UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT
Case No.: 17-13693

GIANINNA GALLARDO, an Incapacitated Person, by and Through Her Parents, and Co-Guardians Pilar Vassallo and Walter Gallardo,

Plaintiff-Appellee,

v.

District Court Case No.: 4:16-cv-00116-MW-CAS

JUSTIN M. SENIOR, in his Official Capacity as Secretary of the Florida Agency for Health Care Administration,

Defendant-Appellant.

_____/

On Appeal from the United States District Court
For the Northern District of Florida, Tallahassee Division

PRINCIPAL BRIEF OF APPELLEE

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APPELLEE'S CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

In compliance with Local Rule 26.1-1, Appellee certifies that the certificate of interested persons in Appellant's principal brief is complete except for the following persons who should be added:

Dudek, Elizabeth, former Secretary of the Florida Agency for Health Care Administration and the original defendant in the district court.

Williams, Stuart F., former General Counsel of the Florida Agency for Health Care Administration and former counsel of record in the district court.

By:/s/ *Bryan S. Gowdy*
Bryan S. Gowdy

STATEMENT REGARDING ORAL ARGUMENT

Appellee agrees with Appellant that this case warrants oral arguments. The case concerns whether the federal Medicaid statutes preempt in part a Florida Medicaid statute. The courts are divided on the first issue. *Compare, e.g., Willoughby v. AHCA*, 212 So. 3d 516, 524 (Fla. Dist. Ct. App. 2017) (finding preemption), *with, e.g., Giraldo v. AHCA*, 208 So. 2d 244, 249-52 (Fla. Dist. Ct. App. 2016)(finding no preemption), *rev. granted*, No. SC17-297 (Fla. Sept. 6, 2017); *infra* Argument I.C., at 38-41.

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STATEMENT OF JURISDICTION

Appellee agrees with Appellant's statement of jurisdiction.

STATEMENT OF THE ISSUES

Appellee disputes Appellant's statement of the issues. Appellee re-states the issues:

I. Whether a State may enforce its Medicaid lien for past medical expenses by taking from the portion of a Medicaid recipient's tort recovery that compensates the recipient for future medical expenses.

II. Whether the district court's declaratory judgment – that Florida may not require a Medicaid recipient to affirmatively disprove its arbitrary formula-based allocation with clear and convincing evidence – may be affirmed on preservation grounds, preemption grounds, or an alternative ground on which the district court did not rely.

By notice of supplemental authority filed with this Court on February 11, 2018, Appellant withdrew the third issue listed in its brief because of a bill enacted on February 9, 2018. *See* Bipartisan Budget Act of 2018, H.R. 1892, 115th Congress, § 53102(b)(1). Accordingly, Appellee does not address the third issue.

STATEMENT OF THE CASE

A. Introduction

This case concerns whether Florida's Agency for Health Care Administration ("the State," "the State agency," or "Florida") has been complying with federal law

when it takes a portion of an injured Medicaid recipient's tort recovery.[1] In the district court, Plaintiff (the Medicaid recipient and Appellee) and the State (Appellant) litigated two issues. First, may a State enforce its Medicaid lien for past medical expenses by taking the portion of a recipient's tort recovery that compensates the recipient for future medical expenses? Second, may the State use an arbitrary formula, unsupported by any evidence, to determine the portion of a recipient's tort recovery that compensates for medical expenses and then require the recipient to prove by clear and convincing evidence that this arbitrary determination is wrong? For both questions, Plaintiff said "no," and the State said "yes." (Doc. 12, at 1-2.) The district court correctly agreed with Plaintiff on both issues. (Doc. 30, at 3-4); *infra* Arguments I and II, at 29-51.

The State divided its statement into two parts. Part A effectively made legal arguments (Appellant's Br. 3-5), to which Plaintiff will respond in her argument section. *Infra* at 16-29. Part B, which stated the facts and proceedings below (Appellant's Br. 5-8), is accurate but omits material information. Thus, Plaintiff supplements the State's statement with her own. *Infra* at 3-14.

[1] "Tort recovery" refers to monies that a Medicaid recipient recovers from a third-party tortfeasor or insurer, by settlement or judgment, as compensation for damages caused by the tort. Those damages may include: past medical costs; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings; and permanent impairment of the ability to earn in the future. *See Ark. Dep't of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 273, 126 S. Ct. 1752, 1757 (2006).

B. Statement of Facts, Course of Proceedings, and Disposition Below.

1. The undisputed facts.

In her summary judgment memorandum, Plaintiff stated the material facts. (Doc. 12, at 3-6.) In response, the State did not dispute a single fact; instead, it conceded, "As explained by Plaintiff, the material facts are undisputed." (Doc. 16, at 1, ¶ 1.) Plaintiff's undisputed statement of material facts was:

> 1. In November 2009, a truck struck Plaintiff after her school bus dropped her off. She suffered catastrophic physical injuries and brain damage. She remains in a persistent vegetative state and is unable to ambulate, communicate, eat, toilet, or care for herself.
>
> 2. Medicaid and Wellcare paid $862,687.77 and $21,499.30, respectively, for Plaintiff's past medical expenses. The combined amount ($884,188.07) represented Plaintiff's entire claim for past medical expenses in her suit against the tortfeasors.
>
> 3. Plaintiff's parents brought an action in state court to recover her damages against the tortfeasors allegedly responsible for her injuries. This action sought recovery of Plaintiff's past medical expenses, as well as her damages for bodily injury, pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life, lost ability to earn money in the future, and future medical expenses. Her parents sought damages for loss of consortium.
>
> 4. Plaintiff's personal-injury action was resolved in two settlements totaling $800,000. Court approval was required due to her incapacity; the court approved the settlements.
>
> 5. [The State] was notified of Plaintiff's personal-injury action and asserted a $862,688.77 Medicaid lien against her cause of action and future settlement.
>
> 6. [The State's] Medicaid lien represents expenditures paid for Plaintiff's past medical expenses. [The State] has not made payments

in the past or in advance for Plaintiff's future medical care. No portion of the lien represents expenditures for Plaintiff's future medical expenses.

7. By letter, Plaintiff's attorney notified [the State] of the settlement. The letter explained that Plaintiff's damages had a value exceeding $20,000,000 and that the settlement represented only a 4% recovery of her $884,188.07 claim for past medical expenses, or $35,367.52. The letter asked [the State] to advise as to the amount it would accept in satisfaction of its $862,688.77 Medicaid lien.

8. [The State] did not respond to the letter or file an action to set aside, void, or otherwise dispute Plaintiff's settlement.

9. The formula at section 409.910(11)(f), Florida Statutes (2016) requires payment to [the State] of approximately $300,000.

10. Because only $35,367.52 of the settlement represented compensation for past medical expenses, Plaintiff disagreed that payment of approximately $300,000 to [the State] was appropriate or lawful. However, under section 409.910(17)(b), the only method of challenging the amount payable to [the State] in satisfaction of a Medicaid lien is to deposit the full amount into an interest-bearing account and initiate an administrative proceeding at the Division of Administrative Hearings in Tallahassee (DOAH). Accordingly, Plaintiff deposited $300,000 in an interest-bearing account and filed a petition with DOAH . . . .

11. In administrative proceedings under section 409.910(17)(b), [the State] has taken the position that: (i) it is entitled to recover its past Medicaid payments from the portions of a Medicaid recipient's settlement representing compensation for both past **and future** medical expenses; and (ii) to successfully challenge the amount payable to it, the Medicaid recipient must prove by clear and convincing evidence that the amount of the settlement allocable to both past and future medical expenses is less than the formula amount in section 409.910(11)(f).

> 12. In the administrative proceeding, [the State] is seeking recovery of its past Medicaid payments from beyond that portion of Plaintiff's settlement representing compensation for past medical expenses.
>
> 13. On June 14, 2016, the Administrative Law Judge granted the parties' motion to abate proceedings and placed the case in abeyance pending resolution of the legal question presented in this case.

(Doc. 12, at 3-6 (citations omitted).)

2. Plaintiff presented a history of the Florida Medicaid statute.

Plaintiff's summary judgment memorandum presented an extensive history of the Florida Medicaid statute, Fla. Stat. § 409.910. (Doc. 12, at 16-25.) The State's only response to this history was to call it "irrelevant" and argue that "Florida allows as much reimbursement to the [State] [a]gency as federal law does." (Doc. 16, at 5.) Some of this history is repeated *infra* in the argument section, at 25-29. This history included a memorandum written by the State agency discussing the 2013 amendments to section 409.910 (Doc. 10-4; Addendum) Plaintiff summarized this history as follows: "[N]either [the State agency] nor the Florida Legislature has ever articulated, much less produced evidence showing, how the formula [in section 409.910] reasonably results in an accurate measurement of the past medical expenses recovered in a substantial number of tort cases brought by Medicaid recipients." (Doc. 12, at 24.) The State agency never disputed this assertion. (Doc. 16.)

Based on the State agency's memorandum, Plaintiff also asserted that section 409.910 was enacted with a purpose of granting substantial advantages to the State over Medicaid recipients, not to protect the recipients' federal rights:

> [A]s [the State agency] admitted, the 2013 amendment's purpose was to give advantages to the State, not to protect a Medicaid recipient's federal property rights. [(Doc. 10-4, at 3-5.)] For instance, [the State agency] opined that, by shifting to the recipient a clear-and-convincing burden of proof, the 2013 amendment would: (i) "increas[e] the likelihood the State [would prevail] in defending Medicaid liens;" (ii) increase the State's collections on third-party liability liens; and (iii) reduce the State's expenses in defending Medicaid liens. [(Doc. 10-4, at 4.)]

(Doc. 12, at 24-25.) The State never disputed this assertion. (Doc. 16.)

3. Some of the State's appellate arguments were not made to the district court or were abandoned.

In its appellate arguments to this Court, the State emphasizes: (i) the timing of when certain provisions of the federal Medicaid statutes were enacted; (ii) two federal regulations, *see* 42 C.F.R. §§ 433.145(a)(1),433.146(a)(1), and (iii) a House conference report, H.R. Conf. Rep. No. 103-213, at 835 (1993), *reprinted in* 1993 U.S.C.C.A.N. 1088, 1524. (Appellants' Br. 11-13, 19-20.) In the district court, however, the State did not present any such arguments either at the summary judgment phase (Doc. 14, 16, 18) or in its post-judgment motion (Doc. 44).

To this Court, the State also argues the district court "erred" because it purportedly "refused to consider any empirical evidence." (Appellant's Br. 25.) Then, it cites as evidence Westlaw citations to twenty-one cases decided by various

administrative law judges at Florida's Division of Administrative Hearings (DOAH). (Appellant's Br. 26-28.) In the district court, however, the State did not present any evidence at the summary judgment stage on how DOAH's administrative law judges, in practice, applied the statutory formula under section 409.910(11)(f)&(17), Florida Statutes. Granted, the State did cite to eleven unreported DOAH cases to support its argument that Medicaid recipients purportedly "have successfully reduced the Medicaid liens time and time again." (Doc. 16, at 10-11.) But the State failed to provide copies of any opinions, findings of fact, or decisions from these DOAH cases, and it failed to provide citations to Westlaw or Lexis that would have enabled the district court to review the unreported DOAH decisions. (*Id.*)

In fact, the State told the district court that it was not relying on DOAH's practical application of the Florida Medicaid statute. Specifically, at the summary judgment hearing, the court asked the State whether it was relying on "practice" – i.e., "how individual [administrative law judges] may or may not apply the provision"—"in any way in terms of your position with the claims brought by [Plaintiff]." (Doc. 70, at 12-15.) The State's counsel responded as follows:

> No, the agency is not relying on the practice that it takes to defend what it's doing. Instead the statutes, the federal statutes and the Florida statutes are not in conflict. There is no need for preemption. So, no, we are not relying upon our practice. … [T]he administrative law judges do different things so I don't believe that the practice of the ALJs is even something that the agency could defend.

(Doc. 70, at 15:11-22.)

4. The district court's summary judgment.

The district court's summary judgment order agreed with some, but not all, of Plaintiff's arguments. (Doc. 30); *Gallardo by & through Vassallo v. Dudek*, 263 F. Supp. 3d 1247 (N.D. Fla. 2017).

First, the court agreed that the federal Medicaid statutes preempted section 409.910, Florida Statutes, insofar as it "allow[ed] [the State] to satisfy its lien from a Medicaid recipient's recovery for future medical expenses." (Doc. 30, at 12-13; *see also id.* at 12-20.) The court rested its conclusion on a "plain reading" of the "unambiguous" text of the federal Medicaid statutes. (Doc. 30, at 13-15, 18-19 (citing 42 U.S.C. §§ 1396a(25)(A)-(B)&(H), 1396k(a)(1)(A)&(b),1396p(a)(1).) The court also relied on the two seminal U.S. Supreme Court cases, *Ahlborn* and *Wos*, though it also acknowledged neither case directly controlled. (Doc. 30, at 16-17 (discussing *Ahlborn*, 547 U.S at 268 and *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 133 S. Ct. 1391 (2013)). The court explained that the handful of non-binding cases cited by the State were not persuasive because they failed to "address the language referencing past medical expenses highlighted in *Ahlborn*, *Wos*, or §§ 1396a(a)(25)(A)–(B), 1396a(a)(25)(H), and 1396k." (Doc. 30, at 17-18.)

