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In this case, excluding the evidence serves the deterrence aim of the exclusionary rule by forbidding the use of evidence obtained through an obvious Fourth Amendment violation. Conversely, to ignore such a blatant lack of probable cause would set a low bar for future police conduct.[29]

We conclude that the deputies' reliance on the warrant was not reasonable and thus did not bring it within the *Leon* good faith exception to the exclusionary rule. The court erred in overruling Sprunger's second motion to suppress.

CONCLUSION

We conclude that probable cause did not support the warrant to search Sprunger's computers for child pornography. We also conclude that it was lacking probable cause to such a degree that reliance on the warrant was not objectively reasonable. Accordingly, the court should have suppressed fruits of the search. We reverse, and remand for proceedings consistent with this opinion.

REVERSED AND REMANDED FOR FURTHER PROCEEDINGS.

WRIGHT, J., not participating.

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[29] See *State v. Gorup*, 279 Neb. 841, 782 N.W.2d 16 (2010).

EDWARD M. SMALLEY, APPELLEE AND CROSS-APPELLANT, V. NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES, APPELLANT AND CROSS-APPELLEE.

811 N.W.2d 246

Filed March 23, 2012. No. S-11-151.

1. **Judgments: Appeal and Error.** The trial court's factual findings in a bench trial of an action at law have the effect of a jury verdict and will not be set aside unless clearly erroneous.
2. **Administrative Law: Statutes: Appeal and Error.** To the extent that the meaning and interpretation of statutes and regulations are involved, questions of law are presented, in connection with which an appellate court has an obligation to reach an independent conclusion irrespective of the decision made by the court below.

3. **Medical Assistance: Federal Acts: States.** The Medicaid program provides joint federal and state funding of medical care for individuals whose resources are insufficient to meet the cost of necessary medical care.
4. ____: ____: ____. The Medicaid program provides federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons.
5. ____: ____: ____. A state is not obligated to participate in the Medicaid program; however, once a state has voluntarily elected to participate, it must comply with standards and requirements imposed by federal statutes and regulations.
6. **Medical Assistance: Federal Acts.** Based in part on its third-party liability provisions, Medicaid has been characterized as a "payer of last resort." Therefore, all other available resources must be used before Medicaid pays for the medical care of an individual enrolled in a Medicaid program.
7. **Ordinances: Presumptions: Proof.** In considering the validity of regulations, courts generally presume that legislative or rulemaking bodies, in enacting ordinances or rules, acted within their authority, and the burden rests on those who challenge their validity.
8. **Administrative Law.** Agency regulations that are properly adopted and filed with the Secretary of State of Nebraska have the effect of statutory law.

Appeal from the District Court for Cass County: RANDALL L. REHMEIER, Judge. Reversed and remanded with directions.

Jon Bruning, Attorney General, and Michael J. Rumbaugh for appellant.

William R. Settles, of Lamson, Dugan & Murray, L.L.P., Dean T. Jennings, of Jennings Law Firm, and G. Michael Fenner, of Creighton University School of Law, for appellee.

HEAVICAN, C.J., CONNOLLY, GERRARD, STEPHAN, MCCORMACK, and MILLER-LERMAN, JJ.

STEPHAN, J.

This case arises from the settlement of a personal injury lawsuit filed by Edward M. Smalley, who was seriously injured in a motor vehicle accident in December 2007. Although Smalley qualified for Medicaid as a result of the accident, the Nebraska Department of Health and Human Services (DHHS), Nebraska's Medicaid administrator, took the position that it would not pay Smalley's outstanding medical bills prior to the disposition of his third-party liability claims. In order to facilitate a settlement of those claims, Smalley's attorney agreed that if DHHS paid the medical bills at the

discounted Medicaid rate, Smalley would reimburse DHHS dollar-for-dollar out of the settlement proceeds. After DHHS paid the bills as agreed, Smalley objected to full reimbursement as contrary to federal law. The disputed funds were held in escrow, and the dispute was tried to the district court for Cass County. The court determined that under federal law, DHHS was entitled to reimbursement of only a portion of the Medicaid payments it had made. The court denied Smalley's requested relief under 42 U.S.C. §§ 1983 and 1988 (2006). DHHS appeals, and Smalley cross-appeals. We conclude that DHHS is entitled to full reimbursement and therefore reverse the judgment of the district court.

