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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,

v.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.

Case No.: SC17-297

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

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

PETITIONERS' INITIAL BRIEF ON THE MERITS

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STATEMENT OF THE CASE AND FACTS

This case requires the Court to reconcile conflicting interpretations from the First and Second District Courts of Appeal regarding a subsection of Florida's Medicaid reimbursement statute, section 409.910(17)(b). As explained in more detail below, federal Medicaid law authorizes Florida's Medicaid agency (the Agency for Healthcare Administration or "AHCA") to seek reimbursement from a tort settlement if AHCA pays for a Medicaid recipient's medical treatment and that recipient then sues and recovers from a third-party tortfeasor. However, federal law also places limits on AHCA's recovery powers. The conflict presented requires this Court to clarify the extent of those limits and to determine from what portion of a Medicaid recipient's tort settlement subsection (17)(b) authorizes AHCA to seek reimbursement.

Specifically, prior to the First District's decision below, every District Court of Appeal in the state (including a prior panel of the First District), as well as the only Florida federal court to have been asked, limited AHCA to recovering only the portion of a Medicaid recipient's tort settlement constituting payment by the tortfeasor for the recipient's ***past*** (already paid) medical expenses. Thus, these courts all concluded that AHCA is prohibited from seeking reimbursement from the portion of a settlement intended as compensation for ***future*** (unpaid) medical expenses – lest the Florida statute be preempted by federal Medicaid law. *See,*

e.g., *Gallardo v. Dudek* (*Gallardo I*), No. 4:16cv116-MW/CAS, 2017 WL 1405166, at *1 (N.D. Fla. Apr. 18, 2017); *Willoughby v. Agency for Healthcare Administration*, 212 So. 3d 516, 523 (Fla. 2d DCA 2017); *Harrell v. State*, 143 So. 3d 478, 480 (Fla. 1st DCA 2014); *Davis v. Roberts*, 130 So. 3d 264, 269 (Fla. 5th DCA 2013); *Garcon v. AHCA*, 96 So. 3d 472, 473-74 (Fla. 3d DCA 2012); *Roberts v. Albertson's Inc*., 119 So. 3d 457, 459 (Fla. 4th DCA 2012).

Here, the First District ignored all that precedent, not to mention the plain language of the governing Medicaid laws and related Supreme Court cases that provide the analytical framework. Instead, the First District aligned itself with three much older cases outside of Florida and held that section 409.910(17)(b) authorizes AHCA to "secure reimbursement . . . 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." *Giraldo v. Agency for Healthcare Administration*, 208 So. 3d 244, 248 (Fla. 1st DCA 2016).

As we demonstrate in this brief, the First District's aberrant conclusion is unsound, unsupported by the statutory text, and should be rejected. This Court should instead adopt the conclusion reached by the Second District and embraced by the majority of courts nationwide – that AHCA can only recover the portion of a Medicaid recipient's tort settlement intended as compensation for those medical expenses that have already been paid.

Juan's Accident

In September 2010, Juan Villa, the Medicaid recipient at the heart of this case, was an active, 19-year-old young man.[1] He was working and going to community college. R.570-71. He was dating. R.570; *see also* R.323, 327. And he loved motocross. R.329, 550. But that all changed when Juan was in a terrible accident while riding an all-terrain vehicle ("ATV"). R.259 ¶1.[2]

The accident was not his fault. Juan was doing everything right: he had on all of the proper protective gear (boots, gloves, helmet), he was an experienced rider, and he was riding in a wide-open area. R.550. Unfortunately, the tire of the brand-new ATV he was riding was defective – the rubber of the tire separated from the rim, causing the ATV to flip and Juan to be thrown from the vehicle. R.259 ¶1, 550-51.

Juan's injuries were catastrophic. Between the T8 and T9 area of his spine, the bones in his vertebrae burst. R.551-52. A piece of bone fragment then severed Juan's spinal cord, leaving him paralyzed from his chest down. R.259-60 ¶2, 552. Juan required extensive surgery and his recovery was riddled with complications

[1] Technically, Juan Villa is no longer the petitioner. He passed away after settling his tort case. His parents were appointed as the personal representatives of his estate and substituted as parties on June 1, 2016. To alleviate confusion and for ease of reading, we continue to refer to Juan as though he is the petitioner.

[2] Many of the documents in the record have numbered paragraphs. To give the record citations as much precision as possible, we note the paragraph number when it is available.

and pain. R.140-41, 260 ¶¶3-7, 551, 553, 557. After nearly a month in the hospital, Juan was released to a rehabilitation facility. R.260 ¶4, 555, 558. Once he got home, as a result of his injuries, Juan developed a urinary tract infection, which turned into sepsis, which then led to pneumonia and respiratory distress – and another five and a half weeks in the hospital. R.260 ¶6, 556-60.

Juan's injuries were so severe that he was living with chronic pain. R.559. Juan was perpetually on painkillers and his prescription had to be changed on a regular basis because his body would become immune to the painkilling qualities of the various drugs. R.586, 630. To say Juan was suffering is an understatement.

The Lawsuit and Settlement

After the accident, Juan filed a lawsuit against the manufacturer of the tire, the manufacturer of the ATV, the U.S. distributor of the ATV, and the local retailer who sold the ATV. R.261 ¶10, 351-80 (complaint), 597.

In April 2015, his attorney, Manuel Reboso, entered into settlement negotiations with one of the four defendants. R.542, 605. (That settlement is confidential, so discussions of the settlement – before this Court and prior courts – are purposely vague to protect its confidentiality. R.261-62 ¶13.)

In preparing for these negotiations, Mr. Reboso had to decide what kind of verdict he could expect if the case went to trial. To do that, he evaluated a life care plan for Juan that an expert had prepared as well as an economist's report that

reduced the life care plan amounts to a present value between $10 million and $29 million. R.382-421 (life care plan), 423-39 (economist report), 575-77, 581-84. Mr. Reboso also looked at comparable verdicts to try to gauge what a jury might award as damages in a case like this. R.585-91, 595. Finally, Mr. Reboso knew that Juan's medical bills (paid by Medicaid, Medicare, and United Healthcare) totaled $347,044.66. R.260-61 ¶9, 343, 346, 349, 572, 574.

Using all of that information, Mr. Reboso determined that a "very conservative" estimate of Juan's total damages (economic and non-economic together) was $25 million. R.596; *see also* R.574-75, 584, 595-96, 602, 610.

The settlement release memorializes that the parties agreed that the total value of Juan's damages was in "excess of $25 million." R.443, 600-01. The release also reflects that its signatories (Juan, the settling defendant, and the defendant's insurance carrier – R.262 ¶13) allocated a specific sum as reimbursement for Juan's past medical expenses. Since the settlement is 4% of the $25 million value of Juan's total damages, the parties agreed that applying the same percentage (4%) to the total value of the past medical bills ($347,044.66) equals the portion of the settlement that is intended to be compensation for Juan's past medical bills ($13,881.79).[3] R.443, 599-601, 603-04.

[3] Specifically, paragraph (f) of the release (R.443) says:

> Although it is acknowledged that this settlement does not fully compensate Claimant for all of the damages he has allegedly suffered,

AHCA Demands the Full Value of its Lien

With the settlement negotiated, AHCA entered into the picture. AHCA's entrance was the result of Florida's Medicaid Reimbursement Statute, section 409.910, which grants AHCA an automatic lien on any benefits a Medicaid recipient may recover, including a tort settlement. § 409.910(6)(c), Fla. Stat. (2015). Subsection (11)(f) of the statute sets forth a formula for calculating how much of the recipient's recovery AHCA can take in satisfaction of its lien. Basically, the formula reflects that, after deducting 25% of the settlement for attorneys' fees, AHCA is entitled to recover up to half of whatever is left. § 409.910(11)(f), Fla. Stat. (2015). But, in 2013, the United States Supreme Court held in *Wos v. E.M.A.*, 568 U.S. 627, 639 (2013), that Medicaid agencies cannot dictate that a formula, like the one in subsection (11)(f), is the one and only way to determinate what amount AHCA can take from the settlement as reimbursement.

