

IN THE SUPREME COURT OF FLORIDA

MARIA ISABEL GIRALDO
and JUAN GONZALO VILLA,
as co-personal representatives of
the estate of JUAN L. VILLA,

Petitioners,

Case No.: SC17-297

v.

L.T. Case Nos.: 1D16-0392
15-4423MTR

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.

ON REVIEW FROM THE DISTRICT COURT OF APPEAL
FIRST DISTRICT OF FLORIDA

PETITIONERS' APPENDIX TO INITIAL BRIEF ON THE MERITS

FLOYD FAGLIE
Florida Bar No. 0569690
faglielaw@earthlink.net
STAUNTON & FAGLIE, PL
189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
Fax: (850) 997-6301

Attorneys for Petitioners

PHILIP J. PADOVANO
Florida Bar: 157473
ppadovano@bhappeals.com
MAEGEN P. LUKA
Florida Bar: 549851
mluka@bhappeals.com
JOSEPH T. EAGLETON
Florida Bar No. 98492
jeagleton@bhappeals.com
BRANNOCK & HUMPHRIES
1111 W. Cass Street, Suite 200
Tampa, Florida 33606
Tel: (813) 223-4300
Fax: (813) 262-0604
eservice@bhappeals.com

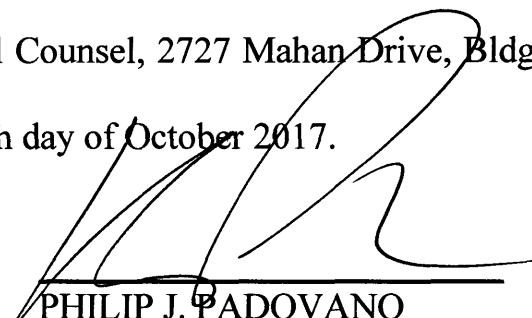
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by email to Elizabeth Teegen, Assistant Attorney General, and Jonathan A. Glogau, Special Counsel (elizabeth.teegen@myfloridalegal.com and jon.glogau@floridalegal.com), Office of the Attorney General, Complex Litigation, The Capitol, Suite PL-01, Tallahassee, Florida 32399-1050, and Tracy George, Chief Appellate Counsel (tracy.george@ahca.myflorida.com), Agency for Health Care Administration, Office of General Counsel, 2727 Mahan Drive, Bldg. 3, MS #3, Tallahassee, Florida 32308, this 26th day of October 2017.

FLOYD FAGLIE
Florida Bar No. 0569690
faglielaw@earthlink.net
STAUNTON & FAGLIE, PL


PHILIP J. PADOVANO
Florida Bar: 157473
ppadovano@bhappeals.com
MAEGEN P. LUKA

189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
Fax: (850) 997-6301

Florida Bar: 549851
mluka@bhappeals.com
JOSEPH T. EAGLETON
Florida Bar No. 98492
jeagleton@bhappeals.com
BRANNOCK & HUMPHRIES
1111 W. Cass Street, Suite 200
Tampa, Florida 33606
Tel: (813) 223-4300
Fax: (813) 262-0604
eservice@bhappeals.com

Attorneys for Petitioners

MARIA ISABEL GIRALDO and
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Appellants,

v.

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Appellee.

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NOT FINAL UNTIL TIME EXPIRES TO
FILE MOTION FOR REHEARING AND
DISPOSITION THEREOF IF FILED

CASE NO. 1D16-0392

Opinion filed December 12, 2016.

An appeal from a Final Order of the Division of Administrative Hearings.
Elizabeth W. McArthur, Administrative Law Judge.

Floyd Faglie of Staunton & Faglie, PL, Monticello; Celene H. Humphries and
Maegen Peek Luka of Brannock & Humphries, Tampa, for Appellants.

Alexander R. Boler, Tallahassee, for Appellee.

WELLS, LINDA ANN, Associate Judge.

On September 12, 2010, Juan L. Villa suffered catastrophic injury to his spine
when the all-terrain vehicle he was riding overturned. Villa, claiming both economic
and noneconomic damages, brought products liability and negligence claims against
those allegedly liable for his injuries. Florida's Agency for Healthcare

Administration (“AHCA”), which administers Florida’s Medicaid program,¹ paid for portions of Villa’s medical care. By accepting Medicaid benefits, Villa automatically subrogated his right to third-party benefits for the full amount of medical assistance provided by Medicaid and automatically assigned to AHCA his right, title, and interest to those benefits, other than those excluded by federal law. See § 409.910(6)(a), (b), Fla. Stat. (2014); see also 42 U.S.C. § 1396k(a)(1) (requiring states participating in the federal Medicaid program to provide, as a condition of Medicaid eligibility, assignment to the state the right to payment for medical care from any third party). These same benefits also became subject to an automatic lien in AHCA’s favor “for the full amount of medical assistance provided by Medicaid” as soon as Villa began to receive treatment for which AHCA became obligated to pay. § 409.910(6)(c), Fla. Stat. (2014).

On March 2, 2015, AHCA asserted a \$322,222.27 Medicaid lien against any future settlement of, or recovery from, the action Villa had brought to recover for the injuries he had incurred in the all-terrain vehicle accident. AHCA later updated the Medicaid lien amount to \$324,607.25.²

¹ See § 409.901(2), Fla. Stat. (2014) (defining AHCA as the Medicaid agency for the state as provided by federal law).

² The ALJ’s order concluded:

9. Nearly all of Petitioner’s past medical expenses following the ATV incident were paid for by Medicaid. As of March 2, 2015, the total

A month later, Villa settled his case against one of a number of defendants in his products liability/negligence action. Although the settlement agreement between these two parties did not itemize the different sums that Villa was to recover for each element of damage that he claimed,³ it did state that his “alleged damages have a value in excess of \$25,000,000.00,” and that Villa and the settling defendant had agreed to allocate \$4817.56 of the undifferentiated settlement total to Villa’s claim for past medical expenses.⁴

amount of medical assistance provided by the Medicaid program was \$322,222.27, representing over 92 percent of the \$347,044.67 paid in total for past medical expenses. The rest of Petitioner’s medical expenses were paid for by United HealthCare (\$1457.40) and Medicare (\$23,365.00).

....

12. By letter dated March 2, 2015, AHCA asserted a \$322,222.27 Medicaid lien against Petitioner’s cause of action and any future settlement of, or recovery from, that action. Thereafter, AHCA updated the Medicaid lien amount to \$324,607.25.

³ Among other things, Villa claimed damages for pain and suffering and mental anguish; for loss of wages and earning capacity; for mental and physical impairment; and for past and future medical expenses.

⁴ Villa’s counsel later testified that this amount was a mathematical error and that the correct sum was \$13,881.79. Counsel admitted that he drafted this provision and intended to put in an amount that represented the same proportion to the total for past medical expenses as the total settlement amount represented to the total value of the damages claimed by Villa. That is, Villa settled for approximately 4% of the total damage amount claimed (\$25,000,000), therefore, according to Villa, making AHCA entitled to only 4% (\$13,881.79) of the amount of Villa’s past medical expenses.

Shortly after settling, Villa's counsel notified AHCA of the settlement and provided AHCA with a copy of the executed settlement agreement, along with an itemization of Villa's litigation costs in the tort lawsuit. The letter asked AHCA to advise Villa of the amount AHCA would accept from the settlement proceeds to satisfy its Medicaid lien. AHCA responded claiming entitlement to \$321,720.16 of Villa's settlement predicated on its calculation of the amount payable pursuant to the formula set forth in section 409.910(11)(f) of the Florida Statutes. See § 409.910(11)(f)1., Fla. Stat. (2014) (capping AHCA's recovery at one half of the total amount of the settlement proceeds after deducting attorneys' fees and costs).⁵

Villa then petitioned the Division of Administrative Hearings (DOAH) for a formal administrative proceeding to contest the amount designated by AHCA "as recovered medical expense damages" and for a determination of the amount payable to AHCA to satisfy the agency's Medicaid lien. See § 409.910(17)(b), Fla. Stat. (2015) (providing that a Medicaid recipient may contest the amount designated as recovered medical expense damages under paragraph (11)(f)). The matter was tried before an administrative law judge (ALJ) the following October, but before a final

⁵ Villa does not dispute the accuracy of the amounts utilized in AHCA's calculations for attorney's fees and costs and stipulated that the final sum requested by AHCA was accurately calculated pursuant to the parameters set forth in section 409.910(11)(f) of the Florida Statutes. He also does not deny that Medicaid paid more than the \$321,720.16 requested to defray his medical costs.

order could be entered, Villa died, and the co-personal representatives of his estate stepped in.⁶

On December 30, 2015, a comprehensive final order was entered rejecting Villa's claim that less than the \$321,720.16 allocated under the paragraph (11)(f) formula should be allocated as reimbursement for Villa's medical expenses. In doing so, the ALJ rejected the notion that the \$13,881.79 allocation purportedly agreed to by Villa and the settling third-party tortfeasor (based on their \$25,000,000.00 estimate of total damages) constituted clear and convincing evidence that an amount less than the paragraph (11)(f) amount should be allocated, because "neither the agreed total value of 'alleged' damages nor the agreed allocation of settlement proceeds [between Villa and the settling third-party tortfeasor] to compensate for past medical expenses . . . can be credited as reasonable products of arms-length adversarial negotiation."

The ALJ also concluded that two-year old hearsay reports from a vocational rehabilitation specialist and an economist failed to supply the evidentiary support essential to the current paragraph (17)(b) challenge because neither report segregated medical damages from non-medical damages and neither reflected circumstances

⁶ Villa died on October 31, 2015, and the ALJ was put on notice before proposed final orders from the parties were due.

existing at the time of the evidentiary hearing.⁷ Lastly, the ALJ rejected Villa's argument that section 409.910(17)(b) impermissibly required him to include any future medical expense award in calculating the amount that must be allocated from his total recovery as available to satisfy the lien at issue.

Villa⁸ here challenges the determination that he failed to "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 [section 409.910](11)(f) or that Medicaid provided a lesser amount of medical assistance than that asserted by the agency." § 409.910(17)(b), Fla. Stat. (2014) (footnote omitted). Villa claims that the factual findings detailed in the final order are unsupported by competent substantial evidence and that the legal conclusions underpinning the final order are erroneous.

We find no error in any of the ALJ's factual findings or legal determinations. First, we reject Villa's claim that because the testimony of the two witnesses he called at the evidentiary hearing (one of whom was his trial attorney) was unrebutted,

⁷ The co-personal representatives of Villa's estate dispute the validity of the ALJ's consideration of the fact that post settlement Villa had died. At most, this was just another reason the court found the dated expert reports unpersuasive.

⁸ While we refer to Villa, it is the two co-personal representatives who make the arguments advanced herein.

that the ALJ had no choice but to accept that testimony as probative. See Fox v. Dep't of Health, 994 So. 2d 416, 418 (Fla. 1st DCA 2008) (“It is well-established that the ALJ was not required to believe [witness’s] testimony, even if unrebutted.”). “[T]he trier of fact is never bound to believe any witness, even a witness who is uncontradicted It is not our prerogative to judge the credibility of witnesses There is no substitute for seeing and hearing persons testify.” Walker v. Fla. Dep’t of Bus. & Prof’l Regulation, 705 So. 2d 652, 655 (Fla. 5th DCA 1998) (J. Dauksch, concurring specially).

More to the point, the burden was on Villa to prove by clear and convincing evidence that a lesser amount was to be allocated from the total recovery. 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).

On the record before us, we cannot disagree with the ALJ’s rejection of trial counsel’s unilateral determination of the amount to designate in the settlement agreement as that portion of the total settlement to be allotted to medical expenses. Likewise, we find no error in the ALJ’s determination that out-dated hearsay expert

reports, which did not segregate medical from non-medical damages, failed to support the relief sought by Villa—a determination that section 409.910(11)(f) should not be applied. Nor can we disagree with the ALJ’s decision that it was proper to reject testimony that the formula used by the parties to the settlement agreement to arrive at a \$13,881 allocation for medical expenses was a “reasonable” or “fair” approach, a fortiori because the settlement agreement prepared by Villa’s counsel allocated not \$13,881 but only \$4,817.56 as the amount against which AHCA could draw, and only later modified that figure. We therefore find no error in the ALJ’s factual determinations about which Villa complains.

Second, we find no error in the ALJ’s legal determination relating to AHCA’s right to secure reimbursement for payments already made for medical costs from not only that portion of the settlement allocated for past medical expenses but also from that portion of the settlement intended as compensation for future medical expenses. We do so initially because that is precisely what Florida law required the ALJ to do. Section 409.910(11)(f) sets forth the formula for determining that portion of a Medicaid recipient’s “recovery” pursuant to a settlement with a third party that must be allocated to satisfy “the total amount” of medical costs Medicaid has provided. § 409.910(11)(f), Fla. Stat. (2014). Specifically, the formula allocates one half of the gross (or entire settlement) recovered (which would include the recipient’s recovery

for past and future medical costs) less only attorney's fees and costs as designated to repay the state's Medicaid agency for the medical expenses that it has paid.

Likewise, section 409.910(17)(b), which authorizes a Medicaid recipient to challenge the amount allocated under section 409.910(11)(f), expressly requires consideration of the amounts the Medicaid recipient has "recovered" to reimburse him or her "for past and future medical expenses." § 409.910(17)(b), Fla. Stat. (2014). Section 409.910(17)(b) then requires the Medicaid recipient to prove by clear and convincing evidence that a smaller portion of this recovery should be made available for payment to AHCA than the amount established under section 409.910 (11)(f):

(17)(b) A [Medicaid] recipient may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula in paragraph (11)(f) by filing a petition under chapter 120 In order to successfully challenge the amount payable to the agency, the [Medicaid] recipient must prove, by clear and convincing evidence, that a lesser portion of the total [settlement] 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)

Id.

Pursuant to prevailing law, Villa was obligated to establish as part of his challenge that portion of his recovery that he claimed was attributable to reimbursement by the third-party tortfeasor for both his past and his future medical expenses. Since Villa intentionally introduced no evidence as to the amount recovered for future medical expenses, the ALJ was correct in determining that he

failed to satisfy his burden under section 409.910(17)(b) to avoid application of the statutory formula contained in section 409.910(11)(f).

Moreover, notwithstanding Villa's assertion to the contrary, nothing in section 409.910(11)(f), section 490.910(17)(b), or the ALJ's application of those provisions runs afoul of either federal law or federal or state legal precedent. "Medicaid is a cooperative federal-state welfare program providing medical assistance to needy people." Roberts v. Albertson's Inc., 119 So. 3d 457, 458 (Fla. 4th DCA 2012) (quoting Agency for Health Care Admin. v. Estabrook, 711 So. 2d 161, 163 (Fla. 4th DCA 1998)); see also 42 U.S.C. § 1396a(a)(25)(A)-(B). Although state participation in this federal program is voluntary, once a state elects to participate, it must comply with federal Medicaid law. Roberts, 119 So. 3d at 458; see also Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990).

Federal law requires that participating states seek reimbursement for medical expenses incurred on behalf of Medicaid recipients who later recover from legally liable third parties. This obligation is not, however, unbounded. As Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268, 282 (2006), confirms, these obligations are circumscribed by the anti-lien (and the anti-recovery) provisions of the federal Medicaid Act, which authorize payment to a state only from those portions of a Medicaid recipient's third-party settlement recovery allocated for payment of medical care. See 42 U.S.C. § 1396p(a)(1) (providing that no lien may

be imposed against the property of any individual prior to death on account of medical assistance paid or to be paid on his behalf under a state plan); see also 42 U.S.C. § 1396p(b)(1) (providing no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under a state plan may be made except in limited circumstances).

In Ahlborn, a Medicaid recipient filed a tort suit seeking to recover damages for past and future medical expenses, permanent physical injury, past and future pain and suffering, mental anguish, and lost earnings among other things. The Arkansas state Medicaid agency intervened in the action to assert a lien for the full amount it had paid for Ahlborn's medical care. After the action settled, without the agency's input and without allocation of the damage awards, Ahlborn sought a declaration that satisfaction of the state's lien "would require depletion of compensation for injuries other than past medical expenses." Ahlborn, 547 U.S. at 274. The United States District Court for the Eastern District of Arkansas concluded that Ahlborn had assigned her right to any recovery from third-party tortfeasors to the full extent of Medicaid's payments for her benefit and thus the state Medicaid agency was entitled to recover the full amount of its lien even if that amount exceeded the amount of her recovery for medical care. The Eighth Circuit reversed, holding that the state "was entitled only to that portion of the judgment that represented payments for medical care."

On appeal to the United States Supreme Court, the state’s claim was that it was entitled “to more than just that portion of a judgment or settlement that represents payment for medical expenses.” *Id.* at 278. The Court rejected that claim, concluding first that federal law authorizing the states to seek reimbursement from legally liable third parties for medical assistance to Medicare recipients extended only to the “legal liability of [the] third party . . . *to pay for care and services available under [a state’s Medicaid] plan.*” *Id.* at 280 (citing 42 U.S.C. § 1396a(a)(25)(A)). The Court next concluded that the federal law’s mandate that “that the State must be assigned ‘the rights of [the recipient] to payment by any other party’” sanctioned only “an assignment of rights to payment for [nothing] other than medical expenses—not lost wages, not pain and suffering, not an inheritance.” *Id.* at 281 (citing 42 U.S.C. § 1396a(a)(25)(H)). Finally, the Court found that the requirement in section 1396k(b) of the Medicaid Act, like other provisions of the Medicaid Act relating to recoveries from third-parties, which requires a state to “fully” reimburse Medicaid from any “amount recovered . . . under an assignment” before the remainder is remitted to the Medicaid recipient, “extends only to recovery of payments for medical care,” *Id.* at 282:

Accordingly, what §1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.

Id. at 281 (citing 42 U.S.C. § 1396k(b)) (relating to “where the State actively pursues recovery from the third party”).

None of these determinations, as Villa argues here, “indicate” that a state Medicaid program may recover only from that portion of a Medicaid recipient’s third-party settlement recovery allocated to past medical expenses. Rather, these determinations confirm that a state Medicaid program is to be paid “first” from “any” recovery from a third-party for the “medical care” of a Medicaid recipient before any others may be paid—this would include recovery of amounts allocated to both past and future medical care. In fact, the Court acknowledged that while the anti-lien prohibition of the Medicaid Act appears to ban “even a lien on that portion of the settlement proceeds [from a third-party tortfeasor] that represents payments for medical care,” the Act carves out exceptions where a Medicaid recipient assigns the right or a chose in action to receive payments for medical care or where the recipient “‘assign[s]’ in advance any payments that may constitute reimbursement for medical costs.” Id. at 284. Ahlborn does not, therefore, “indicate” that a Medicaid recipient’s future medical expense recovery may not be considered in determining that recipient’s total recovery for medical expenses when allocating the amount that should be paid to Medicaid under Florida law.

Wos v. E.M.A., --- U.S. ---, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013), does not alter this conclusion. That decision does no more than confirm that a state may not

take any portion of a Medicaid beneficiary's tort settlement not designated as "payments" for medical care and does not attempt to distinguish or address settlement provisions designated as payments for past medical expenses as opposed to payments for future medical care.⁹

Villa points to no Florida decision that has specifically addressed the issue that we address here today, that is, whether amounts allocated for future medical expenses recovered by a Medicaid recipient in a third-party settlement may be considered in a section 409.910(17)(b) challenge to the application of the statutory formula provided in section 409.910(11)(f). Not even Davis v. Roberts, 130 So. 3d 264 (Fla. 5th DCA 2013), on which Villa relies, addresses this issue. Rather, the issue for resolution there was the same issue addressed in Wos as to whether a state Medicaid agency could "recover more than what [the Medicaid recipient's] settlement allocated for past medical expenses." In Davis, AHCA argued, and the trial court agreed, that no legal authority existed to allow Medicaid recipients to

⁹ In Dillard v. Agency For Health Care Administration, 127 So. 3d 820, 821 (Fla. 2d DCA 2013), the court explained:

In Wos, the Court held that an "irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses." 133 S. Ct. at 1399. The Court suggested that a State could remedy this problem by providing a process for determining which portion of the recovery is attributable to medical expenses. Id. at 1401-02.

demonstrate that some amount less than the amount calculated under the statutory formula stated in section 409.910(11)(f) should be allocated as that portion of a settlement available to pay for the recipient's past medical expenses. The District Court of Appeal, without discussing or applying section 409.910(17)(b),¹⁰ determined that a Medicaid recipient "should be afforded the opportunity to seek the reduction of a Medicaid lien amount by demonstrating, with evidence, that the lien amount [established by section 409.910(11)(f)] exceeds the amount recovered for medical expenses." *Id.* at 270 (quoting Smith v. Agency for Health Care Admin., 24 So. 3d 590, 592 (Fla. 5th DCA 2009)). That is now precisely what section 409.910(17)(b) provides and what Villa attempted to prove, albeit unsuccessfully.