Second, the court agreed the federal Medicaid statutes preempted section 409.910, Florida Statutes, insofar as Medicaid recipients were required to

"affirmatively disprove [section 409.910's] arbitrary formula-based allocation with clear and convincing evidence to successfully overcome [the allocation]." (Doc. 30, at 23; *see also id.* at 23-33.) The court discussed how, in *Wos*, the U.S. Supreme Court had concluded a State's "irrebuttable, one-size-fits-all statutory presumption" was preempted because it "allowed 'the State to take a portion of a Medicaid beneficiary's tort [recovery] not designated as payments for medical care.'" (Doc. 30, at 24 (internal quotations and alterations omitted) (quoting *Wos*, 568 U.S. at 644.) The court concluded that section 409.910 "suffered from [the] same defect" as the state statute at issue in *Wos*, though "for more nuanced reasons." (Doc. 30, at 24-25.)

The district court's nuanced holding is overlooked by the State in its brief. The State incorrectly suggests that the district court's ruling rested solely on section 409.910's shifting to a Medicaid recipient of a clear-and-convincing burden of proof. (*See* Appellant's Br. 6, 25.) In fact, the district court's preemption conclusion rested on both section 409.910's formula-based allocation, which the court found to be "wholly divorced from realty," and section 409.910's "requirement that the recipient affirmatively disprove that [formula-based allocation] [by clear and convincing evidence] to successfully rebut it." (Doc. 30, at 33.) The court was "not saying that Florida [could] not enact a rebuttable, formula-based allocation to determine what portion of a judgment represents past medical expenses; in fact, the Supreme Court

[in *Wos*] has suggested, without holding, just the opposite." (Doc. 30, at 31-32.) The court also stated that Florida "probably" could shift the burden of proof to Medicaid recipients to disprove a statutory allocation. (Doc. 30, at 32.)

But, critically, the district court concluded Florida's particular formula-based allocation – not just the clear-and-convincing burden – violated federal law because it was arbitrary and not a reasonable approximation of the medical expenses paid by Medicaid in a "mine run of cases." (Doc. 30, at 24-29 (quoting *Wos*, 568 U.S. at 637, 643).) The Court observed that "nothing in the record helps explain why Florida chose the precise formula that it did" and thus it was "impossible to judge whether it is 'likely to yield reasonable results in the mine run of cases.'" (Doc. 30, at 25 (quoting *Wos*, 568 U.S. at 643).) The court then provided several examples to demonstrate how Florida's formula was arbitrary and failed, with any degree of accuracy, to approximate the portions of tort recoveries representing past medical expenses. (Doc. 30, at 26-29.) The court also reviewed the legislative record and found that the formula's purpose was to "tilt the scales in [the State agency's] favor." (Doc. 30, at 29.) Only after all this analysis of the formula (Doc. 30, at 24-29), which the State's brief overlooks, did the Court then turn its analysis to the clear-and convincing burden of proof (Doc. 30, at 29-30). The court also suggested that the formula's arbitrary nature, standing "alone" (i.e., irrespective of the burden of proof), conflicted with federal Medicaid law. (Doc. 30, at 29.)

Though the district court agreed with Plaintiff that section 409.910's formula and burden of proof were preempted by federal law (Doc. 30, at 23-33), it rejected Plaintiff's alternative due process argument challenging these aspects of section 409.910. (Doc. 30, at 20-23.) The court described Plaintiff's due process argument as "circular and conclusory," "blurred," and "gaunt." (Doc. 30, at 20.)

In the relief section of its order and in its judgment, the district court declared the federal Medicaid Act prohibited the State from: (i) "seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses," and (ii) "requiring a Medicaid recipient to affirmatively disprove [section 409.910's] formula-based allocation with clear and convincing evidence to successfully challenge it where, as here, that allocation is arbitrary and there is no evidence that it is likely to yield reasonable results in the mine run of cases."[2] (Doc. 30, at 34; Docs. 31, 41.) The court enjoined the State agency from enforcing those portions of section 409.910 that Plaintiff had proved were preempted. (Doc. 30, at 33; Docs. 31, 41.)

5. Proceedings after summary judgment.

After summary judgment, five new attorneys appeared for the State. (Docs. 32-34, 42-43.) The State then filed a post-judgment motion under Fed. R. Civ. 59

[2] The district court amended its original judgment to correct a typographical error. (Docs. 31, 39-41.)

and 60. (Doc. 44.) This motion was exactly 8,000 words (Doc. 44, at 34), the maximum allowed under N.D. Fla. Loc. R. 7.1(F). By comparison, the State's three pre-judgment memoranda on the cross-motions for summary judgment totaled less than 6,800 words. (Docs. 14, 16, 18.) The post-judgment motion raised multiple new arguments. (*Compare* Doc. 44, *with* Docs. 14, 16, 18.) The district court disapproved of the State's tactic, as it was contrary to settled case law that Rules 59 and 60 were "not intended to provide disgruntled litigants with a second bite at the apple." (Doc. 59, at 7; *see id.* at 1-2, 6-11.)

The district court found that the State's post-judgment motion was trying to undo the State's concession at the summary judgment hearing. (Doc. 59, at 11.) In its post-judgment motion, the State argued the court should have considered how section 409.910's formula-based allocation was applied in practice at DOAH. (Doc. 44, at 1, 5-7, 9.) And the State's post-judgment motion provided – for the first time – Westlaw citations to the DOAH opinions that, the State claimed, supported its "practice" argument, and the State cited several DOAH cases that it had not cited in its summary judgment papers. (*Compare* Doc. 44, at 5-7, *with* Docs. 14, 16, 18.) The State's flip-flop from the summary judgment hearing did not go unnoticed by the district court: "[The State] plainly conceded that it was not relying upon the practice of how individual DOAH hearing officers may or may not apply the formula-based allocation. It cannot now reasonably expect this Court to ignore that concession."

(Doc. 59, at 11 (emphasis added) (internal quotations, alterations, and citations omitted).)

After the State filed its post-judgment motion, Plaintiff asked the State, via a public record request under Chapter 119, Florida Statutes, for any records containing "[a]ny analysis by [the State agency] that the statutory formula, § 409.910(11)(f), Florida Statutes, is a reasonable approximation of the amount recovered for past medical expenses incurred by [the State agency]." (Doc. 51-1, at 1, ¶7.) In response, the State admitted it had "no responsive documents." (Doc. 51-2, at 1.)

The district court, for the most part, denied the State's post-judgment motion. (Doc. 59, at 28-29); *Gallardo by & through Vassallo v. Senior*, 4:16CV116-MW/CAS, 2017 WL 3081816 (N.D. Fla. July 18, 2017). The only relief granted to the State was to clarify that the court's injunction did not require the State agency to stop the enforcement of the clear-and-convincing burden of proof. (Doc. 59, at 18-21, 27-28, 28 ¶ 2.) The court justified this clarification by reasoning that DOAH, not the State agency, applied the clear-and-convincing burden of proof. (Doc. 59, at 18-19.) The court, however, reiterated that it still was declaring section 409.910's formula-based allocation and clear-and-convincing burden of proof as being preempted by the federal Medicaid Act. (Doc. 59, at 21-28; Doc. 60.) The court also re-affirmed its prior injunctive and declaratory relief that had enjoined, and declared unlawful, the State agency's attempts to take money from the portion of a Medicaid

recipient's tort recovery representing future medical expenses. (Doc. 59, at 19-20, 29; Doc. 60.)

C. Standard of Review

Plaintiff agrees the standard of review is *de novo*.

SUMMARY OF ARGUMENT

The State agency, by enforcing Florida law, has been violating federal law in two respects. First, the State has been taking money from a Medicaid recipient's tort recovery that compensates the recipient for **future** medical expenses, even though federal law allows the State to take money only from that portion of a recipient's tort recovery compensating the recipient for **past** medical expenses paid by Medicaid. Second, the State has been using an arbitrary formula, which can be rebutted only by clear and convincing evidence, to take money from a Medicaid recipient's tort recovery, even though the State has no evidence that the formula reasonably approximates, in the "mine rune of cases," the portion of the recovery representing past medical expenses paid by Medicaid. The district court agreed with both these points. So should this Court.

On the first point, the district court's statutory interpretation was sound; it was rooted in the plain, unambiguous text of the federal Medicaid statutes. The district court properly read the statutes in context and as a whole. It also correctly rejected the State's attempt to read the assignment provision in isolation and out of context.

The district court's sound reasoning comports with the majority of courts, and the State's attempts to undermine that reasoning are unavailing.

The State's arguments on the second point fail preliminarily for lack of preservation. The State argues that the district court purportedly should have considered evidence of the practice of the administrative law judges. But this argument directly contradicts the concession made by the State's counsel at the summary judgment hearing. And the purported evidence and supporting argument were not presented to the district court until after the entry of summary judgment. The State's arguments also fail on merits. The State overlooks that the primary flaw with its statute (as identified by the district court) is the arbitrary formula-based allocation (irrespective of the burden of proof required to rebut that allocation). No evidence exists that the formula reasonably approximates the medical expenses paid by Medicaid in a "mine run of cases" (or in any case). The federal Medicaid statutes grant recipients protection from state liens on tort recoveries, except those portions attributable to medical expenses paid by Medicaid. Florida's arbitrary formula fails to safeguard these federal property rights and thus conflicts with federal law.

For both points, the district court's order also may be affirmed on an alternative basis not stated in the order. Namely, the assignment provision, on which the State so heavily relies, does not apply because the State failed to seek

reimbursement directly from the tortfeasor or other responsible third party. Thus, the State is not entitled to any portion of Plaintiff's tort recovery.

ARGUMENT

Before this brief addresses the two issues on appeal, *infra* at 29-51, it is necessary to lay a foundation of federal and Florida Medicaid law, *infra* at 16-29.

Statutory and Legal Background

A. Federal Medicaid statutes.

Through Medicaid, federal and state governments jointly fund medical care for individuals who cannot afford to pay. *Ark. Dep't of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 275, 126 S.Ct. 1752 (2006). The federal government pays a significant percentage of the costs; in exchange, the State pays the remaining portion and must comply with federal Medicaid statutes. *Ahlborn*, 547 U.S. at 275.

The pertinent federal Medicaid statutes fall into two categories: (i) the anti-lien and anti-recovery provisions, 42 U.S.C. §§ 1396p(a), 1396p(b); and (ii) the third-party liability, reimbursement, and assignment provisions, *Id.* §§ 1396a(a)(25), 1396k(a). The former provisions prohibit the State from imposing a lien on a Medicaid recipient's property and making recovery of its payments for medical assistance. *Infra* subpart 1, at 17. The latter provisions provide an exception to this prohibition; they permit the State to seek reimbursement of its past Medicaid payments to the extent of the third party's legal liability to pay for care and services

provided by Medicaid. *Infra* subpart 2, at 17-18. These statutes have been the subject of two seminal U.S. Supreme Court cases. *Infra* subpart 3, at 18-25.

1. Anti-lien and anti-recovery provisions.

Federal Medicaid law "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. Specifically, the federal anti-lien provision states, with exceptions not applicable here, that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid **or to be paid** on his behalf under the State plan." *Id.* § 1396p(a)(1) (emphasis added). The federal anti-recovery provision provides, with exceptions not applicable here, that "no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made." *Id.* § 1396p(b).

2. Third-party liability, reimbursement, and assignment provisions.

Medicaid's third-party liability provisions require the State "to ascertain the legal liability of third parties . . . to pay for care and services **available under the plan**." 42 U.S.C. § 1396a(a)(25)(A) (emphasis added). The State must "seek reimbursement for [medical] assistance to the extent of such legal liability" in "any case where such a legal liability is found to exist **after medical assistance has been made available** on behalf of the individual." *Id.* §1396a(a)(25)(B) (emphasis added). "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," a State must have "in effect laws under which, to the extent that **payment has been made** under the State plan for medical assistance for **health care items or services furnished** to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for **such [furnished] health care items or services**." *Id.* § 1396a(a)(25)(H) (emphasis added). "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," a State must require that, as a condition for receiving Medicaid benefits, a recipient "assign the State any rights … to **payment for medical care** from any third party." *Id.* § 1396k(a)(1)(A) (emphasis added).