In response to *Wos*, the Florida Legislature amended section 409.910 to

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> this settlement shall operate as a full and complete Release as to Defendant and Insurer without regard to this settlement only compensating Claimant for a fraction of the total monetary value of his alleged damages. The parties agree that JUAN LUIS VILLA's alleged damages have a value in excess of $25,000,000, of which approximately $347,044.66 represents Claimant's claim for past medical expenses. Given the fact, circumstance, and nature of Claimant's injuries and this settlement, the parties have agreed to allocate $4,817.56 of this settlement towards satisfaction of claims other than past medical expenses. This allocation is a reasonable and proportionate allocation based on the same ratio this settlement bears to the total monetary value of all JUAN LUIS VILLA's damages.

provide the right to a hearing to contest the application of the statutory formula and to give the Division of Administrative Hearings ("DOAH") sole jurisdiction to consider these requests. *See Harrell v. State*, 143 So. 3d 478, 480 n.1 (Fla. 1st DCA 2014). The post-*Wos* version of section 409.910 requires that, if a Medicaid recipient wants to dispute the statutory formula, he or she must place the full amount of the recovery in an interest-bearing trust account and file a petition at DOAH within 81 days of the settlement. § 409.910(17)(a), (b), Fla. Stat. (2015). The Administrative Law Judge ("ALJ") is then tasked, pursuant to subsection (17)(b), with deciding whether the recipient has proven, by "clear and convincing evidence," that "a lesser portion of the total recovery [settlement, verdict, etc.] should be allocated as reimbursement for past and future medical expenses than that amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f)." § 409.910(17)(b), Fla. Stat.

Accordingly, immediately after reaching the settlement, Juan's lawyer sent a letter to AHCA enclosing a copy of the release and explaining that the case had settled and that the settlement had allocated $13,881.79 to past medical expenses. The letter asked AHCA to accept that amount as a satisfaction of its lien against the settlement. R.8 ¶13, *see also* R.449, 605-06. AHCA wrote back and said that what the parties had allocated was irrelevant. AHCA's position was that the formula in section 409.910(11)(f) dictates the amount owed to AHCA for past

medical expenses – and AHCA was demanding the full amount calculated by the formula, $321,720.16. R.8 ¶14, 470,[4] 606-07.

Pursuant to the statute, to resolve the dispute over what amount AHCA could recover from Juan's settlement, Juan put the money in trust and filed his petition at DOAH. R.6-19.

The DOAH Hearing

Juan's counsel presented extensive, unrebutted evidence at the hearing to prove that "a lesser portion of the [settlement] should be allocated as reimbursement" than what was allocated by subsection (11)(f). § 409.910(17)(b), Fla. Stat. He focused on supporting the $25 million value of the damages and the formula used in the release to come up with the $13,881.79 allocation to past medical expenses. Juan's counsel called two expert witnesses, both of whom the ALJ accepted as experts on the valuation of damages. R.254, 549, 638-39. With both experts, Juan's counsel admitted into evidence multiple exhibits, including a life care plan and an economist's report. R.254, 304-489.

One expert was Juan's trial counsel, Manuel Reboso, a lawyer with 31 years of experience (20 of which have been spent in the specialty of products liability). R.542-43. Mr. Reboso testified extensively about the facts that made the case worth $25 million. *See* pp. 3-5, above; *see also* R.548-75.

[4] The letter is on Xerox Recovery Services letterhead because Xerox is AHCA's agent for recovering Medicaid liens. R.572.

James Gustafson was Juan's second expert. He is an attorney with 21 years of experience in complex personal injury actions, including paralysis cases. R.635-37. Like Mr. Reboso, he too reviewed the medical bills, life care plan, economist's report, and a day-in-the-life video. R.639-43. He agreed that a "very conservative" estimate of the present value of Juan's total damages would be $25 million. R.643-46. Mr. Gustafson also testified about comparable verdicts he had examined, which supported his conclusion about the $25 million value of the damages. R. 647-51.

Both experts agreed that the formula in the settlement release used by the parties to allocate the $13,881.79 to past medical expenses was a reasonable approach and yielded a fair number. R.539, 600-04, 626, 653-54.

Mr. Reboso also testified that if AHCA took the $13,881.79, it would only be a partial satisfaction of the lien – because the trial against the three remaining defendants is upcoming. R.599. In other words, AHCA can pursue the remainder of its lien from the jury verdict or potential settlements with those defendants. (As of the date of this brief, that trial has not yet taken place.)

AHCA's Presentation at the Hearing

AHCA presented no witnesses or evidence at the hearing. R.255.

AHCA cross-examined the two experts, but only briefly. Importantly, AHCA's questioning never criticized the $25 million value placed on Juan's

damages. If anything, the tenor of AHCA's questions accepted that $25 million value. R.617, 625, 660. AHCA had no questions regarding the life care plan or economist's report that the experts referenced. Nor did AHCA dispute that the parties to the settlement had stipulated that the damages were at least $25 million and that the parties had agreed to allocate $13,881.79 as the portion of the settlement intended as compensation for Juan's past medical expenses. AHCA's cross-examination did not criticize the size of those numbers either.

AHCA chose not to impeach or rebut the experts' testimony regarding the value of the damages or the amount the parties allocated for past medical expenses because AHCA saw those numbers as "irrelevant." R.281; *see also* R.541 ("[T]he agency is under the belief that there is no relevance to the total value of this case."). Instead, AHCA's cross-examination of both witnesses focused on questions about the value of Juan's future medical care and the lack of a specific allocation in the settlement for that future care. R.629-32, 656-60. AHCA wanted to establish that Juan was only 24 years old when he signed the settlement, that he had a long life ahead of him, and that his injuries meant that his future care costs would be huge. R.622-23, 655, 657-58. At one point, AHCA's counsel even tried to suggest AHCA would wind up paying those future care bills. R.632. Juan's trial counsel corrected AHCA's lawyer, noting that the settlement amount had made Juan financially ineligible for Medicaid. R.632-33.

AHCA's position was that subsection (17)(b) authorizes recovery from the past and future medical expense portions of Juan's settlement, so Juan had to prove what was allocated ***both*** to his past ***and*** to his future medical expenses in order to meet his burden to rebut the statutory formula. R.671. Having failed to prove what was allocated for Juan's future care (an implicitly larger amount), AHCA argued that Juan had failed to meet his burden and that the statutory formula should therefore apply. R.165 (AHCA's proposed final order), 168 ¶17 (same), 171 ¶¶28, 30 (same), 671-73 (AHCA's closing argument).

Juan's Untimely Death

The hearing took place on October 5, 2015. R.151. The questioning – by both AHCA's and Juan's counsel – reflected that everyone there thought Juan had a long and difficult life ahead of him. R.575, 583-84, 6556-58. To everyone's surprise, on October 31, 2015, Juan passed away. R.154.[5]

[5] The ALJ's Final Order would later make a bizarre legal ruling that the relevant timeframe for valuing the damages was not at the time of settlement (when Juan was alive). R.294 ¶85. Instead, the ALJ concluded that Juan had to prove "what a jury would award in total damages in a trial of Petitioner's tort lawsuit" now that Juan had passed. R.293 ¶83; *see also* R.281 ¶56. Since AHCA has always agreed that this ruling was error and the First District appeared to believe this was error, although not one significant enough to justify reversal, Juan does not focus on the issue. *Giraldo,* 208 So. 3d at 252. In any event, the parties to the settlement ***agreed*** to the damages valuation, and it is difficult to understand how the parties could go back and change their contract based on a change in circumstances after they signed. It would be the equivalent of the settling defendant asking for a refund.

The Proposed Orders

Both AHCA and Juan submitted proposed final orders. R.163-73 (AHCA's proposed order); 193-228 (Juan's proposed order).

AHCA's proposed order acknowledged that the settlement allocated $13,881.79 to past medical expenses. R.168 ¶14. AHCA said nothing critical about this allocation to past medical expenses or about the experts' opinions. In fact, AHCA's proposed order appeared to accept the experts' $25 million damages value and the allocation of $13,881.79 to Juan's past medical expenses. R.168 ¶¶14, 17, 171 ¶30.

Instead of taking issue with anything presented at the hearing, AHCA's proposed order focused on what was not presented at the hearing. AHCA proposed that, since it could recover from both the past and future medical expenses portion of the settlement, and Juan had put on no evidence regarding the future medical expenses portion, Juan failed to meet his burden of proof to show that something other than the formula in subsection (11)(f) should apply. R.168 ¶21, 170 ¶23, 171 ¶¶30-31.