In Harrell v. State, 143 So. 3d 478, 480 (Fla. 1st DCA 2014), this court did no more than likewise conclude "we now hold that a plaintiff must be given the opportunity to seek reduction of the amount of a Medicaid lien established by the statutory formula outlined in section 409.910(11)(f), by demonstrating, with evidence, that the lien amount exceeds the amount recovered for medical expenses. When such evidence is introduced, a trial court must consider it in making a determination on whether AHCA's lien amount should be adjusted to be consistent

¹⁰ Section 409.910(17)(b) became effective only four months before Davis was decided and apparently was not in effect at the time of the trial court's ruling in that matter. See Ch. 2013-150, § 2, Laws of Fla. (effective July 1, 2013).

with federal law.” More to the point, at no time did either Davis or Harrell discuss or determine that the amount recovered by the Medicaid recipient for future medical costs or expenses either could or could not be considered in determining whether the amount established by section 409.910(11)(f) exceeds the amount recovered by the Medicaid recipient for medical care.

While it is true that AHCA may only secure payment for the amount it actually expended on Villa’s behalf, that does not mean that it cannot collect that amount from the sums that Villa recovers for both past and future medical expenses. And while we acknowledge that a few post-Ahlborn/Wos decisions have determined that a state Medicaid agency may be paid only from a recipient’s past medical cost award,¹¹ we choose instead to align ourselves with what we believe are the better

¹¹ While several cases conclude any award of future medical expenses cannot be included in that sum available for a state’s lien, they provide little or no support for that proposition. In E.M.A. ex rel. Plyler v. Cansler, 674 F.3d 290, 312 (4th Cir. 2012), the court concluded “[a]s the unanimous Ahlborn Court’s decision makes clear, federal Medicaid law limits a state’s recovery to settlement proceeds that are shown to be properly allocable to past medical expenses.” In In re E.B., 729 S.E.2d 270 (2012), the West Virginia court, adopting Cansler’s view of Ahlborn, concluded that the state’s lien interest in a Medicaid recipient’s lump sum settlement was limited to funds allocated solely to past, not future, medical expenses. However, as the dissent and concurring opinion in E.B. both conclude, the E.B. majority has Ahlborn all wrong—Ahlborn does not say future medical expenses cannot be considered. See In re E.B., 729 S.E.2d at 306 (Ketchum, C.J., dissenting) (“The majority’s holding is the result of an erroneous reading of the United States Supreme Court’s seminal case on this issue, known as Ahlborn. Contrary to the conclusion reached in the majority opinion, Ahlborn clearly held that West Virginia can be reimbursed from any part of a settlement representing damages for medical expenses, past and future.”(footnote giving citation omitted)); see also In re E.B.,

reasoned decisions of those courts which have held that a state agency may secure payment from both past and future recoveries for medical expenses. See In re Matey, 213 P. 3d 389, 394 (Id. 2009) (holding that the state could recover past medical payments from an allocation for future medical care); Cardenas v. Henneberry, 795 F. Supp. 2d 1189, 1197 (D. Colo. 2011) (concluding that because the Medicaid recipient intended to remain on Medicaid, “any funds allocated for future medical expenses should rightfully be exposed to the state’s lien”); see also Special Needs Trust for K.C.S. v. Folkemer, No. 08:10-CV-1077-AW, 2011 WL 1231319, at *12 (D. Md. Mar. 28, 2011) (“The fact that the settlement in this case contained unstipulated amounts that might represent payments for future medical expenses, and the fact that the Department is seeking to recover from this unstipulated amount does not violate the anti-lien provision, especially when Maryland’s recovery statute only allows Maryland to recover the amount that it has spent on past medical care.”).

Finally, we reject Villa’s argument that despite the fact that Villa and AHCA both agreed that Villa’s death had no impact on what the ALJ was to determine, the final order reached the incorrect legal conclusion that Villa’s death, nearly six months after the settlement, affected the analysis of how much of Villa’s settlement

729 S.E.2d at 308 (Workman J., concurring in part, dissenting in part) (“[F]urther examination of Ahlborn and the Fourth Circuit’s treatment thereof in E.M.A. ex rel. Plyler v. Cansler, 674 F.3d 290 (2012), demonstrates the overly restrictive reading the majority undertakes to preclude DHHR from obtaining reimbursement from amounts allocated to future medical expenses.”).

AHCA could recover. While the ALJ did indicate that with the litigation continuing, and Villa having died, a date different from the date of settlement might be applicable, a careful reading of the final order demonstrates that the ALJ's decision is premised on a total failure of proof, rather than the choice of dates on which calculations should have been based. Thus, we find no error meriting reversal in this regard.

As previously stated, “Medicaid is a cooperative federal-state welfare program providing medical assistance to needy people.” Roberts, 119 So. 3d at 458 (quoting Agency for Health Care Admin. v. Estabrook, 711 So. 2d 161, 163 (Fla. 4th DCA 1998)). To keep the Medicaid program viable, Congress recognized that it is necessary to obtain reimbursement when a third party makes payment to the Medicaid beneficiary for medical care already paid for by Medicaid. Roberts, 119 So. 3d at 459. As Roberts explains, the goal of the reimbursement provision of the Medicaid Act was at least in part to protect tax dollars. 119 So. 3d at 459 (citing Tristani v. Richman, 652 F.3d 360, 373 (3d Cir. 2011)). This, no doubt, is at least in part so that other “needy people” may secure the care they so desperately require. Writing on what we conclude as a nearly blank slate on this issue, we conclude the best way to satisfy that goal is to read section 409.910(17)(b) as meaning exactly what it says—that “[i]n order to successfully challenge the amount payable to the agency, the [Medicaid] recipient must prove, by clear and convincing

evidence, that a lesser portion of the total [settlement] 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)” (Emphasis added).

The order under review is, therefore, affirmed.

LEWIS and ROWE, JJ., CONCUR.

**IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT OF FLORIDA**

MARIA ISABEL GIRALDO
and JUAN GONZALO VILLA,
as co-personal representatives of
the estate of JUAN L. VILLA,

Appellant,

Case No. 1D16-0392

v.

L.T. Case No. 15-4423MTR

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Appellee.

_____ /

APPELLANTS' UNOPPOSED REQUEST FOR JUDICIAL NOTICE

Appellants, Maria Isabel Giraldo and Juan Gonzalo Villa, as co-personal representatives of the estate of Juan L. Villa, request this Court to take judicial notice of the following documents and as grounds therefore state:

1. This case centers on the partial settlement of a tort lawsuit brought by Juan Villa for injuries he sustained in an accident. Appellee, Florida's Agency for Healthcare Administration ("AHCA"), paid for portions of Juan's medical care after the accident. One of the questions before this Court is from what source AHCA can seek reimbursement for those payments. AHCA argues that it can seek reimbursement from both the portion of the settlement intended as compensation for past (already paid-for) medical expenses and the portion intended as compensation for future

medical expenses. Appellants argue that federal Medicaid law limits AHCA to seeking reimbursement only from the portion of the settlement intended as compensation for past medical expenses.

2. This Court has adjudicated that dispute at least once before, in *Harrell v. State of Florida, Agency for Health Care Administration*, Case No. 1D12-5597 (Fla. 1st DCA). As in this case, AHCA was also the appellee in *Harrell*. AHCA argued, in a tipsy-coachman posture, to the *Harrell* court that AHCA could recover from the both portion of the settlement that is intended as compensation for past medical expenses and the portion intended as compensation for future medical expenses (the same argument AHCA makes in this case).

3. Since the *Harrell* case was reversed and remanded, the *Harrell* court necessarily rejected AHCA's tipsy-coachman argument. But, while the *Harrell* opinion touches on the substance of the issue, it does not make clear that it is doing so in order to reject AHCA's argument. However, this Court's rejection of AHCA's argument is indisputable if one reviews the *Harrell* briefs. Hence, the request for judicial notice.

4. In *Gulf Coast Home Health Services of Florida v. Department of Health and Rehabilitative Services*, 503 So. 2d 415 (Fla. 1st DCA 1987), this Court held that it is "altogether appropriate for the appellate court to take judicial notice of the existence of other cases, either pending or closed, which bear a relationship to the case at bar"

and that the “notice may include, at minimum, the identity of the parties and their counsel, [and] issues presented in the briefs....” *Id.* at 417. This Court explained that failure to take judicial notice of such items “would handicap the court with a tunnel vision that could lead to inconsistent results in some instances and would simply waste judicial resources in others.” *Id.*

5. To avoid any chance that this Court’s decision could be inconsistent with the opinion in *Harrell*, and to aid this Court in its disposition of this case, Appellants request that this Court take judicial notice of the Initial, Answer and Reply briefs filed in *Harrell v. State of Florida, Agency for Health Care Administration*, Case No. 1D12-5597 (Fla. 1st DCA) (attached as **Exhibits A, B, and C**). Specifically, Appellants request that the Court take judicial notice of the issues raised by AHCA in the *Harrell* Answer Brief (which spent 8 pages on the precise issue raised in the instant appeal) and the response to those arguments in the Reply Brief (which spent 9 pages addressing the issue).

6. Undersigned counsel has conferred with counsel for Appellee and represents that Appellee does not oppose this motion.

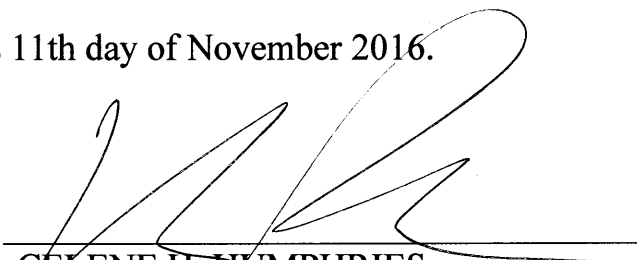
WHEREFORE, Appellants, Maria Isabel Giraldo and Juan Gonzalo Villa, as co-personal representatives of the estate of Juan L. Villa, respectfully request this Court to take judicial notice of, at a minimum, the parties and the issues raised in the Initial, Answer, and Reply briefs in *Harrell v. State of Florida, Agency for Health Care*

Administration, Case No. 1D12-5597 (Fla. 1st DCA) (attached as **Exhibits A, B, and C**).

CERTIFICATE OF SERVICE

I HERBY CERTIFY that a true and correct copy of the foregoing has been furnished by email to Alexander R. Boler (alexander.boler@xerox.com; fltpllegal@xerox.com), Xerox Recovery Services, Inc., 2073 Summit Lake Drive, Suite 300, Tallahassee, Florida 32317 this 11th day of November 2016.

FLOYD FAGLIE
Florida Bar No. 0569690
faglielaw@earthlink.net
STAUNTON & FAGLIE, PL
189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
Fax: (850) 997-6301



CELENE H. HUMPHRIES
Florida Bar: 884881
chumphries@bhappeals.com
MAEGEN P. LUKA
Florida Bar: 549851
mluka@bhappeals.com
BRANNOCK & HUMPHRIES
1111 W. Cass Street, Suite 200
Tampa, Florida 33606
Tel: (813) 223-4300
Fax: (813) 262-0604

Attorneys for Appellant

**IN THE DISTRICT COURT OF APPEAL
FOR THE FIRST DISTRICT
STATE OF FLORIDA**

**KAITLYN HARRELL, a minor, individually and
through her natural parents and guardians,
JOY D. HARRELL and GREG A. HARRELL,
husband and wife, and JOY D. HARRELL and
GREG A. HARRELL, individually,**

Appellant,

v.

D.C.A. Case No.: 1D12-5597

L.T. Case No.: 02003998CA

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION**

Appellee.

_____ /

ON APPEAL FROM THE CIRCUIT COURT OF THE FOURTEENTH
JUDICIAL CIRCUIT IN AND FOR BAY COUNTY, FLORIDA

INITIAL BRIEF OF THE APPELLANT

FLOYD FAGLIE
Florida Bar No.: 0569690
Staunton & Faglie, PL
189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
faglielaw@earthlink.net

ATTORNEY FOR APPELLANT

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STATEMENT OF THE CASE AND FACTS

On March 20, 2000, Joy D. Harrell gave birth to her daughter Kaitlyn Harrell (“Kaitlyn”). (R.159-60) There were severe complications during the birthing process. *Id.* As a result of these complications, Kaitlyn was born in complete respiratory and circulatory arrest. *Id.* Resuscitation efforts were started upon delivery including an unsuccessful initial intubation. *Id.* Kaitlyn was eventually resuscitated. *Id.*

During delivery and afterwards, Kaitlyn’s brain was deprived of oxygen leaving Kaitlyn with catastrophic injuries. *Id.*

As a result of these catastrophic injuries, Kaitlyn has anoxic encephalopathy, spastic quadriplegia, cerebral palsy, mental retardation, a seizure disorder, and remains aphasic. *Id.* She crawls minimally and is unable to walk. *Id.* She suffers from severe speech, language, and fine gross motor impairments. *Id.* She has poor head, neck and trunk control. *Id.* She is confined to a wheelchair and unable to sit. *Id.* She is unable to eat, toilet, or care for herself in any manner. *Id.*

As a result of these injuries, Kaitlyn suffered both non-economic and economic damages including, past and future pain and suffering, mental anguish, disfigurement, permanent disability, loss of capacity of enjoyment of life, past and future medical expenses, and loss of earning capacity and ability to earn money in the future. *Id.* The total monetary value of all Kaitlyn’s damages and the amount a

jury may award in damages (absent any limiting factors such as, disputed facts, causation, liability, insurance policy limits, or insolvency of the parties, etc.) is exceedingly high, even under the most conservative valuations.

Kaitlyn's medical expenses related to her injury had been paid in part by the Medicaid program. *Id.* Medicaid had provided \$360,741.48 in relation to Kaitlyn's care, and this amount represented Kaitlyn's claim for past medical expenses paid by Medicaid.

As a result of Kaitlyn's injuries, her parents, Joy D. Harrell and Gregg A Harrell, also suffered non-economic and economic damages associated with Kaitlyn's injuries, including their cost in caring for Kaitlyn, their mental pain and suffering, and their loss of support and companionship of Kaitlyn. (R.1-20)

In 2002, Kaitlyn's parents on their own behalf, and on behalf of Kaitlyn, brought a medical malpractice action to recover all of Kaitlyn's damages, as well as their individual damages resulting from Kaitlyn's injuries. (R.1-20)

The Defendants in this medical malpractice action vigorously contested liability and causation. Eventually after nine years of litigation, the case went to jury trial. (R441) Prior to the jury returning a verdict, the Defendants while denying any liability, made a confidential settlement offer to compromise all damages. (R.441, 476) This confidential settlement offer was accepted by the

parents in compromise of all damages sought, despite the fact that the settlement was far less than the total monetary value of all damages suffered.

Pursuant to 42 U.S.C. §1396a(A)(25)(A, B, & H), 42 U.S.C. §1396k, and section 409.910(6)(b), Florida Statutesⁱ, as a condition of eligibility for Medicaid benefits, Kaitlyn assigned to the Agency for Health Care Administration (“AHCA” or “Agency”) her right to recover the \$360,741.48 in medical expenses paid by Medicaid from the Defendants. AHCA through its collections contractor ACS / Xerox Recovery Services Group, asserted a \$360,741.48 Medicaid lien against Kaitlyn’s settlement.

Kaitlyn through her parents filed a Petition to Determine Medicaid Lien. (R.158-73) Kaitlyn maintained that since the settlement was in compromise of all damages and did not fully compensate her for all her damages, she had not recovered her entire claim for the \$360,741.48 in past medical expenses paid by Medicaid.

Kaitlyn acknowledged that if the statutory formula at section 409.910(11)(f), Florida Statutes, was applied to her settlement, she would be required to pay the entire \$360,741.48 Medicaid lien. However, Kaitlyn maintained that application of the Florida statutory formula to dictate payment of the full lien would be in violation of federal law as interpreted by the U.S. Supreme Court in *Ark. Dept. of*

ⁱ All references herein to Section 409.910, Florida Statutes, are reference to the 2010 version of the statute, which is the version in effect when the case settled.

Health and Human Services v. Ahlborn, 547 U.S. 268 (2006). She argued that under federal law as interpreted by *Ahlborn*, AHCA may only assert a lien against, and recover from, the portion of her settlement representing her compensation for her claim for past medical expenses paid by Medicaid. Kaitlyn maintained that application of the Florida statutory formula to her settlement would result in AHCA recovering from portions of her settlement not compensating her for her claim for past medical expenses paid by Medicaid, which is a result prohibited by federal law and *Ahlborn*.

Kaitlyn requested the court to determine the process of determining the Medicaid lien reduction, determine the portion of the settlement which the Medicaid lien attaches, and determine the proper payment of the lien. (R.164) To facilitate this request, Kaitlyn asked the court to bifurcate the process by having a hearing initially focused on the legal issues and then to have an evidentiary hearing to determine the lien reduction. (R.163)

AHCA filed an Amended Response to Plaintiffs' Petition to Determine Medicaid Lien. (R.202-333) AHCA's position was simply that the formula at section 409.910(11)(f), Florida Statutes, was the mandatory method of determining AHCA's payment, every Florida District Court to have considered federal law and *Ahlborn* had upheld the mandatory use of the formula, and the court must "deny Plaintiffs' Petition and order the Medicaid claim to be paid pursuant to the formula

set forth in section 409.910(11)(f), Florida Statutes.” (R. 206) In this regard, AHCA asserted that:

“3. Plaintiffs argue that *Ahlborn*, when pared with several non-binding out-of-state cases, somehow allows for the displacement of the statutory-mandated method of determining Medicaid liens. Plaintiffs make such assertion notwithstanding the **determinative fact that various Florida District Courts of Appeal (“DCAs”) — including our own 1st DCA — have considered whether Florida’s Act was somehow invalidated by *Ahlborn*, and every one of these DCAs declined to strike or in any way invalidate Florida’s Act.**

4. Section 409.910, Florida Statutes, contains a formula at paragraph (11)(f). Section 409.910(11)(f) states that the amount of the Agency’s reimbursement from a given Medicaid recipient’s settlement “shall” be determined by such formula. **The application of such formula to the facts in the instant matter — due to the fact that the settlement so dwarfs the amount of the Medicaid benefits paid — results in a mandatory reimbursement of \$360,741.48 to the public treasury.**”

(R. 203)(emphasis in original).

AHCA was emphatic that section 409.910(11)(f) was the mandatory method of determining its payment and that nothing in the Supreme Court’s decision in *Ahlborn* indicated otherwise. *Id.*

Although on October 18, 2013 the trial court conducted a hearing on Kaitlyn’s Petition and AHCA’s Amended Response, the court refused to consider any of the evidence presented. (R.438-80) Instead, the trial court agreed with AHCA’s argument that section 409.910(11)(f) was the mandatory method of determining AHCA’s payment and the Florida appellate courts had upheld the use of this statutory formula even in light of the *Ahlborn* decision. The Court did not

consider the evidence presented, instead finding that it was bound to follow the formula at section 409.910(11)(f) to determine AHCA's payment. In this regard, the Court began the hearing by stating:

“THE COURT: I have read your petition, I have read his response. As I understand the state of the law is -- is it Stellard or Stallard?

MR. STALLARD: Stallard, Your Honor.

THE COURT: What Mr. Stallard has presented in his response is that currently the decisions in Florida that are binding, on this court support his position that the agency is entitled to the full amount of their lien.

MR. STALLARD: That is correct.

THE COURT: That there are cases pending, and apparently there is something that a cert has been granted to -- is that the United States Supreme Court?

MR. STALLARD: Yes, Your Honor.

THE COURT: That might change things if a decision were rendered that would be binding on the Florida courts, but at this juncture at least, this court is obligated to render a decision in favor of the Agency for Health Care Administration for the full amount of its lien.”

(R. 444).

Consistent with the Court's opening remarks, the Court concluded the hearing by acknowledging that it was not going to consider the evidence presented because it was bound to follow the statutory formula at section 409.910(11)(f), Florida Statutes, to determine AHCA's payment. In this regard, the Court stated:

“THE COURT: ... So the question was, was there any argument to be made as to the amount of that lien and that is what triggered, I suppose, this hearing today. But if the court had the ability to – legally to consider the testimony of Mr. Collis and go through the analysis, it would be incumbent on me to do it, but my reading of the Florida statute and the District Court of Appeals decisions construing that statute, which are binding on this court, is there is no need to engage in that type of analysis, it's simply to follow the formula that is laid out in the statute.”

(R. 477).