3. U.S. Supreme Court cases on the federal Medicaid statutes.

The seminal cases interpreting the federal Medicaid statutes are *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752 (2006) and *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 133 S.Ct. 1391 (2013).

a. *Ahlborn.*

In *Ahlborn*, the Court considered whether federal Medicaid law permitted Arkansas to recover the entirety of its Medicaid costs where those costs exceeded the portion of the Medicaid recipient's settlement allocated to past medical expenses. 547 U.S. at 272. Following Heidi Ahlborn's auto collision, the Arkansas Medicaid

agency paid $215,645.30 to her medical providers. She then sued the tortfeasors in state court and "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. The case settled for $550,000. *Id.* at 274. The state agency asserted a lien against the settlement for $215,645.30, the full cost of its payments for Ahlborn's medical care. *Id.*

Ahlborn sued the agency in federal court "seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of **compensation for injuries other than past medical expenses**." *Ahlborn*, 547 U.S. at 274 (emphasis added). The parties stipulated that: Ahlborn's tort claim was worth $3,040,708.12; the $550,000 settlement represented approximately 1/6th of that sum; "and that, if Ahlborn's construction of federal law was correct, the agency would be entitled to the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made." *Id.*

The Supreme Court held that "[f]ederal Medicaid law does not authorize [the agency] to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so." *Id.* The Court rejected the agency's contention that it could access the recipient's entire settlement. *Id.* at 280-81. Instead, the Court relied on the plain language of the third-

party liability provision, § 1396a(a)(25)(B), which directs the State to seek reimbursement for medical assistance "to the extent of such legal liability," and concluded "such legal liability" clearly refers to "the legal liability of third parties … to pay for care and services under the plan." *Id.* Based on this statutory language, the Court concluded the third party's relevant "liability" extended no further than the stipulated sum of $35,581.47, which represented "reimbursement **for medical payments made**." *Id.* at 274, 280-81 (emphasis added). The Court also concluded the agency's recovery was limited by § 1396a(a)(25)(H)'s limitation of the State's assignment "to payment by any other party **for such [furnished] health care items or services**." *Id.* at 281. The Court also observed that § 1396a(a)(25)(H) "echoe[d] the requirements of a mandatory assignment of rights in § 1396k(a)." *Id.*

The Court further concluded the anti-lien provision places "express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf."[3] *Id.* at 283. In fact, "[r]ead literally and in isolation, the anti-lien provisions 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. Read in conjunction with the third-party liability, reimbursement, and assignment provisions, however, the Court

[3] Because the *Ahlborn* parties did not argue the anti-recovery provision in § 1396p(b), the Court "[left] for another day the question of its impact on the analysis." 547 U.S. at 284 n. 13. However, the Court noted that the anti-recovery provision, like the anti-lien provision, "appear[ed] to forestall any attempt by the State to recover benefits paid, at least from the 'individual.'" *Id.*

concluded the assignment authorized by §§ 1396a(a)(25) and 1396k(a) is an exception to the anti-lien provision, and that the exception "is limited to payments for medical care." *Id.* at 284-85. Beyond that, the anti-lien provision protects a recipient's settlement from a forced assignment or lien by the State. *Id.* at 285-86. The Court also "assume[d]" the State could require the recipient to assign "any payments that may constitute reimbursement for medical costs." *Id.* at 284.

The Court rejected the agency's arguments that Ahlborn's settlement proceeds were not "property" under the anti-lien statute, and that a rule of full reimbursement was necessary to avoid the risk of settlement manipulation. *Id.* at 285-87. Significantly, the Court highlighted the "countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Id.* at 288. The Court illustrated its point with an example: a state-court worker's compensation case concluding that a state agency could not satisfy its lien out of loss-of-consortium damages because it would be "absurd and fundamentally unjust" for it to "share in damages **for which it has provided no compensation**." *Id.* at 288 n. 19 (emphasis added).

In summary, the Court concluded the agency, under federal law, could not assert a lien on Ahlborn's settlement in an amount greater than the stipulated amount for "reimbursement for medical payments made." *Ahlborn*, 547 U.S. at 274, 292.

b. *Wos.*

In *Wos*, the Court instructed: "Pre-emption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect." 568 U.S. at 636. The issue in *Wos* was whether the anti-lien provision preempted North Carolina's statute. That statute required up to one-third of a Medicaid recipient's tort recovery be paid to the State to reimburse it for past Medicaid payments. *Id.* at 630. The plaintiff, E.M.A., had suffered birth injuries, and her parents filed a tort suit on her behalf. *Id.* at 630-31. Her expert estimated damages of $42 million, including $37 million for her "skilled home care." *Id.* During the state-court suit, the state agency informed E.M.A.'s parents that it would seek to recover the $1.9 million expended for her medical care. *Id.* at 631. The state court approved a $2.8 million, unallocated settlement and placed one-third of that amount in escrow pending a judicial determination of the state's lien. *Id.* at 1631-32.

E.M.A.'s parents sued the state agency in federal court and argued that North Carolina's reimbursement scheme violated the anti-lien provision, § 1396p(a)(1). *Id.* at 632. The district court disagreed; the Fourth Circuit vacated and remanded. The Fourth Circuit noted that, "[a]s the unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to **past** medical expenses." *E.M.A. v. Cansler*, 674 F.3d 290,

307, 312 (4th Cir. 2012) (emphasis added). Thus, the Fourth Circuit concluded, North Carolina's statute violated federal law because it did not afford the Medicaid recipient an opportunity to rebut the statutory presumption. *Id.* at 312.

The Supreme Court affirmed. Citing to *Ahlborn*, the Court reiterated that the Medicaid statutes set "both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery." *Wos*, 568 U.S. at 633. Specifically, "[t]he Medicaid anti-lien provision prohibits a State from making a claim to any part of a Medicaid [recipient's] tort recovery not designated as payments for medical care" because that provision protects the recipient's property rights in the remainder of the settlement. *Id.* at 636. The Court concluded North Carolina's irrebuttable allocation of one-third of settlement proceeds to medical expenses payable to Medicaid conflicted with the anti-lien statute because North Carolina had "no evidence to substantiate" that such an allocation was "reasonable in the mine run of cases" and it had no process "for determining whether [such an allocation was] a reasonable approximation in any particular case." *Id.* at 637.

In addition, the Court rejected North Carolina's arguments that "other methods for allocating a recovery would be just as arbitrary" and that there was "no ascertainable true value of a case that should control what portion of any settlement is subject to the State's third-party recovery rights." *Id.* at 640 (internal quotations and alterations omitted). The Court concluded that trial lawyers and judges "can find

objective benchmarks to make projections of the damages the plaintiff likely could have proved had the case gone to trial." *Id.* Those "objective benchmarks" would include how likely the plaintiff "would have been to prevail on the claims at trial and how much [the plaintiff] reasonably could have expected to receive on each claim if successful, in view of damages awarded in comparable tort cases." *Id.* at 640-41.

The Court rejected North Carolina's argument that "it would be 'wasteful, time consuming, and costly' to hold 'frequent mini-trials'" on allocating a settlement. *Id.* at 641. Even if the premise of the argument was true, the State was still obligated to comply with the anti-lien provision. *Id.* Furthermore, the Court reasoned, the premise was not true:

> States have considerable latitude to design administrative and judicial procedures to ensure a prompt and fair allocation of damages. Sixteen States and the District of Columbia provide for hearings of this sort, and there is no indication that they have proved burdensome. . . . Many of these States have established rebuttable presumptions and adjusted burdens of proof to ensure that speculative assessments of a plaintiff's likely recovery do not defeat the State's right to recover medical costs, a concern North Carolina raises. . . . **Without holding that these rules are necessarily compliant with the federal statute**, it can be concluded that they are more accurate than the procedure North Carolina has enacted.

Id. (emphasis added).

The Court concluded that, "if States [were] concerned that case-by-case judicial allocations [would] prove unwieldy," States could "adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses, **provided**

that these criteria are backed by evidence suggesting that they are likely to yield reasonable results in the mine run of cases." *Id.* at 643 (emphasis added). But States could not "**adopt an arbitrary, one-size-fits-all allocation for all cases**." *Id.* (emphasis added).

B. Florida Medicaid statute.

In this section, Plaintiff explains: (1) the statutory formula that Florida uses to take money from Medicaid recipients' tort recoveries, *infra* subpart 1, at 25-26; (2) Florida's historic use of the formula in violation of federal law, *infra* subpart 2, at 26-27; and (3) the hurriedly drafted 2013 amendment, advocated by the State agency and enacted by the Florida Legislature, that attempted to save the formula from federal preemption, *infra* subpart 3, at 28-29.

1. The formula.

Florida's formula for allocating the portion of a Medicaid recipient's tort recovery due to the State is as follows:

> (f) . . . [I]n the event of an action in tort against a third party in which the [Medicaid] recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:
>
> 1. After attorney's fees and taxable costs . . ., one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.
>
> 2. The remaining amount of the recovery shall be paid to the recipient.

> 3. For purposes of calculating the agency recovery of medical assistance benefits paid, the fee for services of an attorney retained by the recipient or his or her legal representative shall be calculated at 25 percent of the judgment, award, or settlement.
>
> 4. . . . .

Fla. Stat. § 409.910(11)(f) (2016).

Stated simply, this formula "operates by reducing the gross settlement amount by 25% to account for attorney's fees, then subtracts taxable costs, then divides that number by two, and awards Medicaid the lesser of the amount of benefits paid or the resulting number." *Mobley v. State*, 181 So. 3d 1233, 1235 n. 1 (Fla. Dist. Ct. App. 2015). The statutory amount allocated for attorney's fees (25% of the recovery) is less than the amounts presumptively permitted by Florida's ethics rules. *See* Fla. R. Prof. Conduct 4-1.5(f)(4)(B). The statute makes no exception for cases where a jury verdict determines a different allocation than the formula. *See* Fla. Stat. § 409.910(11)(f) (2016).

2. Florida's historic use of the formula.

Florida has used variants of its formula since at least the early 1990's. *See, e.g.*, Fla. Stat. § 409.2665 (12)(f)2 (1990); Fla. Stat. § 409.910(11)(f)2 (1998). Directly contrary to what the U.S. Supreme Court would later hold in *Ahlborn*, a Florida appellate court in 1998 held, at the State agency's urging, that the agency could use this formula to "satisfy its lien out of the entirety of the third party's liability for the covered injury, even if such liability includes components not

financed by Medicaid, such as attendant care, pain and suffering, or punitive damages." *AHCA v. Estabrook*, 711 So. 2d 161, 166–67 (Fla. Dist. Ct. App. 1998).

Even after *Ahlborn* was decided in 2006 but before *Wos* was decided in 2013, the State agency resisted the proposition that section 409.910'sone-formula had been preempted by federal law. As the State agency informed the Florida Legislature in a 2013 memorandum, "[p]rior to . . . *Wos*, [the agency took] the position that section 409.910(17), Florida Statutes, does not afford Medicaid recipients the right to challenge the percentage of medical expenses . . . allocated pursuant to Section 409.910(11)(f), Fla. Stat." (Doc. 10-4, at 2; Addendum.)

After *Wos* was decided, the State agency admitted in its 2013 memorandum to the Legislature that section 409.910's formula violated federal law.: "Following *Wos*, Florida will no longer be entitled to apply the formula set forth in section 409.910(17)(f), Fla. Stat. [sic], as an irrebuttable presumption." (Doc. 10-4, at 3; Addendum.**)**.) Florida's appellate courts agreed and receded from prior decisions upholding the State agency's use of the formula. *See, e.g., Harrell v. State*, 143 So. 3d 478, 480 (Fla. Dist. Ct. App. 2014); *AHCA v. Riley*, 119 So.3d 514, 516 (Fla. Dist. Ct. App. 2013).

3. The State agency and the Florida Legislature attempted to salvage the formula with the 2013 amendment to section 409.910.

Immediately after *Wos* was decided, the State agency and the Florida Legislature attempted to salvage section 409.910's formula. *Wos* was decided on

March 20, 2013. Just two months later on May 20, 2013, the Governor signed into law a legislative bill that amended section 409.910 effective July 1, 2013. Ch. 2013-48, §6, Laws of Fla.; *see also* Ch. 2013-150, § 2, Laws of Fla.

The 2013 amendment continued to require a Medicaid recipient to pay the State the "full amount of third-party benefits" up to the amount paid by Medicaid for medical assistance. Fla. Stat. § 409.910(17)(a) (2016). However, the 2013 amendment created a new administrative process by which a recipient could challenge the Medicaid lien amount as determined by the formula. Specifically, if a recipient desired to "contest the amount designated as recovered medical expense damages payable to the [State] pursuant to the formula," then she could place the third-party benefits recovered from the tort suit in a trust account and file an administrative petition with DOAH. *Id.* § 409.910(17)(a)&(b). The 2013 amendment required that, to successfully challenge the amount payable to the State under the formula, a recipient had to prove, by clear and convincing evidence, that a lesser portion of the total recovery should be allocated as reimbursement for "past **and future** medical expenses" than the amount calculated under the formula. *Id.* (emphasis added).

This amendment language first appeared in a Florida House bill, as committee substitute 1, on April 3, 2013 (two weeks after *Wos* was decided). (*See* Addendum; Fla. House of Representatives, Bills, Regular Session 2013, CS/CS/HB 939 Bill

History, *available at* www.myfloridahouse.gov.) Eight days later, the State agency filed with a House committee the agency's memorandum, previously discussed *supra* at 5. (Doc. 10-5, at 9 n.16; Doc. 10-4; Addendum) In its memorandum, the State agency failed to explain how the 2013 amendment would protect against a State taking of those portions of a Medicaid recipient's tort recovery that, under federal law, belonged to the recipient, i.e., compensation for damages that do not represent medical expenses paid by Medicaid. (Doc. 10-4; Addendum.) Instead, the agency's memorandum explained that the 2013 amendment's purpose was to give the State cost-saving and other advantages when taking tort recoveries from Medicaid recipients. (Doc. 10-4, at 3-5; Addendum; *supra* at 6.) The legislative staff analysis was equally wanting of any explanation how the amendment would protect Medicaid recipients' federal rights. (Doc. 10-5; Addendum.)

Argument on Issues

I. The federal Medicaid statutes preempt the Florida Medicaid statute insofar as it authorizes the State to take the portion of a Medicaid recipient's tort recovery that compensates for future medical expenses.

