SC17-297

In the Supreme Court of Florida

MARIA ISABEL GIRALDO, *et al.*,

Petitioners,

v.

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

ON PETITION FOR DISCRETIONARY REVIEW FROM THE
DISTRICT COURT OF APPEAL, FIRST DISTRICT
Case No.: 1D16-4423

RESPONDENT'S ANSWER BRIEF ON THE MERITS

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STATEMENT OF THE CASE AND FACTS

Respondent accepts the Petitioner's statement of the facts of this case. Unfortunately, Petitioner's Statement of the Case and Facts is riddled with argument with which Respondent does not agree.

SUMMARY OF THE ARGUMENT

Effective October 1, 2017, Congress amended the Medicaid Act to overrule *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), and *Wos v. E.M.A.*, 133 S. Ct. 1391 (2013), and allow states to recover their Medicaid recipients' medical assistance payments from any payment by a third party that has any liability for services provided to the recipient, regardless of whether the payment is compensation for past medical, future medical, or even nonmedical expenses. Therefore, for any settlement (or judgment or other allocation device, such as the release entered into in this case) entered into after October 1, 2017, no allocation in the settlement will be effective in limiting the recovery of the state to anything less than the full amount of its lien.

The U.S. Supreme Court in *Ahlborn* and *Wos* interpreted the federal anti-lien statute, 42 U.S.C. § 1396p(a)(1), to limit the reimbursement of Medicaid expenses to the **medical expense** damages portion of a Medicaid recipient's recovery. In both cases, the Court repeatedly used the unadorned term "medical expenses." Had it meant *past* medical expenses, the Court would have used that term. Petitioner's attempt to prove the Supreme Court actually meant past medical expenses by resorting to the record in the case is unavailing and actually proves Respondent's point. Given the use of past and future medical expenses in the briefing and argument, the deliberate choice of words by the Court indicates that

the argument about future medical expenses was rejected. There is nothing to the contrary to be found in the clear language of the statutes.

This court should affirm, holding that, as to settlements or judgments prior to October 1, 2017, the State is entitled to seek reimbursement of its Medicaid liens from past and future medical expenses. And as to settlements (or judgments, releases, or any other third-party mechanism purporting to minimize the state's recovery) entered on or after October 1, 2017, the State is entitled to seek reimbursement of its Medicaid liens to the full extent of the lien notwithstanding any allocation in the settlement or judgment or other mechanism.

ARGUMENT

Medicaid is a taxpayer-funded, joint federal-state social welfare program providing medical coverage to individuals who cannot afford to pay their own medical costs. *Arkansas Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). In 2006, state and federal Medicaid spending totaled an estimated $320 billion. *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. *Id*. at 198-99.

Under the Medicaid program, the federal government reimburses a portion of the states' expenses and requires the states to comply with the applicable federal rules and regulations. *Ahlborn*, 547 U.S. 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; *see also* 42 C.F.R. § 433.140(a)(1) (funding to be withheld from a state for failure to conduct third-party reimbursement operations).

To maintain the viability of the Medicaid program, federal law requires states to enact legislation to secure Medicaid's reimbursement from recipients' settlements with, or judgments or awards against, liable third-parties. 42 U.S.C.

§ 1396a(a)(25). The Medicaid act requires states to have laws in effect such that, to the extent the state Medicaid program has provided medical assistance, the state has acquired the rights of the Medicaid recipient to reimbursement from legally liable third parties. 42 U.S.C. § 1396a(a)(25)(H). It also requires states to seek reimbursement when a third party's liability is found after medical assistance is provided. 42 U.S.C. § 1396a(a)(25)(A)-(B). 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 42 U.S.C § 1396k(a)(1)(A).