On October 22, 2012, the trial court entered its “Order on Plaintiffs’ Petition To Determine Medicaid Lien,” which memorialized its ruling from the bench of October 18, 2012. (R.355-56) The Order stated:

“The issue before the Court was how much the Agency was due to be reimbursed from the settlement in this matter.

The Plaintiffs and the Agency agreed that if the Medicaid reimbursement formula at Section 409.910(11)(f), Florida Statutes, were to be applied the Agency would be due \$360,741.48 in satisfaction of its Medicaid reimbursement claim. The Plaintiffs and the Agency disagreed, however, on whether Section 409.910(11)(f), Florida Statutes, should be applied.

Plaintiffs asserted that Section 409.910, Florida Statutes, could not be reconciled with the United States Supreme Court’s decision in *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) (“*Ahlborn*”). This Court’s review of the applicable District Courts of Appeals’ (“DCA”) case law, however, revealed that the DCAs of this State have invariably upheld Section 409.910, Florida Statutes, amidst arguments that such statute cannot be reconciled with *Ahlborn*. As such, this Court is bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency’s reimbursement. Accordingly, the Plaintiffs shall pay the Agency \$360,741.48 in satisfaction of the Agency’s Medicaid reimbursement claim, within 30 days of the entry of this Order.”

(R.355-56)

Kaitlyn timely filed a Notice of Appeal of the trial court’s Order on Plaintiffs’ Petition to Determine Medicaid Lien. (R.359-62)

Kaitlyn filed a Motion to Stay Order on Plaintiffs’ Petition to Determine Medicaid Lien, Dated October 22, 2012 requesting the trial court to permit her attorneys to hold in either their law firm trust account or in an interest bearing

account, the full lien amount pending this Court's resolution of the appeal. (R.364-78) AHCA and its collections contractor, Xerox Recovery Services Group, filed a Response in opposition to Kaitlyn's Motion to Stay, demanding immediate payment of the lien. (R.379-429) At hearing on January 10, 2013, the trial court denied Kaitlyn's Motion to Stay. Immediately thereafter, Kaitlyn paid \$360,741.48 to AHCA / Xerox Recovery Services Group.

SUMMARY OF THE ARGUMENT

The trial court erred in determining that it was "bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency's reimbursement" (R.355-56), instead of considering the evidence to limit the Medicaid lien to the amount of the settlement compensating Kaitlyn for her claim for past medical expenses paid by Medicaid.

The question presented in Kaitlyn's appeal is whether, in light of the U.S. Supreme Court's holding in *Ahlborn*, the statutory formula at section 409.910(11)(f), Florida Statutes, may be used to dictate the amount of Kaitlyn's settlement AHCA may recover, or whether Kaitlyn may present evidence as to the amount of her settlement compensating her for her claim for past medical expenses paid by Medicaid and have the trial court determine the proper payment of the lien.

After Kaitlyn filed this appeal, the U.S. Supreme Court unequivocally resolved the question presented in Kaitlyn's appeal in *Wos v. E.M.A.*, 133 S.Ct.

1391 (U.S. Mar. 20, 2013). In *Wos*, the U.S. Supreme Court held that State statutory formulas dictating payment of a Medicaid lien are preempted by federal Medicaid law, to the extent that the statutory formula can be interpreted as creating an irrebuttable presumption that a fixed percentage of a recipient's tort recovery represents compensation for medical expenses paid by Medicaid. The *Wos* Court explained that, "[a]n irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the portion that is attributable to medical expenses" paid by Medicaid. *Id.* at 1399. The *Wos* Court explained that the reasoning of *Ahlborn* and the design of the federal statute contemplate (like in Kaitlyn's case) the possibility that a Medicaid recipient's settlement may not contain an allocation between various elements of damage. *Id.* The Court outlined that "when a State and the beneficiary are unable to agree on an allocation, *Ahlborn* noted, the parties could "*submit the matter to a court for decision*" *id.* at 1397, 1399. Under *Wos*, a Medicaid recipient must be permitted to contest the application of the statutory formula and present evidence to have the Court determine the proper payment of the Medicaid lien.

The North Carolina statutory formula struck by the *Wos* Court is “nearly identical”ⁱⁱ to Florida’s statutory formula at section 409.910(11)(f). Under *Wos*, applying the statutory formula at section 409.910(11)(f) to dictate AHCA’s payment and foreclosing the trial court from considering evidence to determine the proper payment of the lien is a violation of federal law. *Wos* makes clear that in the instant case, the trial court erred in determining that it was “bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency’s reimbursement” (R.355-56) and that it lacked “the ability to – legally to consider” the evidence and determine the proper payment of the lien. (R.477)

Further, since the trial court’s October 22, 2012 Order, based on recent federal court precedent including *Wos*, Florida’s District Court of Appeals have begun rectifying erroneous prior determinations that the statutory formula at section 409.910(11)(f) dictates AHCA’s payment and a trial court may not limit the Medicaid lien by considering evidence as to the amount of the settlement

ⁱⁱ The underlying federal trial court in *Wos* acknowledged that Florida’s statutory formula at §409.910(11)(f), Fla. Stat., was “nearly identical” to the North Carolina one-third statutory formula and noted that NC’s Medicaid statutory formula was “actually more protective of plaintiff’s than the Florida statute affirmed as consistent with *Ahlborn*” by the Florida 2DCA in *Russell v. Agency for Health Care Admin.*, 23 So.3d 1266 (Fla. 2nd DCA 2010). *Armstrong v. Cansler*, 722 F.Supp.2d 653, 658 (2010); *reversed by*, *E.M.A. v. Cansler*, 674 F.3d 290 (U.S. 4th Cir. 2012); *affirmed Wos v. E.M.A.*, 133 S.Ct. 1391 (U.S. 2013). The Florida Second District has abrogated as incorrect law post-*Wos*, the *Russell* decision cited in *Armstrong* and *Cansler*. See *Agency for Health Care Admin. v. Riley*, -- So. 3d --, 2013 WL 4080999 (Fla. 2d DCA Aug. 14, 2013).

compensating for past medical expenses paid by Medicaid. See *Roberts v. Albertsons*, -- So. 3d --, 2012 WL 5232182 (Fla. 4th DCA Oct. 24, 2012) and *Agency for Health Care Admin. v. Riley*, -- So. 3d --, 2013 WL 4080999 (Fla. 2d DCA Aug. 14, 2013)(abrogating *Russell v. Agency for Health Care Admin.*, 23 So. 3d 1266 (Fla. 2d DCA 2010) as incorrect law post-*Wos*). In both *Roberts* and *Riley*, the District Courts determine that while the statutory formula at section 409.910(11)(f) may provide a default allocation of a settlement, a Medicaid recipient, such as Kaitlyn, must be afforded the opportunity to contest the application of the formula and have the court consider evidence to determine the proper payment of the Medicaid lien.

Under *Wos*, *Roberts*, and *Riley*, it was error for the trial court to refuse to consider evidence as to the proper payment of the lien and determine that it was “bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency’s reimbursement.” This Court should follow the controlling precedent of the U.S. Supreme Court, as well as, the decisions of *Roberts* and *Riley*, and reverse the trial court’s Order and remand the matter back to the trial court for evidentiary hearing. This would allow the trial court to do what it said at hearing it could not (R.477), which is to have the “ability to – legally to consider” evidence and “go through the analysis” to determine the proper payment of the Medicaid lien from Kaitlyn’s settlement.

ARGUMENT

THE TRIAL COURT ERRED IN REFUSING TO CONSIDER EVIDENCE AS TO THE PROPER PAYMENT OF THE MEDICAID LIEN, INSTEAD, INCORRECTLY DETERMINING THAT IT WAS BOUND TO APPLY THE FORMULA AT SECTION 409.910(11)(f) TO DETERMINE THE AGENCY’S REIMBURSEMENT

STANDARD OF REVIEW

The trial court’s legal determination regarding section 409.910 is reviewed *de novo*. See *State, Agency for Health Care Admin. v. Wilson*, 782 So. 2d 977, 978 (Fla. 1st DCA 2001)(citing *Dixon v. City of Jacksonville*, 774 So. 2d 763, 765 (Fla. 1st DCA 2000)).

A. The Federal Third-Party Liability Statutes

States participating in the federal-state cooperative Medicaid Program must comply with federal Medicaid statutes and regulations. See *Wilder v. Virginia Hosp. Assn.*, 496 U.S. 498, 501 (U.S. 1990). Title XIX of the Social Security Act, requires that the State agency administering the Medicaid plan must ascertain the legal liability of third parties to pay for care and services provided by Medicaid and “in any case where such a legal liability is found to exist after medical assistance has been made available... the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.” 42 U.S.C. §1396a(A)(25)(A & B). Every State participating in the Medicaid Program must

have, “in effect laws under which, 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).

While the State after providing Medicaid benefits, must seek reimbursement by acquiring the rights of the Medicaid recipient to recover from liable third-parties “such health care items or services” paid by Medicaid, there are limitations on the State’s recovery that protect the Medicaid recipient’s property. Specifically, the federal anti-lien statute at 42 U.S.C. §1396p(a)(1) states “[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid,” and the federal anti-recovery statute at §1396p(b)(1) states “[n]o adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made.”

All States have elected to participate in the Medicaid program and all States have enacted statutes authorizing recovery from Medicaid recipient’s tort recoveries. Florida’s Medicaid recovery statute is found at section 409.910, Florida Statutes.

The above referenced federal statutes were reviewed by the U.S. Supreme Court in *Ahlborn* and recently in *Wos*. The U.S. Supreme Court has determined

that these federal statutes preempt State statutes which authorize the State to recover more than the portion of the Medicaid recipient's settlement representing compensation for past medical expenses paid by Medicaid. States may only assert a lien against, and seek recovery from, the portion of a Medicaid recipient's settlement representing compensation for past medical expenses paid by Medicaid.

B. Ark. Dept. of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006)

In *Ahlborn*, Ms. Ahlborn settled a personal injury claim for \$550,000. Arkansas Medicaid asserted a \$215,645.50 Medicaid lien against Ms. Ahlborn's \$550,000 lump-sum unallocated settlement. Ms. Ahlborn refused to satisfy the lien from her entire settlement, arguing that the federal law that authorizes States to enact statutes to seek recovery from Medicaid recipient's settlements did not authorize Medicaid to seek recovery from her entire settlement, but instead only authorized Medicaid to seek recovery from the portion of her settlement compensating her for past medical expenses. Ms. Ahlborn filed a federal action seeking, "a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses." *Ahlborn*, 547 U.S. at 274.

After filing the declaratory action, Ms. Ahlborn and Arkansas entered into a stipulation, as to what portion of Ms. Ahlborn's settlement represented past

medical expenses. They calculated that Ms. Ahlborn had suffered \$3.04 million in damages, of which \$215,645.50 (the Medicaid lien amount) was for past medical expenses paid by Medicaid. She had received about 1/6 of the total monetary value of all her damages in the \$550,000 settlement (\$550,000 is 1/6 of \$3.04 million), and thus, she only received 1/6 of her claim for past medical expenses in the \$550,000 settlement, or \$35,581.47 (1/6 of \$215,645.50 is \$35,581.47).

The U.S. Supreme Court reviewed Arkansas' Medicaid recovery statute and determined that it required Ms. Ahlborn to assign to the State her entire cause of action and provided Arkansas a lien against Ms. Ahlborn's entire settlement, not just the portion of the settlement compensating her for past medical expenses. The question for the Court was whether the federal third-party liability statutes authorized States to require an assignment of a Medicaid recipient's entire cause of action and whether federal law limited States to recover from only the portion of a Medicaid recipient's settlement representing past medical expenses. In answering this question, the Court stated:

“[T]he text of the federal third-party liability provisions... focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, “assign the State any rights ...*to payment for medical care* from any third party,” 42 U.S.C. §1396k(a)(1)(A), not rights to payment for, for example, lost wages... ADHS points to §1396a(a)(25)(B)'s requirement that States “seek reimbursement for {medical} assistance *to the extent of such legal liability*” and suggests that this means that the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, “such legal

liability” refers to “the legal liability of third parties ...*to pay for care and services available under the plan.*” §1396a(a)(25)(A). Here, the tortfeasor has accepted liability for only one-sixth of the recipient’s overall damages, and ADHS has stipulated that only \$35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant “liability” extends no further than that amount... [§1396a(a)(25)(H)] makes clear that the State must be assigned “the rights of [the recipient] to payment by any other party *for such health care items or services.*” Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses - not lost wages, not pain and suffering, not an inheritance.”

Id. 547 U.S. at 280 - 81 (emphasis in original)

After determining that federal law only authorized a limited assignment to the State of the Medicaid recipient’s right to recover from liable third-parties past medical expenses paid by Medicaid, the Court reviewed the federal anti-lien statute at 42 U.S.C. §1396p(a), which prohibits the assertion of a lien against Medicaid recipient’s property. Based on the assumption that the required assignment of Ms. Ahlborn’s right to recover past medical expenses paid by Medicaid was a limited exception to the federal anti-lien statute, the Court held that the federal anti-lien statute would affirmatively prohibit a State from asserting a lien against any portion of a settlement not representing compensation for past medical expenses paid by Medicaid.

At the end of the day, the Court held that federal law prohibited States from asserting a lien against, and seeking recovery from, a Medicaid recipient’s entire settlement, because the portion of the settlement not

representing compensation for past medical expenses paid by Medicaid was the unassigned individual property of the Medicaid recipient. Instead, federal law only allowed a State to seek recovery from the portion of the settlement representing compensation for past medical expenses paid by Medicaid, because the Medicaid recipient's right to recover from a liable third-party these past medical expenses paid by Medicaid was the only right assigned to the State.

The Court stated that “third-party liability provisions are unenforceable insofar as they compel a different conclusion.” *Id.* 547 U.S. at 292.

The Court in applying this rule of law held that Arkansas Medicaid was only allowed to recover from the 1/6 of Ms. Ahlborn's \$215,645.50 claim for past medical expenses Ms. Ahlborn actually recovered in the settlement.

C. Wos v. E.M.A., 133 S.Ct. 1391 (U.S. Mar. 20, 2013)

In *Wos*, the U.S. Supreme Court held that the federal anti-lien statute preempted State laws and prohibited a State from using a statutory formula to create a conclusive presumption that a fixed percentage of a Medicaid recipient's settlement represents compensation for past medical expenses paid by Medicaid.

E.M.A. suffered serious injuries at birth which left her deaf, blind, and unable to sit, walk, crawl, or talk. *Id.*, 133 S.Ct. at 1395. A medical malpractice

lawsuit was brought to recover E.M.A.'s damages, as well as her parent's damages associated with E.M.A.'s injuries. *Id.* E.M.A.'s experts estimated that E.M.A.'s medical and life care expenses, loss of future earning capacity and other assorted expenses totaled \$42 million. *Id.* North Carolina Medicaid paid \$1.9 million in benefits related to E.M.A.'s care and asserted a lien in this amount. *Id.*

In November 2006 the Court approved a settlement of E.M.A.'s case for \$2.8 million. *Id.* The settlement did not make an allocation between E.M.A.'s various claims for damage. *Id.* North Carolina Medicaid demanded payment of one-third of the settlement because North Carolina's Medicaid statute stated that North Carolina was entitled to the lesser of either the full payment of its lien or one-third of a judgment or settlement. *Id.*

E.M.A. filed a federal action for declaratory and injunctive relief arguing that federal law as interpreted in *Ahlborn* limited North Carolina to the portion of the settlement representing compensation for medical expenses and the statutory mandated one-third payment to North Carolina violated federal Medicaid law. *Id.* at 1396.

During the pendency of E.M.A.'s action, the North Carolina Supreme Court held that North Carolina's irrebuttable statutory presumption that one-third of a Medicaid recipient's tort recovery is attributable to past medical expenses was permitted under *Ahlborn*. See *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008).

Based on *Andrews*,ⁱⁱⁱ the District Court rejected E.M.A.’s argument and ordered payment of one-third of the settlement to North Carolina Medicaid. See *Armstrong v. Cansler*, 722 F.Supp.2d 653 (W.D. N.C. 2010).

The U.S. Fourth Circuit Court of Appeals in *E.M.A. v. Cansler*, 674 F.3d 290 (U.S. 4th Cir. 2012) reversed and remanded. The Fourth Circuit acknowledged that the North Carolina Supreme Court in *Andrews* held that the one-third statutory allocation was in keeping with Ahlborn, but stated that nothing in the Ahlborn opinion supported such a “crabbed application” of the *Ahlborn* decision. *Id.*, 674 F.3d at 307. The Fourth Circuit stated:

“*Ahlborn* is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care already received. The North Carolina statute’s one-third cap on the state’s recovery against a Medicaid recipient’s settlement proceeds does not satisfy *Ahlborn* insofar as it permits DHHS to assert a lien against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims.”

674 F.3d at 307.

ⁱⁱⁱThe *Armstrong* Court also cited the Florida Second District’s decision in *Russell v. Agency for Health Care Admin.*, 23 So.3d 1266 (Fla. 2nd DCA 2010) in support of its decision. The *Armstrong* Court noted that the *Russell* Court had upheld as in compliance with *Ahlborn*, a Florida statutory formula (§409.910(11)(f), Fla. Stat.) which is “**nearly identical**” to NC’s Medicaid statute and that NC’s Medicaid statutory formula was “*actually more protective of plaintiff’s than the Florida statute affirmed as consistent with Ahlborn*” by the Florida Second District. See *Armstrong*, 722 F.Supp.2d at 658. As stated in Footnote 1 herein, the Second District has abrogated *Russell* as incorrect law post-Wos. See *Agency for Health Care Admin. v. Riley*, -- S.3d --, 2013 WL 4080999 (Fla. 2d DCA 2013).

“As the unanimous *Ahlborn* Court’s decision makes clear, federal Medicaid law limits a state’s recovery to settlement proceeds that are shown to be properly allocable to past medical expenses. In the event of an unallocated lump-sum settlement exceeding the amount of the state’s Medicaid expenditures, as in this case, the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption in favor of the state that allocation of one-third of a lump sum settlement is consistent with the anti-lien provision in federal law.”

674 F.3d at 312.

After rejecting North Carolina’s mandatory one-third statutory payment, the Fourth Circuit remanded the case back to the trial court for an allocation of the settlement. However, North Carolina Medicaid appealed the decision to the U.S. Supreme Court.

The U.S. Supreme Court in *Wos* affirmed the Fourth Circuit’s *E.M.A.* decision and abrogated the North Carolina Supreme Court’s decision in *Andrews*. The Court held that the federal anti-lien statute preempted State statutes, and it was a violation of the anti-lien statute for a State to have a statutory irrebuttable presumption that a fixed percentage of a settlement represents compensation for medical expenses. The Court outlined that the reasoning of *Ahlborn* and the design of the federal statute contemplate the possibility that a Medicaid recipient’s settlement may not contain an allocation between various elements of damage. *Id.*, 133 S.Ct. at 1399. The Court stated that “when a State and the beneficiary are unable to agree on an allocation, *Ahlborn* noted, the parties could “submit the

*matter to a court for decision,” Ahlborn at 288” 133 S.Ct. at 1397, 1399 (emphasis in original). The *Wos* Court proceeded to outline that, “[a]n irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act’s clear mandate that a State may not demand any portion of a beneficiary’s tort recovery except the portion that is attributable to medical expenses” paid by Medicaid. *Id.**

The *Wos* Court held that North Carolina’s statutory irrebuttable one-third entitlement (which is “**nearly identical**”^{iv} to Florida’s statutory formula at §409.910(11)(f), Fla. Stat.) was a violation of federal law as interpreted by *Ahlborn*. A Medicaid recipient must be permitted to contest the application of the statutory formula and present evidence as to the amount of the settlement compensating for past medical expenses paid by Medicaid in order to have the court limit the Medicaid lien.

Under *Wos*, the statutory formula at §409.910(11)(f), Fla. Stat., may not be used to dictate AHCA’s payment from Kaitlyn’s settlement. The trial court must be allowed to consider evidence as to the amount of Kaitlyn’s settlement representing compensation for her claim for past medical expenses paid by Medicaid and limit AHCA to that amount.

^{iv} As stated in Footnote 2 & 3 herein, the underlying federal trial court in *Wos*, identified Florida’s statutory formula at §409.910(11)(f), Fla.Stat., as “nearly identical” to North Carolina’s statutory formula.

The *Wos* decision makes perfectly clear that the trial court in Kaitlyn’s case erred in refusing to consider evidence, instead determining that it was “bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency’s reimbursement.” (R.355-56) Under *Wos*, the trial court must be allowed to do exactly what at hearing it said it could not do (R.477), which is to have the “ability to – legally to consider” evidence and “go through the analysis” to determine the proper payment of the Medicaid lien from Kaitlyn’s settlement. Reversal and remand is required under the binding precedent of the U.S. Supreme Court’s decision in *Wos*.

