatham's timesheet for that month does not contain an entry for February 9, 2014, as he was not scheduled to work on that date.

In a letter opinion, the circuit court found that the Paramedics were "clearly negligent, and probably grossly negligent" in failing to thoroughly read the Advance Directive. However,

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it ruled that they were absolutely immune from liability under Code § 8.01-225(A)(5) because they rendered emergency care in good faith and were not compensated for the care they provided within the meaning of the statute. With regard to MLSC, the circuit court relied on *Linhart v. Lawson*, 261 Va. 30, 34 (2001), and ruled that MLSC was immune from liability because the Paramedics were immune from liability.[6] Stoots moved the circuit court to reconsider its ruling, and, after oral argument, the circuit court issued a letter opinion reaffirming its decision.

Stoots appeals.

II. ANALYSIS

On appeal, Stoots argues that the circuit court erred in granting absolute immunity to MLSC and the Paramedics because Code § 8.01-225 does not apply to the present case. Specifically, Stoots claims that the statute is inapplicable due to the Paramedics' violation of several statutory provisions. She further insists that the circuit court misconstrued the "good faith" requirement of Code § 8.01-225. Finally, she claims that circuit court overlooked the fact that MLSC and the Paramedics were compensated and, therefore, the statute did not apply to them.

Our analysis of these issues begins by noting that, at common law, there is no general duty to rescue. *See* W. Page Keeton et al., Prosser & Keeton on Torts § 56 at 375 (5th ed. 1984) ("[T]he law has persistently refused to impose on a stranger the moral obligation of common humanity to go to the aid of another human being who is in danger, even if the other is in danger of losing his life."). Further, we have recognized "'[i]t is ancient learning that one who assumes

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to act, even though gratuitously, may thereby become subject to the duty of acting carefully, if he acts at all.'" *Didato v. Strehler*, 262 Va. 617, 628 (2001) (quoting *Nolde Bros. v. Wray*, 221 Va. 25, 28 (1980)). "[T]his common law principle is embodied in the Restatement (Second) of Torts § 323," which states:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as

> necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if
>
> (a) his failure to exercise such care increases the risk of such harm, or
>
> (b) the harm is suffered because of the other's reliance upon the undertaking. *Id.* at 628-29.

Thus, at common law, if an individual undertook to perform rescue operations, that individual was held to a duty of ordinary care. It has been observed, however, that such a state of affairs offers no encouragement for individuals to volunteer to help another in danger; rather, it "operates as a real, and serious, deterrent to the giving of needed aid." Prosser & Keeton on Torts § 56, at 378. Indeed, "[t]he result of all this is that the good Samaritan who tries to help may find himself [punished with] damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing." *Id.*

To encourage voluntary rescue efforts, a majority of states have passed so-called "Good Samaritan" statutes which remove the fear of potential liability from individuals who render aid in emergency situations. *Id.* It is through this lens that we examine Virginia's Good Samaritan statute, Code § 8.01-225. We note that, although the statute includes several subsections, each of which describes the circumstances in which the statute operates to exempt individuals from

liability for engaging in certain rescue efforts, this case primarily concerns Code § 8.01-225(A)(5).[7] This subsection states:

> Any person who . . . [i]s an emergency medical services provider possessing a valid certificate issued by authority of the State Board of Health who in good faith renders emergency care or assistance, whether in person or by telephone or other means of communication, without compensation, to any injured or ill person, whether at the scene of an accident, fire, or any other place, or while transporting such injured or ill person to, from, or between any hospital, medical facility, medical clinic, doctor's office, or other similar or related medical facility, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment, or assistance,

> including but in no way limited to acts or omissions which involve violations of State Department of Health regulations or any other state regulations in the rendering of such emergency care or assistance.

Id.

A. Violation of Statutory Provisions

Stoots initially argues that the circuit court erred in granting immunity under Code § 8.01-225(A)(5) because the Paramedics' failure to perform CPR or take other steps to save Calvin's life violated several other statutory provisions. Specifically, Stoots contends that the Paramedics violated statutory duties created under Code §§ 54.1-2982, -2983.3, -2987.1, -2988, and -2901(A)(21). She contends that Code § 8.01-225(A)(5) has no application in such circumstances, as the statute only immunizes individuals from civil liability for "violations of State Department of Health regulations or any other state regulations," not violations of statutory duties. We disagree.

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As an initial matter, we note that many of the statutes cited by Stoots do not create a duty of any sort. Code § 54.1-2982 provides the definitions for advance directives and Do Not Resuscitate Orders, among other things. Code §§ 54.1-2987.1 and -2901(A)(21) authorize health care providers to follow a validly executed Do Not Resuscitate Order. Similarly, Code § 54.1-2988 grants immunity to entities and individuals that provide or withdraw healthcare in accordance with a Do Not Resuscitate Order. As the present case does not involve an actual Do Not Resuscitate Order, these statutes have no applicability.