I. FEDERAL LAW HAS CHANGED MAKING ALL OF THE SETTLEMENT PROCEEDS AVAILABLE TO SATISFY THE MEDICAID LIEN

Effective October 1, 2017, Congress amended the Medicaid Act to overrule *Ahlborn* and *Wos* and allow states to recover medical assistance from any payment by a third party that has any liability for services provided to the recipient, regardless of whether the payment is compensation for past medical, future medical, or even nonmedical expenses. Thus, allocations of settlements are no longer required, and states are entitled to obtain reimbursement from any part of a settlement (or judgment). Given this change, the Court must recognize that, at least for any settlement entered into after October 1, 2017, no allocation will be

effective in limiting the recovery of the state to anything less than the full amount of the lien.[1]

On December 26, 2013, President Obama signed the Bipartisan Budget Act of 2013, Pub. L. No. 113-67, 127 Stat. 1165. Among other things, the Act amended the third-party liability provisions of the federal Medicaid Act to expand the authority of states to recover the cost of medical assistance provided to Medicaid recipients. Under the heading "Strengthening Medicaid Third-Party Liability," Congress expanded every provision that might possibly be construed to restrict the authority of States to access third-party payments:[2]

> **42 U.S.C. § 1396k:**
>
> **(a)** [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 . . . ~~to payment for medical care from any third party~~ <u>any payment from a third party that has a legal liability to pay for care and services under the plan</u> . . . .
>
> **42 U.S.C. § 1396a(a):**
>
> A State plan for medical assistance must—
> . . .

[1] Current state law provides for recovery of an amount determined by the formula set forth in § 409.910(11)(f), Florida Statutes.

[2] For greater clarity, the amendments are set forth here in full rather than in the descriptive style characteristic of federal legislation.

> **(25)** provide—
> **(A)** that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan . . . ;
>
> **(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~~;
> . . .
> **(H)** that 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 such assistance, the State has 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~~ <u>any payments by such third party</u> . . . .

Bipartisan Budget Act of 2013, Pub. L. No. 113-67, § 202(b)(1)–(2), 127 Stat. 1165, 1177 (2013).[3] The amendments took effect on October 1, 2017. Medicare Access & CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 220, 129 Stat. 87, 154 (2015); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-

[3] The same legislation also amends the anti-lien provision to state expressly that States may impose liens against the property of a Medicaid recipient "pursuant to . . . rights acquired by or assigned to the State in accordance with" the assignment and reimbursement provisions." Bipartisan Budget Act of 2013 § 202(b)(3).

93, § 211, 128 Stat. 1040, 1047 (2014); Bipartisan Budget Act of 2013 § 202(c).[4]

The amendments overrule *Ahlborn* and *Wos*. Those cases construed the third-party liability provisions of the Medicaid Act to allow states to recover the cost of medical assistance only from the portion of a judgment or settlement that represents payment for medical care. The amendments repeal the statutory language on which *Ahlborn* and *Wos* relied—language that allows states to recover from third-party payments "for medical care," 42 U.S.C. § 1396k(a)(1)(A), and "for such health care items or services," *id*. § 1396a(a)(25)(H)—and allow states to recover from "any payment" made by a third party with a legal liability for care or services.

Congress is presumed to be aware of judicial interpretations of a statute, *Lorillard v. Pons*, 434 U.S. 575, 580 (1978), and, when it amends a law, intends the amendment "to have real and substantial effect," *Stone v. INS*, 514 U.S. 386, 397 (1995). Thus, effective October 1, 2017, federal law now requires states to recover from the *entire* judgment or settlement, regardless of any allocation between medical and non-medical expenses. If a third party has *any* liability to pay for care and services provided to a recipient, then under federal law *any* payment by the third party to the recipient will be subject to recovery by the state.

[4] A bill now pending in Congress would postpone the effective date of these amendments *nunc pro tunc* from October 1, 2017, to October 1, 2019. *See* H.R. 3922, 115th Cong. § 401(a)(1) (2017).