BACKGROUND

Accident

Shortly before 10 p.m. on December 20, 2007, Smalley was standing outside a vehicle parked on a snow- and ice-packed road in Cass County. Smalley was talking with the owner of the vehicle, who was giving him a ride home from a bar. Both were struck by a vehicle operated by Jerome G. Speck and owned by Mark Morehead Construction, Inc. (Morehead). Smalley was treated at a hospital in Omaha, Nebraska. He sustained serious injuries, including amputation of his legs. The other party also suffered injuries in the accident.

Submission and Denial of Medicaid Claim

Smalley was determined eligible for Medicaid during his hospital stay. In February 2008, he filed a personal injury lawsuit against Speck and Morehead, alleging they were responsible for his injuries. In March, the hospital submitted medical bills in excess of $400,000 to DHHS for payment under Medicaid. DHHS sets maximum reimbursement rates for Medicaid services, and pursuant to statutory regulations and its provider agreement with the hospital, DHHS could fully resolve Smalley's medical bills with a payment of approximately $131,000.[1] Emil Spicka, a medical claims investigator

[1] See 471 Neb. Admin. Code, ch. 2, § 001.03(4) and ch. 3, § 002.02A (2005).

for DHHS, refused to pay the hospital bill on the ground that "third party resources" might be available, such as the liability insurance of Speck and Morehead. The total liability coverage available to satisfy the claim of Smalley and the other person injured in the accident was $1,025,000. At the time DHHS denied payment of Smalley's medical bills, Smalley's claims against Speck and Morehead had not been resolved.

Agreement Between Smalley's Attorney and DHHS

Speck and Morehead agreed to mediate the personal injury lawsuit. Prior to the mediation session, Spicka told Smalley's attorney that DHHS would pay Smalley's outstanding medical bills at the discounted Medicaid rate if Smalley would agree to reimburse DHHS for the full amount of its payments out of the settlement proceeds. After receiving a proffered settlement of $800,000, Smalley's attorney agreed to this proposal because it disposed of the medical bills at a substantially reduced rate, thereby maximizing Smalley's net settlement proceeds. However, the attorney testified that he had reservations about whether DHHS could legally insist upon full reimbursement and that he intended to seek a legal resolution of this issue before consummating the settlement. Smalley's attorney did not mention this portion of his strategy to Spicka when the agreement was reached. Sometime after May 15, 2008, DHHS paid approximately $131,000 to resolve Smalley's outstanding medical bills. DHHS anticipated it would be fully reimbursed out of the settlement proceeds pursuant to its agreement.

Disposition of Medicaid Subrogation Claim

On May 27, 2008, Smalley added DHHS as a defendant in his pending personal injury action against Speck and Morehead. Smalley asserted that fully reimbursing DHHS out of the proceeds of the settlement would be contrary to federal law as applied by the U.S. Supreme Court in *Arkansas Dept. of Health and Human Servs. v. Ahlborn*[2] and that he could not accept the

[2] *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

pending offer to settle his personal injury claim until this issue had been resolved. He sought both declaratory and injunctive relief against DHHS and asserted that DHHS was liable under 42 U.S.C. §§ 1983 and 1988. A few days after Smalley added DHHS as a defendant, the parties entered into a stipulation which permitted Smalley to settle his claims against Speck and Morehead for $805,000. A portion of the settlement amount was placed into a special needs trust for Smalley's benefit, and Smalley's attorney fees and expenses were paid. An amount just over $130,000, representing the reimbursement claimed by DHHS and disputed by Smalley, was deposited in escrow pending disposition of the issue by the district court. DHHS filed an answer and a counterclaim asserting it was entitled to $130,000, representing partial reimbursement of the Medicaid payments it made to Smalley's health care providers.

The district court conducted a bench trial at which Smalley was represented by new counsel. Smalley's original attorney testified, as did Spicka and another representative of DHHS. Over a foundational objection, Smalley's original attorney testified that in his professional opinion, Smalley's personal injury claim was worth at least $6 million. He admitted that he never intended to honor his agreement to fully reimburse DHHS and that he entered into the agreement in order to induce DHHS to pay Smalley's medical expenses at the discounted Medicaid rate. Spicka testified that based upon the representations of Smalley's counsel, he expected DHHS to be fully reimbursed for the Medicaid payments it made on Smalley's behalf. He further testified that in the absence of the agreement, DHHS would have continued its "cost avoidance approach," leaving Smalley to negotiate with the hospital regarding the outstanding bill.