The only statute cited by Stoots that creates a duty of some sort and is potentially applicable here is Code § 54.1-2983.3, which, in addition to providing certain exclusions and limitations regarding advance directives, expressly states that "a patient's advance directive shall otherwise be given full effect." However, the fact that the Paramedics had a statutory duty to give full effect to the Advance Directive does not mean a breach of that duty renders Code § 8.01-225(A)(5) inapplicable. Nothing in the statute supports Stoots's argument that the General Assembly intended to limit the immunity from civil liability only to violations of State Department of Health regulations. Notably, the reference to State Department of Health regulations is prefaced by the phrase: "including *but in no way limited to*." *Id.* (emphasis

added). Such language clearly indicates that the language is inclusive, not exclusive. In other words, the reference to State Department of Health regulations does not operate to limit the applicability of Code § 8.01-225. Rather, this language indicates that the statute is meant to encompass any act or omission related to the rendering of care, "including but in no way limited to acts or omissions which involve violations of State Department of Health regulations or any other state regulations." *Id.* As the present case involves an omission related to the rendering of care by emergency medical services providers, i.e., the Paramedics' failure to perform CPR or take other

steps to resuscitate Calvin, it is clear that Code § 8.01-225(A)(5) may apply, provided the other statutory requirements are met. [1]

B. Good Faith

Stoots next argues that the circuit court misconstrued the "good faith" provision of Code § 8.01-225. **The main thrust of Stoots's argument is that the Paramedics' purported gross negligence establishes that they were not acting in good faith. Stated differently, Stoots takes the position that good faith and gross negligence are mutually exclusive of each other; the existence of one proves the absence of the other. While this construction may be true in some contexts, we cannot say that it applies here, as other provisions of Code § 8.01-225 indicate that good faith and gross negligence can coexist.** [2]

The Court has repeatedly explained that "we presume that [the General Assembly] chose with care the words it used when it enacted the statute we are construing." *Bonanno v. Quinn*, 299 Va. 722, 730 (2021). "[I]t is our duty to interpret the several parts of a statute as a consistent and harmonious whole so as to effectuate the legislative goal." *Virginia Elec. & Power Co. v. Bd. of County Sup'rs of Prince William County*, 226 Va. 382, 387-88 (1983). "Additionally, when the General Assembly includes specific language in one section of a statute, but omits that language from another section of the statute, we must presume that the exclusion of the language was intentional." *Halifax Corp. v. First Union Nat. Bank*, 262 Va. 91, 100 (2001).

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[1] R. Shawn Majette August 28, 2022 Editorial Footnote

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Here, we note that Code § 8.01-225(A)(5) and Code § 8.01-225(A)(10)[8] both include the same good faith requirement. However, the latter subsection also carves out an exception for

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acts or omissions that were "the result of gross negligence or willful misconduct." The inclusion of this exception in another subsection of the statute necessarily implies that the General Assembly recognized that an individual could act in good faith and simultaneously be grossly negligent. In other words, in the context of Code § 8.01-225, the General Assembly did not intend to equate gross negligence with the absence of good faith, i.e., bad faith. Moreover, we must presume that the General Assembly intentionally excluded this language from Code § 8.01-225(A)(5). *See Halifax Corp.*, 262 Va. at 100.

In the alternative, Stoots argues that "good faith" should be judged by a standard of objective reasonableness.[9] Again, we must disagree. When interpreting a statute, courts "ascertain and give effect to the intention of the legislature." *Boynton v. Kilgore*, 271 Va. 220, 227 (2006).

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At common law, a rescuer's actions were judged by a reasonableness standard, *see Restatement (Second) of Torts* § 323 (holding a rescuer liable "for physical harm resulting from his failure to exercise reasonable care" in performing the rescue), and Code § 8.01-225 was enacted to abrogate the common law. Imposing the reasonableness standard would essentially result in a return to the common law and an implicit vitiation of Code § 8.01-225; therefore, we must reject such a construction of the statute.

This Court has recognized that, in certain contexts, the term "good faith" looks at the intent of the actor. For example, in *Rafalko v. Georgiadis*, 290 Va. 384, 398 (2015), we held that "[a] person acts in good faith when he or she acts with honest motives." Thus, a finding of good faith is "based on the court's determination of the mindset of a party." In contrast, the term "reasonableness" looks at the manner in which the actor performs an act. *See Mayr v. Osborne*, 293 Va. 74, 81 (2017) (recognizing that the tort of negligence functions "to encourage individuals to exercise *reasonable* care.") (emphasis added). In light of the fact that the General Assembly has clearly signaled a move away from looking at the manner the act is performed, we hold that, with regard to Code § 8.01-225, the question of whether an individual has acted in "good faith" is best answered by looking at that individual's mindset at the time the conduct is undertaken.