No portion of the Medicaid dollars spent by the State on Plaintiff's medical care represents expenditures for future medical expenses (Doc. 12, at 4, ¶ 6). Nonetheless, relying on a state statute (Fla. Stat. § 409.910(17)(b)), the State's policy is to seek reimbursement for its past Medicaid expenditures from the portion of Plaintiff's tort recovery compensating her for future medical expenses. (Doc. 12,

at 5, ¶ 11.) This taking of money, the State may not do, even if it is authorized by a state statute. The plain text of the federal Medicaid statutes prohibits it.

The district court's statutory interpretation finding preemption was sound, and it correctly rejected the State's isolated reading of the assignment provision. *Infra* subpart A, at 30-34. The State's efforts to undermine the district court's reasoning are unavailing. *Infra* subpart B, at 34-38. And the greater weight of persuasive case law supports the district court's judgment. *Infra* subpart C, at 38-41. Finally, the district court reached the right result because the primary statute on which the State relies, the assignment provision (§ 1396k(a)), applies only when the State sues the tortfeasor or other responsible third party in the name of the Medicaid recipient, which the State has not done here. *Infra* subpart D, at 41-42.

A. The district court's statutory interpretation was sound and correctly rejected the State's isolated reading of the assignment provision.

The district court correctly recognized that a "plain reading of the [federal] statutory text" showed the State's right to reimbursement "only applies to payments made for past medical expenses." (Doc. 30, at 14.) The district court's rationale was firmly rooted in the statutory text:

> The anti-lien provision prohibits [the State] from seeking reimbursement from a recipient's recovery for "medical assistance paid **or to be paid**." [42 U.S.C.] § 1396p(a) . . . But "to the extent that **payment has been made** under the State plan for medical assistance," [the State] may assert a lien or otherwise acquire a Medicaid recipient's rights "to payment by any other <third> party for **such <furnished>**

> **health care items or services**." § 1396a(a)(25)(H). That necessarily suggests that [the State] may only seek reimbursement from funds representing payments for medical expenses that it previously made on the beneficiary's behalf. . . . .
>
> Other provisions bolster that conclusion. For example, §§ 1396a(a)(25)(A)–(B) direct [the State] to seek reimbursement only to the extent of the third party's liability "**to pay** for care and services available under the plan . . . ." *See Ahlborn*, 547 U.S. at 280 ("'[S]uch legal liability' refers to 'the legal liability of third parties . . . **to pay for care and services available under the plan**.'" (quoting § 1396a(a)(25)(A)) (emphasis in original)). Similarly, § 1396k(b) suggests that [the State] may only be reimbursed "for medical assistance **payments made** on behalf of an individual with respect to whom such assignment was executed . . . ." The Medicaid statute's text is unambiguous and must therefore be followed; [the State] cannot reimburse itself for its **past** medical expenses from portions of the recipient's recovery allocated to compensate for **future** medical expenses.

(Doc. 30, at 14-15 (< > indicate original alterations).)

The State disagrees with the district court's consideration of multiple provisions. Instead, it prefers to focus on the assignment provision (Appellant's Br. 16-21), which requires a Medicaid recipient "to assign the State any rights . . . to **payment for medical care** from any third party. 42 U.S.C. § 1396k(a)(1)(A) (emphasis added). The district court below did not "ignore[]" the assignment provision as the State contends. (Appellant's Br. 19.) Rather, it confronted head-on

the State's argument focusing on the assignment provision and concluded it was "unconvincing" for three reasons. (Doc. 30, at 18.)

First, the Medicaid statutes had to be "considered as a whole." (*Id.* (citing *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 94, 114 S. Ct. 517 (1993)). Stated another way, judges must read words "in their context and with a view to their place in the overall statutory scheme" because a judge's "duty . . . is to construe statutes, not isolated provisions." *King v. Burwell*, __ U.S. __, 135 S. Ct. 2480, 2489 (2015) (internal quotations omitted). The State's arguments violate this canon of statutory construction. Reading § 1396k(a)(1)(A) in isolation, the State suggests that, when a recipient statutorily assigns her rights to "payment for medical care," the recipient is assigning her rights to payments for future medical care – for which the State has never paid. This isolated reading, however, cannot be reconciled with the overall statutory scheme. When § 1396k(a)(1)(A) is read in context, it is apparent that a recipient's assignment of her rights to "payment for medical care" is an assignment of her rights for past medical care paid by Medicaid. Specifically, it is for "payment . . . made under the State plan for medical assistance" and for "[furnished] health care items or services." § 1396a(a)(25)(H); *see also* §§ 1396a(a)(25)(A)–(B), 1396k(b).

Second, the district court reasoned that "specific statutes prevail over general ones." (Doc. 30, at 18 (citing *D. Ginsberg & Sons v. Popkin*, 285 U.S. 204, 208, 52

S. Ct. 322 (1932)). The anti-lien provision is specific. It prohibits the State from imposing a lien "on account of medical assistance paid **or to be paid**." § 1396p(a) (emphasis added). In other words, this provision specifically prohibits liens on payments for future medical expenses. The general assignment of rights to "payment for medical care" in § 1396k(a)(1)(A) cannot override this specific language in the anti-lien provision, § 1396p(a).

Third, the district court reasoned, the Court in *Ahlborn* "construe[d] the assignment provision in § 1396k(a) identically" to the third-party liability provisions in § 1396a(a)(25). (Doc. 30, at 18-19.) Specifically, the district court reasoned, "[*Ahlborn*] stated that § 1396a(a)(25)(H)—which limits recovery 'to the extent that payment has been made . . . for medical assistance for health care items or services furnished to' a recipient—'**echoes the requirement of mandatory assignment rights in § 1396k(a)**.'" (Doc. 30, at 19 (emphasis added) (quoting *Ahlborn*, 547 U.S. at 281).)

Finally, one other reason, not stated in the district court's order, supports the rejection of the State's argument based on the assignment provision, § 1396k(a). That reason is explained more fully *infra* in subpart D, at 41-42.

B. The grounds on which the State challenges the district court's reasoning are unavailing.

The State attempts to undermine the district court's reasoning, discussed above, on several different grounds. First, it labels the assignment provision as being

"central[]" to, the "focal point" of, or "controlling" of *Albhorn* and *Wos*. (Appellant's Br. 17, 19, 25.) These labels are false. Nothing in *Albhorn* and *Wos* suggests the Supreme Court put more weight on the assignment provision than the other federal Medicaid provisions.

In *Ahlborn*, the Court quoted extensively the same provisions on which the district court here relied: §§ 1396a(a)(25)(A)-(B), (H), 1396k(a)-(b). *See* 547 U.S. at 277-280. While the Court first analyzed – very briefly – the language of the assignment provision, (§ 1396k(a)(1)(A)), *id.* at 280, that initial consideration did not put it on a pedestal head and shoulders above the other provisions. To the contrary, the Court devoted five reporter pages to analyzing the other Medicaid provisions, including, most importantly, the anti-lien provision, § 1396p(a)(1). *Id.* at 280-85. And *Wos* likewise analyzed all the pertinent provisions, as a whole, with no particular emphasis on the assignment provision. *See* 568 U.S. at 633 (analyzing §§ 1396a(a)(25)(A)-(B), (H), 1396k(a)-(b), 1396p(a)(1)).

The State's second challenge to the district court's order is based on two regulations never cited to the district court. (Appellant's Br. 19 (citing 42 C.F.R. §§ 433.145(a)(1), 433.146(a)(1)); *see* Docs. 14, 16, 18, 44.) Because this argument was not made below, it should be deemed waived. *See, e.g., Gennusa v. Canova*, 748 F.3d 1103, 1116 (11th Cir. 2014). In any event, these regulations – issued by the U.S. Department of Health and Human Services (HHS) – merely parrot the

assignment provision's "payment for medical care" language. They do not override the anti-lien provision or multiple other statutory provisions previously discussed. Nor do they provide any clarity as to meaning of the federal Medicaid statutes, or suggest that HHS agrees with the State's reading of the statutes. In fact, in its amicus brief in *Wos*, HHS agreed that the state statute there was preempted because it "overestimate[d] the portion of the settlement that may appropriately be regarded as payment for **past** medical expenses." Brief of the United States as Amicus Curiae Supporting Respondents, at 10 (emphasis added), *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013) (No. 12-98), 2012 WL 6624226.

The State's third attempt to undo the district court's order fares no better. The State argues that the congressional "intent" and "purpose" behind subparagraph (H) of § 1396a(a)(25) was to limit that subparagraph's application to a "case in which a **health insurer or similar third party** is legally responsible to pay for services for which the State has already paid and the State submits a claim directly to the third party." (Appellant's Br. 19 (emphasis added); *see id.* 19-20.) In other words, the State suggests subparagraph (H) does not apply where, as here, reimbursement is sought indirectly from a tortfeasor or liability insurer, rather than from a health insurer. (Appellant's Br. 19-20.) The State gleans this "intent" and "purpose" from: (i) the next subparagraph, (I); (ii) a conference report; and (iii) the fact that subparagraph (H) was added to the Medicaid statutes sixteen years after the

assignment provision was enacted. None of these points were presented to the district court, and thus should be deemed waived. *See, e.g.*, *Gennusa*, 748 F.3d at 1116.

Regardless, these newly-raised points are flawed for several reasons. First, the district court's interpretation rested on multiple provisions, not just subparagraph (H), and the State's argument ignores the other provisions. Second, *Ahlborn* and *Wos* both relied in part on subparagraph (H) to determine a State's right to seek reimbursement indirectly from a tortfeasor or liability insurer. *E.g., Ahlborn*, 547 U.S. at 276; *Wos*, 568 U.S. at 633. Third, neither *Ahlborn* nor *Wos* placed any special significance on the fact that subparagraph (H) was enacted sixteen years after the assignment provision; indeed, this point is not mentioned in either opinion. Fourth, a court should not resort to legislative history where, as here, the statute's language is plain and unambiguous; s*ee, e.g.*, *CBS Inc. v. PrimeTime 24 Joint Venture*, 245 F.3d 1217, 1222 (11th Cir. 2001); indeed, *Ahlborn* rejected an argument relying on legislative history, 547 U.S. at 291-92. Fifth, the Hose conference report does not evidence any congressional intent to limit subparagraph (H) to health insurers and similar third parties. *See* H.R.. Conf. Rep. No. 103-213, at 835 (1993), *reprinted in* 1993 U.S.C.C.A.N. 1088, 1524.

The State's fourth line of attack is to criticize the district court's statements that the assignment provision is a "narrow" exception to the anti-lien provision.

(Appellant's Br. 21; Doc. 30, at 6, 7, 14; Doc. 59, at 3). While it is true that *Alhborn* and *Wos* never used the word "narrow," the result and reasoning of those cases demonstrate that a court should not liberally read exceptions into the anti-lien and anti-recovery provisions. Moreover, the anti-lien and anti-recovery provisions have several express exceptions. *See* 42 U.S.C. § 1396p(a)(1)(A)-(B), (b)(1)(A)-(C). The assignment provision is an implied exception. *Tristani ex rel. Karnes v. Richman*, 652 F.3d 360, 375 (3d Cir. 2011). In other contexts, the Court has held that "additional exceptions are not to be implied" if Congress has "explicitly enumerate[d] certain exceptions to a general prohibition." *U.S. v. Smith*, 499 U.S. 160, 166, 111 S.Ct. 1180 (1991). And when "a general statement of [congressional] policy is qualified by an exception, [the Court] usually [has] read the exception narrowly" to "preserve the primary operation of the provision."[4] *Comm'r if Internal Revenue v. Clark*, 489 U.S. 726, 739, 109 S. Ct. 1455, 1463 (1989).

As a final ground of criticism, the State asserts the district court "confused two concepts: the amount **for which** and the amount **from which** a State may seek reimbursement." (Appellant's Br. 22.) The district court was not confused. It held: "[The State] cannot reimburse itself **for** its *past* medical expenses **from** portions of

[4] The State implies this canon applies only in tax and insurance cases. (Appellant's Br. 22.) Though *Clark* was a tax case, it relied on a case under the Fair Labor Standards Act. 489 U.S. at 739 (citing *A.H. Phillips, Inc. v. Walling*, 324 U.S. 490, 493 65 S. Ct. 807, 808 (1945)).

the recipient's recovery allocated to compensate for *future* medical expenses." (Doc. 30, at 11 (bold emphasis added).) This holding was grounded in the "unambiguous" federal statutory text and in *Ahlborn*, where the Court noted it "would be absurd and fundamentally unjust" for the State to "share in damages for which it has provided no compensation." 547 U.S. at 288 n. 19 (emphasis added). Finally, this holding comported with the greater weight of the persuasive case law, as is explained next.

C. The majority view supports the district court's holding.

The State argues that "the district court aligned itself" with courts that purportedly "have performed little or no analysis of the governing statutory provisions, but have relied on conclusory statements made by other courts, often in dicta." (Appellant's Br. 22.) Yet, in its brief, the State does not address the primary case on which the district court relied or the vast majority of the cases that Plaintiff cited in her papers below. (*See* Doc. 12, at 28-30, Doc. 27). A significant number of these cases have rigorous analysis (not conclusory statements) and made holdings (not statements of dicta). And they show that the district court's reasoning is sound and aligned with the majority view.