In comparison to AHCA's brief proposed order, Juan's proposed order spent 34 pages extensively discussing both the evidence and the law that applies. R.193-228. And Juan's proposed order obviously argued that he had met his burden of proof and that AHCA should be required to accept the stipulated $13,881.79 the

parties had allocated to pay for Juan's past medical expenses. R.198 ¶36 – 204 ¶59, 226 ¶¶124-28.

The Final Order

The ALJ's Final Order found that Juan had not met his burden under section 409.910(17)(b) to establish that an amount other than the one calculated by the formula in subsection (11)(b) should be awarded to AHCA. R.295 ¶87.

First, the Final Order came to the legal conclusion that AHCA is permitted to take from the portion of the settlement representing compensation for "medical expenses," whether that compensation is intended for medical expenses that have already been paid (past medical expenses) or expenses that will be incurred in the future. R.281-82 ¶57, 288 ¶73. If the parties intended the money to compensate for medical expenses, the ALJ said AHCA could take it. R.291 ¶79.

The Final Order then determined that, since Juan had presented no evidence as to an allocation for future medical expenses, Juan had failed to meet his burden to establish that something other than the statutory formula was allocated as "reimbursement for past and future medical expenses." § 409.910(17)(b); R.282 ¶58, 283-84 ¶¶60-61, 291 ¶79, 292 ¶82, 295 ¶87.

In addition, although AHCA did not impeach or even dispute the evidence Juan presented regarding the $25 million value of the damages and the parties' $13,881.79 allocation to past medical expenses, the Final Order rejected this

unrebutted evidence based on the ALJ's speculation. R.265-66 ¶24 (speculating that the defendant did not agree to the $13,881.79 allocation because there was an inadvertent and irrelevant math error in the settlement), 267-68 ¶28 (speculating that there were pages missing from the reports referenced in the experts' testimony and that the age of the reports might have impacted the experts' testimony), 280 ¶54, 283-84 ¶60.

The First District's Decision

Juan appealed the ALJ's Final Order, and the First District affirmed. The First District interpreted United States Supreme Court precedent as authorizing AHCA's recovery from both the past and future medical expense portions of Juan's settlement and therefore held that section 409.910(17)(b) authorized 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." *Giraldo*, 208 So. 3d at 248-51. Thus, the First District concluded that "[s]ince [Juan] 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 [subsection (17)(b)] to avoid application of the statutory formula contained in section 409.910(11)(f)." *Id*. at 249. The First District also accepted the ALJ's rejection of the unrebutted testimony. *Id*. at 247.

The Second District Issues a Conflicting Opinion

Not long after the First District issued its opinion in this case, the Second District issued its opinion in *Willoughby v. Agency for Healthcare Administration*, 212 So. 3d 516 (Fla. 2d DCA 2017), in which it specifically disagreed with the First District. The Second District decided that the First District's conclusion that subsection (17)(b) authorizes recovery from the future medical expenses portion of a settlement was based on a "misinterpret[ation]" of United States Supreme Court precedent. *Id*. at 523. The Second District then analyzed the language of subsection (17)(b) and determined that, on its face, the statute does not authorize AHCA to seek "reimbursement" from the portion of a settlement intended as compensation for costs that have not yet been incurred. *Id*. at 524. The Second District likewise surveyed Florida cases, cases outside the state, and other ALJ opinions to conclude that "AHCA cannot satisfy its Medicaid lien from proceeds set aside for future medical care expenses." *Id*. at 524-25. The Second District then certified conflict with the First District's opinion in this case. *Id*. at 525.

The Federal Court's *Gallardo* Opinion

At the same time the First and Second Districts were being asked to interpret section 409.910(17)(b), a different Medicaid recipient was asking for related relief in federal court in the Northern District of Florida. The parents of Gianinna Gallardo sought a declaratory judgment that subsection (17)(b) was preempted by

federal Medicaid law to the extent that it "allows AHCA to satisfy its lien beyond the portion of her settlement representing compensation for past medical expenses." *Gallardo I*, 2017 WL 1405166, at *4. The federal court ultimately declared that "the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses" and enjoined AHCA from attempting to seek reimbursement from the future medical expenses portion of Medicaid recipients' settlements. *Gallardo v. Dudek* (*Gallardo II*), No. 4:16cv116-MW/CAS, 2017 WL 3081816, at *9 (N.D. Fla. July 18, 2017).

The Jurisdictional Motion Practice

During the time that *Gallardo I* was pending, AHCA filed its own petition seeking this Court's review of the Second District's *Willoughby* decision. *See Agency for Health Care Admin. v. Willoughby*, Case No. SC17-660 (Fla. Apr. 10, 2017). (So, both sides of the issue sought this Court's review of the conflict.) Immediately after the federal court issued the *Gallardo I* opinion, AHCA changed counsel and withdrew its petition in *Willoughby*. *Id.*

AHCA then filed a motion to stay in this case, asking this Court to put an indefinite hold on the jurisdictional question while AHCA sought rehearing in *Gallardo* and the appeal worked its way to the Eleventh Circuit Court of Appeals.

Mot. to Stay, *Giraldo v. Agency for Health Care Admin.*, No. SC17-297 (Fla. May 19, 2017). This Court denied that motion. *Giraldo v. Agency for Health Care Admin.*, No. SC17-297 (Fla. Sup. Ct. order filed June 7, 2017). (The *Gallardo II* order, upholding the federal court's declaration and injunction, came one month later. *Gallardo II*, 2017 WL 3081816.) Nearly three months after Juan filed his jurisdictional brief, AHCA finally filed its answer brief, arguing that this Court should decline jurisdiction because an amendment to the federal Medicaid statute has supposedly mooted the reimbursement issue for all AHCA liens arising after October 1, 2017. After permitting Juan to file a supplemental brief addressing the impact of the federal court's order and the amendment to the federal Medicaid statute, this Court rejected AHCA's mootness concerns and accepted review of the certified conflict.

SUMMARY OF THE ARGUMENT

The First District's opinion in this case is an outlier, finding company with only outdated cases that are outside of Florida. Instead, the consensus, both inside and outside of Florida, is that state Medicaid agencies such as AHCA are precluded from recovering anything other than the portion of a Medicaid recipient's tort settlement that was intended as compensation for the recipient's past (already paid) medical expenses.

Florida's section 409.910(17)(b) should therefore be read in a way that

makes it consistent with this consensus, which has its roots in two seminal Supreme Court decisions. As the more thorough analysis by the Second District concluded, those decisions dictate that subsection (17)(b) limits AHCA to seeking reimbursement from the portion of a Medicaid recipient's settlement that was intended as compensation for medical bills that have already been paid and precludes recovery from a portion of the settlement allocated as compensation for future medical expenses that have not yet been incurred.

In this case, the portion of the settlement intended as compensation for Juan Villa's past medical expenses was agreed to by the parties to the settlement and unchallenged by AHCA. Thus, this Court should quash the First District's decision, approve the holding of the Second District, and remand with directions that AHCA accept, as a satisfaction of its lien, the $13,881.79 allocated in the settlement for Juan's past medical expenses. AHCA can then pursue the remainder of its lien from any verdict against, or settlement with, the remaining defendants.

ARGUMENT

We begin with an overview of the statutory framework and the two United States Supreme Court cases that provide the context for understanding the certified conflict issue. We then explain why the First District got it wrong in this case and why the Second District got it right in *Willoughby*. Finally, we conclude by explaining why the ***only*** evidence in this case compels this Court to not only adopt

the interpretation of the Second District, but to also reverse and remand with directions that AHCA accept the $13,881.79 that everyone agrees the parties to Juan's settlement allocated as compensation for Juan's past medical expenses.

Standard of Review

As a question of statutory interpretation, this Court reviews the conflict issue *de novo*. *See Borden v. E.-European Ins. Co.*, 921 So. 2d 587, 591 (Fla. 2006).

I. AHCA can recover only the portion of Juan's settlement allocated as compensation for medical expenses that have already been paid.