Indeed, the third-party liability provisions of federal law are no mere authorization that states are at liberty to decline; federal law and federal policy *require* states to pursue third-party reimbursement. *See* 42 U.S.C. § 1396a(a)(25)(B) (requiring a Medicaid State Plan to provide that the state "will seek reimbursement for such assistance to the extent of such legal liability"). Of course, the same amendments that abolish the distinction between medical and non-medical expenses resolve once and for all the question presented here: whether states may recover from payments allocable to future medical expenses. Under federal law, the state can now satisfy its Medicaid lien in full regardless of any allocation in a judgment or settlement agreement.[5]

The amendments make clear that all third-party payments to Medicaid recipients are available to states under federal law, regardless of any allocation made by a court or the parties. The amendments do away with the statutory language that Petitioners argue confines Florida's recovery to amounts allocable to past medical expenses. Because federal law no longer recognizes *any* allocation between past and future medical expenses, this Court should affirm the District Court's conclusion that money in the settlement allocated to future medical expenses is available to satisfy the state's Medicaid lien.

[5] Current state law provides for recovery of an amount determined by the formula set forth in § 409.910(11)(f), Florida Statutes.

II. PETITIONER'S ARTIFICIAL ALLOCATION OF PAST MEDICAL EXPENSES IS CONTRARY TO FLORIDA LAW

In order to qualify for Medicaid in Florida, a recipient must sign an assignment of "all right, title, and interest" to any third-party benefit. It is an absolute assignment vesting legal and equitable title to any third-party benefits to the state.

> The agency is automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the agency from any and all third-party benefits.

§ 409.910(6)(a), Fla. Stat.

> By applying for or accepting medical assistance, an applicant, recipient, or legal representative automatically **assigns to the agency any right, title, and interest such person has to any third-party benefit**, excluding any Medicare benefit to the extent required to be excluded by federal law.
>
> > 1. **The assignment granted under this paragraph is absolute**, and vests legal and equitable title to any such right in the agency, but not in excess of the amount of medical assistance provided by the agency.
> >
> > 2. The agency is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. **Equities of a recipient, the recipient's legal representative, his or her creditors, or health care providers shall not defeat or reduce recovery by the agency as to the assignment granted under this paragraph.**

§ 409.910(6)(b), Fla. Stat. (emphasis added).

Federal law requires, and it is the intent of the Florida Third Party Liability Act, that the state be repaid in full for its Medicaid expenditures when third party benefits become available.

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

§ 409.910(1), Fla. Stat.

Petitioner seeks to avoid the consequences of the required assignment by artificially "allocating" in the settlement only approximately 4% of the amount Medicaid is owed. At the time the parties in the civil case reached a settlement, the parties were aware of how much Medicaid had paid for Petitioner's medical expenses, and therefore the full amount of the Medicaid lien. The parties executed a General Release, in which both parties agreed to a pro rata reduction in the past medical expense portion of the settlement. The General Release estimated the reduction in past medical expenses from $347,044.66 to a mere $13,881.79.

Fla. Stat. Ann. § 409.910(6)(c)7 provides:

> No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the agency joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or

> satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien . . . .

Petitioner's "allocation" illegally impairs the Medicaid lien to which she agreed in order to receive Medicaid benefits.[6] The third-party benefits, at least to the extent of the amount of the Medicaid lien, were assigned to the State of Florida as a condition of receiving Medicaid, and the Petitioner's artificial "pro rata" reduction should not be countenanced. How to allocate undifferentiated settlements like the one here, has never been determined by the Supreme Court.

> A question the Court had no occasion to resolve in *Ahlborn* is how to determine what portion of a settlement represents payment for medical care. The parties in that case stipulated that about 6 percent of respondent Ahlborn's tort recovery (approximately $35,600 of a $550,000 settlement) represented compensation for medical care. *Id.*, at 274, 126 S. Ct. 1752. The Court nonetheless anticipated the concern that some settlements would not include an itemized allocation. **It also recognized the possibility that Medicaid beneficiaries and tortfeasors might collaborate to allocate an artificially low portion of a settlement to medical expenses.**

Wos, 568 U.S. at 634 (emphasis added). There was no stipulation in this case and the allocation of only 4 per cent of the amount Medicaid actually spent can only be attributed to a collaboration "to allocate an artificially low portion of a settlement to medical expenses." In order to be eligible for benefits, Petitioner agreed to

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

transfer all right title and interest in any benefits from a third party to the state to reimburse it for Medicaid expenditures and she should be held to that agreement. The state is entitled to the full amount of its lien and to the extent any allocation by the Medicaid recipient impairs the state's ability to enforce its lien, it is unenforceable.[7]

The federal anti-lien statute prohibits the state from attaching its lien to any property of the recipient. The Medicaid recipient assigned her property rights to the state in order to be eligible for Medicaid in the first place. The anti-lien provision does not limit Florida's recovery of those funds.