The primary case on which the district court relied was *McKinney ex rel. Gage v. Philadelphia Housing Authority*, No. 07-4432, 2010 WL 3364400 (E.D. Pa. 2010). (Doc. 30, at 14-15.) There, a state agency argued that *Ahlborn* permitted it to assert a lien against a third-party's compensation for past and future medical

expenses. 2010 WL 3364400, at *6. The court rejected this argument. *Id.* at *9. It noted that, when *Ahlborn* spoke of "medical expenses," it was referring to "past medical expenses." *Id.* (quoting *Ahlborn*, 547 U.S. at 273). The court then reviewed § 1396a(a)(25)(H): "It is clear from a reading of this statutory language that the . . . word 'such' refers to the 'payment [that] has been made"—that is, the payments the state made on the beneficiary's behalf **in the past** for medical expenses." *Id.* Accordingly, the court held that the state agency "cannot draw on portions of the settlement designed to compensate for future medical expenses in order to reimburse itself for **past** medical expenditures." *Id.*

A Florida court thoroughly analyzed *Albhorn* and *Wos*, surveyed the case law in the aftermath of those decisions, and concluded, "[The] majority view [is] that the Medicaid lien does not attach to settlement funds allocable to future medical expenses." *Willoughby v. AHCA*, 212 So. 3d 516, 524 (Fla. Dist. Ct. App. 2017) (citing, among others, *In re E.B.*, 729 S.E.2d 270, 297-98, 299 n. 35, (W. Va. 2012); *Lima v. Vouis*, 94 Cal. Rptr. 3d 183, 194-95 (2009); *Bolanos v. Superior Court*, 87 Cal. Rptr. 3d 174, 180 (2008); *Price v. Wolford*, 2008 WL 4722977, at *2 (W.D. Okla. Oct. 23, 2008), *reversed in part on other grounds*, 608 F. 3d 698, 708 (10th Cir. 2010); *Lugo ex rel. Lugo*, 819 N.Y.S. 2d 892, 895-96 (N.Y. Sup. Ct. 2006)). The court correctly observed that "[m]any of these decisions painstakingly explain how *Alhborn* compel[led]" the conclusion that the State agency could not take the

portion of the tort recovery representing future medical expenses. *Id.*

An Arizona court has rigorously analyzed a closely related question: whether the state agency could seek reimbursement from the portion of the recipient's tort recovery representing past medical damages for which the state agency had not paid. *S.W. Fiduciary v. Health Care Cost Admin.*, 249 P.3d 1104, 1109 (Ariz. Ct. App. 2011). The court said no:

> [W]e take from [*Ahlborn*'s] emphasis on the anti-lien provision the general rule that a state plan may recover from a victim's tort settlement no more than the portion of the settlement attributable to payments the plan has made on behalf of the victim…Given the Court's refusal to permit the state plan in that case to recover from the other components of the settlement, we conclude federal law does not allow a state Medicaid plan to enforce its lien against any portion of a tort settlement not attributable to the plan's actual payments.

Id. at 1108-09. The court's reasoning would likewise preclude a state agency from seeking reimbursement from damages for future medical expenses.

The district court here acknowledged the minority view. (Doc. 30, at 17 (citing *Special Needs Trust for K.C.S. v. Folkemer*, 2011 WL 1231319, at *9, 12 (D. Md. March 28, 2011); *IP ex rel. Cardenas v. Henneberry*, 795 F. Supp. 2d 1189, 1196-97 (D. Colo. 2011); *In re Matey*, 213 P.3d 389, 993-94 (Idaho 2009)); *see also Giraldo v. AHCA*, 208 So. 2d 244, 249-52 (Fla. Dist. Ct. App. 2016), *rev. granted*, No. SC17-297 (Fla. Sept. 6, 2017). The district court, however, concluded the minority cases were not persuasive because they "do not address the language referencing past medical expenses highlighted in *Ahlborn*, *Wos*, or §§

1396a(a)(25)(A)–(B), 1396a(a)(25)(H), and 1396k." (Doc. 30, at 17-18.) The district court was correct.

The Idaho Supreme Court's case exemplifies the lack of analytical rigor in the minority view. *Matey*, 213 P.3d at 993-94. There, the court failed to quote the multiple statutory provisions (as the district court here did), and it failed to interpret or apply the plain statutory text. 213 P.3d at 993-94. The same can be said of other courts adopting the minority view. *See Special Needs*, 2011 WL 1231319, at *12; *Cardenas*, 795 F. Supp. 2d at 1197; *Giraldo*, 208 So. 2d at 249-52.

D. The district court reached the right result because the assignment provision on which the State relies does not apply in this case.

This Court may affirm for any reason supported by the record, even if the district court did not rely on that reason. *E.g., United States v. Chitwood*, 676 F.3d 971, 975 (11th Cir. 2012). The State's appellate argument centers on the assignment provision, § 1396k(a). (Appellant's Br. 16-21, 25.) That provision, however, does not apply in this case.

Section 1396k(a) governs assignments only; it does not apply where, as here, the State seeks to recover on its lien against funds obtained by the Medicaid recipient from the third party. *Doe v. Vermont Office of Health Access*, 54 A.3d 474, 482 (Vt. 2012). In other words, the assignment provision applies only when the State sues tortfeasors or other responsible third parties in the name of the injured Medicaid recipient; it does not apply where, as here, the State enforces its lien rights against a

settlement that the injured recipient negotiated herself. *S.W. Fiduciary v. Health Care Cost Admin.*, 249 P.3d 1104, 1109-10 (Ariz. Ct. App. 2011). As Judge Pollak stated in dissent when agreeing with the lower court's holding:

> The District Court held that the reimbursement and assignment/cooperation provisions, taken together, indicate that Congress did not intend to permit state Medicaid agencies to free-ride on the efforts of plaintiffs by asserting liens after a judgment or settlement has been obtained. Rather, Congress wanted states to either initiate suit against or intervene in actions against liable third parties, and wanted Medicaid recipients to cooperate in those efforts by providing state agencies with any information they might require.

Tristani ex rel. Karnes v. Richman, 652 F.3d 360, 382 (3d Cir. 2011) (Pollak, J. dissenting). Accordingly, because the State failed to directly sue the tortfeasors or other responsible third parties for the past medical expenses paid by Medicaid, it may not take any portion of Plaintiff's tort recovery. *See id.* at 379-85 (Pollak, J. dissenting); (*see also* Doc. 30, at 30 (noting that the State agency in this case and many other cases fails to sue the tortfeasor directly and instead shifts the costs of seeking reimbursement to the Medicaid recipient).

****

In summary, this Court should affirm the district court's conclusion that the federal Medicaid statutes prohibit the State from seeking reimbursement of past Medicaid payments from the portion of a recipient's tort recovery that compensate the recipient for future medical expenses.

II. The declaratory judgment – that Florida may not require a Medicaid recipient to disprove its arbitrary formula-based allocation with clear and convincing evidence – may be affirmed on preservation grounds, preemption grounds, or an alternative ground on which the district court did not rely.

The district court declared that "the federal Medicaid Act prohibits [Florida] from requiring a Medicaid recipient to affirmatively disprove [section] 409.910 (17)(b)'s formula-based allocation with clear and convincing evidence to successfully challenge it where, as here, that allocation is arbitrary and there is no evidence that it is likely to yield reasonable results in the mine run of cases." (Doc. 30, at 34; Doc. 59, at 29; Doc. 60.) This declaration may be affirmed on: preservation grounds, *infra* subpart A, at 43-46; preemption grounds *infra* subpart B, at 46-51, or an alternative ground on which the district court did not rely, *infra* subpart C, at 51.

A. The State failed to preserve any argument on how the administrative law judges, in practice, apply the Florida Medicaid statute.

The State's primary argument, on its second appellate issue, is that the district court "erred" because it purportedly "refused to consider any empirical evidence" on how the administrative law judges at DOAH practically applied the Florida Medicaid statute. (Appellant's Br. 25-29 (citing Doc. 30, at 31 n.5).) The evidence that the State says should have been considered were twenty-one cases decided by various administrative law judges. (Appellant's Br. 26-28.) The State presented this evidence and argument in its post-judgment motion. (Doc. 44, at 5-6.) But that was

too late. *See, e.g., Michael Linet, Inc. v. Village of Wellington, Fla.*, 408 F.3d 757, 763 (11th Cir. 2005); (*See* Doc. 51, at 1-2 (collecting cases); Doc. 59, at 7 (same)).

The State's post-judgment argument (like its appellate argument here) directly conflicted with a pre-judgment concession the State had made to the district court. At the summary judgment hearing, the State conceded it was not relying on how the administrative law judges practically applied the Florida Medicaid statute. (Doc. 70, at 12-15.) Specifically, when asked by the district court whether the State was relying on "practice" and "how individual [administrative law judges] may or may not apply" section 409.910 (*id.*), the State's counsel said no:

> No, the agency is not relying on the practice that it takes to defend what it's doing. . . So, no, we are not relying upon our practice. … [T]he administrative law judges do different things so I don't believe that the practice of the ALJs is even something that the agency could defend.

(Doc. 70, at 15:11-22.)

Thus, insofar as the district court decided to not consider the evidence of how the individual ALJs practically applied the Florida statute (Doc. 31 n.5), that decision was made at the invitation of the State's counsel (Doc. 70, at 15:11-22). The State, therefore, cannot now complain on appeal about this alleged refusal. *See, e.g., F.T.C. v. AbbVie Products LLC*, 713 F.3d 54, 65 (11th Cir. 2013) (discussing the invited-error doctrine and holding that "a party may not challenge as error a ruling invited by that party" (internal ellipsis omitted)).

The State's "practice" argument was waived for another reason. This Court routinely accepts as binding the concessions of counsel made at oral argument, including concessions from government counsel. *See, e.g.*, *Johnson v. Florida*, 348 F.3d 1334, 1346 (11th Cir. 2003) (Florida's counsel); *Socialist Workers Party v. Leahy*, 145 F.3d 1240, 1246 (11th Cir. 1998) (counsel for Florida's Secretary of State). The same practice applies in the district court. When a party's counsel concedes a point in the district court, the party is bound by that concession, both in the district court and on appeal. *E.g., Korman v. HBC Florida, Inc.*, 182 F.3d 1291, 1294 n. 3 (11th Cir. 1999); *see also Saucier v. Plummer*, 611 F.3d 286, 288 (5th Cir. 2010) ("An attorney's remarks, made in closing, constitute binding admissions against the party he represents" (internal quotations and alterations omitted)). And this Court does not approve of a party presenting an argument on appeal that is inconsistent with the position the party took in the district court. *See Associated Indem. Corp. v. Scott*, 103 F.2d 203, 209 (5th Cir. 1939); *Veolia Water N. Am. Operating Services, LLC v. City of Atlanta*, Case No. 11-14524, 546 Fed. Appx. 820, 824 (11th Cir. 2013) (unpublished). Accordingly, this Court should reject the State's second appellate argument because it cannot be reconciled with the concession its counsel made to the district court.

Finally, the State's written argument in its summary judgment response (Doc. 16, at 10-11) – made before the hearing – does not save the State from waiver and

abandonment of its second appellate argument. That cursory written argument – without any ascertainable citations and with only half of the ALJ decisions cited on appeal – was less than clear. (*Id*.) Thus, the district court held a hearing, asked counsel to clarify the State's position, and the State's counsel clarified that the State was not relying on how the ALJs practically applied the statute. (Doc. 70, at 15:11-22.) The district court was entitled to rely on that concession. *See Korman*, 182 F.3d at 1294 n.3. After counsel's concession at the hearing, what the State had previously stated in its pre-hearing paper became inconsequential.

B. The State's formula-based allocation, coupled with the clear-and-convincing burden of proof, is preempted because the State has never presented any evidence that its formula is likely to yield reasonable results in the mine run of cases.

The method by which Florida allocates tort recoveries has two benchmarks: (i) the formula and (ii) the clear-and-convincing burden of proof. In its brief, the State directs all its firepower at the second benchmark, while it ignores the first. (Appellant's Br. 29-31.) The State misses the mark.

The State contends that, under *Wos*, it may allocate a tort recovery either by: (1) "*ex ante* criteria," provided that "evidence establishes . . . [the] criteria yield reasonable results in most cases," or (ii) "a judicial or administrative process to make the allocation in individual cases." (Appellant's Br. 4 (citing *Wos*, 568 U.S. at 638, 641-43).) Fair enough. But whatever method a State chooses, it cannot overlook the primary lesson of *Wos* and *Ahlborn*. That is, under "the Medicaid Act's clear

mandate," the "State may not demand any portion of a [recipient's] tort recovery except the share that is attributable to medical expenses." *Wos*, 568 U.S. at 639. Stated another way, in devising a method to allocate tort recoveries, a State must aim to protect a recipient's property right to retain all damages paid by the third party except those damages attributable to past medical expenses paid by Medicaid.

In this case, the State has chosen a hybrid method to allocate tort recoveries that includes both *ex ante* criteria (the formula) and an administrative process (DOAH hearings where recipients must overcome the formula with clear and convincing evidence). There is nothing inherently flawed with a hybrid method. That said, the State's particular hybrid method is fatally flawed because no evidence establishes that the State's *ex ante* criteria (the formula) yield reasonable results in most cases (or any cases). This flaw is not addressed anywhere in the State's appellate brief.

But the fatal flaw undeniably exists. When the State was asked to produce records showing the formula accurately allocated tort recoveries in most cases, the State admitted it had no such records. (*See* Docs. 51-1, 51-2.) Nor does any such evidence or records exist in the Florida legislative record. (Docs. 10-4, 10-5; Addendum). Moreover, the belatedly submitted evidence of how the ALJs decide cases in practice is of no help; that evidence does not show whether the formula (the *ex ante* criteria) yields reasonable results in most cases. At most, the ALJ evidence

shows anecdotally[5] – without any statistical or scientific basis[6] – how often recipients disprove the formula.