A. The federal context for the certified conflict in state law.

The starting point for reconciling the conflict in this case is to understand the role federal Medicaid law plays in limiting the Florida Legislature's power to authorize recoupment from a Florida Medicaid recipient's settlement.

The Medicaid program basics

The Medicaid program is a cooperative federal and state program providing payment for medical services to eligible individuals and families. *Ark. Dep't. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). States that participate in the Medicaid program are reimbursed by the federal government for a portion of the payments they make to recipients, provided the states meet certain statutory eligibility requirements. *Id*. at 275-76.

One of those requirements is that the state Medicaid agencies seek reimbursement when a Medicaid recipient recovers money from a third-party

tortfeasor. *See* 42 U.S.C. §1396a(a)(25)(A). Under the reimbursement provision, the federal Medicaid statute requires each participating state to have a plan enabling it to identify any third parties liable for medical expenses funded through the Medicaid program and to "seek reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(B). Thus, as part of what is often called the forced assignment provision, 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).

However, federal law also "places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf." *Ahlborn*, 547 U.S. at 283. And the provisions that contain those limitations "significantly predate the reimbursement and forced assignment provisions." *Tristani v. Richman*, 652 F.3d 360, 370 (3d Cir. 2011). Specifically, a section referred to as the "anti-lien provision" prohibits state Medicaid agencies from imposing a lien "against the property of an individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 U.S.C. § 1396p(a)(1). Similarly, a section known as the "anti-recovery provision" states that "no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except [in limited circumstances not at issue in this case]." 42 U.S.C. § 1396p(b)(1). The two provisions "were

intended to ensure that Medicaid recipients were not forced to directly bear the costs of their medical care." *Tristani*, 652 F.3d at 370.

The thing is, read "literally and in isolation," the anti-lien and anti-recovery provisions forbid states from recovering from ***any*** portion of a Medicaid recipient's settlement. *Ahlborn*, 547 U.S. at 284; *Gallardo I*, 2017 WL 1405166, at *2. Such a literal reading runs headlong into the reimbursement and forced assignment provisions, so the Supreme Court has reconciled the two by holding that the reimbursement statutes are actually narrow exceptions to the broad protections of the anti-lien and anti-recovery provisions. *Ahlborn*, 547 U.S. at 285; *Gallardo I*, 2017 WL 1405166, at *2-3; *see also Tristani*, 652 F. 3d at 370 (noting that, while the anti-lien and anti-recovery provisions protect Medicaid beneficiaries, through the reimbursement and forced assignment provisions, "Congress both protected the public fisc and ensured that beneficiaries did not receive a windfall by recovering medical expenses they did not pay."); *Roberts v. Albertson's, Inc.*, 119 So. 3d 457, 459 (Fla. 4th DCA 2012) ("By enacting these provisions, Congress was concerned about protecting a Medicaid recipient's personal assets, but not the recipient's interest in recovering from third parties medical costs paid on his or her behalf."), citing *Tristani*, 652 F.3d at 372.

Thus, as we will show, the narrow exceptions permit a state Medicaid agency like AHCA to recover from the portion of a settlement allocated as

compensation for medical expenses the agency has paid on a recipient's behalf (either past medical expenses or future medical expenses that have been prepaid), but the anti-lien and anti-recovery provisions prohibit recovery from the portion of a settlement intended as compensation for future, yet-unpaid medical care. And, as the Second District appropriately recognized, Florida's Medicaid reimbursement statute must be read in a way that is consistent with this controlling, federal law.

The two seminal Supreme Court cases

Ahlborn

In *Ahlborn*, the Arkansas Department of Health and Human Services ("ADHS") asserted a lien against Heidi Ahlborn's tort settlement proceeds in the amount of the total payments it had made for Ahlborn's medical care. 547 U.S. at 274. Ahlborn filed suit, seeking a declaratory judgment that the lien violated federal Medicaid law "insofar as its satisfaction would require depletion of compensation for injuries ***other than past medical expenses***." *Id*. (emphasis added). To facilitate resolution of the legal questions, "the parties stipulated that Ahlborn's entire claim was reasonably valued at $3,040,708.12; that the settlement amounted to approximately one-sixth of that sum; and that, if Ahlborn's construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement ***for medical payments made***." *Id*. (emphasis added). Basically, Ahlborn settled for one-sixth

of the full value of her damages, so ADHS should accept one-sixth of the full value of its lien for the "medical payments [it had] made." *Id.*

The federal district court ruled in favor of ADHS, but the Eighth Circuit Court of Appeals reversed, holding that "ADHS was entitled only to that portion of the judgment that represented payments for medical care." *Id*. at 275. The Supreme Court unanimously affirmed. *See id*. at 271.

The basis of the affirmance was the concept that a Medicaid recipient's cause of action (and ensuing settlement) against a tortfeasor is the recipient's personal property within the meaning of the anti-lien statute. The Court assumed that the requirement that a Medicaid recipient assign to the state agency his or her right to settlement proceeds as compensation for medical care does not violate the anti-lien statute. *See id*. at 284. The Court held, however, that the anti-lien statute *does* prohibit Medicaid from recovering more than the amount allocated in the settlement to "medical expenses." *Id.* at 292; *see also id*. at 281 ("[Federal Medicaid law] 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 284-85 ("[T]he exception carved out by § 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.").

Although the Court held that a state Medicaid program could not recover from anything other than the portion of the settlement meant as compensation for (generically speaking) "medical expenses," it is obvious that the Court necessarily meant "***past*** medical expenses." That is so because the relief sought by the plaintiff was a declaration that the Arkansas Medicaid statute "violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation [in the settlement] for injuries ***other than past medical expenses***." *Ahlborn*, 547 U.S. at 274 (emphasis added). The Supreme Court then shaped its analysis around this fundamental fact.

For example, the Supreme Court said that states can "demand as a condition of Medicaid eligibility that the recipient 'assign' in advance any payments that may constitute ***reimbursement*** for medical costs." *Id*. at 284 (emphasis added). But states cannot "force an assignment of, or place lien on, any other portion of [the Medicaid recipient's] property" (i.e., the settlement). *Id*. at 284. "Beyond that [which represents reimbursement for past medical costs], the anti-lien provision applies." *Id*. at 285. The Supreme Court's use of the word "reimbursement" is important. "Reimbursement" means "to repay that expended." *Reimbursement*, Black's Law Dictionary (6th ed. 1990). A tortfeasor cannot "reimburse" a Medicaid recipient (via a settlement) for money that has not been spent. So, when the Court said states can force a Medicaid recipient to assign "payments that may

constitute ***reimbursement*** for medical costs," it meant that a Medicaid recipient had to give to Medicaid any monies the recipient recovered that were intended as compensation for bills Medicaid has already paid. The Court did *not* mean that the Medicaid recipient had to give up money intended as compensation for medical bills the injured recipient would incur in the future.

Indeed, the Supreme Court was unequivocal that "if Ahlborn's construction of federal law was correct, ADHS would be entitled to ***only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made***." *Id*. (emphasis added). And, within that context, the Supreme Court unanimously held that "[f]ederal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47 [the amount the parties agreed was for past medical expenses], and the federal anti-lien provision affirmatively prohibits it from doing so." *Id*. at 292. The Court held that state Medicaid provisions (like Florida's section 409.910(17)(b)) are "unenforceable insofar as they compel a different conclusion." *Id*. In other words, the federal anti-lien provision "affirmatively prohibits" a state Medicaid agency from taking anything other than the portion of the settlement intended as reimbursement for "medical payments made" (i.e., the specifically referenced sum of $35,581.47 – which represented, in that case, Ahlborn's ***past medical expenses***). *Id*.

Wos

Seven years after *Ahlborn*, the Court again revisited the Medicaid reimbursement laws. This time, it was to tell states 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 medical expenses***." *Wos*, 568 U.S. at 639 (emphasis added). While the *Wos* Court did not explicitly address the issue of Medicaid collecting from the past versus future medical expenses portion of settlements, that limitation to past medical expenses was necessarily implicit in its holding. In other words, *Wos* held that states must give Medicaid recipients an opportunity to establish that something other than the amount calculated by the statutory formula is what the parties intended as compensation for past medical expenses. *Id*. at 642-43.