D. The Recent Florida Appellate Decisions Support Reversal and Remand of the Order on Appeal

Since the trial court’s October 22, 2012 Order, Florida’s District Court of Appeals have begun rectifying erroneous prior determinations that the statutory formula at section 409.910(11)(f) dictates AHCA’s payment and a trial court may not limit the Medicaid lien by considering evidence as to the amount of the settlement compensating for the claim for past medical expenses paid by Medicaid. See *Roberts v. Albertsons*, -- So. 3d --, 2012 WL 5232182 (Fla. 4th DCA Oct. 24, 2012) and *Agency for Health Care Admin. v. Riley*, --So. 3d--, 2013 WL 4080999 (Fla. 2d DCA Aug. 14, 2013)(abrogating *Russell v. Agency for Health Care*

Admin., 23 So. 3d 1266 (Fla. 2d DCA 2010) as incorrect law post-*Wos*). In both *Roberts* and *Riley*, the District Courts determine that while the statutory formula at section 409.910(11)(f) may provide a default allocation of a settlement, a Medicaid recipient, such as Kaitlyn, must be afforded the opportunity to contest the application of the formula and have the court consider evidence to determine the proper payment of the Medicaid lien. Both *Roberts* and *Riley* support reversal of the trial court's Order and remand for further proceedings.

After *Ahlborn*, but before the Fourth Circuit Court of Appeal's *E.M.A.* decision and the U.S. Supreme Court's *Wos* decision, there were three opinions issued by Florida appellate courts concerning application of *Ahlborn* to Florida Medicaid liens. See *Garcon v. Agency for Health Care Admin.*, 96 So. 3d 472 (Fla. 3d DCA 2012); *Russell v. Agency for Health Care Admin.*, 23 So. 3d 1266 (Fla. 2d DCA 2010); and *Smith v. Agency for Health Care Admin.*, 24 So. 3d 590, Fla. 5th DCA 2009). In brief, the courts correctly determined that "*Ahlborn* struck down an Arkansas statute to the extent that it allowed for Medicaid recovery that could impinge on an entire plaintiff's award and not merely past medical damages for which Medicaid may be reimbursed." *Garcon*, 96 So. 3d at 474. However, these three courts differed on the impact of the statutory formula at section 409.910(11)(f) and whether a trial court could consider evidence and limit a Medicaid lien. The Third in *Garcon* and Second in *Russell*, held that the statutory

formula at section 409.910(11)(f) was consistent with *Ahlborn* and must be used to dictate AHCA's payment. Under *Garcon* and *Russell*, a Medicaid recipient was prohibited from asking the trial court to consider evidence and limit the Medicaid lien to the portion of a settlement compensating for past medical expenses paid by Medicaid.

The Fifth District in *Smith*, took a different approach. It determined that the statutory formula at section 409.910(11)(f), provided a "statutory cap" or limitation in AHCA's payment. See *Smith*, 24 So. 3d at 591. The *Smith* Court held that under *Ahlborn* a Medicaid recipient must be afforded the opportunity to seek the reduction in a Medicaid lien amount by demonstrating, with evidence, that the lien amount exceeded the recovery in medical expenses. See *Id.* at 592.

After the U.S. Fourth Circuit's decision in *E.M.A.*, the Florida Fourth District reversed a trial court's refusal to consider evidence as to the proper payment of a lien and strict adherence to the statutory formula at section 409.910(11)(f) to dictate AHCA's payment. See *Roberts v. Albertsons*, -- So. 3d --, 2012 WL 5232182 (Fla. 4th DCA Oct. 24, 2012). The *Roberts* Court reviewed *Ahlborn*, the Fourth Circuit's decision in *E.M.A.* and the Florida appellate decisions of *Garcon*, *Russell* and *Smith*. The *Roberts* Court determined that the statutory formula at section 409.910(11)(f), "creates a presumptively valid allocation of settlement proceeds subject to a Medicaid lien when AHCA does not

participate in the settlement.” 2012 WL 5232182 at *9. The *Roberts* Court held that, “[b]ased on the appellate decisions of the Third and Fourth Circuit Courts of Appeal and the federal anti-lien and anti-recovery provisions of the Medicaid Act, we agree with the Fifth District in *Smith* and hold that a plaintiff 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.”

On August 14, 2013, the Second District issued its opinion in *Agency for Health Care Admin. v. Riley*, -- So. 3d --, 2013 WL 4080999 (Fla. 2d DCA 2013).

Riley involved a Medicaid lien in excess of \$225,000 asserted against Mr. Riley’s settlement. Mr. Riley filed a Motion to Determine Medicaid Lien in the underlying trial court proceedings post-settlement. AHCA “maintained that under Florida’s Medicaid Third-Party Liability Act, specifically section 409.910(11)(f), Florida Statutes (2010), and consistent with the Second’s decision in *Russell*, it was entitled to a full reimbursement of its Medicaid lien and that the trial court should not consider evidence presented by the Medicaid recipient that might rebut the application of the formula set forth in section 409.910(11)(f).” 2013 WL 4080999 at *1. **(This is the identical argument AHCA made at the trial court in the instant case.)**

The trial court rejected AHCA’s argument and allocated an amount that was less than the actual Medicaid payments made on behalf of Mr. Riley. *Id.* AHCA appealed the trial court’s order.

While the *Riley* appeal was pending, the Fourth District issued *Roberts* and the U.S. Supreme Court issued *Wos*. After *Wos* was issued, “AHCA modified its position and it now argues that section 409.910 should be read in such a way as to allow a recipient to attempt to rebut the presumption set forth in section 409.910(11)(f).”^v *Id.*

The *Riley* Court concluded that AHCA’s new found position that a Medicaid recipient should be afforded an opportunity to attempt to rebut the statutory presumption is consistent with the holding of *Roberts* and *Wos*. The Second District abrogated its prior decision in *Russell* as incorrect law post-*Wos*. *Id.* at *2.

However, since AHCA had relied upon the Second District’s *Russell* decision at the trial court hearing, the *Riley* Court reversed the trial court’s order

^v After the *Wos* decision, Kaitlyn filed in this proceeding a Motion to Lift Stay and Motion to Vacate the Trial Court’s Order and Remand to the Trial Court for Further Proceedings In-Light-Of *Wos*. It was expected that since AHCA had changed its position and now agreed that a Medicaid recipient, such as Kaitlyn, could rebut the statutory formula by presenting evidence to the trial court, AHCA would not contest Kaitlyn’s request to forego briefing in this appeal and proceed directly back to the trial court. However, AHCA opposed Kaitlyn’s request to this Court, despite its new found position expressed in the *Riley* appeal, that section 409.910(11)(f) does not dictate AHCA’s payment and a trial court may do exactly what the lower court in this case determined it was unable to do – consider evidence and determine the proper payment of the lien.

limiting the Medicaid lien. *Id.* The *Riley* Court remanded the matter back to the trial court for decision in-light-of *Wos* and *Roberts*, acknowledging “that the trial court may ultimately make a decision similar to the decision that it has already made.” *Id.*

Based on *Roberts* and *Riley*, the Florida appellate decisions determining that the statutory formula at section 409.910(11)(f) dictate AHCA’s payment and a trial court may not consider evidence and limit the Medicaid lien are no longer good law. Under *Roberts* and *Riley*, it was error in the instant case for the trial court to refuse to consider evidence to determine the proper payment of the lien and determine that it was “bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency’s reimbursement.” (R.355-56). Based on *Roberts* and *Riley*, this Court should reverse the trial court’s Order and remand for an evidentiary hearing.

E. Concerns Related to the *Roberts* and *Riley* Decisions

While the Florida decisions of *Roberts* and *Riley* support reversal and remand in Kaitlyn’s case, there are problems with the holdings of each. One such problem involves the Fourth and Second District’s characterization of the formula at section 409.910(11)(f) as “creating a presumptively valid allocation of settlement proceeds subject to a Medicaid lien when AHCA does not participate in

the settlement” and as a “statutory default allocation.” *Roberts*, 2012 WL 5232182 at *9. This is creative interpretation based on assumptions not supported by the plain reading of section 409.910(11)(f) or any legislative history. This creative interpretation is discouraged by *Wos*. Further, the creation of this new presumption unfairly places the entire burden of proof on the Medicaid recipient and discourages AHCA from participating in the settlement, negotiating in good faith, or compromising.

To begin with, the effect of labeling the formula at section 409.910(11)(f) as “creating a presumptively valid allocation of settlement proceeds subject to a Medicaid lien when AHCA does not participate in the settlement” or as a “statutory default allocation,” operates to impose the entire burden of proof on the Medicaid recipient to disprove an arbitrary number and place absolutely no burden on AHCA to prove-up the portion of the tort recovery it is entitled to receive. This arbitrary presumption allows AHCA a right not afforded to any other creditor or lienholder, which is to not be required to demonstrate legal entitlement to a given asset. It should be, “appellee’s (AHCA’s) burden to establish the amount of the lien just as any other lienor bears the burden to prove the validity and amount of its lien.” *Smith*, 24 So. 3d at 594 (Torpy, J, dissent).

Further, by labeling this presumption as being triggered only in cases “where AHCA does not participate in the settlement” encourages AHCA not to participate

in the settlement, negotiate in good faith, or compromise. If AHCA knows the presumption is valid so long as it does not participate in the settlement, then AHCA is in a better position if it does not participate, negotiate, or compromise. Instead, AHCA can rest on the arbitrary presumption, and post-settlement, attack and cast doubt on reasonable evidence presented by the Medicaid recipient to challenge the default allocation. This defies the public policy considerations in support of settlement and only serves to ensure lengthy litigation.

Importantly, there is no statutory or legislative indication that the statutory formula should be interpreted as “creating a presumptively valid allocation of settlement proceeds” or a “default allocation.” The plain language of section 409.910(11)(f), simply states AHCA “shall” be paid the lesser of the full lien amount or half of the net “settlement, judgment or award” after deduction of attorney fees (calculated at 25%) and taxable costs. This is a statutory dictate as to the maximum amount AHCA must be paid that serves as a cap in its recovery in cases where the lien is large in comparison to the tort recovery.^{vi}

There is no language within the statutory formula noting that this is a method of allocating a Medicaid recipient’s tort recovery or that this is a

^{vi} It is likely this cap in AHCA’s recovery was placed into the statute to financially encourage Medicaid recipients to pursue personal injury claims and incur the fees, costs and risk associated with such claims, so AHCA can enjoy the fruits of the Medicaid recipient’s endeavors, without bearing any of the burdens or risk associated with pursuing the personal injury claim.

presumption as to the amount of a Medicaid recipient's tort recovery attributable to compensation for medical expenses paid by Medicaid. Coupled with the draconian legislative intent paragraph at section 409.910(1) and the redundant statements that AHCA's recovery may not be limited to some portion of a Medicaid recipient's tort recovery in section 409.910(6)(a), (7), (11)(e), and (12), there can be no doubt as to what the Legislature meant when it included the statutory formula in the statute in 1990. The Legislature intended this statutory formula to operate exactly as it is written, as a statutory cap in AHCA's payment in cases where the lien amount is large in comparison to the size of the tort recovery. If the Legislature wished the formula to be interpreted as a presumptively valid allocation or as a statutory default allocation, it would have stated so and would not have included the various other statements within the statute that conflict with the notion that the formula is anything other than a statutory cap in AHCA's payment.

Further, there is very little legislative history related to the enactment of section 409.910. There is no indication the Legislature was attempting to develop a method of identifying the portion of a tort recovery allocable to medical expenses paid by Medicaid. If that was a consideration, then the Legislature would have reviewed or adopted evidence supporting that the allocation of half of the net tort recovery after deducting 25% for attorney fees and taxable costs was a method to fairly determine the portion of a tort recovery allocable to medical expenses paid

by Medicaid in the majority of cases. However, there is no evidence that the Legislature made any attempt to craft the statutory formula in a manner to fairly identify the portion of a tort recovery attributable to medical expenses paid by Medicaid in the majority of cases, or any specific case. This is likely due to the fact that the intent of the statutory formula is not to identify the portion of a tort recovery fairly attributable to medical expenses paid by Medicaid and there is no evidence supporting the notion that half of a net tort recovery would ever be a valid benchmark as to the amount of a tort recovery compensating for medical expenses paid by Medicaid in the majority of cases.

Accordingly, there is no basis for the Fourth and Second Districts to conclude that the statutory formula is a presumptively valid allocation or a default allocation.

The *Wos* Court warned against “creative statutory interpretation or description at odds with the statute’s intended operation.” The *Wos* Court noted that after *Ahlborn*, North Carolina advanced a “new interpretation of its statute,” under which the statute “defines ‘the portion of the settlement that represents payment for medical expenses’ as the lesser of the State’s past medical expenditures or one-third of the plaintiff’s total recovery.” 133 S.Ct at 1397-98. The *Wos* Court noted that, “North Carolina has picked an arbitrary number – one-third – and by statutory command labeled that portion of a beneficiary’s tort

recovery as representing payment for medical care.” *Id.* The *Wos* Court found fault in this process of creative interpretation to attempt to avoid the pre-emptive force of federal law. The Court stated that “pre-emption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute’s intended operation and effect.” *Id.*

The Court noted that one of the problems with North Carolina’s arbitrary one-third allocation formula is that there is “no evidence to substantiate its claim that the one-third allocation is reasonable in the mine run of cases.” *Id.* at 1399. The Court later emphasized this point in relation to criteria that can be deployed to handle the allocation of tort settlements in an efficient manner noting that any criteria for allocating tort recoveries must be “backed by evidence suggesting that they are likely to yield reasonable results in the mine run of cases, [w]hat they cannot do is what North Carolina did here: adopt an arbitrary, one-size-fits-all allocation for all cases.” *Id.* at 1402.

Since there is no statutory language, legislative history, or evidence that the statutory formula at section 409.910(11)(f), is a presumptively valid allocation of settlements or a statutory default allocation, This Court should not follow the Fourth and Second District’s creative labeling of the statutory formula as a valid presumption or default allocation. The *Wos* Court warned against using semantics

and creative interpretation to label a statutory formula as something it is not, especially, when the statutory formula is not “backed by evidence suggesting that it is likely to yield reasonable results in the mine run of cases.”

Instead, this Court should interpret the statutory formula as it is intended to operate -- as a statutory cap in AHCA’s recovery. See *Smith*, at 591. Not as a presumptively valid allocation of settlement proceeds or as a default allocation, which places the entire burden of proof on the Medicaid recipient and discourages AHCA’s participation, negotiation or compromise. Trial courts under *Ahlborn* and *Wos*, would still be able to determine the payment of the Medicaid lien based on evidence as to the amount of the tort recovery compensating for the claim for past medical expenses paid by Medicaid, but there would not be any arbitrary statutory presumption hindering that process.

F. Since the 2006 *Ahlborn* Decision, the First District has Not Issued a Written Opinion Concerning Florida Medicaid Liens, and the 2001 Decision of *State, Agency for Health Care Admin. v. Wilson*, 782 So. 2d 977 (Fla. 1st DCA 2001) is No Longer Good Law

The First District Court of Appeals has not issued a written opinion discussing the impact of the 2006 *Ahlborn* decision or the recent *Wos* decision. AHCA in its Amended Response told the trial court that the First District had considered *Ahlborn* by stating, “various Florida District Courts of Appeal

(“DCAs”) — *including our own 1st DCA* — have considered whether Florida’s Act was somehow invalidated by *Ahlborn*, and every one of these DCAs declined to strike or in any way invalidate Florida’s Act.” (R. 220) AHCA then cited the First District’s PCA issued without opinion, *Storey ex rel. Storey v. Hickcox*, 44 So. 3d 600 (Fla. 1st DCA 2010)(per curiam affd, citing *Russell*). It was incorrect for AHCA to claim that the First District has issued an opinion concerning *Ahlborn* upon which the trial court could rely because PCA opinions issued without opinion are not precedent and it is error to rely upon PCA decisions issued without opinion.^{vii} See *Department of Legal Affairs v. District Court of Appeal, 5th District*, 434 So.2d 310 (Fla. 1983)(“*The issue is whether a per curiam appellate court decision with no written opinion has any precedential value. We hold that it does not.*”) and *Gould v. State*, 974 So.2d 441 (Fla. 2nd DCA 2007). But be that as it may, the *Storey* PCA has no value since it was “apparently” based on the *Russell* opinion that has now been abrogated as bad law.

The last written opinion concerning Medicaid liens issued by the First District is *State, Agency for Health Care Admin. v. Wilson*, 782 So. 2d 977 (Fla. 1st DCA 2001). The *Wilson* opinion was issued five years before the 2006 *Ahlborn*

^{vii} The Fourth District in *Roberts* noted that the Third District in *Garcon* had cited in support of its decision, this Court’s PCA in *Storey*, but ultimately, the *Roberts* Court did not certify conflict with this Court’s *Storey* PCA. The reason the *Roberts* Court did not certify conflict with the First District is likely because the *Storey* PCA has no precedential value and does not indicate the First District has expressed an opinion on the matter.

decision, which has drastically changed the legal landscape of Medicaid lien disputes. The holding of *Wilson*, that the statutory formula at section 409.910(11)(f) dictates AHCA's payment and the trial court is unable to make a different determination, is no longer good law. This Court should acknowledge this fact in this proceeding in order to avoid future confusion.

G. The Legal Analysis Is Simple

Federal law restricts a State's recovery of its Medicaid lien to only the amount of a Medicaid recipient's settlement representing compensation for past medical expenses paid by Medicaid. The U.S. Supreme Court in "*Ahlborn* struck down an Arkansas statute to the extent that it allowed for Medicaid recovery that could impinge on an entire plaintiff's award and not merely past medical damages for which Medicaid may be reimbursed." *Garcon*, 96 So.3d at 474 (Fla. 3rd DCA 2012). The Fourth Circuit in *E.M.A.* held that, "the unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses" and that North Carolina's statutory irrebuttable presumption that 1/3 of a settlement represents past medical expenses "does not satisfy *Ahlborn* insofar as it permits [NC Medicaid] to assert a lien against settlement proceeds intended (or otherwise

properly allocable) to compensate the Medicaid recipient for other claims.” 674 F.3d at 308, 312.

The U.S. Supreme Court in *Wos* affirmed *E.M.A.* and held that it is a violation of federal law and *Ahlborn* for a State to have an allocation statute creating an irrebuttable presumption that a fixed percentage of a settlement represents compensation for past medical expenses. A Medicaid recipient must be afforded the opportunity to present evidence and have the court limit the Medicaid lien to the portion of the settlement compensating for the claim for past medical expenses paid by Medicaid.

The Florida Fourth District in *Roberts* and the Second District in *Riley* have held that the statutory formula at section 409.910(11)(f), may not be used to dictate AHCA’s payment and a trial court may consider evidence and limit the Medicaid lien to the amount of the settlement compensating for the claim for past medical expenses paid by Medicaid.

In the instant case the trial court refused to consider evidence and limit the Medicaid lien, instead ruling that the Court was “bound to apply the statutory formula at Section 409.910(11)(f), Florida Statutes to determine the Agency’s reimbursement.” This was incorrect. Under *Wos*, *Roberts* and *Riley*, the statutory formula at section 409.910(11)(f) may not be used to dictate AHCA’s payment and the trial court must consider evidence as to the portion of the settlement

compensating for the claim for past medical expenses paid by Medicaid and limit the Medicaid lien to that amount.

The trial court's Order on Plaintiff's Petition to Determine Medicaid Lien should be reversed and this matter remanded to the trial court for an evidentiary hearing.

CONCLUSION

For the forgoing reasons, the trial court's Order On Plaintiffs' Petition to Determine Medicaid Lien should be reversed and the matter remanded to the trial court for an evidentiary hearing.

Respectfully submitted this 1st day of October, 2013.

Staunton & Faglie, PL
189 East Walnut Street
Monticello, FL 32344
T: (850) 997-6300
faglielaw@earthlink.net

/s/ Floyd Faglie
FLOYD FAGLIE, ESQ.
Fla. Bar No. 0569690
Counsel for the Appellant

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served via e-mail to Susan B. Ramsey, Esq., Gary Roberts & Associates, P.A.,

susan@palmbeachtrialattorney.net; 324 Datura Street, Suite, 223, West Palm Beach, FL 33401; Pamela K. Frazier, Esq., Lozier, Thames & Frazier, P.A., pkfrazier@ltflaw.com; 24 W. Chase Street, Pensacola, FL 32502-5614; David E. Olesky, Esq., david.olesky@coopersculley.com; Cooper & Sculley, P.C., 900 Jackson, Suite 100, Dallas, TX 75202; Barry Washor, Queller, Fisher, Washor, et al, 233 Broadway, 18th Floor, New York, NY 10279; William Whitney, Esq., Dunlap & Shipman, 60 Clayton Lane, bwhitney@dunlapshipman.com Santa Rosa Beach, FL 32459; Les McFatter, Esq., Perry & Young, Lmcfatter@perry-young.com; 2612 W. 15th Street, Panama City, FL 32401 and Adam J. Stallard, Esq.fltplegal@xerox.com; and James H.K. Bruner, Sr., Esq. james.bruner@xerox.com ACS / Xerox Recovery Services, collections contractor for the Agency for Health Care Administration, P.O. Box 12188, Tallahassee, FL 32317; this 1st day of October, 2013.

CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief complies with the font requirements of Florida Rules of Appellate Procedure 9.210(a)(2).

/s/ Floyd Faglie
FLOYD FAGLIE, ESQ.
Fla. Bar No. 0569690
Counsel for the Appellant

**IN THE DISTRICT COURT OF APPEAL
FOR THE FIRST DISTRICT
STATE OF FLORIDA**

**KAITLYN HARRELL, a minor,
individually and through her
natural parents and guardians,
JOY D. HARRELL and
GREG HARRELL, husband and wife,
and JOY D. HARRELL and
GREG HARRELL,
individually,**

**DCA Case No.: 1D12-5597
L.T. Case No.: 02003998CA**

Appellant,

v.

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,**

Appellee.

_____/

ON APPEAL FROM THE CIRCUIT COURT OF THE FOURTEENTH
JUDICIAL CIRCUIT, IN AND FOR BAY COUNTY, FLORIDA

ANSWER BRIEF OF THE APPELLEE

ADAM J. STALLARD
Florida Bar No.: 0070756
2316 Killearn Center Blvd.
Tallahassee, FL 32309
Tel: (850) 201-1311
adam.stallard@xerox.com
Attorney for Appellee

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STATEMENT OF THE CASE AND OF THE FACTS

The Appellant suffered injuries allegedly caused by one or more of the Defendants in the case below. The Appellant's treatment for such injuries was provided by the taxpayers, through the Medicaid program. (R. 355). Appellant recovered settlement monies related to the injuries Medicaid paid to treat.¹ (R. 163). Pursuant to Florida law, the Appellant was therefore required to reimburse the Agency \$360,741.48 from such settlement. (R. 355). Such reimbursement—a small portion of the settlement—was more than the Appellant would willingly reimburse the taxpayers—i.e., the taxpayers that provided her medical care when she needed it most. (R. 158-185).

Accordingly, the Appellant litigated the issue in the Circuit Court. The main argument set forth by the Appellant was that the Agency for Health Care Administration (the “Agency” or “AHCA”) was limited to recover only the past medical expense portion of the Appellant's settlement, but that Appellant had failed to recover past medical expense damages in an amount equal to or greater than the small portion of the settlement that the Agency was demanding as

¹ Counsel for the Appellant is emphatic that the settlement amount is confidential. It is unclear whether the Agency is somehow legally prohibited from disclosing the settlement amount, especially since it seems to be in the record on appeal. Nonetheless, out of an abundance of caution, and in the interests of professional courtesy, the Agency will not disclose the settlement amount in this brief. However, it is important that this Court, at least *in camera*, be advised of the settlement amount, and how little, as a percentage, the Agency was required to receive as Medicaid reimbursement.

reimbursement. (R. 183). Appellant argued that it only recovered \$130,151.44 for past medical expenses, and that the Agency was forced to recover less than this amount in satisfaction of their claim. (R. 183).

The Court allowed the Appellant an evidentiary hearing. (R. 440-480). The Court placed no limits on the amount of evidence the Appellant could present. (R. 440-480). The Court expressly stated that it was allowing the Appellant to present whatever evidence she wanted to present. Such evidentiary hearing was held in anticipation of precisely what came to pass—a Supreme Court decision making such evidence relevant to the analysis. (R. 445)

Not only did the Court allow the Appellant to present evidence, but the Appellant actually did so in order to try to prove that the Medicaid claim exceeded the medical expense portion of the settlement. In order to try to “prove” that only a tiny percentage of its settlement was past medical expense damages, Appellant presented the testimony of one witness—Richard Collins. (R. 448-468).

Mr. Collins testified that a jury would likely have awarded Ms. Harrell “approximately 20, 25 million” dollars in damages. (R. 460). This evidence of the “full value” of the Appellant’s damages was apparently presented so that a “full value formula” could be performed to “determine” the past medical expense portion of the settlement. (R.183).

Mr. Collins confessed that he could not think of a single jury award on which to base such valuation, either from Bay County nor any surrounding County, nor any County in Florida, for that matter. (R. 451). Furthermore, Mr. Collins failed to testify as to the actual amount of any head of damages that comprised such full value figure. As such, it was unclear how Mr. Collins could possibly have concluded that a jury in Bay County would award “approximately 20, 25 million dollars” for the Appellant’s damages. Ultimately, Mr. Collins concluded his testimony without so much as asserting a conclusion as to (the value of) the past medical expense portion of the settlement. (R. 468). Indeed, there was no evidence as to medical expense damages portion of the settlement. (R. 440-480).

Following the evidentiary hearing, the Court entered an Order directing the Appellant to pay the Agency within 30 days. (R. 356). This time period past without any such payment, nor any action of any kind from the Appellant. (R. 380). The Agency was paid after a hearing on Appellant’s Motion to Stay. (R. 380).

The Appellant had a Special Needs Trust established to ensure that she maintains Medicaid eligibility and that Appellant’s fellow taxpayers will continue to pay for her medical care, perhaps for the rest of her life. (R. 443)

SUMMARY OF THE ARGUMENT

Florida's Fourteenth Judicial Circuit Court, the Honorable Hentz McClellan, Chief Judge, did not err in ordering that the taxpayers be reimbursed \$360,741.48—a small portion of the recipient's settlement—after having paid 100% of her medical expenses related to the incident in question. As the Circuit Court, and the Appellant herself, stated at the hearing in question, Florida law at that time clearly supported the Court's decision to reimburse the Agency pursuant to Section 409.910(11)(f), Florida Statutes.

To the extent that such legal basis has since become invalid, the result reached by the Circuit Court is nonetheless correct. It may be the case that the Circuit Court determined the Agency's reimbursement amount merely by application of the formula at Section 409.910(11)(f), without regard for any evidence presented by the Appellant that there is some smaller portion of her settlement that represents her medical expense recovery.

Further, it seems that *Wos v. E.M.A.*, 133 S.Ct. 1391 (2013)—which was decided well after the Circuit Court's decision—ordains the use of statutory formulas to determine the medical expense portion of a recipient's settlement, but also requires that states allow Medicaid recipients to *attempt* to prove, with evidence, that the medical expense portion of their settlement is some precise amount less than the statutorily-produced amount. If recipients can prove such

things, the recipients need only pay such amount from the settlement or other recovery in question.

Nonetheless, the Circuit Court's decision is correct because the Appellant failed to prove, with evidence, the actual medical expense portion of her settlement. As such, the Appellant failed to prove that the (11)(f) amount exceeded that portion. In other words, Appellant failed to present evidence to rebut the presumption, and so the presumption stands.

Alternatively, if this Court were to reject the above argument, and find that the Circuit Court's ultimate decision was wrong, the Appellant should not have the opportunity to have yet another evidentiary hearing in Circuit Court. The Circuit Court granted the Appellant the opportunity to present any and all evidence that the Appellant wanted to in order to prove the actual medical expense portion of her settlement. Given the job done by the Appellant's trial counsel in this regard, one can certainly understand the Appellant wanting a second chance to present a persuasive and coherent case. However, such would be a waste of judicial and attorney resources, and would unfairly provide the Appellant with a chance to try, yet again, to prove what it failed to the first time around.

ARGUMENT

The Circuit Court did not err in applying Section 409.910, Florida Statutes, to determine that the Agency should be reimbursed \$360,741.48—a very small portion—of the Appellant’s tort settlement.

Standard of Review

The issue of whether the Circuit Court was right to apply Florida law in this matter is subject to *de novo* review. *See, Borden v. E-European Ins. Co.*, 921 So.2d 587, 591 (Fla. 2006).

I. The Circuit Court’s decision comports with Florida and federal law

A. The Medicaid Program

Medicaid is a taxpayer-funded, joint federal-state social welfare program providing medical coverage to individuals who can not afford to pay their own medical costs. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). In 2006, state and federal Medicaid spending totaled an estimated \$320 billion. *See, Retail Indus. Leaders v. Fielder*, 475 F.3d 180, 198 (4th Cir. 2007), Michael, J., *dissenting*. With the number of Medicaid qualified individuals on the rise, states are struggling to recover the funds necessary to maintain this critical source of public benefits. *See, Id.* at 198-99. One such person who has benefited from this program is Kaitlyn Harrell. In her time of

greatest need, the public treasury extended \$360,741.48 in benefits to provide medical services that the Appellant desperately needed.

Under the program, the federal government offers to reimburse the states that choose to participate in the non-mandatory scheme for some of their expenses, assuming the state programs meet the federal guidelines. *Ahlborn*, at 275; *See also*, 42 U.S.C. § 1396a (providing the criteria for state Medicaid programs). The federal government may issue penalties to a state for not following the guidelines by reducing or withholding federal funding. 42 U.S.C. § 1396c (2006); *see also* 42 C.F.R. §433.140(a)(1) (2012) (funding withheld to a state for failure to conduct third party collections).

To maintain the viability of the Medicaid Program, federal law forces states to enact legislation to secure Medicaid's reimbursement from recipients' settlements with, or judgments or awards against, liable third-parties. *See* 42 U.S.C. §1396a(a)(25). Federal law requires that "any amount collected by the State . . . shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual." 42 U.S.C. §1396k(b). To accomplish this, federal law mandates that participating states *require* Medicaid recipients to assign their rights to claims against third-parties in order to qualify for Medicaid assistance. *See*, § 1396k(a)(1)(A).

B. Section 409.910, Florida Statutes, is a faithful and obedient implementation of the federal statutory directives

In accordance with this federal mandate to recover money for the federal government, the State of Florida enacted the Medicaid Third Party Liability Act, at Section 409.910, Florida Statutes. Section 409.910, Florida Statutes, is a thorough, extensive provision carefully crafted to protect the rights and interests of taxpayers, the government, and Medicaid recipients.

This statute—contained within the TITLE XXX, the “Social Welfare” section of the Florida Statutes—begins with an intent paragraph that makes clear that Medicaid is to be the “payor of last resort” and that “[i]f 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.” §409.910(1), Fla. Stat.

At Subsection (6), the Agency is afforded three independent rights of recovery, only one of which is a “lien”: subrogation ((6)(a)), assignment((6)(b)), and lien ((6)(c)). At subsection (11)(c), Courts are required to segregate an amount from every settlement to pay the Agency’s claim.

At Subsection (11)(f), the State’s ability to collect on these recovery rights is limited to the amount produced by the formula in that paragraph. Subsection (11)(f) begins by stating that it controls “[n]otwithstanding any provision in [Section 409.910] to the contrary. . . .” (Emphasis provided). Therefore, by

operation of the formula at that Subsection, the state can *never* recover more than 37.5% of a recipient's settlement.

As the Florida Supreme Court stated, noting the importance of according deference to the Legislature in funding public welfare programs such as Medicaid, “the judicial branch must be cautious when evaluating the choices made by the legislative branch as to the appropriate funding for programs it has deemed important to the public welfare[,]” and that it should not limit “the funding options available to the legislature when addressing today’s policy problems.” *Agency for Health Care Admin. v. Associated Industries of Fla.*, 678 So.3d 1239, 1243 (Fla. 1996).

In the instant matter, of course, the Agency was ordered to recover only a very small portion of the recipient's settlement—an undeniably fair, reasonable, and modest amount after having paid at least \$360,741.48 to cover 100% of the recipient's medical expenses. This amount was determined by application of paragraph 409.910(11)(f), Florida Statutes. Such provision requires reimbursement of the amount produced by the formula at (11)(f), or 100% of what the Agency paid, whichever is less. Here, that paragraph required full reimbursement. This seems to be where the Circuit Court's analysis stopped.

The Appellant pounces on this apparent fact, stating that *Wos* makes clear that the analysis no longer necessarily stops there, but instead that trial Courts must

ask another question: Did the recipient prove, with evidence, that the actual medical expense portion of their settlement is less than the amount required by the statutory determination? While the trial Court *might* have reached the reimbursement figure in this case by way of an analysis that may no longer comport with federal guidance, the result is correct nonetheless because the Appellant failed to rebut the presumption that the (11)(f) determination represents the medical expense portion of the settlement.

C. The Circuit Court reached the right conclusion, whether or not it was for the right reason

A trial court's ruling should be upheld if there is any legal basis in the record which supports the judgment. *State v. Hankerson*, 65 So. 3d 502 (Fla. 2011), as revised on denial of reh'g, (June 30, 2011). If a trial court reaches the right result, but for the wrong reasons, it will be upheld on appeal if there is any basis which would support the judgment in the record. *Craigside, LLC v. GDC View, LLC*, 74 So.3d 1087 (Fla. 1st DCA 2011).

As the Appellant openly admitted at the hearing in this matter, at the time the Circuit Court made its ruling and entered its order, its decision was in line with DCA precedent. In such ruling and Order, the Circuit Court awarded the Agency the amount determined for reimbursement by paragraph 409.910(11)(f), Florida Statutes, apparently without full consideration of the Appellant's evidence as to the medical expense portion of their settlement. It is contended that this fails to fully

comport with *Wos*, where the *Wos* Court essentially held that a court should provide an opportunity to prove that the medical expense portion of the settlement is some specific amount that is less than the statutorily-determined amount.

Though it may be that the Circuit Court's handling of this case was not perfectly in line with the *then* non-existent *Wos* decision, the result reached by the Circuit Court is nonetheless correct, and should be affirmed by this Court. The trial Court afforded the Appellant an opportunity to present its case. Such case, however, was totally insufficient.

Accordingly, while it seems fairly clear from the record that the trial Court did not consider the Appellant's evidence as to the medical expense portion of the settlement, it is also clear that the Court would have reached the same result—i.e., reimbursement per (11)(f)—had the Court earnestly considered such evidence. A simple overview of the Appellant's trial court presentation will show how botched it was, and why the Court would, of course, have rejected it. As such, the (11)(f) presumption would should stand, and the same result should be reached.

**1. The Appellant's Circuit Court case was flawed in two ways:
Appellant tried to prove the wrong figure, and failed even to
present evidence of that figure**

Throughout the proceedings in trial Court and on appeal, the Appellant has been focused on an ultimately irrelevant figure—the past medical expense portion of the settlement. That is, the Appellant argues that the Agency's reimbursement

from the settlement should be restricted to the *past* medical expense portion of the settlement. However, this is simply not the case. Medicaid reimbursement is instead restricted to the “medical expense/damages/payments” portion of a settlement, to include future medicals.

a. Cases directly addressing whether states can recover the future, as well as past, medical expense portion of a recipient’s settlement or other recovery

In three cases, the courts dealt explicitly and directly with the issue of whether states are restricted to the past, or the past and future, medical portions of a recipient’s settlement. See, *In re Matey*, 213 P.3d 389 (Idaho 2009); *I.P. ex rel. Cardenas v. Henneberry*, 795 F.Supp. 2d 1189 (D. Colo. 2011); *In re E.B.* 229 W.Va. 435 (W.Va. 2012). In *In re Matey* and *I.P. ex rel Cardenas v. Henneberry*, the Courts held that while Medicaid is restricted to what it has already paid, it can recover that amount from the past *and future* medical portion of a recipient’s settlement. In *In re E.B.*, the court held that Medicaid is restricted to the past medical portion of a recipient’s settlement. 229 W.Va. 435 (W.Va. 2012).

b. Guidance from *Wos* and *Ahlborn*

In *Wos*, the United States Supreme Court seemed to make clear that Medicaid reimbursement is limited only to the past and future medical expense/damages portions of a recipient’s settlement. The Supreme Court in *Wos* spoke clearly, indicating that lien recovery is limited only to the medical expense

portion of a settlement, not the *past* medical expense portion. *See, Wos* at 1396-1402. The *Wos* Court referred to the relevant portion of the settlement—i.e., the portion that Medicaid lien recovery is limited to—as many as twenty-eight (28) times in its Opinion as the portion comprised of “medical expenses,” “medical payments,” or “medical damages.” What is equally devastating for the argument that lien recovery is limited to the *past* medical expense/damages/payment portion of a settlement is the number of times the U.S. Supreme Court referred to such *past* medical portion as that which lien-recovery is limited to—zero. As conclusive as these observations are, the “all medicals argument” gets even stronger when one looks more closely at *Wos*.

At no less than three places in the Court’s Opinion it sets up a clear and undeniable dichotomy between the types of damages that Medicaid liens can and can not be satisfied from. *Id.* at 1400-1402. At all three places that clear, bright line is drawn between medical and nonmedical expenses. For example, in the first paragraph of page 1401, the Court deals with North Carolina’s argument that having evidentiary hearings to determine the appropriate portion for lien satisfaction. Such argument is that it “would be ‘wasteful, time-consuming, and costly’ to hold ‘frequent mini-trials’ in order to divide a settlement between medical and non-medical expenses.” (Emphasis supplied).

Later, the Court notes that States “may be able to adopt *ex ante* administrative criteria for allocating medical and non-medical expenses” *Id.* at 1402 (emphasis supplied). This is truly fatal to the “past medicals only” argument. Here, the Court was putting forth possible alternatives for states to adopt in light of its decision in *Wos*, and it clearly and undeniably expresses that the distinction that must be drawn is between medical and non-medical expense damages. To emphasize the obvious, those “non-medicals” that would be off-limits are not future medicals—no one would describe future medical expenses as “non-medical.”

Looking at the federal statutes themselves, one can see that there is absolutely no restriction to the past medical expense portion of a settlement. In *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), a seminal case in the area of Medicaid reimbursement law, the United States Supreme Court looked at three provisions in the federal Medicaid statutes in order to discern states’ requirements and limitations. The *Ahlborn* Court looked at 42 U.S.C. §§1396a(a)(25)(b), 1396k, and 1396p. In *Ahlborn*, the issue was whether states were restricted to the medical expense portion of a settlement, even when

there is no dispute as to what “medical expense portion” means, and where Arkansas even stipulated to a particular figure as that portion.²

c. The federal statutes that the Supreme Court addressed in *Wos* and *Ahlborn* provide no limitation to past medical expense damages

The State of Arkansas made the point that the 42 U.S.C. 1396a(a)(25)(B) and 1396k(a) merely made for recovery floors from which states were free to go up. The Supreme Court found that interpretation to be plausible, but, also determined that 42 U.S.C. § 1396p made for a ceiling, to go with the floor created by the other two provisions. *Ahlborn*, at 283. Thus, the *Ahlborn* Court held that states must recover 100% of what they pay, but not more than the medical expense portion of a settlement. A brief look at these provisions will reveal absolutely nothing in them that makes for a restriction of recovery to *past* medical expenses. 42 U.S.C. 1396a(a)(25)(B) reads as follows:

(a) Contents

A State plan for medical assistance must--

...

(25) provide--

...

² The Arkansas Department of Health and Human Services (Arkansas Medicaid) was a party to that case, unlike here. There, the Arkansas Medicaid agency got together with the recipient and stipulated to the precise medical expense portion of the recipient’s settlement. Nonetheless, Arkansas argued that it was entitled to full reimbursement, notwithstanding that such amount exceeded the stipulated-to medical expense portion.

(B) 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;

Here, it is plain to see that there is no *restriction* to the past medical expense portion of a recipient's settlement, but instead a *mandate* to states to seek reimbursement of the taxpayer funds doled out. In other words, this provision does not *restrict* anyone to anything; rather, it constitutes the federal government forcing states to recover (at least) the medical expenses (past and future) recovered by a recipient.

Similarly, 42 U.S.C. 1396k(a), reads as follows:

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall--

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required--

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

Again, there is absolutely nothing in this provision of federal law that would limit Medicaid recovery to the *past* medical expense portion of a recipient's settlement. It is anticipated that the Appellant, in an effort to force such a meaning into these provisions, will also try to read them as limitations on the states' recovery rights. However, such would be disingenuous, since—again, as the Supreme Court acknowledged, and as is clear from the provisions themselves—these are things the states are *required* to do, not delineations of the upper limits of the states' recovery rights. In other words, and to put it plainly, here the federal government is telling states, “You better seek recovery of what you pay or you will be in violation of federal law,” not, “You better make sure you only recover from the medical expense portion of a recipient's settlement.”