The district court held that DHHS' right to reimbursement was limited by *Ahlborn*,[3] in which the U.S. Supreme Court held that a state Medicaid program is entitled to reimbursement from only that part of a personal injury settlement that represents payment for medical care expenses. Applying a formula used in *Ahlborn*, the district court concluded that Smalley's

[3] *Id.*

claim had a value of $6 million and that the settlement amount of $805,000 represented approximately 13.4 percent of the total value of Smalley's claim. Applying this percentage to the Medicaid payments made by DHHS, the court determined that DHHS was entitled to reimbursement in the amount of $17,420. The court determined that enforcement of DHHS' claim for any greater portion of the settlement proceeds would be inconsistent with *Ahlborn* and enjoined DHHS from pursuing such enforcement efforts. The district court denied Smalley's § 1983 claim and held that he was not entitled to attorney fees pursuant to § 1988.

Smalley filed a motion for a new trial with respect to the denial of his § 1983 claim and his request for attorney fees. The court overruled the motion. DHHS then perfected this timely appeal, which we moved to our docket on our own motion pursuant to our statutory authority to regulate the dockets of the appellate courts of this state.[4]

ASSIGNMENTS OF ERROR

DHHS assigns that the district court abused its discretion in (1) denying full dollar-for-dollar recovery pursuant to the agreement, (2) applying *Ahlborn* to this case, and (3) overruling its objection to the testimony of Smalley's original counsel regarding the value of Smalley's personal injury claim.

On cross-appeal, Smalley assigns that the district court erred in (1) denying his § 1983 claim, (2) denying his request for attorney fees under § 1988, (3) finding unique circumstances existed that made an award of attorney fees unjust, and (4) denying his motion for a new trial on the issue of attorney fees.

STANDARD OF REVIEW

[1,2] The trial court's factual findings in a bench trial of an action at law have the effect of a jury verdict and will not be set aside unless clearly erroneous.[5] To the extent that the

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[4] See Neb. Rev. Stat. § 24-1106(3) (Reissue 2008).

[5] *Hooper v. Freedom Fin. Group*, 280 Neb. 111, 784 N.W.2d 437 (2010); *Eicher v. Mid America Fin. Invest. Corp.*, 275 Neb. 462, 748 N.W.2d 1 (2008).

meaning and interpretation of statutes and regulations are involved, questions of law are presented, in connection with which an appellate court has an obligation to reach an independent conclusion irrespective of the decision made by the court below.[6]

ANALYSIS

The parties' dispute arises from an agreement, the existence and terms of which are not disputed. The record reflects that (1) Smalley, through his attorney, promised DHHS that if it paid Smalley's medical expenses at the discounted Medicaid rate, it would be reimbursed in full from the proceeds of the personal injury settlement; (2) in reliance on this promise, DHHS made the requested payments; and (3) the promised reimbursement was not made. DHHS contends that it relied to its detriment upon Smalley's agreement and that it was defrauded into making the payments by a promise which Smalley and his attorney did not intend to keep. But Smalley contends that DHHS was legally obligated to pay his medical expenses and therefore could not have been induced to do so by a promise of full reimbursement. Smalley also argues that full reimbursement would violate federal law as interpreted and applied in *Ahlborn*. In resolving these issues, we do not comment on the tactic employed by Smalley's counsel in securing payment of Smalley's medical expenses. We are concerned here only with its legal consequence, which must be determined in the context of state and federal statutes and regulations which govern Medicaid. We begin by summarizing those provisions applicable to this case.

Medicaid and Third-Party Liability

[3-5] The Medicaid program provides joint federal and state funding of medical care for individuals whose resources are insufficient to meet the cost of necessary medical care.[7] The program provides "federal financial assistance to States

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[6] *Children's Hospital v. State*, 278 Neb. 187, 768 N.W.2d 442 (2009).