The most direct form of proof is the fact that the Supreme Court affirmed the Fourth Circuit Court of Appeal's holding without qualification. *Id*. at 1402. And the Fourth Circuit's holding was that "federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to ***past medical expenses***" and Medicaid recipients must be given a chance to show what that allocation is "by way of a fair and impartial adversarial procedure" that affords the opportunity to rebut the calculation made by a statutory formula. *E.M.A. ex rel.*

Plyler v. Cansler, 674 F.3d 290, 312 (4th Cir. 2012) (emphasis added). Additionally, the Fourth Circuit characterized the holding in *Ahlborn* as being that "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." *Id*. (emphasis added), citing *Ahlborn*, 547 U.S. at 282. The fact that the Supreme Court saw no need to modify or correct the Fourth Circuit's holding is evidence that the Court understood its holding to mean that states had to give Medicaid recipients a chance to demonstrate that something other than a statutory formula represented compensation for past medical expenses – since the state could only collect the past medical expenses portion of a settlement.

Moreover, in his concurrence, Justice Breyer made it clear that the Court perceived the relevant portion of the settlement as being the portion compensating for "past" medical expenses. He wrote that "the question before us" was how to measure the share of a tort settlement representing reimbursement "for health care items (or services) ***for which a State has already paid*** on behalf of the victim." *Wos*, 568 U.S. at 644 (Breyer, J., concurring) (emphasis added).

In fact, Justice Breyer wrote his concurrence to note that his opinion "rests in part upon the fact that the federal agency that administers the Medicaid statute . . . has reached the same conclusion." *Id*. Justice Breyer was referring to

the amicus brief filed by the Secretary of Health and Human Services, who administers the Medicaid Program through the Centers for Medicare & Medicaid Services ("CMS"). *See* Brief for the United States as Amicus Curiae Supporting Respondents, *Delia v. E.M.A.*, No. 12-98, 2012 WL 6624226, at *1 (U.S. Dec. 17, 2012). If this Court examines the CMS amicus brief, it will see that the federal Medicaid agency was unequivocal that the North Carolina statute "frustrates operation of the anti-lien provision" by applying an irrebuttable formula that may overestimate "the portion of the settlement that may appropriately be regarded as payment ***for past medical expenses***." *Id*. at *10 (emphasis added). The brief consistently refers to the fact that the only thing CMS believes North Carolina can recover is that which is intended as compensation for "past medical expenses" (and that an irrebuttable statutory formula does not account for case-specific details). *Id*. at *11, *17, *22.

Finally, the transcript of the *Wos* oral argument reflects that, even though the *Wos* opinion speaks generically in terms of "medical expenses," everyone understood that they were talking about "past medical expenses." That fact is reflected in the very first words out of the petitioner's mouth, when he said that the Medicaid Act "does not direct how a State must determine what portion of a recipient's third-party recovery is properly attributable ***to past medical expenses***. North Carolina's [statute does that]." *Delia v. E.M.A*, No. 12-98, 2013 WL

1842103, at *1 (U.S. Oral Arg., Jan. 8, 2013) (emphasis added). Later, Justice Alito asked, "Isn't the reasoning of *Ahlborn* that when we know to a certainty how much … [of] the settlement represents medical expenses, then only that much can be assigned to the government?" *Id.* at *11. Remember, in *Ahlborn*, the parties "knew to a certainty" how much "of the settlement represents medical expenses" because they stipulated to the amount that represented compensation for ***past*** medical expenses. *Id.*; *Ahlborn*, 547 U.S. at 274.

In short, although the holdings in *Ahlborn* and *Wos* speak generically of "medical expenses," a closer examination of both opinions makes it obvious that there was no ***need*** to say "past" medical expenses – because everyone (counsel and the Court) understood that the arguments and holdings concerned "past medical expenses."

B. The First District got it wrong; the Second District got it right.

In the aftermath of *Ahlborn* and *Wos*, the Florida Legislature enacted section 409.910(17)(b). This provision of state law says that the statutory formula in section 409.910(11)(b) will be used to calculate how much of a Medicaid recipient's settlement AHCA can take, unless the recipient proves that "a lesser portion of the [settlement] should be allocated ***as reimbursement for past and future medical expenses*** than the amount calculated by the . . . formula set forth in paragraph (11)(f)." § 409.910(17)(b), Fla. Stat. (2015) (emphasis added).

Resolving the conflict about what that sentence means, in light of the controlling federal law, is the point of this case.

The First District's *Giraldo* panel got it wrong

Contrary to the clear direction of *Ahlborn* and *Wos*, as well as the plain language of the federal Medicaid statutes, the First District panel in this case concluded that AHCA could seek reimbursement "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." *Giraldo*, 208 So. 3d at 248. The First District panel was able to reach that conclusion only by ignoring, rather than addressing, many salient points.

For example, when discussing *Ahlborn*, the First District avoided the fact that the relief sought in *Ahlborn* was a declaration that Medicaid could only recover the amount the parties had stipulated as compensation for ***past medical expenses***. *Ahlborn*, 547 U.S. at 274.

The panel was likewise silent about *Ahlborn*'s discussion of the Medicaid statutes and the conclusion that the Medicaid recipient assigns nothing more than the tortfeasor's liability to reimburse for payments that had already been made (as opposed to the tortfeasor's liability for future care). Specifically, the *Ahlborn* Court noted that § 1396a(a)(25)(B) requires states to "seek reimbursement for [medical] assistance ***to the extent of such legal liability***." *Ahlborn*, 547 U.S. at

280 (emphasis and bracket in original). The Court unanimously agreed that the emphasized phrase "such legal liability" referred to "the legal liability of third parties . . . ***to pay for care and services available under the plan***." *Id*. (emphasis in original). The Court noted that the tortfeasor in *Ahlborn* had accepted responsibility for one-sixth of Ahlborn's total damages and the parties had agreed that "only $35,581.47 of [the total damages] represents compensation for medical expenses." *Id*. (Remember, the $35,581 was reimbursement for "past medical expenses." *Id*. at 274.) Thus, the Court said that "the relevant 'liability' extends no further than that amount," i.e., the $35,581 that represented reimbursement for past medical expenses. *Id*. at 280-81. Stated differently, because § 1396a(a)(25)(B) only authorizes Medicaid to take the portion of the settlement representing the tortfeasor's liability for the care and services already paid by Medicaid, that means Medicaid is not authorized to take from that which represents compensation for medical expenses the injured party will incur in the future.

The First District panel further ignored the impact of the language in § 1396a(a)(25)(H), which says "to the extent that ***payment has been made*** [by Medicaid] under the State plan for medical assistance in any case where ***a third party has a legal liability*** to make payment for ***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." 42 U.S.C. § 1396a(a)(25)(H) (emphasis added). On its face, this provision only allows Medicaid to recover whatever constitutes reimbursement for the payments Medicaid has already made (and, by negative inference, does not allow Medicaid to recover whatever constitutes compensation for medical expenses for which no payment has been made – i.e., future medical expenses).

Multiple courts have agreed with this interpretation. For example, in *McKinney ex rel. Gage v. Philadelphia Housing Authority*, No. 07-4432, 2010 WL 3364400, at *9 (E.D. Pa. Aug. 24, 2010), the federal district court said that a plain reading of § 1396a(a)(25)(H) makes clear that "the italicized word 'such' refers to the 'payment [that] has been made.'" Thus, it is obvious that Medicaid "cannot draw on portions of the settlement designed to compensate for future medical expenses in order to reimburse itself for *past* medical expenditures." *Id*. (emphasis in original); *see also Ahlborn*, 547 U.S. at 281; *Gallardo I*, 2017 WL 1405166, at *5; *Lugo ex rel. Lugo v. Beth Israel Med. Center*, 819 N.Y.S. 2d 892, 896 (N.Y. Sup. Ct. 2006). Juan made these arguments below, but the First District panel ignored them.

Instead, without analysis, the First District panel cited to the *Ahlborn* Court's discussion of the reimbursement provision, § 1396k(b), as saying 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." *Giraldo*, 208 So. 3d at 250. The First District determined that "this would include recovery of amounts allocated to both past and future medical care." *Id*.