The last of the three provisions of federal law that the Supreme Court focused on in *Ahlborn* is 42 U.S.C. 1396p(a)(1):

- (a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan
- (1) No 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

The *Ahlborn* Court read this provision as providing for a ceiling to go with the floor created with the previous two provisions. 547 U.S. 268, at 284. Clearly, again, there is nothing in this provision to support the idea that future medical damages are off limits.

d. The Florida District Courts of Appeal decisions also allow for recovery from the future medical expense portion of a settlement or other recovery

There are several recent DCA decisions pertaining to the core issue of the instant case. *See, Riley v. AHCA*, 119 So.3d 514 (Fla. 2d DCA 2013); *Roberts v. Albertson's* 119 So.3d 457 (Fla. 4th DCA 2012); *Williams v. AHCA*, Case No. 4D12-1046 (Fla. 4th DCA 2013); *Dillard v. Agency for Health Care Administration*, -- So.3d --, 2013 WL 6212037 (Fla. 2d DCA 2013). In none of these cases do any of the Courts ever refer to the past medical expense portion of a recipient's settlement as the portion to which the Agency is limited in recovery. Instead, invariably, the portion of the settlement the Agency is limited to is the medical expense, medical payments, or medical damages portion.

Indeed, the only time any Florida DCA has so much as *mentioned* the past medical expense portion of a recipient's settlement as the part to which the Agency's recovery is limited was in *dicta* in *Garcon v. Agency for Health Care Administration*, 96 So.3d 472, 474 (Fla. 3d DCA 2013):

Ahlborn struck down an Arkansas statute to the extent that it allowed for Medicaid recovery that could impinge on an entire plaintiff's award and not merely past medical damages for which Medicaid may be reimbursed.

Not only was this part of the decision plainly *dicta*, but moreover, the *Garcon* Court was merely making an observation about a case *which it distinguished from the case it was deciding*. That distinction—that there was no stipulation by

Medicaid as to medical expense damages in *Garcon*, unlike in *Ahlborn*—is an important one, and one which distinguishes *Ahlborn* from the instant case as well.

2. Appellant failed to make a coherent presentation as to the *past* medical expense portion of the settlement, let alone the medical expense portion more generally

As explained above, Medicaid reimbursement is limited only to the medical expense portion of a recipient's recovery. Appellant's position, on the other hand, is that Medicaid is limited to the *past* medical expense portion of the settlement. Even if one were to pretend that the Appellant's position is correct, Appellant's argument, more generally, would nonetheless fail, because Appellant failed to prove the medical expense portion of their settlement. Accordingly, the Court was correct to award the Agency the (11)(f) formula amount.

a. The law is clear: the Appellant had the burden to prove, with evidence, the medical expense portion of its settlement.

As the United States Supreme Court made clear in *Wos v. E.M.A.*, 133 S.Ct. 1391 (2013), statutory formulas may be used to determine the medical expense portion of a recipient's settlement. While *Wos* also makes clear that a recipient should have the opportunity to prove that the medical expense portion of her settlement is some particular portion smaller than the (11)(f) determination, it is important to not miss the validity and authority of the (11)(f) amount.

When a recipient settles her lawsuit (or otherwise receives third-party benefits), the (11)(f) formula can be executed. This formula operates as follows: the gross settlement is reduced by 25% for attorney's fees, then taxable costs (if any) are subtracted; lastly, the resulting number is divided by 2. The resulting number is the medical expense portion of the recipient's settlement. In the instant case, because of how large the settlement was, the statutory formula produces a very large number that dwarfs what the Agency paid.

What this means is that this figure is established as the medical expense portion of the Appellant's settlement. Both Florida law, and United States Supreme Court case law establish it as such. Accordingly, unless a sufficient rebuttal occurs, this amount is established as the medical expense portion of the settlement, and recipient is liable to pay the taxpayers that amount, or the amount the taxpayers paid to treat the recipient, whichever is less.

So often, the authority and legitimacy of the (11)(f) amount is overlooked, and that amount is virtually dismissed as a mere suggestion to be displaced by little more than a naked assertion that there is some actual, smaller medical expense portion of the settlement. However, the law does not permit such low regard for the amount produced by the formula at Section 409.910(11)(f), Florida Statutes. Instead, as the United States Supreme Court and our DCAs have declared, **such statutory formula amount is the medical expense portion of recipients'**

settlements, unless and until the recipient proves, with evidence, that some other *particular* portion of the settlement is the medical expense portion.

So, the question is, Did the recipient in this matter prove, with evidence, that the medical expense portion of their settlement is less than the amount produced by the (11)(f) formula? Had this been a trial, would the finder of fact really have accepted the recipient's presentation? As will be shown, the answer to these questions is *no*.

b. The Appellant failed to prove, with evidence, that the (11)(f) determination is inaccurate

The appellant tried to prove that only \$130,151.44 of her settlement—an incredibly small percentage—was past medical expense recovery. It is important to begin the analysis of the Appellant's trial court presentation with the plain acknowledgment that all reasonable people will make: alleging that only that small a part of the settlement is question past medicals is absurd. Moreover, it is beyond audacious to contest that the percentage of the settlement that the Agency was demanding as reimbursement—the amount paid to treat the recipient when she needed it most—is too much to reimburse the taxpayers.

It is time for the analysis and discussion in this area of the law to be informed by reason, to be done with an appropriate regard for public policy and the interests of the taxpayers, and with an appropriate level of skepticism toward those who ask courts to believe wild claims about the composition of their settlements.

i. Appellant's evidence was clearly insufficient

At the hearing in this matter, the Appellant presented the testimony of one witness, a Richard Collins, Esq. Mr. Collins was introduced to the Court and Appellant's trial counsel explained that Mr. Collins would be testifying as to the "value of these types of cases." (R. 450).

After Mr. Collins was introduced to the Court, Agency's counsel was allowed to *voir dire* the witness. Knowing that Mr. Collins would be testifying as to "the value of these types of cases," Appellee's counsel inquired as to whether Mr. Collins had any firm basis—such as, perhaps, a jury verdict or collection of jury verdicts—for the opinion he would give. As it turns out, Mr. Collins did not.

Recognizing that Mr. Collins would be relying on his knowledge of "these types of cases," the Agency's counsel inquired as to whether Mr. Collins would refer to jury verdicts from other of "these types of cases." Mr. Collins stated that he would not do so, but that he would instead rely on what he called his

overall experience of being involved in these types of cases throughout the entire state from Dade all the way up to Jacksonville, to Pensacola, and based on the information I was provided to review, and based on my training, education, and experience.

(R. 450-51)

(Emphasis supplied)

Agency's counsel was not satisfied with this vague description of his qualification to determine the value of this particular case, and he figured Mr. Collins must

intend to rely on similar jury verdicts, for, How else could one determine the value of a case? Accordingly, the Agency's counsel inquired as to whether Mr. Collins could recall a single case from Bay County with facts similar to the instant one. He could not.

The same question was posed with respect to Gulf County, then Franklin, then Jackson, then Walton, and Calhoun. (R. 451). The answer regarding each was no. (R. 451). Mr. Collins, the Appellant's only witness, could not recall a single other case or jury verdict from anywhere in the region upon which he could base his expert opinion.

Just moments prior, Mr. Collins had bragged that he had handled cases "from Dade all the way up to Jacksonville, to Pensacola." Apparently, that body of work did not include any similar cases *anywhere* in the region. The Court then allowed Mr. Collins to testify but noted that his lack of knowledge about relevant jury verdicts would go to the weight of his testimony. (R. 452)

Mr. Collins then went on to testify, relying on his "overall experience," and on "information [he] was provided to review. . . ." He referenced what purported to be a report of an economist and of a life care planner. (R. 454). Neither of those two people testified and the reports were not admitted into evidence. Mr. Collins then testified as to the nature of the injuries of the Appellant, notwithstanding that he is not a doctor. (R. 455).

The witness eventually gave his opinion that “a fair number and assessing of values would be “approximately 20, 25 million dollars[,]” and this was “pretty much in the range [Dr. Rafa allegedly] set.” (R. 460-61). On cross-examination, it got even worse when Mr. Collins confessed that the numbers he threw out were nothing more than his “good faith estimate” as to what a jury would award. (R. 465). He also admitted that he was testifying as to mere hypotheticals, given that the underlying facts—i.e., the facts allegedly set forth in the purported economist and life care planner’s reports—had not been proven. (R. 466).

So, the Appellant’s sole witness based his testimony on no jury verdicts, local or otherwise, and the conclusion he came to is just his “good faith estimate” that the case is worth “approximately 20, 25 million dollars.” From there, one supposes that the Plaintiff would have posited the use of a “full value formula” to determine the past medical expense portion of the settlement.

Before getting into the many reasons why the Appellant’s reliance upon a “full-value formula” is fatal to her case, a brief description of such formulas may be helpful. To perform such a formula, one divides the settlement amount by the supposed “full value” of the damages. This, recipients say, shows the percentage of the “actual, full” damages recovered. Then that number can be multiplied by any head of damages within the “full damages claim” to determine how much was recovered of that head of damages in the settlement. So, if there was a 1/3rd

recovery, and someone had \$6million in actual medical damages, then they would have recovered 1/3rd of that, or \$2million, in their settlement.

Before getting into the total inability of this formula to prove what amount of any head of damages was recovered in this or any case, it will be informative to understand how these formulas have, in a very limited sense, crept into the relevant case law. A great many Medicaid recipients have represented to the courts that the United States Supreme Court used such a formula in what could be described as a seminal case in this area of law—*Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006). The Supreme Court did no such thing.

Instead the *parties* in that case—one of which was Arkansas's Medicaid agency—merely used such a formula to come to a stipulation about the medical expense portion of the settlement at issue in that case. Then, the parties presented that figure to the Court as the agreed upon medical expense portion of the settlement—it was only at this point that the court got involved, and there is no indication that the Court could have cared less about how the parties came to the stipulation.

The Court made absolutely no comment on the validity or usefulness of the formula. All the Court cared about, so to speak, was that the parties had agreed as to the medical expense portion of the settlement, therefore perfectly teeing up the

issue of whether Arkansas could be reimbursed more than that amount, as Arkansas was seeking to do, pursuant to its Medicaid statute.

ii. Full value formulas can not prove the medical expense portion of a settlement

Full value formulas may (or may not) be a way to make the vaguest estimations of what is in a settlement, and they may (or may not) be a fine means of coming up with “equitable” allocations of settlements. However, they are simply inadequate to determine the precise medical expense portion of a settlement.

Nonetheless, this method warrants attention on account of the fact that it is championed by the vast majority of the Medicaid recipients who refuse to reimburse the public treasury pursuant to statute. Such people posit these analyses as a way to determine the *precise, limited* portion of a settlement that is comprised of past medical expense damages.

Recipients claim that by doing a “full-value formula” one can determine, *as a matter of fact*, the precise portion of an undifferentiated settlement that is comprised of past medical damages. Then, they try to make the Agency contend with that “fact.” This is, of course, specious.

Who can earnestly say that they can accurately determine the value of the damages in a case that has not gone to trial or been through some other bona fide fact-determination proceeding? In this case especially, a survey of what the

Appellants put forth as the “full value” of the damages reveals not a precise number, but instead a \$5,000,000.00 range. Moreover, that range starts and ends at round, roughly estimated numbers: \$20,000,000.00 and \$25,000,000.00. So, dividing the settlement by some number in that range and then multiplying the quotient by the past medical/medical expense damages figures—i.e., doing a “full-value formula”—does nothing but create the vaguest estimate.

Perhaps the most persuasive attack on “full-value analyses” comes from the United States District Court for the Eastern District of Pennsylvania:

The second problem with Plaintiffs’ ratio theory is that it requires a judicial ascertainment of the platonic “true value” of Plaintiffs’ claims. At best, this would convert *Ahlborn* hearings into mini-trials, replete with competing damages experts and witnesses testifying as to issues like humiliation, pain and suffering, and loss of enjoyment of life. This would seriously undermine the economy of settlement. At worst, this would send judges on a quixotic intellectual journey in search of an illusory number.

Aside from the logistical difficulties that Plaintiffs’ theory would produce, it also suffers from a logical failing. Why should one assume that simply because Plaintiffs settled for a fraction of the supposed “true value” of their claim that this fractional reduction applies uniformly across the various heads of damage? For example, a plaintiff’s past medical expenses can more easily be proven to a jury than can a plaintiff’s non-economic damages. Therefore, plaintiffs face less uncertainty regarding recovery of medical expenses and thus will be less willing during settlement talks to reduce their request for past medical expenses than for other, more uncertain heads of damage.

McKinney v. Philadelphia Housing Authority, 2010 WL 3364400 *7 (E.D. PA. August 24, 2010).

There is another criticism, a logical failing inherent in these full-value formulas. This one was pointed out by the Fifth DCA in *Smith*, where it points out that it can not be assumed that each head of damage was reduced equally:

. . . a tortfeasor could agree, in settlement, to pay 100% of a plaintiff's medical expense claim, but not all non-economic damages. If only the non-economic damage portion of a claim were compromised in settlement, the formula would not work at all. Rather, the full medical expense portion of the original damage claim would be available to satisfy the State's lien, even though the claim settled for less than the damages originally alleged.

Smith, 24 So.3d at 591, n. 1. (Emphasis provided). Taking these criticisms together it is plain to see that the idea that these “full-value formulas” do anything to decipher the *actual, factual* portion of a settlement that is comprised of medical expenses is farcical.

iii. Appellant’s apparent attempt at use of a full value formula failed

Above, it was described how Appellant’s expert testified that the value of the damages in this case was “20, 25 million.” It is simply mathematically impossible to insert a range like this into a formula. The Judge in this case could not have divided the settlement amount by “20, 25 million”—this being the first

step in such a formula. Accordingly the Court could not have performed a full value formula.³ But such formula was the only thing proffered by the Appellant. Appellant's only witness did not testify as to the medical expense portion of the settlement.

But not only did the Appellant's sole "expert" witness not come up with a full value figure, he did virtually nothing to support the range he threw out—it was totally conclusive. Of course, all that a "full value" figure is the sum of the full value of each head of damages—i.e., past medicals, plus future medicals, plus pain and suffering, plus future lost wages, and so forth. But here the witness did nothing to establish, for example, how much the recipient had in the way of loss of future earning capacity. One would necessarily need to know this figure, in order to add it to the other heads of damages to come up with the "full value" of all damages.

And in order to know that head of damages, one would need to hire other experts, and have an economist perform calculations. And so it would need to go with all heads of damages. But none of this was present here. All the Court got was an attorney, providing a conclusive "opinion" that the value of the damages was "approximately 20, 25 million."

³ Note that this incredible range stands in starkest contrast to the precise, non-round, non-range full value figure (\$3,040,708.12) agreed to by the parties, including the Medicaid agency, in *Ahlborn*.

The point is clear: the Court was not presented with a plausible or coherent case that less than the Agency's reimbursement amount was the medical—or, for that matter, past medical—portion of the settlement. Accordingly, there was no basis for the Court to reduce the Agency's reimbursement. Therefore, even if the Court's decision to not consider the evidence was, in light of new case law, wrong, the Court's decision was nonetheless correct. Even under the new case law, the Agency's reimbursement should not be reduced.

II. Regardless of whether this Court affirms the Circuit Court's Order, the Appellant should not be granted a second opportunity to prove her case

To this point in this brief, the Appellee has argued that the Circuit Court's Order was correct, whether or not for the wrong reasons. That is, the Agency has argued that even if the Circuit Court had fully and truly considered the Appellant's evidence, it would still have been correct to reimburse the Agency pursuant to Section 409.910(11)(f), Florida Statutes, because the Appellant failed to prove that some smaller portion of the settlement than the (11)(f) amount was medical damages.

Even if this Court were to reject the Appellee's argument in this regard, and conclude that the Appellant indeed proved, with evidence, there was less than \$360,741.48 in medicals in the settlement, then there would be no need for an additional hearing. Indeed, the point that no additional hearing would be required

seems logically unavoidable if one rejects the “right (if) only for the wrong reason” argument presented above.

As discussed above, the Court indeed granted the Appellant the opportunity to present any and all evidence which the Appellant wished to. Accordingly, to conduct another evidentiary hearing in this matter would be a pure waste of judicial and attorney resources.

III. Section 409.910(11)(f), Florida Statutes, does indeed determine the medical expense portion of recipients’ settlements

At the end of the Appellant’s brief, Appellant swings for the fences, arguing that Section 409.910(11)(f), Florida Statutes, does not even make for a *rebuttable* presumption as to the medical expense portion of recipients’ settlements. This constitutes swinging for the fences, so to speak, inasmuch as it asks this Court to go beyond the holding even of *Wos*.

In *Wos*, the Supreme Court, for the first time, expressly stated that state Medicaid formulas can not be used to conclusively and “irrebuttably” determine the medical expense portion of a settlement. Prior to *Wos*, several states, including Florida, essentially took the position that the number produced by a statutory formula is, notwithstanding any argument or potential evidence to the contrary, the medical expense portion of a settlement.

With *Wos*, the Supreme Court dealt a blow to Medicaid reimbursement efforts across the country, holding that such formula-determined figures must be

rebuttable, with evidence. This holding is mirrored by several Florida DCA cases. *See, Roberts v Albertson's*, 119 So.3d 457 (Fla. 4th DCA 2012), *Riley v. AHCA*, 119 So.3d 514 (Fla. 2d DCA 2013), *Dillard v. AHCA*, -- So.3d --, 2013 WL6212037 (Fla. 2d DCA 2013), *AHCA v. Williams*, -- So.3d --, 2013 WL 6244193 (Fla. 4th DCA 2013). *Wos* constituted something of a major advance for that tiny fraction of Medicaid recipients that fight to reduce their Medicaid reimbursement obligations. The Appellant, however, wants even more.

Appellant takes aim at the idea that paragraph 409.910(11)(f), Florida Statutes, creates even a *rebuttable* presumption as to the medical expense portion of a settlement. (I.B. 27-33). As already stated above, at least four DCA opinions from the past year involve explicit declarations that the paragraph 409.910(11)(f), Florida Statutes, amount is the rebuttable determination as to the medical expense portion of recipient's settlements.

Appellant acknowledges this reality, in part, citing two such cases—*Riley* and *Roberts*. However, Appellant takes issue with the holdings of these cases, arguing that nothing in paragraph 409.910(11)(f), Florida Statutes, indicates that it was meant to determine the medical expense portion of a recipient's settlement.

This is a classic example of an argument that would prove too much. If it were true that statutory provisions that determine, presumptively, the medical expense portion of a settlement, were required to state that explicitly, then *Wos*

itself would have been wrongly decided. Certainly Appellant does not mean to take issue with *Wos*—a case which one would think is most favored by the Appellant. In *Wos*, the Court focused on North Carolina’s Medicaid reimbursement statutory formula, at 108-57A(a), North Carolina General Statutes:

Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department **shall not exceed one-third of the gross amount obtained or recovered.**

Here, there is no express or explicit indication that the amount designated at the upper limit of North Carolina Medicaid’s reimbursement is the medical expense portion of the settlement. Nonetheless, the United States Supreme Court interpreted the law in that way, and Florida DCAs have followed suit regarding our law. The formula at paragraph 409.910(11)(f), Florida Statutes, does determine the presumptive medical expense portion of a recipient’s settlement.

CONCLUSION

This Court should affirm the Circuit Court's decision because the Appellant provided virtually nothing in the way of evidence in Appellant's attempt to prove that the medical expense portion of her settlement was any amount less than the \$360,741.48 that the Agency was demanding for reimbursement.

Respectfully submitted this 20th day of December, 2013.

s/ Adam J. Stallard
ADAM J. STALLARD
Fla. Bar No. 0070756
2316 Killearn Center Blvd.
Tallahassee, FL 32309
T: (850) 201-1311
fltpllegal@xerox.com (service)
adam.stallard@xerox.com

Counsel for the Appellee

CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief complies with the font requirements of Florida Rule of Appellate Procedure 9.210(a)(2).

/s/ Adam J. Stallard
ADAM J. STALLARD
Florida Bar No. 0070756

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served via electronic mail to Floyd B. Faglie, Esq. (faglielaw@earthlink.net), Susan Ramsey, Esq. (susan@palmbeachattorney.net), Pamela K. Frazier, Esq. (pkfrazier@ltflaw.com), David Olesky, Esq. (david.olesky@cooperscully.com), William Whitney, Esq. (bwhitney@dunlapshipman.com), Les McFatter, Esq. (lmcfatter@perry-young.com), and Barry Washor, Esq., Queller, Fisher, Washor, Et Al., 233 Broadway, 18th Floor, New York, NY (by UPS Air), on this 20th day of December, 2013.