[7] *Ahlborn, supra* note 2; *Pohlmann v. Nebraska Dept. of Health & Human Servs.*, 271 Neb. 272, 710 N.W.2d 639 (2006).

that choose to reimburse certain costs of medical treatment for needy persons."[8] A state is not obligated to participate in the Medicaid program; however, once a state has voluntarily elected to participate, it must comply with standards and requirements imposed by federal statutes and regulations.[9] Nebraska elected to participate in the Medicaid program when it enacted the Medical Assistance Act.[10] DHHS is responsible for administering the program in this state.[11]

Among the federal statutes and regulations which govern that administration are those relating to third-party liability for medical expenses that would otherwise be paid by Medicaid. States participating in Medicaid are required by federal law to have a plan providing that the state agency administering the program "will take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under [Medicaid]."[12] The state plan must provide that

> in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.[13]

And, to the extent that a third party is legally liable for a payment which has been made under Medicaid, states are required to have laws through which the state acquires "the rights of such [Medicaid recipient] to payment by any other party for

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[8] *Harris v. McRae*, 448 U.S. 297, 301, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980). See, also, *Ahlborn, supra* note 2.

[9] See, *Ahlborn, supra* note 2; *Thorson v. Nebraska Dept. of Health & Human Servs.*, 274 Neb. 322, 740 N.W.2d 27 (2007); *Pohlmann, supra* note 7.

[10] See Neb. Rev. Stat. §§ 68-901 to 68-971 (Reissue 2009, Cum. Supp. 2010 & Supp. 2011). See, also, *Thorson, supra* note 9.

[11] *Thorson, supra* note 9. See *Pohlmann, supra* note 7.

[12] 42 U.S.C. § 1396a(a)(25)(A) (2006).

[13] § 1396a(a)(25)(B).

such health care items or services."[14] Federal law further mandates that states require individuals seeking Medicaid benefits "to assign the State any rights . . . to payment for medical care from any third party."[15] Any amount collected by a state under such an assignment must "be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed."[16] Any remaining amount is to be paid to the individual.[17]

Pursuant to these federal mandates, Nebraska's Medical Assistance Act provides that an application for Medicaid benefits must include an assignment to DHHS of

> any rights to pursue or receive payments from any third party liable to pay for the cost of medical care and services arising out of injury, disease, or disability of the applicant or recipient or other members of the assistance group which otherwise would be covered by medical assistance [Medicaid].[18]

Further, Neb. Rev. Stat. § 68-716 (Reissue 2009) provides:

> An application for medical assistance shall give a right of subrogation to [DHHS] or its assigns. Subject to sections 68-921 to 68-925, subrogation shall include every claim or right which the applicant may have against a third party when such right or claim involves money for medical care. The third party shall be liable to make payments directly to [DHHS] or its assigns as soon as he or she is notified in writing of the valid claim for subrogation under this section.

[6] Based in part on its third-party liability provisions, Medicaid has been characterized as a "'payer of last resort.'"[19]

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[14] § 1396a(a)(25)(H).

[15] 42 U.S.C. § 1396k(a)(1)(A) (2006).

[16] § 1396k(b).

[17] *Id.*

[18] § 68-916.

[19] *Ahlborn, supra* note 2, 547 U.S. at 291, quoting S. Rep. No. 99-146 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 280.

Therefore, "'all other available resources must be used before Medicaid pays for the medical care of an individual enrolled in a Medicaid program.'"[20] But, as the U.S. Supreme Court noted in *Ahlborn*, it "does not mean . . . that Congress meant to authorize States to seek reimbursement from Medicaid recipients themselves."[21] The federal Medicaid statutes include an "anti-lien provision" which provides 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" under Medicaid, except in certain limited circumstances.[22] Also, federal law 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, except" in certain specific circumstances.[23]

In *Ahlborn*, the U.S. Supreme Court considered federal Medicaid statutes in the context of an attempt by the State of Arkansas to recover Medicaid payments from a personal injury settlement. The client sustained a disabling brain injury in a motor vehicle accident. Arkansas paid Medicaid benefits of approximately $215,000 on her behalf. The client filed suit against the parties she claimed to have caused the accident and received a settlement of $550,000. Arkansas sought reimbursement from the settlement of all Medicaid benefits it had paid, based on a state statute. In affirming the holding of a lower appellate court, the Supreme Court held that Arkansas' claim against the settlement for all the Medicaid benefits it paid "squarely conflict[ed] with the anti-lien provision of the federal Medicaid laws."[24] The Court reasoned that the federal anti-lien provision allowed Arkansas to assert a lien on only that portion of the settlement proceeds representing medical expenses.