III. UNDER *AHLBORN* AND *WOS*, ALL OF THE PROCEEDS OF SETTLEMENT ALLOCATED TO MEDICAL EXPENSES ARE AVAILABLE TO SATISFY THE MEDICAID LIEN.

The U.S. Supreme Court in *Ahlborn* and *Wos* interpreted the federal anti-lien statute of 42 U.S.C. § 1396p(a)(1) to limit the reimbursement of Medicaid expenses to the medical expense damages portion of a Medicaid recipient's recovery. Petitioner's argument that the Supreme Court really meant "*past* medical expenses" is wrong.[8]

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[7] Current state law provides for recovery of an amount determined by the formula set forth in § 409.910(11)(f), Florida Statutes.

[8] The United States District Court for the Northern District of Florida has held that the state may only seek satisfaction of its Medicaid lien from funds allocated for *past* medical expenses. *Gallardo v. Dudek*, No. 4:16-cv-116, 2017 WL 3081816, at *2 (N.D. Fla. July 18, 2017). This case is on appeal to the 11th Circuit Court of Appeals. *Gallardo v. Senior,* case no. 17-13693.

1. *Ahlborn* in 2006

In *Ahlborn*, the U.S. Supreme Court was presented with the question of whether the federal anti-lien statute makes a state Medicaid program's lien unenforceable when the lien exceeds the recovery for medical costs. *Ahlborn*, 547 U.S. at 272. The Court explained that the anti-lien provision would ban a lien on all portions of a recipient's settlement, but that to the extent it is authorized by other federal statutes, an exception to the anti-lien statute is created. *Id*. at 284.

Petitioner spends a great deal of its brief pointing out to this Court the arguments made in *Ahlborn* and *Wos* in order to convince this Court that when the Supreme Court said (repeatedly) "medical expenses" it really meant to say "past medical expenses." Petitioner's argument is misplaced and in fact supports a contrary conclusion. If, as it argues, the Supreme Court was faced with arguments about past medical expenses but chose to use the term medical expenses, we are required to assume that the Court chose its words carefully and knew what it was saying.

When interpreting legislation, "courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253–54 (1992); *see also Simmons v. Himmelreich*, 136 S. Ct. 1843, 1848 (2016) ("[W]e presume Congress says what it means and means what it says."); *United States v. LaBonte*, 520 U.S. 751, 757

(1997) ("We do not start from the premise that [the statutory] language is imprecise. Instead, we assume that in drafting legislation, Congress said what it meant.")

The language chosen by the United States Supreme Court must be given the same, if not greater, dignity. In *CBS Inc. v. PrimeTime 24 Joint Venture*, 245 F.3d 1217, 1222 (11th Cir. 2001), the Eleventh Circuit observed that, "[l]ikewise, we assume the Supreme Court, in saying that, said what it meant." Peeking under the hood of Supreme Court decisions to argue that the Court did not really mean what it said should not be tolerated. In this case, the Supreme Court used the phrase "medical expenses" without the modifier "past;" we must take the Court at its word.

The Supreme Court explains Ms. Ahlborn's position as allowing a lien on "proceeds designated as payments for medical care." *Ahlborn*, 547 U.S. at 284. To this proposition the Court explicitly states, "[w]e agree." *Id*. The assumption the Supreme Court explicitly made concerned whether the assignment could be made as a condition of Medicaid eligibility. *Id*. On the question before it, the Court is direct: "To the extent that forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision." *Id*. This "exception carved out by §§ 1396a(a)(25) and 1396k(a) is

limited to payments for medical care." *Id*. at 284-85. It is only to other portions of the recipient's settlement that the anti-lien statute applies. *Id*.