The State appears to read *Wos* as allowing for arbitrary *ex ante* criteria – unsupported by any evidence – if the State permits a later challenge to that criteria by way of judicial or administrative proceedings. (*See* Appellant's Br. 32-33.) But that is not what *Wos* says. After striking down North Carolina's irrebuttable presumption, the Supreme Court provided guidance on what methods of allocating tort recoveries could pass muster under federal Medicaid law. 568 U.S. at 541-43. The Court suggested one permissible method would be a judicial allocation procedure, similar to what North Carolina used in worker's compensation cases, that would allow a judge to weigh various factors in determining a just and reasonable allocation. *Id.* at 642. As another potentially permissible method, the Court pointed

[5] Plaintiff can present her own anecdotal counter-evidence: cases where the ALJ determined the Medicaid recipient failed to meet the clear-and-convincing burden of proof, although the State presented no evidence. *See, e.g. Savasuk v. AHCA*, No. 13-4130MTR, 2014 WL 350831 (Fla. DOAH Jan. 29, 2014); *Silnicki v. AHCA*, No. 13-3852MTR, 2014 WL 3563663 (Fla. DOAH Jul. 15, 2014); *Puente v. AHCA*, No. 14-2041MTR, 2014 WL 4384015 (Fla. DOAH Aug. 29, 2014); *Agras v. AHCA*, No. 14-2403MTR, 2014 WL 5605444 (Fla. DOAH Oct. 30, 2014); *Jones v. AHCA*, No. 14-3250MTR, 2015 WL 762790 (Fla. DOAH Feb. 19, 2015); *Villa v. AHCA*, No. 15-4423MTR, 2015 WL 9590775 (Fla. DOAH Dec. 30, 2015), *affirmed*, *Giraldo v. AHCA*, 208 So.3d 244, 248 (Fla. Dist. Ct. App. 2016, *rev. granted*, No. SC17-297 (Fla. Sept. 6, 2017).

[6] The State's belated evidence does not show whether the twenty-one cases represent a small or sizeable percentage of the total Medicaid liens enforced by the State.

to judicial and administrative procedures in other states with "rebuttable presumptions and adjusted burdens of proofs," and in some states, these presumptions could be overcome only by clear and convincing evidence. *Id*. at 641 (citing, for example, Okla. Stat., Tit. 63, § 5051.1(D)(1)(d) (West 2011)).

But *Wos* never held, or even suggested, that the *ex ante* criteria used for these presumptions and adjusted burdens of proof could be arbitrary and just pulled out of thin air, as Florida has done here. To the contrary, *Wos* said the exact opposite. It instructed that the *ex ante* criteria must be "backed by evidence suggesting they are likely to yield reasonable results in the mine run of cases." *Id*. at 643. This requirement comports with the rationale for most presumptions that exist in the law.[7] Florida's *ex ante* formula indisputably is not backed by any evidence that it likely will yield reasonable results in a mine run of cases.

Rather than analyze the *ex ante* criteria (i.e., the formula), the State analyzes, in isolation, the clear-and-convincing burden and argues it is not "tremendously burdensome." (Appellant's Br. 30.) The State can use whatever adjective or adverb it wants to describe the burden of proof. Its analysis, however, is misdirected. Again, *Wos* and *Ahlborn* teach that States must devise methods for allocating tort recoveries

[7] Most presumptions exist "primarily because the judges have believed that proof of fact B renders the inference of the existence of fact A so probable that it is sensible and timesaving to assume the truth of fact A until the adversary disproves it." 2 *McCormick on Evid*. § 343 & n. 7 (7th ed. June 2016).

that safeguard against a State taking damages paid by a third party, except for those damages attributable to past medical expenses paid by Medicaid. Does Florida's chosen method accomplish this purpose? No, because the starting point of the State's method is an arbitrary allocation, unsupported by any evidence, that is not likely to accurately determine a proper allocation for the mine run of cases. As the district court correctly recognized, "[t]he arbitrary nature of Florida's . . . statute **alone** is likely enough to rule that it is preempted." (Doc. 30, at 29 (emphasis added).) The fact that this arbitrary formula can be overcome only under a heightened burden of proof (clear and convincing evidence) only makes the arbitrary formula worse because the heightened burden increases the likelihood that a Medicaid recipient will lose a portion of her tort recovery that rightfully belongs to her.

Finally, the State's criticism of the district court's discussion of certain examples is unwarranted. (Doc. 30, at 26-29; Appellant's Br. 30-32.) The district court discussed these examples to illustrate the arbitrary nature of the formula and to show how divorced it was from reality. (Doc. 30, at 26-29.) The court did what many judges do. The court considered hypotheticals and applied the statute to those hypotheticals. Such judicial reasoning is proper and does not warrant a reversal.

C. The district court reached the right result because the assignment provision on which the State relies does not apply in this case.

Plaintiffs adopts by reference the same argument presented *supra* in Argument I.D, at 41-42. Because the State failed to directly sue the tortfeasors or

other responsible third parties for the past medical expenses paid by Medicaid, it may not take any portion of Plaintiff's tort recovery, even if Florida's formula-based allocation in section 409.910 is not preempted. *See Tristani ex rel. Karnes v. Richman*, 652 F.3d 360, 379-85 (3d Cir. 2011) (Pollak, J. dissenting).

****

In summary, this Court should affirm the district court's conclusion that the federal Medicaid Act prohibits Florida from requiring a Medicaid recipient to affirmatively disprove section 409.910 (17)(b)'s formula-based allocation with clear and convincing evidence where, as here, that allocation is arbitrary and there is no evidence that it is likely to yield reasonable results in the mine run of cases.

CONCLUSION

This Court should affirm the second amended judgment (Doc. 60) and the orders supporting that judgment (Docs. 30, 59).

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief complies with the type-volume limitation of Rule 32(a)(7), Federal Rules of Appellate Procedure, in that it contains 12,764 words (including words in footnotes), excluding the parts of the document exempted by FRAP 32(f), according to the word-processing system used to prepare this brief. This document complies with the typeface requirements of FRAP 32(a)(5) and the type-style requirements of FRAP 32(a)(6).

/s/*Bryan S. Gowdy*
Attorney

CERTIFICATE OF SERVICE

I HEREBY CERTIFY service by U.S. Mail and CM/ECF a true and correct copy of the foregoing along with 7 copies upon the following clerk of court, this 12th day of February, 2018:

David J. Smith
Clerk of Court
U.S. Court of Appeals for the 11th Circuit
56 Forsyth St., N.W.
Atlanta, Georgia 30303

I HERBY CERTIFY that a true and correct copy of the foregoing was filed with the Clerk of Court using the CM/ECF system which will serve a Notice of Docket Activity on this 12th day of February, 2018 to the following:

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ADDENDUM

Florida House of Representatives,
Regular Session 2013,
CS/CS/ HB 939, Committee Substitute 1
(filed April 3, 2013)

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 939 (2013)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ____ (Y/N)

ADOPTED AS AMENDED ____ (Y/N)

ADOPTED W/O OBJECTION ____ (Y/N)

FAILED TO ADOPT ____ (Y/N)

WITHDRAWN ____ (Y/N)

OTHER

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

Amendment (with title amendment)

Between lines 255 and 256, insert:

Section 2. Subsection (17) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(17)(a) A recipient or his or her legal representative or any person representing, or acting as agent for, a recipient or the recipient's legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph (6)(c), or who has actual knowledge of the agency's rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the agency, within 60 days after receipt of settlement proceeds, the full

amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in an interest-bearing ~~a~~ trust account for the benefit of the agency pending an ~~judicial or~~ administrative determination of the agency's right thereto under this subsection. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the agency the full amount required by this section or to hold the full amount of third-party benefits or proceeds in the interest-bearing trust account pending ~~judicial or~~ administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 414.39(4)(b), and acted with the intent set forth in s. 812.014(1).

(b) A recipient may contest the amount designated as recovered medical expense damages payable to the agency pursuant to paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petitions shall be filed with the Division of

Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or placing the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. This procedure constitutes the exclusive method by which the amount of third-party benefits payable to the agency may be challenged. In order to successfully challenge the amount payable to the agency, the recipient must prove, by clear and convincing evidence, that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses than that amount calculated by the agency pursuant to paragraph (11)(f) or that Medicaid provided a lesser amount of medical assistance than that determined by the agency. The Division of Administrative Hearings has final order authority for proceedings under this section.

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

(d) Venue for all administrative proceedings pursuant to paragraph (a) shall be in Leon County, at the discretion of the agency. Venue for all appellate proceedings arising from the administrative proceeding pursuant to paragraph (a) shall be at the First District Court of Appeal, at the discretion of the agency.

(e) Each party shall bear its own attorney fees and costs for any proceeding conducted pursuant to paragraph (a) or paragraph (b).

(f)~~(a)~~ In cases of suspected criminal violations or fraudulent activity, the agency may take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

(g)~~(b)~~ The agency may ~~is authorized to~~ investigate and may ~~to~~ request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 414.39 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Attorney General~~,~~ or to any state attorney. Pursuant to s. 409.913, the Attorney General has primary responsibility to investigate and control Medicaid fraud.

(h)~~(c)~~ In carrying out duties and responsibilities related to Medicaid fraud control, the agency may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(i)~~(d)~~ All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft is confidential and exempt from s. 119.07(1):

1. Until such time as the agency takes final agency action;

2. Until such time as the Department of Legal Affairs refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

T I T L E A M E N D M E N T

Remove line 12 and insert:

screening; amending s. 409.910, F.S.; revising provisions relating to settlements of Medicaid claims against third parties; providing procedures for a Medicaid recipient to contest the amount of recovered medical expense damages; amending s. 409.913, F.S.; increasing the

Florida House of Representatives,

Final Bill Analysis,

CS/CS/ HB 939

(filed June 10, 2013)

HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 939	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health Innovation Subcommittee; Pigman	116 **Y's**	0 **N's**
COMPANION BILLS:	(CS/CS/SB 844)	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/CS/HB 939 passed the House on April 24, 2013, and subsequently passed the Senate on April 30, 2013. The bill makes statutory changes to enhance Florida's efforts to prevent fraud and abuse in the Medicaid program. The bill modifies existing statutory provisions relating to provider controls and accountability in the Medicaid program. These modifications include the following:

- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) in writing no later than 30 days after the change occurs;
- Authorizing, rather than requiring, AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement before entering into a provider agreement with that provider, to determine that provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Removing certain exceptions to background screenings requirements for Medicaid providers;
- Requiring AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes their Medicaid provider number under certain circumstances; and
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts and providing a definition of fraudulent acts.

The bill amends s. 409.907(9)(a), F.S., to authorize AHCA to enroll an out-of-state health care provider in the Medicaid Program if the provider is an actively licensed Florida physician who interprets diagnostic testing results through telecommunications and information technology from a distance.

Section 409.910, F.S., provides AHCA with the right and obligation to recover Medicaid medical costs from third parties. The U.S. Supreme Court recently rendered an opinion which casts doubts on the validity of this section. The bill amends this section to comply with the Court's holding and creates a right to an administrative hearing at the Division of Administrative Hearings for Medicaid recipients to contest the amount of AHCA's recoupment of Medicaid medical costs.

The bill amends s. 624.351, F.S., and authorizes designees of the members Medicaid and Public Assistance Fraud Strike Force to serve in the same capacity as the designating member. Additionally it provides that the Strike Force will sunset on June 14, 2014. The bill amends s. 624.352, F.S., to provide that interagency agreements to detect and deter Medicaid and public assistance fraud will no longer be required after June 14, 2014.

The bill appears to have an indeterminate, negative fiscal impact on state government.

The bill was approved by the Governor on June 7, 2013, ch. 2013-150, L.O.F., and will become effective on July 1, 2013.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

Health Care Fraud

In 2009, the Legislature passed SB 1986 to address systematic health care fraud in Florida. Over three have now passed since these anti-fraud provisions were enacted and certain changes have been identified which would enhance Florida's efforts to prevent health care fraud and abuse in Florida's Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and defines the consequences for failure to comply with these requirements.

Medicaid

Medicaid is a medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with costs of nursing facility care and other medical expenses. The Agency for Health Care Administration's (AHCA) Division of Medicaid administers the Florida Medicaid Program. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid reimburses health care providers that have a provider agreement with AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are enrolled in Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include, among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, authority for AHCA site visits of provider service locations and surety bond requirements. The statute does not provide for background screening for non-enrolled providers who participate in the Medicaid program as components of a Medicaid managed care network.

Medicaid Program Integrity

Under s. 409.913, F.S., AHCA, through its Office of Medicaid Program Integrity, is responsible for overseeing the integrity of the Medicaid program, to prevent and minimize fraudulent and abusive billing, and to recover overpayments and impose sanctions as appropriate. The Office of Medicaid Program Integrity reviews anti-fraud plans for all participating Medicaid plans. Additionally, under s. 626.9891, F.S., all insurance companies and managed care companies also submit their required anti-fraud plans to the Department of Financial Services, Division of Insurance Fraud for review.

Sections 409,920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. A person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.[1]

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screenings include, but are not limited to, employment history checks and statewide criminal correspondence checks through the

[1] See s. 409.920(8), F.S.