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[20] *Miller v. Gorski Wladyslaw Estate*, 547 F.3d 273, 278 (5th Cir. 2008), quoting *Caremark, Inc. v. Goetz*, 480 F.3d 779 (6th Cir. 2007).

[21] *Ahlborn, supra* note 2, 547 U.S. at 291.

[22] 42 U.S.C. § 1396p(a)(1) (2006).

[23] § 1396p(b)(1) (Supp. IV 2010).

[24] *Ahlborn, supra* note 2, 547 U.S. at 280.

Accrual of Obligation to Pay Medicaid Benefits

As noted, although Smalley admits to the terms of the reimbursement agreement and further admits that he never intended to hold to its terms, he contends that DHHS has no claim for detrimental reliance or fraudulent misrepresentation because DHHS had an independent legal obligation, existing at the time the reimbursement agreement was entered into, to pay Smalley's outstanding medical bills. His theory is that "'[o]ne suffers no damage where he is fraudulently induced to do something which he is under legal obligation to do . . . .'"[25] Our initial task, therefore, is to determine whether DHHS was legally obligated to pay Smalley's medical expenses at the time it entered into the reimbursement agreement.

Federal Medicaid regulations require state Medicaid agencies to follow certain procedures with respect to the payment of claims involving third-party liability.[26] For purposes of these regulations, "[*t*]*hird party* means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan."[27] The regulations specify two procedures for paying Medicaid claims. Under 42 C.F.R. § 433.139(b)(1),

> [i]f the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

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[25] *Beltner v. Carlson*, 153 Neb. 797, 800, 46 N.W.2d 153, 155 (1951), quoting 23 Am. Jur. *Fraud and Deceit* § 177 (1939).

[26] 42 C.F.R. § 433.139(a) (2011).

[27] 42 C.F.R. § 433.136 (2011).

This procedure is known as cost avoidance.[28] The second procedure is derived from 42 C.F.R. § 433.139(c), which provides, "If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule." This procedure, known as pay and chase, seeks reimbursement from liable third parties after the claim is paid and therefore can only occur after Medicaid pays for services.[29] It is clear from the record that DHHS was aware of Smalley's pending third-party liability claims when it initially denied his request that it pay his outstanding medical bills. But Smalley argues that because there was no "'confirmation from the provider or a third party resource indicating the extent of third party liability'"[30] when his Medicaid claim was filed, DHHS was obligated under 42 C.F.R. § 433.139(c) to pay the claim and "chase" the third parties alleged to be liable.

Smalley does not cite any authority for his interpretation of the federal regulations. And it conflicts with regulations duly promulgated by DHHS which provide that DHHS does not pay a Medicaid claim if there is any possibility that a third party could be liable for the amounts due. According to 471 Neb. Admin. Code, ch. 3, § 004 (2005):

> All third party resources available to a Medicaid client must be utilized for all or part of their medical costs before Medicaid. Third party resources (TPR) are any individual, entity, or program that is, or may be, contractually or legally liable to pay all or part of the cost of any medical services furnished to a client. Third party resources include, but are not limited to —
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> 1. Private health insurance;
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> 2. Casualty insurance, including medical payment provisions;

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[28] *Miller, supra* note 20.

[29] *Id.*

[30] Brief for appellee at 19, quoting 42 C.F.R. § 433.139(b)(1).

> . . . .
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> 12. Liable third parties who are not insurance carriers;
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> . . . .
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> 14. Any other party contractually or legally liable to pay medical expenses.
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> *. . . Medicaid payment is made only after all third party resources have been exhausted or met their legal contractual or legal obligations to pay. Medicaid is the payor of last resort.*

(Emphasis supplied.) Further, 471 Neb. Admin. Code, ch. 3, § 004.03 (2005), provides in part:

> Medicaid clients who have third party resources must exhaust these resources before Medicaid considers payment for any services. Medicaid shall not pay for medical services as a primary payor if a third party resource is contractually or legally obligated to pay for the service.
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> Providers shall bill all third party resources and/or the client . . . for services provided to the client . . . . Medicaid is the payor of last resort.