Throughout its opinion, the Supreme Court characterizes the portions of the recovery contrasting what the statutes allow reimbursement from (the unqualified term "medical expenses" or "medical costs") with what the statutes do not allow reimbursement from (never stating future medical expenses):

> Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care.

Id. at 284;

> 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. at 281;

> The State, through this statute, claims an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claims a right to recover the entirety of the costs it paid on the Medicaid recipient's behalf. Accordingly, if, for example, a recipient sues alone and settles her entire action against a third-party tortfeasor for $20,000, and ADHS has paid that amount or more to medical providers on her behalf, ADHS gets the whole settlement and the recipient is left with nothing. This is so even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other.

Id. at 278; and:

> When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from

> medical costs—like pain and suffering, lost wages, and loss of future earnings.

Id. at 272.

These provisions distinguish medical expenses or medical costs from the portions of the recovery that are obviously not for medical expenses or medical costs. The Court avoided stating that a state's lien is limited to the past-only medical expense portion of the recovery. Speculation can only answer why the Court chose to omit the word "past," if that is what it meant.

Instead, the language of the statutes talks more generally than past medical expenses, and this is a better explanation for why the Court did not qualify the term medical expenses:

> We must decide whether [the state Medicaid program] can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses. The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care.

Id. at 280;

> 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) (emphasis added), not rights to payment for, for example, lost wages.

Id. at 280 (emphasis in original);

> 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 282 (emphasis provided);

> [§ 1396k(b)] does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone.

Id. at 291; and

> At the very least, then, the federal third-party liability provisions require an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.

Id. at 282.

But, to be sure, the Court was not uncertain as to what the Medicaid recipient was suing for. It acknowledged that "[Ahlborn] claimed damages not only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future." *Id*. at 273. In limiting the state programs to the portion for "medical expenses," the *Ahlborn* Court combined past and future medical expenses into one category of damages.

2. *Wos* in 2013

When the anti-lien statute returned to the Supreme Court in *Wos v. E.M.A.*, 133 S. Ct. 1391 (2013), the Court did not change its analysis as to past versus future medical expenses. Unlike the *Ahlborn* case, the *Wos* case concerned not what portion of the recipient's recovery the state may encumber, but how that

portion may be determined. The Court held that a Medicaid recipient must be able to rebut any statutory determination of the medical expense portion of his or her recovery and limit the state program to that amount. *Id.* at 1401-02. The Court retained its use of the general term "medical expense" to describe the limit on state Medicaid program recoveries:

> With a stipulation or judgment under this procedure, the anti-lien provision protects from state demand the portion of a beneficiary's tort recovery that the stipulation or judgment does not attribute to medical expenses.
>
> North Carolina's statute, however, operates to allow the State to take one-third of the total recovery, *even if a proper stipulation or judgment attributes a smaller percentage to medical expenses*. Consider the facts of *Ahlborn*. There, only $35,581.47 of the beneficiary's settlement "constituted reimbursement for medical payments made." *Ibid*. North Carolina's statute, had it been applied in *Ahlborn*, would have allowed the State to claim $183,333.33 (one-third of the beneficiary's $550,000 settlement). A conflict thus exists between North Carolina's law and the Medicaid anti-lien provision.

Id. at 1399 (emphasis provided). The Court discusses how the statutory formula amount could exceed the amount representing medical expenses, which would conflict with the anti-lien statute. To this the Court says, "[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 medical expenses." *Id*. The Court states quite succinctly that the Medicaid statutes "clear[ly] mandate" that the Medicaid

program is limited to the portion of the recovery representing simply "medical expenses." *Id*. That is the clear mandate according to the Court.

Although recognizing that E.M.A.'s injuries require "skilled home care," the *Wos* Court does not categorize this as future medical expenses. *Id*. The Court also recognizes that E.M.A. and her parents would have other tort claims, which may need to be considered to determine what amount of the recovery is attributable to medical expenses. *Id*.