We say the First District provided no analysis because Juan pointed out in briefing that, when the *Ahlborn* Court spoke of § 1396k and the state being "paid first out of any damages representing payments for medical care," the Court necessarily meant "payments made for ***past*** medical care." The *Ahlborn* opinion noted that Medicaid recipients "often will have paid expenses out of [their] own pocket" and when the source of third party funds is health insurance (as opposed to a tort settlement), "the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses." *Ahlborn*, 547 U.S. at 282 n.11. Thus, the Court read § 1396k to mean that, when insurance has paid the bills, Medicaid must be paid back for the money it has spent before the Medicaid recipient is paid back for out-of-pocket costs he or she has spent. But, whether the funds come from a tort settlement or from insurance proceeds, the pool of money used to pay back AHCA or the Medicaid recipient is necessarily the pool of funds intended as compensation for bills that have already been paid (i.e., past medical expenses or prepayment for future medical expenses).

The First District panel also ignored Juan's arguments about *Wos*, saying that *Wos* "does not alter this [panel's] conclusion." *Giraldo,* 208 So. 3d at

250. Blowing by the references to past medical expenses in the Fourth Circuit's opinion and the Supreme Court's affirmance of that language, the First District said that *Wos* had no impact on the issue because the *Wos* Court did "not attempt to distinguish or address settlement provisions designated as payments for past medical expenses as opposed to payments for future medical care." *Id.*

The panel was equally dismissive of the Florida caselaw interpreting *Ahlborn* and *Wos*. Without acknowledging unambiguous language from both a prior First District panel in *Harrell* or the Fifth District in *Davis* (both of which concluded that "*Ahlborn* and *Wos* make clear" that AHCA cannot collect anything from a settlement other than the "recovery representing compensation for past medical expenses"), the panel dismissed both cases as irrelevant – because it did not appear to the panel that the question of past versus future medical expenses was before either court. *Id*. at 251; *Harrell*, 143 So. 3d at 480; *Davis*, 130 So. 3d at 269.[6] The First District panel made no attempt to reconcile its interpretation of

[6] During briefing below, Juan asked the First District to take judicial notice of the briefs in the earlier First District case, *Harrell v. State*, 143 So. 3d 478 (Fla. 1st DCA 2014). As Juan explained in his motion, taking judicial notice of the briefs would allow the panel in this case to see that the court's language about the past versus future issue was not dicta in *Harrell*, but rather was an argument specifically raised by AHCA that was relevant to the outcome of the case. A.23-25. The First District struck Juan's "request for judicial notice" as being a "notice of supplemental authority" and then brushed aside the *Harrell* and *Davis* interpretations of *Ahlborn* and *Wos* as dicta. A.131; *Giraldo*, 208 So. 3d at 251. Juan noted the inconsistency between *Harrell* and this case in a motion for rehearing en banc, which the First District denied. A.133-41, 144.

Ahlborn and *Wos* against the unequivocal, diametrically opposed interpretations in *Davis* and *Harrell*. Nor did the First District panel address the Third District's equally unequivocal interpretation 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 v. AHCA*, 96 So. 3d 472, 473-74 (Fla. 3d DCA 2012) (emphasis added).

Equally true, the First District had no response to the point raised by the Fourth District that the purpose of the Medicaid statutes is to prevent a "windfall." In *Roberts v. Albertson's Inc*., 119 So. 3d 457, 459 (Fla. 4th DCA 2012), the Fourth District explained that Congress enacted the Medicaid reimbursement laws to collect upon monies "a third party makes . . . to the Medicaid beneficiary for medical care already paid for by Medicaid." The *Roberts* court noted that the goal of the Medicaid reimbursement statutes is to "prevent[ ] Medicaid beneficiaries from receiving a windfall." *Id*., citing *Tristani*, 652 F.3d at 373. That is, "by conferring upon the states the right to forced assignment of medical care cost paid by third-parties, Congress intended to ensure that Medicaid recipients do not receive a windfall by recovering medical costs they did not pay." *Id*.

Applying that logic to this case, it cannot be a "windfall" to allow Juan to keep the portion of his settlement intended as compensation for his future medical

care (since he would not be keeping something that someone else has already paid for). It can only be a "windfall" if Juan is permitted to keep the portion of his settlement intended as compensation for past medical care while, at the same time, Medicaid has already paid for that same care.

The First District panel likewise disregarded the majority of the cases outside of Florida. Although it acknowledged 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," the panel chose "to align ourselves with what we believe are the better reasoned decisions of those courts which have held that a state agency may secure payment from both past and future recoveries for medical expenses." *Id*. at 251-52.

Notably, all three of the cases with which the panel chose to align itself were grounded in the argument that the *Ahlborn* holding spoke broadly of "medical expenses," without making a limitation to "past medical expenses." *See I.P. ex rel. Cardenas v. Henneberry*, 795 F. Supp. 2d 1189, 1197 (D. Colo. 2011); *Special Needs Trust for K.C.S. v. Folkemer*, 2011 WL 1231319, at *13 (D. Md. 2011); *In re Matey*, 213 P.3d 389, 394 (Idaho 2009). While that is technically true, as explained above, the limitation to past medical expenses is part and parcel of the *Ahlborn* holding. And, since all three of those cases were decided prior to *Wos's* affirmance of the Fourth Circuit's language about past medical expenses, the basis

for these three opinions is both old and unsound. Nevertheless, these are the cases in which the First District panel placed its trust. *Giraldo,* 208 So. 3d at 252.

In contrast to these three older cases, as the Second District recognized in *Willoughby*, there are at least eight cases around the country that have come to the conclusion that state Medicaid agencies cannot recover from the future medical expenses portion of a settlement. *Willoughby*, 212 So. 3d at 524 (listing eight non-Florida cases reaching the same conclusion). For example, the West Virginia Supreme Court held that West Virginia's statute "directly conflicts with *Ahlborn*, insofar as it permits [that state's version of AHCA] to assert a claim to more than the portion of a recipient's settlement that represents compensation for past medical expenses." *In re E.B.*, 729 S.E. 2d 270, 288 (W.Va. 2012). The First District panel characterized the West Virginia case as "providing little or no support" for its conclusion, *Giraldo,* 206 So. 3d at 252 n.11, but the West Virginia Supreme Court's discussion was over eight pages long. *In re E.B.*, 729 S.E. 2d at 288-296. And one Justice even wrote a concurrence for the sole purpose of highlighting the fact that a majority of courts in the country have concluded that Medicaid can only recover from the past medical expenses portion of a settlement. *Id*. at 305-06 (Davis, J., concurring).

More recently, in *Austin v. Capital City Bank*, 2015 WL 4366519, at *3-4 (Kan. Ct. App. 2015), a Kansas appellate court said that both *Wos* and *Ahlborn*

reflect that Medicaid can only take from a Medicaid recipient's settlement "that which represents compensation for past medical expenses." Those cases are not the only examples. *See, e.g.*, *E.M.A.*, 674 F.3d at 300 ("[T]he 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."); *Price v. Wolford*, 608 F.3d 698, 706 (10th Cir. 2010) (saying that *Ahlborn* "held that a state's recovery of Medicaid payments out of a tort settlement is limited to the portion of the settlement that represents medical costs paid by Medicaid").

The First District panel also failed to examine the language of subsection (17)(b) itself. This subsection says that a recipient must demonstrate that something other than the statutory formula should be "allocated as ***reimbursement*** for past and future medical expenses." § 409.910(17)(b), Fla. Stat. (2015) (emphasis added). A tortfeasor cannot "reimburse" someone in a settlement for money that has not been spent. This Court cannot ignore the meaning of the word in the statute. *See, e.g.*, *Stroemel v. Columbia Cty.*, 930 So. 2d 742, 745 (Fla. 1st DCA 2006) ("[S]tatutes must be given their plain and obvious meaning and it must be assumed that the legislative body knew the plain and ordinary meanings of the words.").

The same is true of the Legislature's use of the word "for" instead of "from." The statute says Juan must prove what was "allocated as ***reimbursement*** for past and future medical expenses." § 409.910(17)(b), Fla. Stat. (emphasis added). Giving the selected word its "plain and obvious" meaning, AHCA can seek reimbursement of funds spent ***for*** future medical expenses, but it cannot seek reimbursement ***from*** funds set aside for future expenses not yet incurred. *See, e.g.*, *Stroemel*, 930 So. 2d at 745. (Again, in this case, the parties stipulated that AHCA "spent $322,222.27 on behalf of Mr. Villa, all of which represents expenditures paid for Mr. Villa's past medical expenses." R.142 ¶12.) The First District's opinion made no effort to address these plain language arguments.