/s/ Adam J. Stallard
ADAM J. STALLARD
Florida Bar No. 0070756

IN THE DISTRICT COURT OF APPEAL
FOR THE FIRST DISTRICT
STATE OF FLORIDA

KAITLYN HARRELL, a minor, individually and
Through her natural parents and guardians,
JOY D. HARRELL and GREG A. HARRELL,
Husband and wife, and JOY D. HARRELL and
GREG A. HARRELL, individually,

Appellant,

v.

D.C.A. Case No.: 1D12-5597

L.T. Case No.: 02003998CA

AGENCY FOR HEALTH CARE
ADMINISTRATION

Appellee.

ON APPEAL FROM THE CIRCUIT COURT OF THE FOURTEENTH
JUDICIAL CIRCUIT IN AND FOR BAY COUNTY, FLORIDA

REPLY BRIEF OF THE APPELLANT

FLOYD FAGLIE
Florida Bar No.: 0569690
Staunton & Faglie, PL
189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
faglielaw@earthlink.net

ATTORNEY FOR APPELLANT

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ARGUMENT

THE TRIAL COURT ERRED IN REFUSING TO CONSIDER EVIDENCE AS TO THE PROPER PAYMENT OF THE MEDICAID LIEN, INSTEAD, INCORRECTLY DETERMINING THAT IT IS BOUND TO APPLY THE FORMULA AT SECTION 409.910(11)(f) TO DETERMINE THE AGENCY'S REIMBURSEMENT

In sum, AHCA acknowledges that the trial court did not consider any evidence, and under later decided precedent, the trial court is required to consider evidence and determine the proper payment of the lien. However, despite this fact, all of AHCA's arguments revolve around the assertion that the trial court's order should be affirmed because, according to AHCA, the trial court reached the right conclusion even though it was for the wrong reason. AHCA's argument in this regard lacks merit, misapplies the tipsy coachman rule and impermissibly ask this Court to consider the evidence in the first instance and make findings of fact when the trial court below refused to consider the evidence and make factual findings.

A. AHCA's Argument that the Trial Court Reached the Right Conclusion for the Wrong Reason.

All of AHCA's arguments revolve around its assertion that the trial court's order should be affirmed because the trial court reached the right conclusion even though it was for the wrong reason.

It is absolute from the record that the trial court determined that it did not have the authority to consider the evidence and was bound to use the formula at section

409.910(11)(f), Florida Statutes, to determine AHCA's payment. The trial court clearly announced its determination in this regard at the conclusion of the hearing by stating, "if the court had the ability to – legally to consider the testimony of Mr. Collis and go through the analysis, it would be incumbent for me to do it, but my reading of the Florida statute and the District Court of Appeals decisions construing that statute, which are binding on this court, is there is no need to engage in that type of analysis, it's simply to follow the formula that is laid out in the statute." (R. 477) Consistent with this statement, the Order on Plaintiffs' Petition to Determine Medicaid Lien stated, "this Court is bound to apply the formula at Section 409.910(11)(f), Florida Statutes, to determine the Agency's reimbursement." (R. 355-56)

AHCA acknowledges that the trial court did not consider evidence and based its ruling solely on the application of the statutory formula. (AB. 4, 10, 11). Further, AHCA acknowledges that under the later decided precedent, of *Wos v. E.M.A.*, 133 S.Ct 1391 (U.S. 2013); *Roberts v. Albertson's Inc.*, 119 So. 3d 457 (Fla. 4th DCA 2013); *Agency for Health Care Admin. v. Riley*, 119 So. 3d 514 (Fla. 2d DCA 2013); *Dillard v. Agency for Health Care Admin.*, 127 So. 3d 820 (Fla. 2d DCA 2013); and *Agency for Health Care Admin. v. Williams*, 127 So. 3d 854 (Fla. 4th DCA 2013), a Medicaid recipient must be afforded the opportunity to challenge the formula at section 409.910(11)(f) and present evidence to have the court

determine the proper payment of the lien. (AB. 4, 5) However, AHCA argues that had the trial court considered the evidence presented, the trial court would have still found that the full lien should be paid.

AHCA is misapplying the tipsy coachman rule and inappropriately asking this Court to make findings of fact when the court with original jurisdiction did not consider the evidence or make findings of fact in the first instance. It is well established that an appellate court may uphold a trial court order if there is any legal basis in the record which supports the judgment. See *Dade County Sch. Bd. V. Radio Station WQGA*, 731 So. 2d 638, 644 (Fla. 1999); *State v. Hankerson*, 65 So. 3d 502 (Fla. 2011); *Craigside, LLC v. GDC View, LLC*, 74 So. 3d 1087 (Fla. 1st DCA 2011). This is known as the tipsy coachman rule.

However, the tipsy coachman rule is inapplicable here because the trial court did not consider the evidence and make findings of fact for a differing legal basis to be applied. It is black letter law that appellate courts are vested with the power of appellate review and it is beyond that jurisdiction for it to undertake to make an original determination of the facts. See *Monticello Drug Co. v. Porter Clothing Co., Inc.*, 149 So. 25 (Fla. 1933) (“The Supreme Court is possessed only of appellate power, it would be inappropriate, if not actually beyond its jurisdiction, for it to undertake to make an original determination of the facts in an equity case where it affirmatively appears that the factual issues involved have never been

considered or determined by the circuit court as a court of first instance”); *Featured Properties, LLC v. BLKY, LLC*, 65 So. 3d 135, 137 (Fla. 1st DCA 2011) (“sitting as an appellate court, we are precluded from making factual findings ourselves in the first instance”); quoting, *Douglass v. Buford*, 9 So. 3d 636, 637 (Fla. 1st DCA 2009); and *Farneth v. State*, 945 So. 2d 614, 617 (Fla. 2d DCA 2006)(“A fundamental principle of appellate procedure is that an appellate court is not empowered to make findings of fact.”). It is for this reason that this Court has recognized the well-established rule that this Court “cannot employ the tipsy coachman rule where a lower court has not made factual findings on an issue and it would be inappropriate for an appellate court to do so.” *Featured Properties, LLC v. BLRY, LLC*, 25 So. 3d 135, 137 (Fla. 1st DCA 2011); quoting, *Bueno v. Workman*, 20 So. 3d 993, 998 (Fla. 4th DCA 2009).

In this case, it is absolute from the record that the trial court did not consider any of the evidence and did not make findings of fact. This is because the trial court determined that it was not authorized to consider the evidence and was instead bound to apply the formula at section 409.910(11)(f) to determine AHCA’s payment. Accordingly, since the trial court did not consider the evidence and make findings of fact it is inappropriate to apply the tipsy coachman rule to determine that the trial court’s ruling was correct for the wrong reason.

All of AHCA's arguments in its Answer Brief are grounded in its assertion that the trial court reached the right result for the wrong reason. As discussed above, AHCA is misapplying the tipsy coachman rule and inappropriately asking this Court to make findings of fact when the court with original jurisdiction did not consider the evidence or make findings of fact in the first instance.¹ All of AHCA's arguments lack merit and must be rejected.

Under the precedent of the U.S. Supreme Court in *Ark. Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) and *Wos v. E.M.A.*, 133 U.S. 1391 (2013), as well as the Florida decisions applying this precedent, it was error for the trial court to refuse to consider evidence and determine the proper payment of the lien. The Order on appeal must be reversed and the matter remanded to the trial court for further evidentiary proceedings.

With AHCA's arguments addressed, the remainder of this Reply Brief will discuss AHCA's related argument raised on appeal that it can recover reimbursement of past Medicaid benefits from *both* the portion of the settlement

¹ As noted in Footnote 5 of Appellant's Initial Brief, after the *Wos* decision, Appellant filed a Motion requesting this Court to relinquish jurisdiction back to the trial court for further proceedings in-light-of *Wos*. AHCA filed opposition to this Court relinquishing jurisdiction to the trial court. If AHCA's only argument was that this Court should misapply the tipsy coachman rule and inappropriately make findings of fact when the court with original jurisdiction did not consider the evidence or make factual findings, AHCA should have consented to the relinquishment of jurisdiction to allow the trial court to do what it is now clear it should have done -- consider the evidence and determine the proper payment of the lien.

compensating for past medical expenses and the portion of the settlement compensating for future medical expenses.

B. Under Federal Law, *Ahlborn*, *Wos*, and the Cases Applying this Law, AHCA May Only Recover from the Portion of a Settlement Representing Compensation for Past Medical Expenses. AHCA is prohibited from Recovering from the Portion of the Settlement Compensating for Future Medical Expenses

AHCA argues that it can recover reimbursement for past Medicaid payments from *both* the portion of the settlement representing compensation for past medical expenses and the portion representing compensation for future medical expenses. (AB. 11 – 19) AHCA made this same tired meritless argument post-*Wos* in *Riley*, *Dillard*, and in the most recent decision on the topic of AHCA’s recovery, *Davis v. Roberts*, --So.3d--, 2013 WL 6687849 (Fla. 5th DCA Dec. 20, 2013). AHCA is incorrect in its assertions and this Court should reject this argument.

1. No Florida Court has held AHCA can recover from the portion of a settlement compensating for future medical expenses. Instead, two Florida Courts have specifically limited AHCA’s recovery to only the portion of a settlement compensating for past medical expenses

AHCA claims that “the Florida District Courts of Appeal decisions also allow for recovery from the future medical expense portion of a settlement.” (AB. 18) However, AHCA does not cite a single Florida decision “allowing for recovery from the future medical expense portion of a settlement.” This is because no Florida Court has stated AHCA can recover from the portion of a settlement

compensating for future medical expenses. In fact, at least two Florida decisions have specifically stated the recovery may only be made from the portion of a settlement compensating for past medical expenses.

The Third District summed-up *Ahlborn* as restricting Medicaid reimbursement from only the past medical expense portion of a settlement by stating:

“*Ahlborn* struck down an Arkansas statute to the extent that it allowed for Medicaid recovery that could impinge on an entire plaintiff’s award and not merely **past medical damages for which Medicaid may be reimbursed.**”

Garcon v. Agency for Health Care Admin., 96 So. 3d 472, 474 (Fla. 3d DCA 2012)(emphasis added).

Despite the fact that the Third District in *Garcon* concisely summed up the *Ahlborn* holding as limiting Medicaid’s reimbursement to the portion of a Medicaid recipient’s settlement compensating for past medical expenses, AHCA has represented to this Court that this is “plainly dicta.” (AB. 18) AHCA’s representation to this Court is contrary to the Florida Attorney General’s position taken before the Florida Supreme Court. The Attorney General on page 2 of its “*Respondent’s Unopposed Motion to Remand for Further Proceedings in light of the United States Supreme Court’s Opinion in Wos v. E.M.A.*” filed Jan. 21, 2014 in *Garcon v. Agency for Health Care Admin.*, Case No. SC12-2406, states that the *Garcon* Court based its decision on *Ahlborn* and “**reasoned** that *Ahlborn* had disapproved of a state statute “to the extent that it allowed for Medicaid recovery that could impinge on an entire plaintiff’s award and not merely past medical

damages for which Medicaid may be reimbursed.””² Thus, the Florida Attorney General has correctly recognized that the Third District reasoned that *Ahlborn* limited Medicaid reimbursement to only the portion of a settlement compensating for past medical expenses.³

Further, the Fifth District in *Davis v. Roberts*, --So.3d--, 2013 WL 6687849 (Fla. 5th DCA Dec. 20, 2013), concisely outlined that under *Ahlborn* and *Wos*, federal law prevented AHCA from recovering beyond the portion of a settlement compensating for past medical expenses. In *Davis*, the trial court determined that AHCA was entitled to full payment of its lien from the Medicaid recipient’s settlement because the formula at section 409.910(11)(f) required full payment of the lien. In presenting the issue, the *Davis* Court stated:

“Appellants argue that section 409.910 is unenforceable to the extent it allows AHCA to recover more than what Hunter’s settlement allocated for past medical expenses. We agree and hold the trial court erred when it determined as a matter of law that it was without discretion to limit repayment of the lien and was instead, required to apply the formula set forth in section 409.910(11)(f).”

Id., 2013 WL 6687849 at *1.

The *Davis* Court then proceeded to review *Ahlborn*, *Wos*, *Roberts* and *Riley*. The *Davis* Court in footnote 4 noted that AHCA had filed a supplemental

² The Attorney General’s Motion for Remand will be filed with this Court as an Appendix.

³ A detailed explanation of federal law, *Ahlborn* and *Wos* limiting AHCA to reimbursement from only the portion of the settlement compensating for past medical expenses can be found on pages 3 – 8 of the “*Amicus Brief of the Florida Justice Association in Support of Petitioners, Nadia Garcon*,” filed Nov. 22, 2013 in *Garcon v. Agency for Health Care Admin.*, Case No. SC12-2406. The Florida Justice Association’s Amicus Brief will be filed as an Appendix.

memorandum “analyzing *Wos*.” The *Davis* Court noted that “AHCA argues, that *Wos* is really distinguishable from the instant case and that this court is not bound in any way by that decision.” *Id.* at *6. In regard to AHCA’s analysis of *Wos*, the *Davis* Court simply stated “we disagree.” *Id.* The *Davis* Court then summed-up its analysis of *Ahlborn* and *Wos* and announced its ruling by stating:

“*Ahlborn* and *Wos* make clear that section 409.910(11)(f) is preempted by the federal Medicaid statute’s anti-lien provision to the extent it creates an irrebuttable presumption and permits recovery beyond that portion of the Medicaid recipient’s third-party recovery **representing compensation for past medical expenses**. Accordingly, we agree with the fourth district in *Roberts* that section 409.910(11)(f) is a “default allocation.” 119 So.3d at 465. As such, we reiterate our prior directive and hold that a Medicaid recipient “should be afforded the opportunity to seek the reduction of a Medicaid lien amount by demonstrating, with evidence, that the lien amount [established by section 409.910(11)(f)] exceeds the amount recovered for medical expenses.” *Smith*, 24 So. 3d at 592; see also *Agency for Health Care Admin. v. Riley*, 119 So.3d 514, 516 (Fla. 2d DCA 2013) (expressly adopting the fourth district’s holding in *Roberts* that a plaintiff 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).”

Id. 2013 WL 6687849 at *4 (emphasis added).

Accordingly, while no Florida court has stated AHCA may seek reimbursement for past payments made by Medicaid from the portion of a settlement compensating for future medical expenses, at least two appellate courts have determined *Ahlborn* and *Wos* limited AHCA to recover from only the portion of a settlement compensating for past medical expenses.

2. Federal law, *Ahlborn*, *Wos*, and the cases applying this law, all confirm AHCA may only recover from the portion of the settlement compensating for past medical expenses

Federal law, *Ahlborn*, *Wos*, and the cases applying this law, all confirm that Medicaid may only recover from the portion of a settlement compensating for past medical expenses.

This question was answered in *Ahlborn*. In *Ahlborn*, Heidi Ahlborn filed a federal action seeking “a determination that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than **past** medical expenses.” *Ahlborn*, 547 U.S. at 274. The *Ahlborn* Court then shaped its analysis and opinion around this fundamental fact.

For example, after discussing portions of the federal Medicaid Act in detail, the *Ahlborn* Court concluded that “the State can also demand as a condition of Medicaid eligibility that the recipient ‘assign’ in advance any payments that may constitute reimbursement for medical costs.”⁴ 547 U.S. at 284. Necessarily, if a payment from a third party constitutes “reimbursement” for medical costs, then the “medical costs” had to have occurred in the past. See, e.g., *Black’s Law Dictionary*, 1287 (6th Edition) defining “reimbursement” as “to pay back, to make restoration, to repay that expended.”) Hence, the *Ahlborn* Court held that a state

⁴ The *Davis* Court also cited *Ahlborn* when explaining that States are “required by the federal government to seek **reimbursement for medical expenses incurred**.” 2013 WL 6687849, at *1. “Reimbursement for medical expenses incurred” would be repayment for past medical expenses.

can demand that a Medicaid recipient “assign” the recipient’s ability to collect payment from a third party for past medical expenses but, “[b]eyond that, the anti-lien statute applies.” 547 U.S. at 285. In applying this rule of law, the *Ahlborn* Court limited Arkansas to recover “only the portion of the settlement (\$35,581.47) that constitutes reimbursement for medical payments made.” 547 U.S. at 274. While Ms. Ahlborn had suffered serious injury that required future medical care, the *Ahlborn* Court did not indicate that Arkansas can recover from any portion of the settlement compensating for these future medical expenses.

So, as the Florida Courts have noted, under federal law as interpreted by *Ahlborn*, AHCA may only recover from the portion of the settlement compensating for past medical expenses.

This is consistent with the text of the federal Medicaid statute and how courts have interpreted *Ahlborn* and *Wos*. One need only look at the limited assignment provided in 42 U.S.C. §1396a(a)(25)(H) to see that the limited assignment granted to AHCA allows only recovery from the portion of a settlement compensating for past medical expenses.⁵ 42 U.S.C. §1396a(a)(25)(H) states, “to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for

⁵AHCA in its Answer Brief devoted 3 pages (AB. 15 -17) block quoting federal statutes reviewed in *Ahlborn* claiming that these statutes did not limit AHCA’s recovery to past medical expenses. AHCA failed to cite 42 U.S.C. §1396a(a)(25)(H), which is a critical statute reviewed in both *Ahlborn* and *Wos*.

such assistance,” (i.e., the “payment that has been made”) then “the State is considered to have acquired the rights of [the Medicaid recipient] to payment by any other party for such health care items or services.” A plain reading of this statute makes clear that “the italicized word ‘*such*’ refers to the ‘payment [that] has been made.’” *McKinney ex rel. Gage v. Philadelphia Hous. Auth.*, No. 07-4432, 2010 WL 3364400, *9 (E.D. Pa. Aug. 24, 2010); *see also Ahlborn*, 547 U.S. at 281; *In Re E.B.*, 729 S.E.2d 270, 298-99, 305-06 (W. Va. 2012). Thus, the assignment given by the Medicaid recipient to Medicaid is only for the right to collect from monies representing compensation for past medical expenses (“payment that has been made” by Medicaid), not monies representing compensation for future medical expenses.

Besides the Florida appellate decisions which limit AHCA recovery to only the portion of a settlement compensating for past medical expenses, a number of courts post-*Ahlborn* have addressed State’s arguments that they can recover from both the recovery in past medical expenses and the recovery in future medical expenses. With few exceptions,⁶ the courts have rejected this argument and limited the State to recover from only the portion of the settlement representing past

⁶ The **only** appellate court in the entire nation to determine that under *Ahlborn* a State can recover from the portion of a settlement representing compensation for *future* medical expenses is the 2009 Idaho decision of *In Re: Matey*, 213 P.3d 389 (Idaho 2009) (cited by AHCA on page 12 of its Answer Brief). However, *Matey* was poorly decided and issued years before the 4th Circuit in *E.M.A.* held “the *Ahlborn* Court’s decision makes clear, federal Medicaid law limits a state’s recovery to settlement proceeds that are shown to be properly allocable to **past medical expenses**.” 674 F.3d at 312; *aff’d*, *Wos*.

medical expenses. See *In Re E.B.*, 729 S.E.2d 270, 298-99, 305-06 (W.Va. 2012)(surveying the cases on both sides of this issue and noting the majority of courts have interpreted federal law and *Ahlborn* to limit Medicaid to recover from only the portion of a settlement representing “*past, not future, medical expenses.*”).

Further, nothing in *Wos* displaces the *Ahlborn* Court’s interpretation of federal law to limit a State to recover from only the portion of a settlement compensating for past medical expenses. As in *Ahlborn*, the U.S. Supreme Court’s discussion of the facts in *Wos* leads to the unequivocal conclusion that Medicaid is limited to recovering only the amount of a Medicaid recipient’s settlement representing compensation for “past” medical expenses. This is true even if the *Wos* Court did not use the word “past” in its holding. For example, when discussing why *Ahlborn* anticipated that a hearing would be necessary to determine how much of a settlement represents compensation for medical expenses, the *Wos* Court looked at the facts a trial court would examine in the *Wos* case. The *Wos* Court noted that, given that E.M.A. was injured at birth, “it is apparent that a quite substantial share [of her total damages] must be allocated to the skilled home care she will require for the rest of her life.” *Wos*, 133 S.Ct. at 1399. In the same breath, the *Wos* Court also discussed the need to identify what E.M.A.’s parents “could have expected to receive as compensation for their other tort claims had the suit preceded to trial.” *Id.* Implicit in the Court’s discussion is the fact that the

category of damages for future medical costs (along with compensation for E.M.A.'s parents' claims) would be excluded from the amounts Medicaid would be able to recover. Hence, the *Wos* Court's conclusion that "[a]n irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to [past] medical expenses." *Id.*

The fact that the *Wos* Court was considering only past medical expenses and interpreted *Ahlborn* to limit recovery to only the portion of a settlement compensating for past medical expenses, is confirmed in its affirmance of the *E.M.A.* decision where the 4th Circuit had consistently stated the *Ahlborn* holding as:

"The [*Ahlborn*] Court concluded that the Federal third-party liability provisions require an assignment of no more than the right to recover the portion of the settlement proceeds which are designated for **past medical bills paid by Medicaid**" *E.M.A.*, 674 F.3d at 294 (emphasis added).