The *Wos* court points to various states' laws and programs that did a better job complying with *Ahlborn* than the North Carolina statute did. *Id*. at 1401. The Court cites to these and quotes only one. *Id.* It selects Oklahoma's use of plain "medical expenses" in their statute: "full reimbursement 'unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence.'" *Id*. (quoting Okla. Stat., Tit. 63, § 5051.1(D)(1)(d)). The *Wos* Court avoids holding any of the state's methods compliant with the federal Medicaid statutes, but its focus on them suggests it would agree with the methods under the arguments that were presented in *Wos* and *Ahlborn*. *Id*.

In the end, the *Wos* court returns to the language of *Ahlborn*: "In some circumstances, however, [North Carolina's] statute would permit the State to take a portion of a Medicaid beneficiary's tort judgment or settlement not 'designated as payments for *medical care*.' *Ahlborn*, 547 U.S., at 284, 126 S.Ct. 1752. The

Medicaid anti-lien provision, 42 U.S.C. § 1396p(a)(1), bars that result." *Id*. at 1402 (emphasis provided).

3. The Statutes Carving the Exception to the Anti-Lien Statute

The Supreme Court in *Ahlborn* and *Wos* looked to the various federal statutes that require reimbursement to the state and federal Medicaid programs. These statutes would conflict with the anti-lien statute, which would otherwise "ban even a lien on that portion of the settlement proceeds that represents payments for medical care." *Ahlborn*, 547 U.S. at 284. To resolve the conflict, the Supreme Court considers these statutes requiring reimbursement to create an exception to the anti-lien statute. *Id.*

These statutes provide:

> (a) A State plan for medical assistance must—
> . . .
> (25) provide—
> (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—
> (i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

> (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;
> (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;
> . . .
> (H) that 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 such assistance, the State has 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; and

. . .

42 U.S.C. § 1396a. These provisions require the state to seek reimbursement to the extent it has provided medical assistance—obviously it is neither required nor allowed to be reimbursed more than what it has expended. But, whether it may be reimbursed what it has expended from more than the settlement or judgment allocated to past medical expenses is an open question. Even if this section only requires a state program to seek reimbursement to the extent of a third-party's liability for what Medicaid has provided, it is not the only section that carved an exception to the anti-lien statute:

> (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;
> . . .
> (C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and
> . . .
> (b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k. This federal law requires state law to provide that a Medicaid recipient "is required" "to assign the State any rights" "to payment for medical care from any third party." Because it is any right to medical care, it must include the right to past medical care and the right to future medical care. The whole idea is that states will be reimbursed what they spent. State laws that do precisely this,

and go no further, cannot be in conflict with the anti-lien statute under *Ahlborn*. Further, the federal law allows the state program to keep as much of what it may collect under the section (which, as explained above, is any amount for medical care) as is necessary for it to be reimbursed. Thus, under § 1396k, the state is to collect everything that represents payments for medical care, and from the payments for medical care the state is to be reimbursed up to as much as it has paid in benefits.

The *Ahlborn* court recognized this. The Court explained that while limited to the medical expense portion of the recipient's recovery, the state has a priority disbursement from the medical expense portion: "[§ 1396k(b)] does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone." *Ahlborn*, 547 U.S. at 291.

This federal law is what carves the exception to the anti-lien statute, therefore compliance with this federal law cannot run afoul of the anti-lien statute.

Because Florida's statute and the determination of the Administrative Law Judge allow the Agency to be reimbursed the amount of its lien from the entire past and future medical expense portion of Villa's recovery, but no further into the non-medical expense portion, the statute and final order are not in violation of the federal Medicaid act's limitations.

CONCLUSION

Based on the foregoing, this Court should hold that the state may recover its Medicaid expenditures from third party benefits in full, regardless of allocations, for all settlements or judgments effective October 1, 2017 forward. Additionally, for settlements or judgments effective prior to October 1, 2017, this Court should affirm the decision of the court below holding that the state may recover its Medicaid expenditures from the amounts allocated in any judgment or settlement to medical expenses and overrule any contrary District Court holdings to the contrary.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been furnished by electronic service through the Florida Courts E-Filing Portal on this 22nd day of December, 2017, to the following:

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CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief was prepared in Times New Roman, 14-point font, in compliance with Rule 9.210(a)(2) of the Florida Rules of Appellate Procedure.

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