Finally, if this Court considers the other situations to which section 409.910 applies, it is obvious that the First District's interpretation cannot be the law. Specifically, section 409.910(11)(f) says that the statutory formula applies to ***any*** "judgment, award or settlement" a Medicaid recipient receives. Suppose that, instead of settling, Juan had taken his case to trial and he put on evidence of his past medical bills as well as evidence of what his future medical care will cost. And suppose that, as they are wont to do, the verdict form asked the jury to determine the tortfeasor's liability for past medical expenses separate from future medical expenses. Here, the First District held that AHCA "may secure payment from both past and future recoveries for medical expenses." *Giraldo*, 208 So. 3d at

252; *id*. at 248.

Which means, under the First District's interpretation, AHCA could ignore the jury's determination of the tortfeasor's "legal liability to make payment for such assistance [Juan's past medical expenses]," § 1396a(a)(25)(H), and recover from the portion the jury clearly set aside as the tortfeasor's liability for future medical expenses. Such an outcome not only exceeds the scope of the federal reimbursement authorizations (*see* pp. 19-22, 30-32, above), it should make us all shudder. (It certainly distressed the Supreme Court during the *Wos* oral argument when North Carolina argued that it could ignore a jury's damages allocations. *See Delia*, 2013 WL 1842103, at *10-17.) But there is no meaningful difference between that hypothetical and the First District's interpretation in this case.

Essentially, to reach the conclusion that AHCA could collect from the future medical expenses portion of Juan's settlement, the First District panel had to cast aside all of *Wos*, large portions of *Ahlborn*, relevant portions of the federal Medicaid statutes, and the interpretations of its own court and sister courts.

The Second District got it right

Unlike the First District, the Second District got it right because it examined the issue without blinders. The Second District said that "*Giraldo* misinterprets *Ahlborn*." *Willoughby*, 212 So. 3d at 523. Analyzing the details of *Ahlborn*, the Second District appropriately noted that the parties had stipulated to the portion of

the settlement representing payment for past medical care. *Id.* at 523-24. The Second District concluded that, implicit in the *Ahlborn* Court's holding was the idea that "only amounts allocable to past payments were subject to [Medicaid's] lien." *Id.* at 524.

Likewise, although it acknowledged that the *Wos* opinion did not squarely address the past versus future issue, the Second District recognized that "the underlying facts" of *Wos* indicated that the Supreme Court believed that the future medical expenses portion of a settlement was off-limits. *Id*. Specifically, the Second District noted that *Wos* affirmed the Fourth Circuit's opinion that North Carolina could not encumber "funds that are not payments for medical expenses already incurred." *Id.*, quoting *E.M.A.*, 674 F.3d at 295.

The Second District also conducted a survey of cases outside of Florida that have been decided "since *Ahlborn*." *Id*. The court cited eight of them and said "many" of those "painstakingly explain how *Ahlborn* compels [the] result" that "the Medicaid lien does not attach to settlement funds allocable to future medical expenses." *Id*. (Notably, the Second District said that the West Virginia Supreme Court opinion, the one the First District said had "no analysis," actually offered "painstaking" analysis. *Id*.) Additionally, the Second District provided examples of ALJ opinions (in Florida) that had reached the same conclusion. *Id*. at 525.

The Second District further recognized that the Legislature's choice of the word "reimbursement" in subsection (17)(b) meant something. The court noted that Merriam-Webster defines "reimburse" as "to pay back someone" or "to make restoration or payment of an equivalent to." *Id*. at 524, quoting Merriam-Webster Online Dictionary, https:/www.merriam-webster.com/dictionary/reimburse. If something is allocated as "reimbursement for past and future medical expenses," that necessarily contemplates that the allocation is meant to pay back money already spent – you cannot "reimburse" someone for future expenses if they have not yet been paid. *Willoughby*, 212 So. 3d at 524.

Finally, although not outcome-determinative, the Second District made note of two facts, also present in this case, that gave it comfort in deciding that AHCA was limited to collecting only the past medical expenses portion of a Medicaid recipient's settlement. First, AHCA stipulated that the past medical expenses portion of Mr. Willoughby's settlement was less than AHCA's lien amount. *Id*. at 525; *see also id*. at 520. Similarly, in this case, AHCA did not dispute (indeed, its proposed order point-blank said) that Juan had proven that only $13,881.79 of his settlement was compensation for his past medical expenses. R.168 ¶14, 171 ¶30. Second, because of the settlement, Mr. Willoughby was "no longer eligible for Medicaid benefits," so AHCA would no longer be paying for his care. *Id.* at 525. Even before Juan's death, the same was true in this case. R.632-33.

We also note that, after *Willoughby*, a Florida federal court has recently addressed the past versus future question as part of a declaratory judgment action. After thoroughly discussing the issue in an original order (*Gallardo I*, 2017 WL 1405166), the court upheld its decision after a rehearing motion, declaring that federal law prohibits AHCA "from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses" and enjoined AHCA from attempting to make any such recovery. *Gallardo II*, 2017 WL 3081816, at *9. The *Gallardo* court grounded its reasoning first and foremost in a "[a] plain reading" of § 1396a(a)(25)(H), the same section discussed above. *Gallardo I*, 2017 WL 1405166, at *5.

This Court should reject the First District's interpretation and embrace the Second District's

Put simply, the First District's opinion in this case is an outlier. The court's conclusion that AHCA can "secure reimbursement . . . 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" is at odds with *Ahlborn*, *Wos*, the plain language of the federal Medicaid statutes, and the opinions of every other appellate court of this state. *Giraldo*, 208 So. 3d at 248.[7]

[7] It is also at odds with the opinions of many (but obviously not all) of Florida's ALJs, which have largely agreed with the Second District's interpretation. *See e.g.*, *Bass v. AHCA*, 2016 WL 3097591, at *7 (DOAH May 27, 2016); *Fourcoy v. AHCA*, 2016 WL 1733493, at *6 (DOAH Apr. 27, 2016); *Velez v. AHCA*, 2016

Based on these authorities, AHCA is limited to recovering only that portion of a Medicaid recipient's settlement allocated as compensation for medical expenses that have already been paid. So, with the First District's interpretation off the table, this Court has two choices when interpreting section 409.910(17)(b)'s charge that the statutory formula in section 409.910(11)(b) will be used to calculate how much of a Medicaid recipient's settlement AHCA can take, unless the recipient proves that "a lesser portion of the [settlement] should be allocated ***as reimbursement for past and future medical expenses*** than the amount calculated by the . . . formula set forth in paragraph (11)(f)." § 409.910(17)(b) (emphasis added).

The less desirable option is to say this subsection is preempted by federal law because the inclusion of the language "future medical expenses" allows the statute to be read to allow AHCA to recover from more than that portion of a

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WL 1554263, at *6-7 (DOAH Apr. 12, 2016); *Doheny v. AHCA*, 2016 WL 1533264, at *6 (DOAH Apr. 8, 2016); *Belinaso v. AHCA*, 2016 WL 1255776, at *14 (DOAH Mar. 25, 2016); *Gaudio v. AHCA*, 2016 WL 698430, at *8 (DOAH Feb. 17, 2016); *Bryant v. AHCA*, 2016 WL 681061, at *12-14 (DOAH Feb. 12, 2016); *McCray v. AHCA*, 2015 WL 9267418, at *6 (DOAH Dec. 16, 2015); *Griffis v. AHCA*, Case No.: 15-3849MTR (DOAH Oct. 30, 2015); *Hunt v. AHCA*, Case No.: 13-4684MTR (DOAH Sept. 10, 2015); *Pierre v. AHCA*, 2015 WL 1781183, at *7 (DOAH Apr. 14, 2015); *Mierzwinski v. AHCA*, 2015 WL 1095841, at *14 (DOAH Mar. 6, 2015); *Gibbons v. AHCA*, 2014 WL 1875794, at *5 (DOAH May 7, 2014); *Leigh Ann Holland v. AHCA*, 2014 WL 4953240, at *13 (DOAH Sept. 29, 2014); *but see Goddard v. AHCA*, 2015 WL 1422267 (DOAH Mar. 23, 2015); *Silnicki v. AHCA*, 2014 WL 3563663 (DOAH July 15, 2014); *Holland v. AHCA*, 2014 WL 1857058 (DOAH May 2, 2014); *Savasuk v. AHCA*, 2014 WL 350831 (DOAH Jan. 29, 2014).

settlement than is intended as a tortfeasor's payment for medical expenses that have already been paid.