Here, there is no evidence indicating that the Paramedics had any bad intent or dishonest motives in their failure to treat Calvin, nor has Stoots been able to point to any fact indicating that they bore any ill will toward Calvin. Thus, while it is undisputed that the Paramedics committed a grave mistake in failing to evaluate the Advance Directive more thoroughly, that mistake, without more, cannot rise to the level of bad faith. Accordingly, the circuit court did not err in finding an absence of bad faith.

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C. Without Compensation

Stoots further argues that the circuit court erred in ruling that the Paramedics and MLSC were not compensated for their actions in this case. With regard to the Paramedics, she contends that the circuit court improperly limited its focus to whether Powell and Chatham were paid for the February 9, 2014 shift.[10] According to Stoots, this case turns on the fact that Powell and Chatham participated in the MIP, which permitted them to designate whether a shift was a volunteer shift or a paid shift. Stoots insists that the MIP could not have been what the General Assembly intended when it said "without compensation" because the MIP allowed Powell and Chatham to claim immunity on any day in which there was an adverse occurrence while also getting paid on other days. We disagree.

"When the language of a statute is unambiguous, we are bound by the plain meaning of that language." *Conyers v. Martial Arts World of Richmond, Inc.*, 273 Va. 96, 104 (2007). By its plain language, Code § 8.01-225(A)(5) only requires that an emergency medical services provider render emergency care "without compensation." Such language presents a simple dichotomy: either a person receives compensation for their actions and may be held liable, or does not receive compensation and is immune from liability. Thus, in direct contravention to Stoots's argument, the statute does not look at whether a person *could be compensated* for their actions; rather, it looks at whether the person is, in fact, compensated.

In the context of Code § 8.01-225(A)(5), the term "compensation" means "[r]emuneration and other benefits received in return for services rendered; esp., salary or wages." Black's Law Dictionary 354 (11th ed. 2019). Here, there is no evidence that any of the

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Paramedics received any form of compensation for their actions on February 9, 2014. Accordingly, the circuit court did not err in finding that the Paramedics acted without compensation.[11]

With regard to MLSC, Stoots takes issue with the circuit court's ruling that MLSC's liability is coterminous with the Paramedics' liability. She contends that MLSC's liability is independent of the Paramedics' liability, especially considering the fact that the circuit court expressly found that MLSC billed and "was paid by [Calvin's] insurance company." To the extent that the circuit court ruled that MLSC's liability was coterminous with the Paramedics' liability, we agree with Stoots that the circuit court erred.

> "It is well settled in Virginia that where [principal] and [agent] are sued together in tort, and the [principal's] liability, if any, is solely dependent on the [agent's] conduct, a *verdict* for the [agent] necessarily exonerates the [principal]." *Roughton Pontiac Corp. v. Alston*, 236 Va. 152, 156 (1988) (emphasis added). In other words, the liability of a principal is only coterminous with the liability of its agent "when a verdict or other finding that the [agent] *was not negligent* is the basis for exoneration of the [principal]." *Hughes v. Doe*, 273 Va. 45, 48 (2007) (emphasis added, internal citations omitted).[12]
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> We have never applied this principle to claims against [a principal] when the [agent] was dismissed with prejudice on a plea in bar or other procedural matter. This limited application reflects the fact

> that the crux of respondeat superior liability is a finding that the [agent] was negligent.

Id.

It is further worth noting that a plaintiff is not required to bring a claim against the agent to maintain a respondeat superior theory claim against the employer. *Id.*

In the present case, there was no finding that the Paramedics were not negligent. Indeed, the circuit court unequivocally reached the opposite conclusion, stating "[c]learly [the Paramedics] were negligent or even grossly negligent, in not reading, understanding, and interpreting [Calvin's] Virginia Advance Directive for Health Care and in not attempting to resuscitate [Calvin]." As there was no verdict in favor of the Paramedics, or finding that they were not negligent, their immunity from civil liability is not dispositive of whether Code § 8.01-225 applies to MLSC. Accordingly, the circuit court erred in ruling that MLSC was immune because the Paramedics were immune.

Having reached this conclusion, we note that the record appears to be insufficient to determine whether the immunity afforded by Code § 8.01-225 applies to MLSC. As Stoots points out, MLSC billed and was paid by Calvin's insurance company. However, the record is silent as to the nature of the bill or the subsequent payment; therefore, we cannot presently determine whether the payment was compensation for services rendered or reimbursement for MLSC's expenses. *See* Code § 8.01-225(E)(v) ("'[C]ompensation'" shall not be construed to include . . . expenses reimbursed to any person providing care or assistance pursuant to this section."). Thus, whether MLSC's actions were "without compensation" cannot be decided on the present appeal.