Particularly instructive is 471 Neb. Admin. Code, ch. 3, § 004.06C (2003), which is captioned "Timely Filing of Claims with Casualty Insurance," and specifies in part:

> Providers must submit claims within 24 months of the date of service. In some casualty third party situations, [DHHS] recognizes that it may take longer than 24 months to resolve the third party obligation. In these situations, [DHHS] can make payment beyond the 24 months if the provider can document that action was taken to obtain payment from the third party. If a provider has received a denial from [DHHS] due to the existence of casualty insurance coverage and the provider has sought payment from the third party, then the provider can request [DHHS] to reconsider payment if the provider has waited 24 months and the third party has not paid the provider.

And 471 Neb. Admin. Code, ch. 3, § 004.06D (2003), states that "[p]roviders shall bill [DHHS] only when all third party resources have failed to cover the service or when a portion of the cost of the service has been paid." Further, § 004.06D1c

provides that DHHS "will recognize and consider payment on claims involving casualty coverage denial," but expressly states that "[*t*]*he insurer's statement that payment cannot be made at this time due to a pending liability determination or litigation is not a valid denial*." (Emphasis supplied.) And 471 Neb. Admin. Code, ch. 3, §§ 004.06F and 004.06G (2003), state, respectively, "[t]he provider shall resolve all third party resources before Medicaid can consider paying a claim even when Medicaid prior authorization has been given" and "[t]he provider shall resolve all third party resources before Medicaid can consider paying a claim even though the client is eligible for Medicaid."

[7,8] In considering the validity of regulations, courts generally presume that legislative or rulemaking bodies, in enacting ordinances or rules, acted within their authority, and the burden rests on those who challenge their validity.[31] There is no such challenge in this case, and we are not free to disregard the regulations upon which DHHS bases its position. Agency regulations that are properly adopted and filed with the Secretary of State of Nebraska have the effect of statutory law.[32] Thus, Nebraska's Medicaid regulations summarized above are controlling law on the question of whether DHHS was obligated to pay Smalley's medical expenses at the time it entered into the agreement with Smalley's attorney. Based upon those regulations, we find that it was not. Instead, DHHS was legally entitled to refrain from paying Smalley's medical bills until the third-party liability claims were resolved.

Effect of *Ahlborn*

Smalley's alternative argument is that even if he fraudulently induced DHHS to enter into the reimbursement agreement, DHHS cannot premise recovery on his promise of full reimbursement, because full reimbursement violates the federal anti-lien provision as discussed in *Ahlborn*. He argues that

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[31] *Scofield v. State*, 276 Neb. 215, 753 N.W.2d 345 (2008); *Jacobson v. Solid Waste Agency of Northwest Neb.*, 264 Neb. 961, 653 N.W.2d 482 (2002).

[32] *Holmes v. State*, 275 Neb. 211, 745 N.W.2d 578 (2008).

"[a] party cannot, by contractual agreement with another party, obtain the power to do something the law forbids."[33]

Ahlborn held that the federal Medicaid statutes forbid state Medicaid programs from imposing a lien on any portion of a personal injury judgment or settlement which does not represent payments for medical care. It did not, however, hold that a state Medicaid administrator is never entitled to full reimbursement, and thus the facial terms of the reimbursement agreement do not violate federal law.

And the facts in this case are substantially different than *Ahlborn*. In *Ahlborn*, the state Medicaid provider, presumably pursuant to state regulations, adopted a "pay and chase" strategy and paid the client's medical bills while the client's third-party claims were pending. After the client settled those claims for $550,000, the Medicaid provider asserted a lien for approximately $215,000, which represented the full amount of medical expenses it had paid on behalf of the client. The parties stipulated that the client's entire claim was reasonably valued at approximately $3 million and that the settlement reached amounted to approximately one-sixth of that sum. They further stipulated that, based upon this percentage allocation, approximately $35,000 of the settlement amount constituted reimbursement for medical payments made. On these stipulated facts, the Court was asked to determine whether the Medicaid provider could recover $215,000 or $35,000. Based on its finding that the state could not assert an interest in a portion of the settlement that was not reimbursement for medical payments, it awarded the latter.