The easier road, and the one that avoids the constitutional question while still giving meaning to the word "future" in subsection (17)(b), is to read section 409.910 the way the Second District has read it. *See Stroemel*, 930 So. 2d at 745 ("Statutes or ordinances should be given that interpretation which renders the ordinance valid and constitutional."). That is, section 409.910(17)(b) allows a Medicaid recipient to avoid the calculation in subsection (11)(f) if the recipient can prove that a lesser amount was allocated as reimbursement for medical expenses ***that Medicaid has already paid*** (whether the payments were for "past" medical care or were prepayments for "future" medical care).

So if, for example, AHCA has a contract with a provider who gives a steep discount for prepayment of regular services (let's say, dialysis) and AHCA made that prepayment, that would be money already spent for "future medical care." When the settlement allocates the tortfeasor's liability for payments that have already been made, this future care payment would be included. AHCA obviously contemplates such a possibility. In this case, for example, it stipulated that all of the payments it had made "represent[] expenditures paid for Mr. Villa's past medical expenses" (R.142 ¶12) and that none of the payments AHCA made were "expenditures for future medical expenses." R.142 ¶13. AHCA reiterated that at

the DOAH hearing. R.629-30.

In short, to harmonize federal law with Florida's goal of replenishing state coffers, this Court should reject the First District's interpretation, adopt the Second District's interpretation, and make clear that section 409.910(17)(b) allows a Medicaid recipient to avoid the calculation in subsection (11)(f) if the recipient can prove that a lesser amount was allocated as the tortfeasor's liability for the medical expenses ***that have already been paid*** (whether the payments were for past medical care or were prepayments for future medical care). AHCA cannot, however, recover its past payments from the portion of the settlement that represents compensation for an injured recipient's unpaid, future medical expenses.

C. Application of the law to the facts of this case.

All that remains, after deciding that AHCA's recovery is limited to the portion of Juan's settlement allocated as compensation for medical expenses that have already been paid, is to apply that legal holding to the facts of this case. As we explain, this Court should quash the First District's decision and remand with instructions that AHCA be directed to accept $13,881.79 in satisfaction of its lien.

Here, the evidence was undisputed that the parties allocated $13,881.79 as compensation for Juan's past medical expenses and there were no prepayments for future care. As the ALJ's Final Order notes, AHCA presented no witnesses and offered no evidence at the DOAH hearing. R.255. The evidence before the ALJ

was the testimony of two separate expert witnesses that the damages in Juan's case were worth, conservatively, $25 million and the testimony of those witnesses that the parties' allocation in the settlement of $13,881.79 to past medical expenses was fair and reasonable. R.539, 574-75, 600-04, 626, 643-46, 653-54. AHCA did not challenge or impeach the testimony that the parties to Juan's underlying lawsuit had agreed to the $25 million figure and that the $25 million figure was reasonable. Nor did AHCA challenge or impeach the testimony that the parties had used the $25 million figure as part of a pro rata formula to allocate $13,881.79 as compensation for Juan's past medical expenses. And, the formula is clearly spelled out in the settlement's release. R.443 ¶f.[8] Indeed, AHCA's proposed final order acknowledged that the parties to the settlement all agreed to the allocation (R.168 ¶14) and that Juan had proven his case as far as what was allocated to past medical expenses. R.171 ¶30.

AHCA went "all in" on the legal argument that it was allowed to recover from both the portion of Juan's settlement intended as compensation for past medical expenses ***and*** the portion intended as compensation for future medical expenses. So, even though AHCA agreed Juan had proven the allocation to past medical expenses, AHCA's argument was that Juan nevertheless failed to rebut the application of the statutory formula because Juan "provided no evidence proving a

[8] The formula is:
(Settlement amount ÷ Value of damages) x Past Medical expenses = Allocation.

future expense portion" of his settlement. R.168 ¶17, 171 ¶¶28, 30-31; *see also* R.165, 671-73; § 409.910(17)(b), Fla. Stat.

AHCA's gamble settles the matter. AHCA put all its eggs in the basket embraced by the ALJ and the First District – the basket this Court should now reject. Since those lower courts were wrong to allow AHCA to recover money that was allocated for expenses AHCA has not paid, it is too late for AHCA to now criticize the $13,881.79 with which it had previously elected not to quibble.

Put simply, the relevant evidence regarding the allocation for the medical expenses that have already been paid was undisputed, unrebutted, and unequivocal. The ALJ thus lacked any discretion to reject this amount. *See Twin City Roofing Constr. Specialists, Inc. v. State, Dep't. of Fin. Servs.*, 969 So. 2d 563, 565-66 (Fla. 1st DCA 2007) (when a conclusion is in conflict with unrebutted testimony, it is not supported by competent, substantial evidence in the record), citing *Wade Bradford Grove Serv., Inc. v. Bowen Bros., Inc.*, 382 So. 2d 719, 720 (Fla. 2d DCA 1980) (ALJ's factual finding reversed because it was contrary to "unrebutted testimony"); *see also Katherine's Bay, LLC v. Fagan*, 52 So. 3d 19, 31 (Fla. 1st DCA 2010) (reversing ALJ's factual finding where there was insufficient evidence in support).

The First District completely missed the point, saying that the ALJ was free to reject "unrebutted" testimony and citing two outdated cases in support. *Giraldo,*

208 So. 3d at 247, citing *Fox v. Dep't of Health*, 994 So. 2d 416, 418 (Fla. 1st DCA 2008); *Walker v. Fla. Dep't of Bus. & Prof'l Regulation*, 705 So. 2d 652, 655 (Fla. 5th DCA 1998). But both of the cases cited by the First District pre-date this Court's decision in *Wald v. Grainger*, 64 So. 3d 1201 (Fla. 2011). In *Wald*, this Court held that a factfinder may reject "uncontradicted testimony" but, in order to do so, the rejection "***must*** be based on some reasonable basis in the evidence." *Id*. at 1206 (emphasis added).

Here, given AHCA's acceptance of the allocation and its own proposed findings, there was no basis in the evidence to reject the $13,881.79 figure. R.168 ¶¶14, 17, 171 ¶30; *see also Willoughby*, 212 So. 3d at 525 (noting that the relevant evidence was stipulated; hence, the final order was "not supported by competent, substantial evidence"). Stated differently, the First District's reasoning that Juan did not meet his burden is inextricably intertwined with its improper resolution of the past versus future issue, because the evidence of Juan's past medical expenses was undisputed.

Accordingly, if this Court rejects the First District's interpretation of section 409.910(17)(b), it should remand with directions for AHCA to accept, as a satisfaction of its lien against this settlement, the $13,881.79 allocated by the parties as compensation for Juan's past medical care – an amount AHCA did not challenge in any way. R.168 ¶14 (AHCA's proposed final order: "the parties

executed a General Release, in which both parties agreed to a pro rat[a] 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."); 171 ¶30 ("Petitioner presented evidence supporting its position reducing the amount of the past medical expense portion of the settlement.").

CONCLUSION

Consistent with the conclusions of every other Florida appellate court, except the First District panel in this case, in order to avoid being preempted by federal law, section 409.910(17)(b) must be interpreted to say that AHCA can only recover as reimbursement that portion of a settlement or judgment which is intended as compensation for medical bills that have already been paid (whether past medical expenses or prepayment for future medical expenses). Applying that law to this case, the unrebutted evidence was that Juan's settlement allocated $13,881.79 as compensation for the medical bills that have been paid. This Court should therefore quash the First District's decision and remand with instructions to require AHCA to accept the $13,881.79 as a satisfaction of its lien against Juan's settlement. AHCA can then pursue the remainder of its lien from any verdict against, or settlement with, the three remaining defendants.

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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.

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CERTIFICATE OF COMPLIANCE

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

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