Department of Law Enforcement and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screenings include, but are not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 408.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

Medicaid and Public Assistance Strike Force

In 2010 the Legislature found that there was a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud.[2] The Medicaid and Public Assistance Fraud Strike Force was created within the Department of Financial Services to oversee and coordinate state and local efforts to eliminate Medicaid and public assistance fraud and to recover state and federal funds to address this need. The strike force consists of eleven members who may not designate anyone to serve in their place.[3] The eleven members are as follows:

- The Chief Financial Officer, who shall serve as chair;
- The Attorney General, who shall serve as vice chair;
- The executive director of the Department of Law Enforcement;
- The Secretary of Health Care Administration;
- The Secretary of Children and Family Services;
- The State Surgeon General; and
- Five members appointed by the Chief Financial Officer, consisting of two sheriffs, two chiefs of police, and one state attorney.[4]

Interagency agreements for the coordination of prevention, investigation, and prosecution of Medicaid and public assistance fraud were executed by various agencies to effectuate the purpose of the strike force.[5]

Medicaid and Third-Party Recovery in Florida

Section 409.910, F.S. is the Medicaid Third-Party Liability Act (Act). Pursuant to the Act, third-party benefits for medical services are primary to any medical assistance provided to a recipient by Medicaid. As such, a Medicaid recipient who receives a settlement, award or judgment in a third-party tort action is required to reimburse the AHCA for any related Medicaid medical costs.[6] The medical costs are calculated as the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid.[7] The recipient cannot contest the amount designated by AHCA as recovered medical

[2] S. 624.351, F.S.
[3] Id.
[4] Id.
[5] S. 624.352, F.S.
[6] S. 409.910, F.S. As an alternative to this payment, a recipient can place the full amount of the third-party benefits in a trust account for the benefit of ACHA pending judicial or administrative determination of ACHA's right to the third-party benefits.
[7] Id.

expense damages. Thus, this section creates an irrebuttable presumption that the amount that AHCA is entitled to from a Medicaid recipient's judgment, award or settlement in a tort action is the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid. A North Carolina statute which created a similar irrebutable presumption was recently struck down by the Supreme Court in *Wos v. E.M.A.*

The U.S Supreme Court, in *Wos v. E.M.A.,* recently invalidated a North Carolina statute which authorized the recovery of third-party benefits from Medicaid recipients.[9] North Carolina's Medicaid third-party liability statute provides that the state will be paid from a tort settlement or judgment the lesser of the total amount expended on the recipient's behalf by Medicaid or 33% of the total settlement or judgment amount.[10] The Supreme Court held that North Carolina's statute was preempted by the federal anti-lien provision due to the fact that the state statute created an irrebuttable, one-size-fits-all statutory presumption that one-third of a tort recovery is attributable to medical expenses.[11] Such an irrebuttable presumption was found to be 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.[12]

Effect of Proposed Changes

The bill makes various changes to Medicaid provider contracting requirements and program integrity functions to improve fraud and abusive billing prevention and recoupment.

Medicaid Program Integrity

The bill requires a Medicaid provider to report, in writing, any change of any principal of the provider to AHCA within 30 days after the change occurs. "Principal" includes any officer, director, agent, managing employee, affiliated person or any partner or shareholder who has a 5% or greater interest in the provider.

The bill defines "administrative fines" and "outstanding overpayment". This functions to clarify the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to AHCA.

Section 409.907(7), F.S., requires AHCA to conduct random onsite inspections of Medicaid providers' service locations within 60 days after receipt of a fully complete new provider's application and prior to making the first payment to the provider for Medicaid services. The bill removes the 60 day time period, as well as the requirement for random inspections. This provides AHCA with greater flexibility in performing its onsite inspections prior to entering into a provider agreement. The bill also removes the exception to random onsite-inspections granted to certain providers as the inspections are conducted at the discretion of AHCA.

Section 409.913(13), F.S., requires AHCA to immediately terminate participation of a Medicaid provider that has been convicted of certain identified offenses. However, in order to immediately terminate a provider, AHCA must show an immediate harm to the public health, which is not always possible. The

[8] Id.
[9] *Wos v. E.M.A. ex rel. Johnson*, ___ U.S. ____, 2013 WL 1131709 (U.S. March 20, 2013).
[10] N. C. Gen. Stat. Ann. §108A–57(a).
[11] *Supra* fn 9.
[12] The federal Medicaid Act requires states to have in effect laws pursuant to which states have the right to recover third party benefits for medical assistance provided by the state Medicaid program. *See* 42 U.S.C. § 1396a(a)(25)(H). Federal law also mandates that state Medicaid programs must require recipients to assign to the state any rights the recipient has to benefits from third parties related to medical care. *See* 42 U.S.C. § 1396k(a)(1)(A). Notwithstanding the foregoing provisions, the Medicaid Act's "anti-lien provision" prohibits states from imposing a lien on the property of a recipient prior to his death on account of medical assistance provided by the state's Medicaid program. *See* 42 U.S.C. § 1396p(a)(1).

bill removes "immediately" from the requirement the provision. AHCA still must terminate a Medicaid provider from participation in the Medicaid program but the termination is no longer in conflict with the Administrative Procedures Act.[13] The bill additionally amends this section to clarify the instances of provider disqualification from participation on the Medicaid program.

Section 409.913, F.S., delineates the noncriminal actions of Medicaid providers for which AHCA may impose sanctions. The section provides penalties for the individual or provider who participated or acquiesced in the proscribed activity. The bill adds individuals or providers who "authorized" to those who may be sanctioned under this section. The bill also adds that AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13).

Currently, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate its contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. The bill amends s. 409.913(16), F.S., to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, AHCA must impose the sanction of termination for cause against the provider. However, AHCA's termination with cause is subject to hearing rights as may be provided under chapter 120. The bill also amends this section to give the Secretary of AHCA discretionary authority to make a determination to refrain from imposing a sanction if it is not in the best interest of the Medicaid program.

The bill amends s. 409.913(21), F.S., to specify that when AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. AHCA may also consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

The bill amends s. 409.913(22), F.S., to state that a provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to AHCA or its agent upon request. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or otherwise must be excluded from consideration. This limitation does not preclude consideration by AHCA of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode.

Section 409.913(25), F.S., requires AHCA to reimburse providers within 14 days for all Medicaid payments that have been withheld from a provider based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Any withheld funds accrue interest rate of 10 percent per year. The bill removes the requirement that these funds be held in a suspended account and clarifies that interest does not begin accruing until after the 14th day. Also, payment arrangements for overpayments and fines owed to AHCA must be made within 30 days after the date of the final order, which is not subject to further appeal.

Section 409.913(28), F.S., provides that venue for all Medicaid program integrity overpayments cases shall lie in Leon County. This creates questions as to whether venue for all administrative fines cases also lie in Leon County. The bill amends s. 409.913(28), F.S., to make Leon County the proper venue for all Medicaid program integrity cases.

[13] See s. 120.569(2)(n), F.S. which requires that "if any agency head finds that an immediate danger to the public health , safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoinable from the date ordered."

Section 409.913(30), F.S., requires AHCA to terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment within 35 days after the date of the final order. The bill expands this requirement to include payment of an agency fine and reduces the time period for reimbursement and/or payment to 30 days after the date of the final order.

The bill amends s. 409.913(31), F.S., to include fines, as well as overpayments, to the outstanding balance due upon the issuance of a final order at the conclusion of a requested administrative hearing.

The bill amends s. 409.920, F.S., to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud or public insurance fraud; including any fraud-related matters that a provider or health plan is required to report to AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to AHCA in any manner, including forums, and incorporates all discussions subsequent to the report and subsequent inquiries from AHCA.

Background Screening

Currently, only enrolled Medicaid providers are contractually required to submit a complete set of fingerprints to AHCA for criminal history screening. The bill amends the statute to require persons who meet the definition of controlling interest for certain hospitals and nursing homes to submit a full set of fingerprints to AHCA.

The bill removes the provision that proof of compliance with Level 2 background screening under ch. 435, F.S., conducted within 12 months before the date the Medicaid provider application is submitted to the AHCA satisfies the requirements for a criminal history background check. This conforms to screening provisions in ch. 435, F.S., and ch. 408, F.S.

The bill amends s. 409.907(9)(a), F.S., to authorize the AHCA to enroll an out-of-state health care provider in the Medicaid Program if the provider is an actively licensed Florida physician who interprets diagnostic testing results through telecommunications and information technology from a distance.

Medicaid and Public Assistance Strike Force

The bill amends s. 624.351, F.S., to allow designees to serve in the same capacity as the designating member of the Medicaid and Public Assistance Fraud Strike Force. It additionally provides that this section will be repealed on June 14, 2014, unless reviewed and reenacted by the Legislature before that date.

The bill amends s. 624.352, F.S., and provides that express authority for interagency agreements to detect and deter Medicaid and public assistance fraud will be repealed on June 14, 2014, unless reviewed and reenacted by the Legislature before that date.

Medicaid and Third-Party Recovery in Florida

Section 409.910, F.S. creates an irrebuttable presumption that the amount that AHCA is entitled to from a Medicaid recipient's judgment, award or settlement in a tort action is the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid. This provision is similar to the North Carolina provision recently struck down by the Supreme Court in *Wos v. E.M.A.* To ensure compliance with federal law, the bill amends this section to create a presumption of accuracy as to the AHCA's determination of the reimbursement amount but allows this determination to be rebutted by clear and convincing evidence. The bill establishes the mechanism for these challenges by providing Medicaid recipients with the right to an administrative hearing at the Department of Administrative

Hearings (DOAH) to contest the amount of AHCA's recoupment. The bill establishes Leon County as venue for these hearings and the First District Court of Appeal as venue for any related appeals. The bill also provides that each party is to bear its own attorney fees and costs.

The bill provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Indeterminate.

The bill appears to have an indeterminate, negative fiscal impact due to the amendment of s. 409.910, F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to meet the same requirements as other Medicaid providers. Health care providers who do not participate in the Medicaid program on a fee-for-service basis but become a member of a Medicaid managed care provider network will be required to undergo background screening.

The total fee for a Level 2 background screening is $64.50 ($24.00 for the state portion, $16.50 for the national portion, and $24.00 for retention). There is an additional fee of $11-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[14]

D. FISCAL COMMENTS:

Section 409.910, F.S., creates an irrebuttable presumption for the amount of Medicaid Medical costs that the AHCA may recover from third parties. This amount is calculated by statutory formula: the lesser of 37.5% of the total recovery of third party benefits or the total amount of medical assistance paid by Medicaid.[15] The holding in *Wos v. E.M.A* casts doubt on the validity of the irrebuttable presumption and requires Medicaid programs to give recipients an opportunity to contest the amount of recovery. Without specific statutory direction, that hearing process would take place adjunct to the recipients' original negligence lawsuits in circuit courts statewide. To ensure compliance with the court decision

[14] Agency for Health Care Administration, *House Bill 944 Analysis & Economic Impact Statement* (March 14, 2013).
[15] Section 409.910(11)(f), F.S

the bill amends s. 409.910, F.S., to give Medicaid recipients the right to an administrative hearing at DOAH to contest the amount of AHCA's recoupment, effectively making the statutory presumption rebuttable. The bill also establishes a standard of proof: the recipient must rebut the presumption with clear and convincing evidence.

From March 2012 to February 2013, AHCA's Third Party Liability (TPL) vendor closed 302 cases based upon calculations derived from the statutory formula.[16] AHCA recovered $4.9 million from these cases, approximately $2 million of which is utilized by the Legislature to fund Medicaid administrative activities.[17] However, AHCA's ability to recover Medicaid medical costs from third parties will likely be reduced as a result the recovery amount hearings caused by the decision in *Wos v. E.M.S.* The amount of this reduction is unknown. However, the amount of any reduction will likely be mitigated by the bill's standard of proof for overcoming the presumption.

In addition to the fiscal impact of reduced collections, AHCA will incur a negative fiscal impact for providing recipients hearings on the recovery amount. The TPL vendor staffed 62 hearings in circuit court contesting the AHCA's entitlement to Medicaid recovery during the last 12 months with a cost of approximately $5,000 per hearing. Although the exact number is unknown, due to the loss of the irrebuttable presumption, AHCA anticipates there will be a substantial increase in the number of hearings to determine the Medicaid recovery allocation.[18] The bill mitigates those costs by requiring the hearings to be brought in DOAH, having venue in Leon County, and setting a burden of proof (clear and convincing evidence). The amount of that mitigation is indeterminate.

AHCA and the DOAH may experience a workload increase. AHCA is not requesting additional resources. AHCA plans to review the workload impacts and request a Legislative Budget Request for Fiscal Year 2014-2015 if the workload cannot be absorbed within existing resources.

[16] Agency for Health Care Administration, *Bill Analysis Relating to Proposed Amendment of Section 409.910(17), Florida Statutes* (April 11, 2013) on file with the Health and Human Services Committee staff.
[17] Id. The federal portion of these recoveries (57.73%) is returned to the Federal Government with the remainder is retained by the state.
[18] Id.