Here, DHHS, pursuant to its regulations, adopted a "cost avoidance" strategy and did not pay Smalley's outstanding medical bills while the third-party liability claims were pending. At the time DHHS entered into the reimbursement agreement and ultimately paid Smalley's outstanding medical bills, it had no legal obligation to do so. The record conclusively shows that DHHS—knowing Smalley had been offered a settlement of $800,000—paid the medical bills, based on

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[33] Brief for appellee at 21, citing *Rath v. City of Sutton*, 267 Neb. 265, 673 N.W.2d 869 (2004).

Smalley's promise that he would reimburse DHHS the full amount of its payment. All parties agree that DHHS' payment of the medical bills at the reduced Medicaid rate resulted in a benefit to Smalley, in that it increased his net recovery of the settlement proceeds.

The district court found that *Ahlborn* limited DHHS' reimbursement "to the pro rata share of the past medical expenses paid by [DHHS] as the same relates to the total value of [Smalley's] claim." In doing so, the court erred as a matter of law. Courts in other jurisdictions have recognized that the pro rata formula applied in *Ahlborn* was simply a result of the factual stipulation entered into by the parties.[34] These jurisdictions consider the pro rata formula as one means of determining the portion of a settlement related to medical expenses, and do not consider the formula itself law.[35] Instead, states are generally free to employ any reasonable means to determine what portion of a settlement relates to medical expenses and is therefore recoverable by a state Medicaid administrator.[36]

Based on the unique facts of this case, the district court should have looked no further than the agreement between the parties. By promising that the $130,000 would be reimbursed in full if DHHS paid his outstanding medical bills at the reduced rate, Smalley agreed that $130,000 of the proffered $800,000 settlement related to medical expenses. This agreement is both consistent with *Ahlborn* and reasonable under the undisputed facts. The district court erred in further reducing the amount DHHS could recover from the settlement proceeds. DHHS is entitled to the full $130,000 held in escrow.

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[34] See, *I.P. ex rel. Cardenas v. Henneberry*, 795 F. Supp. 2d 1189 (D. Colo. 2011); *Armstrong v. Cansler*, 722 F. Supp. 2d 653 (W.D.N.C. 2010); *Morales v. HHC*, 34 Misc. 3d 835, 935 N.Y.S.2d 850 (2011); *Russell v. Agency for Health Care Admin.*, 23 So. 3d 1266 (Fla. App. 2010); *Edwards v. Ardent Health Services, L.L.C.*, 243 P.3d 25 (Okla. Civ. App. 2010); *McMillian v. Stroud*, 166 Cal. App. 4th 692, 83 Cal. Rptr. 3d 261 (2008).

[35] *Id.*

[36] *Id.*

CONCLUSION

The district court erred in not permitting DHHS to recover the full amount of its counterclaim, to be satisfied from the funds withheld from the settlement proceeds pursuant to the stipulation of the parties. The judgment of the district court is reversed, and the cause is remanded with directions to enter judgment in accordance with this opinion. Because DHHS is entitled to the full amount of its counterclaim, Smalley's assignments of error on cross-appeal need not be addressed.

REVERSED AND REMANDED WITH DIRECTIONS.

GERRARD, J., not participating in the decision.

WRIGHT, J., not participating.

STATE OF NEBRASKA, APPELLEE, V.
WILLIAM D. KINSER, JR., APPELLANT.
811 N.W.2d 227

Filed March 23, 2012. No. S-11-558.

1. **Statutes: Appeal and Error.** Statutory interpretation presents a question of law, for which an appellate court has an obligation to reach an independent conclusion irrespective of the determination made by the court below.
2. **Sentences: Appeal and Error.** A sentence imposed within statutory limits will not be disturbed on appeal absent an abuse of discretion by the trial court.
3. **Sentences: Prior Convictions: Habitual Criminals: Proof.** In a habitual criminal proceeding, the State's evidence must establish with requisite trustworthiness, based upon a preponderance of the evidence, that (1) the defendant has been twice convicted of a crime, for which he or she was sentenced and committed to prison for not less than 1 year; (2) the trial court rendered a judgment of conviction for each crime; and (3) at the time of the prior conviction and sentencing, the defendant was represented by counsel or had knowingly and voluntarily waived representation for those proceedings.

Appeal from the District Court for Scotts Bluff County: RANDALL L. LIPPSTREU, Judge. Affirmed.

Brian J. Lockwood and Richard L. DeForge, Deputy Scotts Bluff County Public Defenders, for appellant.

Jon Bruning, Attorney General, and Kimberly A. Klein for appellee.