"*Ahlborn* is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care **already received.**" *Id.* at 308 (emphasis added).

"As the unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to **past medical expenses.**" *Id.* at 312 (emphasis added).

Accordingly, federal law, *Ahlborn*, *Wos*, and the appellate cases applying this law, all confirm that AHCA can only recover from the portion of the settlement representing compensation for past medical expenses.

Therefore, this Court should reject AHCA's arguments that it can recover from the portion of a settlement compensating for future medical expenses and hold that, "*Ahlborn* and *Wos* make clear that section 409.910(11)(f) is preempted by the federal Medicaid statute's anti-lien provision to the extent it creates an irrebuttable presumption and permits recovery beyond that portion of the Medicaid recipient's third-party recovery representing compensation for past medical expenses." *Davis* , 2013 WL 6687849 at *4.

CONCLUSION

The trial court below did not consider any evidence, and under later decided precedent, the trial court is required to consider evidence and determine the proper payment of the lien. AHCA's arguments lack merit, misapplies the tipsy coachman rule and impermissibly ask this Court to consider the evidence in the first instance and make findings of fact when the trial court below refused to consider the evidence and make factual findings.

The order on appeal should be reversed and the case remanded for further evidentiary proceedings for the court to determine the portion of the settlement compensating for past medical expenses and to limit AHCA to this amount.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served via e-mail to Susan B. Ramsey, Esq., Gary Roberts & Associates, P.A., susan@palmbeachtrialattorney.net; 324 Datura Street, Suite, 223, West Palm Beach, FL 33401; Pamela K. Frazier, Esq., Lozier, Thames & Frazier, P.A., pkfrazier@ltflaw.com; 24 W. Chase Street, Pensacola, FL 32502-5614; David E. Olesky, Esq., david.olesky@coopersculley.com; Cooper & Sculley, P.C., 900 Jackson, Suite 100, Dallas, TX 75202; Barry Washor, Queller, Fisher, Washor, et al, 233 Broadway, 18th Floor, New York, NY 10279; William Whitney, Esq., Dunlap & Shipman, 60 Clayton Lane, bwhitney@dunlapshipman.com Santa Rosa Beach, FL 32459; Les McFatter, Esq., Perry & Young, Lmcfatter@perry-young.com; 2612 W. 15th Street, Panama City, FL 32401 and Adam J. Stallard, Esq.fltplegal@xerox.com; and James H.K. Bruner, Sr., Esq. james.bruner@xerox.com ACS / Xerox Recovery Services, collections contractor for the Agency for Health Care Administration, P.O. Box 12188, Tallahassee, FL 32317; this 3rd day of March, 2014.

CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief complies with the font requirements of
Florida Rules of Appellate Procedure 9.210(a)(2).

Staunton & Faglie, PL
189 East Walnut Street
Monticello, FL 32344
T: (850) 997-6300
faglielaw@earthlink.net

/s/ Floyd Faglie
FLOYD FAGLIE, ESQ.
Fla. Bar No. 0569690
Counsel for the Appellant

DISTRICT COURT OF APPEAL, FIRST DISTRICT
2000 Drayton Drive
Tallahassee, Florida 32399-0950
Telephone No. (850)488-6151

December 12, 2016

CASE NO.: 1D16-0392
L.T. No.: 15-4423MTR

MARIA ISABEL GIRALDO and Juan
Gonzalo Villa

v.

Agency For Health Care Administration

Appellant / Petitioner(s),

Appellee / Respondent(s)

BY ORDER OF THE COURT:

**ORDER STRIKING APPELLANTS' UNOPPOSED
REQUEST FOR JUDICIAL NOTICE**

We treat Appellant's request that this court take judicial notice of our earlier decision in Harrell v. State, 143 So. 3d 478 (Fla. 1st DCA 2014), and the briefs filed therein as a Rule 9.225 notice of supplemental authority which we strike for failure to comply with the requirements of that rule. See Fla. R. App. P. 9.225 (providing that notices of supplemental authority may be filed to call attention—without argument—to “decisions, rules, statutes, or other authorities”); Smith v. City of Fort Myers, 944 So. 2d 1092, 1094 (Fla. 2d DCA 2006) (confirming that an issue was not determined in a prior appeal merely because it had been argued as an alternative basis for relief); Ogden Allied Servs. v. Panesso, 619 So. 2d 1023, 1024 (Fla. 1st DCA 1993) (stating that notices of supplemental authority should not be used as an additional briefs); Fla. Dep't of Health & Rehab. Servs v. Martin, 563 So. 2d 1124, 1125 (Fla. 1st DCA 1990) (holding that argument in a notice of supplemental authority is subject to a motion to strike).

I HEREBY CERTIFY that the foregoing is (a true copy of) the original court order.

Served:

Celene H. Humphries
Alexander R. Boler

Floyd B. Faglie
Claudia Llado, Clerk

Maegen P. Luka

co

Jon S. Wheeler

JON S. WHEELER, CLERK



**IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT OF FLORIDA**

MARIA ISABEL GIRALDO
and JUAN GONZALO VILLA,
as co-personal representatives of
the estate of JUAN L. VILLA,

Appellant,

Case No. 1D16-0392

v.

L.T. Case No. 15-4423MTR

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Appellee.

**APPELLANT’S MOTION FOR REHEARING EN BANC AND MOTION
TO CERTIFY A QUESTION OF GREAT PUBLIC IMPORTANCE**
(Intra-district conflict)

This Court should accept en banc review because there is an explicit and direct conflict between Judge Makar’s opinion in *Harrell v. State*, 143 So. 3d 478 (Fla. 1st DCA 2014), and this Court’s recent opinion in *Villa v. State*, Case No. 1D16-0392 (Slip Op. Dec. 12, 2016).

Both opinions addressed the same issue: the limits imposed by federal Medicaid law on the ability of Florida’s Medicaid Agency (AHCA) to seek reimbursement when a Medicaid recipient settles the tort claim that gave rise to the injuries for which AHCA paid. In *Harrell*, Judge Makar wrote that AHCA may seek reimbursement from only “that portion of the Medicaid recipient’s

[settlement] representing compensation for *past* medical expenses.” 143 So. 3d at 480 (emphasis added), citation omitted. But here, the *Villa* panel implied that this language in *Harrell* was dicta, made no effort to distinguish it, and then reached the opposite legal conclusion. The *Villa* panel concluded that AHCA may seek reimbursement from not just past medical expenses, “but also from that portion of the settlement intended as compensation for *future* medical expenses.” Slip Opinion at 8 (emphasis added).

Harrell and *Villa* are irreconcilable. These cases address the same factual situation—and interpret the same binding case law, as we discuss below—but reach contradictory conclusions. This Court should review *Villa* en banc to address this express conflict. Alternatively, as explained at the end of this motion, this Court should certify a question of great public importance.

Brief Background of the Reimbursement Issue

The *Harrell* and *Villa* opinions are based on the interpretation of the same two United States Supreme Court cases, *Arkansas Department of Health and Human Services v. Ahlborn*, 126 S. Ct. 1752 (2006), and *Wos v. E.M.A.*, 133 S. Ct. 1391 (2013).

In *Ahlborn*, a Medicaid recipient challenged a lien imposed by Arkansas’s Medicaid agency. 126 S.Ct. at 1757. The Medicaid recipient sought a declaratory judgment that the lien violated federal Medicaid law because satisfying the lien

would “require depletion of compensation for injuries other than *past medical expenses*.” *Id.* (emphasis added). The Supreme Court unanimously agreed, holding that federal law “affirmatively prohibits” states from imposing a lien on anything more than the portion of the settlement representing compensation for past medical expenses. *Id.* at 1767 (referencing the amount of the settlement the parties agreed represented compensation for past medical expenses and holding that federal law prohibited recovering anything other than this amount).

Similarly, in *Wos*, 133 S. Ct. at 1402, the Supreme Court affirmed the Fourth Circuit Court of Appeals, which wrote that “[a]s the unanimous *Ahlborn* Court’s decision makes clear, federal Medicaid law limits a state’s recovery to settlement proceeds that are shown to be properly allocable to *past medical expenses*.” *E.M.A. v. Cansler*, 674 F. 3d 290, 312 (4th Cir. 2012) (emphasis added). Unlike *Ahlborn*, the parties in *Wos* did not agree regarding the portion of the settlement that represented past medical expenses. Thus, the Fourth Circuit held that, where the settlement does not make an express allocation to past medical expenses, states cannot use an irrefutable statutory formula to determine that amount. Instead, past medical expenses must be determined by “a fair and impartial adversarial procedure.” *Id.* In its affirmance, the Supreme Court clearly indicated that the determination of what amount of the settlement the state could recover was limited to the portion of the settlement representing compensation for medical expenses

that had already been paid – as opposed to future medical expenses. *Wos*, 133 S. Ct. at 1402 (Breyer, J., concurring) (“The question before us is how to measure what share of a judgment or settlement of an accident victim’s lawsuit represents payment (or reimbursement) for health care items (or services) for which a State has already paid on behalf of a victim.”).

Harrell and Villa arrive at contradictory, and irreconcilable, interpretations of Ahlborn and Wos.

In *Harrell*, Judge Makar wrote that “*Ahlborn* and *Wos* make clear that [calculation of AHCA’s recovery by use of Florida’s statutory formula] is preempted by the federal Medicaid statute’s anti-lien provision to the extent it creates an irrebuttable presumption *and* permits recovery *beyond that portion of the Medicaid recipient’s [settlement] representing compensation for past medical expenses.*” *Harrell*, 143 So. 3d at 480, quoting *Davis*, 130 So. 3d at 270 (emphasis added). Thus, Judge Makar said that when AHCA is seeking reimbursement from a Medicaid recipient’s tort settlement, AHCA can only recover from the portion of the settlement that compensates the recipient for medical bills he has already incurred—the rest of the settlement, including compensation for future medical expenses, is off limits. *Id.*

Despite *Harrell*’s unequivocal language, the panel in this case reached the exact opposite conclusion, stating that nothing in *Ahlborn* or *Wos* indicates that the Supreme Court intended to limit AHCA’s recovery to only the past medical

expenses portion of a settlement. Slip Opinion at 13-14. The *Villa* opinion concludes that AHCA has the “right to secure reimbursement for payments already made for medical costs from *not only that portion of the settlement allocated for past medical expenses* but also from that portion of the settlement intended as compensation for *future* medical expenses.” Slip Opinion at 8; *see also* Slip Opinion at 16 (“While it is true that AHCA may only secure payment for the amount it actually expended on Villa’s behalf, that does not mean that it cannot collect that amount from the sums that Villa recovers for both past and future medical expenses.”).

The *Villa* opinion makes no effort to explain how it could reach a conclusion directly and explicitly contrary to *Harrell*. The *Villa* opinion does correctly note that the express issue on appeal in *Harrell* was whether the Medicaid recipient should be given a hearing to rebut the application of a statutory formula when calculating how much of the settlement AHCA could recover. Slip Opinion at 15-16. So, the *Villa* panel implied (but did not say) that the language limiting AHCA to recovering only from the past medical expense portion of the settlement is dicta.

But, as discussed at oral argument, Judge Makar included that language in *Harrell* because it affected the outcome of the case. AHCA argued extensively in the *Harrell* answer brief that, even if *Harrell* was entitled to a hearing (to rebut application of the statutory formula that would otherwise calculate AHCA’s

recovery), AHCA could still recover its full lien because AHCA could recover from the future medical expenses portion of the settlement (which was the bulk of the settlement). Nearly the entire reply brief was spent responding to that argument. Thus, Judge Makar's statement that AHCA was limited to recovering only from that portion of the settlement "representing compensation for past medical expenses" was a response to AHCA's argument in *Harrell* (the same argument AHCA made here). More than that, this statement would have to be followed on remand: when the *Harrell* panel reversed so that there could be a hearing to determine how much AHCA could recover from the settlement, the trial court knew that it could not permit AHCA to recover from the future medical expenses portion of the settlement.¹

¹ Undersigned asked the panel, both by motion and at oral argument, to take judicial notice of the *Harrell* briefs. The panel treated Appellant's "Unopposed Request for Judicial Notice" as a "Notice of Supplemental Authority." The same day it issued the opinion, the panel struck the request, citing two cases that say supplemental authority should be submitted without argument and saying that "notices of supplemental authority may be filed to call attention – without argument – to 'decisions, rules, statutes or other authorities.'" But briefs in another case are never supplemental authority – and the *Villa* panel was not being asked to treat them as such. Instead, in order to prevent "inconsistent results," the panel was being asked to take judicial notice that the *Harrell* briefs made the same arguments presented in this case. *Gulf Coast Home Health Servs. of Fla. v. Dep't of Health & Rehab. Servs.*, 503 So. 2d 415, 417 (Fla. 1st DCA 1987) (holding that it is "altogether appropriate for the appellate court to take judicial notice of the existence of other cases...which bear a relationship to the case at bar" to prevent "inconsistent results" and that the "notice may include, at minimum, the identity of the parties and their counsel, [and] issues presented in the briefs....").

Moreover, even if Judge Makar’s unequivocal statement was dicta, a subsequent panel cannot simply ignore that the statement was made – which is what the panel did here. *See, e.g., Fla. Power & Light Co. v. Price*, 170 So. 2d 293, 297 (Fla. 1964) (“Even if some of the conflicting language in the above decisions may be dicta, it is sufficiently conflicting with the decision under review to warrant assuming certiorari jurisdiction.”).

Put simply, the statement in *Villa* that federal law allows AHCA to recover from “***not only that portion of the settlement allocated for past medical expenses*** but also from that portion of the settlement intended as compensation for future medical expenses” (Slip Opinion at 8) (emphasis added), directly conflicts with Judge Makar’s prior statement in *Harrell* that federal law limits AHCA to recovering from “***[only] that portion of the Medicaid recipient’s [settlement] representing compensation for past medical expenses.***” *Harrell*, 143 So. 3d at 480 (emphasis added), citation omitted. And, based on those two diametrically opposed interpretations of the same federal law, the outcome in this case is the opposite of the outcome in *Harrell*. (Under materially indistinguishable facts, in *Harrell*, federal law precluded AHCA from recovering the portion of the settlement representing compensation for future medical care; in *Villa*, the same federal law permitted AHCA to recover from the future medical care portion of the settlement.)

Thus, there is an express and direct conflict in how this Court has interpreted United States Supreme Court precedent and its impact on AHCA's ability to seek reimbursement from a Florida Medicaid recipient's settlement. This Court should rehear the case en banc to resolve the irreconcilable difference between *Villa* and *Harrell*.

Alternatively, the panel should certify the issue as one of great public importance.

At a minimum, the panel should certify the issue as one of great public importance. The determination of the sources from which AHCA can seek reimbursement under section 409.910 potentially affects the property rights of every Medicaid recipient in the state of Florida. It most assuredly affects the property rights of every Medicaid recipient who recovers for his injuries from a third party tortfeasor. And since the Florida statute was recently amended to give sole jurisdiction to the Division of Administrative Hearings for determination of the amount AHCA can recover from a settlement, this Court is the only court that will have intermediate appellate jurisdiction. Hence, no other appellate court will have the opportunity to examine the issue presented and create conflict jurisdiction. §409.910(17)(b), Fla. Stat. (2015).

Moreover, the instant opinion could have a painful and dramatic impact on Florida's federal funding for its Medicaid program. States electing to participate in Medicaid (and therefore receive money from the federal government) "must

comply with conditions imposed by federal law” or lose their federal funding. *NB ex rel. Peacock v. D.C.*, 794 F.3d 31, 35 (D.C. Cir. 2015). The *Harrell* panel said that federal law, as interpreted by the Supreme Court in *Ahlborn* and *Wos*, “make[s] clear” that section 409.910 is “preempted by federal law” to the extent it allowed AHCA to recover anything more than the past medical expenses portion of a settlement. *Harrell*, 143 So. 3d at 480. If the *Villa* panel is wrong and the error goes uncorrected, the consequences could be dire.

Given the fundamental property rights at stake for Medicaid recipients, the large number of people affected and the importance of federal funding, the issue is obviously of great public importance. Florida’s highest court should be given the opportunity to review whether federal law permits AHCA to seek reimbursement for its past payments from the portion of a Medicaid recipient’s settlement that represents compensation for future medical care.

CONCLUSION

For all the foregoing reasons, this Court should grant rehearing en banc to address the express conflict between Judge Makar’s opinion in *Harrell* and the panel’s opinion in this case. Alternatively, the Court should certify as a question of great public importance whether federal law permits AHCA to seek reimbursement for its past payments from the portion of a Medicaid recipient’s settlement that represents compensation for future medical care.

Rule 9.331 Required Statements Regarding Rehearing and Certification

I express a belief, based on a reasoned and studied professional judgment, that the case or issue is of exceptional importance.

AND

I express a belief, based on a reasoned and studied professional judgment, that the panel decision is contrary to the decision of this Court in *Harrell v. State*, 143 So. 3d 478 (Fla. 1st DCA 2014), and that a consideration by the full Court is necessary to maintain uniformity of decisions in this Court.

FLOYD FAGLIE
Florida Bar No. 0569690
faglielaw@earthlink.net
STAUNTON & FAGLIE, PL
189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
Fax: (850) 997-6301



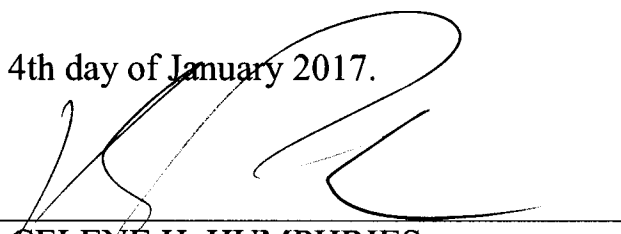
CELENE H. HUMPHRIES
Florida Bar: 884881
chumphries@bhappeals.com
MAEGEN P. LUKA
Florida Bar: 549851
mluka@bhappeals.com
BRANNOCK & HUMPHRIES
1111 W. Cass Street, Suite 200
Tampa, Florida 33606
Tel: (813) 223-4300
Fax: (813) 262-0604

Attorneys for Appellants

CERTIFICATE OF SERVICE

I HERBY CERTIFY that a true and correct copy of the foregoing has been furnished by email to Alexander R. Boler (alexander.boler@xerox.com; fltpllegal@xerox.com), Xerox Recovery Services, Inc., 2073 Summit Lake Drive, Suite 300, Tallahassee, Florida 32317 this 4th day of January 2017.

FLOYD FAGLIE
Florida Bar No. 0569690
faglielaw@earthlink.net
STAUNTON & FAGLIE, PL
189 E. Walnut Street
Monticello, Florida 32344
Tel: (850) 997-6300
Fax: (850) 997-6301



CELENE H. HUMPHRIES
Florida Bar: 884881
chumphries@bhappeals.com
MAEGEN P. LUKA
Florida Bar: 549851
mluka@bhappeals.com
BRANNOCK & HUMPHRIES
1111 W. Cass Street, Suite 200
Tampa, Florida 33606
Tel: (813) 223-4300
Fax: (813) 262-0604

Attorneys for Appellants

DISTRICT COURT OF APPEAL, FIRST DISTRICT
2000 Drayton Drive
Tallahassee, Florida 32399-0950
Telephone No. (850)488-6151

January 24, 2017

CASE NO.: 1D16-0392
L.T. No.: 15-4423MTR

MARIA ISABEL GIRALDO and Juan v.
Gonzalo Villa

Agency For Health Care
Administration

Appellant / Petitioner(s),

Appellee / Respondent(s)

BY ORDER OF THE COURT:

Motion for rehearing en banc and motion to certify a question of great public importance filed by the appellant on January 4, 2017, is denied.

I HEREBY CERTIFY that the foregoing is (a true copy of) the original court order.

Served:

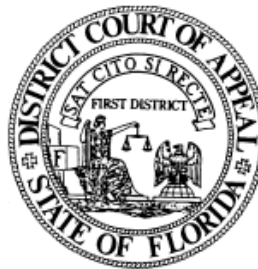
Celene H. Humphries
Alexander R. Boler

Floyd B. Faglie

Maegen P. Luka

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JON S. WHEELER, CLERK



App. E