Florida Agency for Health Care Administration, Bill Analysis of Proposed Amendment § 409.910 (17), Florida Statues

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

Bill Analysis Relating to Proposed Amendment of Section 409.910(17), Florida Statutes

The following summarizes the implications of the recent decision of the United States Supreme Court in *Wos v. E.M.A. ex rel. Johnson*, ___ U.S. ____, 2013 WL 1131709 (U.S. March 20, 2013), on the efforts of the Florida Agency for Health Care Administration ("AHCA" or the "Agency") to recover benefits of a liable third party for medical assistance paid by Medicaid. It further summarizes the proposed amendment to section 409.910(17), and the bases for those proposed changes in light of the *Wos* opinion.

A. Medicaid Third Party Liability Act, section 409.910, Florida Statutes

Once AHCA has provided medical assistance under the Medicaid program, Florida law requires the Agency to "seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid . . . ." Section 409.910(4), Florida Statutes. Where the recipient receives a judgment, award, or settlement in an action in tort against a third party, AHCA is entitled to the lesser of thirty seven and one half percent of the total recovery or the "total amount of medical assistance paid by Medicaid." Section 409.910(11)(f), Fla. Stat.

A Florida Medicaid recipient who receives third-party benefits for medical assistance "is required either to pay the agency, within 60 days after receipt of settlement proceeds, the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in a trust account for the benefit of the agency pending judicial or administrative determination of the agency's right thereto." Section 409.910(17), Fla. Stat.

Prior to the United States Supreme Court's opinion in *Wos*, AHCA has taken the position that section 409.910(17), Florida Statutes, does not afford Medicaid recipients the right to challenge the percentage of medical expenses (i.e., 37.5% of the total recovery) allocated pursuant to Section 409.910(11)(f), Fla. Stat. In other words, that percentage has been treated as an irrebuttable presumption. Rather, hearings were afforded only for the limited purpose of determining whether the Medicaid lien was correctly calculated using the formula set forth in section 409.910(11)(f). Thus, the legal expense of staffing such hearings was minimal, and few hearings were requested or granted by Florida courts.

B. *Wos v. E.M.A.*

The Wos case involved a North Carolina Medicaid recipient (E.M.A.) who brought a medical malpractice lawsuit against the physician, seeking damages for birth-related injuries requiring ongoing medical care paid for in part by North Carolina's Medicaid program.

Like Florida, North Carolina's Medicaid third-party liability statute provides that the state will be paid from a tort settlement or judgment the lesser of the total amount expended on the recipient's

behalf by North Carolina's Medicaid program or 33% of the total settlement or judgment amount, an irrebuttable presumption. *See* N. C. Gen. Stat. Ann. §108A–57(a). In approving the settlement agreement, the court ordered that one-third of the $2.8 million recovered by E.M.A. be placed in escrow while the amount owed to North Carolina's Medicaid program was determined. E.M.A. and her parents filed a Section 1983 action in federal court arguing that North Carolina's statute violated the federal Medicaid Act's anti-lien provision. The district court upheld the constitutionality of North Carolina's statute, which decision was reversed by the federal intermediate appellate court. North Carolina appealed to the U.S. Supreme Court.

The Supreme Court held that North Carolina's statute was preempted by the federal anti-lien provision due to the fact that the state statute created "an irrebuttable, one-size-fits-all statutory presumption" that one-third of a tort recovery is attributable to medical expenses. Such an irrebuttable presumption was found to be "incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recover except the share that is attributable to medical expenses."[1]

The Court noted that it is not necessary to estimate of the amount of medical assistance received by the recipient "when there has been a judicial finding or approval of an allocation between medical and non-medical damages – in the form of either a jury verdict, court decree, or stipulation binding upon all parties."

Following *Wos*, Florida will no longer be entitled to apply the formula set forth in section 409.910(17)(f), Fla. Stat., as an irrebuttable presumption. Rather, if a settlement is reached prior to trial and entry of final judgment – which occurs in most medical malpractice, slip and fall and other claims involving medical expenses -- the Medicaid recipient will be entitled to an evidentiary hearing to determine what percentage of his/her recovery should be apportioned to medical expenses (as opposed to attorney's fees and cost, pain and suffering, lost wages, etc.) and is, therefore, subject to the State's Medicaid lien. In essence, this hearing would adjudicate the issue of what types of damages, and the amount of damages per type, the recipient would have received had he/she been successful at trial. Thus, the scope of the evidentiary hearing would be close in scope, and potential expense, with AHCA bearing the burden of proof that the plaintiff/recipient would have born had the case gone to trial. These evidentiary hearings will be requested in the state circuit courts in which the underlying lawsuit was filed, resulting in the additional expense of AHCA's Office of General Counsel attorneys, or outside counsel representing the Agency, having to defend its Medicaid liens in circuit courts everywhere in the state from the Panhandle to the Florida Keys.

C. Summary of Proposed Amendment to section 409.910(17), Florida Statutes

Although the additional expense of providing evidentiary hearings to adjudicate the proper percentage allocation of medical expense to other damage types cannot be avoided following the decision of the United States Supreme Court in *Wos v. E.M.A. ex rel. Johnson*, ___ U.S. ____, 2013 WL 1131709 (U.S. March 20, 2013) – these expenses can be mitigated. The proposed amendment to section 409.910(17) proposes the following cost saving provisions:

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[1] The federal Medicaid Act requires states to have in effect laws pursuant to which states have the right to recover third party benefits for medical assistance provided by the state Medicaid program. *See* 42 U.S.C. § 1396a(a)(25)(H). Federal law also mandates that state Medicaid programs must require recipients to assign to the state any rights the recipient has to benefits from third parties related to medical care. *See* 42 U.S.C. § 1396k(a)(1)(A). Notwithstanding the foregoing provisions, the Medicaid Act's "anti-lien provision" prohibits states from imposing a lien on the property of a recipient prior to his death on account of medical assistance provided by the state's Medicaid program. *See* 42 U.S.C. § 1396p(a)(1).

- Requiring all challenges to the (now rebuttable) presumptive percentage allocations set forth in subpart 11(f) must be adjudicated in DOAH administrative proceedings – which setting will be less expensive for both the State, and the recipients, given the less formal nature of administrative tribunals, relaxed discovery and evidentiary rules, etc. The amendment requires that such challenges be adjudicated in Leon County in DOAH, and that appeals be adjudicated in the First District Court of Appeals, thereby greatly reducing the expenses and logistical problems that would otherwise be borne by the Agency in adjudicating these issues across the state.
- Shifting the burden of proof to the Petitioner seeking to challenge the rebuttable presumption set forth in subpart 11(f), and imposing an evidentiary burden of clear and convincing evidence on the petitioner, thereby reducing expenses to the State in defending Medicaid liens and increasing the likelihood the State will prevail in defending Medicaid liens (which are credited to the State's general revenue funds when collected).
- Allowing the Agency to rely on its own fiscal records as prima facie proof (i.e., a rebuttable presumption of correctness) as to the amount of the Medicaid lien, thereby reducing the expense and staff time that would otherwise be involved in proving that fact in the required evidentiary proceeding.
- Both the State and the recipient-petition will be required to bear their own attorney's fees and costs, thereby providing greater certainty in budgeting the expenditure relating to the TPL program.
- The Agency anticipates that this amendment could reasonably result in an increase in TPL collections per year over what would be collected in the enforcement of Medicaid liens absent the amendment.

Fiscal Analysis

The true impact of the *Wos v. E.M.A.* opinion is unknown. The Agency anticipates there will be a substantial increase in the number of hearings to determine Medicaid's allocation. In the previous twelve (12) months, March 2012 – February 2013, the Agency's TPL vendor closed 4,093 casualty cases, 302 of which were closed as a result of the calculations based upon the formula contained in s. 409.910(11)(f), F.S.

Casualty Cases: March 2012 – February 2013

Number of Casualty Cases Closed	Number of Casualty Cases Closed Where the Statutory Formula was Applied	Original Medicaid Lien Amount of the 302 Closed Cases	Amount Recovered on the 302 Closed Cases	Percentage of Medicaid Lien Recovered
4,093	302	$19,278,874.89	$4,902,833.21	25.43%

The number of TPL cases that could potentially be impacted by this decision is based on recent data from the Agency's TPL vendor. During the past twelve months a total of 302 cases were closed utilizing the statutory formula. Of the 302 closed cases where the formula was applied, Xerox attended or staffed 62 hearings. The Medicaid lien totals on the 302 cases were $19.2 million of which after the formula was applied, the agency received only $4.9 million.

The estimated loss of TPL collections that could be experienced due to this recent decision is $5 million. This is the worst case scenario assuming all 302 cases would go to hearing with no potential for collection. The federal portion of these recoveries (57.73%) is returned to the Federal Government and the state portion is utilized by the Legislature to fund Medicaid administrative activities.

If there is no change to 409.910(17), F.S., it is estimated that the TPL vendor will experience increased costs to staff the anticipated increase in the number of judicial hearings. Xerox staffed 62 hearings within the last twelve months in circuit court, at a cost of approximately $298,470 – which equates to approximately $5,000 per hearing. It is assumed that all 302 cases where the "formula" was applied would go to hearing, resulting in additional costs of $1,510,000.

If the proposed changes to s. 409.910(17), F.S., are implemented, administrative hearings will place the burden of proof on the Medicaid recipient to prove that the Agency's Medicaid lien allocation is incorrect and it is more likely that the Agency will prevail in those hearings. The loss to TPL collections would be less than the estimated $5 million if no change to the statutes is adopted.

Administrative hearings conducted in a home venue will reduce the TPL vendor's expenses and potentially avoid scheduling conflicts in judicial hearings throughout the State. There will be a workload increase experienced at the Agency and at the Division of Administrative Hearing to conduct the hearings. The Agency is not requesting additional resources at this time but will review the workload impacts and request a Legislative Budget Request for fiscal year 2014-2015 if the workload cannot be absorbed.

United States Congress,
Senate Amendments to House Amendments,
Bipartisan Budget Act of 2018
(February 9, 2018)

In the Senate of the United States,

FEBRUARY 9 (legislative day, FEBRUARY 8), 2018.

Resolved, That the bill from the House of Representatives (H.R. 1892) entitled "An Act to amend title 4, United States Code, to provide for the flying of the flag at half-staff in the event of the death of a first responder in the line of duty.", do pass with the following

SENATE AMENDMENT TO HOUSE AMENDMENT TO SENATE AMENDMENT:

In lieu of the matter proposed to be inserted, insert the following:

SECTION 1. SHORT TITLE.

(a) *SHORT TITLE.—This Act may be cited as the* "*Bipartisan Budget Act of 2018*".

DIVISION *B—SUPPLEMENTAL APPROPRIATIONS, TAX RELIEF, AND MEDICAID CHANGES RELATING TO CERTAIN DISASTERS AND FURTHER EXTENSION OF CONTINUING APPROPRIATIONS*

SUBDIVISION 1—FURTHER ADDITIONAL SUPPLEMENTAL APPROPRIATIONS FOR DISASTER RELIEF REQUIREMENTS ACT, 2018

The following sums in this subdivision are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2018 and for other purposes, namely:

SEC. 53102. THIRD PARTY LIABILITY IN MEDICAID AND CHIP.

(a) MODIFICATION OF THIRD PARTY LIABILITY RULES RELATED TO SPECIAL TREATMENT OF CERTAIN TYPES OF CARE AND PAYMENTS.—

(1) IN GENERAL.—Section 1902(a)(25)(E) of the Social Security Act (42 U.S.C. 1396a(a)(25)(E)) is amended, in the matter preceding clause (i), by striking "prenatal or".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(b) DELAY IN EFFECTIVE DATE AND REPEAL OF CERTAIN BIPARTISAN BUDGET ACT OF 2013 AMENDMENTS.—

(1) REPEAL.—Effective as of September 30, 2017, subsection (b) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note) (including any amendments made by such subsection) is repealed and the provisions amended by such subsection shall be applied and administered as if such amendments had never been enacted.

(2) DELAY IN EFFECTIVE DATE.—Subsection (c) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note) is amended to read as follows:

"(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 2019.".

(3) EFFECTIVE DATE; TREATMENT.—The repeal and amendment made by this subsection shall take effect as if enacted on September 30, 2017, and shall apply with respect to any open claims, including claims pending, generated, or filed, after such date. The amendments made by subsections (a) and (b) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note) that took effect on October 1, 2017, are null and void and section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) shall be applied and administered as if such amendments had not taken effect on such date.

(c) GAO STUDY AND REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit a report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the impacts of the amendments made by subsections (a)(1) and (b)(2), including—

(1) the impact, or potential effect, of such amendments on access to prenatal and preventive pediatric care (including early and periodic screening, diagnostic, and treatment services) covered under State plans under such title (or waivers of such plans);

(2) the impact, or potential effect, of such amendments on access to services covered under such plans or waivers for individuals on whose behalf child support enforcement is being carried out by a State agency under part D of title IV of such Act; and

(3) the impact, or potential effect, on providers of services under such plans or waivers of delays in payment or related issues that result from such amendments.

(d) APPLICATION TO CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B) through (R) as subparagraphs (C) through (S), respectively; and

(B) by inserting after subparagraph (A) the following new subparagraph:

"(B) Section 1902(a)(25) (relating to third party liability).".

(2) MANDATORY REPORTING.—Section 1902(a)(25)(I)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

(A) by striking "medical assistance under the State plan" and inserting "medical assistance under a State plan (or under a waiver of the plan)";

(B) by striking "(and, at State option, child" and inserting "and child"; and

(C) by striking "title XXI)" and inserting "title XXI".