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III. CONCLUSION

For the foregoing reasons, the circuit court's judgment with regard to the Paramedics will be affirmed. However, we will reverse the circuit court's judgment with regard to MLSC and remand the case for further proceedings.[13]

Affirmed in part, reversed in part, and remanded.

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Notes:

[1] "Membership Incentive Program" is how MLSC refers to the program in its General Ledger.

[2] "DNR" is shorthand for "Do Not Resuscitate."

[3] It is unclear whether Calvin died before or after Chatham was picked up.

[4] Stoots also brought a negligent training claim against MLSC which was subsequently dismissed as a matter of law.

[5] The Paramedics and MLSC also moved for summary judgment on the basis that the claim was a medical malpractice claim and Stoots failed to comply with the expert certification requirement of Code § 8.01-20.1. Stoots responded that her claim was not a medical malpractice action, it was a wrongful death claim. Alternatively, she claimed that an expert certification was not necessary because the alleged acts of negligence lay within the range of a jury's common knowledge and experience.

[6] Additionally, the circuit court ruled that Stoots's claim was not a malpractice action. In reaching this conclusion, the circuit court noted that, because the Paramedics and MLSC were immune from liability under Code § 8.01-225, Calvin was not a "patient" under Code § 8.01-581.1 and, therefore, Stoots's claim did not meet the statutory definition of "malpractice." The circuit court did not reach the issues of charitable immunity or sovereign immunity.

[7] Although Stoots also raises arguments related to Code § 8.01-225(A)(1), the circuit court's ruling was explicitly limited to Code § 8.01-225(A)(5). Accordingly, we do not directly address the applicability of Code § 8.01-225(A)(1). However, we acknowledge that our analysis of the "good faith" and "without compensation" issues would apply equally to both subsections under the facts of this case.

[8] Code § 8.01-225(A)(10) states, in relevant part:

> Any person who . . . [i]s a volunteer in good standing and certified to render emergency care by the National Ski Patrol System, Inc., who, in good faith and without compensation, renders emergency care or assistance to any injured or ill person . . . shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment, or assistance, including but not limited to acts or omissions which involve violations of any state regulation or any standard of the National Ski Patrol System, Inc., in the rendering of such emergency care or assistance, *unless such act or omission was the result of gross negligence or willful misconduct*.

(Emphasis added.)

[9] In raising this argument, Stoots relies on our decisions in *Nationwide Mutual Insurance Co. v. St. John*, 259 Va. 71 (2000) and *CUNA Mutual Insurance Society v. Norman*, 237 Va. 33 (1989). *Nationwide* and *CUNA* both addressed whether an individual could be awarded attorneys' fees and costs due to the insurer's bad faith refusal to pay an insurance claim. The Court adopted a reasonableness standard due to the fact that both cases involved statutes that served both remedial and punitive purposes. *See Nationwide*, 259 Va. at 75 (noting that Code § 8.01-66.1(A) is both remedial and punitive); *CUNA*, 237 Va. at 38 (stating the Code § 38.2-209 "is both punitive and remedial in nature."). Further, the reasonableness standard the Court adopted was specifically tailored to those cases, and therefore has limited applicability in other situations. *See Nationwide*, 259 Va. at 75 (requiring consideration of, among other things, whether reasonable minds

could differ in interpreting the insurance provisions, whether a reasonable investigation was made into the insurance claim, and whether the denial of the claim was a negotiation tool); *CUNA*, 237 Va. at 38 (same). The significantly different subject matter and customized holdings of those cases necessarily limit their applicability outside of the context of the relationship between insurer and insured.

[10] Stoots implicitly recognizes that her argument could not apply to Thompson, as the record establishes that he did not participate in the MIP and never received any money from MLSC.

[11] As the record establishes that the Paramedics were not compensated at all for their actions on February 9, 2014, we do not reach the issue of whether Code § 8.01-225(E)(1) would exempt the money the Paramedics received under the MIP from the definition of compensation.

[12] We note that *Linhart*, the case cited by the circuit court, involved the General Assembly's abrogation of sovereign immunity for the principal but not the agent. 261 Va. at 34. As the present case does not involve a similar abrogation of immunity, that case is inapposite and the circuit court's reliance on it was misplaced.

[13] In light of our ruling, the circuit court will need to revisit its ruling on whether Stoots's claim meets the statutory definition of "malpractice" under Code § 8.01-581.1 and, if so, whether the alleged acts of negligence lay within the range of a jury's common knowledge and experience such that she was not required to comply with the expert certification requirement of Code § 8.01-20.1.